

HIV AND AIDS: A JUSTICE PERSPECTIVE

Michael J. Kelly, S.J.

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JESUIT CENTRE FOR THEOLOGICAL REFLECTION

"Promoting Faith and Justice"

P.O. Box 37774 10101 Lusaka, Zambia

tel: 260-1-290410 fax: 260-1-290759

e-mail: jctr@jesuits.org.zm website: www.jctr.org.zm

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Executive Summary

In June 2005, the United Nations acknowledged that the world was losing the struggle against HIV and AIDS and that, despite certain advances, the epidemic remained out of control. This study sees the epidemic as oppressive and dehumanising in itself, with its continuation and spread being rooted in human structures and systems that are themselves oppressive. These constitute a network of domination, oppression and abuse that excludes millions of human beings from sharing in, building up and enjoying a more just and equal world—and the central point from which the strands of the network radiate is the AIDS epidemic.

Conceptual Framework

HIV/AIDS is conceptualised as being driven by four forces: poverty, gender disparities and power structures, stigma and discrimination, and exploitative global socio-economic structures and practices. The more these thrive, the more HIV and AIDS will flourish. Equally, the more HIV and AIDS prosper, the greater the likelihood that poverty, gender disparities and power structures, stigma and discrimination, and disruptive socio-economic structures and practices will flourish and ensure the continuation of the epidemic. These four driving forces manifest themselves in a world where there have been two dominant approaches to responding to AIDS. One approach sees the epidemic as a condition that calls for a biomedical and pharmaceutical response, the other as a condition resulting from human behaviour practices and hence requiring a response that focuses on changing that behaviour.

Both models are critiqued for their concentration on the immediate causes and effects of HIV/AIDS and their failure to deal with the underlying and structural causes of the epidemic. Although there is global agreement that prevention should be the mainstay of the response to the epidemic, the policy directions currently being espoused seem destined to a never-ending struggle with the immediate causes of the epidemic—sexual behaviour, mother-to-child transmission, blood supplies, and injecting drug use. But because initiatives do not directly or sufficiently concern themselves with issues of poverty, inequalities in society, gender disempowerment, or north-south relations, the epidemic is likely to maintain the upper hand and perpetuate its unjust outcomes.

A particular deficiency seen in the behaviour change approach is its unspoken assumption that different patterns of behaviour are real possibilities for an individual and its failure to address the social factors that shape behaviour.

A Just Sexuality

Because sexual activity is the principal route for HIV transmission, the study examines the extent to which injustice frequently occurs in sexual behaviour, with special attention to the extent to which women and girls may be the

victims of such injustice. Instances are enumerated that reveal the double injustice in much sexual behaviour, the act itself being a violation of the rights of a sexual partner, and the act carrying the further injustice of exposing the partner to the risk of HIV transmission.

For a “just sexuality” to prevail, justice must be respected in every type of sexual encounter. At the minimum, this implies the observance of two principles:

1. The no-harm principle that induces “people who move into intimate sexual contact with their occasional, varying, or semi-detached partners” to take “the necessary efficient measures so that pregnancy, HIV and other sexually transmitted diseases ... are prevented”.
2. The equality principle that attaches as much value to the other as to oneself. This principle requires that, at the very least, a person should never be forced, directly or indirectly, to have sexual contact or to violate an exclusive committed relationship with another.

Practical forms of injustice may occur in four sexuality-related areas: narrow understandings that identify sexuality with physical sexual activity; failure to respect, protect and fulfil the rights of young people to comprehensive sex education; a moralising approach that fails to take account of the personal or socio-economic circumstances that may influence or even dictate a person’s behaviour; and failing to affirm that individuals are morally bound to follow what their conscience tells them is correct, even against the requirement of ecclesiastical or other authorities.

The Treatment of AIDS

The treatment of AIDS requires good nutrition, proper medication for common illnesses and opportunistic infections, the availability and accessibility of antiretroviral drugs (ARVs), the medical and social infrastructure that can deliver and monitor treatment measures, and supportive, understanding human care.

