



BECOMING AN HIV AND AIDS COMPETENT CHURCH

PROPHETIC WITNESS AND COMPASSIONATE ACTION



Approved by the 219th General Assembly of the Presbyterian Church (U.S.A.)



2010



PRESBYTERIAN CHURCH (U.S.A.)
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STATED CLERK OF THE GENERAL ASSEMBLY

Fall 2010

Dear Members and Friends of the Presbyterian Church (U.S.A.):

The 219th General Assembly adopted the resolution, “Becoming an HIV and AIDS Competent Church: Prophetic Witness and Compassionate Action,” in exercise of its responsibility to help the whole church address matters of “social righteousness.” As a social witness policy statement, it is presented for the guidance and edification of both church and society, and determines procedures and program for the ministries and staff of the General Assembly. It is recommended for consideration and study by sessions, presbyteries, and synods, and commended to the free Christian conscience of all congregations and members for prayerful study, dialogue, and action. This letter confirms that this social witness resolution satisfies the rules that govern the formation of social policy in the Presbyterian Church (U.S.A.).

We commonly speak of AIDS and the HIV virus as a tragedy and wonder when the public health resources mustered against the disease will succeed in pushing it back everywhere, rather than simply restricting its spread in some areas. As the background study part of this report shows, the roadblocks are both cultural and economic, and differ in the U.S. and abroad. In the global context this disease is primarily spread today by heterosexual encounters and intravenous drug use by persons in situations of poverty and inadequate medical care. Our medical mission personnel and many development specialists, in fact, consider HIV/AIDS to be a “disease of poverty” complicated by matters of belief, gender and race. Thus, while AIDS from unprotected sexual activity—whatever the relationship status and orientation of the victims—carries a stigma factor that can prompt denial and avoidance of testing and treatment, its prevention needs to address economic and social as well as educational factors.

From the first identification of cases in 1981, the Presbyterian Church (U.S.A.) has responded primarily with compassion and this remains an essential keynote. While most Presbyterians advocate responsible sexual behavior in the monogamous context of marriage and covenanted relationship, we are also aware that a judgmental approach often makes prevention and treatment more difficult. This report helps us know the most healing approaches and is to guide our public policy witness, our practice in the mission field, and our interfaith coordination. This report does something that is not done enough: combine Christian hope and care with a clear-eyed social analysis that avoids overly-simple moralism. *The addition of concern for Hepatitis B & C (see Addendum) reflects some of the social complexity.*

“Truth is in order to goodness” begins one of the “historic principles” near the start of the Book of Order. It goes on, “we are persuaded that there is an inseparable connection between faith and practice...” I close with these quotes as I know this issue will remain difficult but that we have a responsibility to address it and can make a difference.

Yours in Christ,

Gradye Parsons, Stated Clerk

Becoming an HIV and AIDS Competent Church: Prophetic Witness and Compassionate Action



Approved by the 219th General Assembly (2010)
Presbyterian Church (U.S.A.)

Developed by
The Advisory Committee on Social Witness Policy (ACSWP)
of the General Assembly Mission Council

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Becoming an HIV and AIDS Competent Church: Prophetic Witness and Compassionate Action

RECOMMENDATIONS

[Editor's Note: In adding mention of Hepatitis B and C to its approval of a report on HIV/AIDS and the church, the 219th General Assembly (2010) also acknowledges the dangers of co-infection with Hepatitis B and C and other blood-borne diseases, and encourages at-risk persons to take appropriate precautions, noting that exposure patterns and treatment protocols differ markedly. For more information, see the addendum to this report (HIV/AIDS and Hepatitis B or C Co-infection), which can be found on-line as a jump link to Item 19-05: <http://oga.pcusa.org/ogaresources/journal2010.pdf>.]

The 219th General Assembly (2010) of the Presbyterian Church (U.S.A.) approves the following measures in response to the HIV and AIDS pandemic:

1. Approve the “Resolution on Becoming an HIV and AIDS Competent Church: Prophetic Witness and Compassionate Action.”

2. Receive the background rationale (to be included in the *Minutes*) [see below]

3. Encourage the PC(USA) to advocate on behalf of, create, and engage in educational programs that reduce the stigma, discrimination, and fear of persons who have been diagnosed as HIV positive as a method to encourage honest disclosure and prevent the further spread of the virus.

4. Challenge the PC(USA) to become an HIV and AIDS competent denomination at all levels of the church and in all its ministries, combining emphasis on compassionate care with action to dismantle the social inequalities that create marginalized populations at great risk, by doing the following:

a. Call upon congregations to accept the challenge to become an HIV and AIDS competent church by studying the HIV and AIDS related policies and resources of the PC(USA), becoming

(1) knowledgeable about the root causes and social determinants of HIV and AIDS risk and vulnerability, including encouraging all Presbyterians, especially ministers of Word and Sacrament and church leaders, to be tested in order to be a visible example to all people and help eliminate the stigma associated with HIV and AIDS testing;

(2) proficient in being a welcoming community for all of God's children;

(3) compassionate in providing pastoral care for persons living with, or affected by, HIV and AIDS; and

(4) prophetic in advocating for social policies that address the social inequalities creating increased risk of infection, nationally and globally.

b. Direct the appropriate entities of the General Assembly Mission Council (GAMC), in consultation with the Presbyterian AIDS Network (PAN), the Racial Ethnic Caucuses of the PC(USA), the Advocacy Committee for Women's Concerns (ACWC) and the Advocacy Committee for Racial Ethnic Concerns (ACREC), to develop:

(1) denominational standards defining the marks of HIV and AIDS competent congregations and ministries, in accordance with PC(USA) policies and in collaboration with ecumenical partners in HIV and AIDS ministries; and

(2) a study guide that provides pastors, church educators, elders, deacons, mission workers, youth and young adults, and lay persons with practical examples of how to discuss and thoughtfully examine, with cultural proficiency and sensitivity, HIV and AIDS issues, including the role of social structures examined in this report, as well as the role of responsible sexual behaviors, through Bible studies, worship, liturgy, preaching, pastoral care, and social justice advocacy.

c. Call upon presbyteries to include pastoral training related to HIV and AIDS competency as part of a qualified candidate's preparation for ministry.

d. Commend Presbyterian theological seminaries that have incorporated HIV and AIDS education into their community life.

e. Urge Presbyterian theological seminaries to expand their programs to develop HIV and AIDS competency in preaching, pastoral care, and social witness.

f. Call upon the members of the PC(USA) and congregations to renew our commitment to the following:

- (1) being a welcoming community for all of God's children;**
- (2) engaging in anti-homophobic educational programs;**
- (3) providing responsible sex education for our children, including such topics as healthy relationships, harm-reduction practices, comprehensive sex education, and abstinence;**
- (4) encouraging safe sex practices, including condom use;**
- (5) encouraging and/or providing pastoral care for persons living with HIV and AIDS; and**
- (6) calling for universal health care.**

g. Commend the work in the area of HIV and AIDS undertaken by the International Health and Development (IHD) ministry area of the General Assembly Mission Council (GAMC), the Presbyterian AIDS Network (PAN) of the Presbyterian Health, Education and Welfare Association (PHEWA), Presbyterian Women (PW), the Peacemaking Program, the Advocacy Committee for Women's Concerns (ACWC), the Advocacy Committee for Racial Ethnic Concerns (ACREC), and the Racial Ethnic Caucuses of the PC(USA).

h. In light of the social determinants that impact the spread of HIV and AIDS described in this report, challenge all entities of the PC(USA) to identify within themselves and their ministry areas the practices and policies through which they can address these underlying forces of poverty, racial inequality, gender inequality, or human rights violations, nationally and internationally, as appropriate: for example, by supporting basic development projects that allocate resources in a manner equitable to women.

i. Direct the Presbyterian Washington Office (PWO) and the Presbyterian United Nations Office (PUNO) to advocate to the appropriate national and international tribunals

(1) that drug treatment and other treatment and prevention modalities for HIV and AIDS, including condom distribution, be made readily accessible, particularly in

rural areas, and more easily affordable or free to destitute people living with HIV and AIDS;

(2) that government establish partnerships with pharmaceutical companies to enable the free or low-cost distribution of anti-retroviral drugs, nationally and internationally;

(3) that the U.S. government increase funding for critical HIV and AIDS research including research focused on (a) infants and children, (b) the risk behaviors of teenagers and comprehensive sexuality education curriculum for teens, and (c) underreported, indigenous, and special-needs populations;

(4) that the social determinants of HIV and AIDS vulnerability inform all HIV and AIDS research and policies;

(5) that U.S. global health diplomacy be expanded to inform all foreign assistance programs focusing on the factors that lead to good health for all people and the eradication of the social determinants of disease (such as poverty, food insecurity, gender inequality, and the violation of human rights); and

(6) that the overall vision of worldwide diplomacy raises the global health diplomacy to parity with other leading values such as trade and commerce.

j. Direct the Stated Clerk of the General Assembly to communicate to the president of the United States, the chairpersons of the Senate and House standing committees on Appropriations and Foreign Relations, and the administrator of the United States Agency for International Development, the Church's support within U.S. foreign assistance programs benefitting HIV and AIDS -infected countries for (a) expansion of HIV and AIDS prevention activities, including condom distribution, and (b) government partnerships with U.S. pharmaceutical companies to enable free and low-cost distribution of anti-retroviral drugs.

For assistance in Education and Action

International AIDS Ministries

<http://gamc.pcusa.org/ministries/aids-international/>

Presbyterian Health Education and Welfare Association AIDS Network (PAN)

<http://gamc.pcusa.org/ministries/phewa/presbyterian-aids-network/>

Advisory Committee on Social Witness Policy (ACSWP)

<http://gamc.pcusa.org/ministries/acswp/>

Presbyterian Social Policy Compilation

[http://index.pcusa.org/NXT/gateway.dll/socialpolicy/1?fn=default.htm\\$=templates\\$vid=pdcdocs:10.1048/Enu.](http://index.pcusa.org/NXT/gateway.dll/socialpolicy/1?fn=default.htm$=templates$vid=pdcdocs:10.1048/Enu.)

Rationale

This report and recommendations are in response to the following referral: *2008 Referral: Item 10-02. On Directing the Advisory Committee on Social Witness Policy to Develop and Fund a Comprehensive HIV and AIDS Policy for the PC(USA)—From the Presbytery of the Pacific (Minutes, 2008, Part I, pp. 58, 59, 1078–82).*

The 218th General Assembly (2008), “recognizing that the HIV and AIDS pandemic is a critical matter of our faith and God’s justice ... direct[ed] the Advisory Committee on Social Witness Policy (ACSWP), in consultation with appropriate General Assembly Council staff, PC(USA) networks, and church partners, to develop and fully fund a comprehensive study on HIV and AIDS for the PC(USA), recommending compassionate action and giving prophetic witness regarding issues related to people living with HIV and AIDS in the U.S.A. and around the world, and report to the 219th General Assembly (2010) (*Minutes, 2008, Part I, pp. 58–59, 1078–79*).

Having consulted with appropriate entities of the church, a work group was appointed by the Advisory Committee on Social Witness Policy (ACSWP) to draft a report responding to the 218th General Assembly (2008) referral. The members of this group included: Delfin W. Bautista, Kezia L. Ellison, Marsha Fowler, Ann Hayman, James A. Lemons, and Clive Neil. Kathryn L. Smith served as consultant on this project. Staff support to the group was provided by Belinda M. Curry, associate for policy development and interpretation for the Advisory Committee on Social Witness Policy (ACSWP).

Introduction

The Presbyterian Church (U.S.A.) has maintained a faithful witness to the vicissitudes of HIV (human immunodeficiency virus) and AIDS (acquired immune deficiency syndrome) since the mid 1980s. We have charted its course from continent to continent, from gay to heterosexual populations, from the point of view of caregivers to concrete suggestions about how local congregations can get involved, to formulating a Presbyterian AIDS Network (PAN) and establishing a special focus on AIDS in the International Health and Development (IHD) ministry area of the General Assembly Mission Council (GAMC). Presbyterian medical personnel have studied this pandemic, Presbyterian Women (PW) have considered it on their overseas journeys, and mission dollars have been given to AIDS-related causes. The PC(USA) has sought to address this issue with the needs of those infected and affected by this pandemic always at the forefront of our study, reflection, ministry, and practice. Almost thirty years from the advent of this virus we know a great deal—we know what it is and how it is transmitted, we know how to prevent its spread with use of condoms and needle-exchange programs, yet despite this knowledge there will be an estimated 53,000 new cases of HIV reported in the United States this year. We found ourselves looking deeply into the new faces of this disease and have realized that there are many “powers and principalities” at play: not new germs, not uncaring churches, not failed care giving, not a lack of profound and even prophetic social witness policy, but the ever constant presence of poverty, gender inequality, human rights violations, and the constellation of stigma, prejudice, and unjust discrimination and marginalization.

This report presents the PC(USA) with a concise but comprehensive look at HIV and AIDS thirty years after it made its first blip on our epidemiological radar screens. We begin with an overview of the development of the HIV and AIDS epidemic in the United States and globally and the church’s response. From this overview, we report on the present context of the global pandemic as it appears in the U.S. and other regions of the world. We turn to Scripture for comfort, guidance, hope, and a prophetic vision of how to respond most faithfully. We then examine the marginalizing social forces that foster the spread of HIV: poverty, racism, sexism, homophobia, stigma, and discrimination. We see how cultural and religious beliefs can contribute to the greater vulnerability of some groups, extending the power of this pandemic. As we journey toward examining the dynamics of unequal social power, we lift up and highlight populations that have been historically underreported or mis-categorized. This leads us to a social analysis and an assessment of our current situation where we address the implications of the

dynamics of these powers and principalities for us as a church, nation, and world. Finally, we return to our theme and goal: that the PC(USA) become an HIV and AIDS competent denomination defined by the merging of compassionate care, so well developed in current church policies and resources, and prophetic witness, now focused on the dynamics of unequal power nationally and globally, with the recognition that attention to both is necessary to stop the tragedy of this pandemic.

I. The Development of a Pandemic and the Church's Response

A. *The Development of a Pandemic*

In the U.S., AIDS was perceived as a gay man's disease by the time its clinical manifestation was recognized and the HIV lentivirus was isolated in the early 1980s. Soon thereafter, AIDS was recognized among injecting drug users and Haitians, then among transfused hemophiliacs, and, subsequently it was discovered that it could be passed from mother to fetus. By January 1983, it was recognized that the disease could be passed through heterosexual sex. That same year, European reports identified two separate epidemic populations: homosexual persons, and persons from Central Africa who had no associations with homosexual sex, injection drug use, or blood transfusion. By the end of 1984, 7,699 AIDS cases and 3,665 AIDS deaths were reported in the United States, 762 cases in Europe, and 108 cases in the United Kingdom. By the end of 1985 it became known that AIDS could be transmitted through breast-feeding and AIDS had been reported in every region of the world. There were 20,303 cases reported to the World Health Organization (WHO), of which 15,948 were in the U.S. alone.¹ Today, worldwide, there are 33 million people living with AIDS, 2.5 million of whom are children; globally 25 million people have died due to AIDS-related complications.² The HIV infection and AIDS have affected and infected persons of every age, sex, marital status, socioeconomic status, sexual orientation, ethnic, and racial group throughout the world; no demographic has remained untouched. This enormous suffering cries out again for compassionate action and prophetic justice.

