
Essay 3

**Behavior change and the role of the Church:
towards reducing and eliminating risk**

Peter Okaalet

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Behavior change and the role of the Church: towards reducing and eliminating risk

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1. No magic bullet

The HIV epidemic has challenged our faith in medical science (which often seems to have a cure or a vaccine for everything), and also in some of those traditional moralities and ways of life that – in all parts of the world – have been relied on to keep communities and their members safe from harm. For HIV prevention, neither medicine nor tradition can offer a ‘magic bullet’. None of the new prevention methods currently being tested is likely to be a hundred per cent effective, and all will need to be used in combination with existing approaches if they are to reduce the global burden of HIV and AIDS.

Interventions that support HIV prevention include behavior change programmes, HIV testing, condoms, male circumcision, treatment of other sexually transmitted infections, and the few female-initiated HIV prevention methods that are currently available. And yet despite all the energy that has gone into the promotion and implementation of these, the number of new cases of HIV continues to rise. Before we come to reflect on the role of the Church in this dilemma, it is important to consider why this is.

2. Drivers of the epidemic

In this paper, I want to look at three sets of factors that may be said to 'drive' the HIV epidemic. These may be grouped under the headings of *biological* drivers, *behavioral* drivers and *cultural* drivers. (Those important drivers that make women particularly vulnerable are addressed below.)

'Biological drivers' are factors that increase the risk that a given act or episode may lead to HIV transmission. These include the presence of other sexually transmitted infection, pregnancy or an immature or injured genital tract. HIV is more easily sexually transmitted at some stages in the infection's progress: for example, during the months immediately following the acquisition of the virus, when the viral load is high. It seems that some viral sub-types are more readily transmitted. Without appropriate medication, HIV can be transmitted from the mother to her child during pregnancy and delivery. And malnutrition makes individuals more susceptible to infection.

'Behavioral drivers' are connected with individual risky behavior. People put themselves at risk of infection if they have unprotected sex or multiple sexual partners. Intergenerational sex carries a high risk of transmission, as does early marriage or early sexual debut (or first sexual experience), and also 'sex in exchange for money'. Alcohol abuse can lead to risky sex or drug taking; so can injecting drug use. Situations of violence against women or children can be thought of as carrying a high risk of HIV transmission.

By 'cultural drivers' I am seeking to identify practices that are so much taken for granted in particular groups or communities that they come to seem like an immutable part of a cultural identity. In my own African context, cultural drivers that place people at particular risk of HIV transmission include wife inheritance, inter-generational sex, cleansing ceremonies and female genital mutilation (FGM). Dry sex and other risky practices lead to increase in the likelihood of transmission of HIV. A particularly explosive set of factors can be present in areas where polygamy is common.

These lists of drivers are not exhaustive. The point of the exercise is rather to point out that our individual efforts to contain the epidemic are always conducted in a context which is either *hostile* or *welcoming* towards HIV transmission, and that these hostile or welcoming factors (which may vary from context to context) need to be part of any effective approach to HIV prevention.

3. Women and girls

In some severely affected regions, says ex-UN special envoy Stephen Lewis, the HIV epidemic has caused ‘carnage among women and girls’.¹ It is now generally accepted that the capacity of a culture or community to resist HIV transmission is associated with the position within it of its female members.

Worldwide, about 46 per cent of HIV positive individuals are women. In Africa, HIV prevalence among women is around sixty per cent and, among men, about forty per cent. In addition, women do most of the work of caring for people living with HIV or dying from AIDS; further, they have responsibility for keeping families together, or caring for their own or other people’s orphaned children when parents die.

In spite of this, they have more limited access to information than men; the ‘ABC’ prevention model is no real help to them in avoiding contracting HIV; violence against women seems to be increasing; and there is evidence from all parts of the world that HIV positive women are more heavily stigmatized than men. While public policy often has men in mind as its default target, the sentinel surveys, on which national and international data are based, are carried out at antenatal clinics, and therefore tell us only about women.

