

The Christian Response to HIV / AIDS

Paper presented by Sr. Dr. Miriam Duggan FMSA at the MSC Public Lecture held in UCC, Cork on 8 October 2009

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Much has been written and spoken about the HIV/AIDS Pandemic affecting the African Continent. I would like to share with you my own experience of dealing with this pandemic. My main focus is Africa and in particular Uganda where I worked for thirty years, and for the past eight in several other Southern African countries.

The first cases were diagnosed in 1982, that is 27 years ago and despite world wide efforts, relentless research, and the investment of millions of dollars, sadly we are still losing the battle.

Present Day statistics;

People Living with HIV (Globally) 33 Million

Sub Saharan Africa 19.8 million

Children under 15 years = 2,000,000, almost 90% in sub- Saharan Africa

New cases in 2007 = 3.2 million of which 45% were in the age group 15- 24.

Deaths from AIDS in 2007 estimated at 1.7 million to 2 million

In 1986 Uganda emerged from 17 yrs of conflict and wars, with great hopes of rebuilding a country once known as the Pearl of Africa, but now a shattered, impoverished country. Only to find that the country was immersed in the biggest world war ever, the tiny HIV virus versus Humankind. A virus, which had been quietly spreading, unnoticed – the silent epidemic.

AIDS has been called many things:

- The nastiest microbe ever to hit mankind.
- The worst plague ever.
- The infection that will not go away.

The first cases in Africa were diagnosed in Rakai, a border town between Uganda and Tanzania where young people were dying of a mysterious illness, which in the local area became known as the Tanzanian Bewitching disease, because the Ugandan troops had plundered villages along the Tanzanian border and it was now considered that the evil spirits were getting their revenge.

Later it was known as slim, as one of the early signs of the disease was weight loss. It was not until 1987 that the hospital where I worked in Kampala obtained the first piece of equipment to test for the infection, and already there was a 13% prevalence rate among pregnant mothers. Very rapidly the virus spread and within a few years Uganda had a prevalence rate of 28% among the adult population and Kampala became known as the AIDS capital of the world.

AIDS was different from many other diseases in that it was mainly young adults that were being affected, the labour force, the fathers and mothers and as such was having an impact on many aspects of life.

The HIV is deceptive in that there is a silent phase when people become infected but have no signs or symptoms and it may be 2 to 8 years later that the person begins to show symptoms and signs of AIDS.

The virus acts by attacking the immune systems of the body. It attacks the T4 helper cells, and with the bodies defence system broken down the person develops all sorts of other infections known as opportunistic infections.

In order to try and deal with the overcrowding at the hospital and having studied the pattern of the disease we decided to set up a mobile home based care programme for the following reasons:

- AIDS was a chronic illness, which at times needed admission for severe opportunistic infections.
- Very few wanted to be on
- Very few patients wanted to be on an AIDS ward or a ward where several people were dying.
- The healthy partner or relative was spending a lot of time travelling to the hospital and away from the home and the care of the children.

The question was how could we bring the services to the people.

Home Based

It was getting involved in the Home based care programme that the real impact of the HIV/AIDS pandemic hit home to me. The medical and nursing care were only a small part of the total care needed once AIDS entered the family, especially if it was the bread winner who first became ill, or worse still both parents. It is probably hard for us in the west to envisage the real poverty that occurs when there are no sick benefits, no unemployment money, and no social services. When one cannot work one quickly becomes very poor – no rent, no food, no fuel, no school fees, no medicine --- only misery and pain.

The Home Care programme quickly developed into a large operation caring for over three thousand patients and their families.

The care needed depends on the stage of the infection.

HIV + active but still fairly healthy - Testing, Counselling. Support Group.

Early stages of AIDS - Medical Care, ongoing counselling and support.
Income-generating projects to occupy and sustain

Advanced stages of AIDS - Intermittent Hospital admission or HBC.
Pastoral Care. Food and Financial support.

