

The People of God Living with HIV/AIDS:

Resources for Education and Pastoral Care





Mother of God, Light in all Darkness

Mother of God, Light in All Darkness,

Shelter Him, our flame of hope,
With your tender hands.

And in our times of dread and nightmares,
Let Him be our dream of comfort.

And in our times of physical pain and
Suffering,
Let Him be our healer.

And in our times of separation from God and
One another let Him be our communion.

AMEN.

“Mother of God, Light in all Darkness,” is based on the Russian Icon “The Pimen Mother of God”. It was “written” for the National Catholic AIDS Network by Fr. William Hart McNichols, S.J., who worked in AIDS Ministry throughout New York State from 1983-1990.

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I: INTRODUCTION





Archdiocese of Los Angeles

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July 7, 2020

My dear sisters and brothers in Christ,

In the early years of the global HIV/AIDS epidemic, Pope Saint John Paul II reminded us: "Today you are faced with [...] the present crisis of immense proportions [...] that of AIDS. [...] You are called to show the love and compassion of Christ and his Church. As you courageously affirm and implement your moral obligation and social responsibility to help those who suffer, *you are, individually and collectively, living out the parable of the Good Samaritan* (cf. Lk 10:30-32)" (Convention Centre, Phoenix, September 14, 1987).

The Catholic Church around the world has responded generously and compassionately to the needs of people with HIV/AIDS. It is the largest HIV/AIDS provider in the world, with organizations such as Caritas Internationalis and Catholic Relief Services carrying out the Catholic Church's global mission through direct services and policy.

Here in the Archdiocese of Los Angeles we created our Catholic HIV/AIDS Ministry in 1986, and it has been reaching out to those infected and affected by this disease ever since. Our Catholic HIV/AIDS Ministry and HIV/AIDS Council continue to serve our people with bilingual education and pastoral care services.

Earlier this year, in his message for the World Day of the Sick, Pope Francis recalled the words of Jesus to those in need of healing: "Come to me, all you who labor and are burdened, and I will give you rest" (Mt 11:28). He also reinforced what Pope Saint John Paul II had said by noting that those who are sick "certainly need a place to find rest. The Church desires to become more and more the 'inn' of the Good Samaritan who is Christ (cf. Lk 10:34)."

I welcome this update of *The People of God Living with HIV/AIDS: Resources for Education and Pastoral Care*, and I pray that these resources will assist those who care for our affected brothers and sisters suffering from HIV/AIDS. In this way, the Archdiocese of Los Angeles will continue bringing hope and healing to those who are suffering.

May Jesus, through the intercession of Mary, grant health and peace to all,

+ José W. Gomez

Most Reverend José H. Gomez
Archbishop of Los Angeles

Pastoral Regions: Our Lady of the Angels San Fernando San Gabriel San Pedro Santa Barbara

“HIV/AIDS brings with it new anguish and new terrors and anxiety, new trials of pain and endurance, new occasions for compassion. But it cannot change one enduring fact: God’s love for us all.”

U.S. Bishops, Called to Compassion and Responsibility (VI, 5)

Catholic HIV/AIDS Ministry, Archdiocese of Los Angeles

Vision Statement

As the people of God of the Archdiocese of Los Angeles, we accept our mission to continue the redemptive work of Jesus Christ.

We are called to be compassionate of all those living with HIV/AIDS.

We are called to love those with HIV/AIDS, recognizing that HIV/AIDS is not punishment from God, but rather, that God is present and loving and a source of strength for all who are suffering.

We are called, as people of God living with HIV/AIDS, to give voice to help others understand the nature of living with this pandemic.

We are called to uphold the dignity of human life, and commit ourselves to cherish each person living with HIV/AIDS.

We are called to be instruments of the reign of God, and as Church, we commit ourselves to build a community of faith and love, which includes those living with HIV/AIDS.

Mission Statement

We provide liturgical, educational, and networking resources and referrals.

We offer pastoral care, visits, speakers, a resource guide, and training.

We bring a Catholic voice to the experience of HIV/AIDS.





CATHOLIC HIV/AIDS MINISTRY

Archdiocese of Los Angeles

Cardinal Roger Mahony began the Catholic HIV/AIDS Ministry in 1986, and Archbishop José Gomez continues the ministry with Fr. Chris Ponnet as his appointed Director. Fr. Chris, in his role as pastor at St. Camillus parish, hosts the Ministry office.

Fr. Chris created a leadership Council of persons from various parishes and regions that represents all those living with or affected by HIV/AIDS. We serve as a consultation office for parishes and communities as well as offer educational resources for the Archdiocese.

HIV/AIDS Resource Guide Collaborators

The following people generously contributed their time, expertise, and creative talents to the creation and updating of this Resource Guide.

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II: CATHOLIC CHURCH STATEMENTS AND RESOURCES



What Catholic Church leaders have said on HIV/AIDS

Compiled by Fr. Chris Ponnet

2016 Pope Francis on WORLD AIDS DAY: “Millions of people live with this disease, but only half of them have access to therapies that can save their lives. I ask you to pray for them and for their relatives, and to foster solidarity so that also the poor can access diagnostics and adequate treatment. I also ask that everyone use responsible behavior to prevent the spread of this disease.”

Nov 30 2015 Pope Francis: (Plane interview on returning from Africa regarding the issues of condoms to limit HIV's spread) “I don't like getting into questions or reflections that are so technical when people die because they don't have water or food or housing.”

2013 UNAIDS said this about the Church: “The Church provides support to millions of people living with HIV around the world, and that Statistic from the Vatican in 2012 indicate that Catholic Church-related organizations provide approximately a quarter of all HIV treatment, care, and support throughout the world and run more than 5,000 hospitals, 18,000 dispensaries, and 9,000 orphanages, many involved in AIDS-related activities.”

2010 Pope Benedict stated: There may be a basis in the case of some individuals, as perhaps when a male prostitute uses a condom, where this can be a first step in the direction of a moralization, a first assumption of responsibility, on the way toward recovering an awareness that not everything is allowed and that one cannot do whatever one wants. But it is not really the way to deal with the evil of HIV infection. That can really lie only in a humanization of sexuality. She of course does not regard [the use of condoms] as a real or moral solution, but, in this or that case, there can be nonetheless, in the intention of reducing the risk of infection, a first step in a movement toward a different way, a more human way, of living sexuality.

June 2 2006 Cardinal Javier Lozano Barragan addressed the US: “Our work focuses on the training of health-care professionals as well as prevention, treatment, care and assistance. We accompany the sick and their respective families at every stage. Specifically, [Caritas Internationalis](#) is engaged in this important work in 102 countries. The [Holy See](#) has launched initiatives all around the world against the pandemic in 62 countries: 28 in Africa, 9 in America, 6 in Asia, 16 in Europe and 3 in Oceania.

1997 *Always Our Children* Excerpts of the National Conference of Catholic Bishops' Pastoral Message to Parents of Lesbian and Gay Children.

“The Church recognizes the importance and urgency of ministering to persons with HIV/AIDS. Though HIV/AIDS is an epidemic affecting the whole human race, not just homosexual persons, it has had a devastating effect upon them and has brought great sorrow to many parents, families and friends. Without condoning self-destructive behavior or denying personal responsibility, we reject the idea that HIV/AIDS is a direct punishment from God. Furthermore: Persons with AIDS are not distant, unfamiliar people, the objects of our mingled pity and aversion. We must keep them present to our consciousness, as individuals and as a community, and embrace them with unconditional love...Compassion—love—toward persons infected with HIV is the only authentic Gospel response...Be available to parents and families who ask for your pastoral help, spiritual guidance and prayer...Help to establish or promote existing support groups for parents and family members. Learn about HIV/AIDS so you will be more informed and compassionate in your ministry. Include prayers in the liturgy for those who have died, and their families, companions and friends. A special Mass for healing and anointing of the sick might be connected with World AIDS Day (December 1) or with local AIDS awareness programs.”

November 1989, *Called to Compassion and Responsibility*, National Conference of Catholic Bishops: “*We offer this document in response to the need--of the nation; the Church; and countless communities, families, and individuals--to confront the crisis of HIV and AIDS. The crisis continues, but it can be met with understanding, justice, reason, and deep faith.*” (VI, 5)

1. AIDS must be responded to with the truth of medicine and facts.
2. We must reach out with compassion and stand in solidarity.
3. As bishops, we must present clear teaching on intimacy and sexuality.

4. Discrimination and violence are always unjust and immoral.
5. Poverty, oppression and psychological facts influence behavior that exposes a person to this disease.
6. The church must work to eliminate poverty and despair.
7. Human sexuality resembles God's love, faithfulness and commitment.
8. AIDS will stop when human behavior changes.
9. Drug treatment needs support and recovery needs to be promoted.
10. Education efforts are needed with clear medical, moral and pastoral teaching. (*summarized from I, 1*)

"Persons with AIDS are not distant, unfamiliar people, the objects of our mingled pity and aversion. We must keep them present to our consciousness, as individuals and as a community, and embrace them with unconditional love. (II, 3)

We as church are called to follow Jesus' example of compassion and forgiveness in our pastoral care of the sick. In our ministry to people with HIV/AIDS, we must have a holistic view of each person, remembering that we are dealing with the not only the physical aspects of HIV, but the emotional and spiritual as well.

Ministering to people with HIV/AIDS and those whose families are touched by HIV/AIDS may differ in some ways from ministering to people with most other illnesses. The HIV/AIDS crisis often provides a forum for stereotyping and prejudice, anger and recrimination, rejection and isolation, injustice and condemnation. The social stigma and harsh social judgments associated with HIV/AIDS, coupled with the high incidence of fear and ignorance about this condition, set this ministry apart. It is the unique challenge of the Church to support and respond to all of the challenges created by the HIV/AIDS pandemic, and particularly those that are spiritual.

"Christ's compassion toward the sick and his many healings of every kind of infirmity are resplendent signs that God has visited his people and that the kingdom of God is close at hand. Jesus has the power not only to heal, but also to forgive sins, he has come to heal the whole man, soul and body; he is the physician the sick have needed of. His compassion toward all who suffer goes so far that he identifies himself with them: I was sick and you visited me. His preferential love for the sick has not ceased through the centuries to draw the very special attention of Christians toward all those who suffer in body and soul. It is the source of tireless efforts to comfort them." (*Catholic Catechism, #1503*)

"We are deeply conscious of the devastation this terrible disease is bringing to many other parts of the world. The United States must play a significant role in responding to the worldwide dimension of the disease." (I, 2)

February 2, 1986 Cardinal Roger Mahony: "The current AIDS epidemic in our country and in our local community places upon the Church and its members a pastoral obligation. This obligation is to respond with care and compassion to individuals suffering from this disease and also to the society threatened by it. The heart of this response must be unqualified respect for the value of human life and for the dignity of the human person because both are bestowed by God... We have the responsibility to educate the total community on what the disease of AIDS is and how it is spread, so that everyone might recognize and accept their moral responsibility in halting its spread, as well as their obligation to help those suffering from it...By serving individual persons with AIDS, by committing ourselves to personal behavior that upholds the human dignity of ourselves and those around us, we as Church respond to the moral imperatives of our Creator...Here in the Archdiocese of Los Angeles, I am calling for the following steps to be taken to assist the victims of AIDS:

- 1 I am asking the Council of Priests of the Archdiocese to work with me in identifying a group of priests who would be willing to take special pastoral responsibility for those AIDS victims living in the area of their priestly assignment;
- 2 I am asking Fr. John McEnhill, SM (A Marianist priest in Canoga Park) to assist in the overall coordination of all pastoral care, educational programs, and outreach to other religious and community groups working in this field. Fr. McEnhill will be a great value in making certain that appropriate pastoral care is offered to those victims of AIDS desiring it.
- 3 I am asking the Administrators of the Catholic Health Care Facilities located within the Archdiocese to work with me and with Bishop Juan Arzube to determine if the Archdiocese can establish a Hospice for AIDS victims somewhere within the Archdiocese.
- 4 I am making contact with Mother Theresa of Calcutta to invite her Sisters or her Brothers to staff the Hospice for us." (February 2, 1986)

THE MANY FACES OF AIDS: A GOSPEL RESPONSE (1987)

Publication No. 195.4 office of Publishing and Promotion Services United States Catholic Conference 1312
Massachusetts Avenue, N.W. Washington, D.C. 20005.4105

A Statement of the Administrative Board United States Catholic Conference November 1987

On November 14, 1987, the Administrative Board of the United States Catholic Conference approved the statement *The Many Faces of AIDS: A Gospel Response*, and thus, it is authorized for publication by the undersigned.

