

Responding to the HIV/AIDS Epidemic in Africa: Churches United Against HIV and AIDS

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Introduction

As a Religious Studies major that is also interested in the field of science, I wanted to write an honors thesis that was able to incorporate both of these fields. Having been to South Africa on a service trip in which I worked at orphanages and HIV/AIDS clinics, I was given a passion towards understanding more about this disease and the people it affects in such a dramatic way. Through my scholarly interests along with personal experiences and passions, I have written an honors thesis which focuses on the organization Churches United Against HIV and AIDS, or CUAHA, and its relationship to the HIV/AIDS epidemic. I will examine the relationship these methods have to Westernized medicine and the current understanding of HIV/AIDS and traditional healing beliefs. I will then give an in-depth analysis of the CUAHA model in response to the epidemic.

In order to properly discuss and analyze CUAHA, a brief introduction and historical reference must be given. CUAHA is “an ecumenical network, uniting churches and creating a shared commitment to HIV and AIDS issues. Through capacity-building and the exchange of ideas and experiences, the network helps churches and faith-based organizations build more effective programs to address the HIV epidemic.” CUAHA was founded in 2002, uniting churches and faith-based groups located in Southern and Eastern Africa. These institutes include “Anglican, Catholic, Lutheran, Methodist, Orthodox, and Pentecostal churches and organizations, non-denominational Christian groups and multi-faith movements.” Through collaboration with partner organizations in Finland, these different churches and faith-based organizations were able to unite and form what is now known as CUAHA. (CUAHA History)

The main supporter for CUAHA is the Helsinki Deaconess Institute in Finland, a Lutheran Christian organization founded in 1867. The first public service act carried out by this Institute

was a hospital for 8 patients, used to treat epidemics, because the other hospitals in Helsinki were poor. The Institute continued to provide assistance to people in need, especially those that lacked adequate healthcare, and formed “a social enterprise group providing a range of social and health care services, as well as educational services.” Today they support many different world crises, such as drug addiction and homelessness, but the organization’s main focus is on the HIV and AIDS epidemic. (Helsinki Deaconess Institute) Please note, the historical information specifically about CUAHA was provided to me by the organization’s website, but the website was recently attacked by a virus and is no longer available; after contacting the organization via Facebook and email, they informed me that it will take several months, if not longer, to re-install the website due to a lack in finances.

My honors thesis is valuable to the study of religion because it demonstrates how religion and science are not necessarily a separate binary but instead can incorporate each other and have a relationship, demonstrated by CUAHA’s model. This is significant, because traditionally in educational settings science and religion have been held as separate entities; for example, when studying in a scientific environment God or other religious ideals are not introduced as possible reasons for the phenomena that are observed. Many times it is assumed that science and religious beliefs must ignore each other and remain separate. I have seen this in both my Religious Studies and science classes while a student here at the University of Colorado; the two fields are completely separate, and the information presented very rarely crosses. If it does, it is in an argumentative way. When discussing the world and the natural phenomena that occur, the explanation is quite often in either scientific terms, or religious ones. However, as I will demonstrate, these two subjects of study have the possibility of influencing each other in a positive manner, regardless of personal beliefs and understandings of how the world operates,

which is a fundamental characteristic of the CUAHA model, and I will show in my analysis in a later chapter.

Regardless of the status of CUAHA's website, I still had access to their main primary work, *Towards an HIV and AIDS Competent Church*, which is the training manual provided to participating faith-based organizations and holds the model that has been constructed by CUAHA. After I provide information on the Western scientific approach and understanding of HIV/AIDS in Chapter 1 and the traditional African beliefs in Chapter 2, I will break down this training manual piece by piece to try and understand the ways in which the model is effective in local African communities, and provide an analysis as to how it incorporates not only traditional beliefs but also Western concepts in responding to HIV and AIDS. I will be arguing that CUAHA's model is an effective model, due to its relationship with African communities, the incorporation of both religion and science, and each facet CUAHA uses in order to influence and help as many people as possible.

Chapter 1

Epidemiology

HIV/AIDS is an epidemic that continues to spread and steadily rise worldwide. Since the epidemic was first identified, more than 75 million people have contracted HIV and approximately 36 million have died from HIV-related causes. The Foundation for AIDS Research states that more than 35 million people now live with HIV/AIDS, and 3.3 million of them are under the age of 15. In 2012, an estimated 2.3 million people were newly infected with HIV, and every day nearly 6,300 people contract HIV. In 2012, 1.6 million people died from AIDS. More than two-thirds, or seventy percent of all people living with HIV, live in sub-Saharan Africa; this means that 25 million people in sub-Saharan Africa have HIV/AIDS. In 2012, approximately 1.6 million people in this area contracted HIV, and approximately 1.2 million people died of AIDS. This is roughly seventy-five percent of all AIDS deaths worldwide in 2012. In comparison to sub-Saharan Africa, in the United States there are about 1.1 million people living with HIV/AIDS, and in Western and Central Europe there are approximately 860,000 people living with HIV/AIDS. (“Statistics: Worldwide”) These statistics demonstrate the fact that HIV continues to be a worldwide epidemic and sub-Saharan Africa is significantly the most impacted geographic population. The fact that sub-Saharan Africa holds such a large percentage of the world population affected by HIV also helps to indicate why many organizations are focusing on this area.

In a historical timeline given by AVERT, short for the organization’s full name AVERTing HIV/AIDS, there “is now conclusive evidence that HIV originated in Africa. A 10-year study completed in 2005 found a strain of Simian Immunodeficiency Virus (SIV) in a number of chimpanzee colonies in south-east Cameroon that was viral ancestor of the HIV-1 that

causes AIDS in humans.” It is thought that the disease was first transmitted to humans around the 1940s, with studies of the spread of the epidemic suggesting “that about 2,000 people in Africa may have been infected with HIV by the 1960s.” The early findings of HIV did not lead to epidemic status; rather, it did not become an epidemic until the early 1980s. (“History of HIV and AIDS in Africa”) AVERT gives a brief summary of the history of HIV/AIDS in Africa and demonstrates the disease’s rapid expansion:

Once HIV was established rapid transmission rates in the eastern region made the epidemic far more devastating than in West Africa, particularly in areas bordering Lake Victoria. The accelerated spread in the region was due to a combination of widespread labour migration, high ratio of men in the urban populations, low status of women, lack of circumcision, and prevalence of sexually transmitted diseases. It is thought that sex workers played a large part in the accelerated transmission rate in East Africa; in Nairobi for example, 85 percent of sex workers were infected with HIV by 1986. (“History of HIV and AIDS in Africa”)

While HIV is a relatively new disease, it spread so quickly due both to these circumstances and also a lack of overall knowledge about how HIV is transmitted..

HIV and AIDS continued as an epidemic, spreading throughout Africa, ravaging the continent in both the Western direction and throughout the South, including Malawi, Zambia, Mozambique, Zimbabwe, Botswana, and South Africa. The rapid transmission and accelerated infection rate throughout Africa was cause for alarm, and also confusing as it was still unclear how HIV worked or even what it exactly was. The way it was transmitted was not clearly understood, and misconceptions spread swiftly, such as the possibility of contracting HIV by sharing food or even by making eye contact with an infected person. Stigmatization of those that had contracted HIV followed these rumors, and was directed towards people involved in prostitution, promiscuity, and the high-risk lifestyles correlated with fear of HIV. (“History of HIV and AIDS in Africa”)

HIV and AIDS quickly became a devastating problem with little government intervention or involvement. “With a few notable exceptions, the 1980s were characterized by an insufficient response to AIDS in Africa.” This was due both to concern over matters deemed more important, such as economic or political affairs, and to a lack of information relating to HIV. “As there was no treatment or cure for HIV infection or AIDS in the 1980s, government strategies had to focus on prevention.” This included “encouraging people to revise their sexual behavior by abstaining from sex or delaying first sex, being faithful to one partner or having fewer partners, or using condoms consistently and correctly.” (“History of HIV and AIDS in Africa”)