B. *The Church's Response*

As this pandemic swept across the world, fear arose and with this fear came stigma, prejudice, unjust discrimination, and social marginalization. Church response began prior to reunion (1983) when the United Presbyterian Church in the U.S.A. first explored a "new medical syndrome identified and designated as Acquired Immunodeficiency Syndrome (A.I.D.S.)." The 195th General Assembly (1983) advocated for (1) justice, (2) media coverage of the disease, and (3) funding for medical research.³

In the mid 1980s, the Presbyterian Church (U.S.A.) began to study myriad issues related to HIV and the accompanying AIDS illnesses. The 196th General Assembly (1984) affirmed that these illnesses should neither be viewed as "punishment for behavior deemed immoral nor as an excuse for discrimination and oppression."⁴ The 200th General Assembly (1988) called again on Presbyterians to show unbiased and genuine compassion for persons living with HIV and AIDS in a resolution titled *To Meet AIDS with Grace and Truth*. Recognizing that HIV and AIDS were thought to be affecting primarily the gay male community; the assembly declared that "all people are precious to God" and urged legislative action "to protect the human and civil rights of persons infected by the HIV, persons perceived to be at risk for such infection, and persons with AIDS or ARC (AIDS Related Complex); [and] urge[d] thorough efforts to investigate, document, and prevent prejudice and violence against all persons who have AIDS or are perceived to be at risk for AIDS."⁵

The church also recognized the harsh reality that unless sufficient resources were allocated within the United States and around the world, both the church and society would soon grapple with the majority of individuals likely contracting the HIV virus through heterosexual contact. It urged attention to the spread of HIV "among drug addicts, their sex partners, and babies" and the development of national strategies for preventive education, civil rights protections, and financing of care.⁶

By 2001, the church had fully recognized that AIDS was now a global pandemic disproportionately affecting women and children, particularly women and children of color. The church responded by

working in partnership with the World Health Organization (WHO) and the United Nations (UN), and in ecumenical and interfaith collaborations demonstrating the love of God and advancing the status of women.⁷ Two years later PC(USA) AIDS policy shifted to the African continent. Through the 215th General Assembly (2003) approval of the *Resolution on Africa*, Presbyterians were challenged to “engage in hands-on mission projects that provide care for people living with ... AIDS in Africa”⁸ and, further, to “advocate boldly for more just and extensive application of human rights principles and pronouncements by governments, nongovernmental organizations, private ... organizations, and religious institutions globally and in Africa.”⁹

For almost three decades, the voice of the Presbyterian church has been strong and clear, calling local congregations and other governing bodies to engage in compassionate, nonjudgmental care, and to respond to those facing a life with HIV and AIDS with respect, support, compassion, and nonjudgmental assistance. Our policies have called upon us to witness to injustice, to do justice, and to promote prevention. The General Assembly has directed our General Assembly Mission Council (GAMC) to work with our legislatures creating public policies and funding that provides ready access to lifesaving drug treatment for those affected by HIV and AIDS. We have produced numerous resources to enable individuals and churches to break the silence and to counter the negative theology often surrounding these issues.¹⁰ We have supported the Presbyterian AIDS Network (PAN), the International Health and Development (IHD) ministry area, and other caring organizations of the PC(USA) including Care Teams. Presbyterian Women have been especially active in these efforts through their support of mission and their global exchange programs.

Yet, since the first cases of HIV and AIDS were recognized in 1981, more than “sixty million people have been infected with the human immunodeficiency virus; nearly half have died and the toll on individuals, families, communities, and entire nations has been profound.”¹¹ In its reach and devastation this pandemic is among the worst infectious scourges in human history. The church is challenged again to sharpen its prophetic witness and deepen its compassionate action.

II. The Current Context of the HIV and AIDS Pandemic

To construct compassionate ministries of justice and healing, it is important to understand the many faces of HIV and AIDS today. It is particularly important to identify social and cultural factors that increase the risk and vulnerability of specific populations to infection. This section provides data on the regional expanse of the pandemic and identifies some of the social and cultural forces at work in that expanse.

A. The United States

From the early 1980s to the present, the number of persons living with HIV in the U.S. is more than 1.1 million, with approximately half of those having developed AIDS. Though a cure is not yet available, advances in treatment have changed AIDS from an inevitably terminal illness to a chronic illness. While the incidence of new infections has declined from its peak in the 1980s and has been stable since 2000, there are 53,000 new cases of HIV infection annually in the U.S. The largest number of cases of HIV infection and AIDS is found among Caucasians.¹² However, in some racial and ethnic communities the percentage of those with HIV is higher than the percentage of Caucasians with HIV.¹³

Patterns of HIV transmission are also shifting. While most new infections in the U.S. are diagnosed among gay and bisexual men, heterosexual transmission across the age spectrum now accounts for a larger share. Women, particularly women of color, represent about 30 percent of new HIV infections. Rates of newly diagnosed infection are increasing among senior citizens who, often because of divorce or the death of a spouse, find themselves becoming sexually active with new partners for the first time in decades.¹⁴ New infections due to contaminated needles from drug use have declined significantly and now represent only a small proportion of new infections. Routine and accurate HIV antibody testing of blood, blood products, tissue, and semen has made the transmission of HIV via blood transfusion, organ

transplant, and artificial insemination a rare occurrence. Antibody testing and effective antiretroviral therapy have brought a significant decline in maternal-to-fetus transmission of HIV.

It is of great concern, however, that racial and ethnic minorities, particularly Blacks and Latinos, have been disproportionately affected by HIV and AIDS throughout this epidemic, representing the majority of new infections and those living with HIV and AIDS, of new AIDS cases, and of AIDS deaths. For example, Blacks accounted for 56 percent of AIDS deaths in 2005. Young adults and teens continue to be at higher risk for infections predominantly transmitted sexually. Younger gay and bisexual men between the ages of thirteen and twenty-nine are at particularly high risk accounting for almost 40 percent of the infections among gay and bisexual men. Other groups face underreporting and, therefore, potentially less access to preventive education and medical treatment. (See Section V. Underreported U.S. Populations.)

Understanding the forces that create these disparate patterns of infection and death is imperative if our church is to fulfill its mandate of prophetic witness and compassionate ministry to people living with HIV and AIDS. Understanding that HIV infection and AIDS is a pandemic impacting any one of us, as pastors, elders, deacons, and laity, is essential to our becoming an HIV and AIDS competent church in which stigma and discrimination have no place.

B. *The Global Context*

Globally, the prevalence rate of HIV infection among 15–49 year olds has plateaued but at an unacceptably high level. AIDS continues to be the leading cause of death worldwide. Men who have sex with men (MSM), injection drug users, and prostitutes are still at high risk of becoming infected. However, the majority of new infections worldwide arise from heterosexual sex. Moreover, HIV and AIDS is the scourge of the global poor. Of the approximately thirty-three million people worldwide living with HIV and AIDS, 96 percent reside in countries with low per-capita incomes, particularly in sub-Saharan Africa. Such countries are beset by other enormous problems including infectious diseases, food insecurity, and poverty. The subsections below highlight regions with emerging epidemics indicating not only the magnitude of the pandemic, but also illustrating the widespread and devastating effects of one virus on various mission areas of the church. To respond with compassionate action and prophetic witness in its global health ministries, the church is challenged to recognize the forces that are changing the face of HIV and AIDS and respond with care that is culturally and linguistically appropriate.¹⁵

1. *Sub-Saharan Africa*

In many regions of the African continent, AIDS is the number one cause of death and has led to a surge in cases of TB (mycobacterium tuberculosis), which is the leading cause of death for people with HIV. Women, in particular, are at higher risk due to greater biological susceptibility, constrained access to diagnosis and treatment services, gender inequalities, and sexual violence. Of the approximately 2.5 million children globally living with HIV, 90 percent live in sub-Saharan Africa.¹⁶ Of the more than fifteen million children under eighteen who have been orphaned as a result of HIV and AIDS, approximately 11.6 million live in sub-Saharan Africa.¹⁷ The PC(USA) International Health and Development (IHD) ministry area works closely with African church partners, contributing both personnel and monetary resources.¹⁸ Cultural and socioeconomic forces impacting the face of HIV and AIDS in Africa are discussed in Section IV.B.2, Social, Cultural, and Religious Barriers to Diagnosis and Treatment, Global; and IV.C. Economic Forces.

2. *Asia and India*

Although Africa has the largest number of people living with HIV, South and Southeast Asia are some of the fastest growing regions for the epidemic.¹⁹ There may be as many as six million Asians infected with HIV. Since many Asian countries suffer from low per-capita incomes, dramatic inequities in income distribution, gender inequality, and poor healthcare infrastructure, providing high-quality medical care to those in need is difficult. The high rate of infection among 15–19 year-old girls reflects women's

powerlessness to control the terms of sexual contact within and outside of marriage. Moreover, while fidelity after marriage is required for many Asian women, many men are not bound by such norms.

The Joint United Nations Programme (UNAIDS) on HIV and AIDS estimates that 2.4 million people are living with HIV in India.²⁰ In the southern states, HIV is “primarily spread through heterosexual contact,” and in the northeastern states HIV infection is highest among “injecting drug users and sex workers.”^{21, 22} India’s National AIDS Control Organisation (NACO) has focused public campaigns on the reduction of stigma and discrimination and the promotion of services with special emphasis given to women and youth, who are particularly vulnerable.²³ According to the U.N. agency for women, UNIFEM, marriage is among the highest HIV and AIDS risk factors for southern African women and Indian women, largely as result of male infidelity.²⁴ India’s efforts to increase HIV and AIDS prevention, education, and access to treatment face challenges, including client compliance with treatment schemes and access to life-saving medicines, appropriate follow-up with patients, socioeconomic and nutritional support, and reduction of stigmatizing attitudes among health staff.²⁵

3. *Latin America and the Caribbean*

The rate of infection and the number of individuals living with the disease in Latin American and Caribbean countries is lower than that in African countries, but some studies suggest that it has the second fastest growing rate of infections today. Rates of infection vary from country to country.²⁶ As in Africa and Asia, sociopolitical conditions make the disease deadly. For example, 250,000 people acquire HIV infection in the region every year and 120,000 deaths occur annually due to AIDS-related illnesses exacerbated by lack of access to life-saving medicines and adequate health care.²⁷ Poverty, lack of adequate education, including comprehensive sexual health education, and widespread social stigma and discrimination, contribute to these numbers. While the infection tends to concentrate in urban areas among men who have sex with men, many of these men also have sex with women. Thus, as in the U.S. and globally, Latin America is experiencing a feminization of the epidemic with rates of heterosexual transmission increasing and a greater number of women being infected. Social mores limit women’s ability to negotiate safer sex practices with husbands/partners and increase their rates of infection.²⁸ The need is growing for health-care centers and education programs that provide intervention strategies that are culturally and linguistically appropriate and inclusive (especially among indigenous populations).

4. *Eastern Europe*²⁹

The UNAIDS reports that “since 2001, HIV prevalence in Russia, Eastern Europe, and Central Asia has roughly doubled, making the region home to the world’s most rapidly expanding epidemic.”³⁰ The instability and socioeconomic issues of this region in the mid 1990s led to increased rates of injection drug use, which acted as a gateway for the HIV epidemic. To curb the pandemic in this region, there have been increased efforts to encourage needle exchange programs and HIV and AIDS education, especially among sex workers.³¹

5. *Global Sex Trafficking*

The relationship between HIV and AIDS and international sex trafficking exposes the deadly interconnection between a virus (HIV) and multiple social factors, including poverty, gender subordination, the demand for young girls who are often from particular ethnic and indigenous populations, unequal and ineffective cross-border law enforcement, and the sex trade industry. In fact, the HIV and AIDS pandemic itself has created a demand among male clients for ever-younger partners or virgins to avoid becoming infected themselves, or in the mistaken belief that having sex with a virgin will cure a person of AIDS. Available research estimates the numbers of trafficked women and children to be in the 100,000 to 250,000 range in 2009.³² Recent findings from South Asia illustrate the high prevalence of HIV among sex trafficking victims,³³ a rate higher than their non-trafficked counterparts.³⁴

Physiological differences make women as much as two-to-four times more susceptible than men to contracting the disease through heterosexual sex. Political, social, and cultural inequality compound the

vulnerability of women and girls who are coerced, tricked, or sold into commercial sex. Risk of infection soars as women and girls are forced to endure multiple sexual contacts without the power to insist upon condom use. Injuries and abrasions heighten physical vulnerability to AIDS transmission, particularly for the youngest whose bodies are still immature.³⁵ These same factors heighten the risk of infection from other sexually transmitted diseases (STDs), the presence of which heightens the risk of contracting HIV by up to a factor of ten.³⁶

The vulnerability of trafficked women to sexually transmitted diseases may be compounded by their inability to speak or understand the language in a foreign land, their poverty and indebtedness, and their lack of freedom of movement—in short, enslavement that impedes access to health care or prevention information and education. The PC(USA) has extensive prostitution- and trafficking-related social witness policy.³⁷ In the face of the HIV and AIDS pandemic, nothing less than the elimination of sex trafficking is required. Thus, the 218th General Assembly (2008) instructed the Stated Clerk to

communicate with the United States Department of Homeland Security (a) to urge the development of methods to recognize and arrest traffickers; (b) to urge the development of methods to identify forged passports and visas in order to limit the number of trafficked victims brought into the United States. . . . to find ways to urge agencies in other countries to stop traffickers from enticing women with the promise of jobs in other countries, and by promoting false marriage.³⁸

III. Where Scripture Calls Us to Be: Compassionate in Action, Prophetic in Witness

A. Compassionate Action

Scripture speaks to all of us, to all those living with HIV and AIDS: those of us infected and those of us affected. It speaks words of comfort and tenderness to those who face their own mortality. It speaks with knowing experience about the fragility of life and the grief of loss: lost joys, lost hopes. It gives voice to the grief that can lead to anger, frustration, or a sense of profound meaninglessness. It understands the desire for death to come swiftly. Our ancient forebears experienced all this agony and gave us voice to cry out in despair. Job, when suffering pain all over his body, groaned, “. . . I would choose strangling and death rather than this body” (Job 7:15 NRSV). He then lashed out at God, saying, “I loathe my life; I would not live forever. Let me alone, for my days are a breath” (Job 7:16 NRSV). So some of us may cry. Others have cried out with the Psalmist in despair: “O my God, . . . do not take me away at the mid-point of my life” (Ps.102:24 NRSV). Those moments of wanting to give in to pain and loss are powerful. So also are the times of our bitterness and complaint. (Job 7:11) Yet, our faith assures all of us, those living with HIV and AIDS and those of us affected by HIV and AIDS, that God is walking through that valley of the shadow of death with us (Ps. 23:4).

Thus, right after the outburst of pain, we hear the Psalmist proclaim, “Bless the Lord, O my soul, and all that is within me bless [the Lord’s] holy name” (Ps. 103:1 NRSV). In that moment of blessing and of proclaiming blessing, the weight of our mortality can be lifted and we recognize the grandeur and wholeness of God’s intentions for us. Living with mortality often involves this moving from despair to blessing, from anguish to thankfulness, and back again. The crucified Christ, who cried out in the Garden of Gethsemane when faced with his own impending mortality, joined us in this very human condition when he cried out as well, “Father, if you are willing, remove this cup from me; yet, not my will but yours be done” (Lk. 22:42 NRSV). We are told that then there appeared an angel from heaven to bring him comfort (Luke 22:43). So we cry out as did Jesus, both to pray for God’s mercies and to proclaim blessings upon God who suffers with us. And in the midst of our anguish and despair, God is there to comfort us and give us hope.

Job’s story of suffering also reminds us that cruel tragedies fall on both the good and evil and that life is indeed a breath for all of us. Before being stricken, Job had it all—wealth, status, family. Yet, as good a man as he was, he had never recognized that hardship and calamity can fall on anyone. He was not prepared when it fell on him. Too often we hear, or perhaps we repeat, the voices of Job’s friends insisting that he must have brought this suffering on himself. Such accusations too often result in

discrimination, derision, and the unjust treatment of people living with HIV and AIDS. Job teaches us to recognize that sorrow and loss is neither an indication of moral failure nor of some impediment to God's loving presence with us. In the face of HIV and AIDS, we encourage one another to reject guilt and self-recriminations. Specifically, we must reject any use of Scripture that would label anyone living with disease as impure or unclean. (See Appendix A.)

