ELCA Strategy on HIV and AIDS[1]

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[1] This strategy will be implemented consistent with actions of the 2009 ELCA Churchwide Assembly related to the Lutheran Malaria Initiative and a social statement on human sexuality.

Introduction

From the time when the syndrome we now call Human Immunodeficiency Virus (HIV) was identified just over a quarter century ago, the global community has moved through various stages of awareness and response to the unfolding Acquired Immunodeficiency Syndrome (AIDS) crisis. AIDS was initially deemed a death sentence. It is now understood to be both preventable and a serious but largely manageable chronic illness.

Tremendous advances have been made medically and socially over the past 25 years in the response to AIDS. However, serious challenges remain in the effort to prevent its further spread and ensure that all in need of life-saving treatment receive it. AIDS has become the most devastating health pandemic in world history. Currently in the United States, more than 1.2 million people are estimated to be living with HIV or AIDS.[2] Globally more than two million people, most of whom reside in sub-Saharan Africa, die each year despite the advent of life-saving treatment. According to the United Nations' latest AIDS report, "in high-prevalence settings, HIV deepens household poverty, slows economic growth, and undermines vital sectors on which economic development depends. In rural areas with high HIV prevalence, the pandemic degrades agricultural sectors and exacerbates food insecurity." [3] In January 2000 the United Nations Security Council held a meeting on AIDS, the first time that the Council has discussed a health issue as a threat to international peace and security.

A Picture in Time: The HIV and AIDS Crisis and the Role of the Church

The AIDS Pandemic in the World

Globally, the AIDS pandemic is a human crisis of unprecedented scope. As stated by the United Nations Development Programme (UNDP), HIV has caused the "single greatest reversal in human development" in modern times.[4] Each day, more than 6,800 people became HIV-positive and more than 5,700 people die from AIDS.[5] In countries hardest hit by HIV, life expectancy has declined by 20 years, poverty has deepened, and economic growth has been reversed.[6]

Consider the following statistics:

- 33.2 million people are living with HIV and AIDS worldwide.
- 2.1 million people died from AIDS in 2007. 72 percent of these AIDS-related deaths occurred in sub-Saharan Africa, where AIDS is the leading cause of death.
- 2.7 million people became HIV-positive in 2007.
- 12 million children under the age of 18 in sub-Saharan Africa have lost one or both parents to AIDS.[7]

In response to an increasingly destabilizing AIDS pandemic throughout the world, the international community pledged its resources and action through a number of commitments early in the 21st century. In 2000, the 189 member states of the United Nations signed the Millennium Declaration, which led to the development of the Millennium Development Goals[8] (MDGs), eight time-bound targets focused on critical areas of human development, including HIV and AIDS, with the overarching goal of reducing by half the number of people living on less than a dollar a day by 2015. The HIV-specific goal, MDG 6, seeks to halt and reverse the spread of AIDS by 2015.

The critical relationship between progress in addressing HIV and success in reducing poverty is increasingly documented and proven. The most effective progress in addressing HIV and AIDS is achieved when progress in all areas of development—including primary education, gender empowerment, and agriculture development—is achieved, and development is aided when progress is made in halting the spread of HIV and AIDS.[9]

In 2001, the 189 member states of the United Nations agreed to the Declaration of Commitment at the United Nations General Assembly session on HIV and AIDS. The Declaration described AIDS as one of the greatest development crises in human history and set time-bound targets, including the goal of universal access[10] to prevention, treatment, and care by 2010, in order to ensure real progress toward ending the HIV pandemic. In 2006, at the five-year implementation review, UN member states reaffirmed their commitment to the Declaration of Commitment and the goal of universal access.[11]

These international commitments to action have resulted in unprecedented multilateral and bilateral actions taken by governments, in partnership with the private sector, civil society, and the faith community, to combat HIV and AIDS. In early 2008, 147 United Nations member states reported their progress on indicators related to the Declaration of Commitment with more detail and reported success than ever before. A six-fold increase for HIV programs in low-to-middle income countries from 2001 to 2007 has resulted in fewer AIDS deaths and fewer new individuals diagnosed with HIV in some countries.[12] The

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[2] "The HIV and AIDS Epidemic in the United States," Kaiser Family Foundation, (*www.kff.org/hivaids/upload/3029-08.pdf*).

[3] "2008 Report on the Global AIDS Epidemic," Joint United Nations Programme on HIV/AIDS (UNAIDS), 2008, p. 14 (*www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp*).

[4] "Human Development Report 2005," United Nations Development Programme, p. 3 (*http://hdr.undp.org/en/reports/global/hdr2005/*).

[5] "AIDS epidemic update: December 2007," Joint United Nations Programme on HIV/AIDS (UNAIDS), 2007, p. 4 (*www.unaids.org/en/KnowledgeCentre/HIVData/EpiUpdate/EpiUpdArchive/2007/default.asp*).

[6] "2008 Report on the Global AIDS Epidemic," op. cit., Chapter 1, p. 13.

[7] "2008 Report on the Global AIDS Epidemic," op.cit., Executive Summary, p. 20.

[8] "What are the Millennium Development Goals (MDGs)?" (*www.elca.org/Our-Faith-In-Action/Justice/Advocacy/Congregational-Resources/ONE-Campaign/Millenium-Development-Goals.aspx*).

[9] "2008 Report on the Global AIDS Epidemic," op.cit., Executive Summary, pp. 22–23.

[10] For more information on the concept of Universal Access, see "Background Paper on The Concept of Universal Access," by Dr Michel Thieren, WHO, Geneva, October 2005, accessed via *www.who.int/hiv/topics/universalaccess/en/index.html.*

[11] "2008 Report on the Global AIDS Epidemic," op.cit., p. 13.

[12] Ibid., Executive Summary, pp. 3–5.

annual number of AIDS deaths has declined over the past two years—from 2.2 million in 2005 to two million in 2007—thanks in large part to the advent of life-saving medicine, even in the most resource-poor settings. And, the global HIV prevalence—the percentage of individuals diagnosed with HIV—has stabilized, thanks to a number of factors including radical changes in sexual behavior in some of the hardest hit countries such as Rwanda, Kenya, and Uganda.[13]

The two primary mechanisms that have facilitated tremendous progress in the response to AIDS globally include the U.S. government's bilateral President's Emergency Plan for AIDS Relief (PEPFAR) and the United Nation's multilateral Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund).

PEPFAR was proposed by then-President George W. Bush in 2003 as a five-year, $15 billion commitment to respond to HIV and AIDS in the most heavily affected countries. From 2003–2008 PEPFAR saved more than 2.1 million lives, provided care for more than 10.1 million people living with or affected by HIV and AIDS, including 4 million orphans and vulnerable children, and provided counseling and testing for more than 57 million. The U.S. Congress and President Bush reauthorized PEPFAR in 2008, establishing a funding level of more than triple the original commitment, $48 billion over the next five years. This spectacular level of commitment, if fully funded through the annual appropriations process, is expected to help provide life-saving treatment for nearly four million people with AIDS, prevent 12 million new people from becoming HIV-positive, and provide care for 12 million people, including five million orphans by 2013.

The Global Fund to Fight AIDS, Tuberculosis (TB), and Malaria was established in 2001 by then United Nations Secretary General Kofi Annan. The concept of the Global Fund emerged in response to the growing devastation that AIDS, TB, and malaria were having on those most in need throughout the world. The Fund is designed to distribute multilateral donor money where it is needed most and can be utilized most effectively through country-driven decision making processes. As of 2008, the Global Fund allocated $11.3 billion in 136 countries.

According to global health experts, however, despite the tremendous progress made in the response to AIDS, the future of the pandemic remains uncertain. Advances in HIV prevention, treatment, and care services are mixed and uneven globally, and often are hampered by lack of political will and resources.[14]

The Joint United Nations Programme on HIV/AIDS (UNAIDS) describes two broad patterns in the global AIDS pandemic: "generalized epidemics sustained in the general populations of many sub-Saharan African countries, especially in the southern part of the continent; and epidemics in the rest of the world that are primarily concentrated among populations most at risk, such as men who have sex with men, injecting drug users, sex workers, and their sexual partners."[15]

[13] Ibid., p.15.
[14] Ibid., Executive Summary, p. 23.
[15] Ibid., p. 10.

Sub-Saharan Africa—in particular southern Africa—continues to be at the epicenter of the pandemic.[16] AIDS continues to be the single largest cause of mortality in sub-Saharan Africa. Out of every four AIDS deaths last year, three occurred in Africa. Two-thirds of all adults living with HIV and nearly 90 percent of children living with HIV reside in the region. Six out of every ten adults living with HIV in sub-Saharan Africa are women—two to three times the proportion in other regions. Nearly 12 million children in the region under 18 have been orphaned by AIDS.[17]

Especially in Africa, but also in other regions, there is a link between HIV and AIDS and poverty. Many of those living with HIV and AIDS reside in very poor communities, often in rural areas, which lack access to adequate nutrition, education, and health care. Those in resource-poor settings who have attained access to life-saving anti-retroviral drugs[18] (ARVs) require adequate nutrition to ensure the full efficacy of the medication. Without strong health-care systems, HIV-related incidence of death is intensified by other preventable and treatable "diseases of poverty," including the most severely opportunistic infections[19] of malaria and tuberculosis.

As is the case in Africa, Eastern Europe, South Asia, and Southeast Asia have experienced declines in new infections, while the number of individuals who have become HIV-positive has increased in East Asia and Oceania. In other parts of the world, the number of individuals who became HIV-positive was estimated in 2007 to have remained stable.[20]

However, regional or continental aggregates can mask country or sub-regional trends. For example, in Asia, Cambodia, and Thailand, HIV prevalences have declined, while those of Indonesia and Viet Nam have increased in recent years. Within sub-Saharan Africa, HIV prevalence varies from less than two percent in the Sahel to above fifteen percent in most of southern Africa.

The complexity of the global AIDS pandemic is increased exponentially by the complexity of cultural, economic, religious,

[16] In epidemiology, an epidemic is a disease that appears as new cases in a given human population (e.g., everyone in a given geographic area; a university, or similar population unit; or everyone of a certain age or sex, such as the children or women of a region) during a given period, at a rate that greatly exceeds what is "expected" based on recent experience. Defining an epidemic is subjective, depending in part on what is "expected." An epidemic may be restricted to one locale (an outbreak), more general (an epidemic) or global (a pandemic). Common diseases that occur at a constant but relatively high rate in the population are said to be "endemic." Widely-known examples of epidemics include the plague of medieval Europe known as the Black Death, the Influenza Pandemic of 1918–1919, and the current HIV epidemic which is increasingly described as pandemic. UN AIDS Terminology Guide (*http://data.unaids.org/pub/Manual/2008/20080226_unaids_terminology_guide_en.pdf*).
[17] "2008 Report on the Global AIDS Epidemic," op.cit. p. 13.
[18] Medications for the treatment of infection by retrovirsues, primarily HIV.
[19] People with advanced HIV infection are vulnerable to other infections and malignancies that are called 'opportunistic infections' because they take advantage of the opportunity offered by a weakened immune system. (*www.avert.org/aidscare.htm*).
[20] "2008 Report on the Global AIDS Epidemic," op.cit., Chapter 2.

political, and social factors that vary from area to area. A strategy to engage in HIV and AIDS response globally will need to be cognizant of and responsive to these complex realities.

The role of gender inequality in the spread of HIV cannot be overstated. The face of global AIDS is becoming younger, poorer, and more female, reflecting changing social, cultural, and economic factors that put women and girls directly at risk.[21] Violence against women is a significant human rights violation and public health problem in every country in the world, with abused women facing a higher risk of contracting HIV. Partnership with men in halting gender-based violence and rape is key to reducing the spread of HIV. Widely accept-ed concepts of masculinity such as bravery, independence, and sexual activity can result in men's inability to see themselves as caring, non-violent, and responsible partners.[22]

The link between conflict and the spread of HIV and AIDS is well established. Patterns of global conflict have changed, particularly in Africa. Conflicts now often are civil wars that last longer and put civilians at greater risk. The collapse of security in conflict leads to conditions that contribute to the spread of HIV and AIDS, including economic insecurity, displacement, and gender-based violence. Women and children are at special risk when they are forced to flee their homes.[23] Displacement leads to economic insecurity and increases instances where women must rely on transactional sex for their survival. War tactics that put women at risk have risen in recent years, including abduction, systematic rape, torture, and mutilation. In addition, military and militia populations tend to have greater instances of sexually transmitted diseases, including HIV, which can spark an epidemic.[24]

The AIDS Epidemic in the United States

Since HIV and AIDS were first recognized in the United States in 1981,[25] AIDS has claimed more than 550,000 lives. While ARVs allow many individuals carrying HIV to live healthy, productive lives, serious challenges remain in addressing the AIDS crisis in the United States. The number of individuals newly diagnosed with HIV annually—56,300—has remained constant since the late 1990s.[26]

As a result, the total number of individuals living with HIV and AIDS continues to increase; currently, about 1.2 million people are living with HIV or AIDS in the U.S.[27] It is estimated that nearly one-quarter of those living with HIV or AIDS are not aware of their status, putting themselves and others at greater risk.[28]

When first recognized in the early 1980s, HIV and AIDS most heavily affected gay men[29] and was deemed a "gay men's disease." However, this epidemic now affects individuals of every age, race, gender, sexual orientation, and geographic region of the United States. But its burden has not been borne equally. The ever-increasing number of individuals living with HIV has been concentrated among African Americans, Latinos, men who have sex with men, and other key populations. Men who have sex with men accounted for 53 percent of new individuals diagnosed with HIV in 2006,[30] while African Americans and Latinos accounted for 63 percent of those newly diagnosed with HIV in 2006. According to the Centers for Disease Control and Prevention, "the rate of new HIV infections among Hispanics in 2006 was three times the rate among whites (29.3 versus 11.5 per 100,000)."[31]

Latinos represented 15.3 percent of the population in the U.S. and its territories, but constituted 22 percent of the HIV and AIDS cases diagnosed in 2006.[32]

The African American community has startlingly high levels of individuals living with HIV. In 2006, 45 percent of individuals newly diagnosed with HIV were from the African American community, even though this community represents only 12 percent of the population.[33] The rate of individuals newly diagnosed with HIV among African Americans was seven times higher than that of white Americans (83.7 versus 11.5 individuals newly diagnosed with HIV per 100,000).[34] Black women comprise 66 percent of new AIDS cases among women and Black teens ages 13–19 accounted for 69 percent of AIDS cases among teens.[35]

The epidemic in the African American community in the United States closely resembles the generalized epidemic in sub-Saharan Africa. Generalized epidemics occur when "adult HIV prevalence exceeds one percent and when one or more

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[21] Examples include child marriage, trafficking and sexual exploitation, gender-based violence, female genital mutilation, transactional sex, intergenerational sex, widow inheritance, lack of property rights, polygamy and sexual violence as a tactic of war.

[22] "The State of World Population 2005," United Nations Population Fund, p. 58.

[23] An estimated 80 percent of the world's 35 million refugees and internally displaced persons are women and children.