It is difficult for people in resource-poor households to meet all these requirements. Structural adjustment programmes and economic instability have had negative impacts on the nutritional status of the poor and have compromised the ability of health services to respond to people’s needs. The burden of providing much of the personal and nursing care required by AIDS patients in their homes falls largely on women who themselves may already be over-burdened and some of whom may also be living with HIV or AIDS. A further negative outcome is that girls may be taken out of school to help provide care in the home or to take over household and child-care responsibilities that can no longer be discharged by mothers or older female relatives who are providing AIDS care. This jeopardises a girl’s future in two ways: her truncated education does not equip her for life in the modern world, and she is deprived of the full education that would equip her with some protection against HIV infection.

The only way in which HIV infection can be controlled once it has gained a foothold in the body is through a combination of antiretroviral drugs. These are very effective in restoring life and vitality, even to patients who were close to death. Once started, antiretroviral treatment must continue for the rest of an individual's life. Moreover, because of the way the virus can develop resistance to the drugs being used, the individual must be monitored on a regular basis to ensure that resistance has not developed or, if it has, to change to other drugs.

Zambia has one of Africa's largest HIV/AIDS treatment programmes, with antiretroviral treatment (ART) reaching about 30 percent of those estimated to be in need. But the treatment came late to Zambia, as to so many other developing countries—about six years after it had been developed. If the treatment had been made available earlier, millions of lives would have been saved. Globally, ART reaches less than one in five of those in need. The rest are left to die. The enduring injustice is that “the people who are dying from AIDS don't matter in this world”. The global movement that seeks to see every person who is in need having access to treatment by 2010 is one that accords well with humanitarian, justice and human rights perspectives.

From a justice and equity stance, numerous other benefits of ART should be noted. Because of the way this treatment improves physical well-being and makes it possible to resume productive work, it acts significantly against poverty. It helps households to remain productive and intact. It prevents children from being orphaned. It dispels many of the fears, myths and misconceptions that underlie stigma and discrimination. Moreover, because it reduces the pressure on health services the provision of universal ART, despite its high costs, can result in major national savings, as can be seen in the case of Brazil.

Notwithstanding its enormous benefits (and the moral and justice imperatives of extending it to every person in need), the treatment of AIDS bristles with still unanswered justice, equity, ethical and practical questions. One set of questions relates to the sustainability of provision and costs. Because persons who begin on a course of ARVs must continue to take the correct medication for rest of their lives, there should be some assurance that they will be able to continue to do so. Currently there is no such assurance, so that the lives of these persons quite literally depend on political and economic decisions that will almost certainly be made in the developed countries and that have not yet come to the foreground. Questions also arise when those on ART have to move to different drugs which are very much more costly and are not always available in the poorer countries.

A second set of questions concerns equity in access to ARVs. There is need for determined measures to ensure that the right to treatment of women, those in rural areas, and marginalized groups (such as commercial sex-workers or prisoners) is respected. There has also been unjust neglect of children. Although 660,000 children were in need of ART in 2005, only about five percent were able to receive it, largely because of the non-availability and/or non-affordability of child-friendly versions of the ARV drugs.

HIV/AIDS and Poverty

There is no simple equation between HIV/AIDS and a country's national wealth or poverty status. AIDS is not a disease of poor countries. Nevertheless, where wealth is concentrated in the hands of a few, the majority are so indigent that they cannot satisfy their basic needs, and society is fragmented and in a state of some disarray, the scene is ripe for HIV and AIDS to make significant inroads. This implies that social and economic measures that will bring about a more just distribution in the wealth of the world and within individual countries are by that very fact measures against HIV and AIDS. Likewise, measures that strengthen civil society, foster stable, predictable and transparent governance, and promote a sense of social confidence throughout society, are also measures against the epidemic.