End stage of AIDS - Medical & nursing care, Pain relief, Pastoral Care.
Will making to protect those left behind, e.g. children
Support for family members, especially the children.

Death - Funeral.
- Bereavement Counselling
- Orphan care

Community Based Programmes.

Having started as a Hospital based programme it soon became aware that there was a great need to involve the community and several community-based programmes were started. Many local women volunteered to help and were given some basic training in how to care for sick Aids patients in the homes. They work with the Home Care

teams. These are the unsung heroes, thousands of them to day spread across several African countries doing hours of heroic voluntary work out of love and compassion. They not only care for the sick person, but also do household chores and care for the children if the mother is sick.

To address the poverty because of lack of income in the home, and to help people who were still mobile but unable to hold down a heavy job, small family income generating projects were set up. We opted for family projects for the following reasons:

- They were able to be operated from the home or nearby
- Other family members could help if the patient got sick.
- They were a work therapy, a reason for getting up.
- They left the person with some dignity that they were able to provide for the family.
- The person could work at a pace appropriate to their health.
- When the parents who were given the project died the relatives who took on the care of the children were able to continue the project to support the children.
- It is also cost effective for the donor rather than handouts.

The projects were simple:

Giving a sewing machine and some materials in order to get started.

Chicken projects, raising broilers, and sometimes pig rearing

Setting up a small stall in the market selling second-hand clothing, or vegetables.

People who were given projects came together once a month to share their success stories and to encourage one another.

These were also opportunities to give short seminars on trading, business management. Great enthusiasm was generated among those living with HIV/AIDS. They were happier and more content and as a result their health often improved. Small as they were they were all part of development as ordinary people learned new skills.

AIDS was challenging us Medics to have a very holistic approach to the care of the sick.

Many people are very poor, or who are unable to work, and needed food supplements. Without nutrition patients succumbed very quickly to infections I have gone into home after home where they did not know when they would get the next meal, but I have been challenged at the way very destitute people are willing to share the little they have.

With the advent of the Ante Retroviral Drugs food supplements are still needed, as the ARV's stimulate the appetite, and it is not possible to take the ARV's without food. A study done on behalf of CAFOD in several African countries on adherence to treatment reported the following; the importance of food security and nutrition is seen as crucial to adherence and particularly in the early stages of ART. The study showed the need to address both hunger and nutrition as an essential part of treatment. ART Medicines must be taken on a full stomach, and proper nutrition can help to lessen some of the side effects as well as strengthening the general resilience.

It must be remembered that ante retroviral drugs are not a cure. They act by suppressing the multiplication of the virus thus allowing the immune system to recover, and thus the health of the person.

These drugs have made a great difference to those who have been lucky enough to get them, but for millions that is not a reality.

One day I was in a busy AIDS clinic someone came from the ministry of health and asked if we would select 7 patients for treatment with anti-retroviral therapy. I looked around the 120 patients present and wondered who? The mother with the newborn baby, the father who was the breadwinner, the professional teacher, the skilled labourer .. the student.

Recent reports from UNAIDS, Geneva have said: "On the basis of data from 143 countries by the end of 2008 almost 3.5 million people in low income and middle income countries were being maintained on antiretroviral therapy – one million more than the previous year. Treatment coverage globally was estimated at 31%: the total estimate needed for therapy under current treatment recommendations is 9.7 million people. The numbers keep rising and with the current recession who will be treated? Now there is another dilemma. Most patients in Africa are on the generic drugs, which are cheaper, some are now becoming resistant and they need to go on second line drugs, but these are not available in generic form".

Once patients start on drugs they need to continue for life. As a result of ARV's death rates are beginning to fall. Different combinations and dosage regimes are recommended in different countries. The most commonly used in Africa are AZT or TENOFOVIR as a nucleoside analogue

The big question is: Can the supply be maintained as numbers continue to increase and as aid budgets are being cut.