Monsignor Daniel F. Hoye General Secretary NCCB/USCC December 7, 1987

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-

Introduction

Dear Sisters and Brothers in the Lord, and All People of Good Will:

In the life of society, as in the lives of individuals, there are events of significance and moments of decision. Today our society is experiencing a significant event and a decisive moment: the ominous presence of the disease known as AIDS (Acquired Immunodeficiency Syndrome).

Whether this infection exists as an unrecognized HIV virus in a pregnant woman or in a small child; whether it weakens the body of a person with ARC (AIDS. Related Complex); or whether it comes as the likelihood of a more imminent death from the disease itself, AIDS is a reality that we all must face.

The Church confronts in this disease a significant pastoral issue. The etiology of this deadly epidemic, its prevention, and the care of those stricken present society with serious moral decisions. How are we to relate to those who have been exposed to the virus or to those who have the disease? What are our responsibilities as members of the Church and society with regard to their care and support? What can and ought we to do in order to prevent the further spread of the disease? How we make these choices with their moral implications will affect both the present generation and, most likely, future ones as well.

In order to help make these and similar choices, we have decided to issue this statement, *The Many Faces of AIDS: A Gospel Response*. We invite you to read it with care and attend to its recommendations.

Our reflections may be summarized in this way:

- As with all other diseases, AIDS is a human illness to which we must respond in a manner consistent with the best medical and scientific information available.
- As members of the Church and society, we have a responsibility to stand in solidarity with and reach out with compassion and understanding to those exposed to or experiencing this disease. We must provide spiritual and pastoral care as well as medical and social services for them and support for their families and friends.
- As members of the Church, we must offer a clear presentation of Catholic moral teaching with respect to human intimacy and sexuality.
- Discrimination or violence directed against persons with AIDS is unjust and immoral.
- As a society, we must develop educational and other programs to prevent the spread of the disease. Such programs should include an authentic understanding of human intimacy and sexuality as well as an understanding of the pluralism of values and attitudes in our society.
- Those who have been exposed to the virus are expected to live in a way that does not bring injury or potential harm to others.

Faithful to the Lord's gospel and to the best of our American heritage, we are confident that our society will make wise decisions as, together, we face this significant moment.

The Many Faces of AIDS A Gospel Response¹

A Statement of the Administrative Board United States Catholic Conference November 1987

One of the distinctive aspects of Jesus' ministry was the manner in which he took the common and not so common events of human life and revealed a meaning or a potentiality that most, if not all, of his contemporaries had not discovered: that human love is revelatory of divine love, that death can disclose the possibility of new life. The challenge facing today's followers of the risen Lord is to do the same with contemporary experiences, whether of joy or sorrow, to discover the deeper meaning that might otherwise remain hidden.

One such experience is the presence of AIDS in our country and other parts of the world. During the last few years, as bishops, we have encountered persons with AIDS in our pastoral ministry. We would like to share some of "the many faces of AIDS" that we have met.

Mary and Phil are in their mid-thirties. Both are successful career professionals. After many years of searching, they found each other and are very much in love. They were married three years ago and are eager to have a child. Mary's friend, who is about to have major surgery, has asked her to donate blood. In keeping with today's blood bank policies and practices, Mary's blood has been tested for exposure to AIDS. The results are positive; she has been infected with AIDS virus from a previous partner. She feels as if her life has been brought to a sudden, tragic end.

John is a young man who was raised in the inner city by a loving single-parent mother. Despite his mother's best efforts, he found his environment to be like a prison and sought escape by turning to drugs. Now after six months of intermittent illness, he has been admitted to a public hospital. The diagnosis is AIDS. He feels as if he has been victimized from the beginning by forces beyond his control.

Peter is in his late twenties and successful in his career. His life journey to this point has not always been easy. He has been aware of his homosexual orientation since his teens, but the reactions of others to this have often left him feeling alone or rejected. Over the years, he has been sexually active, and recently, when his employer discovered that Peter has AIDS, he was fired. He feels frightened and angry as he tries to live without medical insurance.

Lilly is fifteen months old. Her mother, a drug addict, was exposed to the AIDS virus before Lilly's conception, and Lilly was born with AIDS. Her mother abandoned her. Because few will adopt a child with AIDS, Lilly is being cared for in a public hospital. She will know no other home, for it is expected that she will die soon.

What does the Gospel tell us about these representative faces of AIDS?

First, Jesus has revealed to us that God is compassionate, not vengeful. Made in God's image and likeness, every human person is of inestimable worth. All human life is sacred, and its dignity must be respected and protected. The teaching of Jesus about human sexuality and the moral norms taught by the Church are not arbitrary impositions on human life but disclosures of its depth.

Second, the Gospel acknowledges that disease and suffering are not restricted to one group or social class. Rather, the mystery of the human condition is such that, in one way or another, all will face pain, reversal, and, ultimately, the mystery of death itself. Seen through the eyes of faith, however, this mystery is not closed in upon itself. Through sharing in the cross of Christ, human suffering and pain have a redemptive meaning and goal. They have the potential of opening a person to new life. They also present an opportunity and a challenge to all, calling us to respond to suffering just as Jesus did with love and care.

Third, while preaching a Gospel of compassion and conversion, Jesus also proclaimed to those most in need the Good News of forgiveness. The father in the parable of the prodigal son did not wait for his son to come to him. Rather, he took the initiative and ran out to his son with generosity, forgiveness, and compassion. This spirit of forgiveness Jesus handed on to his followers.

For Christians, then, stories of persons with AIDS must not become occasions for stereotyping or prejudice, for anger or recrimination, for rejection or isolation, for injustice or condemnation. They provide us with an opportunity to walk with those who are suffering, to be compassionate toward those whom we might otherwise fear, to bring strength and courage both to those who face the prospect of dying as well as to their loved ones.

In this gospel perspective, we address this statement to our sisters and brothers in the Roman Catholic community of faith and to all people of good will in our society. We speak as pastors who strive to be faithful to the Gospel and the Church's teaching. We also speak as representatives of a religious tradition in a pluralistic society as, together with all persons of good will; we face the new and distinctive challenge of AIDS.

Our reflections are threefold. First, we present some facts about AIDS and comment on what they say to us. Then we address issues associated with the prevention of the disease. Finally, we explore appropriate care for persons with AIDS. At various points throughout this statement, we indicate the responsibilities and obligations of all the members of the Church and society. In an Appendix, we address certain significant related questions. All that we say in this statement is not intended to be the last word on AIDS, but rather our contribution to the current dialogue.

The Facts about AIDS and a Commentary

The AIDS phenomenon is complex. We do not intend to review all of the pertinent facts. The Surgeon General of the United States and others have provided careful analyses of the causes of AIDS, the ways in which it is transmitted, and the various dangers or risks of contracting the disease. Some of those facts are simply highlighted here.

- At the present time, AIDS is an incurable disease. Not restricted to the United States, it is found throughout the world. Currently, two-thirds of the persons afflicted with AIDS in the United States are homosexual or bisexual men. Some estimate that the number of heterosexual persons with AIDS will increase significantly in the next five years. At present, nearly one out of four persons with AIDS is a drug user who used contaminated intravenous needles or other drug paraphernalia infected with the AIDS virus. Four hundred and twenty-three hemophiliacs and people with blood coagulating disorders and two thousand nine hundred and fifty-five women have been diagnosed as having AIDS.³
- AIDS is a disease that cuts across all racial and ethnic lines.⁴
- AIDS is not merely an "adult disease" in the United States. As of October 12, 1987, five hundred and ninety-five children have been reported as having contracted the disease.
- At this time, after extensive research, there is no evidence that AIDS can be contracted through ordinary, casual contact.⁵
- AIDS can be contracted through certain forms of intimate sexual contact and encounters with tainted blood. It can also be transmitted from a mother to her child during pregnancy as well as through artificial insemination and by organ transplants.

AIDS, in other words, is a human disease whose spread, according to the best available scientific knowledge, is limited to identifiable modes of communication and contact.

Because reasonable actions and attitudes are based on facts, not fiction, we mention these facts as a background for some important observations about the AIDS phenomenon. They also apply to those suffering from ARC (AIDS. Related Complex).

First, while it is understandable that there is fear and uncertainty about a disease as new and deadly as AIDS, we encourage all members of our society to relate to its victims with compassion and understanding, as they would to those suffering from any other fatal disease.

Second, we are alarmed by the increase of negative attitudes as well as acts of violence directed against gay and lesbian people since AIDS has become a national issue. We strongly condemn such violence. Those who are gay or lesbian or suffering from AIDS should not be the objects of discrimination, injustice, or violence. All of God's sons and daughters, all members of our society, are entitled to the recognition of their full human dignity.

Third, because there is presently no positive or sound medical justification for the indiscriminate quarantining of persons infected with the AIDS virus, we oppose the enactment of quarantine legislation or other laws that are not supported by medical data or informed by the expertise of those in the healthcare or public health professions. The best of our civic heritage of extreme caution and restraint in restricting human and civil rights should be the norm in this situation, as in all others. We urge legislators to act judiciously rather than to react out of a sense of hysteria or latent prejudice. Especially acute is the problem of health insurance. We decry the exclusion of certain groups of persons from health insurance coverage. At the same time, we recognize the problems faced by the insurance industry as well as those who pay premiums because of the cost of treatment. This exemplifies the weakness of our health care delivery system. This problem must be addressed in a way that will provide adequate and accessible health care for all.

Fourth, we oppose the use of the HIV antibody test for strictly discriminatory purposes. However, if safeguards are provided to prevent such discrimination and to maintain the needed degree of confidentiality, such tests may play an important role in basing patient care on facts rather than fear or stereotypes. Testing for the AIDS virus, with appropriate counseling beforehand and afterwards, should be readily available to all who request it. Those who undergo such testing and receive a negative report can be reassured and educated on risk factors for contracting the virus. Those who receive a positive test result can be promptly offered counseling and care. There may be sound public health reasons for recommending the use of the HIV antibody test in certain situations, either because some persons have a heightened risk of becoming infected or because precautions may have to be taken by others (e.g., prospective spouses, hospital staffs) if the test results are positive. Nevertheless, we agree with many public health authorities who question the appropriateness and effectiveness of more sweeping proposals, such as widespread mandatory testing.

Fifth, we are greatly concerned that some in the healthcare professions or working in healthcare institutions refuse to provide medical or dental care for persons exposed to the AIDS virus or presumed to be "at risk." We call upon all in the healthcare and support professions to be mindful of their general moral obligation, while following accepted medical standards and procedures, to provide care for all persons, including those exposed to the AIDS virus. Similarly, although funeral directors may find it necessary to take appropriate precautions, they are not justified in refusing to accept or prepare for burial the bodies of deceased persons with AIDS. Nor are they justified in unnecessarily charging more for the funeral of persons with AIDS.

Sixth, to the extent possible, persons with AIDS should be encouraged to continue to lead productive lives in their community and place of work. They also have the right to decent housing, and landlords are not justified in denying them this right merely because of their illness.

Seventh, we support collaborative efforts by governmental bodies, health providers, and human service agencies to provide adequate funding and care for persons with AIDS. We also encourage the development of hospice. Like programs that will afford persons with AIDS dignified and effective care and treatment. We call for the development of programs to care for infants and children with AIDS, especially those facing life and death without parental care.

Eighth, because of the virtually epidemic proportions of AIDS, we acknowledge the need for cooperative efforts by private and public entities to discover ways to treat and cure this disease and to commit adequate funding for basic research, applied research, and general education.

Ninth, we call on the federal government to provide additional funding for the care of those infected with the HIV virus that do not have health insurance as well as expanded income support for those impoverished by illness related to the AIDS virus. We also ask the federal government to take the lead in funding the necessary research and educational efforts as well as ensuring protection for those exposed to the AIDS virus against discrimination in insurance, employment, health care, education, and housing. The federal government should also provide funding for voluntary testing and ensure the confidentiality of such testing.

Tenth, current programs and services need to be expanded to assist the families of those with AIDS while they are alive and also to support them in their bereavement. In addition, new programs, services, and support systems need to be developed to deal with unmet and poorly met needs. To accomplish this, parishes and Catholic healthcare providers and agencies are encouraged to collaborate with others to ensure that there is continuity of health care and pastoral services to families and persons with AIDS in response to the unique set of psychological, social, and spiritual issues that may arise during the illness.