[24] Data from Rwanda and Democratic Republic of Congo (DRC) have shown that both during and after conflict, the spread of HIV increases. In Rwanda an estimated 500,000 women were raped during the genocide and 67 percent infected with HIV, and in the DRC prevalence went from 5 to 20 percent in five years . "The State of World Population 2005," op.cit. pp. 6–67 (*www.unfpa.org/swp/ 2005/english/ ch1/index.htm*).

[25] "Basic Information," Centers for Disease Control and Prevention, (*www.cdc.gov/hiv/topics/basic/index.htm*).

[26] "Estimates of New HIV Infections in the United States," Centers for Disease Control and Prevention (*www.cdc.gov/hiv/topics/surveillance/ resources/factsheets/incidence.htm*).

[27] "The HIV and AIDS Epidemic in the United States," op. cit.

[28] "Basic Information," op. cit.

[29] "Current Trends Update on Acquired Immune Deficiency Syndrome (AIDS)–United States, Morbidity and Mortality Weekly Report," Centers for Disease Control and Prevention, September 24, 1982 (*www.cdc.gov/mmwr/preview/mmwrhtml/00001163.htm*).

[30] "Estimates of New HIV Infections in the United States," op.cit.

[31] Ibid.

[32] "The Crisis of HIV/AIDS Among Latinos/Hispanics in United States, Puerto Rico and U.S. Virgin Islands," Latino Commission on AIDS, p. 1 (*http://latinoaids.org/mediaadvisory/AIDSreport07.30.08.pdf*).

[33] "Estimates of New HIV Infections in the United States," op. cit.

[34] Ibid.

[35] "Black Americans and HIV/AIDS," Kaiser Family Foundation (*www.kff.org/hivaids/upload/6089_05.pdf*)

populations have HIV infection levels of five percent or greater. Generalized epidemics are typified by substantial heterosexual transmission and significant numbers of HIV-infected children."[36] Overall, HIV prevalence for African Americans is greater than two percent.[37] Furthermore, the Black AIDS Institute highlights several areas that are of predominantly African American population where the percentage of the population living with HIV or AIDS is at or above five percent. They note that "in Washington, D.C., where more than 80 percent of HIV cases are among Blacks, estimated HIV prevalence in the city is five percent—a rate that approaches the levels of infection documented in Uganda (5.4 percent)."[38] In that city, "heterosexual contact is now the leading transmission mode for new HIV diagnoses."[39] In another example, "in Detroit, reported HIV prevalence is five percent or greater in nine ZIP codes."[40] In fact, the total "number of Black Americans living with HIV is greater than the HIV population of seven of the 15 PEPFAR focus countries."[41]

Several other populations also have been disproportionately affected by this epidemic. Certain rural areas and populations, in particular rural areas in the South and rural African Americans, have been particularly affected. In 2006, 67 percent of all AIDS cases were reported in the South,[42] while African Americans represent about 50 percent of all rural AIDS cases.[43] Rural areas have lagged behind urban areas in "HIV prevention and intervention programs"[44] as a result of geographic isolation and the stigmatization of HIV and higher-risk groups.[45]

The proportion of individuals living with HIV or AIDS among the incarcerated population is much higher than the proportion among the general population. The Centers for Disease Control and Prevention reports that "in each year from 1999 to 2006, the prevalence of confirmed AIDS among the prison population was between 2.7 and 4.8 times higher than in the general U.S. population."[46] In addition, overrepresen-tation of people from communities of color among the incarcerated, in particular from the African American community,[47] is an important factor in the disproportionate number of individuals living with HIV or AIDS in those communities.[48]

A connection exists between poverty and HIV. Women in economically vulnerable situations are more likely to engage in higher risk sexual behaviors to feed themselves and their loved ones, which increases their risk of contracting HIV.[49] A link has been found between homelessness and higher risk sexual behavior. The National AIDS Housing Coalition reports that "the conditions of homelessness and extreme poverty—the inability to maintain intimate relationships, pressures of daily survival needs, and substance use as a response to stress and/or mental health problems—leave homeless and unstably housed persons extremely vulnerable to HIV infection."[50] Persons who are homeless or unstably housed have "rates of HIV infection…three to sixteen times higher…[than] similar persons who are stably housed."[51]

Poverty also hinders the ability of individuals living with HIV to flourish. Many individuals living with HIV are unable to work and earn an income—one study found that up to 45 percent of individuals living with HIV are unemployed.[52] Several studies have found that "access to and utilization of health care services are not equal among all HIV-infected individuals. In particular . . .racial/ ethnic minorities, substance users, the unstably housed, and the mentally ill have poor access to and utilization of health care services."[53] In fact, in 2005 it was estimated that the "death rate among homeless HIV-positive persons is five times the rate of death among housed persons with HIV/AIDS."[54]

The federal government, churches, non-profit agencies, and other members of civil society have responded to the domestic aspect of this crisis. The largest funder of this response has been the federal government. Between 2001 and 2006, the U.S. government spent $74 billion on HIV and AIDS treatment and care in the U.S. and more than $15 billion on research to develop new methods of prevention and treatment.[55]

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[36] "Left Behind! Black America: A Neglected Priority in the Global AIDS Epidemic," p. 25 (*www.blackaids.org/image_uploads/article_575/08_left_behind.pdf*).
[37] Ibid.
[38] Ibid., p. 23.
[39] Ibid., p. 26.
[40] Ibid., p. 23.
[41] Ibid., p. 21.
[42] "Cases of HIV Infection and AIDS in Urban and Rural Areas of the United States," 2006 (*www.cdc.gov/hiv/topics/surveillance/resources/reports/2008supp_vol13no2/commentary.htm*).
[43] "Reported AIDS Cases among Adults and Adolescents by Race/Ethnicity and Population of Area of Residence 2006—50 States and DC" (*www.cdc.gov/hiv/topics/surveillance/resources/slides/urban-nonurban/slides/urban-nonurban7.pdf*).
[44] "What are rural HIV prevention needs?" (*www.caps.ucsf.edu/pubs/FS/revrural.php*).
[45] Ibid.
[46] "HIV Testing Implementation Guidance for Correctional Settings," January 2009 (*www.cdc.gov/hiv/topics/testing/resources/guidelines/correctional-settings/index.htm*).
[47] 35.4 percent of inmates in the custody of State or Federal prisons or in local jails were black. Ibid., p. 7.
[48] "Social context, sexual networks, and racial disparities in rates of sexually transmitted infections," AA Adimora, VJ Schoenbach. *The Journal of Infectious Diseases*. Vol 191 (2005):S115–22 (*www.ncbi.nlm.nih.gov/pubmed/15627221*).
[49] "The Hardness of Risk: Poverty, Women and New Targets for HIV/AIDS Prevention," R Rosenberg, R Malow. *Psychology and AIDS*. Vol. 34 (2006):3–12 (*www.apa.org/pi/aids/psych_aids_exchange_spring_06.pdf*).
[50] "HIV/AIDS Housing Breaking the Link Between Homelessness and HIV," The National AIDS Housing Coalition (*www.nationalaidshousing.org/PDF/breakinglink.pdf*).
[51] Ibid.
[52] "Predictors of Employment of Men With HIV/AIDS: A Longitudinal Study," Judith Rabkin, Martin McElhiney, Stephen J. Ferrando, Wilfred Van Gorp, Shu Hsing Lin. *Psychosomatic Medicine* Vol 66 (2004):72-78 (*www.psychosomaticmedicine.org/cgi/content/abstract/66/1/72*).
[53] **"**Utilization of Health Care Services in Hard-to-Reach Marginalized HIV-Infected Individuals," Chinazo O. Cunningham, Nancy L. Sohler, Mitchell D. Wong, Michael Relf, William E. Cunningham, Mari-Lynn Drainoni, Judith Bradford, Moses B. Pounds, Howard D. Cabral. *AIDS Patient Care and STDs*. Vol. 21:3 (2007):177–186 (*www.liebertonline.com/doi/abs/10.1089/apc.2006.103*).
[54] The E-Newsletter of the National AIDS Housing Coalition, Winter, 2005 (*www.nationalaidshousing.org/winter2005newsletter.htm*).
[55] "Continuing the Fight Against HIV/AIDS in America," White House Fact Sheet 2006 (*www.america.gov/st/washfile-english/2006/February/20060202122158cmretrop0.7736933.html*).

However, even in the midst of this funding, only 45 percent of the approximately 1.2 million people living with HIV or AIDS in the United States receive care for their disease.[56] Hence, additional funds are required so that all individuals have access to adequate, life-saving care.

Inadequate funds, however, are only a part of the problem. About half of these individuals not receiving care do not know they are HIV-positive. Many individuals living with HIV or AIDS or at higher risk of becoming HIV-positive avoid testing due to fear of rejection, stigma, or death. To improve upon this situation and to reduce the spread of HIV, non-stigmatizing education about this disease and effective prevention efforts must be developed and put to use. In particular, in the African American and Latino communities, all levels of government, churches, and all segments of civil society must support actions that address both individual behavior and the structural factors that leave individuals in these populations more vulnerable to HIV. These issues are expanded upon in the sections below.

Role of the Church Globally in the Response to HIV and AIDS

Over the past 25 years the faith community's response to HIV and AIDS has been marked by both failure and success, and important lessons have been learned that can and should shape this church's future response.

During the early stages of the pandemic many churches and people of faith, both in the U.S. and around the world, responded to the AIDS crisis with denial and inaction, often based on simplistic judgments. For too long the church contributed—whether passively or actively—to the spread of HIV and the discrimination of those living with HIV. AIDS was viewed as a disease of "others" who were afflicted because of their "sinful" sexual activity. A medical diagnosis was compounded by a "moral diagnosis" that intensified stigma and discrimination against those affected by and living with HIV.

In some instances, churches around the world failed to act or contributed to the stigmatization of people living with HIV and AIDS. However, at other times over the past quarter century, they also have responded faithfully in the midst of the AIDS crisis. Through renewed engagement with the vulnerable and excluded and ever-deepening biblical and theological reflection, the church globally has learned to recognize the face of Christ in the "other." This recognition eclipses fear-filled or facile judgments and has allowed churches to understand and proclaim more clearly the Good News of God's love for all. It also has allowed churches to recognize and affirm the dignity, gifts, and capacities of people living with and affected by HIV and AIDS.

Today, throughout the world, there are churches that are partnering with governments, the private sector, and civil society to break the silence and stigma related to AIDS and provide prevention, treatment, and care services to those most severely affected by the pandemic. They are utilizing their unique assets—from pastoral ministry to health and education systems to the power of their grassroots advocacy efforts—to model inclusion, reconciliation, and restoration of community. In the midst of the suffering caused by HIV and AIDS, churches seek to deepen their commitments to be inclusive communities of hope, seeking justice in the world.

The ELCA's Response to Date

Since the discovery of HIV and AIDS in the United States in 1981, the effectiveness of the ELCA's domestic and global response has been mixed. The ELCA has missed opportunities to utilize the capacity of all of its expressions[57] because it lacks a strategic vision and plan for engagement. It does not yet have in place a churchwide AIDS plan, as The Lutheran World Federation—a Communion of Churches (LWF) has encouraged all its member churches to do. Yet, when the ELCA has engaged strategically in responding to the challenges of the pandemic, especially in partnership with Lutherans in developing countries,[58] tremendous success has been achieved.

Within the ELCA, diverse understandings about human sexuality, different approaches to biblical interpretation, and discrimination against the lesbian, gay, bisexual, and transgender (LGBT) community impeded the development of a comprehensive HIV and AIDS strategy. Shortly after the formation of the ELCA, the Church Council affirmed a message on HIV and AIDS entitled "AIDS and the Church's Ministry of Caring."[59] The central point of the one-page message was to communicate that "the Church Council of the Evangelical Lutheran Church in America recognizes with gratitude the service of those who care for people with AIDS and their loved ones. It urges church members to support this ministry and to serve those who are suffering with respect and compassion."[60] While this message may have been viewed as cutting edge during that time, the present day reality of HIV and AIDS clearly reveals the shortcomings of a message focused solely on care.

Some ELCA social ministry organizations (SMOs), including hospitals, have responded to the needs of people living with HIV and AIDS. ELCA seminaries and universities have likewise addressed HIV and AIDS within the context of their educational ministries. This church has been blessed by faithful lay members and rostered leaders who have engaged with individuals affected by HIV and AIDS, made their congregations places of welcome and advocacy, and worked both through their congregations and in tandem with SMOs and other nonprofit organizations to respond to those in need due to this pandemic.

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[56] "The HIV/AIDS Epidemic in the United States," March 2008, Kaiser Family Foundation (*www.kff.org/hivaids/upload/3029-08.pdf*).

[57] The three primary expressions of the ELCA are congregations, synods and the churchwide organization.

[58] The United Nations Statistics Division says "The designations 'developed' and 'developing' are intended for statistical convenience and do not necessarily express a judgment about the stage reached by a particular country or area in the development process." (*http://unstats.un.org/unsd/methods/m49/m49.htm*) Some prefer the use of the term "Global North" to describe the most industrially developed (wealthier) nations but also to include those portions of less industrialized countries that are economically wealthier. Conversely, the often-used "Global South" refers to the less industrialized countries generally as well as those portions of the more industrialized countries which are less economically developed.

[59] "AIDS and the Church's Ministry of Caring," affirmed by the ELCA Church Council on November 13, 1988. (*www.elca.org/What-We-Believe/Social-Issues/Messages/Aids.aspx*). See Appendix 1.

[60] Ibid.

The Lutheran AIDS Network (LANET), established in 1995 as a joint network of The Lutheran Church–Missouri Synod (LCMS) and the ELCA, seeks to ensure that the issues and concerns of people living with and affected by HIV and AIDS remains before the church. LANET is comprised of individuals and organizations sharing a passion for responding to HIV and AIDS. This organization has extensive experience with the epidemic, both within the church and in institutions in the wider society. Members include, among others, individuals living with HIV and individuals affected by HIV through loss or care-giving. While LANET represents an important effort to encourage Lutherans in the United States to acknowledge the reality of AIDS domestically and take action, the organization over time has had few resources, which has limited its capacity and effectiveness.

In the 1990s, the ELCA established an inter-unit task force to focus on the domestic and international reality of HIV and AIDS. This task force included staff from a number of areas within this church, including Church in Society, Global Mission, and Women of the ELCA. This task force collaborated in promoting the yearly commemoration of World AIDS Day, establishing a clearinghouse and speakers' bureau, and developing a Web presence. Since the task force's creation, ELCA World Hunger domestic grants have funded work that directly and indirectly serves economically impoverished individuals living with and affected by HIV and AIDS. Since 2003, ELCA staff in Washington, D.C., have prioritized advocacy on U.S. programs responding to the international AIDS crisis, and some state public policy offices have addressed state policy relating to HIV and AIDS.

Globally, the ELCA has a long history of ministry with companion churches and community-based partners in other countries, as well as international ecumenical and interfaith partners. Since the ELCA's formation, it has been engaged deeply with them in ministries to and with individuals living with or affected by HIV and AIDS, reflecting the priorities that companion churches and community-based partners have identified. In recent years, the ELCA, like The Lutheran World Federation of which it is a member, has intensified efforts to build a more strategic HIV and AIDS response within and among the Lutheran churches that are part of the communion.