Within this pandemic of AIDS there is a great challenge for pastoral care, and it is not only the care of the dying but it begins when one knows that they are HIV positive.

During the visits to the homes the team of carers always gave time for a prayer, a word of scripture with respect for each one's faith. It was a case of bringing God into the situation.

Being involved with the pastoral care of HIV/AIDS patients has shown me that when faced with a disease for which there is no cure, somehow the shams and false hoods

of life quickly disappear and the true person emerges, a person one can become very close to.

Stigma

A lot has been said about stigma and discrimination, laws have been passed, declarations signed, but that does not change judgemental attitudes and fear which I consider are the two main reasons for stigmatisation. The best way to break down stigma is to lead by example, to be prepared to visit those who are ill, to shake hands, to enjoy a cup of tea with them, to sit on the bedside, to be friends. Your skin is a perfect barrier against the virus.(Story about chief).

Care of orphans: This is one of the major challenges. It is estimated that there are 15,000,000 orphans as a result of AIDS. 11,600,000 are in sub-Saharan Africa.

Several good initiatives have been started to address the problem. Some of the important points I have learned through been involved in a variety of initiatives:

- That we must provide care for the children orphaned, otherwise they end up in the streets and you have a bigger problem.
- That orphan care is best monitored from a community based project. – The people know who is the true orphan in need is.
- That the orphan child should as far as possible be kept within the extended family, clan or tribe. That children of the same family stay together.
- That the orphan child has great psychological needs not just material needs. (Story of Clare) Counselling for the children at all ages is essential; otherwise we will end up with many disturbed children and adults.

I offer the following model as one that worked best in a poor community in Kamwokya where resources were limited.

The orphans were divided into four main groups.

Group 1. Orphans who lost both parents, had no relatives, and were often the children of migrant workers. For this group households were set up within the community, and a housemother was selected to care for six – seven orphan children. She was given an allowance to care for the children and school fees and clothing was provided. A man in the community was appointed as a father figure.

Group 2. Where there was a Grandmother or Aunt who could come and take care of the children but who had no source of income. Material needs and school fees were provided.

Group 3. Where a relative could take in an orphan child or children and provide shelter and food, but could not afford school fees. With this group school fees were provided.

Group 4. Where people within the community adopted an orphan child and provided all the needs of the child

All the orphans were monitored by a social worker, who not only checked on the homes but also on the schools they were attending.

While we often consider the needs of the orphan child, the child in a home where parents are living with AIDS often has great needs before they become orphans. Frequently they become the carers, caring for their sick parents, not understanding what is happening, and been punished when they arrive late to school or have no time to do their homework.

A lot of sensitising of teachers needed to happen so that they looked out for the troubled child or teenager.

Money is needed to help with the orphan programmes but we should not underestimate the wonderful compassionate generosity of so many of the local people who share from the little they have.

In the early days of the pandemic 25% - 30% of children born of mothers who were HIV positive were born with the virus in their blood, all had the antibody in their blood. To day this has been reduced to 5% with the introduction of the drug Nephramine during labour and after delivery.

Sadly this drug is not available in many parts of Africa, due to lack of infra structure, lack of knowledge, and the availability of the drug. Yet the cost is very little compared to the cost of caring for a child with AIDS, not to mention the suffering involved.

The child with AIDS needs special care and attention, and often their one longing is to attend school with other children.

Prevention

In the early days of the disease many people were infected through receiving contaminated blood or blood products. Now all blood before transfusion has to be double checked as well as a detailed questionnaire filled out. People involved in risk behaviour within the last three months are not accepted as blood donors in order to eliminate the window period.

Having worked as a doctor and caring for hundreds of patients, often present at the bedside of young people facing death and their dreams shattered, it brought home to me that this was a preventable disease, and more needed to be done. Awareness talks were been given but the numbers continued to rise.