Ultimately, Scripture offers a message of comfort for those living with HIV and AIDS. God grieves with us; God mourns with us; God suffers with us in and through Christ. We respond in faith, standing with one another in our grief and loss, as in joy. Some of us will pray when some of us cannot. Some of us will praise, when some are inconsolable. This is the meaning of ecclesia—the people gathered together as one. Let the people of God understand that love and trust are at the center of our response to God, as love and compassion are central to our response to neighbor. We know that healing in the gospels is always an act that challenges the forces of destruction and proclaims a new way of understanding God's vision of wholeness in the world. Our God is a God who proclaims reversal of all status claims. Those whom society relegates to the margins are those whom God embraces and to whom God assigns great honor. As such, Scripture offers the highest dignity to those who are living with HIV and AIDS and the challenges—physical, emotional, and spiritual—this condition, and society in many cases, presents. Truly, there is dignity here, an image of God at work in our midst. This is the message of hope: that God is a God in whose loving compassion we can have absolute faith and trust.

B. *Prophetic Witness*

The Hebrew prophets, angered by the suffering of the poor around them, declared the word of God against the ruling elite and the structures by which they legally impoverished the poor, the widows and orphans, and the strangers in their midst. Central to the preaching of Jesus and the ancient prophets of Israel was the proclamation of God's covenant with us and its ramifications on us. Covenant places an expectation upon people to structure them in ways that strive to represent, albeit inadequately, the values of the kingdom or reign of God. Today, we are becoming increasingly aware that the church must heed the call to reform the social structures impacting all of those living with HIV and AIDS. To take up this responsibility as a church is to reflect our understanding of our covenant with God, those kingdom values, and their place in our hearts.

Jesus gave prophetic witness to the ethics of the reign of God in five ways: (1) teachings on prayer and liturgy; (2) parables; (3) behavior at banquets; (4) healings; and (5) denunciations of religious leaders. Each of these is uniquely germane to the discussion about what the church is called to be in the face of this HIV and AIDS pandemic and to the prophetic reformation of social structures it is called to proclaim.

1. *Prayer and Liturgy*

The Lord's Prayer and the Beatitudes are two liturgical hymns that contain, in concise and beautifully paralleled form, the essential ethical values of the reign of God. The Lord's Prayer begins with an address to God as our Divine Parent, whom we address together in unison. Hence, the very notion of God, in Christian understanding, is tied in with the pronouncement that we are responsible for one another as children of a single Divine Parent. To the extent, then, that we desire to know God, we are thus called upon to know and to be accountable in relationship to all God's people. As such, even to be able to claim to know God as "our Father" is to proclaim our kinship with those who live with HIV and AIDS as God's beloved children.

After calling on God collectively as God's family, we proclaim, "hallowed be your name" (Mt. 6:9, NRSV). The ancient prophets have long called God's people Israel to "hallow" or "sanctify" God's name. How is this to be understood? In Ezekiel, God proclaims the desire to sanctify God's own name in and through God's people (Ezek. 36:23). This is an awe-inspiring covenantal move on God's part. It is in Israel that God has elected to sanctify, to make God's name holy, before the world. As Christians, we gladly accept this covenantal responsibility as well—that in us God chooses to demonstrate to the world God's own holy nature. The responsibility is upon us to live in a way that consciously reflects that nature.

How do we reflect God's holy nature? Ezekiel called on Israel to follow God's statutes and justice, "by whose observance everyone shall live" (Ezek. 20:13, NRSV). By embracing and committing ourselves to advocate for justice, we will find life! In this way, we sanctify God's name before the world.

Five times in Deuteronomy (10:18, 24:19, 24:20, 24:21, 27:19) God calls on Israel to care for those who are on the margins of society—"the stranger, the orphan, and the widow"--thus reinforcing the essence of God's justice. Five times the Deuteronomist makes clear that central to living out the ethics of the reign of God is to create a just society in which the needs of those who are the most vulnerable are met—and not just minimally but at a level that actually causes them to rejoice in the midst of God's people (Deut. 16:11–14). To what extent are we, as the collective people of God, creating environments in which those of us living with HIV and AIDS, here and throughout the world, truly rejoice in our midst? This would be the vindication of God's name as Scripture defines it. This is what it means to proclaim together, "hallowed be your name."

The Lord's Prayer is a collective prayer that ultimately calls for God's reign, power, and glory to be made manifest as God's will is done "on earth as it is in heaven" (Matt. 6:10, NRSV). As such, we are to understand that our willingness to do God's will is made visible as we work to free one another from the conditions wearing us down. In freeing one another, we hallow God's name in the midst of the people and act out God's will here on earth—the justice of God.

Likewise, the Beatitudes, clearly a liturgical proclamation, look forward to the eschatological inversion of all the status signifiers in the world. The poor, those who mourn, the meek, the hungry and thirsty, the merciful, the pure, the peacemakers, and the persecuted are those who receive joy and blessing in the eschatological reign of God. The list comprises people who have little or no status in our collective social consciousness. The corollary message is that God's people are to seek concrete ways to welcome, bless, and celebrate those whom society relegates to its outer margins. Not only in the United States, but worldwide, those living with HIV and AIDS suffer discrimination, derision, and disenfranchisement. For a people who seek to enact the ethics of the reign of God, it is imperative that we hear clearly the voices of persons living with HIV and AIDS, here and throughout the world. Together we can actualize the values of the reign of God, share with the suffering, and attend to their needs. Blessed are the vulnerable, for it is they, prior to the strong, who shall know the reign of God.

2. *Parables*

Likewise, in the parables, Jesus often taught about the nature of the reign of God. In Luke, the opponents of Jesus had just been grumbling because those whom they considered impure were coming to listen to Jesus. As a response, Jesus taught them three parables which Luke has clustered together in his gospel. They are the parables of the lost sheep, the woman with the lost coin, and the prodigal son (Lk. 15:1–7; 15:8–10; 15:11–32). In every case, the message is that those whom our religious communities assign to the social margins are the very people who are valued, even treasured, within the ethics of the reign of God.

These parables challenge the power wielded by those in the religious center of society—the power to marginalize and to disenfranchise those whom, for whatever reason, the social center has deemed unbecoming to represent the values that they espouse. That is a powerful and sobering message for Christians today, for we clearly create or tolerate social models that disenfranchise, silence, and marginalize people whom we have determined do not model, either in their social status, their lifestyles, or their appearance, the values that we choose to espouse. This behavior, claims Jesus, is antithetical to the values of the reign of God. More profoundly, it is behavior that denies God. As Jesus reminds us in Matthew: "just as you did it to one of the least of these who are members of my family, you did it to me" (Mt. 25:35–45, cf. 40).

3. *Behavior at Banquets*

Jesus continued to challenge the social center in his teaching about behavior at banquets. In the ancient Mediterranean world, banquets provided an important means for patrons to honor their clients and for clients to reciprocate with greater honor for patrons. It was a system in which status was ascribed within a closed social group. Those on the outside of the patron/client relationship had no hope of gaining access. Instead, they were relegated to a place of shame and degradation. It is this honor/shame social system that Jesus most strongly attacked in the banquet stories.

Whether it be tax collectors and sinners whom Jesus welcomed (Lk. 5:29–32), or the poor and the physically maimed (Lk. 14:12–14), or simply the uninvited (Lk. 14:15–24), Luke’s message is clear. It is people on the collective margins, and not those who enjoy high status in the current honor/shame system, who receive honor according to the ethics of the reign of God. Jesus’ claim was that to assign publicly honor or shame to people based on the group’s social norms was wrong. So, for example, if people could not reciprocate or represent in their bodies the prevailing social norms, they were assigned lower status. We too, as the people of God in the world today, must reexamine our social structures and ask to what extent they are serving a similar purpose—a purpose antithetical to the ethics of the reign of God.

4. *Healings*

Healings in the gospels are some of the most misunderstood acts carried out by Jesus. As Jesus healed and restored health, he also demonstrated the ethics and the values of the reign of God, inscribing those values on the very bodies of those who were healed.

Thus in the healings in the synagogues of the man with the unclean spirit, the man with the withered hand, and the woman bent over with a crippling condition, we see healings occurring in the place where the people of God gathered to pray and to discuss Scripture on the Sabbath (Mk. 1:21–28; 3:1–6; Lk. 13:10–17). In every case, the event of healing enacted the inclusion of those who found themselves on the margins of the people of God. In each case, the healing story is preceded and followed by Jesus’ teaching about the nature of the reign of God. Jesus exhorted God’s people to seek the things of God’s reign, which results in wholeness, inclusion, enfranchisement, and expanding the center of the community of faith so that all might be included. To the extent that we, the worshipping community, enfold and enfranchise those whom society places on its margins, we are enacting the coming reign of God. In the church’s compassionate and prophetic response to those living with and affected by HIV and AIDS today, the church is learning to become more fully and faithfully the people of God.

In the past, it has been assumed that Jesus did away with the purity laws when he healed people. In the book of Leviticus, it is commanded that no one who has a “blemish,” or “defect” may approach to make an offering—this included those who are blind, lame, maimed, or have skin diseases (Lev. 21:17–20). In this system, God’s holiness exercised a centripetal force: the closer one approached to God’s sanctuary, the more whole in body one was expected to be in order to reflect God’s own holiness. Jesus, on the other hand, proposed a notion of holiness whose force was centrifugal; that is, the holiness emanated outward from God’s presence to enfold the “outcasts of Israel” (Ps. 147:2, NRSV)—those who under a particular interpretation of Leviticus had become marginalized. In this vision, God’s holy presence is still inscribed on the bodies of the people, but the force of God’s holiness is now centrifugal rather than centripetal—emanating out rather than converging in. In like manner, God’s people are called to embody the centrifugal, inexhaustible force of God’s emanating holiness by being sources of healing and wholeness to those bodies whom society has relegated to the margins in shame.

5. *Denunciations of Religious Leaders*

The final category to consider is that which comprises Jesus’ woes and denunciations. First, Jesus denounced those who put a “stumbling block” before the “little ones” whom the religious center had deemed to be less suitable to reflect its values (Mt. 18:6–9). Without question, this challenges us to take

up new initiatives in support of justice toward persons living with HIV and AIDS—in support of those marginalized, the vulnerable ones, in today’s globalized cultures.

Jesus also very purposefully heaped denunciations upon the religious leaders of his day, who, Jesus said, addressing them, “lock people out of the kingdom of heaven” (Mt. 23:13). He added, “You do not go in yourselves, and when others are going in, you stop them” (Mt. 23:13; see also Mt. 23:14–33; Mk. 12:38–40; Lk. 11:52; 20:47). He proclaimed, “... you tithe mint, dill, and cumin, and have neglected the weightier matters of the law: justice and mercy and faith. It is these you ought to have practiced without neglecting ... others” (Mt. 23:23).

The church is faced with the reality that these shattering pronouncements are directed precisely at us—at religious people who sometimes create social spaces into which people cannot enter, because we make our social religious space uncomfortable for them. We acknowledge that, although our ritual and liturgical actions are moving and powerful, we are often unaware of how they may also become a reflection of our own needs. Without intending it, we may create spaces others cannot enter.

The goal to become an HIV and AIDS competent church recognizes our desire to live as Jesus taught as well as our recognition of our unintended inadequacies. If our task, as the collective children of “our Father in heaven,” is to enact the ethics of the reign of God in our behaviors toward all of God’s children, including the vulnerable among us—whether it be in North America, Africa, Asia, South America, Australia, or Europe—including persons infected and affected with HIV and AIDS, then we are called to be healed and made whole even as we work to enfranchise and give voice to those who live with life-threatening conditions.

These values are gospel values: from the five-fold call to protect the outsiders, the orphans, and the widows in Deuteronomy, to the call of Ezekiel to vindicate God’s name by doing what is just, to the Spirit-anointed proclamation of Isa. 61:1, which announces good news to the poor, dressing the wounds of those whose hearts are shattered, and declares emancipation and release to those who are held captive and imprisoned. This is the center of the call to be a people of God who enact the ethics of the reign of God in our midst. It is a privilege, a responsibility, and a mandate upon our covenantal commitments to live in community with one another, creating life, hope, and healing for all.

C. *Reformed Tradition*

Compassionate action and prophetic witness come together in the Presbyterian church’s recognition of the covenantal claim upon our corporate life. In the *Book of Order* the church is called to “... the promotion of social righteousness; and the exhibition of the Kingdom [Realm] of Heaven to the world.”³⁹ Yet *The Book of Confessions* reminds us that we, as well as the whole world, are implicated in the injustices perpetuated by social structures, in the tyrannies and idolatries to which humankind is prone. We “... rebel against God; we hide from our Creator. Ignoring God’s commandments, we violate the image of God in others and ourselves, accept lies as truth... . We deserve God’s condemnation.”⁴⁰ We are thus required, in recognition of our sin and complicity and as “... the people of God[,] to work for the transformation of society by seeking justice and living in obedience to the Word of God.”⁴¹ Jesus’ imprecations upon religious leaders call us to be faithful in “... unmask[ing] idolatries in Church and culture, to hear the voices of peoples long silenced, and to work with others for justice, freedom, and peace.”⁴² As the *Book of Order* enjoins, the Church is to be “Christ’s Faithful Evangelist” by concretely:

(3) participating in God’s activity in the world through its life for others by (a) healing and reconciling and binding up wounds, (b) ministering to the needs of the poor, the sick, the lonely, and the powerless, (c) engaging in the struggle to free people from sin, fear, oppression, hunger, and injustice, (d) giving itself and its substance to the service of those who suffer, (e) sharing with Christ in the establishing of his just, peaceable, and loving rule in the world.

The Church is called to undertake this mission even at the risk of losing its life, trusting God alone as the author and giver of life, sharing the gospel, and doing those deeds in the world that point beyond themselves [sic] to the new reality in Christ.⁴³

In obedience to God, as followers of Christ in the Reformed tradition, we must abhor the injustices that perpetrate harm upon the poor of the world now living and dying of HIV and AIDS. As we are reminded by The Confession of 1967,

The reconciliation of [humankind] through Jesus Christ makes it plain that enslaving poverty in a world of abundance is an intolerable violation of God's good creation. Because Jesus identified himself with the needy and exploited, the cause of the world's poor is the cause of his disciples. The church cannot condone poverty A church that is indifferent to poverty, or evades responsibility in economic affairs, is open to one social class only, or expects gratitude for its beneficence makes a mockery of reconciliation and offers no acceptable worship to God.⁴⁴

IV. Marginalizing Social Forces

A. Poverty, Sexism, Intimate Partner Violence, Racism, and Homophobia

The immediate cause of HIV infection and its progression to AIDS is microbial. The task is (1) to intervene at the point of transmission to prevent new infections, and (2) to administer a therapeutic drug regimen to those who have already been infected in order to prevent progression to AIDS or transmission, especially to nursing infants. By doing so, it should be possible eventually to make new infections rare and to limit AIDS to a long-term, chronic illness. In fact, much has been done through public education, rapid and accurate testing, condom availability, needle exchange programs, safe blood to transfuse, and treatment for pregnant or nursing women.

Yet, if a simple microbiological approach to HIV and AIDS worked, the disease would have long since been stopped in its tracks. Instead, it now involves more than thirty-three million people worldwide who are living with HIV and AIDS, and it is growing. Another twenty-five million have already died of AIDS. Clearly more is needed, but what?

A microbiological approach fails to take into account the social determinants of the infection or disease. Issues of sex, race, age, class, gender identity, domestic violence, and poverty are brought to the fore by the HIV and AIDS epidemic. One cannot truly grasp the complexity of HIV and AIDS today without considering these underlying and exacerbating constructs. The patterns of HIV and AIDS infection parallel the manifestations of social injustice, inequality, and marginalization that God and our Reformed tradition call us to unmask and redress. These injustices increase both risk and vulnerability to HIV and AIDS. As the church has called Presbyterians to welcome persons living with HIV and AIDS with compassionate ministry, the church must now speak forcefully about those social conditions that increase risk and vulnerability and contribute to the expansion of the pandemic. In this report we can only begin to name and decry these conditions.