While the ELCA works with companion churches in all regions as they respond to the HIV and AIDS crisis, a primary focus of the ELCA's engagement has been Africa. More than a decade ago, companion churches in Africa called upon the ELCA to recognize the tragic scope of the HIV and AIDS crisis they were experiencing in their daily lives and "walk the second mile" with them in seeking justice for and serving those affected by this disease in their communities.

A partial result was that, in 2001, the ELCA affirmed "Stand With Africa: A Campaign of Hope."[61] In 2004, the ELCA made this campaign an ongoing emphasis within the ELCA World Hunger Appeal in order to build awareness, focus advocacy, and marshal the financial resources to better assist companion churches and agencies engaged in HIV and AIDS ministries in Africa. This special emphasis has complemented ongoing ELCA engagement with companions in other regions through grants, placement of ELCA mission personnel, consultancy, and other means.

Because of companion synod relationships throughout Africa, knowledge among ELCA members—both of the impact of HIV and AIDS on the ministries of companion churches and of the possibilities for effective common action—has grown over the last decade.

The ELCA's response also has had a community-based focus through the work of Lutheran World Relief, a ministry of the ELCA and The Lutheran Church–Missouri Synod.[62] The ELCA also has engaged ecumenically, in partnership with other churches in the United States through Church World Service,[63] and globally, through membership in the World Council of Churches, as well as through such initiatives as the Ecumenical Advocacy Alliance.[64] More recently, Presiding Bishop Mark S. Hanson and ELCA churchwide staff have participated in the two most recent International AIDS Conferences (Toronto 2006, Mexico City 2008).

Strategy: Looking to the Future: Vision and Goals

The ELCA believes a world is possible where new cases of HIV are prevented and all individuals with HIV or AIDS are able to live with dignity. The realization of this vision will require long-term, focused, and intentional engagement by churches, other faith groups, non-governmental organizations, civil society organizations and institutions, governments, international organizations, the private sector, and individuals of good will.

With over 4.7 million members and more than 10,400 congregations in the United States, in addition to relationships with 68.3 million Lutherans worldwide, the ELCA has the potential to contribute in ways proportionate to its wealth, size, and assets, to the following goals of the wider human community:

- To halt the spread of HIV through effective prevention, treatment, and care.
- To eliminate the stigma and discrimination experienced by those who are HIV-positive.
- To reduce the conditions of poverty and marginalization that contribute to the spread of HIV.

The ELCA Churchwide Assembly in 2007 recognized the need to develop a churchwide HIV and AIDS strategy[65] that would shape this church's contribution to the wider global community's struggle against HIV and AIDS. It acknowledged that the ELCA's response to AIDS, like that of the global church, continues to be characterized by sin and grace, exclusion and welcome, pride and humility, and indifference and engagement

[61] Stand With Africa seeks to assist communities and churches in Africa in their work to overcome HIV and AIDS, banish hunger, and build peace (*www.elca.org/hunger/swa*).

[62] See more about Lutheran World Relief's health work at: *www.lwr.org/ourwork/development/index.asp#health*.

[63] Learn about Church World Service's work at: *www.churchworldservice.org/*.

[64] Learn about the Ecumenical Advocacy Alliance's HIV and AIDS Campaign at: *www.e-alliance.ch/en/s/hiv-and-aids/*.

[65] See Assembly Action CA07.03.12 (Appendix 2).

at home and with global companions. The assembly also acknowledged that this church has much to learn from those living with HIV and AIDS, from companion churches that are at the epicenter of the global pandemic, and from others in the wider society who are responding to the HIV and AIDS crisis. The assembly acted in confidence that, by God's grace, the ELCA will respond yet more faithfully and effectively to the HIV and AIDS pandemic in the coming decades.

In the strategy that follows, the Evangelical Lutheran Church in America affirms the claim made by The Lutheran World Federation[66] and the World Council of Churches—one of the most important lessons the church has learned during the past twenty-five years: the body of Christ has AIDS. The ELCA acknowledges that it is a church that is HIV-positive: both because members of this church have HIV and because the ELCA understands itself as living in the world and responding to its critical issues, this church as a body is HIV-positive.

A church that knows itself to be HIV-positive does not self-righteously turn in on itself; rather it turns outward with empathy and compassion toward the wider human community that is also HIV-positive. A church that knows itself to be HIV-positive is not passive; rather it seeks to act faithfully and boldly in a world where HIV and AIDS is a massive global health and development challenge. A church that knows itself to be HIV-positive does not stigmatize individuals who are HIV-positive; rather it articulates a hope-filled vision that rejoices in God's radical embrace of all who are HIV-positive. Through this strategy, the ELCA invites and encourages all its members, expressions, and related organizations to choose to act in ways that will add value to and build synergy within the global HIV and AIDS response.

The strategy that follows is organized in six sections, which identify key areas for strategic response by a church that is HIV-positive and thus, in the midst of the HIV and AIDS crisis, is:

- Called to biblical and theological reflection in community;
- Called to effective prevention, treatment, and care;
- Called to eradicate stigma and discrimination;
- Called to walk with companion churches and partners in other countries;
- Called to advocate for justice; and
- Called to build institutional capacity and make strategic choices.

In each of these six areas, specific goals and actions give expression to the following cross-cutting commitments:

1. The ELCA will fully live into a) its identity as a church that is HIV-positive and b) its calling to become an HIV and AIDS-competent church (see below). This requires all expressions of this church to become engaged and to build their capacity to respond, with a particular emphasis on congregations. In order to accomplish this, the ELCA will implement a comprehensive and sustained HIV and AIDS campaign.[67]
2. The ELCA will seek direction, leadership, and involvement from individuals who are HIV-positive for all of its AIDS-related activities.
3. The ELCA actively will seek effective partnerships with governments and others in civil society that support the rights of people living with HIV and AIDS and provide appropriate prevention, care, and treatment both in the United States and throughout the world.
4. The ELCA will act according to the accompaniment model for mission in all interactions both domestically and globally.[68]
5. The ELCA will equip its members to be effective advocates with all expressions of government and international organizations.
6. The ELCA will set benchmarks and targets to measure its progress in meeting these goals and fulfilling commitments made in this strategy.

Called to Biblical and Theological Reflection in Community

Theological Foundation

The church of Jesus Christ is called, gathered, and sent by the Holy Spirit to proclaim God's reconciling love for all humanity. The baptized followers of the crucified and risen Messiah—children, youth, men, and women—hear, believe, and receive the living Christ in Word and Sacrament. In word and deed they proclaim Jesus as Lord and are agents of God's reconciling love, which restores community both within the church and in the wider society.

It is God who calls into being the church that is Christ's body in the world. It is Christ, the living Word, whose self-emptying love is the pattern for life in the church. The Lord of the church sets the table and invites all to God's feast of reconciliation with a radical inclusiveness that causes human-built walls of division and exclusion to tumble.[69] The invitation to Christ's table does not come because of human action or status, for "all have sinned and fall short of the glory of God."[70] Rather it is by God's grace—and for the sake of God's mission—that the church is called into being and each person is welcomed into the community of believers.

The wideness—and wildness—of God's grace both amaze believers and challenge the patterns of exclusion and marginalization that are lived out in the wider society. Those who experience God's grace—God's "Yes" in Christ Jesus[71]—know that they are called to say "No" to all forces and attitudes that undermine the dignity of each individual, to the prejudices that stigmatize and exclude, and to all unjust

[66] The ELCA is a member church of both The Lutheran World Federation and the World Council of Churches.

[67] More details will be included when the strategy is implemented. Implementation plans related to HIV and AIDS will be coordinated with the emerging pan-Lutheran initiative which will also focus on malaria.

[68] Accompaniment is *walking together in solidarity that practices interdependence and mutuality*. For more on this concept see Accompaniment is Relationship (*www.elca.org/Who-We-Are/Our-Three-Expressions/Churchwide-Organization/Global-Mission/How-We-Work/Accompaniment.aspx*).

[69] "For he is our peace; in his flesh he has made both groups into one and has broken down the dividing wall, that is, the hostility between us" (Ephesians 2:14).

[70] Romans 3:23.

[71] 2 Corinthians 1:19.

structures in church and society that wound and make it difficult for people to live with the dignity God wills for each person made in God's image.

However, in the midst of the HIV and AIDS crisis, such unjust patterns of exclusion at times imprint themselves upon the life of the church. All too often, individuals who are HIV-positive receive the cold shoulder rather than the kiss of love[72] from other members of their church, just as they experience stigmatization, exclusion, and marginalization in the wider society. Yet the face of Christ often is revealed in the faces of those who are vulnerable and excluded—Christ, who welcomes and teaches. Thus engagement with those who are marginalized because of HIV status is not an act of charity carried out by those who are not HIV-positive; rather, such engagement expresses the deep mutuality to which the church is called. It is transformative, enabling all in the church to understand more fully the Good News in Christ Jesus. It reminds all believers that the hands of the One who sets the table—the One who invites all into community and into a shared communion—bear themselves the stigmata of vulnerability and exclusion. And such engagement enables all within the church better to hear the call of Christ to discipleship, which embraces the scandal of the cross for the sake of the healing of the world.

> "As Christians, when we come to the Eucharist, the meal of forgiveness and unity, let us remember that the Christ who is present there for us, who welcomes us, who forgives us, who gathers us, who sends us to be Christ's body for the life of the world, is the one whose hands bear the stigmata of exclusion and discrimination and vulnerability. It is finally by God's grace and mercy that we are called and free to become Christ to our neighbor."
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> *ELCA Presiding Bishop Mark S. Hanson, International AIDS Conference, Mexico City, August 1, 2008*

Formation and Deliberation in Community

The Evangelical Lutheran Church in America is called to discern at the foot of the cross what it means to be a church that is HIV-positive—a community that suffers when one member suffers and that celebrates the joys of each member.[73] By God's grace, this church and its members will experience the deep repentance and conversion of heart that so often results when Christ is recognized in the face of a marginalized or excluded neighbor. When it acknowledges the brokenness of Christ's body and its own vulnerability, this church will open itself to experience God's healing in new ways and will gain renewed strength and freedom to engage the world with vigor.

In the midst of the suffering and injustice related to HIV and AIDS, the task of the ELCA is to become what God calls it to be: an inclusive community of hope that both experiences in its daily life and seeks in the world the reconciliation and restoration of community that God wills.

The formation of Christian identity among members, congregations, and all parts of the ELCA in the midst of the AIDS crisis involves heart, head, and hands. Such formation will happen through the study of Scripture and deep theological reflection undertaken with people living with HIV and AIDS. It will be undergirded by prayer and energized by worship and participation at Christ's common table. It will be strengthened by intentional and respectful moral deliberation, which will enable members to grow in awareness about HIV and AIDS and strengthen their will to respond in the world.

This formation process will be intensely personal and intentionally communal. Members will find themselves challenged to change: in their individual attitudes and behavior, in their use of time and their patterns of giving, in their daily life and in their vocations, and in their engagement in the wider society and with global companions. Yet members will experience joy and mutual encouragement when such change is nurtured in community, as ELCA members gather together to examine Scripture and seek to be "of one mind in Christ"[74] in the midst of the AIDS crisis. From that growing oneness of mind surely can spring a myriad of actions, undertaken individually and together, that will create a pattern of love, service, and justice that is as wide as the world and as close to home as a word to a neighbor. God's work will be carried out by our hands[75]—and, by God's grace, the pattern of this church's actions will witness to and be a living expression of God's self-emptying love that brings life, hope, and reconciliation in the world.

Goal:

The ELCA will seek to discern what it means to be a church that is HIV-positive through biblical study and theological reflection, education about HIV and AIDS, and active and open moral deliberation that will shape common action in communities and in the wider world.

Actions:

1. Learn from and with its LWF companions:
    a. position its intensified biblical and theological reflection and HIV and AIDS activities within the context of the LWF communion and build upon the foundational biblical and theological reflection that has been done in the LWF and ecumenical arenas;[76]
    b. seek to develop a shared understanding that reflects a common Lutheran identity and a renewed ecclesiology of inclusion.
2. Address directly issues relating to HIV and AIDS, including matters relating to gender, race, drug use, sexual orientation, and sexuality, as well as matters relating to the economic disparities that contribute to the spread of HIV and AIDS.

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[72] 1 Peter 5:14.
[73] 1 Corinthians 12:26.
[74] Acts 17:11, Philippians 2:1-11.
[75] The ELCA's tagline is "God's work. Our hands."
[76] Including the Ecumenical Advocacy Alliance.

3. Provide contextually appropriate education and study materials and processes for congregations that will:
   a. enable ELCA congregations and their members to join members of companion churches in The Lutheran World Federation in intensive study of Scripture in the context of HIV and AIDS;
   b. address such foundational questions as: how do we, as Lutherans, read the Bible? What kind of church do we want to be as we address the AIDS crisis in the 21st century?
   c. educate members about the HIV epidemic in the United States and throughout the world, help facilitate moral deliberation, and identify service and advocacy opportunities in which individuals and communities can engage;
   d. include devotional, prayer, and worship resources that can assist congregations to participate holistically in the churchwide process of discernment and deliberation;
   e. encourage congregations and their members to be open to deep and fundamental change in their daily life and practice in light of this reflection;
   f. include opportunities for young people to be catalysts and leaders;
   g. promote open discussion of the responsibility of men and boys for their own sexual behavior, for the respect of their partners, and for taking greater roles as care-givers; and
   h. develop and promote resources on topics such as contextual theology that assist in analysis of gender roles and positive masculinity.
4. Call upon all seminaries to provide training on HIV and AIDS for ELCA rostered leaders and seminarians, including biblical and theological reflection and training in pastoral care that emphasizes accompaniment of individuals living with HIV and AIDS.

Called to Effective Prevention, Treatment, and Care

Prevention

The HIV pandemic will not be reversed without the implementation of comprehensive, evidence-informed prevention programs tailored both to the general population and marginalized populations at higher risk. In the 2001 United Nations Declaration of Commitment, the international community named HIV prevention as the highest priority in the response to AIDS. Yet, despite the availability of increased financial resources since 2001, an unacceptably high number of individuals globally still lack access to trusted and proven prevention services. Only 50 percent of countries with targets for universal access have targets for critical HIV prevention programs.[77]

The development of new prevention tools, including an HIV vaccine and microbicides,[78] would obviously be the most effective tool against the spread of HIV. Unfortunately, none of the major recent vaccine and microbicide trials have yet led to a vaccine, leaving the scientific AIDS community grappling with questions of how much money should be dedicated to ongoing vaccine trials versus investment in practical prevention programs and resources. The ELCA supports ongoing investment and research for AIDS vaccine initiatives, including microbicide development. At the same time, until an AIDS vaccine or other new prevention tools are developed and proved to be effective, the ELCA supports the implementation and enhancement of aggressive prevention efforts that have been proved to be effective.

