World Council of Churches
Revised and reprinted in Switzerland, 1999
Cluster on Issues and Theme s
Mission and Evangelis m: Health & Healing
P.O. Box 2100
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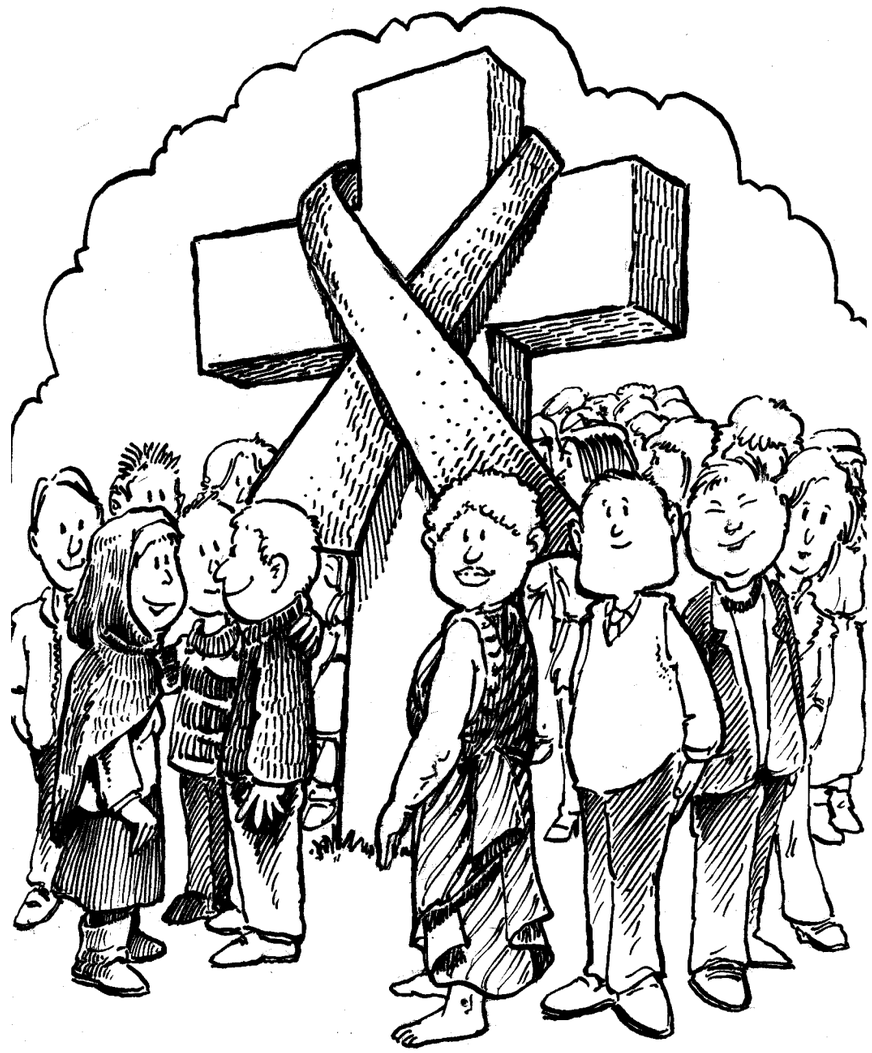
FACING AIDS

Education in the Context of Vulnerability HIV/AIDS



STUDY DOCUMENT AND STATEMENT ON HIV/SIDA

WORLD COUNCIL OF CHURCHES

BEFORE YOU START.....

This Study Guide accompanies the World Council of Churches' Study Document on HIV/AIDS, *"Facing Aids – The Challenge the Churches Response, 1997"*. It contains a structured framework for group learning sessions, designed to help and resource group leaders who intend to undertake HIV /AIDS awareness building. At the same time, we hope that this material will allow easier access to the Study Document itself, and will encourage people to read larger portions of it than we can offer here.

The material used here and in the Study Document is the outcome of the reflections of WCC's Consultative Group on AIDS which, over recent years, was accompanied by a team of educators, and others involved at a practical level in the churches' work on HIV/AIDS.For the four modules in this Study Guide, we have chosen the issues of

COMMUNITY,
CHANGE,
VULNERABILITY, and
CARE AND PREVENTION.

We have tried to use as broad a range of educational approaches as possible, both theoretical and experiential, and to present the material in a way that will be acceptable ecumenically.But in such a general study resource, the suggestions and activities are bound to seem more appropriate for some cultures than others. So it is not intended to be followed slavishly. The material you will find in it needs adapting for particular groups in local contexts and particular cultures, and the task of facilitator must include the initial preparation involved in adapting it to his or her own situation. This is particularly true of the Bible studies, where we only offer the texts themselves. It is also true of some of the experiential learning sessions.

In Appendix III you will find a short list of resource materials, and in Appendices IV - VI the most important texts from the Study, needed for your work. We however strongly suggest that the Facilitator has a complete copy of the WCC Study "Facing AIDS", which can be obtained from us.

Our thanks go to Francisco Ramos, Santiago de Chile, who did the illustrations for us; to all the participants in the Tübingen workshop on Education for Vulnerability; and to the community of health workers at EPES, Santiago de Chile, who have contributed so significantly to the content. Thanks as well to Jenny Roske and Gillian Paterson for helping with proofreading. When you have tried using this material, please let us know what you think of it. In the meantime, for the sake of those living with HIV, we hope you enjoy working with this new Study Guide on HIV/AIDS and Vulnerability.

Karen Anderson, EPES, Santiago de Chile
Gert Rüppell, Unit II, World Council of Churches.

Learning in the context of vulnerabil - ity, demands the readiness to acknowl - edge one's own vulnerability and thus learn together with instead of train - ing for....

SOME THOUGHTS ON HIV/AIDS – LEARNING IN THE CONTEXT OF VULNERABILITY

The prevention of HIV transmission requires first and foremost that people are properly informed about how the virus can – and cannot – be transmitted from one person to the other. The understanding of these facts should enable people to make responsible choices on how this transmission can be prevented. But information alone is not enough to determine human behaviour, which is related to deep emotions, to socio-economic conditions and to cultural and traditional norms and values. In many situations there is also a lack of freedom of choice, so that persons are prevented from acting wisely. Participatory approaches are required in which education is linked to experience. Key elements for the planning of information, education, communication (IEC) programmes are:

- the educational message must be clear and easy to comprehend, using appropriate media targeted specifically for the groups to be educated.

- the most effective educators are people directly affected by HIV/AIDS.

- the communities must be involved in identifying the cultural and social practices which increase or decrease the risk of HIV transmission, and in formulating education programmes appropriate for their situation.

- peer groups which are from the same age range, and acquainted with the social and cultural environment of the target groups, are much more effective in education than people coming from "outside".

Generally speaking, messages using fear and negative images of AIDS have not been effective in producing sustainable modification of behaviour.

STUDY PROCESS
COMMUNITY

RATIONALE :

The magnitude of the loss of lives through HIV/AIDS represents only one aspect of the tragic impact of the epidemic. The epidemic has the potential to undermine permanently the social and economic fabric of affected communities (1). For many people, HIV/AIDS has acted as a spotlight exposing and revealing the many iniquitous conditions, such as poverty and injustice, in our communities' lives which we have neglected to confront (2). As Christians we are challenged to examine the underlying realities in our churches and communities which encourage the spread of HIV/AIDS and to work to address those realities in a way which can help build or restore healthy, safe communities.

The church by its very nature as the body of Christ is called to become a healing community. This community must be a safe space of openness and acceptance; healing spaces, for sharing and telling life and death experiences. Christ's community of care should be an environment of trust and commitment, in which risks can be taken and where all members acknowledge their mutual vulnerability.

The presence of HIV/AIDS in our community, particularly but not exclusively in the church community, requires us to reflect on who we are and how we are responding to the urgent need to act for inclusiveness and justice. We are not simply called upon to offer charity to those whose physical bodies have the virus. We are challenged by our belonging to this community to acknowledge that the virus has come into our own body.

(For further study see Appendix IV)

AIMS :

TO IDENTIFY THE EFFECTS HIV/AIDS HAS ON COMMUNITY LIFE IN ALL ITS ASPECTS AND TO DEVELOP NECESSARY ACTIONS FOR BUILDING SUPPORTIVE AND HEALING COMMUNITIES.

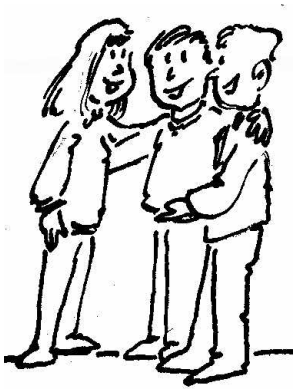
GENERAL OBJECTIVES :

(1) Participants will examine their own experience of community and their experience of the church as community,

(2) Participants will identify the reasons for brokenness in communities and discover the relationship between this brokenness and HIV/AIDS,

(3) Participants will look critically at their own communities to identify who is excluded and why this is so,

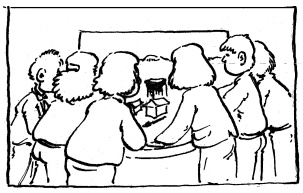
(4) Participants will discover examples of the church as a healing community and will identify concepts and actions towards inclusiveness and renewal of communities.



STUDY PROCESS
COMMUNITY

PART I : LOOKING AT OUR OWN COMMUNITIES

ACTIVITY No 1 – DISCUSSION STARTER



a) The facilitator should select 10-15 photographs and/or headlines from magazines and newspapers that reflect different positive and negative aspects of the local community. To begin have the group look at these materials and then describe together their community, its strengths and weaknesses.

b) Where it is difficult to find photographs and headlines which reflect the community, the group could draw a picture of their community on a flip chart / large piece of paper reflecting both positive and negative aspects.

A round of discussion in which each participant should be given the opportunity to comment on her/his drawings should follow this exercise.

DISCUSSION QUESTIONS :

I. From where do we start ?

1) What does community mean for you?
2) Where have you experienced community?
3) What is your experience with community?
4) What is your experience of the church as a community?
5) Identify elements of brokenness in your communities
6) Are there people living with HIV/AIDS who are members of your community?

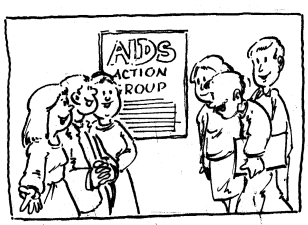
II. Broadening our perception

1) Are there specific groups of people who are not members of our community and if so what might be the reason for this?
2) Why are there broken communities?
3) What is the role of institutionalized communities such as: family neighbourhood, school, church, with regard to persons who are considered to be outsiders?

PART II : EXPERIENCING THOSE LIVING OUTSIDE OUR COMMUNITY

In Part Two the task is to find out, through experiential forms of learning, observations, dialogue and involvement with groups concerned, about their understanding of community, what the elements for community building are and also to learn how persons/groups who are excluded from a particular community understand their lives and situations.

ACTIVITY No 1



Step one) Form a small team to identify community leaders, health centres, churches etc., organizations which are working around the issue of HIV/AIDS. You may use newpapers, telephone directories or other sources of local information.

Step two) Try to make contact with persons or groups often ostracized by the church and the community in general, and also linked in the public's mind to HIV/AIDS. Examples are, prison population, gays and lesbians, commercial sex workers. It would also be important to include organizations of people living with HIV/AIDS.

STUDY PROCESS
COMMUNITY

Step three) Extend invitations to groups asking them to speak on their issues and experiences in church groups, services or council meetings and where possible make appointments to visit groups in their own spaces. Think beforehand about those questions which interest you and can generate discussion and at the same time will give you a chance to understand the problems, dreams and hopes of these persons. Remember to enter into dialogue with an open heart, ready to listen to what people are saying about their experiences.

Try to have at least two different visits. After the visits are completed the group should collectively reflect on and discuss what they have learned from the experience. What were the needs expressed by the groups, that are not being responded to? Make a list of things learned through these dialogues.

Read again the introduction to COMMUNITY. Is the community to which you belong an example of a "safe place" as referred to in the introduction? What evidence would you give for your answer?

PART III : THE BIBLE AND COMMUNITY

The centre of Christ's ministry among the rejected and neglected people of Israel is to restore their sense of belonging to the community of the people of God. In our relationship with people the first thing which is implied in a good relationship is respect for the otherness of the other, and a renunciation of domination. The second, and equally important, characteristic is the affection, love or esteem in which each holds the other. Only with that warmth of regard and sense of interconnectedness will the relationship blossom for both and flourish. Thus in the Bible it is often said that God is love; that "God so loved the world..."(John 3:16), while women and men are called to love God in their turn, and so walk in God's ways. Christ's ministry among the negelected and forgotten in his community, was an expression of this divine love.

Read together the following Biblical texts:
Mark 5: 25-34,
John 4:7-30,
Luke 14: 15-24,

In these stories, Jesus' activity shows how in the midst of pain, brokenness and decay, healing is possible. Where there is no apparent hope, where death seems the overwhelming reality, and against all obstacles, Jesus' acts create a situation, where community can be reinstated and life gains new significance.

QUESTIONS FOR DISCUSSION

Where do we find ourselves in these stories and where do we see the challenge for our congregation?

Do you know of any situation in your community where people were healed despite the medical prognosis?

What can we learn from Christ's way of interacting with people that can guide our own relationships and communication with people living with HIV/AIDS?

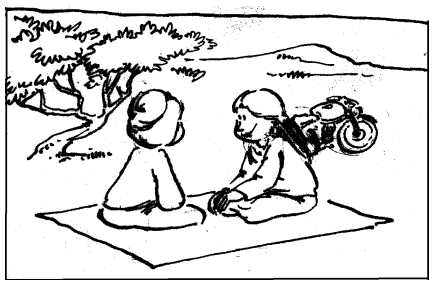
For further study see WCC Document Chapter 3: Theological Perspectives

STUDY PROCESS
COMMUNITY

PART IV : LOOKING AT COMMUNITIES OF HOPE

Read together the following stories from the WCC document:

The example from Zaire (Appendix IV)
Gay Men's Health Crisis, USA, (Appendix IV)
Project Momentum,New York City / USA (Appendix IV)
Northern Thailand, (Appendix IV)



DISCUSS THE FOLLOWING QUESTIONS:

1) How did communities become places of hope in these stories?
2) What did **you** find hopeful about these examples?
3) What did **you** find surprising?
4) How do these stories challenge **us** personally and collectively?
5) Are there examples of "communities of hope" in our own neighbourhood or community?
6) How can **we** respond to the brokenness we see around us?
7) How can **we** make our church a safe place in the time of HIV/AIDS?

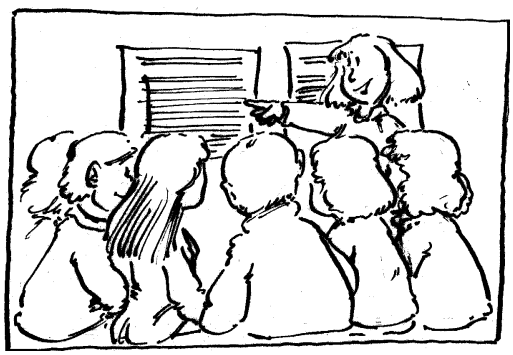
PART V : TAKING ACTION TO MAKE OUR COMMUNITY SUPPORTIVE AND HEALING

Develop a plan of action

By now the group should have:

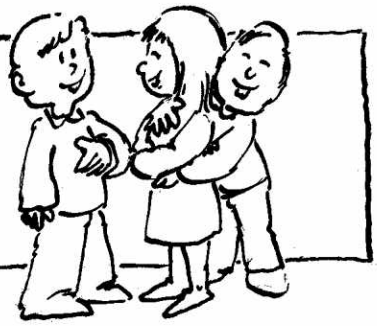
- developed an analysis of their own community or congregation;
- encountered people's hopes and dreams inside and outside the church community;
- discovered examples of communities of hope;
- reflected on the respective biblical foundations.

THE FOLLOWING STEP IS TO HELP THE GROUP MOVE FROM REFLECTION TO ACTION.



1) *Make a list of the problems you identified during your exposure visits both within your church and the broader community.*
2) *Brainstorm a list of actions which your group could take to address these problems.*
3) *List the resources which are available in your community and make a list of those which you need for your plan of action.*
4) *Commit your group to the realization of at least one action you have listed and which you will be committed to carry out.*

STUDY PROCESS
CHANGE



RATIONALE :

The impact of HIV/AIDS has brought tremendous change to the world. It has devastated the lives of many people and affected individuals, families and communities around the globe. At the same time, individuals, communities, churches and governments have come together in new and creative ways to respond to the health and social challenges of the pandemic.