And yet women and girls – who are uniquely vulnerable to HIV, both biologically and culturally – may nevertheless find it impossible, in a

¹ Stephen Lewis, press interview following a visit to Southern Africa, March 2006
<http://www.un.org/apps/news/story.asp?NewsID=17847&Cr=hiv&Cr1=aids>

particular context, to protect themselves. With all the billions of dollars that have been spent on the development of treatments and vaccines, it is outrageous that there is still no cheap, effective, easy-to-use prevention option available to women.

There are many cultural factors that make women particularly vulnerable. Women are under huge pressure to keep their marriages together at all costs. Men are free (and often expected) to have sexual relationships outside marriage, but women may not. Many perceive sexually transmitted infections as women's diseases. And, in many cultures, women face taboos on talking about sex and on using the kind of language that is impossible to avoid in talking about HIV prevention.

Women and girls may be *uniquely* vulnerable, but they are not *unavoidably* vulnerable. In 2005, at the 14th ICASA meeting in Abuja, Nigeria, Dr Joy Ezeilo spoke of the possibilities for legislative intervention to support female-initiated prevention options, namely:

- address poverty: it fuels AIDS, and vice-versa
- promote legislation that covers 'behavior'
- make sure that VCT programmes are linked to the availability of antiretroviral treatments (ART)
- governments should follow the 'three stage processes' with respect to the making of laws:
 - Stage 1: formulation and promulgation;
 - Stage 2: implementation;
 - Stage 3: evaluation.²

4. Understanding the Church

So where does this leave the Church? Indeed what may we say 'drives' the Church, in this era of HIV? And how do those drivers (or modifiers) of 'church' behaviour and culture also end up driving or modifying the

² Dr. Joy Ezeilo, Plenary Presentation, "HIV/AIDS, Gender and Human Rights: How Far is Africa" (14th ICASA meeting, Abuja, Nigeria, December 2005)

behaviour of individuals? Let me outline some general principles that I hope we can agree on.

First, the Church exists to honor God. It is not an HIV project, nor is it there to honor a set of donors.

Second, the wish to bring care and prevention into the context of the Church's relation with its Maker should not be seen as a dualistic approach, or one that involves a split between sacred and secular.

Third, the Church does have a role in shaping the attitudes and behaviour of its members, both by its example, and by promoting understanding of context and values.

Fourth, faith has huge significance, not just in Africa but elsewhere too. This makes it a powerful source of support for those affected by the need for change, and a powerhouse in generating prayer and messages of hope.

So what is the Church?

In Africa, where I come from, the Christian church is growing steadily, and developing an independent African identity. Moreover, we now have on the continent a group of churches that fall under the umbrella of 'African Independent (or Instituted) Churches', indicating that they are not affiliated to the so-called 'mainstream' group of churches that brought Christianity to sub-Saharan Africa. We need to take these into account, too, as we seek to define and reach out to the 'Church' in Africa.

We think of the church in a variety of ways, or through a range of different 'lenses'. We may think of it sacramentally, as 'the Body of Christ' (1 Cor.12: 27). Or maybe for us it is the congregation to which we belong. Or perhaps we think of it as an administrative, co-ordinating body that 'leads' the faithful or adjudicates on matters of faith. We may encounter it as a Christian community-based organization, a development service or an NGO supported by a Christian church or group of churches. But whichever of these institutional 'models' we have in mind when

we talk about 'church', they all have one characteristic: they are there to stay. NGOs pack up their work after programmes finish; churches will never leave the community.

The Church, by virtue of its longstanding, multifaceted presence, has a great potential for supporting people in responding to issues that are of critical (maybe life and death) importance to them. Churches shape people's attitudes and they provide services. They have the capacity to influence the powerful. They bring people together in prayer. They engage in ministries that are often prophetic. Because they are always there, they are able to walk with people on their life's journey: a journey that cannot be hurried; one in which there is, for everything, a season. Above all, the Church is committed to its people; not just some people, but all people, regularly leaving the ninety-nine behind to go and search for the one lost sheep. (John 10:1-18)

5. The role of the Church in reducing risk

So what, specifically, can the Church contribute to the process of HIV prevention?