In examination of the disease HIV/AIDS in a scientific context, the disease AIDS was unknown until 1981, when “AIDS was first recognized as a distinct entity in the United States...the first several hundred people diagnosed were homosexual men.” (Essex 1) As was mentioned before, studies have led to an estimate that people were rapidly becoming infected in the 1960s, but the disease AIDS was not actually identified and classified until 1981. This disease was relatively new, and at the time of its arrival there was no medical knowledge or understanding. Many hypotheses were suggested: for example, “AIDS was caused by frequent immunostimulatory doses of foreign sperm tissue antigens resulting from numerous sexual partners and receptive anal intercourse.” (Essex 1) In other words, frequent anal intercourse with more than one partner resulted in a stimulated immune system due to unknown antigens, or foreign substances, entering a person’s body, which was assumed to lead to AIDS. This was just one hypothesis, among many, when AIDS first became recognized as a disease. It was not until later, after many studies and observations had been made, that the connection between HIV and AIDS “was identified in 1983” and defined as “a retrovirus which, since 1986, has been known as the human immune-deficiency virus (HIV).” (Webb 3)

Explanation: HIV as a Retrovirus and Anti-retroviral Therapies

The term “retrovirus” refers to a group of viruses that encompass HIV along with simian immune-deficiency virus (SIV) and the human T-cell lymphotropic virus (HTLV). In order to give a brief introductory explanation of HIV as a retrovirus, I have extracted a passage from *Essential Biochemistry*:

The human immunodeficiency virus (HIV) is a retrovirus, a virus whose RNA genome must be copied to DNA inside the host cell. After entering a cell, the HIV particle disassembles. The...viral RNA is then transcribed into DNA by the action of the viral enzyme reverse transcriptase. Another viral enzyme, an integrase, incorporates the resulting DNA into the host genome. Expression of the viral genes produces 15 different proteins, some of which must be processed by HIV protease to achieve their mature forms. Eventually, new viral particles are assembled and bud off from the host cell, which dies. Because HIV preferentially infects cells of the immune system, cell death leads to an almost invariably fatal immunodeficiency. (Cornely 541)

This explanation describes the life cycle of HIV in a simplistic way, but it must be unpacked to acquire proficiency as to what this description means.

The transmission of the HIV retrovirus occurs via sexual intercourse, mother-to-child transmission during birth, and parenteral transmission. “Parenteral transmission of HIV occurs most commonly among IDU (Intravenous Drug Use or Injecting Drug User) when needles are shared...Parenteral transmission can also occur by the transfusion of infected blood.” (Morison) In other words, in order to become infected HIV must enter the bloodstream; this takes place via blood, seminal and vaginal fluids. This counters many common beliefs about HIV and AIDS; many people conclude that the disease can be transmitted through kissing, hugging, sharing food, or, in an even more general sense, by touching or coming in contact with an infected person.

“The virus, once within the blood stream, targets the CD4 T-lymphocyte cells, which constitute a vital component in the immune system, as they coordinate antibody production and all immune responses.” This function of the virus is what causes people who are infected to

become susceptible to disease from foreign pathogens. With a lack of antibodies, people with HIV cannot protect themselves or respond to foreign infections; antibody production is necessary for survival, and the virus removes this essential function. “HIV viral RNA is transcribed to DNA within the T-cell cytoplasm. The viral DNA is then incorporated into the host’s nuclear DNA. Replication of the cell results also in viral replication, possibly concentrated within the lymph nodes.” (Webb 3) In layman’s terms, the virus becomes integrated into the host cell so that when the host cell replicates the virus replicates as well, allowing it to multiply and spread throughout the body, further suppressing the immune system.

Once HIV has been transmitted and infected a person, it will slowly develop into AIDS, or Acquired Immune Deficiency Syndrome; this is the final stage of HIV, when the majority of CD4 T-lymphocyte cells have been compromised by the virus and a person’s immune system is no longer able to defend itself against pathogens such as bacteria and other viruses, fungi; in some cases, AIDS even allows for the development of some cancers. (“Learn About HIV/AIDS”)

Attempts at cures for HIV have been made, but so far there has not been success. The main issue that arises when trying to cure HIV is the latency of the virus, which means that the virus lies dormant in the host genome. Because of this characteristic, the virus does not need to mutate in order to evade treatments as long as it is dormant in the host genome. (Stephen) A common drug that has been used is AZT, or azidothymidine, which slows down the replication of HIV; however, these drugs “ultimately do not prevent it and the onset of AIDS is merely delayed.” (Webb 3) Antiretroviral therapy is currently the solution to delaying the onset of AIDS:

Standard antiretroviral therapy (ART) consists of the combination of at least three antiretroviral (ARV) drugs to maximally suppress the HIV virus and stop the progression

of HIV disease. Huge reductions have been seen in rates of death and suffering when use is made of a potent ARV regimen, particularly in early stages of the disease. (World Health Organization)

Again, it is crucial to note that antiretroviral therapy is not a cure for HIV or AIDS, but rather a way to avoid the illness associated with AIDS for a longer period of time. Antiretroviral therapy is only a temporary solution, and after participating with a certain antiretroviral treatment for an extended period of time, it has been observed that HIV reacts to the drug in the person's body and evolves so that it is no longer affected by the drug. (FoundCare) In other words, HIV builds up a resistance to the drug, or the combination of drugs, rendering the therapy no longer effective. This is why this treatment plan is not a cure, but instead it prolongs the life of a person infected with HIV.

Before explaining the different types of drugs available, terms that will be used must first be defined and described, as it is essential to comprehending how the antiretroviral therapies work. Transcription is the process of copying DNA in order to form new RNA, which will later be used to form new proteins. In contrast, HIV has a reverse transcriptase enzyme that does the reverse of normal transcriptase enzymes, and synthesizes DNA using RNA as a template. Many of the drugs used in antiretroviral therapy focus on this enzyme, and I will provide two cocktails as an example. Another key piece in the replication of HIV is the protease, which is an enzyme that breaks the peptide bonds between amino acids, therefore breaking down a protein. This action performed by HIV protease is also affected.

There are four dominant groups of antiretroviral drugs, which include nucleoside reverse transcriptase inhibitors, non-nucleoside reverse transcriptase inhibitors, protease inhibitors, and fusion or entry inhibitors. Nucleoside reverse transcriptase inhibitors were the first available drug in combating HIV. It works by inhibiting HIV's reverse transcriptase, which hinders the ability

of the enzyme to convert its genome to double stranded DNA, which is essential to infect the cell. Non-nucleoside reverse transcriptase inhibitors, or NNRTIs, “also stop HIV from infecting cells by intervening with the transcriptase of the virus. The non-nucleoside drugs work slightly differently from the nucleoside analogues in that they bind in a different way to the reverse transcriptase.” NNRTIs bind to a hydrophobic pocket in the reverse transcriptase of HIV-1; HIV-2 is resistant to most NNRTIs. (Mackie) Protease inhibitors hinder protease, which in HIV “attacks the long health chains of enzymes and proteins in the cells and cuts them into smaller pieces. These infected smaller pieces of proteins and enzymes continue to infect new cells.” The protease inhibitors work by not allowing HIV protease to break down these proteins and enzymes, and therefore stop HIV from replicating. Finally, fusion inhibitors are the most recent drug that has been found, and the one that has been approved is Fuzeon. “The surface of HIV carries proteins called gp41 and gp120. These are proteins which allow HIV to attach itself to and enter into cells. By blocking one of these proteins, fusion inhibitors slow down the reproduction of the virus.” While these are the current categories of drugs involved in antiretroviral therapies, new research and new discoveries are leading to additional drugs, and giving more options for antiretroviral therapies. (FoundCare)

The Challenges Presented By HIV/AIDS

Medicine and religious organizations are trying to find solutions to the same problem; HIV/AIDS is a devastating disease, affecting millions of lives without a viable solution present. Both are trying to help people with the same problems, using different methods and understandings as to what is most valuable when trying to find an answer. For medicine, the most obvious answer to this problem is the discovery of a cure. Religious organizations also

want a cure to be found, but they are unable to conduct the research themselves, and are typically not trained in medicine to provide proper medical care.

