# FROM SILENCE TO CONCERN: THE CHANGING RESPONSE OF FAITH-BASED ORGANIZATIONS TO THE HIV/AIDS EPIDEMIC IN NIGERIA

**BY**

**Olufunke Adeboye PhD**
**Five College African Scholars Program**
**University of Massachusetts**
**Amherst MA**
**USA**
**E-mail: oadeboye@anthro.umass.edu**

**Paper Presented at the CCASLS workshop on HIV/AIDS in Today's Developing World on April 24, 2006 at the Marriot Chateau Champlain, Montreal, Quebec, Canada.**

# FROM SILENCE TO CONCERN: THE CHANGING RESPONSE OF FAITH-BASED ORGANIZATIONS TO THE HIV/AIDS EPIDEMIC IN NIGERIA

## INTRODUCTION

The Nigerian HIV/AIDS situation has been generating considerable concern within several sectors of the society lately. With the number of infected people estimated at almost four million, Nigeria has the third largest number of HIV/AIDS infections after India and South Africa. While government has adopted various strategies to battle the epidemic, it has also repeatedly called for support from the faith-based community, among other groups and stakeholders. It is the response of the Christian segment of the Nigerian faith-based community that is the focus of this paper.

Case studies are selected from mainline and Pentecostal churches and their changing responses to the HIV/AIDS epidemic analyzed. These responses vary from silence, denial, and stigmatization to concern. What factors are responsible for these varying responses? At what point in the response spectrum can we locate particular Christian groups? What is the impact of each of these responses on the society? For those showing concern, how deep is the concern? What tensions/contradictions are generated in the course of showing concern? At the heart of this discourse is the issue of the interpretation of HIV/AIDS by different strands in the faith-based community. Again, how successfully has the Christian community been able to accommodate government proposals for containing the spread of the virus? What does this say about the responsiveness of the faith-based community to wider social issues? The period covered by the study is from 1986 (when the first HIV/AIDS case was reported in Nigeria) to 2005. However, active Christian involvement borne out of concern is still less than ten years old. This work therefore concludes by recommending ways in which faith-based organizations can strengthen their commitment to the campaign against HIV/AIDS by drawing from experiences in other contexts outside Nigeria.

## THE NIGERIAN HIV/AIDS SITUATION

Since 1986 when the first HIV case was reported in Nigeria, the virus has spread gradually. The first national sero-prevalence sentinel survey carried out in 1991 recorded a prevalence rate of 1.8%. In 1996, this rose to 4.5% and peaked at 5.8% in 2001. The last survey carried out in 2003 gave a prevalence of 5.0% (FMOH 2003). This last rate may not necessarily indicate a reduction in the epidemic until it is confirmed by another survey. Moreover, the observation of UNAIDS about the nature of the African AIDS epidemic appears to hold true for Nigeria. According to the 2004 UNAIDS Report, "the AIDS epidemics coursing through this region [sub-Saharan Africa] are highly varied …. It is therefore inaccurate to speak of a single 'African' epidemic …." (UNAIDS: AIDS Epidemic Update 2004). What this implies is that the national prevalence rates do not reflect the intensity of the epidemic in particular states of the Nigerian federation. The 2003 sentinel survey revealed pockets of intense epidemics in some states. For example,

while the national prevalence was 5.0%, Cross Rivers State had 12.0%, Benue State 9.3% and the Federal Capital Territory (FCT) had 8.4%. In fact thirteen out of the thirty-six states, plus the FCT had prevalence rates that were higher than the national average of 5.0%. The worst hit age group fell between 20-24 years, with a prevalence of 5.6% (FMOH 2003). Total death from AIDS related illnesses in 2004 was estimated at 300,000 while the number of AIDS orphans was estimated to be two million in 2005.

Government response to the AIDS crisis could be divided into three phases. The first phase, which was characteristic of other African nations was that of denial, which lasted from 1986-1987 (Ilife 2006: 66-67). This was followed by another phase (1987-2000) in which official response was restricted to the health sector. At this time, national policy was characterized by high ineptitude. General Ibrahim Babangida (1985-1993) and his successor General Sani Abacha (1993-1998) showed no commitment to the issue of HIV/AIDS. In 1987 a National Expert Advisory Committee on AIDS (NEACA) was set up with a few state chapters. This was followed in 1988 by the National AIDS and STD Control Program (NASCP). This scheme suffered considerable neglect despite the efforts of the able Minister of Health, Professor Olikoye Ransome-Kuti. International donors were unwilling then to subsidize an oil-rich country with military rulers who took no interest in the subject. By 1996, the sixth director of the Program had resigned because the Federal government was unwilling to commit funds to it (Ilife 2006: 72).

The third phase, which could be dated from 2000 roughly, corresponded with the inauguration of democracy in Nigeria (1999 till date). Under the leadership of President Olusegun Obasanjo, a multi-sectoral approach to the management of HIV/AIDS was inaugurated in 2000 (even though it had been endorsed in 1997). This was followed by the establishment of a Presidential Committee on AIDS and a National Action Committee on AIDS (NACA) with nationwide branches. A three-year HIV/AIDS Emergency Action Plan was initiated 2001 and implemented in partnership with NGOs, Community-based Organizations (CBOs), Faith-based Organizations (FBOs), and People Living with HIV/AIDS (PLWHAs). The Emergency plan was succeeded in 2005 by a five-year strategic plan (2005-2009). Due to the increasing political commitment to the HIV/AIDS cause, Nigeria began to attract technical and financial support from several international donors such as UNAIDS, Family Health International (FHI), United States Agency for International Development (USAIDS), the World Bank, and the Global Fund to Fight AIDS, Malaria and Tuberculosis and lately, the US President's Emergency Plan for AIDS Relief (PEPFAR).

Highlights of government activities in combating AIDS include: prevention campaigns which adopt the popular ABC strategy (Abstinence, Be faithful, Condomise)[1]. In 2002, government began to dispense anti-retrovirals (ARVs) to PLWHAs at a subsidized rate. This has however been dogged by controversies and protests from PLWHAs because the drugs could not go round and people had to make long trips to get to the dispensing centers in the big cities. Only 10,000 people benefited from this scheme in the first year. Moreover, the one thousand naira (₦1000 approximately $7) monthly fees charged by the government centers was simply beyond the reach of most PLWHAs. Additional expenses such as transportation costs, laboratory tests and treatment of opportunistic infections came to about forty-two thousand naira (N42, 000) per annum. All these placed a huge burden on PLWHAs. At the end of 2005, only 40,000 people were receiving treatment from the government centers. In January 2006, government

announced free treatments and its plans to extend ARVs to a total of 250,000 people within a six-month period[2].

Other features of government activity are: the campaign for the Prevention of Mother-to-child transmission (PCMTC) of HIV and the improvement of blood screening procedures and facilities to eradicate transmission of HIV via blood transfusion. NGO response to HIV/AIDS has been more spontaneous than that of government. In a stakeholder's directory by the Nigerian Medical Research Council in 2005, 198 NGOs are listed as being involved in HIV work in addition to some 27 faith-based organizations (FBOs). While this list is certainly not exhaustive, it nevertheless illustrates NGO commitment to the prevention and management of the epidemic.