If it cannot be said that HIV/AIDS is a disease of poor countries, neither can it be said that it is a disease of poor people. Nevertheless, there is a well-established connection between HIV/AIDS and poverty, with their economic and social circumstances putting the poor at higher risk of HIV infection, and accentuating their susceptibility and vulnerability to infection. The poor are very familiar with malnutrition, micronutrient deficiencies, malaria, tuberculosis, and infestation by bilharzia and other worms. Each one of these conditions depresses the immune system in such a way that an individual becomes more easily HIV infected (and equally, an infected individual who experiences any one of these conditions is a more potent transmitter of HIV). What it means to be poor also increases vulnerability. Under pressure to meet immediate needs, the poor must live for the present. They do not see that they have any future to protect and hence may fail to appreciate the need to protect themselves against the possibility of HIV infection.

HIV and AIDS also have the effect of making the poor poorer. This is due to the way the epidemic causes costs to rise, reduces incomes and resources, and necessitates the diversion of resources. The costs of goods and services increase as industry raises prices to offset the ways in which HIV and AIDS affect its operations. Incomes and resources decline as jobs are lost through sickness or death; farm production is reduced; loans cannot be repaid; households headed by the elderly or children produce less; and the volume of sales declines because customers do not have resources to spare for anything but the most essential purchases. In addition, in order to survive, many households may have to dispose of capital assets, among them productive assets such as animals, machinery or equipment, thereby imperilling their future productivity.

The epidemic is also bringing about a massive diversion of resources—money, time, human engagement, institutions and systems. While this is occurring at both international and national levels, the poor are more severely affected by the way the epidemic eats into their household and personal resources. These are diverted to the disease in the form of payments for medicines, tests, palliative care, cleaning, transport, funerals, periods of mourning. Catering for additional household members in response to the orphans challenge requires that in many households limited resources must

be spread more thinly over larger numbers. Where there is AIDS in the household, labour resources must go to AIDS care and away from productive work.

The cumulative effect of these various situations is that the poor become poorer. Poverty deepens and becomes more extensive. The state of the “wretched of the earth” becomes even more wretched and their susceptibility to HIV infection becomes even more accentuated. Perhaps the oppressive face of HIV and AIDS is seen most clearly in the way it thrives off poverty and reinforces poverty. For AIDS-stricken countries and AIDS-stricken households, “make poverty history” is more than a slogan. It is a cry from the hearts of oppressed people to be freed from the domination of the unjust and exploitative situations that bind them into poverty and tether them to HIV and AIDS.

Women, Gender Disparities and the AIDS Epidemic

On physiological grounds, the risk of HIV infection is greater for women and girls than for men and boys. In addition, women’s risks are increased by a wide array of social, cultural, economic and legal factors, all of which are embedded in extensive theoretical and practical gender inequalities. In particular, at the sexual level, unequal power-relations give women a subordinate position and make them submissive to men. Several established practices in society also have the twofold outcome of demeaning women and enhancing their risk of HIV infection. These include various forms of sexual violence in the home, community and workplace; indulgence towards men who take sexual liberties; and the practice of older married men of having a “girlfriend” on the side. Further, some customary practices, such as early marriage, widow inheritance, ritual cleansing, and dry sex, have the same double effect of treating women as chattels and making them more vulnerable to HIV infection.

The message that women are there to be at the service of men, in sexual and other ways, is transmitted from an early age through child-rearing practices that form girls to be non-assertive and to accept subordinate status in relation to men. The insistence at times of initiation and pre-marital “kitchen parties” that the prime responsibility of a woman is to please her husband at all costs reinforces the message of her inferior status. Effectively this leaves many women psychologically powerless to take steps to protect themselves against possible HIV infection from their husbands.

In African society, as in many other parts of the world, married women often face violence and abuse if they demand condom use or refuse sex from their husbands or long-term partners. While many women are vulnerable to HIV because they are single or without a partner, the disturbing fact is that even more of them are vulnerable to infection because they are married and remain faithful to a partner who does not reciprocate this trust.

Economic factors further accentuate women’s vulnerability to HIV infection. “A woman’s access to property usually hinges on her relationship to a man.