Eleventh, hospitals, because of their responsibility to care for the sick, and Catholic hospitals, because of their special mission and philosophy, have a unique call and role in caring for persons with AIDS. Hospitals have the responsibility

and obligation to ensure that persons with AIDS and their families are cared for compassionately. Hospital personnel and church personnel also ought to go beyond their institutions to become facilitators, advocates, educators, and conveners to ensure that currently unmet and poorly met needs will be addressed in their communities by collaboration and networking with others in developing programs, services, and funding.

Twelfth, as a society, we need effective educational media programs to help reduce fear, prejudice, and discrimination against persons with AIDS, ARC, and antibody. Positive persons and those perceived to be in high Risk groups

The Prevention of AIDS

Within the health care professions, it is customary to make a distinction between the prevention of a disease and its treatment. While treatment is a response after the disease has been contracted, prevention strives to eliminate the conditions and circumstances that give rise to the disease. Because the prospects for the treatment of AIDS have been so dismal, emphasis—and hope—has focused more on its prevention, and this is where the greatest controversy has emerged.

These are sensitive issues. In a brief statement like this, we cannot apply the Church's teaching to all possible human behavior. Instead, in accord with the Church's traditional wisdom and moral teaching, we will offer some general principles and concrete guidelines. We speak to an entire nation whose pluralism we recognize and respect.

These observations come from our profound care for those who place themselves or might be placed in danger of contracting AIDS: intravenous drug users and their partners; children born and unborn; and persons involved in sexual contact that is physically dangerous or morally wrong. In other words, the primary concern of our observations is people's moral and physical well-being, not their condemnation, however much we might disagree with their actions.

Consistent with the insights and values found in the Scriptures, our religious tradition, and a philosophy of the human person that is consonant with both, we believe that the best source of prevention for individuals and society can only come from an authentic and fully integrated understanding of human personhood and sexuality, and from efforts to address and eliminate the causes of intravenous drug abuse. We are convinced that the only measures that will effectively prevent this disease at present are those designed to educate and to change behavior.

We view the human person as one reality with several dimensions: truly to be human means to be open to the world of the spiritual, the world of meaning and truth. Nonetheless, one's participation in the spiritual dimension of life can be inhibited by such social realities as poverty and oppression, by loneliness and alienation, and by other such social and psychological factors.

If, then, we are to address the prevention of AIDS in an effective way, we must deal with those human and societal factors that reduce or limit the quality of human life. When people think their lives devoid of meaning, or when they find themselves in oppressive and despair inducing poverty, they may turn to drugs or reach out for short-term physical intimacy in a mindless effort to escape the harsh conditions in which they live.

The Church and society need to address these realities. We have a responsibility first of all to help people realize that, whatever their circumstance, God's gift of life is precious, and there is more to life than its sometimes depressing or superficial dimensions. We must also attend to issues of economic well-being, as we did in our pastoral letter *Economic Justice for All*. The pastoral demonstrates, at length, poverty's impact upon people's lives. It also emphasizes our obligation to win respect for the true meaning of life as we seek to eradicate those things that debase the quality of life.

Second, in our society, we must offer everyone a fully integrated understanding of human sexuality. Every person, made in God's image and likeness, has both the potential and the desire to experience interpersonal intimacy that reflects the

intimacy of God's triune love. This reflection in human love of the divine love gives special meaning and purpose to human sexuality. Human sexuality is essentially related to permanent commitment in love and openness to new life. It is most fully realized when it is expressed in a manner that is as loving, faithful, and committed as is divine love itself. That is why we call upon all people to live in accord with the authentic meaning of love and sexuality. Human sexuality, as we understand this gift from God, is to be genitally expressed only in a monogamous, heterosexual relationship of lasting fidelity in marriage.

In light of this understanding of the human person, we are convinced that unless, as a society, we live in accord with an authentic human sexuality, on which our Catholic moral teaching is based, we will not address a major source of the spread of AIDS. Any other solution will be merely short-term, ultimately ineffective, and will contribute to the trivialization of human sexuality that is already so prevalent in our society.

That is why we oppose the approach to AIDS prevention often popularly called "safe sex." This avenue compromises human sexuality—making it "safe" to be promiscuous—and, in fact, is quite misleading. As the National Academy of Sciences has noted in its study of AIDS, "many have argued that it is more accurate to speak in terms of 'safer' sex because the unknowns are still such that it would be irresponsible to certify any particular activity as absolutely safe."⁶

What kind of approach *will* we support?

As pastors of dioceses throughout the United States, we commit ourselves and our resources, within our moral restraints and prudent judgment, to provide education to limit the spread of AIDS and to offer support for persons with AIDS.

We will also support legislation and educational programs that seek to provide accurate information about AIDS. This is both legitimate and necessary. Pertinent biological data and basic information about the nature of the disease are essential for understanding the biological and pathological consequences of one's personal choices, both to oneself and others.

Nonetheless, as we have intimated above, we also have a responsibility as religious leaders to bring analysis to bear upon the moral dimensions of public policy. In our view, any discussion of AIDS must be situated within a broader context that affirms the dignity and destiny of the human person, the morality of human actions, and considers the consequences of individual choices for the whole of society.

Since AIDS is transmitted through intravenous drug use, we support and urge increased public support for drug treatment programs, the elimination of the importation of illicit drugs, and every effort to eliminate the causes of addiction in all communities, especially those of the poor.

Since AIDS is also transmitted through sexual practices, legislation and public guidelines should encourage private and public institutions to go beyond mere biological education. Such legislation or guidelines must respect, however, the inalienable right of parents to be the first educators of their children regarding the meaning and purpose of human sexuality.

While we advocate the provision of more than mere biological information in sex education, we recognize that this raises important questions because of existing constitutional restraints or interpretations of the separation of Church and State. We are willing to join other people of good will in dialogue about how such a fuller understanding of human sexuality might be communicated in our public schools and elsewhere. We believe that there are certain basic values present in our society that transcend religious or sectarian boundaries and that can constitute a common basis for these social efforts.

Because we live in a pluralistic society, we acknowledge that some will not agree with our understanding of human sexuality. We recognize that public educational programs addressed to a wide audience will reflect the fact that some

people will not act as they can and should; that they will not refrain from the type of sexual or drug. Abuse behavior that can transmit AIDS. In such situations, educational efforts, if grounded in the broader moral vision outlined above, could include accurate information about prophylactic devices or other practices proposed by some medical experts as potential means of preventing AIDS. We are not promoting the use of prophylactics, but merely providing information that is part of the factual picture. Such a factual presentation should indicate that abstinence outside of marriage and fidelity within marriage as well as the avoidance of intravenous drug abuse are the only morally correct and medically sure ways to prevent the spread of AIDS. So-called safe sex practices are at best only partially effective. They do not take into account either the real values that are at stake or the fundamental good of the human person.

With regard to educational programs for those who have already been exposed to the disease, the situation is somewhat different. For such individuals, without compromising the values outlined above, as a society, we have to face difficult and complex issues of public policy.

The teaching of classical theologians might provide assistance as we search for a way to bring into balance the need for a full and authentic understanding of human sexuality in our society and the issues of the common good associated with the spread of disease.⁷ As noted above, at the level of public programming, we must dearly articulate the meaning of a truly authentic human sexuality as well as communicate the relevant health information.

In the forum of a doctor patient or a similar relationship, it is also necessary to address the question of how best to serve the common good in an individual case. This is what we meant earlier when we said that concrete responses must be made in specific contexts. Historically, this has been an appropriate forum for such advice because the healthcare profession is concerned with both the wellbeing of the individual patient and public health. The same is true today.

In sum, it is our judgment that the best approach to the prevention of AIDS ought to be based on the communication of a value centered understanding of the meaning of human personhood. Such a perspective provides a suitable context for the consideration of legislation or educational policy.

In light of this position, as participants in the public life of this nation, we are willing to commit the best efforts of the United States Catholic Conference to work on such programs. We also wish to assure legislators and public officials that we are willing to collaborate with them in the development of an informed and enlightened public policy for the prevention of AIDS.

We also encourage our Catholic elementary schools, high schools, colleges and universities, and religious education programs to develop curricular guidelines and educational materials to educate their students about the prevention of AIDS. All guidelines and educational materials should stress the importance of chastity and the power of God's love which enables us to live a chaste life. Of course, such guidelines and materials must be developed in collaboration and consultation with parents as much as possible.

Similarly, we ask every diocese to provide priests, deacons, religious, and lay leaders with a complete education about the medical, psychosocial, and pastoral issues related to AIDS and ARC so that they may communicate such information in a manner best suited to their respective communities. This information should include a list of resources and support systems available to persons with AIDS and ARC, seropositive persons, their families, and friends.

We also wish to say a word about the responsibilities of those who find themselves "at risk" of having been exposed to the AIDS virus. Earlier we stated something of the meaning and purpose of human sexuality. If a person chooses not to live in accord with this meaning or has misused drugs, he or she still has the serious responsibility not to bring injury to another person. Consequently, anyone who is considered to be "at risk" of having been exposed to the AIDS virus has a grave moral responsibility to ensure that he or she does not expose anyone else to it. This means that such a person who is

considering marriage; engaging in intimate sexual contact; or planning to donate blood, organs, or semen has a moral responsibility to be tested for exposure to the AIDS virus and should act in such a way that it will not bring possible harm to another.

Care for Persons with AIDS and ARC

In the section on the facts about AIDS, we addressed several areas of concern about the care of persons with the disease and their family and friends. Here we will expand on those themes.

We commend those who have done so much to bring care and comfort to persons with AIDS and their loved ones. Much can be learned from what has already been done.

Persons with AIDS, their families, and their friends need solidarity, comfort, and support. As with others facing imminent death, they may experience anger towards and alienation from God and the Church, as they face the inevitability of dying. It is important that someone stand with them in their pain and help them, in accord with their religious tradition, to discover meaning in what appears so meaningless. Offering or ensuring this human companionship is especially important lest those who would diminish respect for life by encouraging euthanasia or suicide determine how to "care" for persons with AIDS.

We stand together with every person because all of us face eventual death. We reach out in a spirit of solidarity to those who are approaching death more rapidly and prematurely because of AIDS.

We seek to overcome fear and prejudice and to support hospitals, care centers, and other community institutions that provide the necessary physical, psychological, and spiritual care to persons with AIDS.

We pledge that we will work with public, private, and other religious groups to achieve the objectives we outlined earlier. We will support interfaith efforts to provide ministry to persons with AIDS and their families and friends. We will assist in finding temporary housing for families and friends who are visiting people with AIDS and unable to find accommodations on their own, as well as make counseling available when they return home.

It is critical that persons with AIDS continue to be employed as long as it is appropriate. The Catholic Church in the United States accepts its responsibility to give good example in this matter. We ask each diocese to develop, if it has not already done so, a general employment policy for all employees with life-threatening illnesses, including AIDS.

We call upon each diocese to appoint, where appropriate, a person responsible for coordinating its ministry to persons with AIDS and their loved ones.

We also encourage the development of training programs for those who minister to people affected by AIDS or ARC (e.g., hospital Eucharistic ministers, visitors to the sick, confessors). Similarly, we also urge that people be trained to counsel persons before and after they are tested for the AIDS virus.

In order to coordinate and enhance these diocesan efforts and to collaborate with other national bodies, we have expanded the responsibilities of the appropriate entities within the bishops' conference to help us respond to the AIDS challenge and to develop appropriate recommendations for consideration by the Administrative Committee of the National Conference of Catholic Bishops.

In sum, by collaborating with other agencies and programs, we hope that the Church will provide an appropriate example about the manner in which those suffering from AIDS, and their families and friends, are cared for as well as the nature of that care. Through this collaboration, we will help provide the kind of care and services that place persons with AIDS in appropriate settings that best meet their needs. In addition, we encourage the use of church facilities as sites for providing various levels and kinds of care.

Conclusion

We began these reflections by looking at four of the many faces of persons with AIDS. We saw in them the call and the challenge of the risen Lord to become a people of care, compassion, and action on behalf of those who have AIDS or ARC or related conditions, as well as their loved ones. More profoundly, we saw the challenge of which Pope John Paul II recently reminded us, to love as God loves us: "without distinction, without limit." For "He loves those of you who are sick, those who are suffering from AIDS and from AIDS-related complex."

We have heard the invitation of that same Lord, spoken to all members of the human family, to express their sexuality in a truly human manner. We have sensed the challenge of providing for the prevention of AIDS in a complex, pluralistic society. We have recognized our own ecclesial responsibilities in the area of prevention and care, and of the need to collaborate with others.

