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“Give Us a Reason to Live. Give Us a Reason to Hope”: HIV and AIDS in Our Time

In January I traveled to South Africa to meet with a group that included thirty-five Christian ethicists, practitioners, and/or persons living with HIV and AIDS. From five continents, we gathered outside Johannesburg for a Theological Consultation on HIV Prevention sponsored by the Ecumenical Advocacy Alliance (EAA). The meeting brought together both lived experience and expertise in an effort to offer our Christian churches resources for speaking about HIV prevention.

One haunting moment for me occurred the first evening we met, listening to a minister from Johannesburg share a recent experience with youth. Because infection rates among youth continue to increase, this minister regularly offers education on HIV when he meets with youth. He explains what causes HIV and counsels them that if they engage in particular actions they will probably get HIV and eventually die. He tells them that if they refrain from these actions they will not get HIV, and they will live. One day a group of male youth he was speaking with stopped him mid-sentence and said, “Look, it’s not enough that you tell us that this action or that will increase our risk of HIV or not. We need more from you. We need a reason to live. We need a reason to hope!” The need for hope, not simply for prevention and treatment of HIV and AIDS, is crucial, and this need also underlines the realities among vulnerable persons today. Anywhere there is a seeming lack of hope is exactly where we are called to be as Christians. In this column I offer a brief update on the pandemic and offer some directions for further action.

Defining Terms

The human immunodeficiency virus (HIV) causes the acquired immune deficiency syndrome (AIDS). By killing (destroying) or impairing cells of the immune system, HIV progressively destroys the body’s ability to fight infections and certain cancers. Persons diagnosed with AIDS are susceptible to life-threatening diseases called opportunistic infections, which are caused by microbes that usually do not cause illness in healthy people.

Statistics

According to the most recent 2007 AIDS Epidemic Update (UNAIDS 2007), an estimated 33.2 million people worldwide were living with HIV. In 2007, there were an esti-
mated 2.5 million new HIV infections and an estimated 2.1 million deaths. Half the persons living with HIV are women (an estimated 15.4 million) and an estimated 2.1 million are children (under the age of 15).

There were approximately 6,800 new HIV infections a day in 2007, and more than 96 percent of these are in low and middle income countries. About 1,200 are in children. Of the 5,800 among adults, almost half are among women and about 40 percent are among young people (ages 15–24).

The region hardest hit is sub-Saharan Africa, where approximately 22.5 million persons are living with HIV. This region accounts for 68 percent of all adults living with HIV, 90 percent of the world’s HIV-infected children, and 76 percent of all AIDS deaths in 2007. AIDS is the leading cause of death in this region.

More locally, in the United States the numbers of persons infected remains at approximately 40,000 new infections a year (Kaiser, “United States”). The large numbers of persons infected in other regions of the world have at times given persons living in the United States the impression that the disease is not a problem here. Nothing can be further from reality. Black and Latino/Hispanic communities are also disproportionately affected. While in 2006 the U.S. population was approximately 66 percent White, non-Hispanic, the number of AIDS cases among this population was 30 percent. In that same year, the Black, non-Hispanic population, approximately 14 percent of the population, accounted for 49 percent of AIDS cases (Kaiser, “Black Americans”). The Hispanic/Latino population, numbering about 15 percent of the population, accounts for 19 percent of AIDS cases in the U.S. (Kaiser, “Latinos”).

**Progress**

Even in the midst of the challenges, there is positive progress. Within the past decade the annual rate of infections appears to have decreased, and the number of AIDS deaths has declined significantly. By 2007 antiretroviral treatment (ART) reached 3 million persons in low- and middle-income countries, approximately 30 percent of those in need. Consistent work in the field has also led to clearer understandings of the various epidemics in countries and regions, thus contributing to efforts to better channel funds and focus and other activities where needed. More persons living with HIV and AIDS (PLWHA) are involved in HIV prevention and treatment efforts. The plight of children is beginning to be addressed. Pediatric medicines are on the increase, and international attention on orphans and vulnerable children (OVC) is beginning to place resources where needed (Kaiser, “Global”). Civil society and governments are recognizing faith-based organizations as valuable contributors to a response to the epidemic.

**Prevention and Treatment**

Yet even as significant progress is being made with treatment and care, prevention remains a challenge. Stigma, gender discrimination, poverty, and socioeconomic inequalities continue to thwart prevention efforts. An excellent resource on stigma is *A Report of a Theological Workshop Focusing on HIV- and AIDS-related Stigma*. Produced by UNAIDS following a gathering of Christian theologians, the problem of stigma is described powerfully: Stigma “implies the branding or labeling of a person or a group of persons as being unworthy of inclusion in human community, resulting in discrimination and ostracization. Branding or labeling is usually related to some perceived physical, psychological or moral condition believed to render the individual unworthy of full inclusion in the community” (11). The stigma related to HIV and AIDS remains a significant factor in men and women choosing not to seek testing for the virus.
While globally the number of infections is decreasing, there are increases most notably in China, Indonesia, Russia and Ukraine, in European Union countries, and in North America. Some of the hardest hit areas are not yet experiencing decreased infection rates (Lesotho, Swaziland, and South Africa), but other regions are seeing efforts working (UNAIDS 2007). Even as the Catholic Church continues to promote abstinence education and fidelity within marriage, a variety of other prevention efforts abound. Various groups focusing on particular vulnerable populations are promoting: delayed onset of sexual activity; ABC method—Abstinence, Be Faithful, Condoms; SAVE method—Safe(r) practices, Access and Availability to treatment and nutrition, Voluntary counseling and testing, and Empowerment; and virginity pledges. Greater pastoral attention across faith communities, however, is needed to support and find ways to encourage HIV prevention efforts through peer couple to couple supports in dating and in marriage.

Mother to child transmission is decreasing globally, with “33% of pregnant women receiving antiretroviral therapy to prevent mother-to-child transmission of HIV in 2007 as compared to only 10% in 2004” (Kaiser, “Global”). Given that these treatment costs are minimal, however, there is much more work to be done.

Church Involvement

The Roman Catholic Church continues to offer more than 25 percent of all AIDS assistance worldwide. The Catholic Bishops’ Conference of India has offered one of the strongest and most comprehensive statements and plans of commitment. In the United States, various dioceses have demonstrated leadership in committing resources for dealing with the disease. A particularly noteworthy example is the Archdiocese of Atlanta, which has an Office of HIV/AIDS Ministry, and whose efforts to reach out to Black and Hispanic/Latino communities are very intentional.

Current Challenges and Priorities

I close by highlighting two priority areas at this juncture in the pandemic. First, we are a long way from realizing the goal of Universal Access to prevention, treatment, care, and support by 2010. The gap between available resources and actual need continues to increase. The Millennium Development Goals are crucial for achieving Universal Access, demonstrating once again that a multifaceted approach to HIV is essential. Second, sustainable prevention, treatment, care, and support requires greater long-term funding from high-income countries as well as greater commitments from low- and middle-income countries (in the United States, see President’s Emergency Plan for AIDS Relief [PEPFAR]). Contributions from private sectors in civil society are also urgently needed in this area. Some have already responded, most notably the Bill and Melinda Gates Foundation. Because people are able to live longer and more productive lives with treatment, there is a growing need not only for first-line drugs but second- and third-line drugs. Sustainability requires better drug price negotiation so that treatment will reach everywhere.

The call to us as a faith community is to educate ourselves and to participate in as many ways as possible in eradicating HIV in the world today. We, too, are asked to respond to the youth who cried, “Give us a reason to live. Give us a reason to hope.”
References