In this context, some Christians and churches have addressed the problems of HIV/AIDS and human sexuality with openness, compassion and solidarity, while others have nurtured negative, judgmental and condemnatory attitudes. The time has come for all churches to examine and assess their own life and action. We are confronted with a growing need to address issues like love, human relationships and sexuality in a totally new and urgent way. We must strive to join with others in collective action to end all kinds of discrimination and the structural injustices which put people at risk for HIV/AIDS.

The church cannot be a credible witness in the context of HIV/AIDS unless it understands the nature of change in people's lives, the factors that contribute to them, as well as their fears and hopes, and is willing to change itself to become a more loving, inclusive community for all God's people.

AIMS :

TO DEVELOP AN UNDERSTANDING OF HOW HIV/AIDS HAS CHANGED AND CONTINUES TO CHANGE OUR LIVES - AS INDIVIDUALS, FAMILIES, CHURCHES, COMMUNITIES AND SOCIETIES.

TO IDENTIFY HOW WE AS INDIVIDUALS AND COMMUNITIES NEED TO CHANGE IN ORDER TO BUILD HEALTHY AND DIGNIFIED LIVES IN THE CONTEXT OF HIV/AIDS.

TO IDENTIFY THE ROLE OF THE CHURCH AND THE CHRISTIAN COMMUNITY IN PROMOTING LIFE- AFFIRMING CHANGE IN THE TIME OF HIV/AIDS.

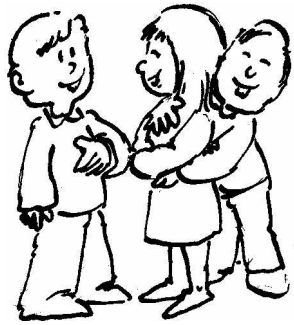
GENERAL OBJECTIVES :

(1) Participants will define change and identify how it operates in their lives.

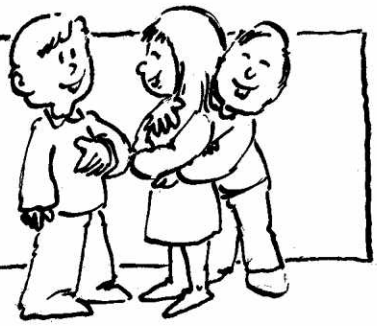
(2) Participants will describe what kind of individual and collective change is needed in the context of HIV/AIDS.

(3) Participants will explore biblical stories which provide examples of change.

(4) Participants will identify resources in the church and community to facilitate and sustain change.



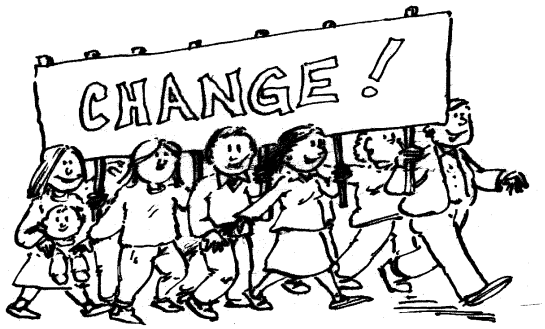
STUDY PROCESS
CHANGE



PART I : LOOKING AT CHANGE AND HOW IT AFFECTS OUR LIVES

ACTIVITY No 1

Read the following text:



CHANGE: ENTERING NEW LAND

Change and the idea of change create different responses in each of us. Change can be perceived as promising or as threatening. Whether we feel that change is basically positive or negative can depend on our personalities. If you strive for security and order, safety and control, you will resist change. Routine and stability is then what you appreciate. If you find routine boring and frightening, and you always want to see new things, change is positive, even necessary. This striving for constant changes can also be an escape from oneself, from intimacy and faithfulness; you may become very restless. Some persons are extreme on one of these sides; most of us are somewhat in between in that we want some things to change and some to remain the same.

Changes are inevitable. They happen all the time. Changes may be dramatic or gradual, and they may be profound or superficial. And they happen to each one of us in many different ways. Sometimes we have no choice, we may for instance lose our job, and our daily lives are completely changed. The structure of a society may also promote or hinder change.

Changes in our private, intimate life are also encouraged. We should eat healthier food, exercise, stop smoking, change sexual habits etc. In other societies or in other times, tradition was more important, - doing the right thing meant living as generations had done before us. " What would my grandfather have done in this situation?", is a relevant question in such societies and cultures.

In our churches, as in many other situations and especially in relation to HIV/AIDS, we want to see behavioural changes and we want to see those positive changes promoted. What then promotes change?

It may be helpful to divide the changing factors into two categories, internal and external.

Internal: Those are what we may call psychological forces, where a person balances the risk and the desires, and makes a decision in her/his mind which one to carry out.

We may call this an internal discussion between the "ought-to" and the "want-to". Through information we try to influence the person to change and thus to have an impact on the decision making process in that individual. Self control of the person is a precondition if this is going to work.

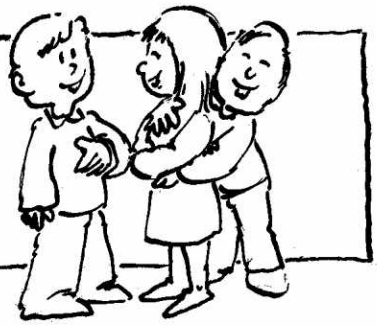
External: These are all kinds of social forces, which influence people's lives from outside. They may be media, advertisements, societal/cultural norms and most effectively group pressures and group values. They supply norms and values to the persons saying "join", "be a part of us", "come with us". We often term this "peer pressure". It is powerful, and can be very destructive, but also tremendously constructive and good, helping a person to safeguard her/his identity.

In fact, change very often happens as a form of dialogue between the internal and the external and we will have to realize the interdependence between them.

It is important to influence both these forces to promote change. Change can only happen based on the reality of our lives, not on how we ought to live.

(Excerpt from a presentation by Anne Skjelmerud,Norway, 1996)

STUDY PROCESS
CHANGE



DISCUSSION QUESTIONS:

a) Divide into small groups. The participants should discuss the above text in relation to their own experiences with change.

1) How does the author of the text describe change?
2) What were the most important changes in your life and given the two categories of the text, was this "internally" or "externally" motivated change?
3) What would you like to change in your life?
4) How will this change occur?
5) Give examples of promising and threatening change.
6) What are the obstacles to change?

Note: *Each group should select a recorder to write its answers on a flip chart/large piece of paper.*

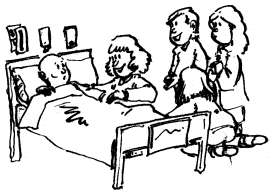
b) The small groups will return to the plenary, where each one will present the results of its discussion.
c) The facilitator will close the session by summarizing the main ideas presented by the groups.

PART II : REFLECTING ON HIV/AIDS AND CHANGE

ACTIVITY No 1

a) Divide the participants into small groups
b) Have each group read one of the following stories and reflect on these questions:

1) Who was changed in these stories?
2) Why were they changed?
3) Do you think these changes were postive or negative, for whom?
4) How did people respond to change?

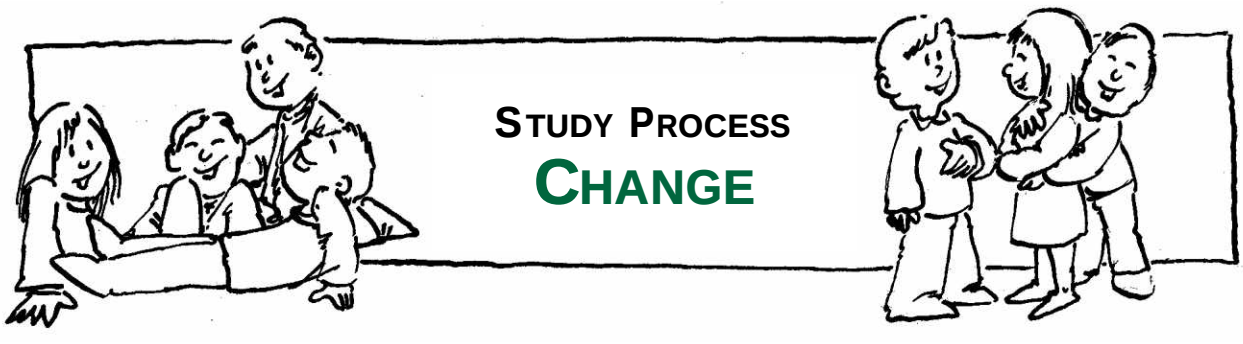


STORY 1 (a Latin American story)

A church-based community health team in Chile had worked for many years confronting common illnesses in urban shantytowns. In the early 90s, when the issue of HIV/AIDS and the vulnerability of poor communities became apparent the group decided to organize a meeting between shantytown health promoters and a large AIDS service organization run primarily by gay men. When the women health promoters arrived at the AIDS organization, many were shocked and embarrassed to see the explicit educational posters. There was a room full of nervous laughter and whispered jokes. When the meeting began, however, there was an amazing transformation as these women began to see the similarities between the discrimination suffered by the gay community and their own situation as poor women. One of the men who was living with HIV told of how he had been treated in the hospital the first time that he had been hospitalized; the nurses left his food outside the door and refused to touch him. He told of how humiliated he felt when he had first been diagnosed and one of the doctors pointed to him and said, "That one's gay, he probably has AIDS."

The women looked at each other in silence as these men explained that they had initiated their work in an effort to respond to the crisis of AIDS which was silently affecting their community and largely ignored by the wider society. It sounded so much like the reality in the shantytowns where the women have come together to deal with their own problems in the absence of governmental responses.

When the meeting was over, one of the health promoters stood up and hugged the young man with HIV. With tears in her eyes she said, "This meeting has been like waking up for me. I never knew



STUDY PROCESS
CHANGE

anything about gays before; we only made jokes about it. Now I see how closely your situation resembles ours and how much we have in common." Today, that woman heads the AIDS network in her community that unites gay organizations, churches, health teams and teachers in the work against discrimination and for health and dignity.

STORY 2 (a Uganda community/women)

"*In the Participatory Action Research Project in Kagoma, Uganda, the community started to discuss and address the issues of inequality and human rights within their local experience of HIV/AIDS.*

Through focus group discussions in the community people realized, for example, that the underprivileged status of women was a problem for the whole community to address. Girls were deprived of rights for education, which in turn made them vulnerable for sexual and economic exploitation which could make them HIV/AIDS infected. Promoting education for girls was identified as a way of reducing the infection rate. This was combined with the enforcement of sanctions against rape. The groups also started to discuss the traditional male/female roles and division of labour in the community, in order to propose changes and strategies to improve cooperation.

STORY 3 (a north american mother**)**

was having a difficult time dealing with her son's homosexuality let alone his AIDS diagnosis, so although she had never travelled alone, she made the trip without him. She didn't know any other person who was openly gay and she had never been to San Francisco before or met any of her son's friends.

However her apprehensions were quickly dispelled. She was surprised at how quickly she was accepted by his partner and their circle of friends and she was impressed by the loving support her son was receiving from all of them. For those who were estranged from their families, she soon became "Mom."

She talked about how much she had changed since she arrived. Caring for her ill son was physically and emotionally draining to be sure but she felt honoured that he was allowing her to care for him. She also felt she was learning something about herself and her relationship to her son. She spoke, as many family members have done, of feeling enriched by the experience. And while it is still difficult to accept her son's illness, she knows that she will be less afraid to talk about it with other family members and friends when she goes back to her home community" (A. Grant, A Mother's Story, Kairos News, Spring 1994, Vol 4, No. 30)

ACTIVITY No 2

In this activity the group discussion will focus on the question of how the understanding of love, intimacy and inter-personal relationships have changed in the time of HIV/AIDS. The facilitator should create a climate of trust in which people can open up and talk about their own fears, anxieties and hopes.

DISCUSSION QUESTIONS:

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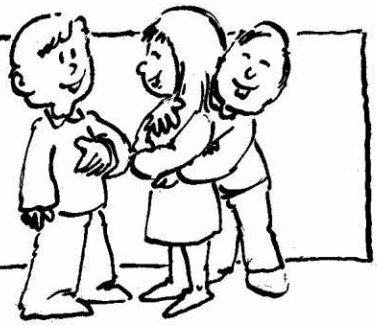
1) In what ways has HIV/AIDS changed our lives - as individuals, families, churches, communities and society?
2) Which of these changes are positive and which are negative?
3) What kinds of individual and collective changes are needed in the context of HIV/AIDS?
4) What barriers/obstacles to change exist in the church and community for youth, women, men and families?
5) What strategies can we develop to deal with these barriers/obstacles?

STUDY PROCESS
CHANGE



PART III : THE BIBLICAL UNDERSTANDING OF CHANGE

The call to change/conversion is at the core of Jesus' teaching as is reported right from the beginning of his ministry (Mk.1:14f.) It is however important to notice that the various biblical stories, which report on how the encounter with Christ has led to change, are complemented by stories, where even Christ himself is changed in the encounter with people, or where he only indicates the direction for change, leaving it to the people to follow or to reject.

These stories were preserved in the early church as concrete models for the pastoral work in discipleship. Even today that remains the central message of them. In many cases, the study of the biblical narratives will show that the call for change has often been a call to the community of disciples themselves.

The following texts for bible studies show different understandings and objects of change, in the ministry of Christ.

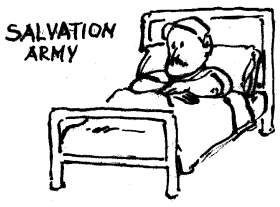
1. *Each group selects a Bible story and presents a dramatization which portrays the main ideas.*
2. *Let each group classify the kind of change which the story is reporting, and find out how it relates to the local congregation.*

Bible studies may be selected from the following:

Mark 7:24-30	The relation of object and subject in the process of change
Matthew 18:1-6	Change in the context of strong and weak
Mark 10:16-23	The risks of change
Matthew 12:1-7	Righteousness vs. change
Luke 19:1-9	Change in personal life

AFTER THE PRESENTATIONS DISCUSS THE FOLLOWING QUESTIONS:

1) What do the Bible stories teach us about change?
2) Why do people change in these stories?
3) Discuss where these Bible texts relate to our own stories of change.

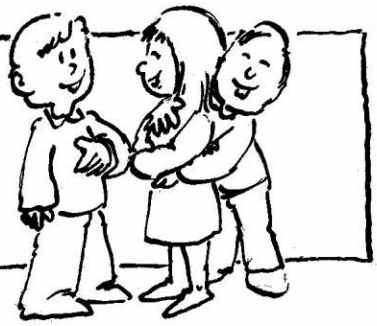


PART IV : PROMOTING LIFE AFFIRMING CHANGES

ACTIVITY No 1

a) The group is asked to explore the community for examples of positive action on change and inclusiveness.
b) Each person in the group should visit an individual, an organization and/or a church that is promoting life affirming changes related to HIV/AIDS.
c) The group is requested to interview these persons or groups informally and report their findings to the larger group. Some guidelines for discussion are found below.

STUDY PROCESS
CHANGE



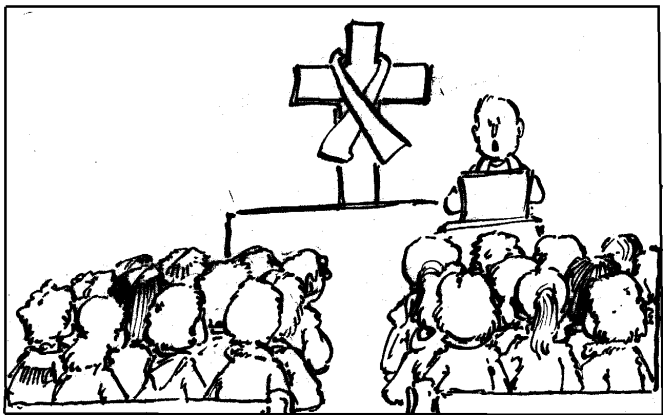
DISCUSSION QUESTIONS I

1) *What are the characteristics of these groups/individuals that make them life affirming?*
2) *Is there any relationship between these groups/individuals and your specific congregation?*
3) *Do these groups cooperate with each other?*
4) *What can we learn from these groups/individuals about change?*

DISCUSSION QUESTIONS II

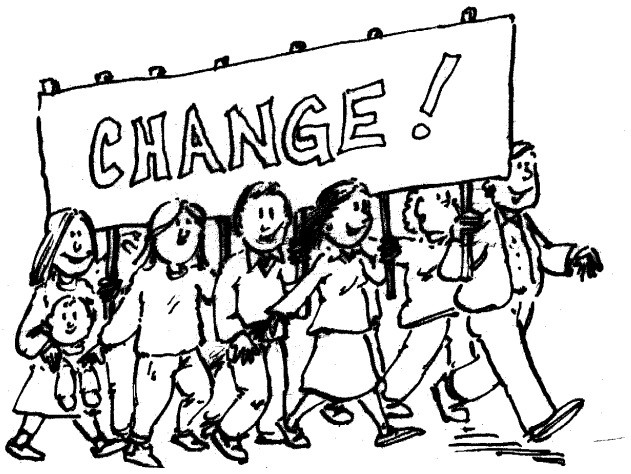
1) *What changes do we need to make in our personal lives, our churches, and in our communities in order to respond effectively to HIV/AIDS?*

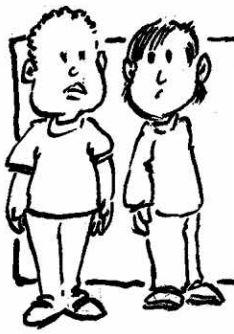
2) *How do we support each other in affecting changes?*



3) *Identify resources in the church and community which can help to facilitate and sustain change?*

4) *What obstacles to change do you see in the communities you belong to?*





Study Process
VULNERABILITY

RATIONALE :

Vulnerability means that something or someone can be hurt or wounded; it means to be exposed to danger or attack, to be unprotected. Our world today bears the signs of vulnerability through various socio-economic and cultural contexts and the trends of globalization and fragmentation that contribute to the fragility in human life and relationships.