When the relationship ends, the woman stands a good chance of losing her home, land, livestock, household goods, money, vehicles, and other property. These violations have the intent and effect of perpetuating women's dependence on men and undercutting their social and economic status."

Compounding all these restrictions and limitations is the heavy HIV and AIDS burden that women must bear. The burden of care that they already carry is greatly increased by additional responsibilities in caring for sick family members and for orphans from their own or their husbands' extended families. Even if personally HIV infected, or ailing from some other illness, women must continue to manage a household, provide care, produce food and generate income. Access to ARVs is problematic for many women who feel disempowered by a culture that gives priority to the health needs of men. "On top of this, women are often daunted by the bureaucracy surrounding (the delivery of antiretroviral therapy). There are official documents to sign and many women cannot read or write, so they feel intimidated."

For the greater part, this stalking of women by HIV and AIDS arises from society's unjust allocation to them of an inferior status. Were it not for the unjust treatment and exploitation that women experience, the epidemic would not have its current worldwide grip. It would not have its current stranglehold on southern Africa. Fewer men would be infected. Far fewer women would be infected, and because this would reduce the incidence of parent-to-child transmission, fewer children would be infected.

Responding to the AIDS epidemic, in terms of prevention, treatment, and impact mitigation, will only succeed when robust, sustained and specific action is taken to reduce and ultimately eliminate the prejudice, discrimination and unjust treatment that women experience. Without a frontal attack on the injustice of gender inequality, the dominance of the epidemic will continue.

Gender equality is necessary in the light of what HIV and AIDS can do to women. But even more fundamentally it is necessary in its own right. AIDS or no AIDS, women and men are essentially equal. Making that equality a lived reality is a major challenge for every individual, community, institution and country.

Stigma and Discrimination

Stigma and discrimination are powerful forces that have the double effect of demeaning individuals infected or affected by HIV and AIDS, and making it more difficult to deal effectively with the disease.

Stigmatisation of a person living with HIV or AIDS means that they are discredited, branded as unworthy, reduced in value, or assume lesser worth in our eyes, and often also in their own eyes. What is not always recognised is that the irrational act of stigmatising also makes the stigmatiser lose value and become less worthy and less human—the stigmatiser responds to those living with HIV or AIDS as if they were of lesser value, and in doing so becomes of lesser value as a human being.

Stigma and discrimination manifest themselves in many settings—in the home, in the community, in the work situation, in health-care settings, and in education settings. What those who are stigmatised experience in every one of these settings represents a denial in practice of human rights. Perversely, the injustice that is brought about in these ways by HIV and AIDS also contributes to the continuation and proliferation of the disease. This is because stigma and discrimination create a culture of silence and denial where it is difficult to take the action necessary to fight HIV effectively.

The injustices that stigma and discrimination represent for people living with HIV or AIDS bring untold personal unhappiness into their lives. Very many of those who become infected with HIV can actually come to terms with their infection. But almost every one of them finds it much more difficult to live with stigma and discrimination. These challenge their sense of personal worth, dignity and what it means to be human. African philosophy recognises that “a person is a person through other persons”. By attacking the bonds that link people to one another, stigma and discrimination undermine the very humanity of infected individuals and make it impossible for some to continue living.

Global Economic Structures and Practices

The years during which globalization worked its way down into the lives of communities and individuals have seen an increase in poverty and inequity. The extent to which it can be said that globalization is directly responsible for the increased poverty of individuals and countries and for growing income inequalities is not clear. But globalization as practised has resulted in wealth, prosperity, influence and future promise for the few; poverty, exclusion, voicelessness, and stagnant hopelessness for the many. The emergence of such situations has considerably increased the susceptibility of countries, communities and individuals to HIV and AIDS, especially when it is recalled that poverty and inequity, working together, provide a fertile breeding ground for the continuation and spread of the epidemic. In this sense, it has to be acknowledged that global economic structures and practices have facilitated the continued domination of the AIDS epidemic and in some circumstances have made their own direct contribution to this dominance.