The most effective prevention efforts are tailored to the unique needs and culture of local communities and specific demographics, and deal explicitly with issues of sexuality, gender relationships, and substance abuse.[79] Hence, the context determines which prevention strategies will be most effective. Sexual transmission, including both heterosexual and homosexual interactions, is the primary way HIV is spread throughout the world. Globally, the most effective prevention strategies for sexual transmission include emphasis on a number of prevention tools that seek to change the behavior of sexually active individuals in ways that protect them and their partners from HIV. UNAIDS outlines various prevention strategies, including[80]:

1. Avoid unsafe sexual and drug-using behavior;
2. Promote correct and consistent use of male and female condoms;
3. Reduce the number of sexual partners;
4. Improve the management of sexually transmitted diseases;
5. Broaden access to HIV testing and counseling;
6. Increase access to harm-reduction programs for drug users;
7. Promote medical male circumcision;
8. Ensure effective disease control in health care settings;
9. Ensure no mother-to-child transmission.

Much attention has been given to the "ABC" model of HIV prevention, particularly in certain countries in Africa. In this approach, A stands for "**A**bstinence," B for "**B**e faithful to one partner," and C for "**C**orrect and consistent use of **c**ondoms." However, the limitations of this approach, especially for women, and its narrow focus have been challenged widely. The International Network of Religious Leaders Living with or Personally Affected by HIV and AIDS (INERELA+), a global organization of religious leaders, has advocated a different approach called "SAVE," which stands for "**S**afer practices, **A**ccess to treatment, **V**oluntary counseling and testing, and **E**mpowerment."

[77] "2008 Report on the Global AIDS Epidemic," op.cit., p. 97.

[78] Microbicides are gels, creams and other products that women can apply to the vaginal area before sexual intercourse that reduce the transmission of HIV. See "Microbicides: So, What Are They? And Why Should You Care?" (*www.kff.org/womenshealth/3117-index.cfm*).

[79] "2008 Report on the Global AIDS Epidemic," op.cit., p. 100.

[80] Ibid., p. 97.

"I believe the willingness of the ELCA Conference of Bishops to have HIV-testing available at their spring 2009 meeting demonstrates that a new era of leadership in addressing HIV and AIDS is emerging among Lutheran bishops in the United States. My hope is that our public act as a Conference of Bishops helps to break the stigma and discrimination associated with HIV and AIDS. We want to provide encouragement for the pastors and lay leaders of this church to make universal testing a priority, so that all persons know their status, receive necessary treatment, and take appropriate action to prevent the further spread of HIV."

Bishop Peter Rogness, ELCA Saint Paul Area Synod

This church will develop a strategic response, in collaboration with its partners, to address those groups of individuals currently at higher risk of becoming HIV-positive within its wider HIV and AIDS efforts. It does so acknowledging that the designation of "higher risk" groups may change as the epidemic evolves. Therefore, it is important that everyone be tested annually for HIV, even as special attention is focused upon groups that are currently at higher risk. The following groups are not exclusive; some individuals are members of several of the following groups:

1. ***Young Adults:*** Globally, young people under age 25 account for half of the world's population. In 2007, 45 percent of new cases of HIV occurred among this age group. The most recent 2006 survey results from 60 countries indicate that only 40 percent of males and 38 percent of females ages 15–24 had accurate and comprehensive knowledge about how to avoid HIV transmission.[81] While these percentages represent improvement in comparison to previous years, there clearly is a tremendous amount of education and awareness raising that must occur among young people to halt and reverse the spread of HIV.

   In the United States, young people ages 13–29 had more cases of HIV than any other age group—34 percent. In this country, the Centers for Disease Control and Prevention contends that these "data confirm that HIV is an epidemic primarily of young people and underscores the critical need to reach each new generation of young people with HIV prevention services."[82]

2. ***Girls and Women:*** Half the people living with HIV are women. Yet in some regions, women who are HIV-positive far outnumber men who are HIV-positive. For example, in sub-Saharan Africa, nearly 60 percent of adults living with AIDS are women. But in the critical 15–24 age group, three quarters of those who are HIV-positive are women. Women are particularly vulnerable when they do not have the correct information about how HIV is transmitted. At the end of 2005, in a worldwide study, only 20 percent of females age 15–24 living in low and middle income countries could correctly identify ways of preventing HIV transmission.[83] Gender inequality—played out in educational, legal, social, religious, and economic spheres—places many girls and women at higher risk. According to UNAIDS, "women and girls are also at increased risk for HIV infection biologically. In unprotected heterosexual intercourse women are twice as likely as men to acquire HIV from an infected partner. Economic and social dependence on men often limits women's power to refuse sex or to negotiate the use of condoms."[84] Many women (averages range from 24 to 40 percent) report that their first sexual encounter was forced.[85] In addition, sexual violence against women, the objectification of women in the media, and human trafficking put women at risk of contracting HIV. These dynamics make necessary HIV and AIDS interventions that focus specifically on women at higher risk. Still, prioritizing women alone will not stop the spread of HIV, so these efforts will not succeed if they do not also take into account the active involvement of men.

The Mashiah Foundation, supported by the ELCA and served by ELCA missionaries Mary Beth and Bayo Oyebade, serves approximately 400 people infected with HIV and AIDS in Jos, Nigeria. Mashiah's clinic, which also receives funding from PEPFAR, provides counseling, testing, medical consultation, and drugs. Its goal is to keep people and families healthy as they live with HIV and AIDS.

An amazing outgrowth of this outreach is the work of a group of strong, tenacious, and faithful HIV-positive women who call themselves "Women of Hope." In Nigeria, intense stigma and discrimination directed toward women make it very difficult to live with HIV. But Women of Hope have moved beyond silence and beyond merely receiving care. They support each other and they assert boldly that, because they have hope in Jesus Christ, they also have hope that they can make a difference in the fight against HIV and AIDS in Nigeria. They speak out about HIV/AIDS rather than hiding it from the world in hopes of eradicating the stigma that

[81] Ibid., p. 98.

[82] "Estimates of New HIV Infections in the United States," Centers for Disease Control and Prevention, August 2008 (*www.cdc.gov/hiv/topics/surveillance/resources/factsheets/incidence.htm*).

[83] "Declaration of Commitment on HIV/AIDS: five years later," Report of the UN Secretary General. A/60/736. 24 March 2006, p 5.

[84] UNAIDS (*www.unaids.org/en/PolicyAndPractice/Key Populations/WomenGirls/default.asp*).

[85] "Violence Against Women," World Health Organization fact sheet,. Revised November 2008 (*www.who.int/mediacentre/factsheets/fs239/en/index.html*).

has caused them so much pain. The 15 members of Women of Hope tell others about their personal experiences with HIV and AIDS in the hope of "saving a generation of Nigerians." They describe themselves as ready to speak out anytime, anywhere, and to anyone in the hope of halting HIV and AIDS and making Nigeria a better place for their children. Their theme song is: "we must go with Jesus anywhere, no matter the roughness of the road." They literally have gone on the road to many different parts of Nigeria to share their own stories of pain transformed into hope.

3. ***Sex Workers:*** Sex workers (including women, men, and transgender individuals) represent one of the populations at highest risk for being diagnosed with HIV, but most are underserved in terms of HIV prevention, largely due to the high stigma and marginalization they face in society. In wealthy countries, like the United States, social services that target sex workers, encouraging the use of condoms and providing access to alternative livelihood options, are fairly common. In poor countries, these services are less common. Research shows, however, that an increase in condom use during paid sex could significantly reduce the number of individuals who become HIV-positive. For example, if condom use increased to 90 percent along the trans-Africa highway between Mombasa, Kenya and Kampala, Uganda, where an estimated 8,000 female sex workers operate, 2,000–2,500 new cases of HIV would be prevented annually.[86]

4. ***Injecting Drug Users:*** HIV is spread effectively and rapidly through injection drug use. In the U.S., 21 percent of the reported cases of AIDS were contracted in this way.[87] In developing countries, HIV also is transmitted rapidly among injecting drug users through contaminated needles and syringes. For example, in Karachi, Pakistan, the percentage of people living with HIV or AIDS among injection drug users rose dramatically from one percent to 26 percent in one calendar year (2004–2005).[88]

   The best way to prevent the spread of HIV from injection drug use is to avoid this practice. However, the ELCA recognizes that many individuals are addicted to drugs and utilize unsterilized means to inject drugs. Effective prevention techniques among injecting drug users include "harm reduction" strategies such as access to substitution treatment, sterile needles, and syringes. Numerous studies have shown that these programs dramatically decrease the spread of HIV without encouraging drug use or the recruitment of first-time drug users.[89]

5. ***Men Who Have Sex with Men:*** Throughout the world, men who have sex with men face a disproportionate risk of becoming HIV-positive. Less than 20 percent of countries with generalized epidemics have implemented prevention strategies targeting this segment of the population.[90] Sexual prevention messages and techniques discussed above, while they should be tailored to the unique realities of each demographic group, are the same for men who have sex with men. Stigma and discrimination against the gay community still serves as one of the greatest deterrents to effective HIV-prevention among men who have sex with men.

The following U.S.-specific aspects of the HIV and AIDS crisis also need to be addressed in an effective ELCA strategy:

6. ***African Americans and Latinos:*** As noted above, prevention strategies also must be focused on addressing the ways in which HIV is spread in particular communities. With respect to the African American and Latino communities, this prevention must not only address individual behavior, but also must address the structural factors that render individuals in these populations more vulnerable to HIV.

   For example, the African American community in the United States is experiencing a generalized epidemic and therefore requires prevention strategies that specifically address the general African American population and not only those engaged in higher-risk sexual behaviors. The Black AIDS Institute notes that "generalized epidemics require more generalized responses in order to curb the spread of infection."[91] To combat generalized epidemics, UNAIDS calls for prevention strategies that start with a focus on populations at higher risk and then move beyond this base to "broader, population-based interventions, such as mass media, school-based education, community mobilization, [and] workplace interventions."[92]

7. ***Individuals Over Age 50:*** In the United States in 2006, individuals age 50 and older accounted for 10 percent of new cases of HIV among men and 11 percent of new cases of HIV among women.[93] Furthermore, individuals 50 and

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86 "2008 Report on the Global AIDS Epidemic," op.cit., p. 111.
87 "Reported AIDS cases for male adults and adolescents, by transmission category and race/ethnicity, 2006 and cumulative—United States and dependent areas" (*www.cdc.gov/hiv/topics/surveillance/resources/reports/2006report/table19.htm*)
88 "2008 Report on the Global AIDS Epidemic," op.cit., p. 113.
89 "Syringe Exchange Programs," Centers for Disease Control and Prevention (*www.cdc.gov/IDU/facts/aed_idu_syr.htm*)
90 "2008 Report on the Global AIDS Epidemic," op.cit., p. 109.
91 "Left Behind! Black America: A Neglected Priority in the Global AIDS Epidemic," op. cit., p. 27.
92 "2008 Report on the Global AIDS Epidemic," op.cit., p. 100; "Left Behind! Black America: A Neglected Priority in the Global AIDS Epidemic," op. cit., p. 27.
93 "Subpopulation Estimates from the HIV Incidence Surveillance System—United States," 2006, Centers for Disease Control and Prevention. *Morbidity and Mortality Weekly Report*, September 12, 2008 (***www.cdc.gov/mmwr/preview/mmwrhtml/mm5736a1.htm***).

older are one-sixth as likely to use a condom as compared to their younger 20-something peers.[94] Of the more than 4.7 million ELCA members in the United States, approximately 60 percent are 50 and older.[95] As part of its AIDS campaign, the ELCA will target this population with appropriate prevention messages.

Governments, with their comprehensive scope of activities and variety of resources available, are key to national and state-wide education efforts to reduce the spread of HIV. Governments have a responsibility to provide citizens with correct medical information and include all options that are available or necessary to protect themselves and their partners from contracting or spreading the virus. The relationship of governments to other sectors of HIV and AIDS response at national levels through national platforms and other response mechanisms is critically important.

Because of their broad grass-roots reach and organizational structures, churches also have considerable assets they can bring to bear to augment the government's prevention efforts, working to educate members and recipients of services about the effective prevention techniques listed above and ensure they have access to proven prevention tools.

> "Many small or rural churches may feel this strategy does not apply to them. It's that, 'We don't have that problem here!' attitude. While many people in rural areas with HIV and AIDS move to major cities, these individuals often have family members in these communities. Many of these relatives live in fear that friends or neighbors will discover they have an HIV-positive relative. As a result, these congregations have an opportunity to provide a support system for these families. These congregations also have the opportunity to reach youth with prevention messages and methods, prior to their becoming a part of an "at risk" group. I strongly believe, had my family in rural Nebraska had a knowledgeable, informed, and supportive church community, we might have been able to have some type of communication rather than our stilted conversations about the weather."
>
> *Robert Schrader, member of Our Savior's Lutheran Church, Denver, Colorado*

Goal:

In collaboration with governments, churches, and members of civil society, this church will work toward the goal that all individuals, but especially, those in populations that have a higher risk of contracting HIV: a) have knowledge of and access to comprehensive proven HIV and AIDS prevention techniques; b) take precautions to minimize the possibility that he or she will contract or spread HIV; and c) be tested annually.[96]

Actions:

1. Call upon individuals in congregations, synods, and the churchwide organization who are responsible for this church's education efforts to incorporate in their work contextually appropriate HIV and AIDS educational materials and programs that:
   a. take into account the experiences of specific groups of individuals, such as individuals over age 50, youth ages 15–24, men who have sex with men, and communities of color;
   b. communicate through a variety of means and with a variety of media (e.g., educational materials including those produced by LANET, posters, workshops, conferences, online media tools, and inclusion in Lutheran publications); and
   c. are integrated with ongoing health and wellness activities of this church.
2. Call upon congregations, synods, and churchwide staff to integrate HIV education into ELCA meetings and activities, including:
   a. Churchwide assembly, synod assemblies, and other major churchwide and synodical meetings (e.g., ELCA Youth Gathering, Women of the ELCA Triennial Gathering, and churchwide gatherings of Lutheran Men in Mission, as well as synodical gatherings of women's, men's and youth organizations);
   b. health fairs and other events, in which opportunities for HIV testing with appropriate counseling can be provided; and
   c. the work of Lutheran parish nurses, urging its national network of Lutheran Parish Nurses to share best practices and ideas for action related to HIV-education in congregations, including prevention, testing, treatment, and care services.
3. Call on ELCA seminaries to share best practices relating to HIV and AIDS prevention activities and to develop intentional means to equip pastors and rostered leaders to take leadership in such activities in congregations.
4. Engage both domestically and internationally with populations that are at higher risk of becoming HIV-positive:
   a. encourage and support the Lutheran Youth Organization (LYO), in partnership with churchwide, synodical, and congregational youth ministry leaders, to develop intentional ways to ensure that all ELCA youth and young adults are knowledgeable about how to effectively prevent HIV transmission, with the goal of sustained, long-term behavior change among ELCA youth and young adults;

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[94] "AIDS risk behaviors among late middle-aged and elderly Americans," Stall R, Catania J,.. The National AIDS Behavioral Surveys . Archives of Internal Medicine. 1994 Jan 10;154 (1):57–63.

[95] "Comparing the Age of ELCA Attendees and the US Population," ELCA Department for Research and Evaluation, 7/9/2002.