Not only does the inability to cure HIV present difficulties to organizations trying to respond, but also the devastation it causes in the lives of those that have contracted HIV/AIDS. It is long and painful, and often accompanied by loneliness due to stigmatization; fear of contracting HIV many times is more powerful than compassion and love. Religious organizations at times can perpetuate this challenge of AIDS, by focusing on what they consider to be the root of the problem: moral misconduct and sin. Instead of focusing on the cure as the main solution, these religious organizations hold behavior modification as their top priority, which they believe will lead to a decrease in the transmission of HIV, therefore slowing the effects it has on the world.

Regardless of if we are examining science or religion, the main challenge presented by HIV/AIDS is that it spreads so quickly, there is no way to cure those that are infected, and it has terrible distressing effects on the lives of those infected by the disease. In contrast to this strict binary, CUAHA attempts to bridge medicine and religion in response to these challenges, by acknowledging the utility medicine has to offer, rather than denying it. This is what makes the model revolutionary in terms of the HIV/AIDS epidemic and I will be discussing the methods they use to bridge this gap, and to offer a solution not only to the physical ramifications from HIV, but also the emotional ramifications.

Chapter 2

To understand and examine the implementation and methods used by a specific religious group such as CUAHA, we must first discuss traditional African beliefs about healing, especially in relationship to the epidemic of HIV and AIDS, and how other religious organizations have influenced the HIV/AIDS response. In this chapter I will discuss and provide examples as to how in Africa healing is not only correlated with, but inseparable from, traditional beliefs and customs. I will follow this with Pentecostal attitudes towards healing, and a brief history of Christian medical missionaries and faith-based organizations in Africa, to provide a compare and contrast to traditional African beliefs.

Traditional African Healing

Unlike the concept of “western medicine,” the African notion of healing incorporates many different beliefs and native rituals in order to provide both an explanation and a treatment for ailments, and specifically, HIV/AIDS. Traditional and native beliefs, which include witchcraft, play a crucial role in African society by incorporating traditional medicine and healing. Healing is not restricted to one set of rituals or beliefs; there are several different methods and types of healers. The two different basic types of traditional healers are the herbalist and the diviner-medium. Herbalists tend to work with natural resources, while the diviner-medium style of healer uses relationships with ancestors and spirits that they believe assist in divination and healing. However, in “recent generations, two other types of healers have emerged that may be termed indigenous but nontraditional, namely the religious faith healer and the alternative healer.” (Green 17) These different types of healers fit in different ways in the context of the HIV epidemic, and they are important in understanding various resources that people in this context may turn to.

Witchcraft is crucial when discussing traditional healing, and is also inseparable from daily life. The line that divides witchcraft from healing is thin, and at times inseparable. For example, in the specific case of South Africa, both healing and witchcraft use what is called *muthi*, or traditional South African medicine, but use it for different functions; in the case of the healers, *muthi* is used to do just that: heal. In the case of witchcraft, *muthi* is used to harm. This leads to a need to be careful, and “a person worried about witchcraft or hoping for health is faced with two central questions: What sort of relation is there between the victim/patient and the substances, and how does this relation connect with the human principle behind the *muthi*?” (Ashforth 143) In other words, does the person seeking healing have a positive relationship with the person who is using the *muthi*? If not, the *muthi* may be used to do harm, but if the relationship between the two people is positive, the *muthi* will be used to provide the desired healing.

This example demonstrates the difficulties when trying to distinguish between a witch and a healer; in contrast, there is an obvious line drawn between traditional medicine, or “African science” and “Westernized” medicine, which Adam Ashforth explains clearly, writing,

“African science” in everyday talk occupies a place alongside the miracles of Scripture and the magic of what is usually referred to as Western or White science in its ability to transform the world in mysterious ways. African science and White science constitute two distinct aspects of human power to understand and shape the world. (Ashforth 146)

This demonstrates the disconnect and the line that is often drawn between African and Western healing. There is a divide between beliefs and concepts commonly held in the Western world, and the beliefs and concepts that are present in African society. The “commodities embodying Western science, classes in physical science taught in schools...

and the doctors staffing clinics and hospitals have an irreducibly alien feel...they are not indigenous, not African. They are “things of Whites,” ...Even when the scientists or doctors are black and African, they are not thought of as practicing *African* science.” While westernized medicine may have the ability to provide medicine for physical ailments, it is not always congruent with the needs in the African community. Western science and medicine are not able to protect against ailments that are due to witchcraft. Instead, traditional healers from within the community have the responsibility of defending against witchcraft, because “witches as well as healers are referred to as ‘African scientists’”, and therefore have the knowledge necessary to perform healing. (Ashforth 146) This distinction between Western science and African science is parallel to the distinction that is made between Western healing and African traditional healing; they are able to respond to different crises and are successful only in the appropriate circumstances.

As the AIDS/HIV epidemic continues to grow there is the inevitable belief that witches are responsible, since the “available interpretations for misfortunes such as AIDS includes concepts of witchcraft and understandings of invisible agency that are substantially different from those of Western biomedicine.” Local healers are trusted over the foreign ideas brought forth by Westernized medicine, because not only are they are able to understand forces such as witchcraft and invisible agency, but they have the tools necessary to respond to it. Belief in these forces is very real in African communities, and “from the perspective of traditional healers and their clients, then, witchcraft undoubtedly constitutes a serious social problem. Multitudes of people are experiencing harm and death by witchcraft ... Legions of healers are battling these evil forces. HIV/AIDS is part of this struggle.” (Ashforth 10) The conviction that witchcraft is real is crucial in understanding

traditional African beliefs and the divide from Western medicine. This is due to the fact that witchcraft is not a widely accepted notion in Western society, and therefore is not often taken seriously. While these beliefs may seem ridiculous from a Western perspective, it is a serious concern in African society, and cannot be ignored or taken lightly.

Traditional concepts of healing are not limited to witchcraft, but include other African beliefs and practices, such as ancestor worship. "The traditional African approach to health and healing is closely linked to their concept of the ancestors who participate in their day-to-day living." (Edwards et. al. 27) This demonstrates a complex historical intertwining between beliefs, which involves various local practices dependent on location and different traditional systems. Traditional healers are paramount in local African communities, as they are acknowledged as "primary health care providers in rural areas...High concentrations of healers in periurban areas suggests that they are still frequently consulted even when hospitals and clinics are available." (Green 19) Again, we see a preference for local healers that are based on African science, rather than depending on Western medicine that is not always explained in terms that African people have had exposure to.

Christianity and Healing in Africa

In sub-Saharan Africa Christianity is an influential religion; the percent of the population that identifies as Christian grew from 9% in 1910 to 63% in 2010. ("Global Christianity – A Report") The Christian denomination that presents the most spiritual healing in its doctrine is Pentecostalism, which is present not only in Africa, but worldwide.

Pentecostalism is based around experiences that are influenced by the Holy Spirit, which include "speaking in tongues," prophecies, visions, healing, and miracles. It is also referred

to as the “Charismatic movement,” and it is the fastest growing denomination in global Christianity. (Asamoah-Gyadu 1) According to the most recent studies, approximately 12%, or 107 million, of Africa’s population are Pentecostals, and this is continually on the rise. Those that belong to African Instituted Churches, or AICs, can also be classified in the Charismatic Movement; approximately 5%, or 40 million people, belong to an AIC. (“Overview: Pentecostalism in Africa”)

Healing is essential to beliefs in Pentecostal churches in Africa; many claim to even heal members of HIV/AIDS. Obviously, many people find faults with this claim, as it gives false hope to those that have been infected. However, this claim of healing provides “religious, spiritual, psychological, and social support to its numerous members.” In order to do this, African Pentecostal churches incorporate indigenous beliefs in a new framework that is focused on fighting evil powers of Satan, or “the enemy,” and bestowing the good powers of God. To fight against the enemy, which in this circumstance is HIV/AIDS, members of Pentecostal churches engage in “deliverance rituals, healing rituals, night vigils, prayer and fasting rituals and thanksgiving rituals (rituals of passage) in order to counteract Satan’s evil machination.” All of these rituals are aimed at fighting against evil forces, and are “packaged to handle spiritual terrorist attacks such as sickness, HIV/AIDS, unemployment, social insecurity, death, emotional stress, hunger, poverty, barrenness and virtually all of life’s vicissitudes.” (Adogame 477-478) Healing is not offered in a medical context but instead purely in one that is spiritual, and is acting against evil spiritual forces by engaging faith and belief systems.