In 1991 prior to the African Aids Conference held in Senegal, about 50 people from different Christian denominations, representative of several African countries met and for four days discussed how best to prevent the spread of HIV and we came up with the following Statement of Belief

Statement of Belief

We believe that individuals and whole communities have the inherent capacity to change attitudes and behaviours. The power to fulfil this capacity is often denied or is not exercised.

This power must now be recognised, called forth and supported from both within and without. This will enable people to initiate and sustain behaviours

that promote a healthy state of mind, body, spirit and environment. A critical component in this process is a supportive response to those living with HIV in the community.

We recognise that behaviour change at individual and community level in the present HIV pandemic is a complex and on-going process. It is inextricably linked to such basic human values as care, love, faith, family and friendship, respect for people and cultures, solidarity and support.

The present pandemic affects everyone. Our experience as affected and infected individuals proves that behaviour change is possible. We believe that behaviour change is the most essential strategy in overcoming the HIV pandemic.

If we look at the Statement there are some key words:

- People have the inherent Capacity to change attitudes and behaviours.
- This needs to be called forth.
- We believe the Behaviour Change is the most essential strategy in overcoming the HIV/AIDS pandemic. We needed to look deeper and to address the behaviours and attitudes that were fuelling the spread of the disease.

At the 7th International Conference on AIDS, June 1991, in Florence, Italy, President Museveni of Uganda said:

“Sex is not a simple manifestation of a biological drive, it is socially dictated.....I have been stressing a return to our time-tested cultural practices which emphasize fidelity and condemnation of premarital or extramarital sex. I believe that the best response to the threat posed by AIDS...is to re-affirm publicly and forthrightly the reverence, respect and responsibility that every person owes to his neighbour. Young people must be taught the virtues of abstinence, self-control and postponement of pleasure and sometimes sacrifice. I feel condoms have a role to play as a means of contraception especially in couples that are HIV positive, but condoms cannot be the main means of stemming the tide of AIDS”

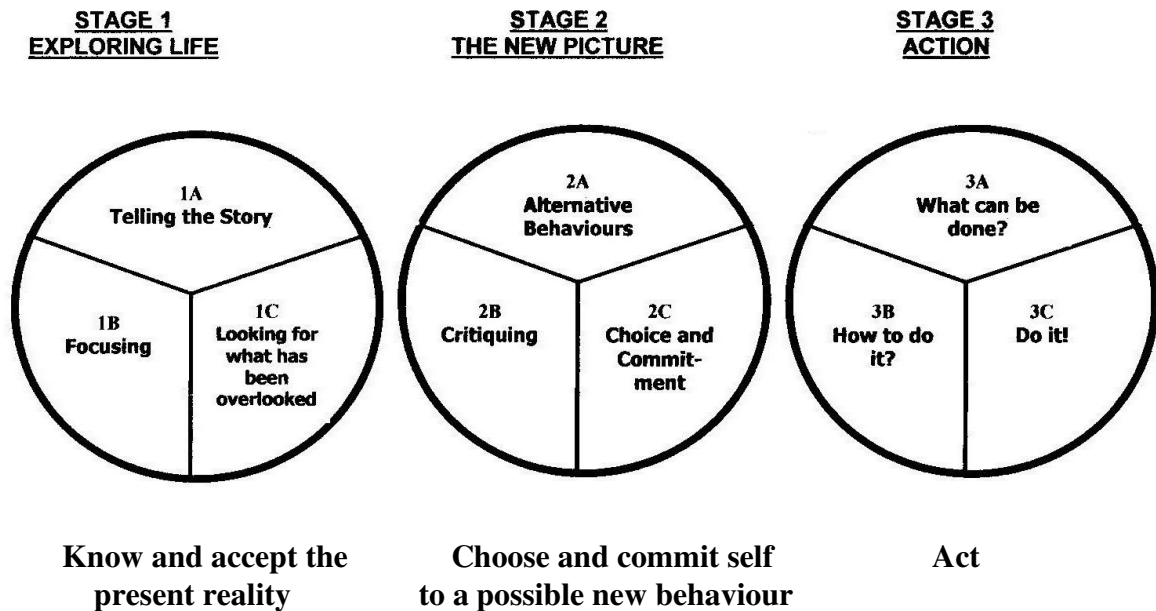
The Uganda Aids Commission was established involving State, Church and NGO's working in the field. The No 1. Policy for prevention was to address the behaviours, the attitudes, and the cultures that were spreading the disease. Uganda opted for ABSTINENCE AND FIDELITY, AND ALLOWED A QUIET PROMOTION OF THE Condom. This was later to become known as the “ABC” approach. In the Church programme the “c” for condom was replaced with “c” for character formation, and later community involvement.