To be vulnerable in the context of HIV/AIDS means to have limited or no control over one's risk of acquiring HIV infection or, for those already infected with or affected by HIV, to have little or no access to appropriate care and support. Vulnerability is the net result of the interplay among many factors, both personal (including biological) and societal; it can be increased by a range of cultural, educational, demographic, legal, economic and political factors.

Currently it is estimated that nine out of ten people with HIV live in areas where poverty, subordinate status of women and children, and discrimination are pre-existing.(WHO)

Racism, sexual harassment, discrimination based on gender or sexual orientation, disparities in economic situation, lack of political will, huge external and internal debts, critical health problems, illicit drug and sex trades and fragmentation and marginalization of communities all contribute to the web of global problems that intensify the VULNERABILITY of human communities to HIV/AIDS.

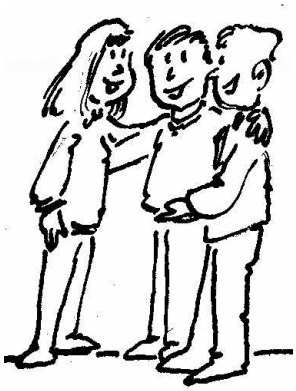
The reality of HIV/AIDS challenges the church to recognize and respond to this situation by addressing the underlying issues of inequality and injustice that have created the conditions for the spread of HIV infection and AIDS. We are called to acknowledge the vulnerability in each one of us and our communities, moving beyond the notion of individual risk, to a new understanding of social vulnerability as crucial not only to our comprehension of the dynamic of the epidemic, but to any strategy capable of diminishing its advance. As churches we are in particular challenged to address the issues and act in light of the inclusive nature of the gospel.

Vulnerability is usually seen as a negative term. However, it contains the possibility of an awareness - an awakening capacity - which may be described as "healthy vulnerability". This implies that we are aware of the limits to strength and power, to growth and success, to our capacities. We must accept that the virus affects us as a community. We are not called to simply offer charity, but we are challenged to see that as we all belong to the body of Christ the suffering caused by HIV/AIDS affects all of us. We must recognize that the crisis of AIDS is our crisis and as such, "Our church has AIDS".

AIMS :

To understand HIV/AIDS as an expression of a fragmented world

To identify the various forms of vulnerability that put us at risk for HIV/AIDS



GENERAL OBJECTIVES :

- ***Participants will identify experiences of vulnerability including situations of powerlessness in their own lives and in their community***

STUDY PROCESS
VULNERABILITY

- ***Participants will explore their own fear and vulnerability related to HIV/AIDS.***
- ***Participants will examine the social,political, economic and cultural factors which enhance the vulnerability of people to HIV/AIDS.***
- ***Participants will explore ways to cope with HIV/AIDS through reflecting on biblical texts which address vulnerability, powerlessness and empowerment.***

PART I : LOOKING AT VULNERABILITY

ACTIVITY No. 1 – DISCUSSION

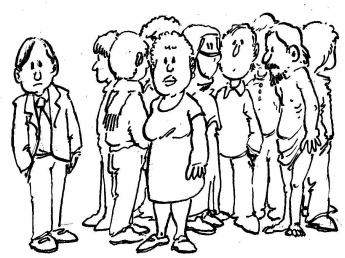
Divide into groups and discuss, writing your findings onto a piece of paper:

* What does it mean to be vulnerable?
* What other word can you use for it?

ACTIVITY No. 2 – GROUP ACTIVITY

Develop *a collage with images of vulnerability. Cut out items from newspapers and magazines which reflect this idea (as an alternative markers or crayons should be provided to draw these images).*

Follow-up *collage: Look at the different aspects of vulnerability, and how they influence you as an individual, and the community.*



ACTIVITY No. 3

Read the statement from the rationale: Current estimates indicate that nine out of ten people with HIV live in areas where poverty, subordinate status of women and children, and discrimination are pre-existing.

For further reading, the group may look at the (Appendix, Vulnerability, 1)

Reflect on the text and give your reactions and comments on it.

DISCUSSION QUESTIONS :

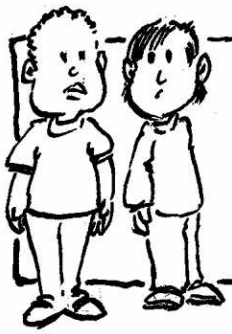
1) Who are the most vulnerable persons in your community?
2) Have these people traditionally been accepted in your church? Explain.
3) Why are people in poor communities more vulnerable to HIV/AIDS?

PART II : LOOKING AT THE RELATIONSHIP BETWEEN HIV/AIDS AND VULNERABILITY

ACTIVITY No. 1:

The group should divide into small groups and read the following story:

"A young girl from a hill tribe in Asia leaves her family to find a job in the big city. Her parents urge her to do that, because they are very poor and cannot survive without additional income as they are subsistence farmers and the prices for their produce are very low.



STUDY PROCESS
VULNERABILITY

GROUP DISCUSSION :

Have the group invent the rest of the story.
What happens to this girl?

After this discussion read the rest of the **TRUE** story:

"In the city, the girl is put into a brothel where many girls are held in captivity by a wealthy brothel owner. Most of the money from the clients goes to the brothel owner, but she manages to send small amounts of money to her family at home.

The brothel is regularly visited by rich men from the city and also by sex tourists coming from different countries, abusing the girls for their personal pleasure. The HIV infection rate among the girls is very high, as many of the clients are HIV infected and pass the virus on to them as they in turn pass it on to other clients."

GROUP DISCUSSION :

1) Compare this ending to the story invented by the group. Were they similar? Why or why not?
2) Identify four factors which have put this young girl at risk for HIV/AIDS.
3) How does this situation make you feel?
4) What can/should be done to help protect this young girl's life and the lives of other girls like her?
5) Do situations like this exist in your community? If not, what situations in your community make women vulnerable to HIV/AIDS?

Let the group develop or share a story from their own locality which would also demonstrate the interplay of factors that leads to vulnerability. Afterwards the group meets in plenary to share the results of their discussions and evaluate the session.

ACTIVITY No. 2

Alternative or additional story about women and vulnerability:

WOMAN, SOUTH PACIFIC: "I was aware my husband was having casual sex when not with me, but I was too ashamed to ask him to take precautions. I kept telling myself, next time. My advice to young mothers is, 'Don't ever wait for next time.' Now I have big regrets. I'm so lucky that I didn't have any more children after I was infected." (Facing the challenges of HIV/AIDS/STDs: A Gender-based response, Royal Tropical Institute (KIT), Amsterdam, l995, p 16).

1) Discuss the factors that make it difficult for this woman to protect herself.
2) Identify comparable situations in your community.
3) How do such situations make you feel?
4) What can be done to help women protect themselves from HIV/AIDS?

For further study and ideas for action read the:
Ecumenical Platform of Action - Women's Health and the Challenge of HIV/AIDS from the Study Document .

Study Process
VULNERABILITY

ACTIVITY No. 3

"We went together to tell his Mum and Dad that he had HIV, but first, the most difficult, to say that he is homosexual. Then we found ourselves propelled to the door, if not physically manhandled, certainly ejected by the torrent of disgust and vindictiveness. Then we were backing down the neat, patterned tile path. His mother screaming, 'The sooner you are dead the better,' and his father, red faced and eyes bulging, slammed the door shut on us.

In the shocking silence I hear the first time his urgent, despairing pleading which I realize he has been repeating throughout. 'But I need you, I'm dying, I love you, I'm afraid, I need you, need you...'

I couldn't get the key into the lock of the car door at first, but anyway he walked on, unseeing except for his misery and abandonment. He walked on, and I sat down in the gutter and wept."

(Testimony from: A Gift Wrapped in Thorns? Cara Trust (1995), London, England).

QUESTIONS FOR DISCUSSION:

1) How did you feel about this story? Who do you relate to in the story? The son, the parents or the friend?
2) How do you explain the parents' reaction? How do you explain the son's reaction?
3) Is anyone to blame? If so, who?
4) In what ways will this reaction affect the son? How does this situation make him more vulnerable?
5) What services does the son need now? What services do the parents need?

PART III : BIBLICAL REFLECTIONS ON VULNERABILITY, HOPE & HEALING

Vulnerability is a theme in the Bible which very often is reported in connection with discipleship, obeying to the call of God. The prophets as well as the apostles show that standing against the dominant understanding of religion and society brings one into conflict with the ruling powers.

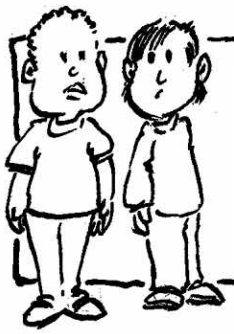
There is also a whole set of stories which show vulnerability as illness or obsession by demons, which needed the healing intervention of Jesus to restore life. All these stories have in common the fact that life-affirming action comes through support from outside.

But as you look at the biblical records, you will also discover that Jesus himself was vulnerable and was saved by the actions of others.

While reading the biblical texts indicated below, try to discover the message that vulnerability addresses for the "non-vulnerable" and identify the forces which caused the vulnerability. What meaning does this have for your local congregation and its activity in the context of vulnerability?

1.Kg 21	Naboth's vineyard	Is. 53	The suffering servant
Jer. 37	Jeremiah in prison		
Mtt. 2:1-15	Child murder at Bethlehem.	Matt 26,69-75	Peter's denial.
Luke 22: 39-46	Jesus in Gethsemane	Acts 16	Paul and Silas in prison

(Study in this context the Appendix V, 2)



STUDY PROCESS
VULNERABILITY

PART IV : THE CHURCH: AGENT FOR CHANGE IN THE CONTEXT OF VULNERABILITY

ACTIVITY No. 1 – AIDS & SILENCE.

Read and discuss the following story:

"I was increasingly convinced that AIDS was a disease that shines in hush and thrives on secrecy. It was prospering because people chose not to talk about it...The quieter we keep it the more it will affect and stigmatize, especially while people believe that AIDS affects some people and not others.

I reasoned that if people could see how it affected us, an ordinary average family, they would understand the importance of coming out. If it could happen to us, it could happen to anybody.

The support that I received after my husband died was in response to my coming out." (in the open)

DISCUSSION QUESTIONS:

1) Are there situations regarding HIV/AIDS in our own communities in which we have remained silent? If so, why?

2) What happens to people and families when their realities are kept in silence? How does silence make people vulnerable?

3) Referring to this story: discuss the relationship between "coming out" and receiving support. What risks did she have to take to come out? In what way did her coming out affect her surroundings, such as other people with HIV, or her own relationships?

4) What role can and should the church play in overcoming silence?

ACTIVITY No. 2

To prepare for this activity the facilitator should make placards with the following statements

1) "WE DON'T WANT A HOSPICE IN OUR NEIGHBOURHOOD FOR PERSONS WITH AIDS"
2) "I WON'T SEND MY CHILDREN TO SCHOOL BECAUSE THERE IS A CHILD WITH AIDS"
3) "I DON'T WANT MY CHILDREN TO RECEIVE SEX EDUCATION BECAUSE IT ONLY PROMOTES EARLY SEXUAL ACTIVITY"
4) "OUR CHURCH MADE BADGES WHICH SAID 'OUR CHURCH HAS AIDS'"
5) "OUR CHURCH IS LOANING ITS BASEMENT SPACE TO 'POSITIVE LIVING' A GROUP OF MEN AND WOMEN WHO ARE HIV+"
6) "OUR CHURCH BULLETIN STATES: WE WELCOME PEOPLE OF ALL SEXUAL ORIENTATIONS"

To begin the session the facilitator should distribute the placards to different people. Form a large circle and ask the person with placard number one to walk across the circle holding the placard high in the air. Have him/her walk several times around the inside of the circle so that everyone can see the statement. Open the discussion using the following questions:

DISCUSSION

1) Does this statement make people vulnerable? Who is vulnerable?
2) Does this statement empower or protect people? Who?
3) Has anything like this happened in your community? Why or why not?

STUDY PROCESS
VULNERABILITY

4) How do you feel about this statement? What impact does this have on the community?
5) How can we respond to this statement?

Repeat the process with the remaining five placards. For statement number three add the question:

6) Do you think this is true? Why or why not?

Finish the session by having the group brainstorm a list of all the factors in their own communities which make people vulnerable to HIV/AIDS and all the factors which help reduce vulnerability to HIV/AIDS.

PART V : ACTING IN THE CONTEXT OF VULNERABILITY

Read together the conclusion of the WCC Study Document, Part VII. **WHAT THE CHURCHES CAN DO**. Then divide into small groups and have each group develop an action plan based on the needs in their own community. Record each work plan on a flip chart/large piece of paper so that it can be shared with the whole group at the end of the session.

Follow the seven steps of planning to develop a concrete plan:

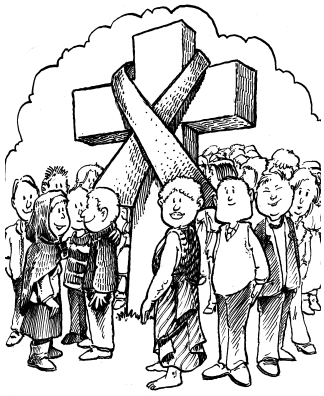
1. **Diagnosis.** What are the problems? What are the needs?
2. What do we want to achieve (**objective**) in a particular period? This week, this month, this year?
3. What are the possible ways of achieving this objective? Brainstorm for proposals.
4. What are the advantages and disadvantages of each proposal? How much time, money and personal effort will be needed for each proposal?
5. Which proposal (**plan**) do we accept? This may include several suggestions.
6. Who will do what, when, where and how?
7. At what point do we need to evaluate? Who should be involved in the evaluation?

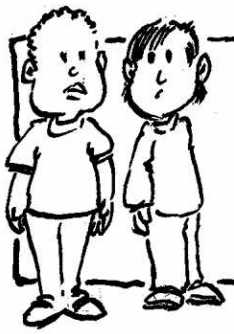
(Taken from: Hope, A. and Timmel, S. (I984). Training for Transformation: A Handbook for Community Workers (Book 2). Zimbabwe, Mambo Press).

In the plenary session, each small group will present its work plan. Discuss the different presentations and select at least one activity to implement. Organize a follow-up meeting to begin the implementation of the work plan.

ACTIVITY No. 4

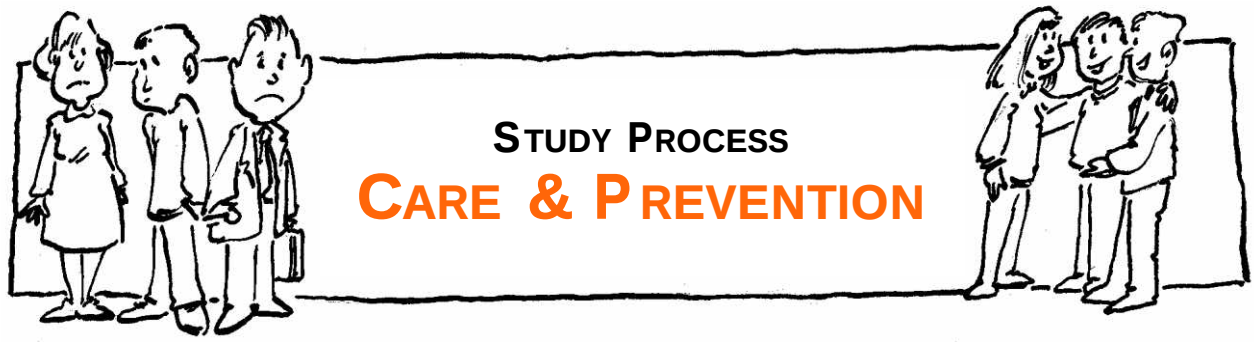
In light of the insights gained during this process organize a liturgy to remember those who have died of HIV/AIDS and those who live with HIV/AIDS. Invite people in your community living with HIV/AIDS to help plan the service.