Initial public response to HIV/AIDS in Nigeria was also characterized by denial. It was regarded as a disease of 'white people' and of 'homosexuals'. As more people tested positive to the virus, the idea started to make the rounds that it was a disease of the sexually 'promiscuous' and 'immoral'. This fueled the stigmatization of PLWHAs, which in turn found expression in several acts of discrimination. While it is true that about 85% of HIV infections in Nigeria are contracted through heterosexual activities, government and NGOs have continued to enlighten the populace on other sources of infection such as the sharing of unsterilised piercing instruments and needles, transfusion of infected blood and mother-to-child transmission. As public awareness campaigns were intensified, some members of the literate public began to change their attitude to PLWHAs, but the general situation in the country is still one of stigmatization and discrimination. Many PLWHAs have defied this by publicly announcing their HIV status, thus breaking the silence surrounding the infection[3]. Such individuals have subsequently spearheaded the formation of strong PLWHA support groups through which they collectively fight for their rights and lobby the government to pay more attention to issues relating to HIV/AIDS such as the discouragement of discrimination and the provision of ARVs. These groups have become strong advocacy instruments and they include: Network of People Living with HIV/AIDS in Nigeria (NEPWAN), Positive Action for Treatment Access (PATA), AIDS Alliance of Nigeria (AAN), and Positive Life Association of Nigeria (PLAN).

## FROM SILENCE TO CONCERN

The current concern shown by some churches about the deepening HIV/AIDS situation in the country did not develop overnight. It was prefaced by an initial denial, which transformed to stigmatization, and later softened to concern. In the early 1990s, when more cases of the infection were identified, religious leaders began to preach against it, characterizing it as the disease of 'sexual sinners'. In a 1994 study, I.O. Orubuloye et al reported that both Christian and Muslim leaders in Nigeria regarded AIDS as a divine punishment for 'sexual transgressions' (Orubuloye 1994; Chepkwony 2004:56-59). By the end of the decade, a handful of churches had had a rethink about their stance and were already favorably disposed to the cause of the infected. Meanwhile, others had become quite vociferous in their condemnation of PLWHAs. A common practice among both mainline and Pentecostal churches at this time was to demand HIV-free medical certificates from intending couples before their marriages were solemnized (Guardian [Lagos], May 1, 2000; May 1, 2001). This act of institutional discrimination

further reinforced the stigma associated with HIV/AIDS in the society as the doors of many churches were closed to PLWHAs. It also strengthened the dichotomy between 'saints' and 'sinners' (cf. Kamaara 2004: 42-46).

General stigmatization of PLWHAs is not surprising because society gives meaning to, and interprets illnesses drawing from a large cultural repertoire and from religious backgrounds. Several studies have shown that the source of stigma is principally not the disease itself, but rather the social imputation of a negative connotation to it (Freund and McGuire 1991:137,157; Oyelese 2003/2004: 125-129). What is surprising is that churches momentarily forgot their original message of love and care and became judgmental on the issue of HIV/AIDS. Pentecostal churches, for instance which normally place responsibility for human sufferings and diseases at the doorstep of the devil did not directly do so in the case of HIV/AIDS. Rather, they held individuals responsible for contracting the infection (through heterosexual activities) just as they blamed the devil for 'afflicting' them. These churches believed that infected individuals made themselves vulnerable to the devil through their sexual choices (cf Nyanzi 2003). In fact, the degree of responsibility allotted to PLWHAs varied from church to church; and this in turn created varying degrees of stigmatization.

Two major developments however, made several churches to soften their hard position on the issue of HIV/AIDS within the last five years. First, church leaders began to realize that HIV/AIDS was actually in the church and had affected not only the laity, but also some clergy. This was an eye-opener because it made religious leaders come to terms with the fact that HIV/AIDS was not a disease reserved for 'sinners'; that AIDS is a social leveler; and, that many church members were not as 'saintly' as the leaders had assumed (Smith 2003, 2004). Some quantitative research by medical experts also accents the prevalence of HIV in the church[4]. Secondly, the Federal government launched a campaign against stigmatization, which specifically targeted churches and discouraged "mandatory pre-marital testing and requirement of HIV-free certificates as a condition for solemnizing a marriage". It insisted that PLWHAs should not be denied of their right to marry (FMOH 2003).

Christian interventions for containing HIV/AIDS came from three categories of FBOs. First is the religious congregation, which is a local grouping of believers such as specific denominations or their individual branches. Second is the religious coordinating body (RCB), which is an intermediary or umbrella organization responsible for coordinating and supporting denominations and their component congregations. The third is the faith-based NGO founded by a religious congregation but which also receives external donor support and employs its own full-time staff. The three case studies examined in this paper correspond to two of the above categories[5]. While Hope Worldwide Nigeria (HWWN) and the Redeemed AIDS Program Action Committee (RAPAC) are both faith-based NGOs, the Catholic Church, which is the largest religious denomination in Nigeria, qualifies as a religious congregation. A brief introduction to each of them is contained in the following paragraphs.

HWWN is a subsidiary of Hope Worldwide, which is an international, faith-based NGO affiliated with the International Churches of Christ (ICOC) with headquarters in Los Angeles, California. The Hope network got to Africa in 1991 and by 2005 had branches in twenty-five African countries (HWW 2005). HWWN was incorporated in 1996 and has since established its presence in eight states of the federation with Lagos as

its headquarters. The Lagos branch of the International Churches of Christ, called the Lagos Christian Church (LCC) coordinates other ICOC branches in Nigeria and mobilizes congregational support for the activities of HWWN. The main thrust of the activities of HWWN is to battle HIV/AIDS.

RAPAC is a ministry arm of the Redeemed Christian Church of God (RCCG). The RCCG was established in 1952 as an indigenous Pentecostal church by one Josiah Akindayomi. As from the 1980s, Akindayomi's successor, Enoch Adejare Adeboye transformed the church by giving it modern trappings and expanding the membership base to include middle and upper class elements. The 1990s saw an intensification of the church-planting efforts of the RCCG with the 'model' parishes (introduced in 1988) proliferating in several urban centers. By 2005, the church had a total membership of almost 900,000 people spread over some 7000 parishes in the 36 states (plus the FCT) of Nigeria[6]. In 1998, the RCCG established RAPAC to mediate the churches intervention in the HIV/AIDS epidemic.

The Catholic Church is the oldest Christian denomination in Nigeria, having first been introduced in the 15th century to Warri, in the Niger Delta. However, it was in the 19th century that it became firmly established. By the end of the 20th century it had spread all over Nigeria, claiming a membership of 20 million people administered in 49 Dioceses and 9 Ecclesiastical Provinces. Of all Christian denominations in Nigeria, the Catholic Church has been in the lead in the provision of social services such as health and education, and in advocating social justice. Thus, by the time HIV/AIDS epidemic broke out, the Catholic Church already had over 300 health institutions scattered all over the country. Before the Church articulated its official HIV/AIDS Policy in 2002, it had already started to treat HIV related cases in many of its hospitals and clinics.