The stories of Mary, John, Peter, and Lilly are not mere examples. They reveal our real, flesh-and-blood sisters and brothers. Our response to their needs, and the needs of other persons with AIDS, will be judged to be truly effective both when we discover God in them and when they, through their encounter with us, are able to say: "In my pain, fear, and alienation, I have felt in your presence a God of strength, hope, and solidarity."

By the grace of God, may this happen soon!

Appendix

Some Serious Questions—and Responses

In the preceding pages, we have articulated a theoretical framework for responding to the challenge of the spread of AIDS in our society and made some spec observations and directives. The application of this guidance will be the responsibility of each diocesan bishop.

During recent months, several critical questions have arisen. While these questions are not entirely new, they are being asked in a new context: the fact that AIDS is considered by some a disease of pandemic proportions. We offer the following guidance in these matters. It is our prudential judgment that this guidance is faithful to the authentic teaching of the magisterium and to the Church's traditional moral wisdom.

1. Should there be educational programs about AIDS in our schools, religious education programs, and adult education programs?

While we recognize, above all, the inalienable rights of parents as the primary educators of their children and their importance in this area, we also affirm that there ought to be educational programs about AIDS at every appropriate level of Catholic schools and religious education programs. Adapted to the maturity of the learners, these programs should communicate the biological facts about AIDS as well as the values which should form their consciences. Several dioceses in the United States and Canada have developed guidelines for these educational efforts. The guidelines of the diocese of Cleveland provide an example of one approach to developing an initial pastoral response. Essential to these efforts are programs to assist parents in their responsibility to be the primary educators of their children.

2. When should these programs begin?

The answer to this question will depend, in part, on the particular situation of the respective diocese and/or school. In areas where it is known that young people in the fifth and sixth grades (or younger) are being influenced by a drug culture or by social acceptance of promiscuous sex, formal education should begin as early as possible.

3. In light of the medical evidence and the guidance offered in the statement, how should the Church relate to people who have been infected by the AIDS virus and are being served by its educational or social service programs or who are employees?

The Church is called to model for the larger society the loving concern and compassion of Jesus for the sick and the suffering. This is not a ministry just for our healthcare institutions or for a few dedicated individuals, but for the whole Church. All diocesan agencies and parishes have roles to play in ensuring dignity, acceptance, care, and justice for people with HIV infection and their families.

We recommend that dioceses draw up, as soon as possible, their own policy on the responsibility of the Church as pastoral minister, employer, educator, and social service provider and clarify the application of state and local public policy to the diocesan guidelines.

Pastoral Ministry

We encourage dioceses to identify the following:

- those responsible for the design and implementation of a diocesan plan for pastoral care of persons with AIDS;
- those responsible for training and support of pastoral ministers; and
- the ways in which the human, civil, and canonical rights of the person with AIDS will be respected, especially in the matter of confidentiality.

Employment

Many people with AIDS infection are able to continue working for long periods without further risk to themselves or others. Such persons are entitled to the same treatment with regard to employment as other persons. Those unable to continue working because of their physical deterioration should continue to receive health and other benefits available to other employees.

Church agencies should carry on employee education programs designed to dispel irrational fears about the dangers of contracting AIDS through casual contact in the workplace. Employees, such as healthcare and child care workers, who may come in contact with the body fluids of persons with AIDS, should receive continuing comprehensive and thorough education in infection control procedures. Special efforts must be made to have adequate personnel, equipment, and supplies on hand to prevent needless exposure to the virus by such employees.

Education

Infection with AIDS in and of itself should not be a reason to exclude students from any Catholic elementary or secondary school, religious education program, or institution of higher learning. However, alternate educational and catechetical arrangements may be made for infected children whose behavior has been shown to be a danger to others. Infected preschool children and neurologically damaged children who lack control over their body functions or who have a history of biting others will need special consideration. Catholic daycare and foster care providers should seek to provide programs and procedures to make available assistance to such children and their families. Church agencies serving pregnant women have a special responsibility to provide practical help and support to AIDS-infected women during pregnancy, delivery, and the postpartum period.

Social Services

Catholic social service and health agencies are called to work together to ensure the availability of medical care and support services to persons with AIDS infection. No client, patient, or applicant for services from a Catholic agency or facility should be denied assistance, and employees should be held accountable for compliance with this policy. Diocesan

agencies should also advocate for the development and funding of community-based services for persons with AIDS.

Confidentiality

Every precaution should be taken to protect the confidentiality of records, files, and other information about the HIV status of employees, students, applicants, clients, and patients.

4. How are Catholic hospitals to respond to the desire of healthcare professionals who feel that it is their responsibility to provide "safe sex" information in order to reduce the spread of disease?

As we indicated above, we must be clear about our position: An integrated understanding of human sexuality provides the basis for any truly adequate program to prevent the sexual transmission of AIDS. Catholic healthcare institutions and those who serve in them should be unequivocal about the moral teaching of the Church in their programs and personal counseling. It is important that Catholic healthcare institutions provide educational programs about AIDS for their staffs and the public at large. It would be contradictory for these institutions to advocate a "safe-sex" approach to the prevention of the disease. It would be permissible, in accord with what has been said earlier about not promoting "safe sex" practices, to speak about the practices recommended by public health officials for limiting the spread of AIDS in the context of a clear advocacy of Catholic moral teaching.

On the more personal level of the healthcare professional, the first course of action should be to invite a patient at risk, or one who already has been exposed to the disease, to live a chaste life. If it is obvious that the person will not act without bringing harm to others, then the traditional Catholic wisdom with regard to one's responsibility to avoid inflicting greater harm may be appropriately applied.

These are not all of the questions and issues which we face. There are other concerns about such matters as patient confidentiality, contact tracing, the relationship between individual and societal rights. We encourage theologians and others to continue discussing them in light of the insights of our tradition and the Church's teaching.

Notes

1. AIDS is an acronym for "Acquired Immunodeficiency Syndrome." According to current medical information, the source of the disease is a retrovirus that, in this statement, will be referred to as the HIV virus or the AIDS virus. Currently, only about 10.15% of those infected with the virus meet the AIDS case definition established by the Centers for Disease Control. In this statement, we include those who have the syndrome itself, those who have ARC (AIDS-Related Complex), and those infected by the AIDS virus.
2. Many diocesan bishops have issued statements about AIDS as well as guidelines in regard to the employment and education of persons with AIDS. These contributed greatly to the development of this statement.
3. The statistics about this disease are continually updated. This statement relies on the most recent figures issued by the Centers for Disease Control on October 12, 1987.
4. One of the most sensitive issues faced in the preparation of this statement is the fact that disproportionate numbers of blacks and Hispanics have been infected by the AIDS virus. Raising this issue could be perceived as motivated by racism, which is contrary to the very gospel spirit that informs this statement. On the other hand, to ignore the pertinent statistics could contribute to the spread of the disease among some of the most vulnerable and marginalized members of our society. For example, current statistics issued by the Centers for Disease Control on October 12, 1987, indicate that 25% of people with AIDS are black, while blacks constitute 12% of the United States population. Similarly, 14% are classified as Hispanic, while those who are considered to be Hispanic are 7.9% of our population. Recently, programs have been developed within the black and Hispanic communities to educate their members about

the danger of AIDS. Programs such as this might be the most appropriate way to begin addressing this complex situation.

5. AIDS: *Information/Education Plan to Prevent and Control AIDS* in the United States, U.S. Department of Health and Human Services (March 1987), p. 9.
6. "Institute of Medicine of the National Academy of Sciences, *Confronting AIDS: Directions for Public Health, Health Care and Research* (Washington, D.C.: National Academy Press, 1986), p. 97.
7. Augustine, *De ordine* ii. 4. 12. Thomas Aquinas, *De regimine principum* iv. 14; *Summa theologiae* 1.II. 96. 2; 101. 1, ad 2; II-II.10.11: "Humanum regimen derivatur a divino regimine, et ipsum debet imitari. Deus, autem, quamvis omnipotens et summe bonus, permittit tamen aliqua mala fieri in universo, quae prohibere posset, ne, eis sublatis, maiora bona tollerentur, vel etiam pejora mala sequerentur. Sic igitur et in regimine humano illi qui praesunt recte aliqua mala tolerant, ne aliqua bona impediuntur, vel etiam ne aliqua mala pejora incurrantur, sicut Augustinus dicit in II de Chdine." (Unofficial Translation: "Human governance is derived from divine governance, and it ought to imitate this divine governance. Although God is omnipotent and good in the highest degree, nevertheless he permits certain evil things to develop in the universe, which he would be able to prevent except that, if these things were taken away greater goods would be eliminated or even greater evils would follow as a consequence. So also in human governance, those who govern rightly tolerate certain evils lest certain goods be impeded or also lest some greater evil obtain, as Augustine said in the second book of his *de Chdine*.") For a reading of this tradition of the toleration of the lesser evil, see Adelard Dugre, "La tolerance du vice d'apres saint Augustin et saint Thomas," *Gregorianum* VI (1925), pp. 442.446. The classic articulation of this principle by the modern papal magisterium can be found in *Ci riesce* of Pius XII, December 6, 1953, AAS. Annus xxxv, series ii, vol. xx, pp. 798.801. For an example of the typical discussions and application of this among the subsequent moralists, cf. Marcellino Zalba, *Theologise moralis summa*, 11. (second edition, 1957), no. 118, para. 1-2, p. 47.

CALLED TO COMPASSION AND RESPONSIBILITY (1989)

A Response to the HIV/AIDS Crisis *National Conference of Catholic Bishops and United States Catholic Conference*

Following the Spring 1988 meeting of the National Conference of Catholic Bishops at Collegeville, Minnesota, an ad hoc committee was appointed to draft a statement on the AIDS epidemic. Approval of the text by the body of bishops was given during the plenary assembly in Baltimore, Maryland, in November 1989. Accordingly, publication of *Passion and Responsibility: A Response to the HIV/AIDS Crisis* is authorized by the undersigned.

Monsignor Robert N. Lynch General Secretary NCCB/USCC

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Notes

I. Introduction

1. The Many Faces of AIDS

The *Human Immunodeficiency Virus* (hereafter HIV) continues to spread throughout the world. As a contribution to the nation's response to this complex disease and its devastating consequences, we wish to help turn ignorance into understanding and understanding into action. We, the Catholic bishops of the United States, approach this task from the perspectives of faith and reason: faith which believes that health and sickness, life and death have new meaning in Jesus Christ;⁽¹⁾ and moral reasoning which supports the insights concerning human nature and individual dignity, which we here affirm. We address this statement to the Catholic community and to all people of goodwill. It is our hope that these reflections will stimulate discussion and foster understanding of the ethical and spiritual dimensions of the HIV crisis.

We speak conscious of the interest and discussion occasioned by the release in 1987 of *The Many Faces of AIDS: A Gospel Response* by the Administrative Board of the United States Catholic Conference.⁽²⁾ As that document itself pointed out, it was "not intended to be the last word on AIDS, but rather a contribution to the current dialogue."⁽³⁾ Meeting in Collegeville, Minnesota, in the spring of 1988, our conference of bishops committed itself to issuing a further document.⁽⁴⁾

There are good reasons for doing so. Public discussion concerning HIV has intensified in the last two years, and new facts, fears, and initiatives have emerged. The AIDS crisis has worsened. The need for compassion has grown more urgent. Also, we are mindful of the 1988 *Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic*,⁽⁵⁾ which calls upon religious groups to be of "special assistance," especially by emphasizing "the worth and dignity of every human being."

The Many Faces of AIDS made several important points, which we now reaffirm.

1. AIDS is an illness to which all must respond in a manner consistent with the best medical and scientific information available.
2. As members of the Church and society, we must reach out with compassion to those exposed to or experiencing this disease and must stand in solidarity with them and their families.
3. As bishops, we must offer a clear presentation of Catholic moral teaching concerning human intimacy and sexuality.
4. Discrimination and violence against persons with AIDS and with HIV infection are unjust and immoral.
5. Social realities like poverty and oppression and psychological factors like loneliness and alienation can strongly influence people's decisions to behave in ways which expose them to the AIDS virus.
6. Along with other groups in society, the Church must work to eliminate the harsh realities of poverty and despair.
7. The expression of human sexuality should resemble God's love in being loving, faithful, and committed. Human sexuality in marriage is intrinsically oriented to permanent commitment, love, and openness to new life.
8. The spread of AIDS will not be halted unless people live in accord with authentic human values pertaining to personhood and sexuality.
9. Since AIDS can be transmitted through intravenous drug use, there is need for drug treatment programs, a halt to traffic in illicit drugs, and efforts to eliminate the causes of addiction.
10. Considering the widespread ignorance and misunderstanding about HIV infection and its modes of transmission, educational programs about the medical aspects of the disease and legitimate ways of preventing it are also needed.