1. Poverty

For both women and men, there is a reciprocal relationship between poverty and HIV and AIDS: the presence of poverty ensures increased vulnerability to and risk factors for HIV and AIDS while at the same time the presence of HIV and AIDS brings about poverty. This is true at the level of nations as well as individuals. Thus, in the U.S. and abroad, the pandemic increasingly affects poor women of color. Poverty brings horrible choices to women—sometimes exchanging sex for a better place in the food line, as described by a member of our International Health and Development (IHD) staff. When women are infected, children too are profoundly affected, if not also infected. Limited resources must stretch to cover medications (more on that follows), nutrition worsens, children are withdrawn from school to become caregivers, and another generation is doomed to poverty. Barnett and Whiteside, writing about children with HIV and AIDS, note more broadly that “AIDS deepens poverty and increases inequalities at every level, household, community, regional and sectoral. The epidemic undermines efforts at poverty

reduction, income and asset distribution, productivity and economic growth. AIDS has reversed progress towards international development goals because of the influence it has on all development targets.”⁴⁵ Thus, men and women who are poor, marginalized throughout the world, have the added burden of living with HIV that further reinforces their poverty and entraps another generation. The prevention of HIV and AIDS has become dependent upon the reduction of poverty and the reduction of poverty depends upon the reduction of HIV and AIDS. The same relationship pertains to other infectious diseases such as malaria and tuberculosis.⁴⁶ Poverty always exists in combination with other marginalizing forces, as will be noted below.

2. *Gender Inequality and Intimate Partner Violence*

According to a report released on November 9, 2009, by the World Health Organization (WHO), millions of women die each year from conditions that could be avoided—if they were men. In addition to hazards like female infanticide and maternal deaths, women are more likely to contract HIV on exposure, suffer from domestic abuse and depression, and lack access to basic health care that could help them survive.⁴⁷ (See Section IV. B. Social, Cultural, and Religious Barriers to Diagnosis and Treatment and Appendix B “Gender Inequality and the Persistence of HIV and AIDS.”)

The WHO report lifts up five key areas of concern: (a) widespread inequities between men and women in developed and developing nations; (b) the lack of recognition for sexuality and reproduction as central to women’s health; (c) the toll of chronic diseases, injuries, and mental illness on health care maintenance; (d) the lack of a fair start for all girls as critical to the health of women; and (e) that societies and their health systems are simply failing women. Globally, HIV is the leading cause of death and disease in women of reproductive age.⁴⁸ Some studies show that women are more likely than men to acquire HIV from an infected partner during unprotected heterosexual intercourse. Yet, many cultures condone sex between young women and older men who are more sexually experienced and more likely to be infected with HIV.⁴⁹

Intimate partner violence is an important, but often neglected, factor contributing to the spread of HIV and AIDS among women in many countries. Despite national and international laws against rape and other forms of assault, the failure of governments to enact marital rape laws, combined with cultural norms and practices subordinating women’s roles within the family and society, inevitably contribute to the spread of HIV and AIDS among women. Violence in sexual acts creates tears through which the virus enters. In some African countries, for example, the high incidence of infection among married women infected by their husbands is often the result of the wives’ inability to demand the use of condoms, and/or to refuse sexual relations with their husbands for fear of violent retaliation. Enactment of marital rape laws without enforcement, however, will not stop the spread of HIV and AIDS among married women.⁵⁰ While Presbyterians have condemned the prevalent use of violence in patriarchal cultures, violence against women remains a hidden problem with great human and health-care costs.⁵¹

Because they are less likely to be part of the formal labor market, women lack access to income, job security, and the benefits of social protection, including access to health care. Within the formal workforce, women often face challenges related to their lower status, discrimination and sexual harassment. They have to balance the demands of paid work and work at home, giving rise to work-related fatigue, infections, mental illness, and other problems. Yet, it is women who bear the responsibility for caring for children, the sick, and the elderly in most cultures.

Lessons can be learned from bold national initiatives that have sought to address social inequality and exclusion in ways that promote gender equality and women’s health. For example, Chile’s multisectoral and integrated approach to social protection for the poor includes a universal program for early child development. *Chile Crece Contigo* (Chile Grows with You) includes access to child care, education, and health services to help young children achieve their optimal physical, social, and emotional development, while enforcing the right of working mothers to nurse their babies with supportive employment.⁵²

3. *Racism*

Presbyterians have condemned the power of racism for decades: “People of good will have long recognized that eradicating the sin of racism from church and society is a high priority. It cannot be done without sacrifice. Experience has taught that people cannot leap from centuries of racial polarization into a new vision. It is a long journey that will require discernment, prayer, and worship based action.”⁵³

And yet, structural racism still plays a significant role in propagating the spread of HIV and AIDS. In urban areas, racism relegates racial minority groups into segregated neighborhoods of concentrated poverty lacking access to jobs, adequate education, secure housing, medical insurance, and health care. Black and Latino Americans are disproportionately affected by HIV and AIDS, and that disparity has widened over time.⁵⁴ Blacks account for more new HIV infections, AIDS cases, people estimated to be living with HIV disease, and HIV-related deaths than any other racial ethnic group in the U.S.⁵⁵ Analysis of national household survey data found that 2 percent of Blacks in the U.S. were HIV positive, higher than any other group.⁵⁶ The epidemic has had a disproportionate impact on Black women, youth, and men who have sex with men (MSM), and its impact varies across the country. Moreover, Blacks with HIV and AIDS may face greater barriers to accessing care than their White counterparts. For example, a variety of studies show that Blacks and Hispanics are less likely than Whites to receive certain diagnostic tests and medications.⁵⁷

For similar reasons HIV and AIDS has disproportionately affected the Hispanic/Latino American population. According to the CDC: “Hispanics/Latinos comprise 15 percent of the U.S. population but accounted for 17 percent of all new HIV infections occurring in the United States in 2006. During the same year, the rate of new HIV infections among Hispanics/Latinos was 2.5 times that of whites. In 2006, HIV and AIDS was the fourth leading cause of death among Hispanic/Latino men and women aged 35–44.” Furthermore, “the rate of new AIDS diagnoses among Hispanic/Latino men is three times that of white men, and the rate among Hispanic/Latina women is five times that of white women.”⁵⁸ Although many Latinos are Spanish speaking, there are language, dialect, and cultural differences that impact the effectiveness of public health messages.

Unintentional racism can also cause Latinos, Hispanics, Native Americans, Asians, and Pacific Islanders to be lost or hidden in the statistics or underreported in research. The diversity within the Asian and Pacific Islander population has made effectively reaching these communities and quantifying the pandemic difficult. “Although Asians and Pacific Islanders account for approximately 1 percent of the total number of HIV and AIDS cases” they are a population in which HIV and AIDS diagnoses are increasing—unlike the rest of the U.S. population. Native Americans and Alaska Natives also face similar issues of underreporting due to cultural diversity and dispersion between rural/reservation and urban settings. “. . . [W]hen population size is taken into account, this population in 2004 was ranked 3rd in rates of AIDS diagnoses, after African Americans and Hispanics. The rate of AIDS diagnoses for this group has been higher than that for whites since 1995.”⁵⁹

4. *Homophobia*

From the beginning of the epidemic, HIV and AIDS were associated with gay men. AIDS was called the gay plague, gay cancer, and Gay Related Immune Deficiency (GRID). As a result, there has been an enduring association between the stigma of HIV and AIDS and the stigma of homosexuality. Predominantly negative attitudes toward homosexuality have influenced people’s attitudes and behavior toward people with HIV in general and gay and bisexual men in particular. As early as 1978, the PC(USA) stated: “Persons who manifest homosexual behavior must be treated with the profound respect and pastoral tenderness given to all people of God. There can be no place within the Christian faith for the response to homosexual persons of mingled contempt, hatred, and fear that is called homophobia.”⁶⁰

The association between HIV and AIDS and homosexuality has affected how governments and institutions have reacted (or, more accurately, failed to react promptly, adequately, and consistently) to HIV and AIDS. The issue of intimate partner violence within the gay community has been neglected and

unacknowledged by most social institutions. The few studies that have been done on this growing problem indicate that violence among gay/lesbian couples is just as common as among heterosexual couples (with the added threat to those living with HIV and AIDS of the use of denied access to care as a weapon). As early as 1978, the Presbyterian church stated that homophobia is a sin.⁶¹ We continue to contend that homophobia is a sin and must be eradicated from our faith-based traditions.

5. *Stigma, Prejudice, and Unjust Discrimination*

Inequality affects people in society through the vehicles of stigma, prejudice, and unjust discrimination. The HIV-related stigma has been defined as, “a process of devaluation of people either living with or associated with HIV and AIDS.”⁶² Prejudice is an “unreasoned dislike, hostility, or antagonism” towards another.⁶³ Discrimination makes distinctions between individuals, but when rooted in prejudice is unjust. Persons who are stigmatized and who suffer unjust discrimination are consequently often socially marginalized. Stigma, prejudice, unjust discrimination, and social marginalization represent forms of social power that further the risk and vulnerability to HIV and AIDS in several ways:

- Fear of stigma or discrimination can deter people from seeking testing, thereby undermining prevention efforts. It can also deter those with HIV infection from seeking information or education, engaging in safe sex, disclosing their HIV status to sexual partners, seeking treatment, or following through with a treatment regimen.
- In some instances, national or local laws, such as immigration laws, discriminate against persons infected with HIV or who have AIDS. In the U.S., restrictions against the immigration of noncitizens, or travel by noncitizens, with HIV and AIDS will end in 2010.⁶⁴
- Work places, health-care settings, and voluntary associations (including churches) can be places of profound HIV-stigma, prejudice, and discrimination. For example, some health insurance may exclude HIV and AIDS, may charge a super-premium, or may deny insurance based on a preexisting condition such as HIV and AIDS seen as a providing serious financial exposure. In some instances, physicians, nurses, and hospital staff have been shown to be agents of HIV-related stigma.^{65, 66, 67}
- Laws that criminalize injecting drug use, men having sex with men, and prostitution deter the persons involved from seeking testing or treatment and are a barrier to prevention and treatment.
- Housing discrimination can lead to further marginalization and homelessness, both of which increase HIV risk and make treatment difficult for those who are infected. When a person does not have stable housing, they may engage in risky behaviors to ensure a place to sleep. People living with HIV and AIDS may be forced to move because of discriminatory practices or relegated to “affordable” housing that may interfere with their access to continuous care or drug assistance.⁶⁸
- Laws against HIV-related discrimination or crimes against persons with HIV and AIDS are not always enforced.⁶⁹
- Nongovernmental networks of persons advocating for those living with HIV and AIDS often lack any kind of meaningful financial or resource support.⁷⁰

B. *Social, Cultural, and Religious Barriers to Diagnosis and Treatment*

There are cultural, traditional, ethnic, religious, and social norms and practices that affect attempts at prevention, diagnosis, and treatment and that foster the spread of HIV and AIDS. It is not within the scope of this report to do more than to name and briefly comment on some of the issues to which an HIV and AIDS competent church needs to be sensitive.

1. United States.

Every nine and a half minutes, a person in the U.S. becomes infected with HIV.⁷¹ Yet, of the 1.1 million people living with HIV in the U.S., one in five persons does not know they are infected. Why do people not know their status? Is it fear, apathy, or a combination of these and other factors?

The Kaiser Family Foundation conducted a survey in the spring of 2009 on public opinion about HIV and AIDS and found that most people, especially young adults, do not feel that they are at risk for HIV infection. People also reported hearing less about domestic HIV and AIDS now than they did five years ago. Concern about contracting HIV is reported to be higher in the African American community and has remained steady since 2000; yet, the concern of African American youth has dropped from 54 percent in 1997 to 40 percent in 2009.⁷² In a national culture that is dictated by trends, HIV has decreased in “popularity” since the early 1990s. However, there has not been a drastic improvement in the overall statistics, and the epidemic has become worse for certain populations including African American women, youth, young men of color who have sex with men, and Hispanics/Latinos.

It is this focus on risk instead of vulnerability, from both an individual and a public health perspective, that has been one of the barriers to increased HIV testing and diagnosis. Risk is defined as “the probability or likelihood that a person may become infected with HIV.” Vulnerability “results from a range of factors outside the control of the individual that reduce the ability of individuals and communities to avoid HIV risk.”⁷³ Although there has been discussion about incorporating HIV tests into comprehensive health screening and care—allowing those at risk and those vulnerable to be tested—the predominate message has been to focus on testing populations who are at high or increased risk. While identifying and screening high risk groups provides important information related to public health trends, it may lead to a false sense of security for large segments of our population that do not fall into particular risk categories.

Cultural beliefs affect a population’s HIV risk. These include beliefs about sexuality, the body, women’s roles, and what is appropriate to discuss and with whom. Silence about sexuality, the body, matters of sex, and HIV and AIDS is a barrier in many cultures and subcultures in the U.S. The role of religion in open conversations about sexuality, sexuality education, and issues of HIV transmission may positively influence risk factors in the spread of HIV and AIDS.⁷⁴

One of the major barriers to diagnosis for people of faith is the various debates about contraception and condom use. Promoting condom use is often seen as promoting sex; however, the issue is much more complex. The PC(USA) has strong policy on the efficacy of condom use in the prevention of transmitting HIV, but also must emphasize the need for broad use, including for married couples. For example, there are serodiscordant couples (one partner is HIV positive, the other is not) that must be encouraged to use condoms in order to prevent the spread of the virus to the HIV negative partner. These couples need support and guidance, especially when it comes to family planning. Although the phrase has become taboo, serodiscordant couples must truly plan to have children whether naturally, through in vitro fertilization/another biomedical method, or through adoption.⁷⁵ The church and its leadership must be prepared to guide families through these difficult life choices and promote healthy and safe relationships (including male and/or female condom use), instead of reinforcing gender roles. Promoting condom use is not about promoting sex, it is about promoting a healthy life; and by not advocating for the use of condoms within and outside of the Presbyterian Church (U.S.A.), innocent people are put at risk.