Through Pentecostalism there is a constant interplay between social and modern contexts, along with traditional native beliefs incorporating Christian faith. This complex

mixing between social, political, traditional, and religious factors is essential to healing and faith in the African context. Faith is made up of many different aspects, such as “local religious heritages, world religions, notions of science and progress, the biomedical discourse of AIDS campaigns and the authority of the state that endorses them, and not least, reflections about the experience of material deprivation...” (Becker 2) The interaction between these different critical aspects of everyday social life and faith provide an understanding to African people about their current societal situation and the adversary circumstances that accompany it.

Faith-based organizations, along with Pentecostalism, offer an understanding that African people, especially those that are infected with HIV, can relate to by incorporating struggles from everyday life such as poverty and sickness into their teachings; this is “part of the attraction of faith-based explanations of HIV/AIDS that they resemble the problems Africans face...they do not promise only to help people deal with AIDS, but offer explanations also of other social ills, and suggest entire ways of life.” (Becker 7) Healing is not limited to traditional healing, but by incorporating both traditional and Pentecostal Christian aspects, people infected with HIV are offered comfort that addresses not only the disease but also their societal circumstances. Becker addresses the connection between native Africans’ positions in society along with healing, writing,

The encounter between religious practice and AIDS...is part of Africans’ long-standing struggle with adversity, assault, and domination. Thus, both the turn towards faith healing, with its processual, euphoric and trance-like qualities, and the re-examination of behavioural rules and scriptural teachings in the context of AIDS draw on long-standing notions and practices. (Becker 7)

The Pentecostal Church creates an environment in which people feel safe and comfortable, because the different rituals of the Church resemble traditional beliefs, and it is providing

answers to a world in which the strife that is commonly experienced cannot otherwise be explained. The different rituals of the church provide hope and comfort to people living not only with HIV/AIDS, but also for the poverty and low socioeconomic status that they are experiencing. Pentecostal churches claim spiritual warfare motifs, and the Bible and prayer are the best ammunition that is provided to “thwart the enemy’s plans. Prayer, fasting, repentance, forgiveness and righteousness are clusters of attitudes and practices deemed to embody obedience to God,” and therefore fight against the misfortunes placed upon them due to spiritual warfare. Many Pentecostal churches are dedicated to spiritual warfare and resolving problems solely through spiritual means. “Elaborate prayer rituals are enacted and victims are believed to experience and undergo theotherapy (spiritual healing) as a consequence of the spiritual duel.” However, some Pentecostal Churches, such as the Redeemed Christian Church of God that Adogame provides as an example, also use programs to educate on AIDS prevention, encourage activities that will divert youth from acquiring HIV, and raise funds for ARTs. (Adogame 478-482)

Faith-based organizations such as Pentecostalism and AIC’s can offer an understanding that westernized medicine cannot; scientific dialogue that African people have not had any exposure to is not used; instead language that incorporates faith and spirituality is used, which is more easily understood. “Christian faith healing, setting off where medical doctors give up or where modern medicine is unavailable, can be taken as a step towards emancipation from scientism as opposed to science itself.” (Becker 10)

Through the offering of spiritual responses rather than depending on solely medicinal and Western responses, Pentecostalism offers more hope for the future along with the comfort that comes from community. This is not to say that Christianity is always divided from

science and modern medicine. Rather, groups such as CUAHA have begun to incorporate western medicine along with faith healing.

Medical Missionaries in Africa: A Brief History

Due to the immensity of the epidemic in Africa along with the lack of a cure, many Christian mission organizations have taken action against HIV/AIDS. Medical missions in Africa are not new; rather, there were medical missions throughout the world by 1850. Medical missions can be defined as “medical activities that are carried out by personnel in institutions which are administered by a religious organization.” (“Missions and Missionaries”) In Africa, the medical personnel that were involved in the late 19th century included David Livingstone, a Scottish explorer and missionary, and Cardinal Charles Lavigerie, a “brilliant Catholic mission strategist, who in the 1860s sent African medical students to study Western medicine at the University of Malta.” The numbers of medical missionary organizations continued to grow, and in “1910 there were more than 10,000 religious missionaries in the field in Africa – 6,000 Protestant and 4,000 Catholic. Roughly 10 percent of these were truly medical missionaries.” Protestantism and Catholicism began to take root and spread throughout Africa. However, economic development, along with modern medicine, did not take root and spread in the same fashion. This has resulted in many countries holding only one medical school and very few resources available to allow development in relationship to public health. (Olanmi and Perry)

With the spread of HIV and AIDS in Africa throughout the late 20th century and into the early 21st century there was a drastic increase in the need for medical assistance and care. The presence of the epidemic created a surge in humanitarian efforts through organizations such as the Peace Corps, who today “send thousands of volunteers (usually young adults) to Africa every year to facilitate health education efforts, to establish support services for orphaned children and

HIV/AIDS-infected communities and even to provide direct medical care.” Organizations that became engaged in the campaign against HIV/AIDS, along with the Peace Corps, included the International Red Cross and Red Crescent, and the World Health Organization. In the 1980s throughout the 2000s organizations such as the U.S. Global AIDS Program, the UN Global Fund to Fight AIDS, and the President’s Emergency Plan for AIDS Relief, or PEPFAR, played active roles in the fight against HIV/AIDS. (Olakanmi and Perry)

Faith Based Organizations, or FBOs, are essential in Africa to have an effective response to the HIV/AIDS epidemic. In developing parts of the world, such as Africa, FBOs are “the major providers and support services to people living with HIV/AIDS.” The position leaders have in society is the main reason for this, as they are influential and have many connections throughout the community. FBOs also “tend to have a good understanding of local social and cultural patterns,” such as traditional healing beliefs and native practices. This enables them to incorporate not only faith-based practices, but also to relate to the traditional healing practices in order to reach as much of the community as possible. They are also becoming more connected with health care providers and educational researchers. These various connections between faith, traditional beliefs, and relationships with modern health care and education gives FBOs such as CUAHA an ability to provide a well-rounded approach towards HIV, by incorporating beliefs and knowledge from many different sources. (Green 3-5)

Religious leaders are crucial in African society; this is not restricted solely to healers, but as a category overall in both traditional and church contexts. In a book published by UNICEF they write, “The churches have strengths, they have credibility, and they are grounded in communities. This offers them the opportunity to make a real

difference in combatting HIV/AIDS.” Instead of being just a part of the community, religious leaders are crucial in communities, and have a huge influence on the ideas and thoughts of those that they serve. Again UNICEF writes, “Overcoming HIV/AIDS and the stigma that fuels its spread is one of the most serious challenges of our time. It requires courage, commitment and leadership...especially among religious leaders who can use the trust and authority they have in their communities to change the course of the pandemic.” (UNICEF 1-8) Traditional healers, churches, and religious leaders have acquired the trust of the people in the community they are a part of, through time, dedication, and relationship building. This gives them an advantage over other groups such as governmental organizations, because trust is essential when discussing topics that affect personal lives, such as HIV and AIDS. Churches and religious leaders have credibility in the communities they are a part of, which means that the messages they are passing on to people are also credible, and can be used as a tool when fighting against the epidemic of HIV.