Study Process

VULNERABILITY



STUDY PROCESS

CARE & PREVENTION

RATIONALE :

The church as the body of Christ is expected to give both spiritual direction and moral guidance within its own communities and beyond. Such direction and guidance need to be given in caring love for the individual and in recognition of the value and dignity which each human being has in the face of God. Thus it is important to acknowledge, that the church is the communion of the one body with many members, each distinct: "God so arranged the body that there may be no dissension within it, but the members may have the same care for one another. If one member suffers, all suffer together with it; if one member is honoured, all rejoice together with it. Now you are the Body of Christ and individually members of it" (I.Cor.12:25-27).

It is when the church adequately responds to the suffering, sick, to people living with HIV/AIDS, when it ministers to and learns from them - that the relationship between the church and such persons will indeed "make a difference", and thus become "growth-producing". Through this relationship we are pushed back on ourselves, because in the Gospels we are required to love as a demand, a requirement, not an option.

In this context the rapid growth of HIV/AIDS has sharply raised the question of the caring quality of the local congregation. HIV/AIDS becomes a testing ground for the pastoral capacity of a congregation. Providing comprehensive physical, emotional and spiritual care and support for people living with HIV/AIDS and their families helps limit the impact of the pandemic. As HIV/AIDS expands, the need for preventive education, medical care, counselling and adequate social services also increases. The church is called to act with compassion and to work for justice to respond to these needs at the local, national and global level. The church can work with and for people living with HIV/AIDS in working to speak the truth and to work against discrimination and social injustice, and in that it can contribute to prevention.

The HIV/AIDS pandemic challenges the church to rediscover and strengthen its ministry to those under threat of death, or dying. It believes, that hope is not lost when a person is infected with HIV; it believes that the spiritual resources of the church can be used to help people to accept, and to come to terms with their own mortality.Where such caring is exercised it also becomes an act of prevention . As St. Basil the Great has taught, the church needs to create an atmosphere of openness and acceptance, where goodness and love can prevail in the community and thus love will issue forth in the lives of the human community as a whole.

In living as a caring community, and in facilitating change in the personal as well, as in the socio-economic and cultural-political arena, the church thus can develop practical approaches to HIV/AIDS which contribute to prevention. It is through caring with and about people that changes happen in attitudes and behaviour and in the environment. There is a link between the care process and peoples response, through which they move towards their own change and healing. In doing so they prevent HIV/AIDS from speading and find hope for the future of their families and communities. The nature of true and loving care is to be *transforming* and this is what they are living out (SD 83)

AIMS :

- TO UNDERSTAND THE LINK BETWEEN CARE AND PREVENTION AND TO ACCEPT THE PRACTICAL AND SPIRITUAL CHALLENGE OF BECOMING A HEALING COMMUNITY
- TO REFLECT ON THE DYNAMIC ROLE OF COMPASSION IN CARE AND PREVENTION FINDING EXPRESSION IN "LOVE IN ACTION".

STUDY PROCESS
CARE & PREVENTION

GENERAL OBJECTIVES :

- ***The participants will reflect on what the Bible teaches about care and prevention.***
- ***Participants will become aware of the needs of the people living with HIV/AIDS in their own community.***
- ***Participants should identify practical ways through which the church can become active in care and prevention.***
- ***Participants will seek ways to develop or strengthen programmes of prevention and care in the community.***
- ***Participants will explore the variety of approaches to healing and the link between liturgy and healing.***

PART I : LOOKING AT CARE AND PREVENTION IN OUR OWN COMMUNITY .

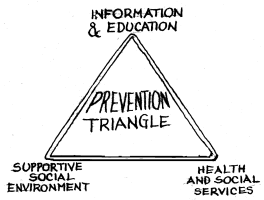
ACTIVITY No. 1 – FROM WHERE WE START

Group activity

Note: The Facilitator should provide large sheets of paper /flipchart, for the participants to work with during this session, prepare the text as a "hand out" and draw the "Triangle" on a large piece of paper.

1. Divide participants into groups and ask them to write their understanding of and experiences with care and prevention on the flipchart. Ask the group to concentrate on HIV/AIDS and provide a list of the needs they think people living with HIV/AIDS have.
2. Aterwards share the results in a discussion and make a list of the prevention messages and programmes that the group is aware of in their community.

ACTIVITY No. 2



Read and discuss the following statement before you do the next activity, as background information

"Prevention activities over the past decade all over the world have shown that prevention can work if it includes the following three essential elements:

Information and education about modes of HIV transmission and information on how to avoid becoming infected. Most effective if the messages are directed towards specific target populations.

Health and Social Services: Services include counselling, testing, treatment programmes for injection drug users, support programmes and condoms. Effectiveness depends on whether the services are geographically accessible, financially affordable, occur in a favourable environment, delivered by skilled personnel, sustainable over time.

Supportive social environment: the term empowerment is useful to describe the process through which invididuals assume for themselves the power to determine their behaviour. (Mann, et.al. (1992), AIDS in the World, Cambridge, MA: Harvard)

ACTIVITY No. 3 – Group activity

Participants are sent out to visit the community and to find out:

STUDY PROCESS
CARE & PREVENTION

- What forms of care and prevention work are available in your community/congregation?
- Who is involved? Interview care receivers and care givers.
- What kinds of needs and resources do you discover from this?
- What lessons have been learned? How have people providing or receiving care experienced this?

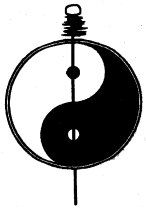
When the participants return share with each other

- What kinds of needs and resources did you discover during your visits?
- What lessons have been learned?
- What have been the experiences of people providing or receiving care?
- How do we understand the alternative approaches in light of the prevention triangle? What needs are being met?
- How do these methods complement or contradict our own beliefs and practices?
- Is everyone in need of care receiving an equal share of it? (quality and equality of care).
- Who is providing care?

Draw a graph which contains a structural picture of the total findings of the group. (sociogram)

ACTIVITY No. 4 – WE and OTHERS

GROUP EXERCISE:



Step 1: Explore alternative modes of healing and care available in your or neighbouring communities.

Step 2: Invite a speaker who is involved in traditional or alternative healing to make a presentation in your church.

Step 3: As follow-up of this experience discuss among your group how this relates to the experiences you have made during your visits.

You may find a number of "traditional" forms of healing, the following lists some:

Naturopathy: A system of medicine which looks at the whole person - body, mind and spirit in the context of his/her natural environment and in relationship with it. It uses what is naturally available, with the minimum amount of necessary modification, to promote health, build up stamina and body resistance, and prevent diseases.

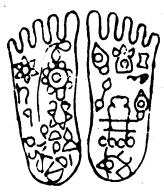
Herbal Medicine: The use of plants to facilitate the return of the body's balance to normal or to relieve fever and headache and other body pains. Herbal medicine comes in decoction, infusion, tincture, as oil extracts.

Homeopathy: A system of medicine formulated in the rule, "Let likes be treated by likes". Homeopathy treats the patient, not the disease.

Pranic healing is an ancient science and art of healing which utilizes PRANA or vital energy to heal the whole physical body. It is also called psychic healing, vitalic healing, Therapeutic Touch, laying on of the hand, magnetic healing, faith healing, and charismatic healing.

Massage: Manipulation of the whole body using the fingers, knuckles, hands, elbow, or the feet in order to stimulate the flow of the body's energy patterns and so harmonise them. Some prefer to massage acupuncture points and meridians. In Japan, this form of massage is called shiatsu or literally finger pressure. In the USA, this is called acupressure or acupuncture without needles. Deep massage manipulates the tissues of the body that are tense or feel hard and knotted because of repeated strain on a muscle or the whole body. Massage is very soothing to people living with HIV/AIDS.

Brassica nigra, Mustard



Contact no 151, WCC Geneva

STUDY PROCESS

CARE & PREVENTION

PART II : BIBILICAL PERSPECTIVES ON CARE AND PREVENTION

In the following Bible studies the central question is the inter-relationship of caring and prevention. "For God so loved the world that he gave his only son" (John 3:16) is the most complete expression of that love which leads to compassionate caring. The Bible is full of stories about love. Love is expressed in care for others, the restoration of community, the transformation of unjust situations, the healing of woundedness. Very often in these episodes, human life is saved and relationships are healed by love acting as preventive care. In the following Bible studies you may therefore find it helpful to draw on the insights from the Bible studies on Community, Change and Vulnerability which you will find in the Study Document itself.

As you go through the texts and find your own stories in the Bible, you may want to ask:What kind of prevention is achieved through caring for the other? How do you see the interlinkage of care and prevention in the texts chosen? What does prevention mean in those cases?

Read and study one or more of the following texts :

Ruth 1:6-22	Ruth and Naomi
Dtn 6:4-24	The great commandment
Isaiah 53	The suffering servant
Lk 10:29-37	The good Samaritan
Mark 2:1-12,	The healing of the paralytic
Mt. 25:31-46	The last judgement
I.Cor.:12:12-26	One body, many members

Human relationship plays a vital role in the reflections on HIV/AIDS

Read and reflect in this context the Statement of the Archbishop of York (SD 3B) and reflect on: John 4:1-30 The women at the well.
What understanding of healing and human relationship issues does this text raise?
Read from the Study Document the rest of section 3 B on Human Sexuality.

GROUP ACTIVITY

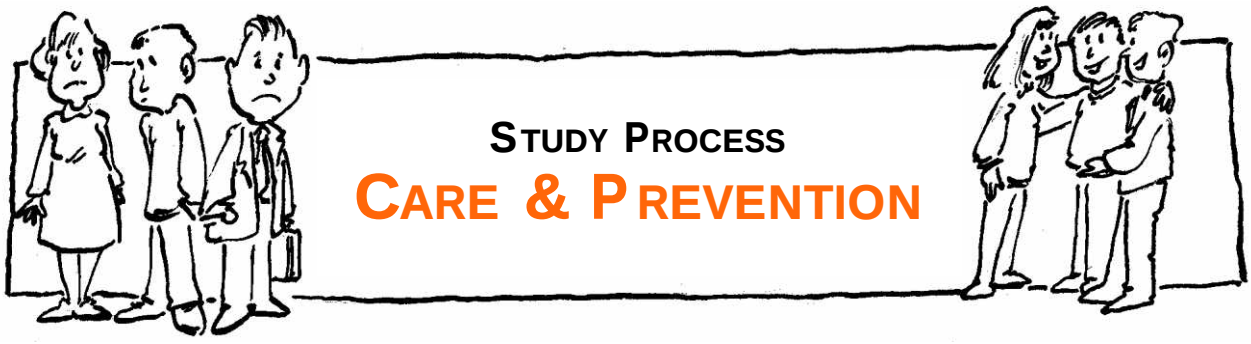
- How would you articulate the central issues of that text in a popular flyer for your community, how for a news article?
- Re-write the text and try to publish it or get the congregation to help you make a flyer.

For more information on the issue you may wish to draw on the material available in your region on sex education or draw on the Study Document chapter 4, p. 60f.

PART III : THE CHURCH AS AN INSTRUMENT FOR CARE & PREVENTION

WHERE DOES THE CHURCH GET ITS MANDATE?

"Jesus Christ demonstrated God's love to all human beings and came to be in the midst of human struggle. If the churches are to fulfil this mission, they must first recognise that HIV/AIDS brings the lives of many people into crisis, and secondly that it is a crisis which churches must face. The very relevance of the churches will be determined by their response" (from WCC Study Document p.1).



STUDY PROCESS
CARE & PREVENTION

ACTIVITY No. 1 – Group exercise

Read and reflect on the following stories to see examples of what the church has done and is doing in situations of care and prevention.

STORY 1:

"Kiran, a counsellor at the Salvation Army hostel in Bombay, India, tells of his experience when he was told he was HIV-positive. He had gone to a hospital for physical check-up to obtain a work permit to work in Saudi Arabia. When he went to receive his results, in the middle of sixty persons in the clinic, the nurse shouted to him that he had HIV/AIDS. He was shocked. He asked again what she meant. He was told that he had AIDS and that he would soon die. He said he stumbled home very distraught, angry and confused. There was no counselling. He was not prepared for this news. There was no privacy in the clinic. He learned of the Salvation Army hostel. There he found compassion, care, acceptance. He was able to regain some self-respect in a support group. Now he is one of the leading counsellors at the Salvation Army hostel. He helps the hostel to establish testing and counselling services.

STORY 2:

In Kagoma, a rural community in Uganda, the Participatory Action Research (PAR) was introduced to address the issue of AIDS in the community. In order to explore what were the factors in their lives that promoted AIDS and made the population vulnerable to AIDS, an extensive process of focus group discussions was undertaken in the community. The groups were homogeneously composed, so that the participants in each group would generally share the same life conditions and positions in society (unmarried youth/boys/girls, married women/men, community leaders, church leaders etc.)

DISCUSSION QUESTIONS

- What in these stories are either cultural or economic barriers to care and prevention?
- How would you describe the role of the church in these cases as an agent for care and prevention?

ACTIVITY No. 2 – Group Activity

Read together from the Study Document, the story of Arthit and Urai (Appendix IV)

Discuss in your group the questions following that story, 1-4!

- Afterwards try to outline what the church can learn from this example in the various cultural and religious contexts?

PART IV : WHAT HAS THE CHURCH TO OFFER ?

ACTIVITY No 1

At this point the group should first review what they have learned so far from this study process.

The facilitator should provide some large piece of paper to collect all the insights during the discussion.

Some suggested questions which should be answered:

STUDY PROCESS
CARE & PREVENTION

1) What are the main needs identified in the community?
2) What skills are available in the group and how can they be matched with the needs?
3) Discuss many activities which the group can undertake (for example, adoption of persons with HIV/AIDS, support group for care givers,counselling workshop, and so on.)

ACTIVITY No 2

Read the following text from the Study Document

Afterwards discuss in how far this model can be practised in your congregation and in how far the discription given here is valid for your community:

"Focus group discussion in churches could be encouraged as a vital ministry for the church. Questions such as the following could be raised: what unique contribution does the church bring to our efforts to face the challenges of HIV/AIDS? Has the church become a "ghetto," isolated from the life of the people? Does the church touch the existential lives of people? How can the church deal with, and be responsive to, the life of the community? How can the church be supported in identifying its priorities, and in tackling difficult issues related to its identity, life and mission? How can the church identify efficient and relevant action to meet the challenge of HIV/AIDS? How can those in the church best reflect on what they have learned in meeting this challenge?

The role of the church should be seen in the light of its particular cultural context as well as in the light of the universal gospel message.

An example of a church where focus group discussion on HIV/AIDS took place was in the Armenian Church in Lebanon. The church in Lebanon has particularities because the society has become pluralistic. This is the context of the mission and the life of the church. Culture carries a direct influence on life and HIV/AIDS issues, in a context where the Lebanese Christians have maintained their particular way of life. Ideally, the church is where people seek solutions; but actually, the church has been shying away from the realities of everyday life. There is minimal dialogue with youth. The church is slow in reacting to social issues. The church faces difficulties in preparing young people for sexuality. Religion and sexuality were not seen as contradictory, but practical approaches became problematic. Therefore the need is seen for the priests to have education on human sexuality. Priests are poorly informed about HIV/AIDS. Their source of information is what they read in newspapers or see on television. Action on HIV/AIDS is delegated to non-governmental organizations. It is something the church is not involved in.