2. The Church's Concern

As we enter more deeply into the public dialogue regarding HIV infection, we are conscious of the social responsibility of the Church. In his encyclical letter *On Social Concern*, Pope John Paul II speaks of it in these terms:

[T]he Church is an "expert in humanity," and this leads her necessarily to extend her religious mission to the various fields in which men and women expend their efforts...in line with their dignity as persons...In doing so the Church fulfills her mission to evangelize . . . when she proclaims the truth about Christ, about herself and about man, applying this truth to a concrete situation...The teaching and spreading of her social doctrine are part of the Church's evangelizing mission. And since it is doctrine aimed at guiding people's behavior, it consequently gives rise to a commitment of justice, according to each individual's role, vocation and circumstances. ⁽⁶⁾ As far as HIV is concerned, moreover, social responsibility has an important international dimension. The problem is not confined to the United States and cannot be solved only here. We are deeply conscious of the devastation this terrible disease is bringing to many other parts of the world. The United States must play a significant role in responding to the worldwide dimension of the disease.

The Church enters into this conversation in the conviction that "faith throws a new light on everything, manifests God's design for man's total vocation, and thus directs the mind to solutions which are fully human" (*Pastoral Constitution on the Church in the Modern World*, n. 11). Indeed, "only God . . . provides a fully adequate answer to these questions. This He does through what He has revealed in Christ His Son. . ." (*ibid.*, n. 41).

The 1988 *Report of the Presidential Commission* states: "The term 'AIDS' is obsolete. 'HIV infection' more correctly defines the problem. The medical, public health, political, and community leadership must focus on the full course of HIV infection rather than concentrating on later stages of the disease (ARC and AIDS)" (*Executive Summary*, XVIII).

3. Progress to Date

Real progress has been made in the battle against HIV infection. For example:

1. Dioceses throughout the United States have made significant strides in addressing the HIV epidemic. The steps include providing care for children with AIDS, opening and maintaining hospices for persons with AIDS, maintaining facilities for homeless people, providing pastoral and health care through Catholic health facilities, implementing HIV education programs, and publishing documents that address the issue of HIV infection and its prevention.
2. The medical community has developed therapies that extend the lives of people with HIV infection while enhancing their quality. New discoveries raise hopes for the eventual cure or prevention of the disease.
3. The federal government has adopted a more realistic approach to this health crisis. The twelve chapters of the 1988 *Report of the Presidential AIDS Commission* contain important recommendations requiring close study and response.⁽⁷⁾
4. Numerous volunteer groups and organizations, including those of the homosexual communities, have made significant efforts in caring for those with HIV and have developed new and effective services to help meet the many unmet needs of those who are ill.

Many, though not all, persons with AIDS have many of the following characteristics: young; alienated from family; frightened (of isolation and abandonment, of pain and suffering, of dependency and loss of control); embarrassed and/or guilty; more or less alone; possibly angry; isolated by societal attitudes and a backlash of anger; without financial resources.

4. The Obstacles Remaining

Numerous obstacles to addressing the AIDS problem still remain.

- Self-abusive behavior through drug abuse and sexual promiscuity continues in this country.
- Lack of education about HIV in large segments of the society fosters continued misunderstanding about the epidemic. For example, confusion about how the infection is transmitted generates some unwarranted fear and undue alarm.
- Technology often outpaces ethical reflection; the study of ethics is widely neglected in school curricula.
- People infected with HIV or at risk of infection may not be aware of their situation; others shirk their basic moral obligation to refrain from behavior that can do grave harm to others.
- Public campaigns often promote solutions that are contrary to morality and against human dignity.
- Persons infected with HIV still too often suffer discrimination, disrespect, violence, and inhumane treatment.
- There is a lack of adequate housing, "step-down units," and home health care.
- Federal funding for AIDS care remains insufficient.

5. More to Accomplish

While encouraged by progress in the struggle with HIV, we must not exaggerate it. Where research is concerned, for example, the Fifth International Conference on AIDS held in Montreal in June 1989 noted that even the well-studied AIDS virus known as HIV-1 has not yielded up all its secrets.

HIV infection is transmitted mainly in three ways: through sexual contact (e.g., exchange of blood, semen, and vaginal secretions); through parenteral exposure (needle-sharing for drugs, blood transfusions); and through perinatal exposure (i.e., a mother infected with HIV can transmit the virus to her baby during pregnancy, delivery, or breast feeding).

Statistics show that AIDS is spreading, with large increases in AIDS cases and deaths projected in the years ahead. As many as 54,000 Americans may die from AIDS during 1991 alone. ⁽⁸⁾

More accurate statistical systems to monitor HIV infection are badly needed. Since many people are infected with HIV for long periods before showing symptoms of AIDS, health officials still do not know the current extent of the epidemic. Not only will the lives of many of these infected persons be substantially shortened, all of them also are capable of transmitting the infection and thereby spreading the epidemic.

Furthermore, without better data the nation cannot really know whether current strategies for controlling the spread of the virus are working. Nor will we be able to prepare adequately for future demands for hospital beds and health-care services.

As we write, the number of diagnosed AIDS cases in the United States is more than 100,000.

- HIV is increasingly emerging as a problem for minorities and the homeless in inner cities.
- In most parts of the country AIDS remains largely a disease of homosexual men.
- Nearly 20,000 Americans are expected to be afflicted with AIDS in the next four years from transfusions administered before HIV blood-screening was begun.
- Higher rates of AIDS among adults have resulted in more cases among newborn children who were infected by their mothers' blood in the womb. No less tragic are AIDS cases among children born to drug-addicted parents. ⁽⁹⁾

All this bears out an assertion made at the 1989 Montreal International Conference on AIDS: The HIV epidemic is following an uncontrolled, unstable, volatile, and dynamic course. ⁽¹⁰⁾

It is of critical importance to recognize the shift of the disease to economically disadvantaged populations. In the opinion of the Centers for Disease Control (CDC), AIDS may become predominantly a minority disease. This would be disastrous for African Americans and Hispanics. Though only 12 percent and 8 percent of the U.S. population, respectively, they currently account for a disproportionate 24 percent and 14 percent of the reported U.S. cases of AIDS, according to CDC statistics. The figures are even more striking for women with AIDS, some 52 percent of whom are African American and 20 percent Hispanic, and for children with the disease (80 percent African American or Hispanic).

There is a clear connection between these figures and the fact that, according to the National Institute of Drug Abuse, an estimated 70 percent of the nation's 1.28 million intravenous addicts are African American or Hispanic. Underlying this statistic, of course, are the social and psychological injuries inflicted by poverty and discrimination.

6. Some Basic Facts about HIV and AIDS

While our basic concern as bishops is the moral teaching and pastoral outreach of the Church to those affected in any way by the growing HIV infection across the country, still we must point out the various medical, scientific, and sociological dimensions of the problem. Here we give a brief overview of some of these key issues.

Infection with HIV is followed by incubation and latency periods whose duration varies enormously from individual to individual. It is currently thought that 50 percent will develop full-blown AIDS within 10.8 years, 75 percent within 16 years, and "almost 100 percent in 30 years." ⁽¹¹⁾

Although people who are HIV-infected do not manifest AIDS symptoms during the subclinical period, they are subject to serious emotional, social, and physical problems. At the point when AIDS is diagnosed, a variety of symptoms emerge: prolonged fevers; rashes; swollen lymph glands; fungi around the nails; oral thrush; shingles; lymphoma; severe psoriasis; cryptococcal meningitis; cancers of the tongue, rectum, and brain; and the illnesses classically associated with the disease, pneumocystis carinii pneumonia and Kaposi's sarcoma (lesions that spread over the body surfaces). These are opportunistic infections that, in various combinations, eventually prove fatal. Also, 75 percent of people with AIDS suffer significant brain damage often leading to dementia. ⁽¹²⁾

While the progress of the HIV infection cannot be predicted in every case, there are identifiable stages.

- **HIV positive or antibody positive:** The blood shows antibodies indicating exposure to HIV. At this "seropositive" stage, the individual may remain asymptomatic for five to ten years, but he or she can transmit the virus to others.
- **ARC (AIDS-Related Complex):** This includes symptoms such as chronic diarrhea, recurrent fevers, weight loss, persistent swelling of the lymph nodes. The term "ARC" has fallen into disfavor, however, because of medical disagreements regarding these symptoms and manifestations.
- **AIDS:** This refers to the most severe clinical manifestations of the HIV infection. It includes opportunistic infections, as well as the pneumocystis carinii pneumonia and neoplasms such as Kaposi's sarcoma.

7. Three Problems and the Need for Education

HIV/AIDS is not only a biomedical phenomenon but a social reality rooted in human behavior. It is a product of human actions in social contexts. The actions and their circumstances are shaped by larger cultural and social structures.

Associated with this epidemic are at least three widespread problems.

First, there is the public health problem. As applied to HIV/AIDS, the term *epidemic* is sometimes misunderstood. Typically during epidemic, new cases of a disease increase dramatically in a short period of time, peak, and then decline; there may also be cycles of rise and decline. ⁽¹³⁾ The following points are important to understanding the HIV/AIDS epidemic.

- AIDS cases lag behind the spread of HIV infection. Typically, years elapse between the time an adult is infected with HIV and the diagnosis of AIDS. Thus, current counts of new AIDS cases do not tell us how widely HIV is spreading.
- A decline in either the spread of HIV infection or new AIDS cases, or both, would not mean that the danger had passed. HIV is already substantially seeded in the U.S. population. It will likely continue to spread, if not in epidemic form, then in a persistent, more stable "endemic" (literally, "dwelling with the people") form.
- The threat of epidemic and endemic disease will be most serious for groups most heavily seeded with HIV infection. These are IV drug users and homosexual and bisexual men who have sex with men, as well as their female sexual partners and offspring
- AIDS data suggest that the African American and Hispanic populations may be more heavily seeded with HIV infection than other ethnic groups and may be disproportionately threatened by the virus. ⁽¹⁴⁾

The second problem concerns discrimination arising from ignorance and fear. ⁽¹⁵⁾ The 1988 *Presidential Report* affirms: "Fear and misunderstanding about HIV infection has been the underlying cause of much of the anxiety, hostility, and discrimination shown towards HN-infected individuals." The result has been a variety of unconscionable deeds: the fire-

bombing of a family's home because their sons had AIDS; the exclusion of students from school because they are infected with HIV; the isolation and virtual quarantining of other children in school situations; refusal by physicians and health-care workers to care for persons with AIDS; and assertions that a cure for AIDS will never be found because it is God's judgment on its victims.

The third problem is the refusal to discuss publicly the direct link between sexual activity and intravenous drug use on the one hand and HIV/AIDS on the other. Silence about the connection between these forms of behavior and HIV/AIDS is not only intellectually dishonest, but unfair to those at risk.

HIV/AIDS must be opposed with early diagnosis, testing, education, counseling, and persuasion. People must be shown the right thing to do and encouraged to make right choices. The discovery of effective therapies or vaccines, desirable as those are, would not change the need for personal accountability and response. In this respect, the HIV/AIDS epidemic is similar to outbreaks of other, nonfatal diseases transmitted by particular kinds of behavior. For example, gonorrhea and syphilis persist in the United States even though drugs effective against them have been available for forty years. The obvious lesson is that to eradicate some diseases, people must desist from the behavior that spreads them. Given the severity of the HIV/AIDS epidemic, this need is particularly great.

The spread of HIV can be controlled by lasting changes in the way people act. We repeat: People need education and motivation, so that they will choose wisely and well. Providing information that is both accurate and appropriate is a logical and necessary starting point. This requires understanding an intended audience in order to formulate and deliver a persuasive message. Educational programs and public information campaigns cannot rely simply on fear as a motive. They must provide convincing assurances that something can be done to prevent infection--which the changes in behavior that are being recommended are possible and will do some good. These educational programs should be directed to both individuals and groups.

8. The Intent of This Document

In the remainder of this document we issue five calls: to compassion, to integrity, to responsibility, to social justice, and to prayer and conversion. For: "The joys and the hopes, the griefs and the anxieties of the people of this age, especially those who are poor or in any way afflicted, these too are the joys and the hopes, the griefs and the anxieties of the followers of Christ." ⁽¹⁶⁾

II. A Call to Compassion

1. Compassion and Human Dignity

Compassion is much more than sympathy. It involves an experience of intimacy by which one participates in another's life. The Latin word *misericordia* expresses the basic idea: The compassionate person has a heart for those in misery. This is not simply the desire to be kind. The truly compassionate individual works at his or her own cost for the others' real good, helping to rescue them from danger as well as alleviate their suffering.