2. *Global*

The following practices, which can be found in many cultures around the world, are highlighted because they increase the risk of HIV infection and contribute to the changing face of the HIV and AIDS pandemic. As the global migration of people increases, many nations face a growing presence of customs with which they are unfamiliar and which, perhaps, they find to be a violation of their own values.

a. *Underage Female Marriage*

The World Health Organization (WHO) notes that the incidence of HIV and AIDS among young females, specifically adolescent females in developing countries is growing at an alarming rate. Their 2004 report states:

Of substantial consequence, yet largely ignored, is the fact that the majority of sexually active girls aged 15–19 in developing countries are married, and these married adolescent girls tend to have higher rates of HIV infection than their sexually active, unmarried peers. Thus married adolescent girls not only represent a sizeable fraction of adolescents at risk, but they also experience some of the highest rates of HIV prevalence of any group.⁷⁶

The research of Clark and co-workers found that in Kenya and Zambia marriage greatly increases a young girl's likelihood of becoming HIV seropositive.⁷⁷ Their research finds that:

... early marriage increases coital frequency, decreases condom use, and virtually eliminates girls' ability to abstain from sex. Moreover, husbands of married girls are about three times more likely to be HIV-positive than are boy friends of single girls. Although married girls are less likely than single girls to have multiple partners, this protective behavior may be outweighed by their greater exposure via unprotected sex with partners who have higher rates of infection. These results challenge commonly held assumptions about sex within marriage.⁷⁸

b. *Female Genital Mutilation or Cutting*⁷⁹

Currently there is some debate over which phrase should be used to describe this custom. However, it is estimated that an additional three million young females are subject to some form of cutting of their genitals each year. This practice is deeply rooted in culture and religion, including the Christian religion in some regions. The reasons for the practice are many and varied.⁸⁰ Female genital mutilation or cutting is associated with a heightened risk of HIV infection because of the often unhygienic means by which the cutting is done. The resultant sewing, scarring, and risk of tissue tearing on penetration also increases the risk of contracting HIV.

c. *Wife Inheritance*

Wife or widow inheritance is “The union of a widow to a male relative of her deceased spouse, by which she becomes his wife and property along with the land and property from her husband's death.”⁸¹ This East African practice began as a means for a community to care for its widows and served to protect those women who had lost their husband. The widow would not remarry. Her husband's family would take responsibility for her and her children for meeting their needs for food, clothing, shelter, education, protection, and so forth. The responsibility would fall to a married male relative of her deceased husband (e.g., brother-in-law, cousin-in-law) who would take her into his home. There was a taboo against sex with the relative's widow. Over time, however, this taboo fell and is seen to be a significant contributing factor to the spread of HIV in East Africa. If the widow's husband had died of AIDS and she were seropositive, her “inheritor” would become infected, and would subsequently pass the infection to his own wife.⁸²

d. *Widow Cleansing*

Widow cleansing is “forced sex between a widow and a man compensated to have sex with her, which is thought to cleanse the widow of her dead husband's spirit. It may also refer to a widow having sex with the male relative of her deceased husband.”⁸³ As in widow inheritance, if a woman's husband had died of AIDS and she were infected, HIV would be passed to the “cleanser” (sometimes a designated village cleanser or relative of her deceased husband) with whom she had sex and then from him to other women with whom he had sex (e.g., his wife) or other women whom he “cleansed.” This practice was seen as

. . . a way to break with the past and move forward—as well as an attempt to establish a family’s ownership of the husband’s property, including his wife. . . . It also prevents women from inheriting property that has been their family’s main source of support.⁸⁴

e. *Infant/Virgin Rape*

In some regions a prevailing myth is that sex with/rape of a virgin (a female child) or infant rape will cure one of HIV and AIDS.⁸⁵

f. *Polygamy When the Husband Is HIV Positive*

Polygamy can increase the risk of HIV transmission to all of the wives and potentially to the infants of breast-feeding wives.⁸⁶

g. *Prohibitions Against Male Circumcision*

Large clinical trials in Africa indicate that male circumcision can decrease the risk of men from becoming infected with HIV through heterosexual intercourse.^{87,88} In the face of compelling scientific evidence, the WHO/UNAIDS have called for an expansion of safe male circumcision practices.⁸⁹ While approximately 30 percent of the world’s men are circumcised, worldwide there are non-circumcising societies, cultures, ethnicities, traditions, and religions that resist circumcision on cultural grounds, even for medical reasons.^{90,91}

C. *Economic Forces*

1. *Biomedical Scientific Research: Searching for a Cure and Promoting Prevention*

We are essentially faced with two options: to cure the patient and to prevent infection. The first, a cure, has remained elusive. HIV and AIDS differ from other viral infections, such as polio, in that it directly attacks the immune system itself, effectively damaging the body’s ability to fight the virus. The virus also has the ability to replicate and mutate very rapidly, developing drug resistance quickly, and to hide within human host cells, evading the immune system and drugs. In 1995, a new class of antiretroviral drugs (protease inhibitors) was introduced, followed by other drugs that attacked the virus in new ways and which were then used in combination therapy. These drugs have dramatically reduced mortality rates and prolonged life spans. But to date it has not been possible to find a drug that would kill every virus in the body of an infected individual, so that a course of treatment would be weeks or months, rather than a lifetime. At this point, there is no cure on the horizon.

Prevention, the second option, has been tackled from many different angles. There are a number of proven HIV-prevention and harm reduction strategies: behavior modification, condom use, antiretroviral treatment to prevent mother to baby HIV transmission, clean syringe and needle exchange for drug users, and screening of blood and blood products for transfusion. Although there is debate over the efficacy of male circumcision, large clinical trials in Africa indicate that male circumcision can help prevent men from becoming infected with HIV through heterosexual intercourse.

In the developing world and particularly among people who are poor everywhere, prevention becomes more complex. Access to health care and preventive education is extremely limited creating enormous challenges to the provision of appropriate information and education, rapid testing, expensive pharmaceuticals in complex combination therapy, monitoring of compliance and disease status, and adequate nutrition. Despite this complex array of issues, individuals, organizations, and programs, including the PC(USA) International Health and Development (IHD) ministry area, are engaged in heroic efforts to overcome these hurdles.

The National Institutes of Health has identified the priorities for research, and has allocated more than \$3 billion toward various facets of research and training related to HIV and AIDS in 2010. A significant

portion of this funding is directed at research—basic, clinical, translational, social, behavioral, and epidemiological. Such research is essential to overcome the HIV pandemic. It is critical that the church understand the importance of research in combating this pandemic, and that every means be used to advocate for increased funding of research on HIV and AIDS globally.

2. *Pharmaceuticals*

Now that people are living much longer lives with HIV and AIDS, it has become one of the most expensive chronic diseases. In the U.S., most HIV positive individuals can receive coverage and care through private insurance, Medicaid, or a state AIDS Drug Assistance Program (ADAP). The average cost of one HIV medication per month is \$500 and can go as high as \$2315 per month.⁹² Most people with HIV are on more than one medication at a time, so even with insurance or state programs, the out-of-pocket cost can still be high. There are also state differences in who may qualify for treatment and what drugs they can receive. For example, there are sixty-nine approved drugs on Kentucky's ADAP drug list compared to 130 approved drugs on Indiana's list.^{93, 94} Indiana's drug list includes three options for antinausea drugs (a frequent side-effect from antiviral medications) compared to only one option for ADAP qualifiers in Kentucky. In addition to such discrepancies, if a person living with HIV and AIDS wants to move to a different state, they may not be able to receive coverage for their medications, or due to paperwork, face discontinuity of care.

In developing countries, the issue is about getting appropriate treatments into countries in the first place. According to AVERTing HIV and AIDS (AVERT), an international HIV and AIDS charity, "the availability of cheap antiretroviral drugs has been instrumental in treatment scale-up for resource-poor settings hard hit by the AIDS epidemic. Four million people in low- and middle-income countries are currently receiving drugs to treat HIV and AIDS."⁹⁵ This would simply not have been possible without a reduction in the price of anti-retrovirals, and other strategies in which the U.S. Global Health Initiative has played a significant role.⁹⁶ Despite significant advances, a number of problems related to the price of anti-AIDS drugs remain. Not all drugs to treat AIDS are available at a suitably cheap price for poor countries, meaning that many of the newer, more effective drugs are only available in the West. At a cost of \$10,000–15,000 per person per year, these drugs are not only too expensive for the vast majority of infected people in resource poor countries, but, more often than not, are too expensive for those in developed countries.

It is an ethical imperative that life-saving medications be made available to developing countries at the lowest cost possible. These essential medications must then be given to patients, the majority of whom are impoverished, at no cost. Currently, only one third of the people who need antiretroviral therapy are receiving it. While some pharmaceutical companies provide Highly Active Antiretroviral (anti-HIV Therapy) (HAART) directly to developing countries at markedly reduced costs, these efforts have been inadequate. Companies have also provided drug formularies to generic companies in India to produce low-cost medications; however, quality control and international patent laws remain an issue.

The pharmaceutical industry is enormously and famously profitable. In 2002 the combined profits for the ten drug companies in the Fortune 500 (\$35.9 billion) were more than the profits for all the other 490 businesses put together (\$33.7 billion).⁹⁷ Surely, this industry must assume greater responsibility for ensuring adequate treatment of all people infected with HIV throughout the world, from making low-cost medications available to pursuing more research related to the pediatric populations. The world simply cannot afford more HIV infections. Beyond the pure costs of drugs and related health care, the toll on individuals, families, communities, and entire nations is enormous.

V. Underreported U. S. Populations

While HIV and AIDS is a global pandemic, it continues to be a U.S. epidemic. The surveillance system in the U.S. is now considered one of the most complete with respect to infectious and communicable diseases, but it is not without blind spots. Problems with reporting point to issues of ethics

and power that result in many populations and demographics being underreported and mischaracterized. Below we focus on the intersection of some of these populations and HIV and AIDS.

A. *Demographic Groups*

1. *Native Americans*

American Indians and Alaska Natives surveillance statistics are substantially less reliable for several reasons. These include incomplete surveillance data, non-reporting of data collected by Indian Health Services, racial misclassification and underreporting, and avoidance of testing because of concerns for confidentiality in a closed-community where one would likely be tested by friend, relative, or acquaintance in a reservation health facility.^{98, 99, 100}

2. *Asian Americans and Pacific Islanders*

According to the Center for Disease Control and Prevention (CDC), “In recent years, the number of AIDS cases diagnosed among Asians and Pacific Islanders has increased steadily. Although Asians and Pacific Islanders account for approximately 1 percent of the total number of HIV and AIDS cases in the thirty-three states employing long-term, confidential name-based HIV reporting, the Asian and Pacific Islander population in the United States is growing.”¹⁰¹

Among Asians and Pacific Islanders, there are many nationalities—Chinese, Filipinos, Koreans, Hawaiians, Indians, Japanese, Samoans, Vietnamese, and others— many cultural factors, much socioeconomic diversity, and more than one hundred languages and dialects. Because many Asians and Pacific Islanders living in the United States are foreign-born, they may experience cultural and language barriers to receiving public health messages. Additionally, many health surveys are administered only in English (and perhaps Spanish), a situation that may cause miscommunication or exclude Asians and Pacific Islanders who do not speak English from demographic statistics. In addition, these persons may also be mis-categorized or even missed in statistical counts so that their demographics are skewed.

3. *Transgender, Transsexuals, Lesbian Communities*

Statistics for HIV and AIDS are likewise unreliable for transgendered people who are likely greatly under-counted because they live their lives across the gender spectrum and may self-identify as female, male, trans-women or trans-men, nonoperative transsexuals, transvestites, or cross-dressers, among others.¹⁰² Thus tracking MTF’s (Males-to-Females) by the Centers for Disease Control and Prevention (CDC) HIV classification system has failed with MTFs showing up as either men who have sex with men or heterosexual women. Researchers maintain that transgender-specific categories need to be included on all federal and local data collection forms. In spite of the lack of a large volume of definitive research, it is believed that HIV prevalence among trans-women is higher than estimates from studies with gay men, as well as injection drug users of the same age.¹⁰³

Transphobia is blamed for the lack of reporting, study, research, and care given to the MTF population. As a result of pervasive transphobia, transgender people are denied access to social support, housing, employment, healthcare, education, and other resources, in addition to a lack of inclusion and accurate demographic reporting.¹⁰⁴

There is very little medical documentation of woman-to-woman sexual transmission of AIDS. However, according to the Lesbian AIDS Project of the Gay Men’s Health Crisis (GMHC), a significant number of women who identify primarily as lesbians have contracted AIDS through intravenous drug use or heterosexual sex.¹⁰⁵ The HIV and AIDS cases related to WSW (Women who have Sex with Women) are the results of engaging in high-risk behaviors that place them at risk for HIV transmission. “These risks are exacerbated by racial disparities in health care access, as well as by homophobia, sexism, and stigma,” said Marjorie J. Hill, chief executive officer of GMHC. “We seek to clarify confusion regarding lesbians and WSW risk in order to create visibility for this marginalized subpopulation of women.”¹⁰⁶

4. *HIV and AIDS in Rural America*

Stigma is a serious problem for people with HIV and AIDS in all communities, but particularly in rural areas. According to the Kinsey Institute for Research in Sex, Gender and Reproduction, “people with HIV and AIDS in rural communities carry an extra burden with their disease in that many are stigmatized as unworthy of community support and adequate health care.”¹⁰⁷ People diagnosed with AIDS who live in rural areas now account for 8 percent of all cases nationwide, up from 5 percent in 1996. Despite these growing numbers, most AIDS control strategies have focused on urban communities.¹⁰⁸ Further, it must be noted that many people living with HIV and AIDS in rural communities struggle with access to adequate medical treatment and services as result of a serious shortages in doctors, nurses, dentists, and the overall healthcare workforce.

B. *HIV and AIDS in Prisons and Jails*

The Joint United Nations Programme on HIV and AIDS (UNAIDS) notes that “[in] most countries around the world HIV prevalence is higher among prisoners than in the general population.”¹⁰⁹ Incarcerated individuals face a peculiar situation in that their rights and actions are limited; however, risk behaviors for HIV infection and transmission still occur in detention. Prisoners may lack access to protective measures, be subject to violent conditions, including rape, and have inadequate health services.¹¹⁰ In some countries, lack of knowledge about HIV transmission also perpetuates the problem.

More than 2.2 million persons are in U.S. prisons where HIV and AIDS is up to five times more prevalent than in the general population.¹¹¹ Although inmates comprise only 0.8 percent of the U.S. population, it is estimated that 20–26 percent of those with HIV infection pass through a correctional facility each year.¹¹² Many with HIV and AIDS are addicted to illicit drugs and contracted HIV prior to incarceration through needle sharing, sex trading, or unprotected sex with multiple partners. In fact, the U.S. National Commission on AIDS noted that “policies that mandate confinement for drug-related offenses primarily are responsible for ... dramatic increases in imprisonment.”^{113, 114, 115} Lawrence Greenfeld at the Bureau of Justice found that one in four inmates in the system has engaged in some form of substance abuse.¹¹⁶ Many had engaged in intravenous drug use,¹¹⁷ the second most prevalent mode of HIV transmission.

In the Mahon focus group study, inmates reported that both men and women engage in a range of sexual behaviors between prisoners as well as prisoners and guards.¹¹⁸ Although there has been debate over prisoners’ rights, and whether providing condoms and clean needles promotes sexual activity and drug use, it is ultimately the community that suffers when these individuals return home and spread the virus. Exposure to HIV and AIDS infection should not be used as a deterrent or form of punishment for engaging in prohibited sexual behavior while incarcerated. In some facilities, HIV counseling, testing, and partner notification programs have been implemented for adults. But very few facilities make available the means for reducing the risk by distributing condoms, dental dams, exchanging needles, or providing bleach for cleaning needles. Despite overwhelming evidence that condom use prevents the transmission of HIV, U.S. prison officials continue to limit the availability of condoms. The H.R. 1429, the “Stop AIDS in Prison” Act, introduced in the current Congress by Representative Maxine Waters, would require the Bureau of Prisons to provide non-mandatory HIV tests of all Federal prison inmates upon entering prison and being released from prison, prevention education, and comprehensive treatment for those who test positive.¹¹⁹

C. *U.S. Military Personnel*

1. *Active U.S. Military Personnel*

In 2008, 1.445 million persons were on active duty in the U.S. military: Army, Navy, Marines, Air Force, and Coast Guard. Another 839,000 are in the selected Armed Forces, National Guard and Reserves.¹²⁰ To begin with, it should be noted that the prevalence of HIV infection among U.S. military personnel is lower than that of the general population for three reasons: “homosexual men and male and

female intravenous-drug users are underrepresented in military personnel. Second, persons with hemophilia are not medically eligible for military service. Third, seropositive military recruit applicants are denied enlistment.”¹²¹ Yet, those in the active military are confronted by the HIV and AIDS pandemic in unique ways. A 1996 study reported that the U.S. Army found a behaviorally related increase in vulnerability to HIV infection among our military personnel. “Risk factors include high rates of sexual partner change, elevated rates of STD, relatively low rates of condom use with prostitutes and other “casual” partners, and significant mixing between groups having high- and low-risk behavior patterns, as well as higher and lower HIV prevalence.”¹²² The military has responded with an aggressive testing program. Active duty U.S. military personnel have been tested for HIV infection since 1986. Since 2004, the U.S. military has required HIV testing of all military personnel every two years.¹²³

