Christianity

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Christianity, a monotheistic religious movement diverse in form and expression and marked by a common commitment to the life and teachings of its founder Jesus of Nazareth, has informed varied faith-based responses to HIV/AIDS since the beginning of the pandemic—from early pronouncements against HIV prevention measures (e.g., condom use and needle exchange) to further marginalization of gay men living with the illness. However, recent initiatives have emerged to stem the tide of the epidemic with prevention and care programs that are aligned with orthodox Christian doctrine. Christian-based HIV programming (CBHP) gained visible momentum during the second decade of the epidemic. This is most notable among churches in urban African-American enclaves in the USA and southern African countries—both regions with disproportionate representations of persons newly infected with HIV and living with AIDS. Moreover, as a result of research identifying a strong link between rising HIV incidence and inequitable socioeconomic conditions, a response to the epidemic began to gain ground, largely influenced by the evangelical social justice movement.

Established CBHP at churches and Christian-based social service organizations have included community education about HIV transmission prevention, church leadership training, HIV-stigma reduction media campaigns, outreach to HIV high-risk groups, promotion of HIV-antibody testing and counseling, and emotional and practical support for people living with HIV (PLHIV). CBHP in the USA are often conceived of and implemented in partnership with external organizations. Collaborative partnerships between churches and public health institutions are conceptualized as faith-based or faith-placed. Faith-based interventions take into account the religious culture and beliefs of targeted individuals and communities,

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whereas faith-placed interventions view the religious organization as a location for delivering interventions, regardless of their religious content.

Recent scholarship on the development of CBHP has highlighted the important challenge of identifying points of integration between orthodox Christian doctrine, ecclesiastical practices, and response to HIV. For example, some have argued that scriptural teachings of transformative and unconditional compassion as modeled by Jesus Christ uniquely positions CBHP to address what may be the most challenging aspect of HIV care and prevention—namely, the stigma of living with HIV and/or belonging to a perceived HIV-risk group. Texts from the Old and New Testaments that consistently referred to the sins of oppression and admonishment of those who unjustly treat those who carry less social power, have challenged Christian institutions to apply these principles to HIV/AIDS. Others have emphasized the important pairing of upholding justice and proclaiming the atoning work of Jesus Christ—a primary task for Christians. Proponents of this approach to Christian evangelism specifically argue that propagating the life and work of Christ is inseparable from teaching the responsibilities of becoming a Christian—that is, confronting social and economic injustices. Threads of liberation theology, for example, that emphasized solidarity with exploited communities have been woven into the responses of many churches in African and South-American countries.

Within Christian subgroups that acknowledge the importance of responding to the epidemic, there are formidable challenges to implementing CBHP in the Americas and southern regions of Africa. First, limited financial and human resources are generally directed towards the needs of congregation members and target constituent groups rendering involvement in HIV programming less feasible. Second, collaborations with external HIV-organizations are frequently stifled by ideological differences about HIV prevention measures, sexual ethics, substance abuse, and harm reduction interventions. Third, there exists a lingering bias against CBHP, one that was largely formed during the first decade of epidemic against fundamentalist churches that viewed HIV/AIDS as divine retribution against homosexuals. Finally, HIV involvement potentially compromises the churches' perceived moral standing and authority within their communities and may alienate the churches from their constituents. This threat of compromised social standing is particularly felt in select African countries where many coexisting churches compete in the religious marketplace for a small group of unaffiliated individuals.

Recent scholarship has focused on how religious institutions such as Christian churches influence broader social milieus within which HIV risk behavior occurs and illness stigma proliferates. The argument follows that diverse Christian traditions play a formidable role in shaping cultural and political scripts that inform social responses to the epidemic. In the USA, this is exemplified among diverse immigrant and African-American churches that weld considerable influence over community norms and values—ones that can facilitate or undermine public health efforts in HIV prevention and treatment. The importance of preserving traditional, moral, and institutional values has rendered active involvement in HIV-related activities a challenge among many ethnic Christian churches. However, researchers

have urged strategic approaches to address these institutional barriers by identifying proximal and distal points of integration between HIV prevention and treatment, doctrinal teaching, and cultural faith practices.

Related Topics: Coping, faith community, prevention strategies, religion and spirituality.

Suggested Reading

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