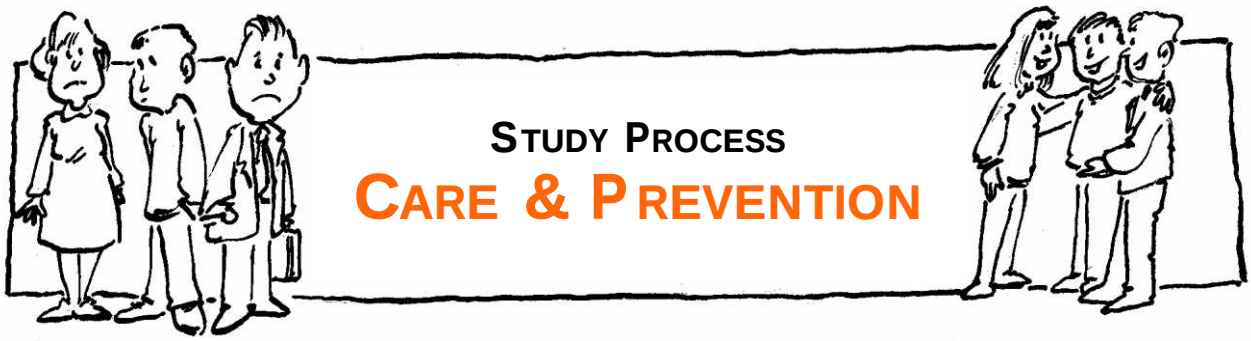
ACTIVITY No 3

Look at the role of worship and liturgy in care and prevention. Read the section from the WCC Document (78):

"Worship Life: The celebration of life through renewal in worship

"Worship - a special moment for celebration - attempts to place daily life on the stage. The repetition of gestures, words, sounds, colours that form the moment of celebration re-creates a reality that in many aspects is lived in an unconscious way.

Worship is more than the scheduled moment of celebration. Worship is the connection with this moment of celebration and life itself. Worship is the time to recognize that we are created in God's image. It is a time to recognize our differences, to learn to be together, to be in touch, and to overcome prejudices.Worship calls the body in its totality to express daily life moments and to recognize God's will and the importance of God's commitment to care for people and creation. The worship can help the churches to remove the barriers that we create in daily life of human communities by "opening up their windows" - eyes, ears and all the senses - for ordinary experiences and ways to express God's



Study Process
Care & Prevention

presence amidst the people and creation. We need to recognize the importance of renewing the ways we celebrate life and our faith as we worship together, as we read the Bible, pray and praise and as we share experiences, life stories and bear one another's burdens. Some are challenged to enlarge their fellowship and include other Christian denominations and other faiths. In this fellowship, the community joins hands and hearts for a healing service for all humankind amidst tragedies and suffering and to heal people, cultures, nations and creation.

The unique thing the church can offer is for persons to be included in the worship and the prayer of a community which understands itself as a healing community, cared for by the Grace of God. Such a community can be a safe place, where in prayer people can express anxieties, frustations and hope, and also celebrate the gifts of life. Holy communion has a central place in celebrating relationship with God, and as an expression of hope, also for life after death. Persons living with the virus may help the congregrations (or groups in the church) to revitalize the prayer life and liturgical , communal expressions of the church.

The following text gives some insight, how people living with HIV/AIDS are reflecting on central questions of our Faith, such as the "Mystery and Grace - Hope and Resurrection"by Ernesto Barros Cardoso. (cf. Facing Aids, 35-43)

" The Key to understanding hope seems to me this courage or energy to throw oneself into Mystery, the Sacred, what is beyond!...I wonder what further action would be necessary to perceive this contact with the Mystery and the whole range of unheard of and unusual situations, and the perplexity that they cause in the mutilated and suffering bodies that seek hope and signs of resurrection. I remember the absurd amount that Job suffered and how, at the end of his experience with doing theology with his own body, he learned to reject rationalisations imposed as truths - I remember what he had learned, but also what his friends said was "the foundation", "the basis" of arguments, and how they said that he should trust them, accept the pain, confess his sin and, who knows, be forgiven and cured!... Yes, at the end of his experience, Job collapses when he sees the Sacred in all its grandeur, and says: "I knew of thee then only by report, but now I see thee with my own eyes" (Job 42:4)... Hope and Resurrection are intimately related to his profound experience of faith. This confrontation usually does not find words and arguments that can express its impact. A radical change of perception, of view and of projection...

In the face of the drama of so many bodies walking
seeking a home a shoulder, an embrace,
a meaning that helps to understand this pain, to face it,
and go beyond resignation...
and then integrate it as a part of life experience
of exercising the limits imposed daring to advance
and extend the margins imposed by illness...

I think the attitude of the leadership of the churches, its thinkers (theologians) and its ministers (deacons and pastors), should help these people - the multitude of homeless, roofless, shelterless, familyless, energyless, futureless people... to recover and re-encounter, from within their pain and their suffering body, the responses and arguments, the inexhaustible spring that helps to make radical changes. Only confrontation with the Mystery, with the always-open Revelation of God, can break down the faith in well-prepared speeches which - for that very reason - no longer "convince" many people.Now is when symbols, gestures, indirectness, silence are fundamental...learning to do liturgy with people who suffer...learning to discover signs of the Sacred in the midst of garbage and dregs, learning to recognize this "holy land" in order to remove one's sandals and...in silence and profound expectations, to meet what is "further beyond!" (cf. Moses)

STUDY PROCESS
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GROUP ACTIVITY

- Reflect on this text in the context of preparation of a worship in your own congregation.
- How would you describe what the author says, in your own words?
- Where do you see the relation to care and prevention work of the church?
- Afterwards read the example from the liturgical life of the Orthodox tradition.

"Within the Russian Orthodox Church spiritual healing gains a new momentum. Its practice draws on the mid 19th century Russian Saint Feofan the Recluse. He included healing as an element of the praxis of liturgy containing several steps, such as follows:

Most important is to create a special atmosphere of love, attention, understanding and respect around the sick and the suffering which comprises several aspects.

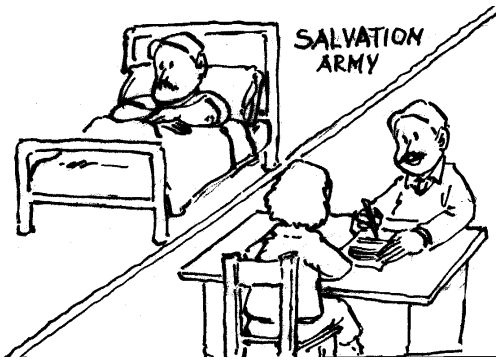
The next central step is to assist in care which contains several aspects a priest will have to observe.

The priest is to help the faithful to come to an awareness of the brokenness (sinfulness) of one's way of life with the help of a counsellor or spiritual director and to assist in finding ways of renewed, healed life (repentance);

Holy Communion is a central focus point for this process of care and healing; supporting the correction of one's former way of life, by means of active repentance (love in action)".

Anatoly Berestov

ACTIVITY No 4



The group is asked to visit religious communities in the local area and find out, how are they helping those in need of care and prevention.

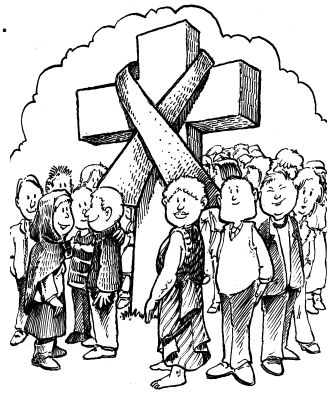
Note to the facilitator: Have the group divided into several subteams and develop together a questionnaire

After the group has returned find out what kind of different approaches there are; the group may want to make a little information brochure on Care & Prevention in the local community.

ACTIVITY No 5

Visit the local Churches and ask the church leaders/ elders, how you could organize together an ecumenical worship on care and prevention.

Plan and organize the worship together with people living with HIV/AIDS.



APPENDIX I

The Impact of HIV/AIDS and the Churches' Response

A statement adopted by the WCC central committee on the basis of the WCC consultative group on AIDS study process
September 1996

I. Introduction

1. Already in 1987 the executive committee of the World Council of Churches called the churches to address the urgent challenges posed by the spread of HIV/AIDS throughout the world. Appealing for an immediate and effective response in the areas of pastoral care, education for prevention and social ministry, the executive committee noted that "the AIDS crisis challenges us profoundly to be the church in deed and in truth: *to be the church as a healing community*".[1]

2. The spread of HIV infection and AIDS has continued at a relentless and frightening pace. The cumulative number of persons infected by the virus — women, men and children on all continents — is about 28 million by mid-1996; and it is estimated that 7000 new infections occur each day, including 1400 babies born infected. Individuals, communities, countries and churches are highly affected by this pandemic.

3. Given the tragic impact of AIDS on persons, communities and societies all over the world; given its direct impact upon many Christians and churches; recognizing the need for careful reflection on a number of inter-related issues bearing on the churches' understanding of and response to AIDS; and believing it imperative that the churches address *together* this issue of global concern, the WCC central committee at its meeting in Johannesburg in 1994 commissioned a comprehensive study to be done by a consultative group on AIDS.[2]

4. In its reflection the group has focused on theological and ethical issues raised by the HIV/AIDS pandemic, on questions of human rights in relation to AIDS, and on pastoral care and counselling within the church as a healing community. As it draws its findings into a final report, the consultative group wishes to make available the present statement indicating some of the main concerns and implications of its work. We request that this statement be *adopted* by the central committee, that the report from the study be *welcomed* by central committee, and that both be shared with the churches for their reflection and appropriate action.

II. The impact of HIV/AIDS

5. HIV is a virus and, medically speaking, AIDS is the consequence of viral infection; but the issues raised by the pandemic are far from purely medical or clinical. They touch on cultural norms and practices, socio-economic conditions, issues of gender, economic development, human responsibility, sexuality and morality.

6. The HIV/AIDS pandemic is not just a matter of statistics. Its effects are impoverishing people, breaking their hearts, causing violations of their human rights and wreaking havoc upon their bodies and spirits. Many who suffer do so in rejection and isolation. In a striking way HIV/AIDS has become a "spotlight" revealing many iniquitous conditions in our personal and community lives, revealing our inhumanity to one another, our broken relationships and unjust structures. It reveals the tragic consequences of personal actions which directly harm others, or of negligence which opens people to additional risk. The pandemic exposes any silence and indifference of the churches, challenging them to be better informed, more active, and more faithful witnesses to the gospel of reconciliation in their own lives and in their communities.

7. Almost every day there are new discoveries, new information, new hopes and accounts of how communities are affected by, and are dealing with, the challenge of HIV/AIDS. The reality of the pandemic seems increasingly complex, confounding the generalizations, stereotypes and partial or false information which all too often dominate discussion of HIV/AIDS. We know, for example, that HIV/AIDS is not confined to particular groups within society, although in any given country particular groups may be more affected.

8. AIDS was first recognized in industrialized countries where, indeed, the vast majority of the funding for research, prevention and care has been concentrated. Now in its second decade, the pandemic is expanding fastest in countries with poor economies, where all the economic, political and social mechanisms that keep countries poor interact to produce a context in which AIDS thrives. Thus AIDS has become a development issue. The HIV/AIDS pandemic adds a heavy burden on health-care systems. The cost of treatment is often completely disproportionate to the incomes of the affected families. In Thailand, for example, the cost of treatment for one person with AIDS absorbs up to 50 percent of an average annual household income.

9. AIDS impacts societies in many ways, challenging some traditional notions of the social order. In some places, the pandemic is raising questions about the meaning and role of the family; elsewhere it has focused attention on those using drugs and their increased risk; still elsewhere it has raised questions about human sexuality and relationships. In the course of the pandemic the role of gay communities in compassionate care and effective prevention has been recognized. This perspective has challenged the churches to rethink their relation to gay persons.

10. The pandemic is also having profound consequences for family and community life. In addition to causing the illness and death of members of the most productive age groups, it severely restricts the opportunities for those — for the most part, women and girls — who care for persons suffering from the disease. In some societies whole communities are weakened by the pain and disruption HIV/AIDS brings to families and other basic social units. Grandparents find themselves caring for their sick children or orphaned grandchildren, and children and young people are forced to become the bread-winners for others.

III. The beginnings of a response

11. The challenges posed by AIDS require both a global and a local response. How can we develop the will, knowledge, attitudes, values and skills required to prevent the spread of AIDS without the concerted efforts of governments, local communities, non-governmental organizations, research institutions, churches and other faith communities?

12. A full range of inter-related approaches is called for. Effective methods of prevention include sexual abstinence, mutual fidelity, condom use and safe practices in relation to blood and needles. Education, including education for responsible sexual practices, has been shown to be effective in helping to stop the spread of the infection. Other measures which inhibit its spread or help to deal with the suffering which it causes include advocacy for justice and human rights, the empowerment of women, the training of counsellors and the creation of "safe spaces" where persons can share their stories and testimonies. In addition all societies — whether "developed" or developing — need to address practices such as drug abuse and commercial sex activity, including the increasing incidence of child prostitution, as well as the root causes of destructive social conditions such as poverty, all of which favour the spread of HIV/AIDS.

13. Strategies for prevention and care may fail if those affected by HIV/AIDS play no part in designing or carrying them out. In the course of the current study, the consultative group noted the role played by the WCC in promoting participatory action research on "AIDS and the Community as a Source of Care and Healing" in three African countries.[3] This process enabled village people to analyze the issues and problems raised by AIDS and to develop actions which foster prevention and care.

14. From the beginning of the pandemic some Christians, churches and church-related institutions have been active in education and prevention programmes and in caring for people living with HIV/AIDS. The consultative group was privileged to have worked with several of these during the study. The group observes, however, that by and large the response of the churches has been inadequate and has, in some cases, even made the problem worse. As the WCC executive committee noted in 1987, "through their silence, many churches share responsibility for the fear that has swept our world more quickly than the virus itself".[4] Sometimes churches have hampered the spread of accurate information or created barriers to open discussion and understanding. Further, churches may reinforce racist attitudes if they neglect issues of HIV/AIDS because it occurs predominantly among certain ethnic or racial groups. These groups may be unjustly stigmatized as the most likely carriers of the infection.

15. The situation continues to call for "metanoia in faith" and a fresh resolve by the churches to address the situation directly. This must be done in a spirit of humility, knowing that we do not fully understand the scope and significance of the HIV/AIDS pandemic. It requires openness to new information, long discussion of sensitive issues and readiness to learn from the experience of others, as we seek a more adequate response to the challenges posed by HIV/AIDS today.

IV. Theological dimensions

16. The HIV/AIDS pandemic raises difficult theological issues in the areas of creation, human nature, the nature of sin and death, the Christian hope for eternal life and the role of the church as body of Christ. Furthermore the reality of AIDS raises issues, such as human sexuality, vulnerability and mortality, which stir and challenge us in a deeply personal way. Christians and the churches struggle with these theological and human issues and they differ, sometimes sharply, in their response to some of the challenges posed by HIV/AIDS. But it is imperative that they learn to face the issues *together* rather than separately, and that they work towards a common understanding of the fundamental questions — theological, anthropological and ecclesiological — which are involved.

17. The church's response to the challenge of HIV/AIDS comes from its deepest theological convictions about the nature of creation, the unshakable fidelity of God's love, the nature of the body of Christ and the reality of Christian hope.

18. The creation in all its dimensions is held within the sphere of God's pervasive love, a love characterized by relationship, expressed in the vision of the Trinity as a model of intimate interaction, of mutual respect and of sharing without domination. This inclusive love characteristic of the Trinity guides our understanding of the Christian claim that men and women are made in the "image of God". Because humanity is created in God's image, all human beings are beloved by God and all are held within the scope of God's concern and faithful care.

19. Within the fullness of creation we affirm the potential for goodness of the human body and of human sexuality. We do not completely comprehend the meaning of human sexuality. As with other aspects of creation, sexuality also can be misused when people do not recognize their personal responsibility; but it is to be affirmed strongly as one of God's good gifts, finding expression in many dimensions of human existence. The churches have recognized marriage as the primary place for the expression of sexuality in its various dimensions.

20. We live from God's promise that nothing can separate us from the love of God in Christ: no disasters, no illness or disease, nothing done by us and nothing done to us, not even death itself, can break God's solidarity with us and with all creation (Rom. 8:38-39). And yet the creation "groans in travail" (Rom. 8:22); we see in the world much suffering, injustice and waste. Some of this can be understood as the consequence, for ourselves and others, of the exercise of the freedom given by God to God's creatures; some of it, we sense, may be part of a larger pattern of which we now glimpse only a part; some of it defies understanding, leaving us to cry: "I believe; help my unbelief!" (Mark 9:24).

21. Finally we live by hope, holding our questions and doubts within the larger frame of God's love and final purpose for our lives and for all creation: life abundant, where justice reigns, where each is free to explore all the gifts God has given them. More particularly, we live by hope in Christ: Christ gone before us into glory is the basis for our hope. We share in the sufferings of Christ — Christ who is Immanuel, "God with us" — "that we may also be glorified with him" (Rom. 8:17). And in our weakness we are sustained by the "Spirit who lives within us", interceding when we know not how to pray and finally granting anew "life to our mortal bodies" (Rom. 8:11,26; cf. Eph. 3:16).