[96] "HIV Testing in Healthcare Settings," Centers for Disease Control and Prevention (*www.cdc.gov/hiv/topics/testing/healthcare/index.htm*) Accessed February 13, 2009.

b. encourage ELCA schools, colleges, and universities to share best practices relating to HIV and AIDS prevention activities among youth and young adults and to expand such activities;
c. encourage and support companion churches and partners in other countries as they develop evidence-informed prevention strategies, policies, and programs, including those that focus on youth and young adults and address specific gender-related circumstances that make young women and girls particularly vulnerable to becoming HIV-positive;
d. expand sustainable HIV and AIDS prevention efforts and services that encourage the emergence from drug dependency to healthy, productive livelihoods;
e. address the stigmatization of sex workers through relationships that provide education and access to proven prevention techniques and to alternative livelihood opportunities for these individuals, many of whom engage in this work out of financial desperation;
f. encourage this church, utilizing the expertise of its relevant program units and related associations, to act effectively to address the disproportional impact of HIV and AIDS in communities of color in this country, and to support prevention efforts by the federal government that addresses the unique contextual factors in the African American and Latino communities that render these populations more vulnerable to HIV; and
g. encourage the sharing of best practices among ELCA social ministry organizations and other ELCA-related agencies and institutions, as well as among global companions, in HIV prevention and the implementation of comprehensive and proven prevention strategies targeted to populations at higher risk of becoming HIV-positive.

> "Contrary to popular belief, not everyone with HIV can get quality medical care. In the spring of 2001, I learned I was HIV-positive after admittance to the hospital to treat severe bacterial pneumonia. During my two-month hospital stay, my job was terminated and as a result, I lost my insurance and my house. Soon after losing insurance, the hospital discharged me without medication, referral doctor's numbers, or follow-up care, to a hospice for homeless men with AIDS. After about a month, I was able to obtain medical care under the Colorado Indigent Care Program (CICP). When I left hospice on December 23, 2001, I went to the one medical provider available under CICP—Denver Health. I was seen by a physician's assistant, rather than a doctor. As my health improved, I began to ask more questions; I was unsatisfied with the answers I received. In June 2004, my clinician dropped me due to my continued insistence that I play a role in my medical care. At this time, I still had several months before my Medicare coverage would begin. Since I didn't figure I would get any better care at Denver Health, I went without medical care until October 2004. Then I got on Medicare and began to go to University Hospital. While University Hospital is not perfect, my doctor now answers my questions and enables me to take an active role in my medical care."
>
> *Robert Schrader, member of Our Savior's Lutheran Church, Denver, Colorado*

Treatment

The discovery of Highly Active Antiretroviral Therapy (HAART) in 1996 transformed the reality of AIDS to that of a serious but largely manageable chronic illness. The advent of HAART has allowed people who are living with HIV to have access to these drugs and to live healthy and productive lives. Since 1996, many people living with HIV in wealthy countries have had access to life-saving ARV treatment. In the United States, members of civil society continue to advocate for universal access to these medicines.[97] Expanding ARV access to people living with HIV in low-to middle-income nations poses a formidable challenge due to both cost and the weakness of health-system infrastructure throughout the developing world.

Over the course of the last decade, people living with HIV and their allies successfully gained commitment from the international community to work toward universal access to life-saving treatment for all people living with HIV by 2010. The concerted effort of national governments, activists, and other public and private entities like the Clinton Global Initiative[98] and the Bill & Melinda Gates Foundation[99] successfully persuaded drug companies to reduce the cost of ARVs and allow for the production of generic medication to ensure that people who are living with HIV in even the most impoverished settings might be able to attain access to life-saving treatment. The reduced cost of ARVs has allowed developing nations, in cooperation with efforts of the Global Fund and the President's Emergency Plan for AIDS Relief (PEPFAR), dramatically to expand access to ARV treatment. At the end of 2007, more than three million people in resource-poor settings were receiving ARV treatment, a 10-fold increase as compared to 2001, representing one of the greatest successes the international community has achieved in the response to AIDS.[100]

While these tremendous gains should be celebrated, much work remains to be done to achieve universal access. Today, new cases of HIV continue to outpace the number of people on ARVs by 2.5 to one.[101] Moreover, inequities between developed and developing nations persist, children are not benefitting from

[97] See the advocacy goals of the ELCA below.
[98] See www.clintonglobalinitiative.org .
[99] See www.gatesfoundation.org/.
[100] "2008 Report on the Global AIDS Epidemic," op.cit., p. 130.
[101] Ibid., p. 9.

treatment advances as compared to adults, and efforts to address the most deadly opportunistic infections like tuberculosis demand more aggressive attention from the international community.

Faith-based organizations are playing a critical role in treatment services throughout the world. Enhancing their efforts in cooperation with government, private sector, and other civil society organizations is critical to achieving the level of scale-up necessary in order to achieve universal access. According to the World Health Organization (WHO), faith-based organizations are providing as much as 40 percent of all HIV-related health services in some countries, with unique strength for service provision in rural areas of poor countries. [102]

Goal:

This church will contribute its unique assets and gifts toward the internationally recognized goal of universal access to HIV and AIDS treatment, both domestically and internationally, giving particular attention to ministry in impoverished and rural settings.

Actions:

1. Encourage ELCA-affiliated hospitals and other health-related networks, social ministry organizations, and ELCA global companions engaged in health ministries to: record and promote best practices in HIV treatment, plan strategically with government (where appropriate) and other members of civil society to expand access to underserved individuals and communities, and identify opportunities for sustainable expansion of Lutheran and ecumenical ministries that increase access to treatment by people living with HIV. Encourage the broader church to learn from the best practices of these institutions.
2. Provide information to ELCA members about HIV and AIDS counseling and treatment options in their local communities.

Care

There are numerous aspects of care for people living with HIV that extend beyond the basic provision of ARV treatment. Many elements of such care are included in the category of palliative care, which is defined by PEPFAR as:

> Basic health care and support, symptom management, and end-of-life care [including the following elements]: Routine clinical monitoring and management of HIV and AIDS complications…opportunistic infection (OI) prophylaxis and treatment…management of opportunistic cancers…management of neurological and other diseases associated with HIV and AIDS…symptom diagnosis and relief…social support, including organization of basic necessities such as nutrition, financial assistance, legal aid, housing, and permanency planning. End-of-life care that includes mental health care and support…social support…support for caregivers, and bereavement support for family members.[103]

Pastoral care within the context of a caring faith community is a unique contribution that the church can provide to those living with HIV. When first receiving an HIV-positive diagnosis, individuals and their families need the support and embrace of loving communities. Following that initial period, ELCA members, rostered leaders, and related institutions have a special role to play in walking with people who are HIV-positive as they learn how to "live positively"[104] with their condition over the years. Pastoral care and support for people who are HIV-positive, as well as their families and loved ones, is essential at every point. Both pastoral and peer counseling, especially within the church setting where the understanding of God's embracing love is shared, can provide a strong foundation for hope-filled living with HIV.

Congregations that build strong relationships with HIV and AIDS organizations and social ministry organizations in their communities can enhance their ability to walk with those who are HIV-positive. Together, they can assist them to navigate the various local, state, and federal programs that provide assistance to those living with HIV and AIDS and advocate with them in this context, where appropriate.

Should the disease progress, increasing levels of care and support may become necessary. When individuals become too sick to be employed and, as a result, lose their health care and ability to pay for food and housing, assistance in these areas is sometimes needed. Other simple acts—from driving an individual to a doctor's appointment to dropping off a hot meal—provide welcome support. As symptoms intensify and the end of life approaches, the presence of pastors and both congregational leaders and members provide comfort and support to those with AIDS and their caretakers.

Such a continuum of care springs from this church's identity and its calling to walk with all those who live with chronic or life-threatening diseases. As stated in the ELCA's 1988 message, "AIDS and the Church's Ministry of Caring":

> The church's ministry of caring is a grateful response to God's caring for us. The undeserved love of God announced for all in the Gospel of Jesus Christ is our reason for standing with our neighbor in need…In the same way we are called to "be Christs" for all in our midst who suffer and are ill. Our calling summons us to compassion for, acceptance of, and service with people affected by AIDS both within and outside of our congregations.[105]

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[102] Faith-based organizations play a major role in HIV/AIDS care and treatment in sub-Saharan Africa, World Health Organization. Note for the media, February 8, 2007 (*www.who.int/mediacentre/news/notes/2007/np05/en/index.html*).

[103] "HIV/AIDS Palliative Care Guidance #1," An Overview of Comprehensive HIV/AIDS Care Services in the President's Emergency Plan for AIDS Relief. February 3, 2006 (*www.pepfar.gov/guidance/75827.htm*).

[104] "Living positively with HIV and AIDS UNAIDS" (*http://unworkplace.unaids.org/UNAIDS/living_positively/index.shtml*) Accessed February 17, 2009.

[105] "AIDS and the Church's Ministry of Caring," op. cit.

In many settings throughout the world, the need for care can be even more challenging due to the lack of consistent ARV access; the weak nature of many health systems; the high prevalence of HIV in some areas; the large number of orphans and vulnerable children, especially in households with limited productive capacity; severe stigma relating to HIV and AIDS; and issues related to food security, deep poverty, and gender inequity, such as the fact that globally nearly 90 percent of care-giving falls to women.[106] Such care-giving duties can take women away from their livelihoods and their ability to provide for their children, creating a tragic cycle of poverty and vulnerability. Companion churches respond in a variety of ways, including counseling; visitation by pastors, deaconesses, and lay members; provision of food and shelter; support for the children of individuals living with HIV and AIDS; transportation to and from health clinics; advocacy in accessing health care; and protection of rights. In countries where church health systems are well developed, such as Tanzania, palliative care initiatives may weave together pastoral and appropriate medical care with other support services.[107] Some church-related programs provide safe havens for vulnerable people (i.e., women who have been marginalized because of the stigma of HIV and AIDS) and provide a context in which they can build hope-filled "positive" lives. Comprehensive services include aspects of palliative care (i.e., assistance in accessing ARVs and health treatment, peer support, and nutrition), but go beyond care to income generation and advocacy for just treatment.[108] In some instances, local financial and human resources are augmented by support from the ELCA and other Lutheran and ecumenical partners, as well as from PEPFAR and other international donors.[109]

> "The plight of many people suffering from HIV and AIDS, especially those in the rural areas where many of our hospitals operate, can now be relieved because the medication, qualified staff, and means of transportation have been possible through PEPFAR. We are extremely grateful for the support of the American people."
>
> *Mr. Brighton Killewa, General Secretary of the Evangelical Lutheran Church in Tanzania*

Goal:

This church will work with Lutheran and other ecumenical partners, governments, the private sector, and secular groups, toward the goal that all individuals affected by and living with HIV have access to palliative and pastoral care services in addition to receiving medical treatment.

[106] "Women & HIV/AIDS, Confronting the Crisis," op. cit.
[107] For example, palliative care initiative, Selian Hospital, Tanzania.
[108] For example, Mashiah Foundation in Nigeria, which is supported by ELCA Missionary Sponsorship, Mission Support and World Hunger.
[109] For example, 2007 PEPFAR support for Local Community Competence Building and HIV and AIDS Prevention in Tanzania and Zambia.

Actions:

1. Encourage, through this church's HIV and AIDS campaign, ELCA congregations, synods, and the churchwide organization, together with church-related social ministry organizations, to provide appropriate care for those living with and affected by HIV and AIDS.
2. Develop a network that includes staff from ELCA-related hospitals, social ministry organizations, and related institutions and agencies of the ELCA that will allow such institutions to share best practices and publicize their available HIV-care related services.
3. Seek to equip and encourage the ELCA's rostered leaders, members, and congregations to provide counseling, pastoral care, and lay caring ministries to support those living with HIV and AIDS in their local area. This includes helping individuals to live positively with HIV, providing care during treatment, and offering end-of-life support for individuals suffering from AIDS and for their partners, family, and friends. Such actions could include:[110]
   a. Building ongoing relationships of trust and support between individuals who are HIV-positive and those who are not. Due to isolation that results from discrimination and stigma, many individuals living with HIV and AIDS are lonely and would welcome visits, phone calls, outings, and shared meals.
   b. Praying with and for people living with HIV and those who support them in worship and through prayer groups or prayer shawl and quilt ministries that support HIV-positive individuals in nursing facilities or hospitals.
   c. Organizing healing worship services, in partnership with local AIDS service organizations, for those living with HIV.
   d. Starting an HIV and AIDS support group, utilizing where necessary outside experts who are HIV-positive to train congregational members in appropriate activities and support. Such activities could include providing transportation to the doctor or the grocery store for individuals living with HIV whose illness makes those tasks difficult.
   e. Collecting and distributing food, especially fresh fruits, vegetables, and high protein foods that are particularly needed by individuals living with HIV. A congregation could give this food to an agency that provides food to individuals living with HIV and AIDS or network with an organization to help prepare hot meals, especially on weekends when such assistance is particularly needed.
   f. Taking a designated offering for medicine, supplies, or for organizations doing HIV and AIDS-related work. A congregation could also collect money and let it be known within HIV and AIDS community that the congregation accepts referrals to purchase medicine or supplies and food.

[110] Based on a conversation with Loretta Horton, director for Poverty Ministries Networking, ELCA Church in Society, 2008.

g. Selecting an AIDS service organization in a congregation's local area to support on an ongoing basis.

4. Encourage and support companion churches and international partners as they provide the continuum of pastoral and palliative care to individuals living with HIV and AIDS.

Called to Eradicate Stigma and Discrimination in the ELCA and Throughout Society

Stigma and discrimination against individuals affected by and living with HIV and AIDS continues to be one of the most significant forces that undermines progress on HIV prevention, treatment, and care throughout the world. In this context stigma is defined as "a process of devaluation of people either living with or associated with HIV and AIDS." The primary roots of stigma include the fear of becoming HIV-positive and the negative, values-based assumptions about people living with or associated with HIV. Discrimination is defined as "actions based on stigma" and can take many forms,[111] ranging from individual physical acts to discriminatory laws enforced by governments. In 2006, civil society and government stakeholders in 122 countries identified stigma and discrimination to be among the top five challenges to achieving universal access to prevention, treatment, and care.[112]

Together, in their most basic form, stigma and discrimination encourage silence. Silence about the reality of HIV hampers prevention efforts. The fear of stigma and discrimination often prevents individuals who may be at risk of becoming HIV-positive from being tested. Stigma and discrimination also lead to isolation, which often prevents individuals living with HIV from seeking the treatment, care, and support they need to live a healthy and productive life. In addition, there is a growing body of research supporting the theory that stigma increases the incidence of unsafe sex practices.[113] In its most elaborate form, as demonstrated by travel restrictions, discrimination can lead to unjust and unfair treatment of individuals living with HIV by their and other governments.

Governments, the private sector, civil society organizations, and faith-based institutions can take strong and consistent action to combat stigma and discrimination. The international community encourages national HIV plans to include performance indicators or benchmarks relating to stigma and discrimination.[114] UNAIDS has identified the following successful strategies:

1. Preventing HIV-based discrimination;
2. Promoting HIV knowledge and awareness, tolerance, and compassion;
3. Increasing involvement and visibility of people living with HIV;
4. Scaling up treatment;
5. Prohibiting discrimination against populations most at risk; and
6. Empowering the community among populations most at risk.[115]

Governments have a central role to play in ensuring that local, state, and national laws do not actively discriminate against individuals living with HIV. As of 2008, 74 countries restricted the entry and stay of HIV-positive individuals based solely on their HIV status, and 12 of these countries enforced outright bans against entry by individuals living with HIV. Such laws are discriminatory and reinforce stigmatization of individuals living with HIV, and must be challenged and changed through public-policy advocacy (see the "Called to Advocate for Justice" section below). On the other hand, 67 percent of countries report the implementation of laws that seek to protect individuals living with HIV from discrimination.