Sr. Kay Lawlor MMM put together a process for Behaviour Change, known as Education for Life. What was needed was a process to help people to look at where they were putting their lives at risk, and help to make the change required. Awareness programmes were only the first step. People needed to look at the root causes why AIDS was spreading and to address them.

AIDS has been presented as a medical problem and treated as such. The fact is that it is mainly a behavioural problem and therefore it is the underlying behaviours that need to be addressed:

- The free sex society, the promiscuity and unfaithfulness.
- The Drug addiction.
- The alcohol addiction
- Sex abuse
- The attitudes towards women
- The poverty that promotes the fertile soil
- The social injustices

THE BEHAVIOUR CHANGE PROCESS



Behaviour Change is a complex process that can be broken down into three major stages.

1. Know and accept the present reality (Behaviour)
2. Choose and commit self to a possible new behaviour.
3. Act.

The Basic Belief is:

- I need to change
- I have the capacity to change
- I can call on the Spiritual power to help me change.

The diagram above shows the three stages.

Stage 1. Questions are asked around the present reality, whereas in stage 2 questions look at alternatives.

The Methodology Used.

Full participation by the whole group as the answers come from the group.

Workshops are usually carried out with groups of 40-50 people over a three to five day period.

Questions are given for discussion in small groups, with answers presented in the larger group and further discussion.

Other questions are answered through role-play and critique.

Input is given of the ways of transmission, on Global and local statistics of the prevalence of HIV and AIDS.

Values are discussed and identified

Scientific information is given around the condom and its effectiveness. Failure rates are discussed, and how condoms do not address the addictive behaviours. The difference between risk reduction (safer sex) and risk avoidance is debated, the lack of evidence that more condoms means less AIDS, the advantage of abstinence and faithfulness, and the importance of avoiding drugs. Participants are encouraged to make informed responsible life-giving choices.

There is also a spiritual component to the programme with respect to each participant's faith.e.g Scripture is used to affirm, or to challenge. There are times for personal reflection and for prayer. Facilitators prepare short skits to illustrate different values. There is a time of forgiveness, reconciliation in order to heal the past, and prayer to the spirit to live the new. " God's Spirit is not one of timidity, but of power, and love and self control" Maybe it is that gift of self-control that is so much needed.

Through this process people have been helped to:

- Discover what needs to change in their lives?
- Take the necessary steps to bring about change.
- To make responsible choices, and not to be pushed along by negative peer pressure.
- To know that there is a Spiritual power that can help them sustain a good behaviour or to change.
- To know that they can be a witness for change and save lives.

I have seen thousands of young people make commitments to abstain from sex until marriage, and many people re-commit themselves to be faithful in marriage, and people taking steps to break with alcohol and drug addictions.

I am convinced that if we are to stop the further spread of AIDS we need to urgently address the behaviours and attitudes that are spreading the disease. I am not saying it is easy, it takes a lot of working at, but it is far harder to watch people getting infected and dying.

3rd level students are trained to facilitate these programmes.

We often hear that women are disadvantaged and that poverty drives them into risk behaviour and of the need to empower them with alternative sources of income, all of

which I agree, but more importantly we need to work with the men to change their attitudes and behaviours.