One major observation about the above FBOs is that they utilize existing church structures and networks in their mobilization against the epidemic. For example, the organizational structure of RAPAC is engrafted on the existing configuration of the RCCG. Similarly, the Catholic Church uses existing Diocesan and Parish structures to prosecute its anti-AIDS campaign. The orientation of HWWN is slightly different because of its international connections, but from time to time, it falls back on the human and material resources of the LCC to support its activities. What follows now is a comparative analysis of the activities of these three Christian bodies in the fight against HIV/AIDS in the areas of prevention, care and support, and mitigation of the impact of the epidemic.

## AREAS OF CHRISTIAN INTERVENTION

### *Prevention Campaign*

FBO strategies for preventing further spread of HIV rest on three legs. First is the reduction of stigma and the breaking of the silence in the churches. Second is the creation of awareness within churches, while the third is the promotion of behavioral change. The first two are closely related, and in fact go hand in hand. The first few years of RAPAC's existence, for instance, were spent organizing sensitization seminars to educate first the pastors, and later the laity on the reality of HIV/AIDS. RAPAC campaigned against stigmatization of PLWHAs in the church by invoking the love of Christ and appealing to members to demonstrate Christian virtues in their dealings with the infected (Adeboye

2006). Discrimination against PLWHAs was most effective in small settings such as the home fellowship and cell groups, and within very small congregations where people knew one another well. The following experience of Sister Agnes (not real name) who is a 'worker' (an active member) in an RCCG parish illustrates the point:

> I was in the Children's Department as a teacher when I discovered my status and told my pastor. Shortly after this disclosure, my name was announced that I should leave the Children's Department and go to the Bookshop. I went to meet my pastor to find out why I was being moved. He said parents may refuse to bring their children to the department if I remained there. I was surprised to learn that the 'parents' were already aware of my status[7].

The LCC on its own part, also raised awareness about HIV/AIDS in its congregation by educating members on how the virus is contracted, how it could be avoided and treated. However, all these amounted to nothing more than intellectual awareness. What actually broke the ice in the LCC was the personal testimony of members living with HIV, who had been flown in from a sister church in South Africa to train counselors for the church in Lagos. This singular act gave the virus a human face. It transferred HIV/AIDS from a nebulous, distant infection to an undeniable personal reality. The Catholic Church also started by training clergy in eight Dioceses to create awareness about HIV/AIDS, and to enable the priests initiate discussions on it from the pulpit. Local Parish Action Committees on AIDS (PACAs) also organized seminars and invited resource persons to educate parishioners on HIV/AIDS

In promoting behavioral change among youth and married members, all the three FBOs use peer educators. Youth groups, women groups, teenage and men's groups in the churches are all mobilized in this regard. Between 2002 and 2004, HWWN, for instance, claimed to have trained over 400 peer educators, who in turn reached out to over 100,000 youth (HWWN 2005). Among unmarried youth, the message is abstinence, while for the married, the emphasis is on fidelity or faithfulness to ones spouse. It is however interesting to note that each of these three FBOs has different views on the issue of condom use. The RCCG is against condom use by the unmarried because it negates Christian standards of morality, which frowns at pre-marital sex. But it allows it in the case of sero-discordant couples. The Catholic Church, on the other hand, does not approve of condom use on any ground, not even for discordant couples. Instead, the Church recommends that "expression of love between HIV sero-discordant couples" should be "through non-genital means. This also helps to avert abortion" (Catholic HIV Policy 2002). This policy does not seem to draw any distinction between the use of condom to prevent HIV and its use as a family planning device. While the LCC frowns on pre-marital sex and does not promote condom use among the youth in the church, HWWN openly advocates it among the youth with whom it works outside the church.

The attitude of HWWN to condom use is quite understandable because, of the three groups it is the only one that has taken its prevention campaign beyond the church congregation to public schools. It is also part of an international FBO that has considerable experience in HIV/AIDS work in the wider society. In 2001, HWWN started a prevention program in eleven tertiary institutions in Lagos State with funding from USAID and FHI. This was scaled up in 2003 to include all Senior Secondary

Schools in Epe Local Government Area of Lagos State (HWWN 2005). It is within this context that it proclaimed the condom message. RAPAC, on the other hand provides sexuality education within the RCCG, and in other churches to which it is invited. The aim of this sexuality education is to equip adolescents and teens with skills that they need to practice abstinence. It also seeks to foster effective parent/child education. The approach of the RCCG is also to mainstream HIV/AIDS into existing church programs. Church drama groups disseminate information on HIV/AIDS during performances. Modules on HIV/AIDS have also been built into the syllabus of the RCCG Bible College (cf. Dube 2003). And during large convocations of the RCCG held at the international headquarters – the Redemption Camp- RAPAC mounts information stands where it gives out literature on HIV/AIDS and offers interpersonal counseling (Adeboye 2006). There is also a media campaign in which the General Overseer of the RCCG, E.A. Adeboye, appears on national television in a three-minute advert, giving tips on HIV prevention and appealing to the public to rise up and kick out the virus from the nation.

Finally, the Catholic Church in its health institutions has put in place several measures to prevent further spread of HIV/AIDS. These include: screening of donated blood for HIV, prevention and treatment of sexually transmitted infections, prevention of mother-to-child transmission (PMTCT) using ARVs and counseling on infant feeding.

***Treatment and Care***

In focusing on treatment and care, the following areas would be explained: voluntary counseling and testing (VCT); post-test counseling and pastoral care; medical care and treatment; and, promotion of mental health and restoration of hope to PLWHAs. One remarkable observation about the FBOs discussed here is that PLWHAs are not required to join any of them before they could have access to the care or treatment offered. People could come from any religious background and receive care from these groups.

Voluntary counseling and testing is the starting point for receiving care. Until a person tests positive, care and treatment cannot commence. In fact, the thinking now is that people should only be counseled to go for tests only when there are available avenues for treatment in the event of a positive result. This is also to remove the fear of testing. All the three FBOs in focus now encourage voluntary, pre-marital testing (as opposed to mandatory testing) after due counseling. In the LCC, if either or both of the parties tests positive, the church counsels them and allows them to make a choice of their own[8]. The RCCG also adopts this official policy. In addition to frowning against mandatory pre-marital testing, the Catholic Church is also against pre-employment HIV screening in all its institutions (medical, educational etc). And according to the Church, "members of staff of Catholic institutions who become HIV infected or develop AIDS shall retain their rights to employment (Catholic HIV Policy 2002).