Such laws should be strengthened, enhanced, and encouraged in all nations.[116]

Among members of civil society, faith-based organizations—including institutional churches—must play a central role in combating social stigma and discrimination. Churches, as noted in the overview, were once at the center of promoting stigma against individuals living with HIV, compounding a serious medical diagnosis with a "moral diagnosis" that resulted in simplistic judgments and an environment in many houses of worship that was not welcoming to those with HIV and AIDS. The ELCA acknowledges its past failings and urges institutional and individual repentance for previous attitudes and actions that were intended or perceived as stigmatizing or resulted in discriminatory actions toward individuals living with HIV. On August 1, 2008, at the International AIDS Conference in Mexico City, ELCA Presiding Bishop Mark S. Hanson began a presentation on stigma and discrimination by washing the feet of two women living with HIV. "I am absolutely convinced that we as religious leaders and we in the religious community that so shunned and shamed people with HIV and struggling with AIDS…must begin first by engaging in public acts of repentance," he said. "Absent public acts of repentance, I fear our words will not be trusted."[117]

Today, the ELCA recognizes that, as a church called to radical inclusiveness as demonstrated by Jesus Christ, it is incomplete without the integral inclusion of all of God's people, including those who live with and are affected by HIV and AIDS.[118] The church's story is incomplete without their story. The ELCA is not faithful to its calling to be Christ's church when it marginalizes or excludes people living with HIV.

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[111] "2008 Report on the Global AIDS Epidemic," op.cit., p. 76.
[112] Ibid., p. 77.
[113] "Discrimination against HIV-Infected People and the Spread of HIV: Some Evidence from France," Patrick Peretti-Watel, Bruno Spire, Yolande Obadia, Jean-Paul Moatti for the VESPA Group. PloS One, an open-access journal. (*www.plosone.org/article/info:doi/10.1371/journal.pone.0000411*).
[114] "2008 Report on the Global AIDS Epidemic," op.cit,, p. 79.

[115] Ibid., p. 77.
[116] Ibid.
[117] "ELCA Presiding Bishop Washes Feet of HIV-Positive Women," ELCA News Service, August 4, 2008 (*www.elca.org/aids/release*).
[118] Luke 15:1–11.

"…For the past nine years I have been attending a camp for over 100 HIV-positive children and their families. Most of these children have lost one or both parents to AIDS and many a sibling…Most children born HIV-positive in Australia are conditioned at a young age "never to tell" and lose hope and self-esteem…At high school, my family asked permission for me to attend camp, but when it became clear that it was AIDS camp, the principal demanded that either I tell the whole school community of my HIV status or leave immediately. I regret not standing up for myself now, but at the time I was so shocked by this reaction that I left, started at a new school and resolved never to disclose my status at school again…But the discrimination continues, as I recently discovered I need a blood test to study at university and that travel restrictions apply in many countries around the world, which will effect my education. I will overcome these obstacles, but most HIV-positive children will not…The social stigma of HIV is an unacceptable barrier to empowering HIV-positive youth. It impacts on our ability and willingness to access education, the workforce, and health systems. Children with HIV deserve the same rights and opportunities as everyone else. You must ensure young people living with HIV have their voices heard."

Stephanie Raper, a high-school age student in Australia born HIV-positive, made this presentation during the civil society interactive hearing at the United Nations High Level Meeting on AIDS, June 10, 2008.

Goal:

The ELCA will join government, the private sector, and members of civil society in taking action that will lead to the elimination of stigma and discrimination against individuals who are HIV-positive. The ELCA seeks, in all of its expressions, to become a safe space where people living with HIV are empowered, their human dignity respected, and their many gifts to the community are welcomed.

Actions:

1. Develop contextually appropriate HIV and AIDS educational programs for congregations that
   a. take into account the experiences of specific groups of individuals, such as individuals over age 50, youth, men who have sex with men, and communities of color;
   b. equip members, rostered and lay leadership, parents, and youth and young adults, to talk theologically and practically about HIV and AIDS, drug use, human sexuality, and sexual orientation; and
   c. address explicitly stigma and discrimination, including its connections to race, class, gender, and sexual orientation.
2. Coordinate efforts to eradicate HIV-related discrimination and stigma with the other HIV and AIDS-related educational efforts outlined above in this document.
3. Encourage participation by rostered and lay leaders, including bishops, in activities to raise awareness and dispel stigma, such as:
   a. public acts of repentance for prior acts of stigmatization and discrimination against individuals living with HIV; and
   b. public HIV testing.
4. Incorporate this church's commitment not to engage in illegal discrimination based on HIV status into the ELCA Human Resources 1) semi-annual review of ELCA churchwide employment policies; and 2) regular reports to the ELCA Church Council.[119]
5. Serve, through ELCA Human Resources, as a resource for synods and congregations that wish to conduct a similar review of their human resources policies.
6. Learn from and with member churches of The Lutheran World Federation as they address in their own contexts subjects relating to sexuality and other social, cultural, religious and economic factors that contribute to the stigmatization and exclusion of people living with HIV.
7. Take strong action—both bilaterally with companion churches and multilaterally through The Lutheran World Federation—to eliminate stigma and discrimination against people living with HIV in all aspects of church and community life.
8. Involve individuals living with HIV and AIDS in all aspects of the life of the church.
9. Encourage the congregations, synods, churchwide organization, social ministry organizations, and other related agencies and institutions of the ELCA, in cooperation with The Lutheran World Federation and its member churches, to create mechanisms to share "best practices" in eradicating stigma and discrimination.

Called to Walk with Companion Churches and Partners in Other Countries

The ELCA's core commitments inform its HIV and AIDS work with companion churches in other countries and with other international partners. Yet the ELCA's global engagement is specific to the mission context of each companion. The following goals and actions reflect both the ELCA's core commitments and what it has learned over the past quarter century from its work with global companions.

Engagement with Global Companions and Partners: The ELCA will engage with companions in other countries with mutuality and respect, just as it is committed to living out the

[119] People living with or affected by HIV and AIDS should be involved in this review at least annually.

accompaniment model for mission in its domestic engagement.[120] Accompaniment means recognizing the assets, the wisdom, and the vision that companions in other countries and the ELCA bring to a common response to HIV and AIDS. It means building relationships that are characterized by intentional and active learning, which is marked by an awareness of and sensitivity to differences in culture and experience. This learning builds up the capacity of both companions to engage in God's mission of reconciliation and the restoration of community. Such learning is both two-way (between the ELCA and an individual companion), and multilateral, with new learning shared among companions in the wider community of churches. Accompaniment means encouraging, supporting, and challenging the other as companions determine together how best the church can respond in particular situations. In its HIV and AIDS response, the ELCA will respect the calling of companion churches to shape the HIV and AIDS response within their specific context for ministry.

> On a late February afternoon, a frail 22-year-old woman who had both AIDS and malaria was lying on a small mat outside her family's home in Munene, a village in Mozambique. Each day Linda was visited by church caregivers, who sometimes were able to bring food to her very poor family. These caregivers are part of our global church's response to HIV and AIDS, which the ELCA supports through the World Hunger Appeal.
>
> Gaunt and weak, Linda was helped to sit up, and the visitors inquired how she was doing. "I am hungry," she said. Her body was wracked by two deadly diseases, but what she felt most acutely—and what was making her fight against these diseases so difficult—was the lack of food. Linda's words give voice to the tragic interweaving of poverty and AIDS that is a fact of daily life for so many throughout the world. Any effective HIV and AIDS strategy must address this reality.

Goal:

The ELCA's engagement with global companions in the effort to overcome HIV and AIDS will reflect this church's commitment to accompaniment in mission and mutual learning.

HIV and AIDS, Poverty, and Sustainable Development:. Poverty and exclusion make communities and individuals more vulnerable to HIV and AIDS, and HIV and AIDS increases the impoverishment of already poor communities. This is the day-to-day experience of many ELCA companion churches and international partners. The ELCA shares with its global companions a commitment to develop HIV and AIDS responses within the context of engagement with impoverished communities through both community-based sustainable development and advocacy with governments to achieve the U.N. Millennium Development Goals.

Goal:

The ELCA will coordinate and integrate its HIV and AIDS response with its ongoing sustainable development efforts, expressing the commitments, values, and priorities that guide its wider sustainable development efforts.[121]

Actions:

1. Give priority to people and communities that are most vulnerable and underserved, including:
    a. people living with HIV and AIDS who also live in poverty;
    b. marginalized women and girls;
    c. vulnerable children/orphans;
    d. communities that have inadequate access to health care and other services; and
    e. key populations at higher risk, including injection drug users, sex workers, and men who have sex with men.
2. Support holistic responses with groups and communities living with HIV as they address factors that contribute to their vulnerability: access by impoverished communities to health care and treatment, food security, job creation and income generation; empowerment (especially of women); and advocacy.
3. Take an asset-based approach to small-scale, community-focused activities, in order to recognize the gifts individuals and communities bring to developing sustainable solutions vis-à-vis HIV and AIDS and building hope for the future.
4. Address power and gender roles that contribute to the disempowerment of women, recognizing the role religious organizations have in creating cultures that work to redefine gender roles and responsibilities.
5. Give priority to activities that build the capacity of groups, communities, and churches to respond more effectively to the AIDS crisis and leverage long-term change.
6. Engage in rights-based advocacy, calling on governments to assume their rightful role in securing justice for individuals and communities within the context of access to health care and poverty reduction.
7. Build capacity with companions through knowledge-based planning, monitoring, and evaluation, developing clear timelines and measurable outcomes.

The Lutheran World Federation: The ELCA is committed to learning from and with companion churches of The Lutheran World Federation and participating both in the communion's engagement with people living with HIV and AIDS and its processes of biblical and theological reflection that will lead to

[120] See "Global Mission in the Twenty-first Century: A Vision of Evangelical Faithfulness in God's Mission," (*www.elca.org/~/media/Files/Who We Are/Global Mission/GlobalMission21.pdf*).

[121] A description of these commitments can found in ELCA Global Mission's policy documents: *Development; Health Ministry; Principles and Commitment to Human Rights; Commitment to Women; South-South Strategy* (*http://archive.elca.org/globalmission/policy/index.html*).

transformation and engagement in the world.[122] The ELCA also participates in the LWF's engagement of its member churches in intensified awareness building, strategic planning, sharing of financial and human resources, leadership development, prayer, and mutual support. Multilateral Lutheran engagement throughout The Lutheran World Federation is in the "first circle" of global engagement in the ELCA's HIV and AIDS response.

Goal:
As a member church, the ELCA will contribute to the strengthening of The Lutheran World Federation's HIV and AIDS response.

Actions:
1. Give priority in the ELCA's HIV and AIDS response to multilateral engagement through The Lutheran World Federation within the context of the ELCA's wider ecumenical commitments.
2. Coordinate the ELCA's HIV and AIDS response with that of other Lutheran churches from both the global North and South in the context of the LWF.
3. Engage in efforts to articulate a common vision and an integrated plan of action that reflects a common Lutheran identity, which will be lived out in very different contexts (that reflect different customs, cultures, relationships with government, church size, and historical relationships).
4. Participate in the LWF efforts to identify and maximize assets of the global Lutheran system (e.g., major health care systems, human resources, grassroots congregational, regional and international structures).
5. Make the ELCA's assets—including its relative wealth and its access to powerful government, business, health, and educational institutions—available in the communion-wide HIV and AIDS response.
6. Participate in the LWF efforts to:
   a. build plans for strategic engagement that are based on accurate, comprehensive, and country-specific assessment of the situation in which member churches operate, the current capacities of these churches, and their potential capabilities to engage in HIV and AIDS ministries separately and in partnership with others in civil society and government;[123]
   b. build the capacity of the LWF-member churches to shape ever more effectively their HIV and AIDS response and leverage the maximum positive change;
   c. identify and develop regional and cross-regional processes for sharing best practices, especially those that utilize a rights-based approach that seeks movement from relief to empowerment to transformation;
   d. strengthen the churches' role vis-à-vis governments within the context of civil society relationships in their countries and increase their capacity to access the financial, informational, and institutional resources available from governments and other institutions;
   e. strengthen the capacity of the LWF as an international and regional actor to engage with the UN, governments, and international organizations in rights-based advocacy, in efforts to secure access to health care services for vulnerable populations, in service provision (where appropriate given the local context), and in integrated community-based development that addresses the context in which HIV and AIDS flourishes;
   f. develop and implement strategies and programs in a participatory manner that is open to new knowledge and scientific research and is shaped by the experience of people living with HIV and AIDS;
   g. support processes of planning, monitoring, and evaluation that are community-based and outcome-oriented in order to facilitate the best choices among many options and the best stewardship of human and financial resources;
   h. develop the capacity of young leaders, especially those living with HIV and AIDS, to shape the church's response; and
   I. facilitate networking among Lutheran churches.

Church-to-Church (Bilateral) Relationships: Engagement with the LWF-member churches with which the ELCA has a church-to-church relationship also is in the "first circle" of the ELCA's international HIV and AIDS response. The same principles that guide the ELCA's multilateral action through the LWF guide its work with individual companion churches. The priorities of these companion churches, which build on their assets and reflect their specific contexts for ministry, guide the development of plans in such areas as: theological and biblical reflection; education and evidence-informed prevention, with a focus on human rights and gender; reduction or eradication of theological, medical, and cultural stigma within churches and within their communities; medical care and treatment for those living with HIV and AIDS (in particular where companion churches have church-related health care systems); village- or community-based health programs; palliative care; care for orphans and vulnerable children; rights-based HIV and AIDS advocacy with their governments and other institutions; leadership development; and integrated sustainable development, including income generation.

"You bait fish with what you know the fish would like to eat." This African saying describes why the Lutheran Communion in Southern Africa (LUCSA) has made computers the core of an innovative HIV and AIDS prevention program for youth and children. Info-hut provides computer access in the context of a local tradition, a special African hut that traditionally provided the

[122] See "Compassion, Conversion, Care: Responding as churches to the HIV and AIDS pandemic," An Action Plan of the Lutheran World Federation, January 2002 (*www.lutheranworld.org/What_We_Do/HIV-AIDS/LWF-HIV_Aids.html*).
[123] For example, the recent multi-country Malaria and HIV and AIDS assessment of the Lutheran Communion in Southern Africa which will provide the foundation for strategic action in that region in the coming decade.

place in a village where young and old could gather to share wisdom and information.

The Info-hut is a simple structure outside a school that is equipped with computers. Children and youth, who don't have access to computers, vie for the opportunity to learn to use them. But with every key stroke, they also learn about HIV and AIDS. Some students receive more intensive training and then teach their peers both basic computer skills and about HIV and AIDS. After school hours, Info-hut is also open to the community. Modest access fees make the project sustainable.