22. Strengthened by this hope, we wrestle with the profound questions put to us by suffering. We affirm that suffering does not come from God. We affirm that God is with us even in the midst of sickness and suffering, working for healing and salvation even in "the valley of the shadow of death" (Ps. 23:4). And we affirm that it is through bearing the suffering of the world on the cross that God, in Christ, has redeemed all of creation. Our hope is rooted ultimately in our experience of God's saving acts in Jesus Christ, in Christ's life, death and resurrection from the dead.

23. Remembering the suffering servant (Isa. 42:1-9; 49:1-7; 50:4-11; 52:13-53:12), we are called to share the sufferings of persons living with HIV/AIDS, opening ourselves in this encounter to our own vulnerability and mortality. This is to walk with Christ; and as Christ has gone before us through death to glory, we are called to receive "the sure and certain hope of the resurrection". This is God's promise that God's promise, for us and for all creation, is not destroyed by death: we are held within the love of God, claimed by Christ as his own and sustained by the Spirit; and God will neither forsake us nor leave us to oblivion.

24. We affirm that the church as the body of Christ is to be the place where God's healing love is experienced and shown forth. As the body of Christ the church is bound to enter into the suffering of others, to stand with them against all rejection and despair. Because it is the body of *Christ* — who died for all and who enters into the suffering of all humanity — the church cannot exclude anyone who needs Christ. As the church enters into solidarity with those affected by HIV/AIDS, our hope in God's promise comes alive and becomes visible to the world.

25. We celebrate the commitment of many Christians and churches to show Christ's love to those affected by HIV/AIDS. We confess that Christians and churches have also helped to stigmatize and discriminate against persons affected by HIV/AIDS, thus adding to their suffering. We recall with gratitude the advice of St Basil the Great to those in leadership positions within the church, emphasizing their responsibility to create an environment — an ethos, a "disposition" — where the cultivation of love and goodness can prevail within the community and issue in the "good moral action" which is love.[5]

26. We affirm that God calls us to live in right relationship with other human beings and with all of creation. As a reflection of God's embracing love, this relationship should be marked not just by mutual respect but by active concern for the other. Actions taken deliberately which harm oneself, others or the creation are sinful; and indeed we are challenged by the persistence of sin, which is the distortion of this right relationship with God, other persons, or the natural order. Yet sin does not have the last word; as we are "renewed by the Holy Spirit" (cf. Titus 3:5) and continue to grow in our communion with God, our lives will show forth more of God's love and care.

27. The World Council of Churches executive committee emphasized in a 1987 statement the need "to affirm that God deals with us in love and mercy and that we are therefore freed from simplistic moralizing about those who are attacked by the virus".[6] Furthermore we note how easily a moralistic approach can distort life within the Christian community, hampering the sharing of information and open discussion which are so important in facing the reality of HIV/AIDS and in inhibiting its spread.

28. In the light of these reflections, and on the basis of our experience in this study, we wish to avoid any implication that HIV/AIDS, or indeed any disease or misfortune, is a direct "punishment" from God. We affirm that the response of Christians and the churches to those affected by HIV/AIDS should be one of love and solidarity, expressed both in care and support for those touched directly by the disease, and in efforts to prevent its spread.

V. Ethical dimensions

29. In responding to the challenge of HIV/AIDS Christians are motivated by urgent imperatives, passionately felt: to show Christ's love for the neighbour, to save lives, to work for reconciliation, to see that justice is done. Making ethical decisions, however, requires a process of *discernment* which includes gathering the latest information, wrestling with deeply sensitive issues and weighing differing, sometimes conflicting views and interests. This process needs to be undergirded by Bible study, prayer and theological reflection.

30. Christians make ethical choices following principles which derive from their understanding of the biblical witness and their faith convictions. These may be stated and developed differently in various traditions, but are likely to include the following points:

- because all human beings are created and beloved by God, Christians are called to treat every person as of infinite value;

- because Christ died to reconcile all to God, Christians are called to work for true reconciliation — which includes justice — among those alienated from one another;
- because we are "members one of another", being built up by the Spirit into one body, Christians are called to responsible life within community.

31. Such principles — the infinite value of each person, the gospel of reconciliation, the call to responsible life within community — have to be applied to such questions as: How do churches respond to their members living with HIV/AIDS? How can churches promote responsible behaviour without being judgmental and moralistic? What public health measures to reduce HIV/AIDS transmission should churches advocate? How can resources for care and research be fairly shared? This means in each case exploring all available options, weighing the benefits (and difficulties) of each, and finally asking, "which of the possible courses of action best expresses Christ's love for all those involved?"

32. Such a process of discernment is often difficult: the options may not be fully clear; none of the options may be wholly satisfactory; the implications of some biblical or theological principles for specific problems today may not be clear. It is all the more important, then, that Christians and churches reflect and work on these ethical issues *together*. The challenge of HIV/AIDS demands nothing less than an *ecumenical* response.

33. Churches are expected to give both spiritual direction and moral guidance, and to play a responsible role in the discussion of these issues in the wider society, as well as in discussions of biomedical ethics. Witnessing to their own faith convictions, they enrich the wider debate and make common cause, where possible, with persons of goodwill who appeal to more general sets of ethical principles such as respect for persons, beneficence and non-maleficence, and justice.

34. The churches have crucial contributions to make to this wider debate. For example first, in accordance with their commitment to *truth* they can emphasize that the process of ethical discernment leaves no room for judgments based on superficial generalizations or stereotypes, on fear, or on incomplete or false information. The churches can do much to promote, both in their own lives and in the wider society, a climate of sensitive, factual and open exploration of the ethical issues posed by the pandemic.

35. Second, in accordance with their emphasis upon *personal and communal responsibility* the churches can promote conditions — personal, cultural, and socio-economic — which support persons in making responsible choices. This requires a degree of personal freedom which is not always available: for example, women, even within marriage, may not have the power to say "no" or to insist on the practice of such effective preventive measures such as abstinence, mutual fidelity and condom use.

VI. Human rights in relation to HIV/AIDS

36. The HIV/AIDS pandemic raises important issues relating to human rights. People living with HIV/AIDS generally encounter fear, rejection and discrimination, and often are denied basic rights (such as liberty, autonomy, security and freedom of movement) enjoyed by the rest of the population. Because such reactions contradict the values of the gospel, the churches are called to formulate and advocate a clear policy of non-discrimination against persons living with HIV/AIDS.

37. One of the tasks of the WCC over the last three decades has been to be actively involved in human rights standard setting, promotion and protection. The last decade has witnessed a significant trend in the development of international norms and standards in relation to people that are discriminated against on grounds of race, gender, ethnicity and religion. There are other kinds of discrimination as well. Some of them arise because of lack of awareness and fear. People living with HIV/AIDS fall in this category. They are often denied their fundamental right to security, freedom of association, movement and adequate health care.

38. The issue of human rights also has important implications for the spread of HIV/AIDS. We note the alarming rise in sex tourism. Some men in societies in both the North and the South abuse the young and poor children for prostitution or in an effort to try to escape infection. This is also an issue of violence against children. We further note that men and women who are denied their fundamental human rights, whether on the grounds of social status, sexual orientation or addiction to drugs, are thereby made especially vulnerable to the risk of HIV infection. Thus broadly-based strategies which advocate human rights are required to prevent the spread of HIV.

VII. Pastoral care and counselling within the church as healing community

39. By their very nature as communities of faith in Christ, churches are called to be healing communities. This call becomes the more insistent as the AIDS pandemic continues to grow. Within the churches we are increasingly confronted with persons affected by HIV/AIDS, seeking support and solidarity and asking: are you willing to be my brother and sister within the one body of Christ? In this encounter our very credibility is at stake.

40. Many churches, indeed, have found that their own lives have been enhanced by the witness of persons living with HIV/AIDS. These have reminded us that it is possible to affirm life even when faced with severe, incurable illness and serious physical limitation, that sickness and death are not the standard by which life is measured, that it is the quality of life — whatever its length — that is most important. Such a witness invites the churches to respond with love and faithful caring.

41. Despite the extent and complexity of the problems, the churches can make an effective healing witness towards those affected by HIV/AIDS. The experience of love, acceptance and support within a community where God's love is made manifest can be a powerful healing force. Healing is fostered where churches relate to daily life and where people feel safe to share their stories and testimonies. Through sensitive worship, churches help persons enter the healing presence of God. The churches exercise a vital ministry through encouraging discussion and analysis of information, helping to identify problems and supporting participation towards constructive change in the community.

42. Many trained and gifted members of the community, as well as some pastors, are already providing valuable pastoral care. Such care includes counselling as a process for empowerment of persons affected by HIV/AIDS, in order to help them deal with their situation and to prevent or reduce HIV transmission.

VIII. Conclusion: what the churches can do

43. This study has shown us the delicate, interwoven relationships of human beings and their connectedness to all of life. It has proved neither desirable nor possible to do a "one-dimensional" study of AIDS, describing only its dramatic spread and devastating impact on those who are directly affected. Rather, the AIDS pandemic requires the analysis of a cluster of inter-related factors. These include the theological and ethical perspectives that inform, or arise from, our understanding of AIDS; the effects of poverty on individuals and communities; issues of justice and human rights; the understanding of human relationships; and the understanding of human sexuality. Of these the factor of sexuality has received the least attention within the ecumenical community. We recognize that further study in this area is essential for a deeper understanding of the challenges posed by HIV/AIDS.

44. Our exploration of these themes has brought us face to face with issues, understandings and attitudes of major consequence to the churches and their role in responding to the pandemic. Through their witness to the gospel of reconciliation, the value of each person, and the importance of responsible life in community, the churches have a distinctive and crucial role to play in facing the challenges raised by HIV/AIDS. But their witness must be visible and active. Therefore we feel it essential to highlight the following concerns as points for common reflection and action by the churches:

A. The life of the churches: responses to the challenge of HIV/AIDS

1. We ask the churches to provide a climate of love, acceptance and support for those who are vulnerable to, or affected by, HIV/AIDS.

2. We ask the churches to reflect together on the theological basis for their response to the challenges posed by HIV/AIDS.

3. We ask the churches to reflect together on the ethical issues raised by the pandemic, interpret them in their local context and to offer guidance to those confronted by difficult choices.

4. We ask the churches to participate in the discussion in society at large of ethical issues posed by HIV/AIDS, and to support their own members who, as health care professionals, face difficult ethical choices in the areas of prevention and care.

B. The witness of the churches in relation to immediate effects and causes of HIV/AIDS

1. We ask the churches to work for better care for persons affected by HIV/AIDS.

2. We ask the churches to give particular attention to the conditions of infants and children affected by the HIV/AIDS pandemic and seek ways to build a supportive environment.

3. We ask the churches to help safeguard the rights of persons affected by HIV/AIDS and to study, develop and promote the human rights of people living with HIV/AIDS through mechanisms at national and international levels.

4. We ask the churches to promote the sharing of accurate information about HIV/AIDS, to promote a climate of open discussion and to work against the spread of misinformation and fear.

5. We ask the churches to advocate increased spending by governments and medical facilities to find solutions to the problems — both medical and social — raised by the pandemic.

C. The witness of the churches: in relation to long-term causes and factors encouraging the spread of HIV/AIDS

1. We ask the churches to recognize the linkage between AIDS and poverty, and to advocate measures to promote just and sustainable development.

2. We urge that special attention be focused on situations that increase the vulnerability to AIDS such as migrant labour, mass refugee movements and commercial sex activity.

3. In particular, we ask the churches to work with women as they seek to attain the full measure of their dignity and express the full range of their gifts.

4. We ask the churches to educate and involve youth and men in order to prevent the spread of HIV/AIDS.

5. We ask the churches to seek to understand more fully the gift of human sexuality in the contexts of personal responsibility, relationships, family and Christian faith.

6. We ask the churches to address the pandemic of drug use and the role this plays in the spread of HIV/AIDS and to develop locally relevant responses in terms of care, de-addiction, rehabilitation and prevention.

NOTES

[1] Quoted in the *Minutes* of the 38th meeting of the WCC central committee, Geneva, WCC, 1987, Appendix VI, "AIDS and the Church as a Healing Community", p.133.
[2] *Minutes* of the 45th meeting of the WCC central committee, Geneva, WCC, 1994, pp.45-49, 102f.
[3] See *Participatory Action Research on AIDS and the Community as a Source of Care and Healing*, Geneva, Christian Medical Board of Tanzania, Uganda Protestant Medical Bureau, Eglise du Christ au Zaire and WCC, 1993.
[4] *Loc. cit.*, p.135.
[5] *Ascetic Works*, 2.1.
[6] *Loc. cit.*, p.135.

GLOSSARY ON HIV/AIDS

APPENDIX II

An HIV/AIDS glossary

Affected: a term used for the family, friends and other persons associated with someone living with HIV/AIDS.

AIDS (Acquired Immune Deficiency Syndrome): a group of signs and symptoms or a combination of diseases caused by the Human Immunodeficiency Virus (HIV), which impairs the body's ability to fight infection, making it especially susceptible to opportunistic infections, of which the most common include Pneumocystis carinii pneumonia and certain cancers, such as Kaposi's sarcoma, a skin cancer.

AIDS test: a misnomer sometimes incorrectly used to refer to the HIV antibody test HIV (Human Immunodeficiency Virus): the virus that can eventually cause AIDS. People infected with HIV may look and feel well for a number of years before any opportunistic infections develop. Many people infected with the HIV virus are completely unaware of the fact, unless they decide to have a medical blood test. However, they can be carriers of the virus, transmitting it to other people.

HIV antibody test: a laboratory test made on a small sample of blood to detect whether the body has reacted to the presence of HIV by trying to protect itself against the virus through producing antibodies. Though the presence of antibodies indicates that a person has been exposed to the virus, their absence does not necessarily mean that the person is not infected with HIV, since this reaction takes an average of three months after infection to show up in the blood. If the test is positive, the infected person will have been able to pass on the virus from the moment of infection. It is not possible to tell from this test when or how the person tested will proceed to AIDS.

HIV-positive (or *seropositive*): a term indicating that the HIV antibody test on a person has indicated the presence of antibodies in the blood. If the test is positive, it means that the person has been exposed to HIV and that his or her immune system has developed antibodies to the virus.

Immune deficiency: impairment of the body's ability to resist infection.

Immune system: the body's natural defence system which protects it from infection by recognizing bacteria, viruses and diseases in general. It consists of cells that (among other things) produce antibodies, which can recognize materials as foreign to the body and then attempt to neutralize them without injury to the person's cells.

Incubation period: the period of time between infection by the disease-causing organism and the onset of signs and symptoms of the disease. In people with HIV infection, the average incubation period is seven to ten years.

Infected: a term used for a person who has the HIV virus within his or her body.

IVDU (*Intravenous Drug Use*): one of four main high-risk behavioural patterns resulting in HIV infection. Drug use may involve using and often sharing unsterilized needles and syringes that serve to transmit HIV.

Opportunistic infection: an infection caused by an otherwise harmless micro-organism that can become pathogenic when the host's resistance is impaired.

Transmission : the spread of the disease-causing organism from one person to another. The major modes of transmission of HIV are penetrative sexual intercourse, shared contaminated equipment of intravenous drug users, transfusion of unscreened blood (blood which has not been tested) and from mother to unborn or newborn infant.

TERMS TO AVOID

Terms to avoid	Why to avoid them	Use instead
Carrying AIDS AIDS carrier AIDS positive	These terms confuse two distinct phases: being infected with HIV and having AIDS. People can have AIDS, but they cannot "carry" it.	HIV-antibody positive; people with HIV.
AIDS test	The most commonly used test detects antibodies to HIV. There cannot be a test for AIDS; the diagnosis for AIDS is based on clinical symptoms.	HIV antibody test
AIDS virus	This term can lead to confusion between HIV and AIDS.	HIV (Human Immuno-deficiency Virus)
Catch AIDS	It is not possible to "catch" AIDS. Although it is possible to "catch" HIV, this is a misleading expression, because it may suggest that transmission of HIV is similar to transmission of colds or flu.	Contract HIV; become infected with HIV; become HIV-positive.
AIDS sufferer	Having AIDS does not mean being sick all the time. Someone with AIDS can continue to work and lead a normal life for some time after diagnosis. The term "suffering"is thus inappropriate.	Person with AIDS.
AIDS victim	The language of "victim" suggests helplessness.	Person with AIDS, person who has AIDS.
Innocent victim	This term implies that anyone else with AIDS is "guilty".	
High-risk groups	The fact of being classified as a member of any particular group does not put anyone at greater risk; it is what he or she does, regardless of group, that may put him or her at greater risk. In other words, one should speak of risk behaviour, not of high risk groups.	High-risk behaviour.