Post-test counseling is also very crucial because it assists the individual concerned to overcome stigmatization and to make good choices about himself and the society. Will he embrace grief and dejection or live positively with the infection? Will he wallow in self-pity or join the community's battle against HIV? Will he take responsible steps to prevent infecting others or go crazy with anger and try to pass on the infection? These are some of the issues raised during counseling sessions (cf. Nussbaum 2005). The churches give hope to PLWHAs and help them to accept their sero-status, and adjust their

lifestyles accordingly in terms of diet, hygiene, and healthy habits. This realization that this type of counseling requires special skills has made the churches to train their leaders in order to meet this challenge. Apart from the medical staff in the Catholic institutions, Parish Catechists and marriage counselors are also trained to undertake pre- and post-test counseling[9]. RAPAC has also trained several pastors in the RCCG as HIV/AIDS counselors[10]. In the LCC, all the evangelists (church leaders) are certified HIV/AIDS counselors[11]. Furthermore, in 2001, HWWN commenced counseling services at nine government hospitals in Lagos State.

The question of whether or not PLWHAs should declare their status publicly is another choice which counselors assist them to make. It is only in the Abuja Diocese of the Catholic Church that several individuals have stepped forward to declare their status. And this was made possible also because of the existence of strong support groups. However, the same cannot be said of the remaining 48 Dioceses of the church[12]. In the RCCG, the first clergy to declare his HIV status was Assistant Pastor Pat Matemilola in 2000 (Matemilola 2005). The support he experienced in his parish has created a social space for others within the same assembly to disclose their HIV positive status. Matemilola is now the National Coordinator of the Network of People Living with HIV/AIDS in Nigeria (NEPWAN). There is also the case of Rolake Odetoyinbo, the first Nigerian woman to go public about her HIV positive status, and a member of the RCCG. Rolake later became an AIDS treatment activist and heads an NGO called Positive Action for Treatment Access (PATA)[13]. In addition to a weekly show on national television on HIV/AIDS, she also writes a weekly column titled "In Moments Like This: Living with HIV" in the *Sunday Punch*, Nigeria's most widely read newspaper. This brings us to the role of support groups. While the Catholic HIV/AIDS Policy has detailed recommendations on the composition and role of support groups, in practice, only a handful of such groups are functional as is evident in the Abuja case cited above. HWWN has over ten support groups in Lagos with a membership of about 500 PLWHAs and PABAs. RAPAC even has fewer than ten.

In the area of pastoral care, the three FBOs have continued to reach out to PLWHAs mainly through the use of volunteers from their respective congregations. RAPAC has volunteers who pay home visits to PLWHAs, pray with them and offer them encouragement from the Bible. They also distribute material donations (food items, clothing, household supplies) collected by the church to the PLWHAs (Adeboye 2006). In the LCC, 'Benevolence' Sunday services are conducted to raise material donations for PLWHAs within and outside the church[14], while the Catholic Church allows all Dioceses to organize second Collections in all Parishes once a year for HIV/AIDS Programs. This is in addition to budgetary provisions in each Diocese to support HIV/AIDS activities (cf. Bate 2003).

The treatment of PLWHAs is also a matter of great concern to the FBOs. Under the PMTCT initiative, HWWN provides free ARV treatment for HIV positive expectant mothers and their babies, as well as free replacement feeding for the babies for the first year to prevent transmission through breast-feeding (HWWN 2005). In 2005, 700 women benefited from this scheme. HWWN also provides free medical consultations and free treatment of opportunistic infections to other PLWHAs. It works from its bases in the nine government hospitals with which it is affiliated[15]. Because of its wider network of health institutions, the Catholic Church is able to reach out to a greater number of people

although it does not give free ARV treatment. Its philosophy of health care is to establish "a continuum of care between home, community and health institution to meet medical and psychological needs of people living with HIV/AIDS" (Catholic HIV/AIDS Policy 2002). It treats, among other things, opportunistic infections for which it charges moderate fees.

The RCCG has only a handful of health institutions that can treat HIV/AIDS cases, so most of the time, it refers patients to other government and mission hospitals. Majority of its own health institutions are designated 'maternity centers', which specialize in deliveries and child care. However, RAPAC has been able to donate ARVs and medical equipment to many government hospitals in Lagos through the Med-Share Program of the North American Chapter of the African Missions of the RCCG started in 2004 (Adeboye 2006). What this group of RCCG members in North America does is to solicit for donations of drugs and medical equipment from companies in the USA and Canada, which they send to RAPAC to distribute in Nigeria and to other RCCG mission fields in other parts of Africa. RAPAC then donates Nigeria's share of the medical supplies, especially ARVs to government hospitals since it does not dispense directly to patients. Although, given the immense needs of the nation, these donations amount to a very small fraction, they nonetheless assist in a little way. It is also common in the RCCG and in the other two FBOs to find intra-church associations and societies covering the cost of ARVs for some groups of PLWHAs they have identified. Again, home based care (HBC) is also promoted by these FBOs who train volunteers in the administration of home care and sends them out in teams to visit and care for sick PLWHAs in their community.

Perhaps, the most unique service/care rendered by these FBOs is in the area of mental health promotion and restoration of hope to FBOs. Mental health is here defined as "the emotional and spiritual resilience which enables us to enjoy life and to survive pain, suffering and disappointment. It is a positive sense of well-being and an underlying belief in our own and others' dignity and worth" (Friedli 2001:56). Thus mental health promotion aims to "strengthen individuals and increase emotional resilience through interventions designed to promote self-esteem, life and coping skills; communicating, negotiating, relationship and parenting; skills to improve the capacity to cope with life events, transitions and stresses such as parenting, bereavement, redundancy, unemployment, retirement" (Ibid). To this list one could add the trauma and stress of living with HIV/AIDS and the burden of having to care for a loved one who has the virus. This last category describes the experience of PABAs. That the faith community has been able to devise fruitful interventions to address these needs shows that not only does it promote mental health; it also provides spiritual therapy for mental health problems such as depression and stress. In fact, research has shown that many people with mental health problems (that were not even related to HIV/AIDS) have found great support within their congregation and have found prayers, worship, religious belief and belonging to a religious community both helpful and affirming (Ellison and Levin 1998). The 'testimony' of Rolake Odetoyinbo quoted below illustrates this point well. In December 2000,

> My parents, my younger brother and I went to the Redemption Camp [of the RCCG] for the Holy Ghost Festival [tagged] VICTORY AT LAST …. [There,] I cried my heart out to God

> and begged Him to heal me …. God heard my cries and healed my broken heart and mended my life …. The last time I took the HIV test, the virus was still in my bloodstream but I know God permitted this for a purpose. My healing is a settled matter, but while I await the physical manifestation, I will use this to the glory of God, to bring hope and joy to those in similar circumstances (Odetoyinbo 2004).

Closely related to this is the issue of faith healing as it applies to the RCCG. The church believes that God can cure HIV/AIDS and prays regularly for the healing of PLWHAs. But according to the *Redemption Light*, the official organ of the church, "the focus of the church's involvement in the AIDS scourge is not only in the area of healing. Faith for healing is good but it is the prerogative of God. In His time and in His own way, He does it" (Olubiyi 2005). This means that the church is willing to pray for the infected, but does not guarantee instantaneous healing since that is "the prerogative of God". So where there is no healing, the church, through RAPAC offers palliative care and counseling and encourages PLWHAs to take ARVs. Thus the stand of the RCCG is neither against the possibility of a divine cure for HIV/AIDS nor against a biomedical management of the illness. It evolved as an interface between the two options.