Notwithstanding increased worldwide concern about the AIDS epidemic, the broad global approach, especially as embodied in behaviour change policies, seems to be a combination of containment and what might be called “otherisation”: do not let the epidemic extend beyond the world’s current hotspots; confine it to the marginalized groups (commercial sex workers, men who have sex with men, injecting drug users, the poor in developing countries); make it somebody else’s problem, “out there”, elsewhere, belonging to “Them” but not to “Us”. Inevitably, of course, this institutionalises stigma and discrimination at the heart of global policy. In practice, it means denying HIV and AIDS as a global disease and ultimately as a global concern. But, a global society is too porous, too flexible, too changeable, too interconnected for this to work.

More specifically, the World Bank and the International Monetary Fund (IMF) have come in for stringent criticisms in recent years because of the adverse impacts of their structural adjustment policies on health and education systems. Critiques, ranging from sharp disparagement to carefully worded academic evaluations, link these policies to the spread of the AIDS epidemic. Thus, Stephen Lewis writes that “one of the critical reasons for Africa’s inability to respond adequately to the pandemic can be explained by user fees in health care ... and user fees in education”. The essential basis for the criticisms is the way both institutions gave first priority to economic stability, far ahead of every social need and human right, including the right to life and to good health.

Global trade structures are relevant to the AIDS epidemic on two grounds: first, trade structures have much to do with maintaining a country in or freeing it from poverty; and second, the Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement has much to do with the availability and flow of antiretroviral drugs and other technologies for responding to HIV and AIDS.

HIV/AIDS prevention efforts need to be grounded in the broader struggle for social and economic rights for the poor. But international trade relations currently do not favour poor countries in Africa or elsewhere in the world. Instead they are heavily weighted in favour of the wealthier countries, while simultaneously creating barriers to the market access of goods from poorer countries. This unfair global process serves to maintain countries in their poverty and by that very fact to maintain the AIDS epidemic that ravages them. Much the same could be said about debt, with many countries spending as much or more on debt servicing than they do on their health services. The limits that the never-ending servicing of debts places on a country’s ability to pull itself out of poverty are also limits on its ability to respond to the AIDS epidemic.

The TRIPS Agreement covers all areas of technological innovation, transfer and dissemination. Its relevance to the AIDS epidemic is that the TRIPS Agreement covers access to the life-preserving antiretroviral drugs that have been developed by a small number of pharmaceutical giants in Europe and the United States. The Agreement also covers access to other important epidemic-related technologies, such as tests for the diagnosis of HIV in very young infants.

The World Trade Organization has acknowledged the public health problems coming from HIV/AIDS and other epidemics and encouraged member states to make full use of the flexibilities built into the TRIPS Agreement. But while there has been some progress, the consensus of practitioners is that, even with the most recent amendments of December 2005, the regulations still do not allow drugs, especially those that are being newly developed, to be made readily available at affordable prices. Little has been done to open the door to provide a legal way for poorer countries to develop, manufacture or import life-preserving drugs.

The Movement of People

Large-scale population movements contributed to the early explosive spread of HIV and AIDS. They continue to do so. It is estimated that some 150 million individuals are living permanently or for extended periods in a country other than their own. In addition there are the millions who migrate from rural to urban areas within their own countries, in addition to other internal migrants. Economic reasons are at the root of much migration, both internal and international. Usually, migrants are looking for work or better-paid work. There is also much involuntary migration. This includes refugees from situations of conflict or civil strife, and displacement due to conflict or natural disasters.

Factors such as much mobility, separation from protective customary norms, working in high risk situations, working in isolated situations, protracted border formalities, and transactional sex, increase the vulnerability of mobile populations to HIV. Because their concerns are with the more immediate challenges of physical survival and financial need, most individuals on the move regard HIV as a distant risk. But during their travels or at their destinations, many of them experience conditions that provide an optimal context for HIV transmission.