Deployment offers other risks. Information regarding the level of risk of HIV exposure in areas of deployments as well as in areas of future deployments is not always available. While the military maintains its own blood supplies, it must rely upon warm blood transfusions or local supplies when devastating circumstances outstrip their supply, heightening the risk of HIV infected transfusion.¹²⁴ Another issue revolves around continued HIV testing and assessment of HIV subtypes infecting active forces and overseas populations during foreign deployments; such monitoring is essential to ensuring adequate treatment, care, and research.¹²⁵ An HIV test is now uniformly required at least every two years.¹²⁶ This is frequent enough to intervene between infection and the progression to AIDS, but may not be frequent enough to track HIV exposure. An issue affecting both active military and veterans is the correlation between Post Traumatic Stress Disorder (PTSD) and high-risk behaviors such as substance abuse. Post Traumatic Stress Disorder and substance abuse working in tandem may lead to impaired decision-making thereby creating the potential for increased exposure to HIV and other blood borne pathogens.¹²⁷

2. *U.S. Military Veterans*

As the country’s largest provider of HIV-related care, the Veteran’s Health Administration (VHA), through a network of hospitals and clinics, has enabled many HIV-positive veterans to afford healthcare and obtain regular treatment. However, serious concerns regarding the adequacy of medical care and HIV testing at the Veterans Affairs (VA) hospitals and clinics have arisen.¹²⁸ For instance, following positive tests of veterans for HIV and Hepatitis B and C, Congress and the Department of Veterans Affairs launched a full-scale investigation into the adequacy of care provided by three southeastern VA hospitals that potentially put thousands of veterans at risk of infection due to exposure to unsterilized medical equipment used in colonoscopies and other medical procedures.¹²⁹ Further, in the face of an ever-increasing population with various and complex physical disabilities, as well as often facing “challenges of substance abuse, mental health problems, and financial issues,” it is clear that the VA lacks sufficient resources and personnel—specifically doctors, nurses, chaplains, counselors, and social workers—to meet the diverse and various physical, mental, and emotional needs of veterans.¹³⁰

Regarding HIV testing, the VA currently tests only those patients who request HIV testing in writing, those receiving care for “intravenous drug abuse and diseases associated with HIV” or are “otherwise at high risk for HIV infection.”¹³¹ Recognizing that the HIV-positive rate in veterans is greater than the general population¹³² and that too many veterans are leaving VA care without knowing they are HIV positive, advocates and political officials have worked tirelessly to change the law requiring the VA to offer pre-test counseling and a signature consent, which further creates barriers and stigma around testing. Accordingly, in reevaluating testing policies, the CDC has strongly encouraged the VA to recognize that “general consent for medical care should be considered sufficient to encompass consent for HIV testing.”¹³³

VI. The Dynamics of Power and the Persistence of HIV and AIDS

[edited slightly for clarity]

As new methods of prevention and treatment are discovered and developed, we must not add them to old patched wineskins. A truly comprehensive approach to the root causes and social determinants of HIV

and AIDS risk and vulnerability requires an entirely new wineskin: the removal of disparities in power that perpetuate those social determinants nationally and internationally. Unmasking sin and idolatries in society and the church requires political will, moral commitment, the courage of our faith convictions, all linked for us to the illumination and aid of the Holy Spirit.

The surpassing causes of increased risk and vulnerability to HIV and AIDS are poverty, gender inequality, human rights violations, and the constellation of stigma, prejudice, discrimination, and social marginalization. The commonality among all these causes is the unequal distribution of power. Our failure to address these inequalities will lead to the failure of our attempts to address the incidence and effects of HIV and AIDS. A few demonstrative examples are useful here:

- Legal and undocumented immigration and ethnic and religious conflicts around the world have created pools of marginalized people in many countries. These groups of lower social standing are excluded from economic and social participation, as well as from educational and health resources. This has led to their suffering systematized poverty and discrimination, and prejudice holds them there. These conditions substantially increase the risk and vulnerability to HIV and AIDS of these communities. Given their social standing, the stigma associated with HIV and AIDS often further makes these communities the focus of blame for the presence of the virus in the society, further separating them from the resources that would reduce their vulnerability.

- International development and banking bear some responsibility for exacerbating the conditions in which HIV and AIDS spread. Often structural adjustment policies required borrowing countries to reduce social expenditures on health, sanitation, education, water delivery systems and purification, welfare, and more. These policies create conditions for the spread of the disease. For example, cuts to health care in response to structural adjustment policies have been shown to be correlated with a rise in HIV and AIDS and mycobacterium tuberculosis (MTb).¹³⁴

- In addition to the immediate impacts on employment, health, and poverty, cuts in social expenditures have profoundly gendered effects. The burden of providing for health, sanitation, and welfare (regarded as “women’s work”) has fallen disproportionately on women, often women already living in abject poverty. As jobs have moved into urban areas, rural men have left for cities, leaving women and children behind to fend for themselves. Already suffering from typically unequal sexual power relations that increase their risk, these women have also borne this increased vulnerability through their economic standing. This has likewise increased the vulnerability of children to disease, lack of education, and food insecurity.¹³⁵

Further, these international organizations insisted on trade adjustments, including the reduction of trade barriers, enhancements in the rights of foreign investors, market deregulation, and privatization. The PC(USA) has addressed these issues in several of its recent policies, including *Hope for a Global Future*(1996) and *Resolution on Just Globalization* (2006). The weakened bargaining position of developing countries has reinforced the long-run institutionalization of economic disparities, the entrenchment of foreign business interests at highly unfavorable terms, and the restructuring of production toward export markets and away from the provision of domestic consumption goods. Studies confirm that these conditions create a moderate-term increase in vulnerability to HIV and AIDS.^{136, 137, 138}

Future globalization policies must include explicit consideration of their impact on vulnerable groups and the costs of increasing HIV and AIDS risk and vulnerability among these groups. Briefly, such areas of concern include the following.

- The current structure of international intellectual property rights. Literally holding the power of life and death, these fiduciary relationships primarily benefit the shareholders of firms, not those most at risk and vulnerable to the disease.

- Current agricultural policies have resulted in a worldwide growth of urban poverty and slums by shifting jobs to urban areas. Men, who seek jobs in the cities leaving their families behind, provide

conditions where sex trade—and HIV infection—may flourish. Poor women in urban areas are deeply affected as they may be unable to secure any work other than that provided by participation in the sex trade in these cities, and engage in “survival sex.” This circular migration of men and women for economic reasons has compounded the spread of HIV infection as people move back and forth between rural and urban work settings and between spousal and non-spousal partner, increasing vulnerability in home areas.

- Food aid policies. As Christians we are enjoined to “feed the hungry.” It seems counterintuitive to say that utilizing our crop surplus to support “food aid” internationally (not referring to emergency relief) can harm those whom we would wish to help. Yet, it can. Shipping food to developing nations that is free or below market price, undercuts that nation’s farmers. They cannot compete and are driven out of work, off their farms, and into poverty.¹³⁹ Alternatively, they may be driven to produce stigmatized or unlawful alternative cash crops such as opium poppies or khat.¹⁴⁰

Reducing these market and power differentials requires protective regulation as well as renunciation, reconciliation, and forgiveness to counter individual and social avarice, greed, and sin. Where inequality is vast and governments weak, overcoming market failures and outright predation in the distribution of medications calls on the powerful to not use power for their own advantage, but to the advantage of those affected by HIV and AIDS.

Paul Farmer writes, “... we must remember that effacing the inequality of outcomes is not the same as eliminating the underlying forces of inequality itself.” He goes on to quote economist, Amartya Sen: “when we assess inequalities across the world in being able to avoid preventable morbidity or escapable hunger, or premature mortality, we are not merely examining differences in well-being, but also in the basic freedoms that we value and cherish.”¹⁴¹ “In a very real way, inequality itself constitutes our modern plague.”¹⁴²

Given the power of economic globalization, the hardest task is to challenge the ways in which we knowingly or unknowingly participate in the maintenance of our own position and in the perpetuation of a power differential that keeps us at the center of abundance and others at the margins amidst poverty, powerlessness, and the deadly advance of HIV and AIDS.

VII. Becoming an HIV and AIDS Competent Church

The Presbyterian Church (U.S.A.) has long affirmed the need for ecumenical and interfaith dialogue and collaboration (*Book of Order*, G-15.0101-G-15.0104).¹⁴³ In the face of enormous injustice, immense suffering, and the death of millions of God’s children, God calls the PC(USA) to partner collaboratively with other churches and faith communities to respond to the HIV and AIDS pandemic with prophetic vision, faithful imagination, just action, and loving compassion. Since 2008, the World Council of Churches (WCC) has campaigned to promote “HIV-competent churches.” In working systemically, particular HIV-competent churches are called to develop the institutional and theological capacity as well as leadership and resources needed to respond to the pandemic. Going beyond HIV-competent churches, we must be an HIV-competent denomination. The PC(USA) as a whole is challenged to learn from, partner with, and strategically collaborate with other churches, faith communities, governmental, business, and civil organizations to comprehensively address the HIV and AIDS pandemic (*Book of Order*, G-15.0105).

The World Council of Churches (WCC) defines “an ‘HIV competent church’ as a church that has first developed an *inner competence* through internalization of the risks, impacts and consequences and has accepted the responsibility and imperative to respond appropriately and compassionately. In order to progress to outer competence, there is need for *leadership, knowledge and resources*. *Outer competence* involves building theological and institutional capacity in a socially relevant, inclusive, sustainable and collaborative way that reduces the spread of HIV, improves the lives of the infected and affected, mitigates the impact of HIV and ultimately restores hope and dignity” [italics in the original].¹⁴⁴

Creating a denomination that is HIV and AIDS competent is a big challenge, but a great necessity. And it should be noted that the specific responses for HIV competent churches will vary from church to church and denomination to denomination. Presbyterians must ask themselves:

- “Do I know enough about HIV and AIDS to make informed decisions and help my local congregation develop the educational programs and outreach ministries that will make this world a better place for people living with HIV and AIDS?” This harkens back to the earlier question posed in this report, “Do those with HIV and AIDS delight in the work and witness of the Presbyterian Church (U.S.A.) related to our HIV and AIDS policies and programs?”

- What are the best practices for individuals, churches, and denominations that are competent in issues related to HIV and AIDS? For Presbyterians this knowledge comes from study, research and policy formation, hands-on experience, and faith in God’s love to bring hope and to heal.

- How are our common assumptions and practices unintentionally, even indirectly, helping to maintain unjust structures of poverty, racism, sexism, homophobia, stigma, and discrimination?

The World Council of Churches manual (WCC) titled, *Beacons of Hope: HIV Competent Churches a Framework for Action*, spells out several benchmarks for competency related to the HIV and AIDS pandemic, including:¹⁴⁵

1. *Pastoral Care*

Encouraging neighborhood congregations to engage in systems that ensure home visits, opportunities for fellowship, marriage enhancement programs, pre- and post-marriage counseling and safe places for people living with HIV to frequent are suggested, lifting up widows, widowers, and single parents as needing particular attention.¹⁴⁶

2. *Preaching*

The preaching of worthy and well-informed sermons on the HIV pandemic and creating worship services with liturgies, prayers, and orders of worship that include silence, contemplation, words, songs, dances, and practices that celebrate life, love, and the hope that faith brings to all of life’s struggles need also to be lifted up, including prayers for those living with HIV and AIDS.¹⁴⁷

3. *Education*

Another characteristic of HIV competent denominations is the development of prevention materials designed to keep people safe and HIV-free. Creating sexually healthy congregations means producing sexuality education curriculum that is medically accurate, biologically sound, and culturally sensitive. Local congregations are encouraged to hold frank discussions about the social factors creating risk and vulnerability for HIV infection as well as practical remedies such as the use of condoms, clean needles and syringes. Individually and collectively dealing with high-risk cultural practices and reaching out to those who are at risk are all critical components of HIV competency.

HIV/AIDS competent churches offer hands-on care to folks living with HIV and AIDS in our congregations and neighboring communities and identify youth who are at risk, infected, or affected by HIV.¹⁴⁸ The critical aspects of treatment, availability of clinics, and the staggering cost of HIV and AIDS medicines are also of concern to HIV competent churches. Best practices for an HIV competent pastor might include the ability to refer a pregnant woman and her spouse to a neighborhood clinic for screening and other services. An HIV competent congregation might take on the responsibility for dispensing medications or creating a space for HIV testing, and an HIV competent denomination would indeed decry drug manufacturers making inordinate profit from the manufacture of antiretroviral drugs for treating AIDS.

The PC(USA) has developed through its social witness policy many of the criteria found in the WCC document even though the *Beacon of Hope* manual is not specific to the PC(USA). Presbyterian churches

and agencies have been faithfully responding to the HIV and AIDS pandemic since the early 1980s developing Christian education and youth group curriculum. Presbyterian Women (PW) at all levels of the church have responded through education, prayer, Bible study, and mission work to the global HIV and AIDS pandemic. Local congregations have engaged in hands-on ministry with people living with AIDS and their families. The PC(USA) has cooperated meaningfully and respectfully with other denominations and world faiths to create policies and programs that address HIV and AIDS in a global framework. These are all benchmarks of an HIV and AIDS competent church.¹⁴⁹

4. *To Become an HIV and AIDS Competent PC(USA): Compassionate Care and Prophetic Witness*

It will be critical for the PC(USA) to develop coherent criteria for Presbyterian HIV competent local congregations in the form of a study guide for implementing these best practices, instilling the inner competencies of individual church folk, and then facilitating and leading to the institutional and outer competency required to defeat this disease. A denomination that recognizes and accepts the imperatives of HIV for itself, its individual members, and its congregations has the knowledge, willingness, and experience to respond in an inclusive, effective, and prophetic manner. In addition, an HIV and AIDS competent church goes toe to toe with the powers and principalities of poverty, discrimination, stigma, and violence. It does not shy away from controversial issues. It recognizes the role of the church in the Reformed tradition to challenge and reform social structures. It accepts the unique role that it can play, not only in bringing help, but strong policies; offering prayer, and compassionate action; doing what is right, and proclaiming a prophetic witness.

VIII. Conclusion

Our foundational values compel us to make the HIV and AIDS pandemic one of our highest priorities as a denomination. In our recommendations, not only do we lift up the excellent work that has been carried out under our existing PC(USA) social witness policy, but we would extend previous analysis to bring new social, institutional, and economic factors under the ethical scrutiny of the gospel. This includes more rigorously examining the underlying causes of poverty. We must continue to highlight that discrimination on the bases of gender, race, class, and/or sexual orientation is antithetical to the gospel witness. This means continuing to advocate for fully-funded programs to challenge these discriminatory forces, especially in the context of HIV and AIDS education.

We cannot ignore the structural problems that exacerbate HIV and AIDS among the underreported and those who are incarcerated. This means evaluating drug company profits as they affect access to treatment for persons living with HIV and AIDS. Our challenge is to keep people living with HIV and AIDS central in our focus, to create life-giving communities of faith in our own neighborhoods while avoiding a national myopia that privileges Western needs over those of other regions. Too often social policy is focused on the visible rather than the vulnerable—the viable rather than the vanquished. Our challenge is to take seriously the biblical mandate to become a community that cares for the interests of the most vulnerable—to cause them to rejoice and to vindicate God’s name by placing their interests at the center of our focus. Our success will be measured not by the amount of money we amass or by the amount of notoriety we may receive on behalf of our brothers and sisters living with HIV and AIDS, but rather by the extent to which those whom HIV and AIDS have relegated to the social, political, or economic margins gain greater honor, dignity, and fullness of life.

ADDENDUM: HIV/AIDS and Hepatitis B or C Co-infection

[Note: This addendum was added after the 219th General Assembly (2010) as an acknowledgement of the dangers of co-infection with Hepatitis B and C and other blood-borne diseases.]

Introduction: This addendum is intended to prevent possible confusion by an action to add Hepatitis B & C to the recommendations for action in a report on HIV/AIDS. In response to a request for clarification by a commissioner who is also a medical doctor, the Stated Clerk indicated to the 219th General Assembly (2010) that measures would be taken to ensure that the (electronic) transmission of erroneous or unsupported information would be prevented. Hence this addendum and the authorization of booklet printing with this clarification.