When working with young women in prostitution, which was mainly for survival, it was important to offer an alternative source of income, and this meant getting them into training or setting up income-generating projects.

While poverty can drive women into prostitution a study done in six African countries showed that the richest people in Africa have higher HIV prevalence rates than the poorest, disputing commonly held beliefs that AIDS is a disease driven by poverty. Rich men can afford to buy sex, and they have more partners, and travel more.

Trafficking of Human persons.

Trafficking of people mainly women and children ranks among the three most profitable criminal activities in the world together with illegal drugs and the trafficking of arms, The UN estimates that between 2-3 million are trafficked across borders mainly from poorer countries to rich countries. Scores of young women are lured daily by false promises into what become a hellish journey of sexual slavery and violence.

If women are more vulnerable to the infection of HIV because of political, social and cultural inequality, those most at risk are surely those who are trafficked, coerced, forced or tricked into commercial sex. Sex trafficking is almost an inevitable death sentence for the victim for several reasons:

- First because they are virtually enslaved, and have no ability to insist on any protection.
- Secondly they are forced to endure intercourse with multiple concurrent sexual partners.
- Thirdly violence is common in commercial sex and particularly prevalent when women and children are forcibly subjected to sex against their wills. Injuries and abrasions sustained during sexual contact heighten physical vulnerability to HIV transmission.
- Young girl's physically immature bodies are highly vulnerable to injuries which significantly heighten their risk of infection.

Jay Silverman in the Harvard School of public Health (2007) issue states that those "We in Public Health have too often turned a blind eye to sex trafficking and those most vulnerable to its consequences, very young girls, and as the study reveals they may well be a key piece in the global HIV/AIDS puzzle.

Dr Chris Beyer of John Hopkins has linked the phenomenon of sex trafficking to the spread and mutation of the AIDS virus and stated that new strains are posing resistance to treatment. What we are seeing is that the trafficked part of the sex industry is aiding the global dispersion of the HIV sub-types.

This trafficking of people is our modern day slavery and we cannot close our eyes to it. To combat this awareness programmes are needed in poorer countries, and legislation against it in richer countries. Sweden has almost stamped out the trade by making it a crime to pay for sex.

As I learned on my recent trip to Africa when I was doing awareness programmes in several countries orphans are very vulnerable.

We need to find ways to protect the orphan child.

The attitudes of the employers who promote social injustices need change e.g. the workers in the mines who are required to be far away from their wives and families, and can only return home once a year. Brothels are provided to keep the men happy while they are away from home.

To prevent the further spread of HIV Uganda opted for Behaviour Change and to address the root causes for the spread of the disease, and are getting results. Church and State worked together.

Prevalence rates antenatal clinics.

1987	1991	1997	2000	2005	2007
24%	30%	15%	7%	6%	6.2%

National Prevalence Rate fell from 26% in 1991 to 6% in 2006

Prevalence Rate Age group. 15 – 19years = 2.1% and 19- 25 years = 5.4%

Dr. Daniel Low-Beer (Health and Population Unit, Cambridge University) has this to say:

“ The clearest example of decline in HIV prevalence and changes in sexual behaviour comes from Uganda. The prominence of Africa’s success has led to discussion of whether there are lessons to learn for other countries and to whether Uganda provides a basis for wider International HIV prevention. Other countries in east and southern Africa that have committed greater resources and have implemented many elements of global policy, condom provision, treatment of STI’S media programmes, testing and counselling have seen HIV prevalence increase through the 1990s. Many of these countries have made progress in important areas, e.g. South Africa has the highest rate of condom use and Botswana is advanced in terms of treatment, but they have not seen the same decline in HIV infection that is seen in Uganda,

If risk avoidance did not occur, HIV did not decline, even with greater resources, condom use, counselling, education and treatment.