The division between religious organizations and governmental programs is detrimental, and it results in a lack of overall service to those that need it. Olakanmi and Perry conclude, writing,

Promoting public health in Africa will require the combined diligence of indigenous, religious, governmental and nongovernmental groups. Unfortunately, bureaucratic barriers often prevent these groups from collaborating. As just one example, in Kenya, Catholic Church-related clinics provide 40 percent of all HIV/AIDS care (by its own estimates, the Catholic church provides about 25 percent of all care worldwide). Yet the Global Fund cannot be easily accessed by local churches or church-related clinics, such as those in rural Nairobi province – the sole providers there. One lesson from history is that closer coordination among groups whose mission calls them to serve the poor of Africa might alleviate current problems in the HIV/AIDS crisis. It is imperative that such unified efforts are encouraged and fostered in the 21st century. (Olakanmi and Perry)

This demonstrates how a division between religion and medicine is counterproductive in responding to HIV/AIDS. As I have stated above, FBOs have spent decades integrating into

African communities and forming relationships that many government supported programs do not have. Along with these relationships comes the understanding of traditional and native customs, and this information can be used in education about HIV/AIDS, along with attempting to provide care and therapies. Organizations that are solely medical do not have as much information about communities, and they also do not have the materials or knowledge that is necessary to be able to provide the information about HIV/AIDS to local people in a way that they understand and is beneficial to them. Regardless of these necessities held by local churches, faith-based organizations often do not have access to funding, which makes it difficult, if not impossible, to provide adequate care. This divide between social and religious organizations is debilitating when both groups are trying to address the same problem. As Olakanmi and Perry state, closer coordination rather than continued division between these groups would be extremely beneficial, and would possibly alter the fate of the HIV/AIDS epidemic through a network of support and teamwork. The CUAHA model attempts to bridge the divide between religion and medicine and create the aforementioned network, which will be demonstrated by the analysis of their model in the next chapter.

Chapter 3

This chapter will offer an in-depth analysis of the CUAHA model, by using material from preceding chapters along with CUAHA's main primary resource, *Towards an HIV and AIDS Competent Church*. This training manual gives clear guidelines of CUAHA's model in response to HIV and AIDS. In order to be what CUAHA has termed an "HIV/AIDS competent church," the training manual has specifically noted several aspects of both religious organizations and African culture that must be addressed when confronting the HIV/AIDS epidemic. The model provided by CUAHA is one of simplicity, in order to be able to reach a larger community independent both of denomination and level of understanding of the epidemic. By keeping the language in the training manual very simple and vague, CUAHA is able to connect with each individual faith-based organization, rather than showing bias towards a specific denomination or church. I will outline the different aspects of the training manual, and provide further analysis as to the effectiveness of the model provided by CUAHA.

Ecumenical Model

CUAHA is an ecumenical organization, which they define as a "unique network that brings Catholic, Pentecostal, Orthodox, Lutheran, Methodist, Anglican, and Coptic churches together in an effort to address HIV and AIDS." CUAHA emphasizes the importance of faith-based organizations and religious leaders in African communities, due to the inseparable relationship between religion and African society. CUAHA's manual towards becoming what they have defined as HIV/AIDS competent states, "Religious leaders hold an important position in African societies, regardless of what religion or denomination they belong to." This demonstrates the influence that these leaders have, regardless of which

faith organization they belong to; their opinion matters, regardless of what type of answers are being sought after. These influences may be faith or spirituality, relationships, and financial concerns, amongst many other things. This includes HIV/AIDS, which cannot be looked at as a separate issue but instead must be understood as a completely altering aspect of the life of a person who is infected. "Their role has never been restricted to religion or spirituality as such, but has covered all aspects of human life ... Religious leaders have always functioned as appreciated counselors." (Happonen and Jarvinen 5) They are not only important members of African society, but they are people that are looked to for advice and for counsel, and their opinions are not taken lightly, but instead are considered seriously. CUAHA, in order to clarify this concept in an even clearer fashion, writes,

Faith-Based Organizations are in a unique position in Africa to address HIV and AIDS. For example, they attract large crowds, meet regularly, and have been active in health and education sectors. Traditionally, religious leaders have not only dealt with the spiritual needs of the people, but have also served as counselors, psychologists, sociologists, healers, and so on. Therefore, churches and church leaders have a prominent role in African societies ... It places communities of faith in a privileged position to influence people's behavior and attitudes, even in relation to the HIV pandemic. (Happonen and Jarvinen 14)

This provides another source as to how religion and faith are fundamental and intrinsic parts of African culture. Rather than occurring outside of the HIV/AIDS epidemic, or avoiding it as some religious organizations have done, CUAHA is stating that religious organizations, more specifically religious leaders, need to be actively involved in the HIV/AIDS epidemic, in accordance with the rising number of members who have been affected by the disease. Members of religious communities may be infected themselves or may have family members and loved ones who are infected. This corresponds to the

discussion of FBOs in the previous chapter, and further exhibits the efforts being made by CUAHA to bridge the divide between medicine and religion.

In order to address this issue, churches and other faith-based organizations must be what CUAHA has defined as HIV/AIDS competent. The definition they provide is in three parts, and they write, “Competency is defined various ways. CUAHA suggests that an HIV and AIDS Competent church: (1) Understands the HIV and AIDS challenge at hand; (2) Has the ability and corresponding skills related to HIV and AIDS; and, (3) Is able to respond to the pandemic.” According to CUAHA, if a church or religious organization is able to accomplish these three things, and therefore be competent in relationship to the HIV/AIDS epidemic, then they will be using the correct methods to respond to the HIV/AIDS epidemic. Due to their prominent placement in African society, these religious organizations have the influence necessary to successfully accomplish becoming a competent church. They have both the leadership and the societal standing necessary for people to not only listen, but also to follow what is advised. Not only do religious organizations have the high ranking status in society, but they also have “significant human and financial resources at their disposal and a large network that can help disseminate sound information to masses of people.” (Happonen and Jarvinen 16-17) Along with the leadership status held by religious organizations, there are other significant human resources which can be used to provide the necessary skills and knowledge in response to HIV/AIDS, along with the financial resources which allow these people to obtain the skills and knowledge that is necessary for this response.

Again, it is because of the church’s position in African society that CUAHA believes their model will be successful. “UNICEF and UNAIDS have pointed out that ‘Religious

leaders are in the unique position of being able to alter the course of the epidemic' and that 'there is undoubtedly still untapped potential within faith-based communities to contribute to the AIDS response.'" CUAHA is continually demonstrating the importance that these faith-based organizations hold within the communities, and is using this as an argument to support their model. "Pastors and church leaders have a ready audience. If church leaders see the importance and relevance of speaking and educating people about HIV and AIDS, they do not need to search for a receptive audience." (Happonen and Jarvinen 18) Instead of seeking out those that have been infected with HIV/AIDS, CUAHA is supporting the fact that by becoming competent leaders in the church, people who have been infected will come to the leaders, based on the understanding of the disease and the support that will be offered in response to it. This is due to the prominence held by these organizations; the relationship held to the community is the only way that CUAHA's model will be successful, and it is important for faith-based organizations to understand this relationship in order to be competent while fighting against the HIV/AIDS epidemic.

In order to become competent in the context of the HIV epidemic, CUAHA has a specific subset of topics that must be understood by churches before they can accomplish this; they write, "The CUAHA network identified 13 key aspects that constitute HIV and AIDS competency in a faith-based organizational context." (Happonen and Jarvinen 19) These topics are divided into three categories, and are as follows: the foundational aspects, which include facts about HIV and AIDS and sexuality; the strategical (response) aspects, which include prevention, stigma, advocacy, empowerment, leadership, and healing; and lastly, the ecclesiastical aspects, which contain liturgy and sacraments, counseling, testing, networking, and caring. At the end of each of these chapters, the people being trained take

a quiz to test their competence. By the end of this book and after taking each quiz, the person who is being trained should be competent in responding to HIV and fulfill the three categories provided by CUAHA that outlines what this means. In order to have a substantial understanding of this model, and what it takes to become competent, each of these categories must briefly be discussed.

Foundational Aspects

This portion of the book published by CUAHA contains the chapters about facts and sexuality. These are the foundations of understanding HIV/AIDS, and without a comprehension of these two aspects, the rest of the model will not be able to be understood. This contains the most basic information possible, and will provide the basis for competency. The foundational aspects are not presented in a strictly factual form, but incorporate religion into the information, therefore allowing it to continually be faith-based.

The statement provided by CUAHA for the “Facts” chapter of the book is, “The HIV and AIDS response must rest on facts. Understanding the modes of HIV transmission, the impact of HIV and AIDS, and methods of prevention are essential in containing the spread of the virus. The church addresses cultural practices and religious beliefs that relate to HIV and AIDS.” (Happonen and Jarvinen 25) By understanding the facts about HIV and AIDS, church leaders who are responding are able to do so in a way that is not only informative, but in a way that will be able to glorify God. Rather than focusing on the modes through which a person became infected, they will be able to see a fuller picture that includes a basic understanding of what the virus is doing in the body and the suffering that coincides with infection.