Goal:

The ELCA will intensify bilateral engagement with companion churches addressing HIV and AIDS within the context of its commitment to The Lutheran World Federation, in order to maximize coordination and minimize duplication of efforts.

Actions:

1. Support companion churches as they develop ministries of accompaniment and advocacy that will bring the church closer to people living with HIV and AIDS and bring people living with HIV and AIDS closer to the church.
2. Recognize the mutual challenges to both companions involved in accompaniment, encourage mutual transformation of attitudes related to HIV and AIDS, and build the capacity of both companions to speak truthfully about issues central to the HIV and AIDS pandemic, including gender relations and traditional gender norms, sexual practices, violence, and the danger of silence.
3. Support companion church efforts to identify areas of synergy with governmental and non-governmental organization (NGO) infrastructures for prevention and awareness building, care, treatment, and advocacy within their country in order to avoid duplication of efforts.
4. Work with companion churches as they create strategic plans that clarify the specific roles and niches in which they wish to play within the existing in-country infrastructures.
5. Coordinate HIV and AIDS activities with other health programs of companions and with other health initiatives (e.g., malaria).
6. In responding to war and conflict, include HIV prevention and the social protection of women and girls as a priority.
7. Expand engagement with companions in HIV and AIDS and malaria response:
   a. Mobilize additional financial resources through a U.S.-based fundraising campaign that highlights cooperation with companion churches and the LWF as they address diseases whose impact is intensified by poverty, specifically HIV and AIDS and malaria; and
   b. Encourage, through the ELCA Companion Synods Program, engagement with companion churches that emphasizes two-way accompaniment and learning.

Ecumenical Engagement: The ELCA will seek to engage in HIV and AIDS response in cooperation with other churches. This posture reflects the ELCA's deep theological and ecclesiological beliefs. It also recognizes that, in terms of impact and effectiveness, "we're stronger together than separately." This is true both within local communities and at global tables, where governments and international organizations plan and act. Churches, which are at the same time grass-roots, regional, national, and international, can make an even greater contribution to the human community's HIV and AIDS response when they work together—and through their actions give a united witness to God's reconciling and restoring love.

Goal:

The ELCA's HIV and AIDS engagement will reflect this church's commitment to strive for unity within the broader body of Christ in the world and be oriented toward ecumenical engagement wherever possible and practical.

Actions:

1. Encourage and support companion (Lutheran) churches as they engage with other churches or councils of churches in advocacy and in prevention, treatment, and care.
2. Build upon the groundbreaking theological reflection that has been done within the wider ecumenical community and be an enthusiastic participant in future studies.
3. Seek opportunities to develop, with Lutheran and ecumenical partners, common strategies relating to the Global Fund to Fight AIDS, Tuberculosis, and Malaria and other entities in order to make additional external funding available to churches; and seek to "use resources to leverage resources" in creative ways.
4. Utilize and build on the programs on positive masculinities and young women's leadership, such as those developed by the World Council of Churches and the World YWCA.[124]
5. Intensify engagement with ecumenical partners in rights-based advocacy relating to HIV and AIDS and poverty vis-à-vis the U.S. government, international organizations, and NGOs and foundations.
6. Build capacity in partnership with ecumenical alliances and networks:
   a. through analysis of existing responses and strategies, exploration of recent research and emerging technologies, and identification of best practices; and
   b. through the "mapping of assets"—in particular health assets—within Lutheran and ecumenical systems.

Sub-Saharan Africa and Other Regions: As noted above, Africa bears a disproportionate burden in the HIV and AIDS crisis. Almost three-quarters of those deaths worldwide in 2007 occurred in Africa, and over 67 percent of people living with HIV reside in the sub-Saharan region. The impact of this disease in Africa is pervasive: "In the countries most heavily affected,

[124] See "If I Kept It to Myself: women intervene in a world of AIDS," World YWCA, The Global Coalition on Women and AIDS, 2006 (*www.worldywca.info/index.php/ywca/world_ywca/communications/resources/if_i_kept_it_to_myself*).

HIV has reduced life expectancy by more than 20 years, slowed economic growth, and deepened household poverty. In sub-Saharan Africa alone, nearly 12 million children aged less than 18 years have become orphans as a result of the pandemic. The natural age distribution in many national populations in sub-Saharan Africa has been dramatically skewed by HIV, with potentially perilous consequences for the transfer of knowledge and values from one generation to the next."[125]

The response of Lutheran churches in Africa to HIV and AIDS has taken many forms. Given its grassroots structures and its historic focus on education, churches have engaged in prevention activities through a range of activities, from congregational information sharing to community education initiatives. From the early years of mission engagement in sub-Saharan Africa, however, health care has been a major focus of the partnership between partners from the global North and the emerging churches in the region. Some African churches (e.g., in Tanzania, Cameroon, and Madagascar) have extensive church-related health systems; others operate individual hospitals and clinics and/or engage in village education (e.g., Liberia and Central Africa Republic). Such health-related institutions and structures are a strong foundation for action related to HIV and AIDS in Africa, providing both medical care and treatment and the means for community-based prevention activities.

At the same time, the care of families living with HIV and AIDS and of orphans left to fend for themselves has been a significant focus for churches. The response to orphans has ranged from the provision of basic food needs (e.g., in Malawi) to more holistic responses to orphans and vulnerable children that include advocacy to protect their rights, training to assist child-headed households to generate income, education about HIV and AIDS to prevent these children from contracting HIV, and group empowerment in community (e.g., in Uganda). The sheer numbers of children orphaned by AIDS and their relationships in communities where congregations worship and serve has made the care and support of children orphaned by AIDS a priority for many churches in Africa.

The ELCA has learned much from its engagement with companion churches in Africa through the continuation of health and other ministries and through the expansion of HIV and AIDS projects supported since 2001 by the ELCA's Stand With Africa campaign. In April 2008, the ELCA Church Council affirmed initial plans to develop a major campaign, in partnership with Lutheran World Relief, The Lutheran Church–Missouri Synod, and the United Nations Foundation, that would continue the ELCA's commitment to awareness building, advocacy, and fundraising relating to HIV and AIDS and also provide a second focus on malaria. The campaign will continue as separate, but deeply interrelated, commitments of this church.

Even as it works with companion churches in Africa, the ELCA continues to engage in strategic planning with companion churches in other regions, as they respond to HIV and AIDS in the widely varying situations in which they do ministry. Outside of sub-Saharan Africa, relative priority is given to work with companion churches in situations of economic poverty and in situations where engagement can help contain the rapid spread of HIV and AIDS (e.g., India, Indonesia, Papua New Guinea, Russia, and Haiti).

> In Tanzania, some Lutheran churches are supported in their outreach to orphans and other vulnerable children by the American people. Through the President's Emergency Plan for AIDS Relief (PEPFAR), U.S. taxpayers are supporting programs like the Continuum of Care for People Living with HIV/AIDS in Tanzania (CHAT), which was granted $5 million in 2006 for three years of programming. CHAT provides holistic, home-based care for adults and children living with AIDS and critical services for orphans and other vulnerable children in need of basic services like school supplies, bedding materials, and nutritional support. Working through the congregations and dioceses of the Lutheran church in Tanzania, CHAT has supported more than 1600 children since August 2008.

Goal:

The ELCA will seek to walk faithfully with companion churches most affected by the HIV and AIDS crisis, with a special focus on engagement with companions in sub-Saharan Africa.

Actions:

1. Direct the preponderance of ELCA global HIV and AIDS response to engagement with companions in sub-Saharan Africa, given the disproportionate impact of the pandemic on that continent, the relative poverty of many of the churches in the region, and historical relationships with companion churches in Africa.
2. Shape this church's HIV and AIDS response with companions primarily in Africa, but also in other regions of the world, in ways appropriate to the conditions of economic poverty in which their members live.
3. Support companions engaged in health programs as they seek to coordinate HIV and AIDS response into all aspects of care—from health education to palliative care.
4. Seek coordination among various health initiatives, including those relating to HIV and AIDS, malaria, and tuberculosis.
5. Support companion churches, other partners, and The Lutheran World Federation in their outreach to children orphaned by AIDS as they assist these children to secure the basics of life, to maintain their rights, and to shape their own future.

Faith-based Organizations, Civil Society, and Government: Since God works through both the Church and the structures of society to provide for human welfare, the ELCA also engages in HIV and AIDS work through inter-faith relationships, community-based organizing, work with non-governmental organizations, and creative and critical dialogue with

[125] "2008 Report on the Global AIDS Epidemic," op. cit., p. 13.

governments and international organizations. The ELCA approaches its international HIV and AIDS work with both humility and confidence, seeking to answer the question: How best can the ELCA—and the wider Christian community—contribute to the HIV and AIDS work of the wider global community of which it is a part? A key contribution, rooted in its identity as church, is casting the vision of the justice God requires for those living with HIV and AIDS and engendering the hope for the future that springs from that vision. The unique "added value" that the church brings to the HIV and AIDS pandemic springs from its biblical and theological reflection and is rooted in its pastoral response.

It is from this perspective that churches engage in HIV and AIDS work with others in civil society, businesses, and government, bringing the strength of their grass-roots, regional, national, and international networks to the common effort to reduce stigmatization against people who are HIV-positive. They join in community education and prevention, health care, and integrated sustainable development work. They also engage with others in civil society in shaping through advocacy the wider societal response to HIV and AIDS and holding governments accountable to the people they serve.

Goal:

The ELCA will seek to be a strong, competent, and faithful partner with others in civil society through common or complementary responses to HIV and AIDS and creative and critical engagement with governments and international organizations.

Actions:

1. Work with governments and international organizations, hospitals and universities, other non-profits, foundations, and corporations, and a diversity of religious groups, as they listen to those living with HIV and AIDS and fashion creative and integrated responses to the pandemic. Such engagement will build on the strengths of these institutions, avoid duplication of efforts, and seek to develop a common vision and concrete goals for action.
2. Engage with secular and religious organizations, such as the Ecumenical Advocacy Alliance (EAA) and UNAIDS, in calling the governments of the world to accountability for providing and appropriately directing funding and other support, with a focus on universal access to health care and ARVs. Through such engagement, the ELCA will be committed to bringing to light inequities and calling for justice for all those living with HIV and AIDS, whether in wealthy or in impoverished communities.
3. Continue to work through The Lutheran World Federation, Lutheran World Relief, Church World Service, the World Council of Churches, and other partners as they address HIV and AIDS through rights-based engagement with communities in sustainable development.

Called to Advocate for Justice

The call to be a public church and engage in public policy advocacy on the critical issues of our time is a central priority for the Evangelical Lutheran Church in America (ELCA) and one of the many ways the ELCA participates in God's mission in the world. As stated in the 1991 social statement, "The Church in Society: A Lutheran Perspective," the ELCA is called to:

> …work with and on behalf of the poor, the powerless, and those who suffer, using its power and influence with political and economic decision-making bodies to develop and advocate policies that seek to advance justice, peace, and the care of creation.[126]

The Lutheran tradition has long viewed government as a vital instrument through which the common good can and should be served. Recognizing this and urging a robust response from government at all appropriate levels to the AIDS crisis both at home and abroad should be, therefore, a critical component of this church's HIV and AIDS strategy.

National governments throughout the world are called upon and have committed to providing the leadership necessary within their respective countries to address HIV and AIDS aggressively with the goal of achieving universal access to prevention, treatment, and care by 2010. The U.S. government, at the federal, state and local levels, has the clear responsibility to provide for its own citizens who are living with and affected by HIV and AIDS. At the same time, as previously outlined, the federal government is playing a leading role in the international response to HIV and AIDS worldwide through the President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund. In addition to the direct service and education of its members, the ELCA has a fundamental responsibility to engage its members in effective public policy advocacy with and on behalf of those most severely affected by the HIV pandemic.

In order to leverage the Lutheran voice with and on behalf of individuals living with HIV and AIDS and key populations at higher risk of becoming HIV-positive, members of the ELCA are encouraged to join the ELCA advocacy network. By signing up at *www.elca.org/advocacy*, ELCA members will receive timely alerts on a broad range of social justice issues, including the U.S. government's response to the HIV pandemic at home and abroad. It is through these alerts that the ELCA engages its members in effective advocacy actions through letters, phone calls, meetings, lobby days, and conferences.

In order to support and encourage a robust response on HIV and AIDS from the U.S. government (federal and state), corporations, and the United Nations, the ELCA will prioritize the following goal and actions.

Goal:

The ELCA will join others in civil society in seeking to ensure that governments and corporations do their part to achieve the goals of the wider human community:

[126] "The Church in Society: A Lutheran Perspective" (*www.elca.org/What-We-Believe/Social-Issues/Social-Statements/Church-in-Society.aspx*).

1. To halt the spread of HIV through effective prevention, treatment, and care.
2. To eliminate the stigma and discrimination experienced by those who are HIV-positive.
3. To reduce the conditions of poverty and marginalization that contribute to the spread of HIV.

Global Actions:

1. Continue and increase engagement in global structures of the United Nations (such as UNAIDS), the Global Fund to Fight AIDS, Tuberculosis, and Malaria, the Ecumenical Advocacy Alliance (EAA), and The Lutheran World Federation (LWF).
   a. Advocate for increased funding to be made available for faith-based groups and churches.
   b. Integrate this strategy with the LWF's plan of action.
   c. Continue collaboration and advocacy with corporations and the professional communities represented at United Nations meetings.
   d. Continue collaboration and advocacy with corporations and the professional communities represented at the International AIDS conferences.
   e. Advocate with national governments and international institutions to keep promises made to address AIDS and achieve the Millennium Development Goals (MDGs).

Actions Relating to the Federal Government (International):

1. Continue and enhance advocacy for full funding of the U.S. PEPFAR authorization in each annual appropriations process, including the full appropriation for the Global Fund.
2. Continue to work to improve PEPFAR policies as they related to prevention, treatment, and care with a special emphasis on orphans and vulnerable children, women-led prevention methods, and strengthening of health systems.
3. Advocate with Health and Human Services (HHS) and Homeland Security departments for new HIV-travel policies that meet the human rights standards set by the United Nations.
4. Continue engaging Lutherans in advocacy for the United States' fair-share contributions toward the MDGs, including improved, poverty-focused aid, debt cancellation, and fair trade.
5. Work in collaboration with LWF to increase the number of Lutheran ministries receiving Global Fund funds and with ELCA Global Mission and partners to increase the number of Lutheran ministries receiving PEPFAR funds.

Actions Relating to the Federal Government Actions (Domestic):

1. Advocate for the development of a comprehensive national AIDS strategy that reflects the needs of all affected communities.
2. Advocate for full funding of the Ryan White HIV/AIDS Treatment Modernization Act in the annual appropriations process and for the provisions of Medicare and Medicaid and other programs that support those living with HIV and AIDS.
3. Advocate for the passage of the Early Treatment for HIV Act (ETHA).
4. Advocate for sensible, comprehensive, and effective prevention programs, with a special focus on those groups most affected. These prevention programs should address the unique contextual factors in the African American and Latino communities that render these populations more vulnerable to HIV.
5. Advocate for comprehensive sex education.
6. Coordinate and collaborate with LANET.
7. Advocate for equitable access to health care.
8. Advocate for government measures that support and encourage routine, voluntary HIV testing with appropriate counseling in health care settings.
9. Advocate for repeal of the federal funding ban on needle and syringe exchange.