The hope that the churches give to PLWHAs is not only to increase their will to live, but paradoxically also prepares them to face death. This has been described as "a reason to live and a readiness to die" (Nussbaum 2005). And it is probably only within faith communities that the issue of the fear of death is dispelled by the anticipation of a continued 'disease-free' existence in the 'afterlife' (Chukwu 2004:72). The Catholic Church, for instance, has special rites for the terminally ill. The priest administers the last sacrament, and prepares the sick to face death without fear[16] (Kiriswa 2004:87). However, one should add here that not all churches have such positive and tranquilizing effects on PLWHAs. Many still explain HIV/AIDS infection in terms of sins committed by those involved, thus causing them great suffering and emotional damage.

***Mitigation of the Impact of HIV/AIDS***

In working to assuage the impact of HIV/AIDS on the society, the FBOs in focus have concentrated their energies on the care of Orphans and Vulnerable Children (OVCs) and widows[17]. In the management of AIDS orphans in Nigeria, the idea of establishing special orphanages for them is not popular among FBOs (and sometimes it is not clear whether a child's parent died from AIDS or from other causes). Rather, they are accommodated in existing orphanages. In fact, a more popular practice is to assist OVCs right in their own homes or in the homes of relations and others that have fostered them. HWWN, of the three FBOs examined here is most passionate about the plight of OVCs. Every year it organizes a 10-kilometer HOPE WALK to raise funds for OVCs and create awareness about them in the society. The last HOPE WALK in December 2005 attracted 1,200 volunteers. Under a special ARK Scheme, the funds raised are disbursed as scholarships to finance the education of the children. The scheme, which started in 2001, has been able to award 130 scholarships. However, as a result of the December 2005 HOPE WALK, funds have been raised to cover scholarships for an additional 350 children (HWWN 2005).

Other forms of support for OVCs in the care of HWWN include: nutritional assistance (food donations), counseling and free medical treatment for the children and their caregivers. The children also enjoy regular home visits from HWWN volunteers, who organize them into several clubs and what HWWN calls the "Children's Parliament" where they receive feedback from the children on how to further improve their lot. Not all OVCs under HWWN benefit form educational scholarships. Some are enrolled under the Life Skill Development Program which commenced in 2004. This is a training institution located at the HWWN headquarters in Lagos where skills like leatherworks, bead-making, textile crafts (weaving, dyeing), pottery and ceramics are taught to the children to enable them become financially independent[18]. In collaboration with HWW South Africa, HWWN developed appropriate child survival booklets which address issues such as children's rights and income generation. HWWN has no corresponding scheme specifically targeted at widows. But as caregivers to OVCs, many widows benefit from the free medical treatment and nutritional support from HWWN. Within LCC, AIDS widows are classified as PABAs and this qualifies them for pastoral care and support. The also benefit from existing church schemes for general widows[19].

The Catholic Church operates fourteen Orphanages in Nigeria. Although these are for general orphans, they also accommodate AIDS orphans. The preference of the church, however, is to identify the children's caregivers within the community and assist them. Within the Catholic framework, this type of assistance is coordinated at the Diocesan level. Abuja Diocese, for example, is responsible for 65 orphans that are not in any orphanage[20]. In the area of the care of widows, the Catholic Justice and Development Commission fights the cause of those who are being maltreated and denied of their inheritance rights. Several Parishes also have Widow Support Schemes. In addition to these are existing charity organizations within the church such as St Vincent's, which takes care of the poor, widows and orphans[21].

In the RCCG, there were several welfare schemes for orphans even before the HIV/AIDS ministry was inaugurated. The only Orphanage operated by the church (Heritage Home) does not discriminate against AIDS orphans. Apart from the RCCG central scholarship scheme, there are also parallel programs at the Provincial, Area, and Parish levels, which cater for the needs of indigent children, and into which OVCs are also brought. As is the case in the Catholic Church, existing 'ministries', which reach out to widows at all levels (Provincial, Area, and Parish) also attend to AIDS widows. Some of the schemes seek to empower the women economically by giving them vocational training and granting them soft loans to establish small businesses. Widow support groups also provide fellowship opportunities for the women. Examples of these include the Tabitha Fellowship in Lagos Province 2 and 'Heads High' Ministry in Lagos Province 7 of the RCCG.

Another way of mitigating the impact of HIV/AIDS on the society is by confronting poverty. Poverty is to be seen here, not just as a contributory cause to the spread of HIV/AIDS, but also as a major consequence of the epidemic. There thus appears to be a dialectical relationship between the two because while poverty pushes people into high risk groups like sex workers and drug users, the aftermath of AIDS reinforces poverty and creates new strands of lack, which in turn exposes many to greater risks of infection. The churches seem to have recognized this vicious cycle and have strengthened 'ministries' targeted at the high risk groups. The case of the RCCG

illustrates this. Its Christ Against Drug Abuse Ministry (CADAM) rehabilitates drug users while its Holistic Ministry is directed at commercial sex workers. The relevance of these two ministries in the context of current HIV/AIDS campaigns cannot be overemphasized. Individuals converted from drugs and sex work are taught new skills and assisted to establish small businesses of their own, while taking care of those that are already HIV positive among them.

## CHRISTIAN INTERVENTIONS: HOW EFFECTIVE?

An objective assessment of the FBO interventions discussed above would help in identifying aspects that require modification and scaling up, and those that are simply not working. This concern is borne out of a purely utilitarian perspective that desires the greatest good for the greatest number of people. However, a purely mechanical approach to this would immediately run into problems. This is because some aspects of this impact are almost impossible to gauge. How does one quantify relief, reduction in anxiety, encouragement and other such intangibles? (cf Nussbaum 2005). For example, how many 'joules' of care and love are dispensed when a church volunteer visits a PLWHA on a weekly basis? Or, how many 'amperes' of encouragement does a PLWHA receive per counseling session in a post-test encounter with her pastor? While PLWHAs may individually testify to the benefits derived from such interventions, it is difficult to evaluate their intensity, volume or depth.

A possible alternative is to examine how the FBOs have evaluated themselves. In other words, what do the documents and records of these groups reveal about their activities, especially in terms of the balance sheet of stated goals and practical end results? Unfortunately, research, self-monitoring and evaluation are still very weak among the groups and what presently exists does not say much other than the general conclusion that there is still a lot of work to be done and that most interventions still require considerable scaling-up for the services dispensed to go round, or at least have a wider spread. Again, the fact that some of these specific interventions are new initiatives that are hardly off the ground makes the idea of a rigorous assessment, even by neutral researchers, appear rather premature. The Catholic Five-Year Strategic Plan on HIV/AIDS, for instance, is just in its third year of implementation. RAPAC is yet to come up with a systematized policy document after eight years of operation. HWWN, which appears to possess the institutional framework (as an international FBO) to implement the monitoring and evaluation of its interventions has not done much in this regard. Its approach seems to be to get projects off the ground first and allow them time to stabilize before embarking on evaluation.