2. The Ministry of Jesus

We learn compassion's meaning from the model of Jesus. His ministry contains many examples. He gives sight to the blind (Matthew 20:30-34; Mark 10:46-52; Luke 18:35-43) and makes the crippled walk (Matthew 9:2-7; Mark 2:3-5; Luke 5:18-24); he touches and heals lepers (Matthew 8:3; Mark 1:41; Luke 5:13); he shares a meal with people considered legally impure (Matthew 26:6; 9:10; 11:11; Mark 2:15-16; Luke 5:30); he shames the judges of the adulterous

woman and forgives her sin (John 8:1.10). With compassion, Jesus breaks through the barriers of sickness and sinfulness in order to encounter and heal the afflicted.

He tells us to do as he did, for "Whatever you did for the least brothers of mine, you did for me" (Matthew 25:40). We need to bear in mind his warning on this matter.

When the Son of Man comes in his glory . . . all nations will be assembled before him Then he will say to those on his left, "Depart from me, you accursed For I was hungry and you gave me no food, I was thirsty and you gave me no drink, a stranger and you gave me no welcome, naked and you gave me no clothing, ill and in prison, and you did not care for me What you did not do for one of these least ones you did not do for me." And these will go off to eternal punishment (Matthew 25:31-32, 41-46).

3. The Good Samaritan

The story of the Good Samaritan presents the call to compassion in concrete terms (Luke 10:30-37). Pope John Paul graphically demonstrated its meaning when in 1987 he embraced a young boy with AIDS at Mission Dolores Basilica in San Francisco. This was a way of saying that in each case AIDS has a human face, a unique personal history. The Holy Father verbalized that message on Christmas Day 1988, in his "Urbi et Orbi" blessing. "I think of them all, and to all of them I say, 'Do not lose hope.'" And he added that those with AIDS are "called to face the challenge not only of their sickness but also the mistrust of a fearful society that instinctively turns away from them." On May 4, 1989, he returned to this subject, declaring in a homily in Lusaka that the Church "proclaims a message of hope to those of you who suffer . . . to the sick and dying, especially those with AIDS and those who lack medical care." ⁽¹⁷⁾

In his apostolic letter *On the Christian Meaning of Human Suffering* (1984), ⁽¹⁸⁾ Pope John Paul calls each of us to imitate the Good Samaritan: "Man owes to suffering that unselfish love which stirs in his heart and actions. The person who is a 'neighbor' cannot indifferently pass by the suffering of another." ⁽¹⁹⁾

In his 1987 visit to Mission Dolores Basilica, Pope John Paul spoke of the meaning of compassion-again, in the specific context of AIDS.

[T]he love of God is so great that it goes beyond the limits of human language, beyond the grasp of artistic expression, beyond human understanding. And yet it is concretely embodied in God's son, Jesus Christ, and in his Body the Church God loves you all, without distinction, without limit. He loves those of you who are elderly, who feel the burden of the years. He loves those of you who are sick, those who are suffering from AIDS and from AIDS-Related Complex. He loves the relatives and friends of the sick and those who care for them. He loves us all with an unconditional and everlasting love. ⁽²⁰⁾

Persons with AIDS are not distant, unfamiliar people, the objects of our mingled pity and aversion. We must keep them present to our consciousness, as individuals and a community, and embrace them with unconditional love. The Gospel demands reverence for life in all circumstances. Compassion--love--toward persons infected with HIV is the only authentic gospel response.

III. A Call to Integrity

1. The Dignity of the Human Person

In his 1980 encyclical *Rich in Mercy*, Pope John Paul says that compassion and mercy are rooted in the recognition of human dignity and integrity. Authentic compassion and mercy call us to "a whole lifestyle [that consists in the constant

discovery and persevering practice of love as a unifying and also elevating power despite all difficulties of a psychological or social nature" (n. 14).

In praying to the Father "That they may all be one . . . as we are one" (John 17:21-22), Jesus revealed something we could not have known by ourselves: There is a likeness between the unity of the divine persons in the Trinity and the unity of human persons with one another. In practical terms, we learn from the model of the Trinity that we become most fully ourselves by giving ourselves to others. ⁽²¹⁾ An abuse of self is somehow also an act of injustice to others, and, by the same token, the abuse of others is an abuse of self and an abuse of our relationship with God, the Creator and Father of us all.

All human beings are created in God's image and are called to the same end, namely, eternal life in communion with God and one another. For this reason, the greatest commandment is to love the Lord with all one's heart and soul and mind, and the second is like the first: to love one's neighbor as one's self. ⁽²²⁾ For people growing daily more mutually dependent and a world in which interdependence is increasing, this is a truth of paramount importance since it provides a transcendent rationale for the pursuit of good human relationships.

2. Human Integrity

God is love (1 John 4:9). This means that the inner reality of God is a mystery of relationship. But God has created humankind to share in his divine life (Genesis 1:26-27). The basic goodness of humanity is confirmed in Genesis 1:31: "God looked at everything he had made, and he found it very good."

Pope Paul VI in his encyclical *Humanae Vitae* (1968) underscored the importance of the "total vision of man" (n. 7). Yet today this "total vision" is often dismissed or ignored in favor of particular elements or aspects of personhood and limited ideas of human fulfillment.

Fundamentally, we are called to realize the basic goodness of our personhood as God has created it. This is not a prerogative or an obligation only for Christians. Everyone, whether believer or nonbeliever, is obliged to honor the integrity of the human person by respecting himself or herself along with all other persons. ⁽²³⁾

The meaning of sexuality and personhood can only be fully discerned within this framework of human integrity. In God's plan as it existed at the beginning (Genesis 1:1,17) we find the true meaning of our bodies: We see that, in the mystery of creation, man and woman are made to be a gift to each other and for each other. By their very existence as male and female, by the complementarity of their sexuality, and by the responsible exercise of their freedom, man and woman mirror the divine image implanted in them by God.

The Church makes an invaluable contribution to society by pointing out that the full meaning of human integrity is found within the context of redemption and its call in Christ to "live in newness of life" (Romans 6:4). ⁽²⁴⁾ Saint Paul reminds us that redemption means, among other things, that we must "respect" our own bodies and the bodies of others and must live always "in holiness and honor." By self-respect and mutual respect, we observe God's original plan.

Originally, God endowed our bodies with a harmony which Saint Paul speaks of as "mutual care of the members for one another." It corresponds to that authentic "purity of heart" by which man and woman "in the beginning" were able to unite as a community of persons. Now, by redeeming us, Jesus graces us with a new dignity: the Holy Spirit dwelling within us. We are called to live as temples of the Spirit.

All this requires that we understand ourselves, and live, not just naturalistically, as it were--as bundles of bodily drives and instincts--but in a manner that respects the integrity of our personhood, including its spiritual dimension. Through the grace of the Spirit, that can be done.

3. The Challenge of Chastity

Human integrity requires the practice of authentic chastity. Chastity is understood as the virtue by which one person integrates one's sexuality according to the moral demands of one's state in life. It presupposes both self-control and openness to life and interpersonal love, which goes beyond the mere desire for physical pleasure. In particular, desire for union with another must not degenerate into a craving to possess and dominate. Chastity calls us to affirm and respect the value of the person in every situation.

While chastity has special meaning for Christians, it is not a value only for them. All men and women are meant to live authentically integral human lives. Chastity is an expression of this moral goodness in the sexual sphere. It is also a source of that spiritual energy by which, overcoming selfishness and aggressiveness, we are able to act lovingly under the pressure of sexual emotion. Chastity makes a basic contribution to an authentic appreciation for human dignity.

4. Obstacles to Integrity and Chastity

Many factors militate against the practice of chastity today. Our culture tends to tolerate and even foster the exploitation of the human person. People are pressured to seek power and domination, especially over other persons, or else to escape into self-gratification. Television, movies, and popular music spread the message that "Everybody's doing it."

One can scarcely exaggerate the impact this has. Casual sexual encounters and temporary relationships are treated on a par with permanent commitment in marriage. It is taken for granted that fidelity and permanence are not to be expected, and may even be undesirable. Sin is made easy because the reality of sinfulness is denied.

What is sin? It is an act motivated by the deliberate refusal to live according to God's plan. It is a disruption, more or less serious, of the order that should prevail in our relationships with God and with one another. It is the root cause of alienation and disintegration in individual and social life. It is a practical denial of God's presence in oneself and one's neighbor.

5. The Challenge and Call to Youth

A. Hope of the Future

The obstacles to human integrity of which we speak are especially daunting today for young people. Yet the Church sees in the young the hope of the future. As Pope John Paul said at the youth assembly in Los Angeles in 1987: "The future of the world shines in your eyes. Even now you are helping to shape the future of society." ⁽²⁵⁾

That underlines how necessary it is that the rest of us help young people live chaste and responsible lives. Youth should be a time of idealism. And most young people do wish to do what is right. They want to be responsible, and they are

capable of understanding that authentic integrity, while demanding much of them, offers them rich rewards in individual and communal fulfillment. Adults for their part must actively support young people, not stand by idly while media and other social influences inundate them with amoral and immoral messages. ⁽²⁶⁾

Integrity and chastity, which we propose here, are virtues that, with God's grace, can be realized by all people of goodwill, by people of any religion and indeed of no religion. But their realization not only presupposes a creation that is good, it presupposes a willingness on society's part to create and sustain a social environment in which individuals truly can know and choose what is right.

Perhaps the most important thing that adults can do in this regard is themselves to be models of upright living. Young people are bewildered by the contradiction between adult preachments about the dangers of drugs and alcohol and adult reliance on the same substances; by adult messages on the theme of sexual responsibility and adult models of extreme irresponsibility in the sexual sphere. This sort of double standard has a debilitating impact on the young.

B. Youth, Sexuality, and Marriage

The sexual dimension of a person is ordered to the establishing and maintaining of honest, committed personal relationships. The *Holy See's Declaration on Certain Questions Concerning Sexual Ethics* affirms that sexuality is not only "one of the principal formative elements in the life of a man or woman" but also "the source of the biological, psychological and spiritual characteristics which . . . considerably influence each individual's progress toward maturity and membership in society" (n. 1).

Sexual intercourse is an expression of maturity achieved within the committed relationship of marriage. Adolescents who engage in sexual intercourse are sometimes misled into believing that they have already arrived at maturity; indeed, many are pressured to have sexual intercourse precisely as a sign that they have reached adulthood. Not only is this a great temptation for them, it fails the test of human integrity.

Sexual intercourse is meant to be both exclusive and committed, and it has these characteristics only in marriage. It should never be regarded as a form of conquest or as a means of paying for attentions. One of the great evils of casual sexual intercourse is that, more often than not, the relationship is exploitative for one or both of the parties.

Nor does sex before marriage really shed light on whether a potential partner is, for example, trustworthy, even-tempered, capable of loving and being loved, caring, affectionate, industrious, considerate, faithful, sensitive, stable, disciplined. It takes time and a variety of different friendships to find a suitable marriage partner. During adolescence, young people should be developing attachments and testing them through companionship. In this process, sexual intercourse is not a research tool for ascertaining compatibility. Rather, it is meant for marriage, to express and complete a compatibility whose existence has already been established by more reliable means.

Sexual intimacy is thus a sign of a special kind of relationship, which has two inseparable aspects: It is unitive (the persons give themselves unreservedly to each other, take permanent and public responsibility for each other, accept the risk of a shared life), and it is procreative (that is, fundamentally related to begetting, bearing, and raising children).

Sexual intercourse is the expression of this special marital relationship. Only in the context of this relationship do genital sex acts have full human meaning. It is marriage that gives intercourse its true meaning.