It can sensitize people to the existence of HIV and the risks it presents, and it can share with them its educational messages. Most important, it can give to people that most empowering of gifts, namely accurate, scientific, correct information. It can do this through pulpit ministries and preaching, through music, dance and drama, and through songs and testimonies. It can encourage people to talk openly about sex, without which effective HIV education is impossible. It can use the Bible study materials that are currently available. It can and must involve people who are themselves living with or affected by HIV or AIDS. It can make it clear that saying 'no' to AIDS is a lifelong commitment. 'HIV prevention is for life' it must say.

Further, Christian churches (like other religions) are value-based institutions. HIV prevention is not just a matter of finding the appropriate technical interventions: it is to do with the values people

hold, and the effectiveness with which these are handed on to young people. Celibacy and abstinence outside marriage and mutual faithfulness in marriage are the most reliable forms of HIV prevention; they are also part of church teaching. It is because we believe that every human being is made in the image of God that we seek to eliminate stigma and discrimination and to include people living with HIV and AIDS (PLWHA) at leadership level.

It is because we believe that sex is part of God's plan for human beings that we want to be able to talk openly in our churches, and for sex and sexuality not to be shrouded in embarrassed and guilty silence. It is because we believe in the basic dignity of every man and woman that we seek the elimination of ignorance, illiteracy and poverty. Thus, like Job, we start with *information*, and we move towards *understanding, inspiration, illumination, and wisdom*. (Job 28:28)

6. What is an 'AIDS-competent Church'?

With all this in mind, we should now be in a position to consider the question: what, then, is an 'AIDS-competent Church'?

An AIDS-competent Church is first and foremost one that turns its back on denial and acknowledges the reality and enormity of the problem of AIDS. It is a Church that knows its own strengths and weaknesses, and uses its strengths as a starting point for a scaled up response. It is a Church that recognizes vulnerability and risk and works to reduce them. It is a learning Church that listens and shares; a Church that has zero tolerance for stigma and discrimination; a Church in whose ministry people living with HIV or AIDS are playing a central part. It is a Church that is living out its full potential, both as an organization and as a congregation.

We are returning, therefore, to the image of the Church as the Body of Christ responding to HIV and AIDS. We must become listening churches with *large ears* – quick to hear the challenges of the people; compassionate churches with *warm hearts*; churches with *quick feet*

that respond rapidly to need; and touching churches with *anointed hands*. In the Body of Christ, churches will have *loud voices*, raised on behalf of the marginalized. They will be research-oriented: churches with *sharp minds*, seeking for truth, asking relevant questions, and seeking relevant answers.

For that reason, we use the word 'CRITICAL' as an acronym for the kind of holistic approach that must characterize an AIDS-competent church in any particular context. In Africa, which is my home, a 'critical' approach brings together the following:

- **Community** – how it influences our society;
- **Religion** – how it imbues our actions;
- **Involvement** – what it means for us;
- **Technical capacity** – what it means in a global health crisis;
- **Infrastructure** – what challenges us in rural and urban Africa and elsewhere;
- **Capital** – why it is more than money;
- **Access** – how globalization can pull Africa forward;
- **Leadership** – what is necessary for success at all levels: local, national, regional and international.

7. The need for and role of HIV and AIDS curricula in theological education

The Church has continued to offer the much needed mitigation. At a meeting in Kampala, Uganda in April 1994, church leaders from across Africa developed biblical principles and guidelines to help the Church take action to meet the challenges presented by the HIV and AIDS pandemic. Whereas their perspective of HIV and AIDS may have changed since then, the principles they proposed seem to endure. In the *Kampala Declaration*, the church leaders affirmed:

The Church is [God's] instrument to proclaim and promote life. [...] We believe that God has called us at this unique moment in history to be instruments of His hope and eternal life. His life and hope may yet be seen even when sickness consumes our bodies and a virus saps the strength of those we love.

We plead for God's people to:

- engage in dialogue at all social and structural levels;
- wrestle with the issues, so that we might understand and apply principles of truth in a way that will bring about appropriate change [which] must include some traditional cultural practices as well as some modern trends that affect the family.