Perhaps a more productive approach to the issue of performance assessment is to examine how the FBOs have fared in handling specific challenges directly related to the discharge of their duties. The first challenge here is an internal one and is mainly theological. HIV/AIDS touches on a number of important theological issues, which the churches cannot ignore as long as they are serious about their commitment to the anti-AIDS battle. The most salient issues here are: the role of disease in God's creation; understanding of suffering and death, interpretation of sin and forgiveness; love and acceptance; the concept of sexuality; and gender relations (Weinreich and Benn 2003). All but the last of these concerns have begun to receive varying degrees of attention by the FBOs examined here. Biblical sources of gender inequalities and injustice are still

unchallenged by the churches. For example, many churches teach fidelity as part of HIV prevention strategies. But what should a 'faithful' wife do in the case of a spouse who is not only 'unfaithful', but is also unwilling to use the condom after testing positive to HIV? Churches have not empowered married women to negotiate safe sex with their husbands in such cases. Women thus endure 'death-dealing' relationships because most churches do not support divorce. The silence of the church on this has made some feminist theologians to advocate not only a gender-sensitive, multi-sectoral approach to the issue of HIV/AIDS, but also an 'engendered theology' for the church (Haddad 2002; Dube and Maluleke 2001; Dube 2004).

A faith-based group that has consistently championed the cause of oppressed women especially within the context of HIV/AIDS is the Circle of Concerned African Women Theologians, a pan-African group formed in 1989. In line with its mission of undertaking research and publishing theological literature with special focus on religion and culture, the Circle has over thirty books to its credit. The ones that specifically address HIV/AIDS are: *African Women, HIV/AIDS and Faith Communities* (2003) and *Grant Me Justice! HIV/AIDS and Gender Readings of the Bible* (2004)[22]. The concern of the authors of the above two books is to present, among other things, new female-friendly interpretations of the Bible that challenge earlier androcentric versions hitherto used to support patriarchal oppression within the church. For the Circle, the fight is still ongoing on behalf of African women who bear the brunt of HIV/AIDS, but for the churches, gender is yet to be mainstreamed into their interventions.

The second challenge to the FBOs is external. Many are unable to take full advantage of 'partnerships' with other groups involved in the anti-AIDS battles due to differences in strategies (abstinence versus condoms). HWWN, as an international FBO has no problem fraternizing with secular NGOs, government bodies and international donors. In fact, of the cases studied here, HWWN most readily accesses funds not only from the private sector in Nigeria, but also from external donors. Inability to network with other secular stakeholders in the HIV/AIDS battle threatens to incapacitate other FBOs because they stand to gain a lot from other groups and the AIDS crusade cannot be won as a unilateral offensive. Experience from other countries where HIV/AIDS has eaten deep into their system shows that perspectives are likely to shift when people become more closely involved in the lives of the PLWHAs (even when official policies remain unchanged). In South Africa, for instance, while the official church 'ban' on condoms still subsists, many FBO workers have realized that respecting and protecting life can mean unofficially discussing condom use on a one on one basis. Thus while church authorities preach against condoms, grassroots workers bring it in through the back door whenever they find a great need for it[23].

Abstinence certainly has its value especially where it leads to late sexual debut among youths. This is a prevention tool that has been proven to be effective in Uganda, which when combined with other strategies, like condoms and fidelity brought down the national prevalence from 21% in 1991 to 6.1% in 2000 (Green 2003). The idea is that a combination of strategies works best. Thus, religious leaders, even where they will not allow condom use within their constituencies should not disparage its usefulness in other contexts. In the same way, secular activists are to respect churches' position and not downplay the A and B portions of the ABC campaign. This ideal of cooperation and

tolerance is succinctly captured in a Christian prevention campaign developed in Tanzania by Father Bernard Joinet, a professor of psychology, called the *Fleet of Hope*.

> Fr Joinet images compare the AIDS pandemic to a flood from which the only escape is to climb on board the *Fleet of Hope*, an inseparable combination of three boats, the *Fidelity*, the *Abstinence* and the *Condom*. It is explained that whereas the government or the UN and NGOs have a responsibility to get people on board, no matter into which boat, groups like churches, tribes or families may urge their members to climb into a specific boat, according to their common shared values. However, the *Abstinence* is not only for monks nor is the *Condom* only for poor sex workers. Everyone may at some determined moment have to change from one boat to another to avoid the risk of drowning. A typical example is that of the 'condomizing womanizer' who runs out of stock; he can either drown or board the *Abstinence* until the pharmacy opens the following morning[24].

Such broadminded synthesis apart from reducing potential tension in the implementation of the three strategies also makes networking easy for the different groups concerned. Similar models could also be adopted in Nigeria. In cases where large-scale secular NGOs are reluctant to partner with churches directly, they may work through religious coordinating bodies that will supervise and monitor the churches. The benefits derivable from networking and cooperation devoid of strategy deadlocks cannot be overemphasized. On one hand, NGOs and government bodies benefit from the churches' wider reach and tradition of care, while on the other hand, the churches will have access to the latter's funds and technical expertise.

Finally, there are several miscellaneous issues of practical concern which could be tackled by a pragmatic deployment of both internal and external resources. First is the neglect of widowers in many intervention programs. The peculiar needs of men infected and affected by HIV/AIDS require special attention. The activities of Rev. Gideon Byamugisha of Uganda in mobilizing religious leaders infected by HIV/AIDS in Sub-Saharan Africa are quite remarkable. But what becomes of widowers that are not religious leaders? Another problem is the concentration of most intervention efforts in the cities and urban centers while the rural communities suffer relative neglect. This ought to be addressed urgently and a poverty-relief component added to the rural interventions. While it has been observed that the strength of the interventions in the three case studies rests on the use of volunteers, these individuals should not be overworked so as to avoid burnouts. Strategies should be devised to broaden the volunteer base of each FBO. Lastly, the big gap between administrative policy and practice in the execution of intervention programs should be bridged.

## CONCLUSION

This study has shown the different areas in which FBOs have been involved in the anti-AIDS crusade in Nigeria. Although they joined the battle late, FBOs have great potentials given their tradition of care (through health institutions), spirit of service, and

pastoral care, all of which reach beyond the physical bodies into the emotional and mental health of PLWHAs. A major conclusion of this study is that Christian intervention in the Nigerian AIDS crisis, though welcome, is presently neither deep-rooted nor widespread. There is thus the need for FBOs that are presently outside the anti-AIDS arena to take up the challenge and join in the crusade against the deadly virus, while those already involved should scale up their activities. Christian concern should also be genuine and deep-rooted enough to provoke modifications and re-interpretations of existing theologies that hinder effective/meaningful interventions.

This study has also shown that the church is not always predisposed to opposing popular beliefs in the wider society depending on which doctrinal prism it adopts. This is evident in the initial denial of HIV/AIDS and the ensuing stigmatization of PLWHAs by the church. This was partly due to the fact the church took its cue from popular discourses on the virus, which were then strengthened by the full weight of its religious authority. This, to say the least, is a great indictment on a church that claims that its fundamental message is one of love and forgiveness. Moreover, in terms of the general sensitivity and responsiveness of the church to wider socio-political issues, it appears that mainline churches, from their past records, have shown more consistent commitment than other Christian groups, to issues of social justice and good governance. It is therefore anticipated that such mainline churches would not only intensify direct interventions in the HIV/AIDS situation, but also serve as the voice of the infected and the affected by demanding that political authorities and politicians give priority to HIV/AIDS especially on their agenda for 2007 elections.