This material has been adapted from Beverly Booth, "Health Professionals and the AIDS Epidemic: Say What You Mean and Mean What You Say", Contact, no. 136, Apr. 1994, pp.10f.; and *Guide to HIV/AIDS Pastoral Counselling*, Geneva, WCC AIDS Working Group, 1990, pp. v-vii.

APPENDIX III

Educational Resources on HIV/AIDS

Gender Issues and HIV/AIDS

Facing the Challenges of HIV/AIDS/STDs: A Gender-based Response . Maria de Bruyn, Helen Jackson, Marianne Wijermars, Virginia Curtin Knight and Riet Bervens. Published by: Royal Tropical Institute, Amsterdam, Southern Africa AID Information Dissemination Service, Zimbabwe, and World Health Organization Global Programme on AIDS. c. 1995. ISBN: 90 6832 708 9.

This publication aims to provide policy-makers, planners and programme implementers with information and ideas on how to incorporate a gender-based response to HIV/AIDS and STDs into their policies and programmes. It contains background information on HIV/AIDS/STDs; educational tools and list of resource centres. The tool cards and posters are designed as guides for practical activities to promote gender awareness as well as attitude and behaviour change.

Available for free from:

Royal Tropical Institute
Mauritskade 63
1092 AD Amsterdam, The Netherlands
Fax: 31 20 6654 423

Sexuality and HIV/AIDS

Sexual Health, Assertiveness and HIV. Carol Painter . Produced in association with the Sheffield Centre for HIV and Sexual Health. Daniels Publishing.

The resource manual explores the ways in which assertiveness can help negotiate safer sex. It explores the social and emotional needs related to sexual health and shows how assertiveness training might help these goals to be achieved. It stresses the importance of enabling and encouraging vulnerable groups to negotiate safer sex. It focuses on the vulnerability of a wide range of people in relation to HIV and the cultural factors that might make it difficult to negotiate safer sex. It also looks at the ways in which people can develop the healthy sense of self-esteem that is needed to express sexuality both safely and confidently.

Available at: Daniels Publishing
38 Cambridge Place
Cambridge CB2 1NS
United Kingdom
Fax: 0223 467145

Prevention and Care of HIV/AIDS

Community Action on HIV: A Resource Manual for HIV Prevention and Care . Tamara Aboagye-Kwarteng and Rob Moodie, ed. International Health Unit, Macfarlane Burnet Centre for Medical Research. c. April 1995 ISBN 0 642 22583 4.

The resource manual provides a clear and relevant information on HIV infection which wil assist Australian NGOs and their partners in planning, designing, implementing and evaluating HIV prevention and care projects and improve project design through emphasizing the relationship between the HIV epidemic and wider development issues.

Available for free and may be used for non-profit purposes from:

Macfarlane Burnet Centre for Medical Research
International Health Unit
PO Box 254
Fairfield Vic 3078
Australia
Fax: (61 3) 9482 3123

AIDS Home Care Handbook. c. World Health Organization 1993.

The handbook is an illustrated teaching guide that helps health care workers give important advice about HIV/AIDS. It is also a reference guide containing detailed information aabout common AIDS-related problems and possible causes, what can be done at home to alleviate these problems, and when to seek further help.
The information provided is based on accepted international guidelines and the extensive programme experience of many individuals and agencies working to combat the HIV/AIDS pandemic.

Available at: World Health Organization
Avenue Appiah
Geneva, Switzerland

HIV/AIDS and the Church as a Healing Community

The Congregation: A Community of Care and Healing: HIV/AIDS Awareness Resources . Beth Basham, ed. Presbyterian Church (USA)/Presbyterian AIDS Network. c. 1993.
The resource manual is written for congregations who desire to be better informed and who may be seeking ways in which to become involved in HIV/AIDS Ministry.

Available at: Presbyterian Church (USA)
100 Witherspoon Street
Louisville, KY 40202-1396
USA

HIV/AIDS Ministry: A Practical Guide for Pastors. Patricia Hoffman.
This resource provides pastors, lay church professionals and church leaders with practical, straigthforward information on how to deal with issue of HIV/AIDS from a compassionate basis. Practical models of response will enable any congregations to develop its own compassionate outreach.

World Council of Churches' HIV/AIDS Resource Materials

What is AIDS? Birgitta Rubenson. (Available in English, Spanish, French)
The booklet contains basic facts about HIV/AIDS.

Confronting Aids T ogether . Participatory Methods in addressing the HIV/AIDS epidemic. Including learning from the WCC experience in East and Central Africa, Anne Skejelmerud/Christopher Tusubira, Oslo, DIS 1997
The book will help groups to deal with the method of paricipatory action research in Health Community Work, addressing HIV/AIDS.

Learning About AIDS: A Manual for Pastors and Teachers . Birgitta Rubenson. revised 1994
The booklet will help teachers, pastors, and youth leaders to give relevant information about AIDS to those they work with.

A Guide to HIV/AIDS Pastoral Counselling . Jorge Maldonado,ed. Published by: WCC AIDS Working Group. 1990. (Available in English, French, Spanish, Portuguese)
The guide covers the various aspects of pastoral counselling and factual information on HIV/AIDS. Case studies with questions for thought and discussion is included to help the counsellor determine when he or she is ready to begin counselling.

Making Connections: Facing AIDS - An HIV/AIDS Resource Book . Joao Guilherme Biehl, Janet Kenyon, Siv Limstrand, Anu Talvivaara, eds. Published by the Youth Desks of the World Council of Churches and Lutheran World Federation. (Available in English, French, Spanish)
The book provides resources for dealing with youth and AIDS as one of the greatest challenges in our time. It is a tool for thinking and acting and not a manual of recipes. It acknowledges the complexity of the issue as people are struggling for their lives.

All these publications are available at the:
World Council of Churches
PO Box 2100
1211 Geneva 2
Switzerland

Community

1. THE BODY OF CHRIST, THE HUMAN BODY AND HIV/AIDS

As the body of Christ, the church is to be the place where God's healing love is experienced and shown forth and God's promise of abundant life is made freely available. In making tangible the love and care of Christ, the church offers a prophetic sign and foretaste of the kingdom. In its confession, proclamation, worship and service, the church is called to witness to the presence of Christ in the world.

Christ's offer of abundant life is to be made available to all. The inclusiveness of Christ is especially seen in his parables about meals, such as that of the great banquet pictured in Luke 14:15-24, with their emphasis on the generosity of God's invitation, which does not discriminate among those invited on grounds of their merits, abilities, beliefs or moral standing.

Because all persons fall within the scope of God's love and are honoured with Christ's care, we are called to honour one another as if in each person we encounter Christ himself. When we fail to honour the icon and image of the divine which we should see in ourselves and in our neighbours, then we are not being true to our calling as members of Christ's body, the church.

As Christ identifies with our suffering and enters into it, so the church as the body of Christ is called to enter into the suffering of others, to stand with them against all rejection and despair. This is not an option; it is the church's vocation. And because it is the body of *Christ* — who died for all and who enters into the suffering of all — the church cannot exclude anyone who needs Christ, certainly not those living with HIV/AIDS.

In opening itself to persons living with HIV/AIDS, in entering into their suffering and bearing it with them, in standing with them against rejection and despair, the church expresses more fully what it is to be the body of Christ. And as the church enters into solidarity with persons living with HIV/AIDS, its hope in God's promise of abundant life comes alive and becomes visible to the world.

Some churches are showing courage and commitment in manifesting Christ's love to persons affected by HIV/AIDS. Other churches have contributed to stigmatizing and discriminating against such persons thus added to their suffering. The advice of St Basil the Great comes to all those in leadership positions within the church, emphasizing their responsibility to create an environment — an ethos, a "disposition" — in which the cultivation of love and goodness can prevail within the community and issue in that "good moral action" which is love.

The church is called to stand with persons who are affected by HIV/AIDS. This "standing with", this service of the church on behalf of those who suffer, will take different forms in each situation depending on the needs and possibilities. In some cases the church will need to work for better medical care for affected persons; in other cases, to work for improved counselling services, or for the defence of basic human rights, or to ensure that accurate factual information is available within the church and to the general public, or to ensure that a climate of understanding and compassion prevails. Most of the time all of these efforts and more will be needed.

In the incarnation, God in Christ has entered into the world, breaking down the barriers between the spiritual and the material, claiming the material world as a place where God is present and active for good. *(Facing Aids, 43)*

2. THE INDIVIDUAL AND THE COMMUNITY

The complex relationship between rights and duties is confirmed by the status of human beings as created in the image of God. The Bible, rather than referring to "rights", speaks about duties to God within the covenant; this is in order to safeguard others from abuses and to give all people an equal possibility to benefit. God is described as love; and human beings, created in God's image, are therefore called and given the possibility to reflect that reality. The image of God is an inclusive description of the human family, not a cause for human pride. In light of this, humanity's very existence as love and koinonia should be approached according to the principles of relationships with others, including the natural world. Such an approach will in fact result in implementing the idea of human rights and duties.

For this reason, human rights also has to do with economic and social, environmental and ecological justice, and with the relationship between the individual, community and government.In saying this, however, it is important to be clear about the community's interests — and to identify who determines the nature of these. What is often put forward as *the* interest of the community may in fact be based on the selfish, individual interests of dominant "representatives" of the community.

In authentic koinonia, rights and duties are considered in harmony. The "individual", as usually described, does not prevail over the communitarian, but neither does the communitarian suppress the individual. From this theological perspective, the very idea of human rights can be looked at only in the light of life in community rather than *against* community.

There is consequently no necessary conflict between the rights of the person and the interests of the community. Human rights should be a tool for the empowerment of both persons and communities, in order to restore their dignity and enhance the quality of life. *(Facing Aids, 72)*

3. THE CHURCH AS A HEALING COMMUNITY

The church, by its very nature as the body of Christ, calls its members to become healing communities. Despite the extent and complexity of the problems raised by HIV/AIDS, the churches can make an effective healing witness towards those affected. The experience of love, acceptance and support within a community where God's love is made manifest can be a powerful healing force. This means that the church should not — as was often the case when AIDS was first recognized in the gay community — exclude, stigmatize and blame persons on the basis of behaviour which many local congregations and churches judge to be unacceptable.

It is important to acknowledge that the church is a communion of one body with many members, each distinct:

But God has so arranged the body, giving the greater honour to the inferior member, that there may be no dissension within the body, but the members may have the same care for one another. If one member suffers, all suffer together with it; if one member is honoured, all rejoice together with it. Now you are the Body of Christ and individually members of it (1 Cor. 12:24b-27).

When the church properly responds to people living with HIV/AIDS, both ministering to them and learning from their suffering, its relationship to them will indeed make a difference, and thus become growth-producing. And if through this relationship — out of fidelity to others who are suffering and because of the significance of those who suffer — we are again pushed back on ourselves, it is because in the gospels we are *required* to love: this is a demand, a requirement, not an option. *(Facing Aids, 77)*

4. THE DIVINE RELATIONSHIP OF LOVE

If the first characteristic of a good relationship is respect for the otherness of the other and renunciation of domination, a second, equally important characteristic is the affection, love or esteem in which each holds the other. Only with that warmth of regard and sense of interconnectedness will the relationship blossom and flourish for both. Thus the Bible portrays a God of love, who "so loved the world..." (John 3:16), and beseeches women and men in their turn to love God and to walk in God's ways.

No creature is excluded from this love and this pilgrimage. If God's love had to be *earned* by what men and women do, no one would be worthy of it. But because it is given, everyone is included. All those who tend to be forgotten, excluded, denigrated or marginalized in every society in this world are never abandoned, because the divine relationship is constant. Even those who refuse this relationship are not cut off from the omnipresent love of God.

HUMAN BEINGS IN RELATION

To be human is to be in relation, to be involved in a web of connections with others — in the family, at work, in the church, at leisure. Above and beyond all this human relating is the relationship God freely offers to all in love. Relations with other human beings, like relations with God, may manifest the same respect for the otherness of the other which makes freedom possible and the same warmth of relationship in the form of love.

Christians may speak confidently concerning God who is known in relationship because such a relationship of freedom and love was enacted visibly in Jesus Christ. During his life — which is as important for belief as his death, although it has had less attention in the Western theological tradition — Jesus showed in practice what it is to live this relationship with God, encountering others with the promise and demand of the kingdom.

There was in the way Jesus behaved an *openness* to people of all kinds, without barriers of class or race or gender. Just as God in love accompanies all creation, so Jesus went among the poor, telling them that they were loved by God even if they had not been able to keep the law scrupulously. He dined with a rich Pharisee, and told another who came to see him at night that he needed new vision and had to be born again (John 3:3). He healed Jewish lepers and a Roman soldier's child. There were women in the group that travelled with him, and unlike many holy men he did not shrink from the touch

of a prostitute. In all that breadth of relationship, Jesus incarnated the *accessibility* of God, who "shows no partiality" (Acts 10:34; Rom. 2:11), but is open to all — rich or poor, sick or healthy, old or young.

When people and churches live out of relationship with God and follow Jesus, therefore, they will be continually open to others and offer relationship to them, even to those who seem very different. Just as there is no closing off of relationships in the gospel accounts of Jesus, so churches cannot withdraw into being congenial groups of the like-minded, refusing openness to and esteem for others who are physically or socially different.

A similar observation emerges from considering Jesus' relations with the religious establishment of his day. He attended the synagogue and was certainly no religious dissenter. But he denounced or bypassed religious practices and ordinances which put difficulties in the way of ordinary people in their relationship with God. Not only did he preach the immediacy of unconditional divine love and forgiveness, but he also put it into practice through his own accessibility and his going to where the people were. All this has something to say to the churches about human being-in-relation. It speaks powerfully against churches which confess that nothing separates us from the love of God (Rom. 8:39) and then go on to set up barriers of their own between themselves and other people. *(Facing Aids, 23)*

5. EXAMPLES: LOOKING AT COMMUNITIES OF HOPE

REPUBLIQUE DU CONGO (ZAIRE)

In Zaire a team visited a man who had been abandoned by his family because of his illness. He was pitifully lonely, waiting for visitors, and looking for what the team might be bringing for him. Some discussion began to build his confidence to take the initiative to call his family together. The team offered to come and talk with them in the hope of encouraging reconciliation. He invited them; and when the team left he was looking very different from when they first arrived. He was looking forward to an opportunity for family reconciliation, not just for his own benefit but for the well-being of his children and grandchildren all of whom, he felt, need to protect themselves.

(Ian Cambell in a report of a Salvation Army team visit to Zaire)

GAY MEN'S HEALTH CRISIS

Two months after the Federal Centre for Disease Control's (CDC) 1981 report of the first cases of an illness to become known as AIDS, eighty men alarmed by the report gathered in New York writer Larry Kramer's apartment to hear a doctor speak about "gay cancer". Passing the hat, the men contributed $6635 for biomedical research. Six months later, this fund-raising group became Gay Men's Health Crisis (GMHC).

Even as GMHC, one of the largest AIDS service organizations in the USA, was coming into existence, members of Metropolitan Community Churches and Episcopal churches in New York, San Francisco and Los Angeles were voicing concern and taking action regarding AIDS and those infected by the virus. They thereby launched the very first religious community response to AIDS — a response "from the pews up". Those who had long worshipped together and shared church socials together were now together in the face of the virus as they had never been before. They began to provide personal care services including meals, house-cleaning, transportation to clinics or hospitals; they provided emergency financial assistance or housing; they offered free legal or dental services. And they began to devise new liturgical responses to their suffering.

(From the AIDS National Interfaith Network, Washington DC, USA)

REPORT FROM NORTHERN THAILAND
Case Study: the Strength of a Woman

The Church of Christ in Thailand has experienced the importance of community involvement in counselling and on this basis has developed case studies to assist churches in reflecting on pastoral care and healing community. These case studies, drawn from concrete experiences, include questions for discussion and reflection. One of these studies is as follows:

Arthit and Urai lived together with their six-year-old daughter Nut and Arthit's parents in a village about 30 km. south of Chiang Mai. They learned that they were both HIV-positive when they went for medical check-ups prior to deciding whether to have a second child. Arthit, angry with himself for having brought this upon his family, became suicidal. Urai's love, equanimity and firmness kept him from taking his life. "Whatever happens, we'll face it together," she said. When Arthit was diagnosed with cryptococcal meningitis, he again felt discouraged and defeated. On top of the physical suffering came the pain inflicted by others. Neighbours stopped coming to visit for fear of contracting HIV. People in the market where Urai sold fresh vegetables avoided her stand, and her business slowed drastically. The family of Arthit's sister even took Nut away for fear that she would contract HIV by living under the same roof. Although he had been very close to his daughter, Arthit's own irrational fear even stopped him touching and holding Nut. He missed her comfort and warmth. He would not go outside the house, he stopped eating and he stopped taking care of himself. Still, Urai rose early each morning to go and sell her vegetables, only allowing herself to cry for a few minutes in the darkness before her husband awoke, refusing to let him see her tears. Again, it was her love, determination and commitment to him that made life worth fighting for and pulled Arthit back from despair.