Numerous equity and justice concerns arise from the HIV vulnerability of mobile populations: the crying need to see an end to all forms of human trafficking; ensuring that all migrants have access to health, testing, care, treatment and support services, and that they are encouraged to make full use of these services; the protection of migrants with HIV or AIDS from discrimination and xenophobia when they are in another country; ensuring that infected migrants can continue to live where their access to ARVs commenced; establishing immigration regulations that do not block entry (or require deportation) on grounds of HIV infection; accelerating the issue of visas and goods documentation at borders, so as to reduce HIV-risk delays; establishing better living and working conditions for seasonal agricultural and fishery workers, domestic workers, and transient mine workers; developing local work opportunities so that there will be less migration on economic grounds.

Brain Drain

Many severely affected countries, especially the poorer ones, find that their ability to respond to HIV and AIDS is being hampered by the loss of their skilled health and other professionals to wealthy industrialized countries. Responding to the epidemic is further hampered by the considerable movement of health care professionals within countries (from rural to urban areas, from the public sector to private practice, and from primary health care to secondary and tertiary provision) and from poorer to wealthier developing countries (as from Zambia to Botswana).

This “brain drain” of health care workers from Africa is further crippling already fragile health care systems throughout the continent, as they struggle to provide ART to hundreds of thousands of people. An anomaly in this situation is the readiness of countries that support developing countries’ training

programmes to bleed away many of the best products of these programmes once training has been completed and some experience garnered.

A further anomaly is that the provision of ART within countries is exacerbating the shortage of personnel for other basic health care services. Externally funded HIV/AIDS programmes usually offer better salaries and conditions than ministries of health. These are attracting doctors, nurses, pharmacists and technical staff away from public-sector positions to work in these foreign-funded programmes. The result is a further weakening of already fragile health care systems.

Impacts on the Young

As the epidemic of HIV and AIDS continues to unfold, the world is becoming more keenly aware of the various ways it impacts on the young—children affected by HIV and AIDS (including orphans), and youth or young people under the age of 25. Orphans and vulnerable children (OVC) are of concern because of the way the epidemic robs them of what cements them to the past, undermines their present opportunities, and jeopardizes their future. Young people under the age of 25 are of concern because they are the AIDS generation—they have never known a world without HIV and AIDS; and because they are at the ages where they are most susceptible to HIV infection—young people, aged 15–24, account for about half of new adult HIV infections and 28 percent of the global total of adults living with HIV or AIDS.

The major justice issue relating to orphans and vulnerable children is failure at almost every level to build them into comprehensive responses to the epidemic. The Zambian Government has acknowledged that it is not giving sufficient priority to the problems of OVC, while poverty reduction strategy papers (PRSPs) do not manifest a strong commitment to the needs of orphans and other vulnerable children, with many of them not mentioning the issue at all.

While UNICEF and some prominent NGOs tend to lead the world in the campaign for more meaningful interventions on behalf of OVC, the response of the faith-based organizations at the grassroots level, where the challenge really occurs, has also been outstanding. A proliferation of faith-based community initiatives, led by a veritable army of religiously committed and motivated volunteers, is making a major contribution to the protection of Africa's orphaned generations. The religious leadership could do even more if it placed mobilizing action to care for orphans, vulnerable children and families affected by HIV/AIDS higher on their agendas, spoke about the issue more frequently at church services and on other suitable occasions, and maintained pressure on government and civil society never to overlook the needs of children.

However, the veritable avalanche of community responses to the OVC challenge should not mask the fact that so many families experience difficulty in coping. Underlying their apparent success is the selfless sharing strategy that frequently characterises those living in poverty—the poor helping the

destitute by sharing what they cannot afford. But this is hardly something that can be held up as a good model of coping.

Injustices against children may also be perpetrated when families are broken up on the death of a parent or when orphans or street children are “repatriated” from their town setting to a rural village. Enabling orphaned children to stay together as a sibling group is often of fundamental importance to their emotional and psychological well-being. Further, in addition to infringing their right to participate in decision-making affecting their future, the practice of repatriating children to the village from which the deceased parents are believed to have come frequently creates numerous social problems that result in much unhappiness both for the children and for those in the village where they are re-located. There is need for much greater adherence to the principle that in all that concerns children, the best interests of the child should be a primary consideration.