Finally, this study has accented the need for FBOs to cooperate and network with other secular bodies involved in assuaging the epidemic. The AIDS battle cannot be won by a single group. All hands are to be on deck and differences underplayed to make room for meaningful partnerships/coalitions in the anti-AIDS crusade. The benefits of cooperation are not just multiple; they also accrue to all the parties involved. This, in fact, is the message of an African proverb which says: "If you want to go fast, go alone; but if you want to go far, go together with others". FBOs should go together with other secular groups.

**REFERENCES**


Adeboye, Olufunke. 2005. "Transnational Pentecostalism in Africa: The Redeemed Christian Church of God". In *Enterprises Religieuses Transnationales en Afrique De l'Ouest*, edited by A. Mary, R. Otayek and L. Fourchard. Paris: Karthala.

_____ . 2006. "The Redeemed AIDS Program Action Committee". In *Traditional and Modern Health Systems in Nigeria*", edited by T. Falola and M. Heaton. Trenton, NJ: Africa World Press.

Akani, C.I., Erhabor, O, and Babatunde, S. 2005. "Pre-Marital HIV Testing in Couples From Faith-Based Organizations: Experience in Port-Harcourt, Nigeria". *Nigerian Journal of Medicine* 14 (1): 39-44.

Bate, Stuart. 2003. "Catholic Pastoral Care as a Response to the HIV/AIDS Pandemic in Southern Africa". *The Journal of Pastoral Care and Counseling* (JPC) 57 (2): 197-209.

Campbell, Catherine. 2003. *Letting them Die: Why HIV/AIDS Prevention Programmes Fail*. Oxford: James Currey.
Catholic Secretariat of Nigeria. 2002. *Nigerian Catholic HIV/AIDS Policy*
Chepkwony, Adam K. Arap. 2004. "Christian and Traditional African Attitudes Towards HIV/AIDS". *African Ecclesial Review* 46 (1): 55-66.
Chukwu, Cletus N. 2004. "Bodily Life: A Philosophical Approach to HIV/AIDS". *African Ecclesial Review* 46 (1): 67-79.
Cimperman, Maria. 2005. *When God's People Have HIV/AIDS: An Approach to Ethics*. New York: Orbis Books.
Coleman, J.A. 2003. "Religious Social Capital: It's Nature, Social Location, and Limits. In *Religionas Social Capital*, edited by Corwin Smidt. Waco: Baylor University Press.
Dube, Musa W. 2003. (Ed.) *HIV/AIDS and the Curriculum: Methods of Integrating HIV/ AIDS in Theological Programmes*. Geneva: WCC Publications.
_____ . 2004. "Grant Me Justice: Towards Gender- Sensitive Multi-Sectoral Readings of the Bible". In *Grant Me Justice! HIV/AIDS and Gender Readings Of the Bible,* edited by Musa W Dube and Musimbi R.A. Kanyoro. Pietermaritzburg: Cluster Publications.
Dube, Musa W and Maluleke, Tinyiko S. 2001. "HIV/AIDS as the New Site of Struggle: Theological, Biblical and Religious Perspectives". *Missionalia* 29 (2): 119-124.
Dube, Musa W and Kanyoro Musimbi. 2004. Grant Me Justice! HIV/AIDS and Gender Readings of the Bible. Pietermaritzburg: Cluster Publications.
Ellison, Christopher G. and Levin, Jeffrey S. 1998. "The Religion-Health Connection: Evidence, Theory and Future Directions". *Health Education and Behaviour* 25 (6): 700-20.
Federal Ministry of Health, Nigeria. 2003. *National Guidelines for HIV/AIDS Voluntary Counselling and Testing (VCT) Services in Nigeria*. Abuja: FMOH.
Federal Ministry of Health, Nigeria. 2004. *2003 HIV Sero-Prevalence Sentinel Survey*. Abuja: FMOH>
Freund, P.E.S. and McGuire. 1991. *Health Illness and the Social Body: A Critical Sociology*. Englewood Cliffs, New Jersey: Prentice Hall.
Friedli, Lynne. 2001. "Social and Spiritual Capital: Building 'Emotional Resilience' In Communities and Individuals". *Political Theology* 4: 55-64.
Fukuyama, Francis. 1995. *Trust.* New York: Penguin Books.
Green, Edward C. 2003. "How Faith-Based Organizations Have Contributed to AIDS Prevention". In *The Hope Factor: Engaging the Church in the HIV/AIDS Crisis*. Waynesboro: Authentic Media and World Vision.
*Guardian* (Lagos). May 1, 2000 and May 1, 2001.
Haddad, Beverly. 2002. "Gender Violence and HIV/AIDS: A Deadly Silence in the Church". *Journal of Theology for South Africa* 114: 93-106.
Hope Worldwide Nigeria. 2005. *Who We Are, What We Do* (Information Brochure)
Hope Worldwide Africa. 2005. "The Great Nigeria Hope Walk". Available on http://www.africa.hopeww.org/world/africa/sections/programs/nhw.htm Accessed on March 16, 2006.
Hope Worldwide Africa. 2005. "Nigeria Program". Available on http://www.africa.hopeww.org/world/africa/sections/programs/nigeriaintro.htm