The chapter that follows, titled “Sexuality,” provides more information that corresponds with transmission of HIV. However, rather than presenting it strictly in a scientific fashion, CUAHA incorporates religion, writing, “God created sex. Sex is a natural and positive thing. HIV is primarily spread through sexual contact. The church promotes safer sexual practices. The church deals openly and frankly with the issue.” (Happonen and Jarvinen 29) Instead of sex being a purely evil act and one that should be punished, CUAHA is both recognizing it as both an act that was provided by God and also one that is natural. HIV/AIDS is a topic that is often rejected by churches and ignored due to the relationship it has with sexuality, but CUAHA is stating that it must be addressed openly. This must be done in order to try and prevent further infections. Instead of preaching a dialogue of pure abstinence, it is acknowledged that this is not always the case, so safer sex needs to be practiced. This is vastly different from what is thought to be a church’s message; often, a message solely of abstinence before marriage is taught. However, in order to be competent, CUAHA is stating that this cannot be the only message provided. They realize that pure abstinence by every member in the community is not a realistic goal, and instead try to promote safer sex through the use of condoms and less sexual partners is much more practical.

Strategical (Response) Aspects

This section of the book provides information on methods that competent churches will use in order to respond to HIV; it not only gives information for things that can be done, but also messages for a person in a leadership position to provide to people who have been infected.

The first chapter in this subset of the book is "Prevention." As mentioned before, many times churches take an unmitigated abstinence approach; the message provided is clearly one of wait until marriage, and remain faithful within that marriage. This is often known as the ABC approach, or Abstinence, Be faithful, and use Condoms. However, CUAHA writes, "In its ethical and moral teaching the church takes into account that factors such as poverty, socio-economic status, gender culture, etc. increase the vulnerability to infection. The church provides knowledge about the best methods of preventing the transmission of HIV." They mention the ABC model, but address the fact that this is overly simplistic and does not incorporate cultural and traditional views. It also does not allow for the fact that HIV can be transmitted through means other than sexual contact, such as blood transfusions. Instead, CUAHA mandates that a competent church provides information on all possible ways of preventing HIV, and "All relevant information and methods need to be provided for people to make personal ethical choices." (Happonen and Jarvinen 35-37)

Rather than making choices based on their own doctrine, churches that are competent will provide all information available in order to allow people that come to them to make their own personal decisions.

The next chapter is "Stigmatization," and is focused on stigmatization related to HIV and AIDS. Those that have been infected often become outcasts in society due to the disease, and are regarded as sinful people. CUAHA states that "AIDS is not a plague sent by God" and a competent church will not stigmatize those that are infected. "The church does not stigmatize or discriminate against persons with HIV or AIDS, nor does it violate human rights." Instead of shunning people who are infected, they not only must be included within the faith-based community, as an act against discrimination, but an active position against

stigmatization must be encouraged within the local community as a whole. Stigma associated with HIV “is one of the most powerful barriers to the prevention of HIV transmission and effective treatment,” and in order to be a competent church, leaders must fight against this barrier in accordance with CUAHA’s model. As we have seen before, the church is in a leadership position within the community and has the ability to affect the amount of stigma within the society they are a part of. CUAHA identifies this as a crucial part of making their model effective, as the “fight against stigmatization saves lives. It relieves suffering, and it greatly increases the quality of life even in situations where effective medication is not available.” Stigmatization enables HIV, because it leads to a person not wanting to get tested and have to face becoming outcast from society. Fighting against stigma associated with the disease will make significant progress towards eradicating HIV. (Happonen and Jarvinen 39-40)

Following stigmatization is “Advocacy,” which also incorporates the church as an active player in the lives of people infected with HIV. CUAHA’s statement on advocacy reads, “The church acts for and with those infected and affected. They have the right to live a life of dignity. HIV infection may lead to vulnerability. The church should seek ways and provide means for vulnerable people and groups to defend their rights.” This coincides with stigmatization, with faith-based organizations being responsible for becoming active defenders of those that are vulnerable within their region. Once more we see the role that religious leaders have as an integral part of CUAHA’s model, due to the fact that they are “central figures in African communities. They are perceived not only as advisers in spiritual matters but are also turned to when seeking answers to questions about everyday life...He or she enjoys a unique position in defending the rights of the most vulnerable.” As an

attribute of their position within African society, religious leaders can fight against stigma while becoming advocates for victims of the HIV virus. It is essential that leaders are following these guidelines and understand their role and status in order to make the model provided effective. They not only must be advocates, but they be empowered to fulfill this role, with the “motivation, ability to identify and solve problems, utilization of available resources, and multiplication of intervention efforts.” (Happonen and Jarvinen 43-47) It is through empowerment of the religious organization that they are able to oppose stigmatization through advocacy for people infected with HIV. This empowerment is achieved through becoming an HIV/AIDS competent church, and utilizing the various resources that are available to them.

“Leadership” is the next chapter in the training manual, and it is once more addressing the integral role church leaders have in society, and outlines the messages that should be provided by leaders that are a part of an HIV/AIDS competent church. “Church leaders speak openly and empathetically about HIV and AIDS. The leaders participate in HIV and AIDS activities... The church leaders allocate resources to HIV and AIDS ministry. The leaders ensure that there is an implemented HIV and AIDS policy.” Through this statement we see the allocation of an active engagement with HIV and AIDS, rather than ignoring the issue or setting it to the side. Activism is a constant theme that has been set throughout the response section of this book, and is the most crucial aspect of CUAHA’s model. (Happonen and Jarvinen 51) The position faith-based leaders have in African society has continually been brought up in each chapter, and in order for the guidelines placed by CUAHA to be followed it is the most important feature of being an HIV/AIDS

competent church. Without recognition of the placement religious leaders have in society none of the directions provided by CUAHA will hold ground.

Healing is the final chapter in this section, and it is one of the most important aspects of the CUAHA model, as it is the chapter that very clearly demonstrates the need to bridge the divide between medicine and religion. The official statement given by CUAHA on healing is, "An HIV and AIDS competent church believes in divine healing. Healing is understood holistically. Medicine is a part of healing. Healing is tied to the will of God. Falling ill is not the result of unbelief." Rather than separating and making a distinction between healing and medicine, CUAHA proclaims medicine to be a part of healing, and in order to be an HIV/AIDS competent church this must be recognized. CUAHA describes an HIV competent church as understanding "healing holistically. Healing includes many aspects such as inner healing, psycho-social healing, and life management. The various activities of churches may create a supportive environment for healing." (Happonen and Jarvinen 55) This reflects on traditional African culture and beliefs; rather than separating faith and religious beliefs from society, CUAHA is demonstrating a holistic approach that parallels African societal norms. Religion is not separate from healing, but instead must be incorporated and understood in the context of healing. In order to be what CUAHA qualifies as competent, a distinction between life outside of the church and inside the church for a person who is infected with HIV cannot be made. In opposition to this view, they are stating that it is necessary to intertwine private and public life, and the church plays a crucial role in this. This will create a holistic healing process that will not isolate religious or medical healing, but instead mandates an incorporation of every aspect of the

lives of people who are infected with HIV by integrating both a medicinal response and a faith based healing response.

In comparison to what we have previously seen, where Westernized medicine is something that is both misunderstood and distrusted, CUAHA is announcing its stance that medicine cannot be held separately, but instead must be included in a holistic belief about healing, which incorporates both religious healing and Westernized medicine. The organization acknowledges not only that both preventative measures and medicinal therapies have been available, but also that religious groups have often held themselves separate from these available options. "Unfortunately, the churches were not that active in these efforts. Perhaps the churches felt that HIV medication is not their business." (Happonen and Jarvinen 56) Instead of perpetuating the belief that HIV medication is something that must be overlooked by the church, CUAHA is both recognizing and conceding the need for these resources, and accepting responsibility that will allow them to use available resources to help the community.