After visiting a specialist at the hospital, and receiving medication for his meningitis, Arthit's condition improved within a matter of days. Some time later Arthit and Urai heard about a Buddhist meditation centre where the abbot taught a technique designed for people living with AIDS. Based loosely on psychological and psychosomatic principles, and using a model which combined traditional Buddhist teachings and healing, it was providing many people with an effective spiritual discipline. It helped to release their pent-up emotions, focus their minds and to clarify their thoughts and planning, resulting in improved health and a strengthened immune system. After a one-week session at the centre, they returned home feeling utterly renewed, refreshed, re-invigorated, and with new desire and energy for the struggle for life. At home they kept up the meditation, growing stronger day by day. While pain, problems, obstacles, frustration, grief and family issues which brought disagreement and quarrels did not disappear, Urai and Arthit felt able to confront them one by one, day by day, without fear.

About this time they were introduced to the Church of Christ in Thailand's AIDS ministries team. The team visited weekly, brought basic medicine they needed and, more importantly, just sat and talked quietly with them, giving them a chance to express their feelings, giving voice to their thoughts and breath to their dreams. Soon Arthit's sister returned Nut to them, and Arthit himself packed away the thin mattress from the front room of the house where he had become accustomed to lying when he was sick or feverish. "I don't need it now," he said, "because there are no longer any sick people in this house." Urai gradually assumed the role of unofficial counsellor to people with problems in their district — anyone who needed a listening ear, a helping hand or a shoulder to cry on. She was a source of encouragement and hope for dozens of persons and families who were HIV-positive. Even some who had shunned her in the marketplace sought her help, asking what made her so strong in the midst of her crisis.

One day Urai appeared at the CCT AIDS ministries office with fear and confusion in her eyes. Arthit had terrible headaches, could not rise from bed, and there were new skin lesions even worse than before. "Does this mean he is really at the last stage now?", she whispered between gasps, with barely enough strength to force the words out. Then the tears, held back for months, came rushing out. We sat with her and let her cry until she finished, then found some pain medication for her to take to Arthit, and promised to visit them both the next day.

When members of the team arrived at their home, Arthit was just as Urai had described. Yet it became clear after only a few minutes of sitting and talking together that the most distressing and disheartening thing was that neither Arthit's father nor mother, nor anyone else in the household or neighbourhood dared to touch him. They were afraid even to spend more than a few moments at a time in the room with him. He wanted to sit and look out of the window, but no one would help him up. Our workers went to Arthit's side, touched his face and arms, and applied ointment to the affected skin. Placing their arms gently around his waist, they eased him to his feet, and supported him as he walked the few paces to the door to see the sunshine.

From that day nearly ten months ago, Arthit began to improve. He weighs more now than he did before getting sick, and while you might see the scars on his face and arms if you looked for them, you cannot help noticing the radiant smile which is on his face most of the time. It is a hard-won smile which comes from learning to live and love each day, one day at a time. Urai, still Arthit's rock, solace and joy, continues in good health offering friendship, advice, encouragement and hope to many others living with HIV. Some have formed an informal support group which meets regularly in their home. And reporting on what has been a personal and family disaster, "I have found true love... I think it's worth it, don't you?"

QUESTIONS FOR DISCUSSION:

1. In the context of the HIV/AIDS pandemic, how should Christians and churches respond to claims of healing potential (physical, spiritual and otherwise) arising from other traditions, such as Buddhist meditation or natural "folk" medicines?

2. Imagine yourself in Arthit's place. How would he feel about being touched, or physically cared for in the way he was by members of the CCT AIDS ministries team? How would you feel about being touched? How would feel if your parents refused to touch you?

3. In terms of mental, spiritual, social and relational health, how much of Arthit's and Urai's success in living with HIV/AIDS is due to medical care and treatment, and how much to other sources?

4. Consider Urai's role in this story. What observations, as general as they may be, would you venture to make regarding the role of women (wives, mothers, daughters, etc.) in Asian households during times of disease, death and crisis? Where does Urai's strength come from?

From a report by Prakai Nontawasee on the Church of Christ in Thailand's Health Promotion Unit; Source-Report on the Meeting of the Sub-Group on Pastoral Care and Healing Community, New York, pp.35-38. (Facing Aids, 89)

APPENDIX V

Vulnerability

1. SOCIO-ECONOMIC AND CULTURAL CONTEXTS

Socio-economic and cultural contexts are determining factors in the spread of HIV/AIDS. Because these circumstances differ in from place to place, countries, districts and even villages may have quite different HIV/AIDS stories and current profiles. But the WHO currently estimates that nine out of ten people with HIV live in areas where poverty, the subordinate status of women and children, and discrimination are prevalent.

Development practice with respect to HIV is paradigmatically the practice of human development. This is so for significant reasons. The focus of HIV is people's sexual, psychological and social relations and behaviour. No roads, fertilizers, procurement systems or stock exchanges are available to distract attention from or mask the fact that people are the focus of its practice. It is critical to explore the relationship between economic, social and cultural variables and the spread of HIV — who becomes infected with the virus and with what spatial distribution. Examples which have been identified as having a causal role in the spread of the virus include gender (more specifically the economic, social and cultural lack of autonomy of women, which places them at risk of infection); poverty and social exclusion (the absence of economic, social and political rights); and labour mobility (which is more than the physical mobility of persons and includes the effects on values and traditional structures associated with the processes of modernization). At the core of the problem of transmission of HIV are issues of gender and poverty.Thus, the classical components of development — transportation systems, labour markets, economic growth, governance, poverty and more —are within the causal framework which determines the patterns and speed of spread of the virus. These components will also be affected by the impact of the spread of the virus, its associated mortality and morbidity and the burden of dependency and social disruption it will create. No longer can the implications of failures to alleviate poverty or success in employment be understood in isolation. All of the components of development affect what happens with the HIV epidemic. *(Elizabeth Reid, UNPD, Facing Aids 14)*

At the root of the global socio-economic and cultural problems related to HIV/AIDS are the unjust distribution and accumulation of wealth, land and power. This leads to various forms of malaise in human communities. There are more and more cases of economic and political migration of people within and outside of their own countries. These uprooted peoples may be migrant workers looking for better-paying jobs or refugees from economic, political or religious conflicts. Racism, gender discrimination and sexual harassment, economic inequalities, the lack of political will for change, huge external and internal debts, critical health problems, illicit drug and sex trades, including an increase in child prostitution, fragmentation and marginalization of communities — all these factors, which affect "developed" as well as "developing" societies, form a web of inter-related global problems which intensify the vulnerability of human communities to HIV/AIDS.
(Facing Aids, p.23f)

2. HUMAN BEINGS IN RELATION

To be human is to be in relation, to be involved in a web of connections with others — in the family, at work, in the church, at leisure. Above and beyond all this human relating is the relationship God freely offers to all in love. Relations with other human beings, like relations with God, may manifest the same respect for the otherness of the other which makes freedom possible and the same warmth of relationship in the form of love.

Christians may speak confidently concerning God who is known in relationship because such a relationship of freedom and love was enacted visibly in Jesus Christ. During his life — which is as important for belief as his death, although it has had less attention in the Western theological tradition — Jesus showed in practice what it is to live this relationship with God, encountering others with the promise and demand of the kingdom.

There was in the way Jesus behaved an openness to people of all kinds, without barriers of class or race or gender. Just as God in love accompanies all creation, so Jesus went among the poor, telling them that they were loved by God even if they had not been able to keep the law scrupulously. He dined with a rich Pharisee, and told another who came to see him at night that he needed new vision and had to be born again (John 3:3). He healed Jewish lepers and a Roman soldier's child. There were women in the group that travelled with him, and unlike many holy men he did not shrink from the touch of a prostitute. In all that breadth of relationship, Jesus incarnated the *accessibility* of God, who "shows no partiality" (Acts 10:34; Rom. 2:11), but is open to all — rich or poor, sick or healthy, old or young.

When people and churches live out of relationship with God and follow Jesus, therefore, they will be continually open to others and offer relationship to them, even to those who seem very different.

Just as there is no closing off of relationships in the gospel accounts of Jesus, so churches cannot withdraw into being congenial groups of the like-minded, refusing openness to and esteem for others who are physically or socially different.

A similar observation emerges from considering Jesus' relations with the religious establishment of his day. He attended the synagogue and was certainly no religious dissenter. But he denounced or bypassed religious practices and ordinances which put difficulties in the way of ordinary people in their relationship with God. Not only did he preach the immediacy of unconditional divine love and forgiveness, but he also put it into practice through his own accessibility and his going to where the people were. All this has something to say to the churches about human being-in-relation. It speaks powerfully against churches which confess that nothing separates us from the love of God (Rom. 8:39) and then go on to set up barriers of their own between themselves and other people.

There can be no valuable relationship in which each does not desire the *well-being* of the others. God's concern for the well-being of creation is visible in Jesus' healing of the sick and his exorcising of demons. Medical work and forms of other healing maintain that tradition. This is one way human beings express both the openness and the esteem and affection of their being-in-relation to those with HIV/AIDS, even though no cure has been found.

Relationships continually require an enlargement of understanding. No one understands from the start everything about being in relation. It seems that this was the case even for Jesus. The gospels tell of Jesus' encounter with a Syrophoenician woman who asked for his help (Mark 7:24-30; Matt. 15:21-28). At first he answered that his calling was to Israel alone; but through this woman he came to understand that his ministry was to extend far more widely. Similarly, human beings in relation are always being called on to extend their understanding, especially when confronted by new situations like that brought by the HIV/AIDS pandemic. Again, Jesus praying in the garden of Gethsemane that the cup of suffering might be taken from him does not appear as one who is iron-clad in divine immunity, but rather as a person who went forward without the certainty of any such position and *trusted* in God. Nor are we required to be invulnerable and certain in our relationships. Rather we are called to be open, learning and trusting.

It is demanding to follow the way of Jesus in relationships. Such open being-in-relation, which acknowledges no barriers but seeks the well-being of all, will seldom be popular with the authorities. In political terms, Jesus was crucified because of who he was and what he did represented a threat to the power which maintained public order as the Roman authorities saw it and to the religious sensibilities of the Jewish leaders. Yet one understanding of the resurrection is to see in retrospect that no matter how abandoned and forsaken by God (Mark 15:34) Jesus felt himself to be, God was present through it all and finally vindicated him. Not even the greatest misunderstanding or repression can separate those who are "on the way" from this sustaining love of God and from the fellowship of the church.

(Facing Aids, p.23f)

APPENDIX VI

Care and Prevention

1. SAFE PLACES FOR SHARING, TELLING AND LISTENING

The church can be a healing community only if it is truly a sanctuary, that is, a safe space, a healing space. For healing, people need a place where they can be comfortable in sharing their pain.The church needs to create an atmosphere of openness and acceptance. St Basil the Great taught that it is up to those in leadership positions in the church to create an environment, an ethos, a "disposition" for the cultivation of goodness and love in the community. The leadership of the church is called upon to nurture the seeds of the *Logos*, God's own word and God's own energy among the people. By creating a proper atmosphere or disposition, that "good moral action" which is love will issue forth in the lives of the human community.

> *The advice of St Basil the Great comes to all those in leadership positions within the church, emphasizing their responsibility to create an environment — an ethos, a "disposition" — in which the cultivation of love and goodness can prevail within the community and issue in that "good moral action"* which is love. *(Facing Aids, 44)*

Creating "safe spaces" for telling one's own story within our church communities is therefore a practical step through which congregations can become healing communities. The church, which is built upon and shaped around the master story of the gospels, can offer a forum where those who are afflicted can, in trust and acceptance, let down their guards and share their stories. Of course, this is not easily done. Self-disclosure, surrendering the chains of shame and guilt that have held one in bondage, may seem like a kind of "death". Many would rather keep the contents of such a story hidden — not realizing that a person's hold on the story is often as much the problem as the story's hold on the person. *(Facing Aids, 79f)*

2. ARCHBISHOP OF YORK JOHN HABGOOD, SPEAKING AT A HEARING ON AIDS DURING THE WCC CENTRAL COMMITTEE MEETING IN JANUARY 1987

The AIDS virus is fragile. For its transmission it depends upon intimate contact. And there is an interesting connection between intimacy and vulnerability. Every intimate contact makes us vulnerable in all sorts of ways, not only through transmission of infection but also psychologically and in our personal identity. This is why every civilization has in various ways surrounded intimate relationships with rules, with structures, with ceremonies, with taboos. These have, as it were, protected the relationships.

What I see the AIDS epidemic as teaching us is that we can no longer treat these intimate relationships lightly. That is where the world has lost its sense that close contact between human beings needs to be within an ordered framework... This, it seems to me, is a moral and theological understanding which can be expressed in ways which are accessible not only to those with Christian commitment but to all those who think seriously about our human nature and our contacts with one another. *(Facing Aids, 31)*

3. HUMAN SEXUALITY

Sexuality is an integral part of human identity. It is expressed in a variety of ways, but finds particular expression in intimate human relationship. It is "erotic" in the classic sense, that is, it drives one to move beyond oneself into encounter with another in relationship. And while this aspect of human identity finds particular expression in the dimension of physical intimacy, it cannot be separated from its emotional, intellectual, spiritual and social dimensions. A Christian understanding of sexuality seeks to take account of the fullness of all these dimensions, yet recognizes the mystery which God has given to human beings in sexuality as a whole.

Christianity has traditionally understood sexuality to be a gift of God for the task of procreation. In some traditions this is linked with an understanding of human beings as "co-creators" with God. While the role of sexuality in procreation is clear, a broader understanding of sexuality also values its role in enriching partnership between persons and in bringing pleasure. Society has therefore come to recognize a diversity in the types of human sexual relationships and continues to face questions, for example, about the acceptance of non-heterosexual identity.

Along with its potential for bringing the richness of intimacy and joy to human relationships, sexuality makes people particularly vulnerable — to each other and to social forces. In connection with HIV/AIDS, sexuality increases vulnerability in two ways. First of all, as we have seen, many physical expressions of sexuality can bring one into contact with HIV infection. Second, the very fact that humans are sexual beings makes them vulnerable to the many and varied social factors which influence moral decisions and actions.

Like other aspects of creation, sexuality can be misused if people do not recognize their personal responsibility. Thus societies have always sought to protect people from vulnerability in this area. Through value systems which classify certain behaviours as socially unacceptable or through more formal means such as the institution of marriage, the expression of human sexual desire has been regulated and directed in ways deemed necessary for responsible and safe community life. Churches have particularly affirmed the role of marriage in this regard. In spite of all these attempts to provide protection and encourage responsibility, the abuse of sexual power and relations remains a reality. This is particularly apparent in the growing commercialization of sex and in sex tourism.

But ideas of what is sexually moral (that is, of what is "right" and not "wrong") are formed in a constant interaction between personal and community values. There is continuing debate about the origins of sexual identity, that is, whether it is genetically "given" or learned through social development. But it is certain that belief in and adherence to moral *behaviour* are developed in social interaction.

Christian faith and the churches clearly have an important role in influencing how this interaction occurs, and in the development of personal and community beliefs. In many instances Christianity and other religions have helped to develop, if not determine, prevailing systems of social moral responsibility. A case in point, as noted earlier, is the affirmation of the primary nature of marriage in building family and community. *(Facing Aids, 30f)*

"Orthodoxy is quite clear on this point: the sexual life of men and women is possible only in marriage, the purpose of which is procreation. Throughout the Christian world, marriage has become so unstable that it now seems almost unnecessary. In Russia, almost half of marriages break up, leaving about half a million children without one parent every year. Sixty percent of men and forty percent of women commit adultery, and infidelity ranges from one-time unfaithfulness to creation of a second and even a third family on the side. It is in this age that children enter sexual relations nowadays. The young people who do not want to marry entertain themselves sexually, corrupting their own bodies and souls. To speak nowadays about sexual restraint before marriage is something abnormal and even "amoral".

Meanwhile, marriage is God's institution. Orthodoxy has always taught that marriage has a great calling and regarded it as God's will and the fulfilment of one's earthly duty, which is procreation and propagation of Christian faith on earth.

Anatoly Berestov, Russian Orthodox Church,
WCC consultative group on AIDS meeting, Geneva, September 1994