Iannaccone, Laurence R. 1990. "Religious Practice: A Human Capital Approach". *Journal for the Scientific Study of Religion* 29 (3): 297-314.
Ilife, John. 2006. *A History of the African AIDS Epidemic*. Oxford: James Currey.
Joinet, Bernard and Nkini, Wilhelm G. 1996. "The Fleet of Hope: Offering Options To Achieve Healthy Behaviour". Available on http://www.kit.nl/ils/exchange_content/html/1996_2_fleet_of_hope.asp?/ils/exchange_con… Accessed March 23, 2006.
Kamaara, Eunice. 2004. "Stigmatization of Persons Living with HIV/AIDS in Africa: Pastoral Challenges". *African Ecclesial Review* 46 (1): 35-54.
Kiriswa, Benjamin. 2004. "Pastoral Care and Counseling of Persons Living with HIV/AIDS". *African Ecclesial Review* 46 (1): 80-99.
Marler, Penny Long and Hadaway, C. Kirk. 2002. "Being Religious or Being Spiritual In America: A Zero-Sum Proposition?" *Journal for the Scientific Study of Religion* 41 (2): 289-300.
Matemilola, Pat. 2005. "Pat Matemilola". In *Positive Voices: Religious Leaders Living With or Personally Affected by HIV and AIDS*, edited by Gideon Byamugisha And Glen Williams. Oxford: Strategies for Hope Trust.
Moore, Bryan Edward. 2002. "Power Perfected in Weakness: Narratives of Pastors Living, Coping, and Ministering with HIV/AIDS". Master of Divinity Thesis, Emmanuel School of Religion, Johnson City, Tennessee.
Nussbaum, Stan. 2005. *The Contribution of Christian Congregations to the Battle with HIV/AIDS at the Community Level*. Colorado Springs: GMI Research Services.
Nyanzi, S. 2003. "The Role of Faith Healing in an HIV High-Risk Area: A Case Study of Balokole Churches in Masaka District, Uganda". *CODESRIA Bulletin* 2,3 &4: 89-91.
Odetoyinbo, Rolake. 2004. "Taking the HIV Test" (In Times Like This: Living with HIV) *Sunday Punch* (Lagos) August 8.
Olubiyi, Olaitan. 2005. "Fighting HIV/AIDS in Jesus' Name". *Redemption Light* 8 (12): 19.
Orubuloye, I.O., Caldwell, J.C. and Caldwell, P. 1994. "The Role of Religious Leaders In Changing Sexual Behavior in Southwestern Nigeria in an Era of AIDS". In *Sexual Networking and AIDS in Sub-Saharan Africa: Behavioral Research and Social Context*, edited by I.O. Oruboloye, J.C. Caldwell, P. Caldwell and G. Santoro. Canberra: Health Transition Center.
Oyelese, A.O. 2003/2004. "Stigma, Discrimination and Ostracization: HIV/AIDS Infection in Nigeria". *International Quarterly of Community Health Education* 22 (1&2): 125-129.
Paul, Gregory S. 2005. "Cross-National Correlations of Quantifiable Social Health With Popular Religiosity and Secularism in the Prosperous Democracies". *Journal of Religion and Society* 7: 1-17.
Phiri, Isabel A., Haddad, Beverly and Masenya, Madipoane. 2003. *African Women HIV/AIDS and Faith Communities*. Pietermaritzburg: Cluster Publications.
Portes, Alejandro. 1998. "Social Capital: Its Origins and Applications in Modern Sociology". *Annual Review of Sociology* 24: 1-24.
Putnam, Robert D. 2000. *Bowling Alone: The Collapse and Revival of American Community.* New York: Simon & Schuster.

Smith, Daniel Jordan. 2003. "Imagining HIV/AIDS: Morality and Perceptions of Personal Risk in Nigeria". *Medical Anthropology* 22:343-372.
_____ . 2004. "Youth, Sin and Sex in Nigeria: Christianity and HIV/AIDS-Related Beliefs and Behavior among Rural-Urban Migrants". *Culture, Health and Sexuality* 6 (5): 425-437.
Tiendrebeogo, Georges and Buykx, Michael. 2004. *Faith-Based Organizations and HIV/AIDS Prevention and Impact Mitigation in Africa*. Amsterdam: Royal Tropical Institute.
UNAIDS. 2004. AIDS Epidemic Update: Sub-Saharan Africa
UNAIDS. 2005. AIDS Epidemic Update: Sub-Saharan Africa
Unruh, Heidi Rolland and Sider, Ronald J. 2005. *Saving Souls Serving Society: Understanding the Faith Factor in Church-Based Social Ministry*. Oxford University Press.
Verter, Bradford. 2003. "Spiritual Capital: Theorizing Religion with Bourdieu against Bourdieu". *Sociological Theory* 21 (2): 150-174.
Weinreich, Sonja and Benn, Christoph. 2003. *AIDS: Meeting the Challenge*. Geneva: WCC Publications.
Woodberry, Robert D. 2003. "Researching Spiritual Capital: Promises and Pitfalls". Available on http://www.metanexus.net/spiritual_capital/pdf/woodberry.pdf Accessed on March 11, 2006.
Zohar, Danah and Marshall, Ian. 2005. *Spiritual Capital: Wealth We Can Live By*. San Francisco: Berrett-Koehler Publishers.

**NOTES**

1. The emphasis of government, like those of other international NGOs and donors was initially on the condom strategy. But since 2004, emphasis has shifted to abstinence and fidelity, probably due to donor restrictions as in the case of PEPFAR.
2. National Action Committee on AIDS (NACA) boss, Babatunde Osotimehin said only 30% of PLWHAs will require ARVs. 30% of 4 million infected people is 1.2 million.
3. Such individuals include Yinka Jegede Ekpe, Pat Matemilola, Rolake Odetoyinbo, Mamman Musa Pumta etc.
4. A study carried out between 2000 and 2003 in Port Harcourt, Nigeria on pre-marital HIV testing on couples from faith-based organizations produced startling results. Of the 168 (84 couples) tested 35 (29.8%) were positive. None of them had been transfused with blood, and 31 (96.9%) of those that tested positive admitted to having had pre-marital sex with their partners. This rate of 29.8% is significantly higher than the national prevalence of 5.0% and the 6.6% reported for Port Harcourt in the 2003 sentinel Surveillance report (Akani et al 2005)
5. A good example of a religious coordinating body is the Inter-Faith HIV/AIDS Alliance established in 2002 with the support of the Balm in Gilead, a faith-

based NGO from the USA. Inter-faith comprises both Muslim and Christian groups working together to fight the epidemic. It is not included in this study because its area of operation is mainly in capacity building, and to coordinate the activities of the FBOs under it.

6. For more details on the early history of the RCCG see Adeboye (2005).
7. Interview with Sister Agnes (not real name) in Lagos on September 21, 2005.
8. Interview with Chris Ogbonnaya, Lead Evangelist, Lagos Christian Church on October 30, 2005 in Lagos.
9. Interview with Dr Joana Nwosu of the Catholic National HIV/AIDS Department at the Catholic Secretariat, Lagos, on June 20, 2005.
10. Interview with the Project Manager of RAPAC, Pastor Laide Adenuga, on August 24, 2005.
11. Interview with Lead Evangelist LCC, previously cited.
12. Interview with Dr Joana Nwosu, previously cited.
13. For more details on PATA's activities, visit their websites at www.patanigeria.org
14. Interview with Steve Emeh, Program Development Manager, HWWN, at the HOPE headquarters in Lagos on October 17, 2005.
15. Ibid.
16. Interview with Dr Joana Nwosu as previously cited.
17. In HIV/AIDS work, an orphan is a child who has lost either parent to the epidemic.
18. Interview with Steve Emeh as previously cited.
19. Interview with Lead Evangelist, LCC as previously cited.
20. Interview with Dr Joana Nwosu as previously cited.
21. Ibid.
22. For full citation of the works see Phiri et al (2003) and Dube (2004) in the References.
23. Bishop Kevin Dowling from the heavily HIV-infected mining district of the Rustenburg Diocese in South Africa is alleged to have said "people living with HIV must be invited and challenged to use a condom in order to prevent the transmission of potential death to another person or to protect themselves from infection, especially in abusive and destructive relationships". Tiendrebeogo and Buykx (2004:28)
24. This summary is produced by Tiendrebeogo and Buykx (2004: 27). For details on the Fleet of Hope, see Joinet and Nkini (1996).
25. Quotation taken from Information booklet produced by the Baptist AIDS Awareness, quoted in Nussbaum (2005; 56).