Once a man and woman are married, they begin a journey that is uniquely theirs. Sexual intercourse forms part of the background against which they grow in love and knowledge of each other. The words of Pope John Paul in *Familiaris Consortio* are of great importance: "To bear witness to the inestimable value of the indissolubility and fidelity of marriage

is one of the most precious and most urgent tasks of Christian couples in our time" (n. 20). Important, too, is what he said to young people in 1987 at the Louisiana Superdome:

Jesus and His Church hold up . . . God's plan for human love, telling you that sex is a great gift of God that is reserved for marriage. At this point, the voices of the world will try to deceive you with powerful slogans, claiming that you are unrealistic, out of it, backward, even reactionary. But the message of Jesus is clear: Purity means true love and it is the total opposite of selfishness and escape. ⁽²⁷⁾

C. Youth and HIV

National studies on contraception and teenage pregnancy suggest that young people are not particularly knowledgeable or skillful in dealing with their sexual lives. Moreover, teenage pregnancy is very often related to socioeconomic problems. The experience of poverty is frequently accompanied by fatalism, deprivation, and boredom, while pregnancy holds out the promise of status and a sense of self-worth. These circumstances have at least two implications for the transmission of HIV. First, there is a large group of heterosexually active but relatively immature young people; second, there is little understanding of how to encourage change in their behavior patterns once these are already well established.

This, however, is scarcely a problem only for the poor. Today sexual intercourse seems to be an element in the experience of a majority of young people in our country. ⁽²⁸⁾ For some, apparently, it is no longer linked to marriage or even to permanent relationships. Yet, at the same time, many young men and women feel profound anxiety in their struggles to establish sexual identity and fit sexuality into their lives. This underscores how critically important it is that the moral and religious values we have sketched in speaking of integrity and sexuality be properly taught to the young.

Education in human sexuality that tells young people in effect that abstinence and "safe sex" are equally acceptable options sends a contradictory, confusing message. Nor should education in sexuality be reduced to mere biological facts and processes, unrelated to their ethical significance.

We repeat: Young people need to know the human and religious meanings of personal integrity and chastity. Chastity requires treating the gift of human sexuality with reverence. Chastity is both a human attitude and a spiritual gift that helps overcome selfishness and aggressiveness. It empowers people to act lovingly while avoiding destructive relationships that are superficial and trivializing. ⁽²⁹⁾

Jesus tells us: "Love one another as I have loved you" (John 15:12). His self-giving, life-giving love led him to accept the cross as an unavoidable part of carrying out his redemptive mission. In the name of self-giving love, we too must accept the discipline of sacrifice so as to achieve true happiness and fulfillment for ourselves and others. Casual and permissive sex does not prepare people for faithfulness in marriage or help them appreciate the sanctity and dignity of the human person.

IV. A Call to Responsibility

1. AIDS and Homosexuality

It is a matter of grave concern that, while many homosexual persons may be making changes in specific sexual practices in response to HIV/AIDS, fewer may be choosing to live chaste lives. ⁽³⁰⁾ This further underlines the critical importance of the Church's teaching on homosexuality.

In 1975 the Congregation for the Doctrine of the Faith presented this teaching in its *Declaration on Certain Questions Concerning Sexual Ethics*.⁽³¹⁾ The document reiterates the Church's constant teaching regarding the intrinsic immorality of homosexual activity, while recognizing that not every homosexual is "personally responsible" for his or her homosexual orientation.

The teaching was further clarified in 1986 in the Congregation's *Letter to the Bishops of the Catholic Church on the Pastoral Care of Homosexual Persons*. It affirms the Church's view that heterosexuality is normative. While homosexual inclination in itself is not a sin, neither is homosexual activity "a morally acceptable option."⁽³²⁾ This conclusion rests on the vision in Genesis of the God-given complementarity of male and female and the responsibility for the transmission of human life.

HIV and AIDS have had a terrible impact on the homosexual community. The *Report of the Presidential Commission* says, for example, that "Violence against those perceived to carry HIV . . . is a serious problem. The Commission has heard reports in which homosexual men in particular have been victims of random violent acts that are indicative of some persons in society who are not reacting rationally to the epidemic. This type of violence is unacceptable and should be condemned by all Americans" (9-103). We emphatically condemn such violence. It is entirely contrary to gospel values.

The Church holds that all people, regardless of their sexual orientation, are created in God's image and possess a human dignity which must be respected and protected. Thus we affirmed in *To Live in Christ Jesus* (1976): "The Christian community should provide them [homosexual persons] with a special degree of pastoral understanding and care" (n. 9). Specific guidelines regarding such pastoral support are found in our 1973 document *Principles to Guide Confessors in Questions of Homosexuality*. It envisages a pastoral approach that urges homosexual persons to form chaste, stable relationships.⁽³³⁾

2. AIDS and Substance Abuse

As we have stressed, however, HIV/AIDS is by no means exclusively a homosexual problem. Intravenous drug use also plays a large role in the spread of HIV. Nearly 70 percent of the reported cases of heterosexually acquired AIDS in the United States have been associated with IV drug use; almost 75 percent of pediatric AIDS cases have been diagnosed in cities with high seroprevalence rates among IV drug users. These data, combined with the potential for the rapid spread of HIV infection among IV drug users through needle-sharing, define a problem whose solution requires both immediate action and long-term research.

Drugs and HIV are linked in several ways.

- Direct transmission of HIV occurs through the sharing of hypodermic needles, syringes, and paraphernalia used in "shooting up" drugs.
- Sexual transmission occurs from infected IV drug users to their sexual partners.
- Perinatal transmission occurs when women who are IV drug users or the sexual partners of drug users become infected and transmit the virus to their infants during pregnancy, delivery, or breast feeding.⁽³⁴⁾

One must also recognize the fact of increased sexual risk and needle-using behavior on the part of persons under the influence of drugs or alcohol. Even with good intentions, abusers may not live up to promises they have made to themselves and others. Those at risk because of their use of alcohol and drugs are called to change their behavior. They merit our special attention and need to be embraced in light of their double burden of illness and addiction.⁽³⁵⁾

In evaluating the moral issue here, it is important to see substance abuse as an actual or potential disease for some persons--a disease, however, for which there are treatment and hope. It should not be supposed that a confirmed substance abuser can simply stop, and this assumption--that the addict would stop if he or she really wanted to--can easily become a rationale for not aggressively encouraging treatment. Often, drug or alcohol abuse points to an underlying emotional illness of which it is a symptom rather than the cause. We believe those who suffer from substance abuse should be referred to appropriate treatment programs and should also receive necessary mental health counseling. ⁽³⁶⁾

While drug abuse is a chronic, progressive, life-threatening disease, addicts can be freed from this form of enslavement. Participation in a treatment program is as an interim step that allows substance abusers to receive comprehensive psychological help and counseling on how to avoid HIV.

As that suggests, drug dependency treatment should always be accompanied by education and counseling about the risk of infection and how to avoid it. Education for intravenous drug users who reject treatment should focus on the risk of repeated exposure to HIV and on the availability of help in conquering their addiction.

In this whole area, education and treatment are of paramount importance. Specific programs suited to particular groups are needed. Persons who have not begun intravenous drug use but are at risk of doing so may be reached through programs in elementary and high schools; those who do not attend school may be reached through health clinics and clinics for sexually transmitted disease, neighborhood and religious groups, day-care centers, employers, job-training programs, and street outreach projects; in areas with high rates of drug use, health departments can open storefront AIDS education centers and use mobile vans, with staffing by professionals and "street smart" personnel.

Education and treatment aimed at changing behavior are the best way to control the spread of HIV among intravenous drug users and to prevent passage of the virus to their sexual partners and to children in the womb. Although some argue that distribution of sterile needles should be promoted, we question this approach for both moral and practical reasons:

- More drug use might result while fewer intravenous drug users might seek treatment.
- Poor monitoring could lead to the increased spread of HIV infection through the use of contaminated needles.
- Distribution of sterile needles and syringes would send message that intravenous drug use can be made safe. But IV drug users mutilate and destroy their veins, introduce infection through contaminated skin, inject substances that often contain lethal impurities, and risk death from overdoses.

A better approach to the drug epidemic would be increased government support for outreach and drug treatment programs.

3. AIDS and the Use of Prophylactics

The "safe sex" approach to preventing HIV/AIDS, though frequently advocated, compromises human sexuality and can lead to promiscuous sexual behavior. We regard this as one of those "quick fixes," which the *Report of the Presidential Commission* says foster "a false sense of security and actually lead to a greater spread of the disease."

Sexual intercourse is appropriate and morally good only when, in the context of heterosexual marriage, it is a celebration of faithful love and is open to new life. The use of prophylactics to prevent the spread of HIV is technically unreliable. ⁽³⁷⁾

Moreover, advocating this approach means, in effect, promoting behavior that is morally unacceptable. Campaigns advocating "safe/safer" sex rest on false assumptions about sexuality and intercourse. Plainly they do nothing to correct the mistaken notion that nonmarital sexual intercourse has the same value and validity as sexual intercourse within marriage. ⁽³⁸⁾

We fault these programs for another reason as well. Recognizing that casual sex is a threat to health, they consistently advise the use of condoms in order to reduce the danger. This is poor and inadequate advice, given the failure rate of prophylactics and the high risk that an infected person who relies on them will eventually transmit the infection in this way. It is not condom use that is the solution to this health problem but appropriate attitudes and corresponding behavior regarding human sexuality, integrity, and dignity.

By contrast, there is an urgent need for education campaigns in the media, in schools, and in the home that fosters a view of human sexuality that is sound from every point of view. ⁽³⁹⁾ At the same time, we are conscious of the powerful relationship between economics-the profit motive-and the promotion of contraceptives, pornography, and the marketing of sex in entertainment. This fact should be taken into account in our education efforts.

V. A Call to Social Justice

1. Continued Research and Care

We urge continued scientific and medical research aimed at finding a cure for HIV as well as treating persons with AIDS. Government agencies should draw up clear educational guidelines on the use and effectiveness of new and emerging drugs (e.g., AZT, azidothymidine). ⁽⁴⁰⁾ Similarly, government and private agencies should provide the public with information about new methods and drugs.

Social justice also requires that public and private agencies seek creative ways to meet the health and human service needs of those who are HIV positive. To date, acute general hospitals have borne the primary burden of caring for this population. It is imperative that a continuum of care be developed that allows for the integration of all necessary services within a given community: nutritional services, home health care, ambulatory care, transportation, hospital services, extended and/or skilled nursing care, and hospice services.

Such a system of care will assure the appropriate placement within the continuum of care of persons who are HIV positive or who have AIDS and will avoid placing an unnecessary and inappropriate burden on any given sector of the provider community. All health and human services for persons who are HIV-positive or who have AIDS should be delivered in a sensitive and nondiscriminatory manner. At the same time, we also recognize the right of surgeons and other medical personnel to adequate protection against HIV. ⁽⁴¹⁾

The health and human services described should be available to all who suffer from the disease including those without the resources to pay. ⁽⁴²⁾

2. Routine Voluntary Testing and Educational Programs

Broadly based routine voluntary testing and educational programs are needed as a matter of public policy. These voluntary programs should always guarantee anonymity and should be preceded and followed by necessary counseling for individuals diagnosed as HIV-positive or negative. Counseling should supply information about the disease, the moral aspects involved, immediate emotional support, and information about resources for continuing emotional and spiritual support. It should also underscore, sensitively but forthrightly, the grave moral responsibility of individuals with HIV to inform others who are at risk because of their condition.

3. Immigrants and Refugees

There are special problems associated with HIV testing for immigrants and refugees: For example, false positive test results from other countries may have the effect of excluding people from the U.S. In addition, permanent resident aliens may be unjustly deported before their circumstances can be adequately examined. A more flexible and humane government policy seems necessary.

4. The Person with HIV/AIDS as a Handicapped or Disabled Person

A growing body of legislation considers the individual with HIV a handicapped or disabled person. In 1978, in a statement on persons with disabilities, we said: "Defense of the right to life...implies the defense of other rights that enable the individual with disabilities to achieve the fullest measure of personal development of which he or she is capable" (*Pastoral Statement of the U. S. Catholic Bishops on Persons with Disabilities* [November 15, 1978; revised 1989] para. 10).

Pope John Paul has recently spoken to this same point, defending the inalienable dignity of all human persons and the need especially to protect those "who are vulnerable and most helpless: this is the task which the Catholic Church, in the name of Christ, cannot and will not forsake." ⁽⁴³⁾

Discrimination against those suffering from HIV or AIDS is a deprivation of their civil liberties. The Church must be an advocate in this area, while also promulgating its own nondiscrimination policies in employment, housing, delivery of medical and dental care, access to public accommodations, schools, nursing homes, and emergency services.

5. Those Who Care for Persons with HIV

The provision of HIV/AIDS services involves some unusual problems. One of these is stress on staff. Many feel a growing and eventually intolerable sense of helplessness as they watch patients, mostly young people die. In providing services, it is important to take into account how long a particular individual can remain on the front line, as it were, and to provide support systems that help those dedicated people deal with their own grief and anger. We also urge all health facilities to develop practical guidelines to protect physicians, nurses, paramedics, and all other health-care workers against contracting HIV and to provide adequate training and supplies for infection control.