“20 years into the pandemic there is no evidence that more condoms lead to less AIDS,” stated Dr. Edward C.Green of Harvard’s Centre for Population and Development Studies. Citing data on condom availability in many African countries, Green went on to say that “we are not seeing what we expected: that is that higher levels of availability result in lower HIV prevalence.”

Quoting Dr Green “Many of us in the public health communities didn’t believe that abstinence or delay, and faithfulness were realistic goals. It now seems we were wrong. Billions of dollars and the lives of countless men and women and children will be wasted if ideology trumps proven health policy. Let anyone think that such an emphasis on abstinence is the result of conservative religious leaders who place their ideologies above science. Green noted “I’m a flaming liberal; don’t go to church, never voted for a republican in my life. His appreciation for the effectiveness of promoting abstinence comes from witnessing its results. Had South Africa implemented Uganda’s emphasis on self-control, one scientist noted, 3.2 million lives

could have been saved. The effectiveness of the Ugandan approach has led scientist to consider it a social vaccine against HIV.

This is the same Dr Green who came out in the defence of Pope Benedict some months ago when the Pope made the comment that condoms were not the answer to AIDS in Africa, and which caused a media storm.

Dr Norman Hearst of the University of California in San Francisco supported this analysis that more condoms did not mean less AIDS with statistics from Kenya, Botswana, and other countries, which show an increasingly alarming pattern of increased condom sale correlation with rising HIV prevalence. In the presence of an epidemic, unless a person changes his or her risk behaviours it may be only a matter of time before he or she is infected. For this reason Dr Norman Hearst said that he feared that we are raising a generation of young people that believe that the condom will prevent HIV. When people are not taught the difference and are left thinking that risk reduction equals protection, they are more open to take risks that they cannot afford.

Another reason why condoms have failed to stop AIDS is that when a person is infected with other STD's they are up to five times as likely to get HIV if exposed. This is why one researcher remarked that "safe sex" has not been safe in the UK and in Africa it has been positively dangerous.

The condom debate continues and many times the Catholic Church is condemned for its stance in promoting sex within marriage, and is against the use of condoms. In recent years scientific research is more and more showing that condoms are not the answer.

The churches stance comes from a profound analysis of the need to integrate sexuality in an exclusive and permanent relationship open to life in the context of marriage. The wisdom of this view is become clearer especially in the light of the spread of HIV/AIDS.

Critics may belittle the Pope or the Church but as the saying goes "All truth passes through three stages. First it is ridiculed. Second it is violently opposed. Third, it is accepted as being self-evident.

A study commissioned by UNAIDS concluded "Prevention campaigns relying primarily on the use of condoms have not been responsible for turning around any generalized epidemic"

Partner reduction

According to Green and Ruark every African country where HIV infections have declined has seen a decrease in the proportion of men and women reporting more than one partner in a year and a decline in premarital sex among young people.

Vaccine

Several promising, large scale trials trying to prevent the spread of HIV have produced sobering results as researchers discussed at the 15th Conference on Retroviruses. The largest trial known as STEP by Merck & Co was stopped last

autumn because more people in the vaccine group got infected with HIV than in the placebo group. The STEP trial marks the third human vaccine trial that has failed. In recent days there is talk about a break through by combining two vaccines ... time will tell.

But maybe on reflection there is a vaccine, but one that is not very popular – a return to the creator’s law of no sex outside of marriage and faithfulness within marriage.

Microbicides; These are gels and creams to be applied vaginally or anally to prevent transmission of the human immunodeficiency virus. In a trial in South Africa involving 6,202 women, half which were given Carraguard, a tasteless odourless gel, and half got placebos. All got counselling on how to prevent HIV and for good measure all were given condoms. After three years 134 women had become infected as against 151 on the placebo group.

Two other microbicides to finish testing have in fact made women more likely to become infected. A spermicide called nonoxynol-9 and a product called ushercell.