This acknowledgment is crucial, because CUAHA identifies previous faults with religious organization's responses to AIDS, and presents a non-traditional stance within their model. They have a modified approach to the confrontation provided by the HIV/AIDS epidemic, and they write,

However, medicine and healthcare are a part of healing. A competent church understands the development of medicines as God's providence. A church leader does not have to be a medical doctor to advise and guide a person living with HIV to find correct medical treatment. A part of holistic healing is achieving an improved physical condition through medicine. The church should have some basic knowledge of medication relating to HIV and AIDS and know how to access medical help. If at all possible, the church should assist in making medication available to all. For the church staff, the primary question should not be how a person became infected with HIV but are they receiving the proper care. (Happonen 55)

CUAHA is declaring that medicine must not solely be accepted by the church but must be embraced as a vital component of their model, recognizing it as healing that is provided by God. The CUAHA framework promotes the use of medical care and encourages leadership and staff to help promote the utilization of resources available, and even employs churches to assist in the availability of treatments needed to treat people who are suffering from HIV/AIDS. By including this in their model, CUAHA is attempting to connect religious leaders in the community with contemporary treatments, rather than forcing a separation between faith-based healing, scientific research, and antiretroviral therapies.

Through addressing medicine as an important option rather than a foreign idea that is imposed, CUAHA is trying to create competent churches in the context of HIV and AIDS, instead of continuing the traditional separation between church and medicine as has been seen throughout the history of the HIV epidemic in Africa. They are attempting to do as Olakanmi and Perry suggest in the conclusion of “Medical Volunteerism in Africa,” in which they state that both governmental and scientific efforts must be united with religious organizations in order to try and combat HIV/AIDS. By identifying their model as a holistic one, CUAHA has built a bridge between medicine and religion, and has endorsed the valuable traits provided both by religion and medicine. They have identified the valuable ramifications extending from this connection and it is an essential aspect of their model.

Ecclesiastical Aspects

This is the final category in the book, and addresses the religious elements that accompany HIV activism by churches. It outlines different physical roles that churches can play within their communities, such as counselling and testing, and provides guidelines as to how this

can be accomplished. Many of the topics of chapters are intertwined, and will be discussed in this fashion.

The first chapter of this section contains the subject of “Liturgy and Sacraments,” and presents topics that a competent church will address in sermons and worship services. “HIV and AIDS are in the church... The church includes HIV and AIDS related topics in sermons, prayers, teaching, and education.” (Happonen and Jarvinen 61) This is another opportunity the church has to play an active role, and gives a platform necessary to stand against stigmatization in communities, and for leaders to incorporate people who are infected along with those who are not, thus fighting against stigmatization not only through messages but also through actions.

Another way CUAHA’s model provides guidelines for the church to be engaged in HIV/AIDS in their communities is through “Counseling” and “Testing.” It is part of HIV/AIDS competence to train church staff to be able to perform these duties in a way that is beneficial to HIV infected people. “The church leadership must ensure that ministers are properly trained in HIV and AIDS related counselling and cooperate with clinical counsellors.” Counselling is a crucial aspect of therapy for the disease through providing comfort for those that are infected, and testing helps to prevent the infection from occurring in the first place, if at all possible, by avoiding infection in those that do not have HIV. It is also beneficial for those that do get tested, because it “is a way to receive available services. If a person is found to be HIV positive, he or she can seek appropriate medical care.” (Happonen and Jarvinen 66-70) By providing not only access to testing, but also counseling, churches that are competent can provide resources at all stages of HIV and AIDS.

“Networking” is the next part of CUAHA’s model, and it is considered necessary in order for churches to succeed in their HIV efforts. “No one church can respond to AIDS alone. The response is a concerted effort...Churches share their proficiency and learn from the experience of others.” By including this, CUAHA is allowing their model to expand and incorporate more and more religious organizations by utilizing those that are already involved. Instead of solely spreading their message individually, CUAHA is able to cover more ground and therefore circulate between different circuits of faith-based communities. “Many networks are very informal and at times it happens quite naturally. Even a casual discussion may be a start of a small-scale network.” (Happonen and Jarvinen 73-74) CUAHA depends on networking in order to have a successful regional model; without this, they would have to impose it upon new organizations.

The final chapter and therefore final facet of CUAHA’s model is “Caring.” “The church takes an active role in caring. Care is provided unconditionally. Caring is not used for proselytizing but is faith in action. Caring ministry is multi-dimensional including nutrition, support, treatment, counselling, advocacy, and empowerment.” In other words, caring encompasses every component of CUAHA’s model, and this term is used to conclude the model that they are suggesting. In order to be a competent church, the church must first care enough to use each feature provided by CUAHA’s program. This term also refers to various members of faith-based organizations, which then can be employed to carry out a role outlined in the 13 part framework that has been set up by CUAHA. The term caring is used to tie everything together, and bring the CUAHA model full circle. An important piece in the statement given by CUAHA is caring “is not used for proselytizing but is faith in action.” (Happonen 77) In contrast to other missionary models CUAHA is not using their

model to convert people to Christianity, but instead have determined that by providing care and comfort to people infected with HIV they are demonstrating their faith. In other words, care is not proselytizing but instead is faith in action. In CUAHA's framework the church has a responsibility to the members of its community, but also needs to be respectful of beliefs that may be different. This de-emphasizes the role of the church as a religious organization and instead places emphasis on a leader's responsibility to the community as a whole.

Two Foundational Aspects: Concluding the CUAHA Model Outline

There are three things that stand out in the CUAHA model. The first is the importance of religious leaders and the essential part they play in connecting a religious organization with the community. The second is the ecumenical networking that has been created by CUAHA, which allows the model to reach out to a larger group of people. If the model was constricted to one denomination, not nearly as many people in the community would be able to be reached, and the model would not be nearly as effective. The third aspect is the abilities faith-based organizations have over solely governmental programs when responding to HIV/AIDS. These three aspects function together to enable a successful model, and provide the framework for each clear sub-category that CUAHA has set. Obviously, each of the different chapters provided in CUAHA's training manual hold an important role; however, none of them would operate without the placement of leaders in African society, the network created by being an ecumenical organization, and the placement FBOs have that allow them to reach out to African societies. When tied together, these three aspects overall allow CUAHA's model to have a strong foundation in African society, and overall a greater impact.

Conclusion

CUAHA has managed to make a model that has the goal of reaching out to and including all members of the community; not only those that are members of the participating religious organization, but also those that have no affiliation. As I have demonstrated in the previous chapters, the placement of religious leaders in African communities is crucial, both through their status in African communities, along with their assistance to the CUAHA model, which will allow the model to be successful. Again, it is through the trust and credibility that these leaders have that they will not only be able to communicate the messages provided by the CUAHA model, but also have members of the community listen. By bridging the gap not only between believers and non-believers, but also between faith and western medicine, CUAHA is incorporating all aspects of HIV and AIDS treatment strategies and responses, and making a model that attempts to reach out to everyone, rather than a select few members.

The incorporation of both members of the church along with other members of the community is something that a number of churches have not done. Many other religious organizations not only have the goal of responding to HIV/AIDS, but also proselytizing. CUAHA's model does not do this, and this is part of what will make it a successful model in comparison to others. Instead of having the goal of converting more members, churches associated with CUAHA reach out to everyone with the mission of caring for and providing help to those that have been affected by what can only be called a devastating disease. Their model continually presents an anti-discrimination and ant-stigmatization rhetoric, which is crucial for people who are infected to accept help offered by CUAHA. As I have shown in quotes in previous chapters, stigmatization is one of the most critical enemies in

the battle against HIV/AIDS; it does not allow people infected with HIV to have access to a network of help and care, but instead leads to isolation, which is harmful and painful to any human, especially those dying from a painful and deadly disease.

To be frank, I was surprised by CUAHA's model. In my independent study the previous semester, I had continually seen churches that preached an ABC model, which stands for Abstinence, Be faithful, and use Condoms. This is a model that is not produced with indigenous culture in mind, and the belief systems and understanding of the world do not overlap. The ABC model is produced in the context of Western Christianity, not in the context of local beliefs and systems, in which there is a different view of what Abstinence and Being faithful means. It also does not take into account that there is a mixing between traditional views along with Christianity. As Becker writes, "the famous ABC ('Abstinence, Be faithful, use a Condom) formula for HIV prevention barely scrapes the surface of the way people experience, practice and think about sex." (Becker 4) In contrast to this popular model, the CUAHA model attempts to take many viewpoints into consideration, creating a more holistic approach; they acknowledge that there are traditional beliefs and African society does not have the exact same views as Western European and North American Christians.