Corporate Social Responsibility Advocacy Actions:

1. Advocate with corporations to provide personnel policies and practices that end stigma and discrimination in the workplace.
2. Advocate with corporations to provide access to awareness programs, counseling, testing, and treatment for all employees.
3. Advocate with corporations in order to assure universal access to essential medications.
4. Advocate with pharmaceutical companies for affordable and accessible medications designed for children.
5. Advocate with corporations to avoid challenges to a government's full implementation of the TRIPS agreement.[127]
6. Advocate with corporations to support and participate in the United Nations efforts for access to medicines and the proposed "Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines."

> "ELCA Corporate Social Responsibility has been part of a coalition of faith-based organizations that have been in continued dialogue with the pharmaceutical company Merck. This dialogue seeks to ensure expanded availability of life-saving HIV drugs especially for children, particularly in Africa. Over the last few years, we have helped pharmaceutical companies to understand their efforts that respond to the HIV and AIDS crisis not as philanthropy, but as a part of their business model."
>
> *Pat Zerega, director for ELCA Corporate Social Responsibility*

[127] The World Trade Organization adopted a Declaration on the TRIPS [Trade-Related Aspects of Intellectual Property Rights] Agreement and Public Health in November 2001 which affirms the right of countries to allow someone else to produce the patented product or process without the consent of the patent owner or determine whether they face a national public health emergency which would permit the use of generic drugs. (www.wto.org/english/tratop_e/trips_e/factsheet_pharm00_e.htm), (www.wto.org/english/tratop_e/trips_e/public_health_faq_e.htm).

State Public Policy Advocacy Actions:
1. Advocate for full funding of national and state programs that provide resources to address HIV and AIDS.
2. Advocate for sensible, comprehensive and effective prevention programs, with a special focus on those groups most affected. These prevention programs should address the unique contextual factors, including poverty, in the African American and Latino communities that render these populations more vulnerable to HIV.
3. Advocate for comprehensive sex education.
4. Coordinate and collaborate with LANET and relevant program units of the ELCA.
5. Advocate for equitable access to health care.
6. Advocate for government measures that support and encourage routine, voluntary HIV testing with appropriate counseling in health care settings.
7. Collaborate with AIDS networks at the state level.

Called to Build Institutional Capacity and Make Strategic Choices

The ELCA, like companion churches in other countries, is not an extension of government or an international organization, hospital, or other institution; it is not a multinational corporation or the World Bank. Though there is a temptation to try to "do it all," the ELCA, in both its domestic and global HIV and AIDS response, needs to keep in mind who—and whose—it is: a community called into being by a loving God to seek reconciliation and the restoration of community, both within the church and in the wider world. At the same time, the ELCA recognizes that God works through other structures and institutions in society to create the context in which humans can live together in peace and dignity. With humility, the ELCA recognizes that other institutions do many things to address HIV and AIDS more appropriately and more effectively than it does; it is committed to not "reinvent wheels" that already are turning or duplicate efforts that can and should be done elsewhere in the society.

As the ELCA—along with its companion churches—responds to HIV and AIDS, all benefit from a clarity of purpose vis-à-vis other institutions in society, and, in particular, governments. While there will be times when churches "step into the gap" to save lives, churches must not, by their action or lack of action, acquiesce to a government's abdication of its responsibilities to those with HIV and AIDS.

Given the complex global HIV and AIDS response system and the ELCA's commitment to accompany companion churches in mission, the ELCA does not occupy a simple "niche" in its international HIV and AIDS response (e.g., a singular focus on a specific type of care). The ELCA walks with companion churches, listens to them, and shapes its response to reflect their mission priorities within their specific context, which differs widely from region to region, and country to country.[128]

Domestically, the ELCA's response also will be multifaceted. It will develop a strategic response, in collaboration with its partners, to address those key populations at higher risk of becoming HIV-positive. As such, this church continually must make strategic choices as it balances its efforts between those populations at higher risk of becoming HIV-positive and its members, some of whom also may be members of populations at higher risk of becoming HIV-positive. In particular, this church's response will be attentive to the generalized epidemic among African Americans in this country.

Goal:

In making strategic choices among the many "good things" that could be done in HIV and AIDS response, the ELCA will act in ways: 1) that are appropriate to its role as a church and its understanding of God's mission; 2) that strengthen its own institutional capacity to respond effectively; and 3) that wisely steward financial and human resources in order to leverage the greatest positive change.

Actions:
1. Strengthen the institutional capacity of the ELCA to encourage theological reflection and bold action in response to HIV and AIDS:
   a. Create the necessary opportunities and mechanisms that will enable all expressions of the ELCA to engage in the implementation of this strategy;
   b. Develop the capacities of the ELCA as a church system[129] to plan, monitor, and evaluate the effectiveness of its HIV and AIDS efforts over time;
   c. Encourage continuous learning and the sharing of best practices, both within the church as a whole and within its various parts; and
   d. Provide staff, funding, and institutional support that will enable the churchwide organization and its program units to engage creatively with synods, congregations, and church-related agencies, institutions, and networks in order to:
      1. assist them as they develop targeted plans that strengthen their capacity to live out the ELCA's vision and commitments in their specific calling or context for ministry (e.g., training church leaders, youth engagement, congregational engagement);
      2. develop program and resources that build on best practices; and
      3. coordinate and communicate effectively among the many groups within the ELCA system that are part of this strategy.

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[128] Diversity of response: Global Mission (GM) works with companions to assess the capacity to implement HIV and AIDS work and to determine appropriate levels of mutual cooperation. For example, for companions that have strong organizational and personnel capacity, GM's role may be to provide a grant. In other instances, GM may assist in long-term capacity building. In countries where companions have the opportunity to apply for funding from major international funders, GM may work with them to build up their management and financial capacity so they can become recipients of external funding.

[129] The ELCA's "church system" in this context is understood to include its three expressions (congregations, synods, and the churchwide organization), plus related agencies, institutions, and related networks.

2. Direct human and financial resources where:
   a. the ELCA domestically and in partnership with companion churches in other countries has the capacity—or can build the capacity—to do what is needed effectively and in ways that express its identity as church;
   b. there is energy and a desire to engage in HIV and AIDS response in ways that have the potential to transform the church and/or the wider society and to move from a relief to empowerment mode in HIV and AIDS response;
   c. action by the ELCA or its companions and partners can fill a gap in HIV and AIDS response and where other external partners are not engaging;
   d. the ELCA and its partners and companions can optimize their assets, generate additional resources from other sources, and leverage the maximum systemic change;
   e. "best practices" are shared among churches and partners, regionally and among regions, through use of appropriate technology and the building of ongoing personal and institutional relationships;[130]
   f. the ELCA can strengthen existing networks (e.g., domestic and international ecumenical and interfaith networks, networks of companion churches developed through the LWF regional offices);
   g. there is a commitment to common planning, monitoring, and evaluation within the context of mutual accountability; and
   h. common efforts express a commitment to holistic wellbeing or where there are pre-existing connections to cooperative sustainable development initiatives.

Conclusion

An effective churchwide strategy will move the ELCA from an episodic to a strategic response to the HIV and AIDS crisis and is built on the assumption that the ELCA's response will be "both/and":

1. Both local and global: lived out in congregations and local communities even as it is lived out through the engagement of the wider church with companion churches and international partners, with learning flowing back and forth, from one sphere to the other;
2. Both individual and corporate: involving person-to-person engagement as well as the learning that happens when the church and its agencies engage in cooperative efforts with other institutions in society;
3. Both theological and practical: rooted in study of Scripture and reflection on God's will as well as in the experience gained through engagement with those living with HIV and AIDS, people living in poverty, experts in the field, and individuals and institutions with experience in building up communities;
4. Both inward-focused and outward-directed: as the church seeks within its membership to "become what it is called to be," even as it is propelled outward to seek justice and restoration of community in the wider world.

This churchwide HIV and AIDS strategy acknowledges that the reality of AIDS in the 21st century demands strong action. Indifference or a shallow response is not an option if the church is to be faithful to its calling. This strategy builds upon past actions and lessons learned. It details how to bring to bear the strength of all parts of the ELCA system in strategic ways that will contribute to and encourage a more effective domestic and global response by this church and by government and other members of civil society. It is a strategy that is rooted in hope and joyful confidence that this church will be transformed and energized for this task through its ongoing encounter with the living Christ in Word and Sacrament and with those affected by HIV and AIDS, in whose faces this church recognizes the face of Christ.

[130] An asset for the ELCA is the sheer number of relationships with companions, which give it the opportunity to see the wide variety and quality of HIV and AIDS program ministries. The ELCA, working with LWF, is in a good position to provide the fora for sharing best practices among companions, plus opportunities for short-term training and other activities through which learnings can be shared among companions and capacity built.

Appendix A: AIDS and the Church's Ministry of Caring

In the presence of the human suffering, anxiety and tragedy in the AIDS crisis, we commit ourselves anew to the ministry of caring. The Church Council of the Evangelical Lutheran Church in America (ELCA) recognizes with gratitude the service of those who care for people with AIDS and their loved ones. It urges church members to support this ministry and to serve those who are suffering with respect and compassion.

AIDS (acquired immune deficiency syndrome), often with an intensity greater than many diseases, calls us to remember our common humanity. The suffering of persons with AIDS demonstrates anew that life for all is vulnerable, limited, and broken, yet also graced with courage, hope and reconciliation. As a disease that affects women, men and children around the world, it shows how closely we are bound together in relationships of mutual trust, need and responsibility.

The church's ministry of caring is a grateful response to God's caring for us. The undeserved love of God announced for all in the Gospel of Jesus Christ is our reason for standing with our neighbor in need. Jesus responded graciously to persons who were sick without assessing their merit. In the same way we are called to "be Christs" for all in our midst who suffer and are ill. Our calling summons us to compassion for, acceptance of and service with people affected by AIDS both within and outside of our congregations.

This ministry of caring requires that we be well-informed about the nature of AIDS. We urge our members to read the Surgeon General's brochure "Understanding AIDS," and we encourage our congregations to discuss the subject in their educational programs. Knowledgeable and sensitive Christians are needed to help counter the prejudice and injurious discrimination that people with AIDS experience. Wise and informed people are needed to participate in the complex public policy debates surrounding the disease.

This ministry of caring challenges us to support efforts in the churches and in the wider community that serve those with AIDS, their friends and families. We will continue to encourage nurses, doctors, caregivers and pastors who witness to God's grace in their daily ministry with people with AIDS.

This ministry of caring embraces the hospitality of our congregational life, whose center is worship. There through Word and Sacrament the Holy Spirit offers to all the comfort and the hope of the victorious God of the cross. There persons who suffer come to know that they are not forgotten, since God cares. There we participate in the concerns and care of the sick through prayer, the laying on of hands and services of healing. United by baptism, all are invited to receive the touch of care. "Welcome one another, therefore, as Christ has welcomed you, for the glory of God" (Rom 15:7).

"AIDS and the Church's Ministry of Caring,"
affirmed by the Church Council on November 13, 1988

Appendix 2: 2007 Churchwide Assembly Action (CA07.03.12)

CA07.03.12

1. To commit the Evangelical Lutheran Church in America to a deeper engagement in addressing the AIDS pandemic through the development of a churchwide strategy for action in the coming decade, which will:
   a. build on the experience and commitments of the past and the strength of ELCA congregations, synods, churchwide structures, institutions, and agencies;
   b. utilize the best thinking of ELCA experts, practitioners, congregational leaders, related institutions and agencies, and people living with HIV and AIDS, as well as ecumenical and global companions, in the development of this strategy;
   c. express the ELCA's commitment to work in cooperation with the Lutheran World Federation and in tandem with ecumenical partners both in this country and throughout the world;
   d. express the ELCA's commitment to engage proactively with others of good will in civil society and in government as they respond to the AIDS crisis; and
   e. continue to move from crisis management to a more integrated, effective, and sustainable long-term response to the AIDS pandemic;
2. To express the solidarity of the ELCA with all people who are living with HIV and AIDS and with their families, both in this country and throughout the world:
   a. recognizing and giving thanks for the gifts, skills, and experience that people living with HIV and AIDS bring to addressing the pandemic and committing this church to work closely with them in its response;
   b. rejecting categorically the stigma and discrimination that are at times associated with HIV and AIDS;
   c. working to ensure universal access both to compassionate care and to effective treatment and prevention;
   d. engaging in education to prevent the further spread of HIV and AIDS; and
   e. providing a welcome in all aspects of church and congregational life to people living with or affected by HIV and AIDS;
3. To encourage ELCA members, congregations, agencies and institutions, synods, and the churchwide organization, at the same time this strategy is being developed, to:
   a. continue and extend their ministries among and with people living with HIV and AIDS;
   b. pray for people directly affected by HIV and AIDS and for churches, communities, and governments that they may have both the will and the wisdom to act boldly and effectively to address this crisis;
   c. intensify their support for the second-mile "Stand with Africa" campaign as well as the broader World Hunger Appeal, which enable this church to assist companions throughout the world as they respond to the AIDS crisis; and
   d. advocate with the U.S. government, urging it to:
      (1) demonstrate global leadership to achieve agreed-upon international goals, including universal access to treatment, care, and prevention by 2010;
      (2) contribute its proportionate share to fund fully the Global Fund to Fight AIDS, Tuberculosis, and Malaria; and
      (3) abolish the extraordinary requirements that make it difficult and painful for people living with HIV to receive a visa to enter the United States for any purpose, and prohibit discrimination against people living with HIV and AIDS;
4. To convey the deep appreciation of this church:
   a. to all those who provide care and support for those living with HIV and AIDS and those who seek a cure for this disease, in particular those members of this church who live out their Christian vocation as nurses, doctors, health researchers, and care providers;
   b. to ELCA pastors and congregations actively engaged in ministry with people living with HIV and AIDS as they support, counsel, and advocate with them for just and compassionate action in this church and in the wider society;
   c. to all those who have provided financial support to HIV and AIDS research and care, both in this country and throughout the world;
   d. to all those ELCA members whose financial gifts have enabled the ELCA to walk with companion churches in their response to the AIDS crisis, in particular through their "second mile" giving to the World Hunger Appeal's "Stand with Africa" campaign and companion synod action;
   e. to Lutheran social ministry organizations, hospitals, health facilities , and voluntary organizations, including the Lutheran AIDS Network (LANET), that provide assistance to people living with HIV and AIDS as well as leadership in church and society on this issue;
   f. to the Lutheran World Federation, Lutheran World Relief, Lutheran Immigration and Refugee Service, ecumenical agencies (both domestic and global), and others with which the ELCA partners to provide care, address the impact of HIV and AIDS in communities, prevent the further spread of the disease, and advocate

with governments to step up their action in addressing this pandemic; and

g. to companion churches in other countries, with which the ELCA is privileged to walk in ministry, as they respond to often overwhelming human need resulting from the spread of HIV; and

5. To request that the Church in Society and Global Mission program units take the lead in developing this strategy, which will be brought to the Church Council for adoption in 2008 and reported to the 2009 Churchwide Assembly.

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