We are watchmen standing in the gap and stewards of the hope of God offered in Christ. The pain and alienation of AIDS compel us to show and offer the fullness and wholeness that is found in Him alone. In this, our time of weakness, may the rule of Christ's love bring healing to the nations.³

One of the recommendations coming out of the all Africa church leaders' consultation on AIDS⁴ organized by WCC in 2001 was that participants needed to develop HIV and AIDS curricula for Christian theological institutions. Theological and Bible colleges in Africa, after all, are the breeding grounds for pastors and clergy. MAP International, the organization that I work with, for example responded to that cry by developing *Choosing Hope: Eight HIV and AIDS Curriculum Modules*, targeting theological and Bible schools in Africa.

Choosing Hope: Eight HIV and AIDS Curriculum Modules

1. Understanding hope through knowing facts about HIV and AIDS
2. Discovering hope in the HIV epidemic through our Biblical foundation
3. Spreading hope through mobilising the church to HIV and AIDS ministries

³ *AIDS in Africa: The Church's Opportunity* (Nairobi: MAP International, 1996).

⁴ World Council of Churches, *The Ecumenical Response to HIV/AIDS in Africa: Plan of Action*, Geneva WCC 2001

4. Developing hope through changing feelings and attitudes about HIV and AIDS
5. Sharing hope through pastoral care to families and communities affected by HIV and AIDS
6. Offering hope through HIV and AIDS pastoral counselling
7. Giving hope to parents and youth for AIDS-free living
8. Ministering hope through home-based care to people with AIDS.

*MAP International*⁵

It is important for users of these modules, and ultimately for the recipients of these teachings, to interpret and fit these teachings into their own cultural, organizational, economic and educational context, under the authority of Scripture.

Over the years, other organizations and institutions – including the World Council of Churches (WCC), the Ecumenical HIV and AIDS Initiative in Africa (EHAIA) and the University of KwaZulu Natal (UKZN) – have developed further materials for use in theological institutions and Bible colleges.

Equipping would-be clergy and pastors in theological institutions with HIV and AIDS knowledge and skills, prior to their posting and eventual work in their respective congregations and communities, is mandatory. This, I believe, will go a long way in shaping effective responses to the pandemic at grassroots level – and possible change of behavior – for the good of all.

8. Individual factors

In this last section, I want to say a word about individual, personal responses to the challenge of HIV prevention. We need help; we need

⁵ *Choosing Hope: Eight HIV and AIDS Curriculum Modules* (Nairobi: MAP International, 2003).

companions on the journey; we need our families and faith communities; but at the end of the day, with God's help, we must each of us take responsibility for ourselves.

Dr Creflo Dollar has proposed that we see our own behaviour in the context of eight factors that determine our individual behaviour and destiny.⁶ They are:

- the *words* we listen to or read: whether it's media, books or the Bible;
- our *attitudes* and whether they are conformed to the mind of Christ (Phil.2:5-11);
- our *emotions* and the extent to which they are influenced by external or internal factors;
- the way we make *decisions*: whether they are motivated by spur-of-the-moment impulses or long-term goals and values;
- our *actions* and whether these promote or reduce the risk of contracting or transmitting HIV;
- our *habits*: the company we keep, and what needs to change;
- our *character*, including an assessment of who we are, or what others say about us;
- our final *destination*: the goal towards which our life's journey is taking us.

But this struggle is valueless without the One who is the Founder and Head of the Church. 'Without me,' said Jesus, 'you can do nothing.' (John 15:5) Jesus had no servants, yet they called Him Master. He had no degree, yet they called Him Teacher. He had no medicine, yet they called Him Healer. He had no army, yet kings feared Him. He won no military battles, yet He conquered the world. He committed no crime, yet they crucified Him. He was buried in a tomb, yet He lives today...

⁶ Dr. Creflo Dollar, *Interview*, CBN, January 2008

So – finally - we should never forget that it is in families and communities and human relationships, not in the solitude of one's own heart, that the task of HIV prevention is lost or won. As the UNGASS Commitment of 2001 put it:

'AIDS is not over...until it is over for everyone...!'