By incorporating these beliefs, CUAHA has the ability to be more relatable, influential, and effective in the communities they are trying to access. This understanding and ability to integrate the different elements of African society is what will make the CUAHA model more effective than other models that have been put into place. It uses religious leaders' status in society, something that government programs do not do, in order to spread information and contact as many people as possible. As CUAHA continually

states, and I have stated, religious leaders hold authority and influence in the communities they are a part of. When they speak, others listen. This authority and public influence is crucial to CUAHA's approach being successful, as it is the basis of the entire model. It cannot be emphasized enough how important these religious leaders' statuses are in African society.

Another element that makes CUAHA's model effective is the fact that they are not intimidated by people who do not have the same faith or belief as the religious organization. Instead of being afraid, they reach out to them in equality to those that are not members of their church. This takes away any limitations in the audience that they are able to reach out to, and gives the leaders even more of an influence over a larger community, rather than a small congregation. By providing access to treatments, a safe community, and comfort, CUAHA is exemplifying what is typically known as "faith in action." They are modeling their faith to an entire community through the services they provide; by doing as they say, rather than just preaching it, CUAHA is setting an example in the community, which will lead to an environment in which there is trust. This is crucial if they are to have the ability to provide resources such as testing, counseling, and ARTs; without trust, no person infected with HIV will seek out these resources, which will then be rendered useless.

Finally, as I have mentioned numerous times before, the bridge between Western medicine and Christianity is crucial to CUAHA's model. Rather than focusing the majority of their energy on fighting the battle of spiritual warfare, as many Pentecostal churches do, CUAHA uses Western resources that are available, such as testing and ARTs. By offering prayer along with these resources, CUAHA is taking a pragmatic approach towards the HIV/AIDS

epidemic. They acknowledge the sensibility of medicine, rather than denying it or placing it in a foreign Western context. This is very important because it does not promote denial of the problem, or give any unwarranted promises of healing or a cure. By using faith and religion as a way to explain Western approaches to HIV/AIDS, CUAHA is providing not only a comforting stance, but a realistic one that does not give false hope.

CUAHA published an evaluation report in which they have determined their own effectiveness and success as an organization during the years of 2009-2011, along with the worldwide change in the HIV/AIDS epidemic. They begin by giving the status of HIV in the years leading up to the evaluation report, which showed that in the region CUAHA participates the incidence rate has been either stable or declining; the HIV incidence rate declined by more than 25% in sub-Saharan Africa between 2001 and 2009. AIDS-related deaths decreased by 20% in sub-Saharan Africa between 2004-2009; among children AIDS-related deaths declined by 26% during this same time period. However, sub-Saharan Africa continues to hold the majority of HIV infections globally, with South African countries continuing to have the largest HIV epidemic worldwide. This allows CUAHA to argue that there is still a need for assistance and response to HIV/AIDS, regardless of the statistics from the years leading up to 2009. (CUAHA Evaluation Report 34-36)

CUAHA points out some marks of success, which include officially being recognized as an International Non-Governmental Organization in 2011. The evaluation report has determined that the effort made towards the HIV/AIDS epidemic by CUAHA has been effective, and will only continue to be more effective as the organization continues on. The evaluation report states that CUAHA has “enhanced response of churches and FBOs to the HIV and AIDS pandemic and has improved quality of life of people living with or affected by HIV and AIDS in the Eastern

and Southern Africa.” They make sure that their model is in congruence with national strategies by planning and monitoring national/regional/district/community-based responses towards the HIV/AIDS epidemic to ensure partnership with governmental organizations. They “implement activities that are in line with the national strategic plans/frameworks for HIV and AIDS interventions in respective countries.” They report that the greatest achievement made by CUAHA has been the unification of Christian churches of different denominations and religious ideologies which has allowed a unified response to HIV and AIDS. The churches involved with CUAHA report a greater ability to help people infected with HIV through the training manual, and members of the communities these churches and FBOs serve report that they have had a significant improvement in quality of life through programs established by CUAHA. The model has been implemented in seven different countries, and over 4,000 copies of the training manual have been provided as a resource. CUAHA has also assisted in the implementation of programs to assist HIV/AIDS caregivers, along with education about HIV prevention. (CUAHA Evaluation Report 59-81)

While my personal assessment of CUAHA’s effectiveness and the evaluation report differ in reasoning as to how they are successful, I must also provide some criticism to their model and program. The evaluation report provided by CUAHA did not give any statistics to specifically indicate improvement in the lives of the people that they are interacting with. There were no numbers provided as evidence for people receiving treatment, counselling, or testing. There was also no data provided as to exactly how many churches participate in CUAHA’s model. While they do give data on the number of copies of the training manual that have been given, we are not aware of how many churches and faith-based organizations have received

training. This can lead for some criticism of CUAHA's own determination of effectiveness, as it can be argued that they do not have substantial data to support this claim.

I am also hesitant as to how much influence CUAHA can have in the communities with a lack of governmental partnership and funding. Funding is essential in trying to succeed at what they have set out to do, and it appears that this is where they are most lacking. Without funding, it will be impossible to employ staff to assist in the program, and to provide training materials, treatments, counselling and testing services. In order to make a significant impact, this is the greatest obstacle that CUAHA will need to overcome. Government partnership may be difficult due to political unrest and corruption, but partnership with organizations such as Ministries of Health located in Africa, the Center for Disease Control's Global AIDS Program, and the Health Resources and Services Administration Global HIV/AIDS Programs, would provide funding, an increase in training, technical assistance, and access to ARTs, along with additional human resources such as physicians, epidemiologists, public health advisors, and laboratory scientists. (U.S. Department of Health and Human Services) These resources would allow CUAHA to make a greater impact, acquire higher levels of medical training, and provide more treatment and care to those that have been infected by HIV and are suffering from AIDS.

Regardless of my critiques and suggestions, it must be noted that CUAHA has played a role in responding to HIV and AIDS, based on the data that is available. Again, as Olakanmi and Perry state, "Promoting public health in Africa will require the combined diligence of indigenous, religious, governmental and nongovernmental groups." I have used this quote multiple times because it perfectly demonstrates the relationships that need to be made in responding to the HIV/AIDS epidemic. CUAHA is making an effort to combine each of these groups. They incorporate indigenous belief systems along with religious systems, and combine

them into one design that is used to reach the entire community. They are also attempting to integrate governmental and nongovernmental groups through medicine and scientific approaches with testing and access to available HIV therapies, and by recognizing the functions of these groups, instead of placing them as a distinct and separate identity. Through this, they are making a model that approaches HIV/AIDS from each distinct way, and therefore have the most successful model in comparison to other religious and missionary models that have been presented thus far. In order to become even more influential and maintain what CUAHA strives to do, they will need access to more funding and continue to network between different churches and faith-based organizations. In doing this, they will have access and influence over a larger community of people, and will be able to provide more aid and resources to those that have been affected by HIV and AIDS.

My honors thesis was written to make the argument that CUAHA has an overall effective model, other than the few critiques and improvements I have suggested above. This is due to CUAHA's relationship with African communities, the incorporation of both religion and science, and each facet CUAHA uses in order to influence and help as many people as possible, which was broken down in great detail in Chapter 3. My honors thesis also served as an example demonstrating the positive outcomes that arise when the binary between religion and science is broken, as examined throughout the thesis. The examination of the relationship between religion and science is the value this thesis has to the academic study of religion, because I have shown that it is beneficial to have more interaction between different fields of study in scholarship instead of maintaining a separate relationship, which can open up many topics for further research. There is the potential to research even further the influences religion and science have on each other, especially the interactions between medicine, healing, and various religious

traditions. My thesis solely examines one organization, and it is imperative that research and attempts at incorporating multiple fields of academia continues; this will serve to strengthen not only programs at the University of Colorado, Boulder, but also may affect the way organizations throughout the world run.

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