In the United States, Hepatitis B and C viral co-infection are among the leading causes of hospital admission and death among HIV infected persons. While this report does not discuss Hepatitis B or C, and while they differ from HIV/AIDS in transmission, treatment, health impacts, and level of stigma, the danger of co-infection, particularly in the U.S., merits some discussion. Internationally, Hepatitis B and C are not considered diseases of poverty, nor are they predominantly diseases of poor women in developing nations, as are HIV/AIDS. (Note: Hepatitis, or disease of the liver, includes the form spread by the “A” virus that can be transmitted by contaminated water or food poisoning and is treatable by vaccine with generally full recovery, though antibodies remain in the blood providing immunity.)

Hepatitis B virus (HBV) is a blood borne viral infection transmitted primarily through high-risk sexual behavior. Hepatitis C virus (HCV) is a blood-borne viral infection transmitted primarily through injection drug use. Though it can be, it is not efficiently transmitted sexually. Thus these viruses share much of the same modes of transmission as HIV. They can also be transmitted by an infected pregnant woman during delivery to a newborn. Approximately 10 percent worldwide and 5 percent domestically of all persons infected with HIV are co-infected with HBV/HCV.¹ Among injection drug users specifically, coinfection with HIV and HCV is common (50 percent–90 percent). Not only are persons who are HIV infected at behaviorally increased risk of contracting HBV/HCV, the rate of progression and complications from viral hepatitis are accelerated in patients with HIV co-infection.² Both HBV and HCV have acute and chronic forms though HBV less frequently progresses to chronicity. Both can progress to cirrhosis or liver cancer and are the most frequent causes of liver cancer.³

Vaccination is available for both Hepatitis A virus (HAV; not associated with HIV) and B viruses. There is no vaccination for HCV. The CDC recommends vaccination of children against HAV and HBV.^{4,5} To prevent HBV infection in HIV-infected persons, the CDC Advisory Committee on Immunization Practices recommends universal Hepatitis B vaccination of susceptible patients with HIV/AIDS. Treatment for either HBV or HCV is supportive, not curative. In view of the incidence of HIV—hepatitis coinfection and its personal and social consequences screening of all persons at risk of HIV should also include screening for HBV/HCV. Access to treatment for HBV/HCV as well as for HIV/AIDS needs simultaneously to be assured.

According to the Centers for Disease Control and Prevention (CDC) the three most common forms of acute viral hepatitis in the United States—Hepatitis A, B, and C—have declined dramatically between 1995 and 2005, with Hepatitis A and B at the lowest levels ever recorded since the government began collecting surveillance data more than forty years ago.⁶ Hepatitis B and C are diseases that can lead to liver cancer and death. The main factor behind the declines in new cases of Hepatitis A and B were the availability of vaccines and strong federally supported immunization programs. The declines in Hepatitis B were greatest among children and teens age fifteen and younger, likely the result of high vaccination coverage in this age group.⁷ Declines in reported new cases of Hepatitis C were likely due to reductions in high-risk behaviors among injection drug users, as well as efforts to diagnose individuals infected with Hepatitis C and the promotion of health behaviors to reduce person-to-person transmission of the virus.

“The sharp declines in rates of Hepatitis A and B are one of the big public health success stories of the last ten years. The drops in new cases of Hepatitis A and Hepatitis B are evidence that our prevention

strategies have been successful, particularly the widespread use of vaccines for Hepatitis A and Hepatitis B. In order for these declines to continue, our prevention efforts must be sustained,” according to Dr. Kevin Fenton, director of CDC’s National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.⁸

The reported cases of acute Hepatitis B also dropped to the lowest rate ever recorded in 2005 (1.8 per 100,000), a decline of 79 percent from 1990. In addition to the declines noted in children, Hepatitis B rates also declined among adults but remained highest among those 25 to 44 years of age and among people with behavioral risk factors such as high-risk sexual activity and injection drug use. Cases of Hepatitis C have also declined steadily since the late 1980s. However, this trend should be viewed with caution since surveillance for acute Hepatitis C is limited because many individuals do not immediately develop symptoms and may not know they are infected.

In 2006, CDC issued new guidelines to increase vaccination coverage among adults at risk for Hepatitis B encouraging vaccination of adults at high risk for Hepatitis B, particularly those with multiple sex partners or whose sex partners are already infected, men who have sex with men, and injection drug users. More than 4.5 million Americans are currently living with chronic Hepatitis B and Hepatitis C. Numbers of persons overseas with these diseases, singly or in combination, are based on extrapolations from areas with more adequate screening and treatment programs.

¹ CDC. Coinfection with HIV and Hepatitis C Virus. Atlanta: CDC, November 2005.

² CDC. MMWR. Guidelines for Preventing Opportunistic Infections Among HIV-Infected Persons—2002. Atlanta: CDC, June 14, 2002 /51(RR08);1–46.

³ Institute of Medicine of the National Academies. Hepatitis and Liver Cancer.

A National Strategy for Prevention and Control of Hepatitis B and C: Report Brief. Washington DC: IOM, January 2010.

⁴ CDC. MMWR. Prevention of Hepatitis A Through Active or Passive Immunization Recommendations of the Advisory Committee on Immunization Practices (ACIP). Atlanta: CDC, May 19, 2006 / 55(RR07);1–23.

⁵ CDC. MMWR. Hepatitis B Vaccination Recommendations for Infants, Children, and Adolescents MMWR 2005;54(RR-16).

⁶ CDC stats for Hepatitis reported cases in the U.S. through 2003
<http://www.cdc.gov/hepatitis/statistics.htm>.

⁷ Morbidity and Mortality Weekly Report (MMWR), “Surveillance for Acute Viral Hepatitis—United States, 2005,” is available at www.cdc.gov/mmwr.

⁸ For information about viral hepatitis visit <http://www.cdc.gov/ncidod/diseases/hepatitis/>.

Appendix A

Two Biblical Questions

When Christians face living with HIV and AIDS, there are two questions they may ask of the Bible: (1) Are the biblical purity codes regarding blood pertinent to persons living with HIV and AIDS? (2) Is there a parallel with leprosy (in Hebrew, *tzara'at*)? The answer to both is, decidedly, “No.” Many, for instance, point to the woman with the hemorrhage of blood in Mark 5:25–34 in order to claim that Jesus has overruled purity codes from the Bible. Sadly, this has resulted from a very real misunderstanding about biblical law in general and the purity codes specifically. First of all, in Mark 5, we are never told whether the woman’s hemorrhage was menstrual or whether it came from another part of her body, which would not convey impurity. Secondly, we are told in Leviticus 15:11 that, by washing her hands, the woman would not have conveyed ritual impurity to those she touched. Moreover, Mark mentions “the crowd pressing in” upon Jesus and, we can assume, upon the woman as well (v. 31). Clearly, they were not concerned about impurity. Finally, Jesus never mentions impurity in the story. Instead, the story is about healing and wholeness. Jesus, in healing her, focused only on her health and freedom from affliction. So for those persons living with HIV and AIDS, the message of Mark 5 is a message of healing. It is *not* one that implies impurity associated with blood.¹⁵⁰

Additionally, to make explicit a connection between persons living with HIV and AIDS, which is a blood-borne virus, on the one hand, and those suffering from various discharges in Leviticus, on the other, carries with it a whole host of problems—biomedical, cultural, literary, and interpretive.¹⁵¹ We are saddled with a long history within Christianity of exaggerating the social effects of biblical law in Jesus’ day and of imagining social stigma when there was none.¹⁵² The message of Mark 5 is that God desires healing and wholeness for God’s people, pure and simple.

Likewise, those living with HIV and AIDS have no reason to draw a parallel between their situation and the ancient biblical condition of leprosy, or *tzara'at*. First, to make a comparison with HIV and AIDS is to import a whole host of inappropriate or mistaken assumptions into the conversation.¹⁵³ Secondly, *tzara'at* had to do with ritual and cultic exclusion from the Temple, an issue that it is far from clear would have been of great concern in distant Galilee, in the gospels, and certainly of no concern today. Moreover, to raise the issue, even if to do so in the context of encouraging people to embrace our sisters and brothers living with HIV and AIDS, is to imply an association between our sisters and brothers and the ancient stigma of leprosy—an association that is not warranted in the biomedical evidence, the symptoms, or the biblical scholarship. Hence, in trying to argue against that stigma, we introduce an association in people’s minds that is clearly not warranted. Peter said it well in Acts 10:28, “God has shown me that I should not call anyone profane or unclean.”

Appendix B

Gender Inequality and the Persistence of AIDS

Structural, that is legal, inequalities as well as those of custom and culture also raise risk and vulnerability. Since the 1980s, the largest rise in HIV and AIDS has occurred among women and adolescent girls. In contrast to the myth of “safety in marriage,” it has been said for many women around the world, the greatest risk for HIV infection is marital sex. Gender inequality, that is, a power differential between men and women, puts women at particular risk of HIV infection in some very specific ways.

- Sociocultural norms often restrict women’s access to information about sex and reproduction. Even when women, including married women, have access to information and condoms, women cannot negotiate their conditions of sex: “gender norms that prescribe unequal and more passive role for women in sexual decision making undermine women’s autonomy, expose them to sexual coercion, and prevent them from insisting on abstinence or condom use by their male partners.”¹⁵⁴ Paul Farmer notes “... risk of acquiring HIV does not depend on knowledge of how the virus is transmitted, but rather on the freedom to make decisions. Poverty is the great limiting factor of freedom indeed, gender inequality and poverty are far more important contributors to HIV risk than is ignorance of modes of transmission or ‘cultural beliefs’ about HIV.”¹⁵⁵

- In addition to being unable to demand condom use from her partner, wives in serodiscordant couples often have no access to a husband’s screening results and are unable to protect themselves from infection.

- In many low- and middle-income nations, women and girls are systematically restricted in access to general education, securing their continuing dependence upon men for their economic and general welfare, including access to health and medical resources. Employment external to the home may be culturally or legally proscribed.

- In some regions a prevailing myth is that sex with/rape of a virgin (young girl) will cure one with HIV and AIDS.

- Traditional cultural norms for males often expect and accept or condone early and multiple sexual involvement, multiple contemporaneous sexual partners, multiple marriages, extramarital sex, drug and alcohol use, and gender violence including wife beating. “Widespread violence against women not only represents a global human rights crisis but also contributes to women’s vulnerability to HIV.”¹⁵⁶ These male gender norms are not limited to low- and middle-income nations as the sex trade that arises around U.S. military bases in other nations gives evidence.

- In many nations, male dominance and the subordination of women is structural and codified in law.

- In some nations, neither budget nor policy, nor custom, allow for women’s full and free access to HIV preventive services.

- Rape of women remains a tool of warfare.

Appendix C Resources

Denominational Statements

Below is a listing of resources that state denominational resolutions and policies related to HIV and AIDS.

American Baptist Churches in the U.S.A. Resolution on the AIDS Crisis—<http://www.abc-usa.org/resources/resol/aids.pdf>.

Central Conference of American Rabbis Responsa on AIDS and HIV—<http://data.ccarnet.org/resp/tindex.html>.

Christian Church of Christ (Disciples of Christ) General Assembly Resolution Responding to the Pandemic of HIV and AIDS—<http://www.djan.net/resolutions/0127.pdf>.

Church of the Brethren Statement on AIDS—http://www.brethren.org/ac/ac_statements/87Aids.htm.

Episcopal Church Standing Committee on HIV and AIDS Report and General Convention Resolutions—<http://www.episcopalarchives.org/e-archives/bluebook/33.html>

Mennonite Central Committee—Generations at Risk: Join Hands, Stop AIDS, <http://mcc.org/aids/faq/>.

Presbyterian Church (U.S.A.) General Assembly Action on HIV and AIDS and related issues—listed with resources, <http://gamc.pcusa.org/ministries/aids-international/>; Presbyterian Social Policy Compilation, [http://index.pcusa.org/NXT/gateway.dll/socialpolicy/1?fn=default.htm\\$f=templates\\$vid=pcdocs:10.1048/Enu](http://index.pcusa.org/NXT/gateway.dll/socialpolicy/1?fn=default.htm$f=templates$vid=pcdocs:10.1048/Enu).

Roman Catholic Statements from the Vatican—http://www.vatican.va/roman_curia/secretariat_state/documents/rc_seg-st_doc_20010627_declaration-aids_en.html, from the U.S. Catholic Bishops—<http://www.usccb.org/sdwp/international/ctoresp.htm>.

Union of Reform Judaism Position Statement—<http://rac.org/advocacy/issues/issuehiv/>.

Unitarian Universalist Association Social Justice Statements on Health Issues including Opposing AIDS Discrimination, AIDS/HIV Crisis, and Global HIV and AIDS—<http://www.uua.org/actions/health/>.

United Church of Christ Social Policy Statements Related to HIV and AIDS—<http://www.ucc.org/hivaids/policy.htm>.

United Methodist Church Social Principles on HIV/AIDS—http://www.umc.org/site/c.lwL4KnN1LtH/b.1625675/k.901E/AIDS_Overview.htm.

The United Synagogue of Conservative Judaism Resolutions on HIV/AIDS—<http://www.uscj.org/HIVAIDS5338.html>.

Faith-Based Manuals and Curricula

Affirming Persons-Saving Lives: AIDS prevention curriculum published for adults, teenagers, and children, United Church Board for Homeland Ministries, United Church of Christ, <http://www.ucc.org/hivaids/ap.htm>.

AIDS and Your Religious Community: A Hands-on Guide for Local Programs. Blumenfeld, Warren and Scott Alexander. Unitarian Universalist Association (UUA) Bookstore, Boston, Mass.

Developing HIV/AIDS Policy Statements in Communities of Faith, The Children's AIDS Fund.

Also available are *HIV/AIDS in the Faith Community: Sample Policy Packet*, a packet of eight sample policies and *The Church's Response to the Challenge of HIV and AIDS: A Guideline for Education and Policy Development* to use as a resource for churches creating HIV and AIDS programs and policy. See <http://www.childrensaidsfund.org> and search by title.

Faith-Based HIV Prevention Interventions, A Technical Guide for Working with Communities of Faith, by Robin Orsborn. February 2003. http://www.mihivnews.com/pdf/files/faith-b_manual.pdf.

Faith Community Responses to HIV and AIDS, The Center for Development and Population Activities, Training Manual, June 2003. <http://www.cedpa.org/content/publication/detail/697>.

Healing Begins Here: A Pastor's Guidebook for HIV/AIDS Ministry Through the Church, HIV/AIDS Church Outreach Program and Ark of Refuge, California, 2004. <http://www.arkofrefuge.org/guidebook.html>.

HIV and AIDS: A Manual for Faith Communities, National Coalition of Pastors' Spouses (NCPS), 2005. <http://www.pastorspouses.com/home/>.

HIV and AIDS Prevention, Care and Support Across Faith-based Communities: An Annotated Bibliography of Resources (Africa), Family Health International, 2006.
<http://www.fhi.org/en/HIVAIDS/pub/guide/abofaithbased.htm>.

Many Threads, One Weave: An HIV and AIDS Training and Resource Manual for the Parish.
National Catholic AIDS Network, 1999, updated 2002.

What People of Faith Should Know About HIV. Channing Bette Company, Inc, 2002. <http://store.channing-bete.com>.

What Religious Leaders Can Do About HIV and AIDS: Action for Children and Young People, UNICEF and UNAIDS, 2003. (Available in English and French.) http://www.unicef.org/publications/index_19024.html.

For a complete listing of sexuality education curricula for faith communities, see
<http://www.religioustudies.org/curricula.html>.

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Colson, Charles W., and Anne Morse. "Beyond Condoms: To Alleviate AIDS, We Must Sharpen Our Moral Vision." *Christianity Today* 47, no. 6 (2003): 64–64.

Couture, Pamela D., and Bonnie J. Miller-McLemore. *Poverty, Suffering and HIV-AIDS: International Practical Theological Perspectives*. Cardiff: Cardiff Academic Press, 2003.