The relationship of HIV/AIDS to youth encompasses a wide range of issues, four of which have strong justice overtones. Although young people under the age of 25 comprise almost half of the world’s population, teenagers and young adults are not given sufficient voice.

1. Although the majority of young people know something about HIV and AIDS, teenagers and young people still do not have access to enough correct information.
2. Teenagers and young adults do not have sufficient access to youth-friendly health services and HIV testing facilities.
3. Many teenagers and young people lack economic security and prospects for employment, with about half those without jobs being aged 24 or less.

The non-availability of employment and work prospects for young people is a key missing ingredient in global strategies against HIV and AIDS. It is not merely that because young people have so little to do that they have more time for behaviours that may put them at risk of being infected with HIV. It is much more that they are deprived of opportunities for developing their human dignity and self-respect.

Impacts on the Elderly

In many developing countries the AIDS epidemic has increased the burden on older people in two ways. First, because of the deaths of their children they can no longer receive the financial and other support that their children would otherwise have provided for them; and second, in their frailty and very often in their poverty, they have to take on care responsibilities for orphaned children. Older people have always been involved, to some extent, in caring for the young. But because of AIDS, the extent of this care has greatly increased.

The burden of orphan care is falling more extensively on the weaker members of society—women who are old, very often poor, and not infrequently in poor health. A distinctive characteristic of the evolving household model is that

often there is no middle generation (women or men) but only the old and the young somehow supporting one another. The elderly caregivers are apprehensive about their ability to care for and rear the young, but feel under pressure to take on this responsibility because there is no one else who can do so. Because of age, the personal health status of elderly caregivers is often not good and it may be worsened by the stress, anxiety and burden of providing care. This fills many of them with an overwhelming sense of worry and concern.

Caring for these frail caregivers can test the commitment of a society to principles of justice and equity. Two questions arise:

1. How can these elderly carers be enabled to cope with the economic, caring and psychosocial demands placed on them?
2. Who will care for these elderly carers when they are no longer able to care for themselves or their dependants?

There is a strong case for the adoption of exceptional measures for the protection of elderly caregivers. In common with children affected by HIV and AIDS, they are a very vulnerable group. But, unlike orphans and vulnerable children, they are a much-neglected group. The United Nations has suggested the adoption of social protection measures to respond to the needs of this very vulnerable group, but so far few governments have taken any action (although the promise and the affordability shown by pilot cash transfer schemes might change this situation).

The Vulnerability of the Earth

HIV/AIDS affects systems directly and indirectly through sickness and death. This applies not merely to human systems, such as education or health, but also to the ecological systems on which humanity depends so intimately. The immediacy with which households experience the labour and financial impacts of AIDS impairs their ability to make sustainable use of natural resources. When time, energy and money must be spent to relieve the effects of AIDS sickness, and when there are fewer healthy individuals in a household who can put in a full day's work, concern for long-term ecological integrity is not a high priority. Because of this, there is more likelihood of exploitative relationships in which natural resources are over-used or poorly managed.

Reduced ability to transmit knowledge and skills and actual degradation of natural resources are the two principal channels through which this occurs. Rural populations are aware of the need to maintain a balanced relationship with the environment that sustains them. Centuries of experience have resulted in patterns of cropping, animal husbandry, fishing and general environmental management that yield good returns to the individual without wreaking harm on the environment. The knowledge and skills for maintaining this balanced relationship are passed from generation to generation, not in a formal way but through the informal learning of children from their parents and elders. HIV/AIDS has put this under threat. So many have died or are seriously ill in the generation with the knowledge and skills that they are no

longer able to transmit these to their children. The result is considerable risk of environmental degradation, as through over-fishing or fishing at the wrong time of year, failure to preserve certain tree species, or lack of attention to watercourses and where run-off is directed.