Male circumcision is the latest effort to prevent the transmission of HIV. There are claims that it reduces the risk of infection by 60%

Youth Alive.

After carrying out Behaviour change programmes for some months we found that young people were coming back asking for more help. They needed further support to stand against the negative peer pressure. Thus Youth Alive was born.

Youth Alive clubs were established as positive peer support groups and as a way to provide ongoing character formation. Based on Christian faith and values, they elcome youth of all denominations and beliefs.

The vision of Youth Alive is to see people make informed and responsible choices in order to fulfil their dreams and ambitions and through its different programmes to create an AIDS free generation.

Objectives of Youth Alive.

- To educate youth regarding HIV/AIDS.
- To help them grow in awareness of correct spiritual, moral and cultural values.
- To encourage and assist youth to develop their talents and avoid idleness.
- To address poverty.
- To develop a healthy state of mind, body, spirit and environment.

Activities.

- Education for life Workshops
- Adventure unlimited
- Ongoing formation workshops, character building, talent formation
- Involvement in rallies, Musical festivals, sports, music, drama.

This programme has now spread into 21 African countries and hopefully good results will follow. This coming December in Nairobi young people from all these countries are participating in a conference entitled “**AIDS prevention, our responsibility.**”

From the UNAIDS Global Report 2004.

“Young people between the ages of 15 years – 24 years are the most threatened, globally accounting for half of all new cases of HIV/AIDS, and the greatest hope of turning the tide against AIDS. The future of the pandemic will be shaped by their actions.

Experience proves this. The few countries that have successfully decreased national HIV prevalence rates have achieved these gains mostly by encouraging safer behavioural choices among young people, placing youth at the centre of the response.

There is no age restriction for leadership. Young people are assets not liabilities. Their voice needs to be heard, and their talents cultivated so that they can be instruments for change.

The Global Fund has provided ARV treatment to 30% of people who need it. If we continue to add millions of new cases each year where is the money for the ARV's going to come from? What about the accumulative numbers .. 2.9 million new cases last year? Prevention is essential and urgent.

The battle can be won if we dare to address the root causes, namely the attitudes and the behaviours, the poverty, and the social injustices and to be guided by the scientific evidence of what works rather than driven by a lucrative industry. It would seem there is a great resistance to do exactly that.

Daniel Wilson, a World Bank Scientist told the International AIDS Conference in 2007 “The major lessons for generalised epidemics is that we have to reduce multiple concurrent partners, Intergenerational sex, sexual coercion, and the cultures of Alcohol and drugs abuse. We need fundamental community change and safer sexual environment”.

In conclusion;

At a Symposium held in Uganda in Dec 2006, involving many researchers, 20 years of efforts at prevention were reviewed. The conclusion was – growing evidence suggests that having multiple sex partners especially concurrent is the major driver of the generalised epidemic in Africa. When behaviours improve when men and women practice mutual fidelity national prevalence rates tend to fall.

Abstinence works and should be promoted. It works best as part of a broader character formation effort.

Research also showed that condom promotion had the potential for behavioural disinhibition, or acquiring a false sense of security that led to more risk behaviour. We need to treat AIDS as a behavioural issue that calls for behavioural solutions. Primary Behavioural change deals with the problem itself getting at what is needed for primary prevention, while the medical model deals with symptoms.

We have been speaking mainly about Africa. What about Ireland. Do we have HIV infections? In 2008, 405 new cases of HIV were reported, 28 cases of AIDS, and 3 deaths. This brings the total number people living with HIV to 5,243 . These numbers may be small but they are increasing each year.

What are we doing to stop the spread.? Is our focus on behaviour or a piece of latex rubber?

Maybe historians will look back at this moment in salvation history when God drew close to his people looking for a response: A response, which is twofold:

A gospel response – a reaching out in love, in care and sharing.

A call to change and return to God's ways. A call to conversion.

END

**The lecture was organised by the MSC Mission Support Centre, Western Road, Cork
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