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Dube, Musa W. "Theological Challenges: Proclaiming the Fullness of Life in the HIV/AIDS & Global Economic Era." *International Review of Mission* 91, no. 363 (2002): 535–49.

Farley, Margaret A. "Partnership in Hope: Gender, Faith, and Responses to HIV/AIDS in Africa." *Journal of Feminist Studies in Religion* 20, no. 1 (2004): 133–48.

Haddad, Beverley. "Reflections on the Church and HIV/AIDS." *Theology Today* 62, no. 1 (2005): 29–37.

Kurian, Manoj. "The HIV and AIDS Pandemic: Changing Perceptions on Sexuality in Faith Communities." *Ecumenical Review* 56, no. 4 (2004): 432–36.

Mageto, Peter. "A Silent Church = Death: A Critical Look at the Church's Response to HIV/AIDS." *Currents in Theology and Mission* 32, no. 4 (2005): 291–98.

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Web Resources: Faith-Based Organizations Supporting HIV and AIDS Initiatives

- African Jesuit AIDS Network—<http://www.jesuitaids.net/>.
- Arab Religious Network Responding to AIDS—<http://www.harapas.org/ReligiousLeaders.asp>.
- The Balm in Gilead—<http://www.balmingilead.org/>.
- Caritas Internationalis—<http://www.caritas.org/>.
- Council of Religious AIDS Network—<http://www.aidsfaith.com/about.asp>.
- Christian Aid—<http://www.christian-aid.org.uk/hivaids/index.htm>.
- Christian AIDS Resource and Information Service—<http://www.cabsa.co.za>.
- Christian HIV and AIDS Alliance—<http://www.chaa.info/>.
- Disciples of Christ AIDS Ministry—<http://www.homeland.org/education/children/aids.shtml>.
- Ecumenical Advocacy Alliance—<http://www.e-alliance.ch/hivaids.jsp>.
- Jerusalem AIDS Project—<http://www.aidsnews.org.il/english.htm>.
- Jewish AIDS Network—<http://www.shalom6000.com/janc.htm>.
- LANET—Lutheran AIDS Network—<http://www.lutheranaids.net>.
- National Catholic AIDS Network (USA)—<http://www.ncan.org/>.
- National Episcopal AIDS Coalition (NEAC)—<http://www.NEAC.org>.
- National Native American AIDS Prevention Center (NNAAPC)—<http://www.nnaapc.org>.
- Religion & AIDS Resources from The Body—<http://www.thebody.com/religion.html>.
- Tearfund—<http://www.tearfund.org>.
- Siloam—<http://www.siloamwellness.org>.
- United Church of Christ—<http://www.ucc.org/hivaids/>.
- United Methodist Church—<http://gbgm-umc.org/health/aids>.
- Universal Fellowship of Metropolitan Community Churches (UFMCC)—<http://MCCchurch.org>.
- World Conference of Religions for Peace—<http://www.wcrp.org>.
- World Council of Churches—<http://www.wcc-coe.org/>.
- World Vision International—http://www.wvi.org/wvi/aids/global_aids.htm.
- World YWCA—<http://www.worldywca.info/>.

Web Links to Secular U.S. AIDS Organizations

- AIDS Action Council—<http://www.aidsaction.org>.
- AIDS Alliance for Children, Youth, and Families (APCCYF)—http://www.aids-alliance.org/aids_alliance/home.html.

AIDS Nutrition Services Alliance (ANSA)—<http://www.aidsnutrition.org>.
AIDS, Medicine & Miracles—<http://www.aidsmedicineandmiracles.org>.
American Foundation for AIDS Research (AmFAR)—<http://www.amfar.org>.
Broadway Cares/Equity Fights AIDS—<http://www.broadwaycares.org>.
The CARE Team Network—<http://www.careteam.org>.
Children Affected by AIDS Foundation (CCAF)—<http://www.caaf4kids.org>.
Children's AIDS Fund—<http://www.childrensaidsfund.org>.
Fundors Concerned About AIDS—<http://www.fcaids.org>.
HIVinsite—<http://hivinsite.ucsf.edu>.
Human Rights Campaign—<http://www.hrc.org>.
Kaiser Daily HIV/AIDS Report—http://www.kaisernetwork.org/Daily_reports/rep_hiv.cfm.
National AIDS Fund—<http://www.aidsfund.org>.
National Association of People with AIDS (NAPWA)—<http://www.napwa.org>.
National Gay and Lesbian Task Force (NGLTF)—<http://www.thetaskforcenglftf.org>.
National Minority AIDS Council (NMAC)—<http://www.nmac.org>.
Pediatric AIDS Foundation—<http://www.pedaids.org>.
Project Inform—<http://projinf.org>.
The NAMES Project—<http://www.aidsquilt.org>.

Web links to public health and scientific data

Center for AIDS Prevention Studies—<http://www.caps.ucsf.edu/>.
Center for Disease Control and Prevention (CDC) HIV and AIDS—<http://www.cdc.gov/hiv/dhap.htm>.
Children's AIDS Fund—<http://www.childrensaidsfund.org>.
Global AIDS Alliance—<http://www.globalaidsalliance.org/>.
Joint United Nations Programme on HIV and AIDS (UNAIDS)—<http://www.unaids.org/>.
USAID—http://www.usaid.gov/our_work/global_health/aids/.
The World Health Organization—<http://www.who.int/hiv/en>.

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- ³ *Minutes*, 1983, Part I, p. 816.
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- ⁸ *Minutes*, 2003, Part I, pp. 38, 592.
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- ¹⁸ See “Resources for your ministry” to support International AIDS Ministries at <http://www.pcusa.org/aids-international/resources.htm#packet>.
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Asia and India

- ²⁰ “UNAIDS: India” available at: <http://www.unaids.org/en/CountryResponses/Countries/india.asp>.
- ²¹ National AIDS Control Organization “Annual HIV Sentinel Surveillance Country Report” available at http://nacoonline.org/upload/NACO%20PDF/HIV%20Sentinel%20Surveillance%202006_India%20Country%20Report.pdf ; See also “India: HIV & AIDS Statistics” available at <http://www.avert.org/indiaaids.htm>. Further, the International HIV/AIDS Alliance explains, “An estimated 2.4 million people are living with HIV in India. Nationally around 0.3% of adults are infected but there is wide geographical variation, with two thirds of infections reported in six of the country’s twenty-nine states (Andhra Pradesh, Tamil Nadu, Maharashtra, Manipur, Nagaland and Karnataka). HIV prevalence is 4–5 times higher in these than in other Indian states.” See International HIV/AIDS Alliance available at <http://www.aidsalliance.org/linkingorganisationdetails.aspx?id=9>.
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- ²³ National AIDS Control Organisation, “Department of AIDS Control Ministry of Health and Family Welfare Government of India: Annual Report 2008-2009” (2009) available at http://nacoonline.org/upload/Publication/Annual_Report_NACO_2008-09.pdf. Recognizing the need for increased access to treatment and continued education, as of 2009 NACO had set up 646 clinics targeting the general population and 488 “high-risk” clinics focusing specifically on “Injecting Drug Users (52 sites), Female Sex Workers (137 sites), Men Having Sex with Men (40 sites), and STD Clinic Attendees (248 sites).
- ²⁴ Women and Risk of HIV and AIDS Infection, 2008, International Women’s Health Coalition. Fact Sheet.
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⁴⁰ *The Book of Confessions*, 10.3, lines 33–36, 39.

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⁴² *The Book of Confessions*, 10.4, lines 69–71.

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HIV/AIDS Today
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Stigma, Discrimination and Unjust Prejudice

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Study Questions for Discussion:

These questions are designed to be used with the resolution, *Becoming an HIV and AIDS Competent Church: Prophetic Witness and Compassionate Action*, adopted by the 2010 General Assembly. The background paper and appendices are formatted, slightly edited and given downloadable covers and text to enhance usefulness.

These questions are also coordinated with the DVD, *The Changing Face of HIV/AIDS*, produced by the Presbyterian AIDS Network (PAN), a network of the Presbyterian Health, Education and Welfare Association (PHEWA). This DVD can be accessed online at:

<http://gamc.pcusa.org/ministries/phewa/presbyterian-aids-network>

A copy of the DVD can be ordered, free of charge, from The Church Store, <http://store.pcusa.org> or call (800) 524-2612 PDS (Presbyterian Distribution Service) # 24-354-10-003

Study groups are encouraged to view the DVD either in its entirety first, or to view a section or two of it in connection with the four session study suggested below. The DVD comes in six segments with a summary of actions to take at the end, and cites this resolution at the beginning of each segment. Together with the extensive resource lists, these questions and the DVD are intended to serve as a study guide.

Overview of study: The study reviews both religious and medical progress in dealing with a still spreading, still devastating disease. To speak of spiritual progress is to claim God's grace in the on-going struggle to de-stigmatize those of us who suffer from HIV/AIDS. Morally, there is progress when risky behavior and vulnerability decrease and support for faithfulness and responsibility increase. Medical progress in diagnosis and pharmaceutical treatment are undeniable. Yet these advances underline the theological difference between healing and curing, and the practical distance between good care and prevention and the lack of public health capacity and will, both abroad and at home. A prophetic and compassionate Christian approach analyzes and names marginalizing social forces and sheer lack of power at work, along with other diseases of poverty. Hence the need for an HIV/AIDS Competent Church to minister and advocate with those affected for healing practices and large-scale strategies to curtail this epidemic. (Rationale and Introduction)

Four areas for discussion:

- A. Where is God and where is the Church?
 - B. The Challenges in the United States
 - C. The Challenges in other countries
 - D. Strategies and Responses: The recommendations for action
-
- A. Where is God and where is the Church? (Sections I and III)
 1. How is the response to HIV/AIDS similar to the response to any medical tragedy, and how has it been different? Do the cries of anguish and the questions, why me, and why us, not hold for all serious illness? What roles do guilt and blame play?
 2. What are the steps by which the study suggests that the impulse to judgment can be transformed by Jesus' own critique of the righteous? How are the prophetic and the compassionate elements of Christian response modeled in Jesus?
 3. What are the five elements of Jesus' "kingdom" or commonwealth of God ethic that are recommended for the church, as for us as imitators of Christ?
 4. How do you see the dynamics between purity and wholeness as they affect the nature of community? (Do you agree with the interpretation of the healing of leprosy and hemorrhage in Appendix A?)

5. Along with guidance about risk and vulnerability, what elements should parents and teachers emphasize to encourage strong and faithful relationships and responsible family life?

DVD Segment 1: Camp Heart to Heart in Mount Lebanon, KY: Which primary forms of spiritual and social support does this introductory section show? How important are places of refuge and sharing with peers?

DVD Segment 2: Hope Springs, Baltimore, MD: How holistic a picture is this, and how much a picture of “normal” church involvement? How is this (and the other examples) a picture of an “HIV/AIDS competent” program?

- B. The Challenges in the United States (Section II. A; all of Section IV but particularly B. 1. and Section V., “Underreported U.S. Populations”)
 1. Since the early 1980s, what shifts in HIV/AIDS prevalence have prompted some to think that the pandemic is over?
 2. What are the dynamics of stigma and literal marginalization that affect those suffering from or vulnerable to HIV/AIDS in the United States?
 3. How much are problems in the U.S. reflective of broader problems in public healthcare and economic inequality? Are these, in turn, shaped by “structural racism” and gender inequality?
 4. What roles do ignorance and denial about sexuality and homophobia play in obscuring the nature and spread of the disease in the U.S.?
 5. How would you address the very real demographic differences in infection rate identified in Section V without reinforcing the stigmas? Are any groups missing?
 6. Is it helpful to emphasize continuities between the U.S. and overseas?

DVD Segment 4: AIDS Interfaith Ministries of Kentucky. Which U.S. communities are addressed by this agency and its caring leadership? What public health issues are lifted up?

- C. The Challenges in Other Countries (Section II. B; all of Section IV but particularly subsections B. 2. and C; much of Section VI, “The Dynamics of Power and the Persistence of HIV and AIDS”)
 1. What strikes you from the brief overview of HIV/AIDS rates in the initial survey of continents (II.B)? What broad combinations of cultural and cross-cultural factors do you see?
 2. Are gender-related factors heightened generally in the developing world and, if so, how do they affect the witness, mission and example of the church? Group members may wish to lift up particular practices and church responses. Which of the practices (expanded upon in Appendix B) seems most urgently in need of change?
 3. In what ways do prostitution and sex trafficking differ and how much do they contribute to the spread of AIDS in the major afflicted areas?
 4. Section IV identifies “marginalizing social forces,” starting with poverty, and ends with a discussion of research, prevention, and pharmaceuticals. If HIV/AIDS is considered a “disease of poverty,” what does this say about funding and health delivery systems in the developing world?
 5. The addendum about Hepatitis B and C brings in two diseases that have some overlap or “co-infection” rate with HIV/AIDS in some countries. What are the pro’s and con’s of combining consideration of these diseases and HIV/AIDS?

6. Section VI looks at the dynamics of power in countries within a system of economic globalization that makes explicit and implicit demands on the public sector. In general, how do these big trends in trade, aid, city growth, and migration impacts on family structure influence personal and family responsibility? What are signs of hope in this picture?

DVD Segment 3: The Granny Connection. What does this segment suggest about responses to the family breakage in the U.S. and in Ghana? How do we identify with orphans and others overseas?

DVD Segment 5: The Women's Collective in Washington, DC. What does this segment suggest about the differences between the treatment of women with HIV/AIDS here and overseas? Or, does this segment suggest that parts of the U.S. are underdeveloped in certain ways?

D. Strategies and Responses: Recommendations

1. What are the chief areas in which a church can show HIV/AIDS "competence?" Which of these are most feasible for a congregation to develop?
2. Sex education and AIDS prevention, including condom use, are controversial in some areas overseas as well as at home. What are the key areas where Presbyterian witness and advocacy may be distinctive?
3. The DVD segments especially make addressing the humanity of "positive" individuals a matter of mutual blessing. How idealistic is this outside of structured programs and protected environments? What are other areas where the blessings of honesty and openness may carry over?
4. How much are we looking at a funding problem that requires serious commitment from governments and very wealthy foundations? How can the church best influence those bodies and the corporations that develop and hold vital patents?
5. How can the Presbyterian Church (U.S.A.) better reach those in the most vulnerable populations? While voluntary HIV/AIDS testing, for example, is vital and was affirmed by the General Assembly, what are its advantages and disadvantages for most Presbyterians?

DVD Segment 6 lifts up many of the steps necessary for an HIV/AIDS competent response. Which ones seem most feasible in your community? Would there be any opposition within or outside your congregation?

A Prayer for Inspiration:

"That We May Know God's Grandeur" by Rev. Chris Glaser

O holy One, too often
we resist your rule,
we pass by your glory,
we mistrust your grace.

We divide ourselves between
the privileged and the underprivileged,
the acceptable and the unacceptable,
us and them.

Too often:

Our religion,
intended to bond us to one another
as well as to you,
becomes another source of division.

Our diversity,
reflecting your many faces,
becomes a cause of concern
rather than gratitude.

Your creation,
revealing your grandeur,
we spoil and devour
rather than respect.

Free us from our closets!
Free us from our tombs!
Free us even from a heaven
that does not also embrace earth.

Give us, please,
the ecstasy you enjoy
by bringing us together
in friendship, in community, in prayer,
on earth as in eternity.

Give us, please,
the intimacy you inspire
through mutuality and consensus,
in relationships
political, sexual, spiritual.

Give us, please,
the compassion you manifest
in your exorbitant love
for creation and all creatures,
great and small.

Thank you for our opportunities
to make things right,
to make life good,
to be your presence in the world.

We pray this in your many names:
may it be so!

(This prayer reprinted from *Prayers for the New Social Awakening: Inspired by the New Social Creed*, edited by Christian Iosso and Elizabeth Hinson-Hasty, (Louisville, KY: Westminster John Knox, 2008).





The Advisory Committee on Social Witness Policy (ACSWP)
<http://gamc.pcusa.org/ministries/acswp>

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