Through HIV and AIDS “our own flesh and blood, the earth, is dying”, but very few seem to care. Years must elapse before the damage that HIV does to the human body reveals itself in the sicknesses of AIDS. It could be the same with the earth. The present generation has the responsibility of finding innovative ways to ensure that the epidemic does not undermine the future of humans or their environment. This is a matter of justice to the present generation, to future generations, and to the earth on which we all depend for sustenance.

The Response of the Christian Churches to HIV and AIDS

There is need to acknowledge and proclaim the enormous contribution that the major faiths, and in particular the Christian Churches, continue to make to HIV prevention, care, support, treatment, and impact mitigation. Their activities in this area are firmly grounded in a strong human rights based approach that promotes a culture of life, respect for the sacredness of the individual, and the celebration of life. They also draw their inspiration from social teaching that advocates strongly for the transformation of economic, political and social structures that effectively exclude the poor and deny the equal personal role and dignity of women. In other words, church teaching consistently and effectively addresses some of the major driving forces of the AIDS epidemic. The immediate contact of the faith communities with people at the grassroots level, in their homes and elsewhere, further strengthens their ability to address the various concerns that arise from the epidemic.

With their closeness to the people and their long experience, the Churches in Zambia have come to recognize that it is neither effective nor sufficient to treat HIV as an object of intervention, in isolation from its social and economic contexts. While they recognize the behavioural and medical concerns that HIV and AIDS raise, they do not concur that it is sufficient to address the epidemic from outside by the technological interventions of a condom, a test kit or an antiretroviral drug. Instead, they see it as requiring a more holistic approach that addresses both economic and personal development. Hence, an increasing amount of church activity is being dedicated to social and economic development, while a major share of church concern has always been with personal development.

Because of this, in addition to their traditional health and education activities, the various church bodies in Zambia work for the improvement of agriculture, water and sanitation, improved livelihoods, acceptance of the equality between men and women, improved nutritional status for children and adults, and the development of infrastructure. Each of these activities relates significantly to developing an environment that is less conducive to HIV transmission. In the majority of cases, the churches undertake this work without recognizing explicitly that it contributes to the control of HIV and AIDS.

While much has been accomplished, there is room for even more—more forthright speaking on every possible occasion about the epidemic; absolute rejection of every utterance, pronouncement or practice that carries any connotation of stigma or discrimination; working even more resolutely at the major tasks of eliminating poverty and ending the subjugation of women; mobilizing their communities for a massive humane and practical response to the orphans challenge; and galvanizing their members into action for the reduction of HIV transmission, the promotion of a just sexuality, the provision of care and support for those infected or affected, and the mitigation of the impacts of the disease and epidemic.

The time of AIDS is a time of great perplexity. But it is also a time of great challenge and a time of great grace. The Church has the responsibility of discerning God in the current situation and of hearing what God is saying to it through the crisis of HIV and AIDS. It is also duty bound to help others experience God even in the circumstances of HIV and AIDS. In the final analysis, the responsibility of the Church is to live, speak and act as Christ would have done in this era of HIV and AIDS, to be Christ to those who are infected and affected, to bring Christ's message of hope and certain victory to suffering people and a suffering world.

Conclusion

This study has been animated by three considerations:

1. There is strong synergy between the AIDS epidemic and four basic root causes: poverty; gender disparities and power structures; stigma and discrimination; and exploitative global economic structures and practices.
2. Responding to HIV and AIDS is intimately connected with the practice of justice.
3. AIDS and justice issues are so intimately linked that action on behalf of justice will almost automatically be action against the epidemic.

Dismantling the unjust structures in which poverty, the low status of women, stigma and discrimination, and exploitative global economic practices, are embedded, and establishing just structures and practices in their place, will create a terrain in which the human immuno-deficiency virus can no longer flourish. Equally, action against the epidemic will be action on behalf of justice. As this report shows, the shape and extent of the AIDS epidemic is determined by various unjust forces, many of them outside the areas normally addressed by HIV and AIDS programmes. Addressing HIV and AIDS serves as an entry point and catalyst for addressing these broader injustices. Briefly, then, one can say that the more HIV/AIDS, the less justice—but the more justice, the less HIV/AIDS.