Similar guidelines should be developed for the protection of law enforcement and corrections personnel and others in public service who may be at risk.

Dioceses should also develop guidelines not only for preventing infection but also for respite and counseling for health-care professionals, volunteers, and pastoral workers, and for family and loved ones who care for HIV-infected persons.

While some have allowed their disapproval of the actions of certain persons with AIDS to interfere with the provision of care to these persons, the Report of the Presidential Commission points out that this is a "minority view" (Section VII). Generally speaking, health-care workers tirelessly provide quality care to HIV sufferers with compassion and sensitivity. We applaud and thank them and we encourage all health professionals to rise to the same high level of care and beneficence.

6. Families of Persons with AIDS

The consequences of whether a person with HIV/AIDS lives hopefully or dies in despair are borne not only by that individual but also by his or her entire family. ⁽⁴⁴⁾ An HIV or AIDS diagnosis may mark the first time the family has had

to confront a loved one's drug problem or homosexuality. This sharp encounter with a difficult reality can lead to anger, guilt, sorrow, and even rejection on the part of family members; it can even drive a family into a kind of collective isolation. Families should recognize that Jesus has set for all of us an example of loving kindness to all persons and that he calls us to reconciliation with those from whom we have been estranged.

Catholic communities, especially parishes, should reach out to these families with understanding and practical help—for example, by providing respite-time from caring for their sick members. Acceptance and emotional and spiritual support are crucial needs.

Families of HIV patients badly need to talk about what they are experiencing. Although family members usually are ambivalent about disclosing the nature of their relative's disease to outsiders, it is important for them to communicate. The Catholic community should create networks of people prepared to assist such families in this way.

7. The Public Good and Confidentiality

A. Nondiscrimination and Individual Privacy

Our understanding of the common good expresses our vision as a people of the kind of society we want this to be. The common good is, therefore, central to the evaluation of legislative and public policy proposals. Two objectives are fundamental to any adequate understanding of the common good: first, preserving and protecting human dignity while guaranteeing the rights of all; second, caring for all who need help and cannot help themselves.

The appropriate goals of AIDS-related legislation include helping to prevent the transmission of HIV; providing adequate medical care; and protecting civil rights, that is, nondiscrimination in employment, schooling, entertainment, business opportunities, housing, and medical care, along with the protection of privacy.

Dioceses and church-related institutions should also pursue these objectives in appropriate ways through their own policies and practices. Their hiring decisions, for example, should not be based on the fact that particular job applicants are HIV-infected but on other factors such as qualifications, ability to do the work, and moral character.

Individual privacy and liberty are highly valued in our society. Liberty, however, carries with it the obligation not to harm or interfere with others. If HIV-infected persons have rights that others must respect, they also must fulfill their fundamental ethical responsibility to avoid doing harm to others. As the *Report of the Presidential Commission* says, this is "an affirmation of the rights of others" (9-99).

B. Rights of the Human Person

Framing and implementing public policy frequently requires the balancing of individual and community rights and interests. With respect to HIV/AIDS, it is important to infringe as little as possible, in light of community needs, on individual liberty, privacy, and confidentiality. Other, quite specific, conditions must also be met. For example, respect for persons requires informing people that they are being tested when donating blood; they also have a right to be informed of test results; and both pre- and post-testing counseling should be available. ⁽⁴⁵⁾

Although specific exceptions might be made, universal mandatory testing does not seem justified at this time.

C. Disclosure and Confidentiality: General Guidelines

While the presumption should always favor confidentiality, there may be circumstances that warrant disclosure. In deciding for disclosure or confidentiality in a particular case, the following points are relevant.

1. The two main factors in favor of disclosure are (a) the need to prevent the infection of others and (b) the need to provide medical care to the person who is HIV-positive or has AIDS. If disclosure in a particular case will reduce the danger of infection to others or increase the ability to treat the individual effectively, it may be the right course of action if no other effective action is possible.
2. Of primary importance in weighing the individual's interest in and right to confidentiality are (a) the ability to confine the disclosure to those who have the right to know, (b) the likelihood that recipients of the information will use it for proper purposes, and (c) the obligation to maintain patient confidentiality.

VI. A Call to Prayer and Conversion

1. Discover Christ in Those Who Suffer

Our response to persons with AIDS must be such that we discover Christ in them and they in turn are able to encounter Christ in us. Although this response undoubtedly arises in the context of religious faith, even those without faith can and must look beyond suffering to see the human dignity and goodness of those who suffer.

Without condoning self-destructive behavior or denying personal responsibility, we reject the idea that this illness is a direct punishment by God.⁽⁴⁶⁾ At the same time, we recognize that suffering and sickness are consequences of original sin, which each of us has confirmed by personal sin.

Even as he permits human suffering, however, God wills to bring out of it some greater good for our sake. Jesus reveals a God who is compassionate and forgiving. Sinners are special objects of his merciful love. And who are the sinners? We have all been touched by original sin, and all of us commit personal sins of our own. The story of the prodigal son (Luke 15:11-32) calls each of us to personal conversion and reform. The prodigal son discovered that the way he had chosen, the way of sin, was leading him to death. His very life hung on the choice to return to his father. And the father's love was so total, so unconditional, that he joyfully welcomed his son home. Mindful of our own misguided and sinful choices, we also must return to God, our Father, who waits to embrace us with open arms.

2. Suffering and Death

Pope John Paul urges those who suffer never to lose heart. Christ, the innocent Son of God, knew suffering in his own flesh. For us, too, suffering, accepted and lived as Jesus accepted and lived it, can be redemptive.⁽⁴⁷⁾

Faith does not tell us to seek suffering for its own sake, but it does tell us that suffering and death, joined to the suffering and death of Jesus, the Lord of life, lead ultimately to growth, fulfillment, and lasting joy. The experience of suffering can be a vital time in one's life, a time for becoming reconciled both to life and to death and for attaining interior peace.⁽⁴⁸⁾

Finally, suffering and death lead to the resurrection. Death is not the end. Christ gathers up suffering, sin, and death into his triumph. His resurrection means we also have a future which God is preparing for us in the midst of suffering and death, just as Christ's glory was being prepared on the cross.

But suffering has meaning not just for those who suffer. In the case of HIV and AIDS, the entire Christian and human community is called to respond with compassion, love, and support. Any suggestion of assisted suicide or euthanasia as a response offends against human integrity and God's law. Our fundamental task is to assist the suffering and dying, not to terminate their lives.

Every human death somehow mirrors the death of Christ: It is the entrusting of the spirit to him who created us for eternal life. ⁽⁴⁹⁾ The Christian can be serene in the face of death because of Jesus' promise: "In my Father's house there are many dwelling places . . . I am going to prepare a place for you" (John 14:2). ⁽⁵⁰⁾ Life and death are not polar opposites but points on a continuum that leads to eternal life.

3. Christian Hope and Joy

Hope is an essential component of the Christian response to suffering and death. Persons with AIDS and their families and loved ones need prayer and spiritual support to sustain them in hope. At the very heart of human life lie profound questions about meaning, identity, individual and communal destiny, transcendence, reconciliation, love, God. This is the context of Pope Paul VI's words concerning Christian hope: "It is indeed in the midst of their distress that our fellowmen need to know joy, to hear its song." ⁽⁵¹⁾

The lives of holy men and women offer many examples of hope and joy in the midst of difficulties and sufferings. One thinks of St. Therese of Lisieux, a young woman who suffered greatly, and who courageously abandoned herself into the hands of God, entrusting her littleness to him. One thinks of the message of Mother Teresa of Calcutta, who reminds us constantly that love is stronger than hatred, life than death, and that the lives of ordinary people bear witness time and again to the human capacity for extraordinary courage and compassion. Persons with AIDS, she holds, are Jesus among us. Christian hope and joy guard us against the temptation to desert them-and him.

4. Ministry to Persons with HIV/AIDS

The Church offers all its members the rich treasury of grace through its sacramental life. For those who are ill, the Church offers the Sacrament of the Anointing of the Sick, together with the Sacrament of Penance and the Eucharist. These encounters with Christ in forgiveness, healing, and the restoration of the life of grace are profound moments of conversion and renewal. For family members, as well as health-care workers, these same sacramental sources of grace provide the inner strength and needed hope that the world cannot give. We encourage all who minister in the Church to bring the full sacramental life of Christ to those who most need to be touched by his healing hand.

We urge daily prayer for those suffering from HIV and AIDS. We also encourage dioceses to provide qualified priests, deacons, religious, and lay people who will communicate the necessary information about HIV/AIDS. Every diocese should have a list of resource persons and support systems for persons with HIV/AIDS and their families.

Where appropriate, a diocese should also have a person responsible for coordinating its ministry in this area. Dioceses should likewise develop training programs for those who minister to people affected by AIDS (e.g., eucharistic ministers in hospitals, visitors to the sick, confessors, and counselors). Catholic health facilities should continue to provide local professional leadership in responding to the needs.

5. The Church and Those Who Suffer

In sum, then, in its ministry to and for persons with HIV/AIDS, the Church calls everyone to conversion; offers sacramental reconciliation and human consolation; seeks to assist all those who suffer; proclaims faith's explanations of suffering, sin, and death in the light of the cross and the resurrection; and accompanies those who suffer on their journey of life while helping them face death in the light of Christ. We recall again the words of *Salvifici Doloris*:

In the messianic program of Christ, which is at the same time the program of the Kingdom of God, suffering is present in the world in order to release love, in order to give birth to works of love towards neighbor, in order to transform the whole of human civilization into a "civilization of love" (n. 30).

We offer this document in response to the need-of the nation; the Church; and countless communities, families, and individuals-to confront the crisis of HIV and AIDS. The crisis continues, but it can be met with understanding, justice, reason, and deep faith.

HIV/AIDS brings with it new anguish and new terrors and anxiety, new trials of pain and endurance, new occasions for compassion. But it cannot change one enduring fact: God's love for us all. We proclaim anew this message: "God so loved the world that he gave his only Son, so that everyone who believes in him should not perish but might have eternal life" (John 3:16).

Notes

1. "None of us lives for oneself, and no one dies for oneself. For if we live, we live for the Lord, and if we die, we die for the Lord; so then, whether we live or die, we are the Lord's" (Romans 14:7-8).
2. United States Catholic Conference Administrative Board, *The Many Faces of AIDS: A Gospel Response* (Washington, D.C.: USCC Office for Publishing and Promotion Services, 1987).
3. *Ibid.*, p. 6. *The Many Faces of AIDS* treated nine basic topics: (1) gospel values; (2) facts about AIDS; (3) societal responsibilities; (4) health-care professionals/institutions; (5) testing; (6) persons with AIDS; (7) public policy; (8) pastoral issues; and (9) prevention of AIDS.
4. See "AIDS Discussion at June Bishops' Meeting," *Origins* 17 (1988) 726; and "AIDS Statement: Proposal of Cardinal Bernardin Accepted," *Origins* 18 (1988) 118-120. The precise motion was:

... That the president appoint an ad hoc committee to prepare a new, updated statement on the AIDS crisis which will respond to the new facts, fears and efforts which have emerged in recent months. The committee, in preparing the new statement, will have the benefit of the extant board statement on AIDS (*The Many Faces of AIDS: A Gospel Response*), the discussions which have taken place since its publication, dialogue with the Congregation for the Doctrine of the Faith and participation by all the bishops in open, plenary session.
5. Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic (Washington, D.C.: June 1988); citation here, 1V, 115.
6. *Sollicitudo Rei Socialis* (December 30, 1987) n. 41.
7. The chapters of this report are: Incidence and Prevalence; Patient Care; Health Care Providers; Basic Research, Vaccine, and Drug Development; The Public Health System; Prevention; Education; Societal Issues; Legal and Ethical Issues; Financing Health Care; The International Response; and Guidance for the Future.
8. HIV and AIDS statistics change rapidly. Here we present only some current data. The Centers for Disease Control (CDC) projects, for example, that by 1992, 20,000 AIDS cases nationally will have been diagnosed in those who had blood transfusions before HIV screening in early 1985. The CDC also reports the alarming statistic that presently there is a 0.2 percent rate of HIV infection among 16,861 college students. The General Accounting Office maintains that AIDS cases are now underreported, with the true toll a third higher than reported. In addition, 2 percent of those infected are under 13 years of age; 58 percent are white; 26 percent are African America; 15 percent are Hispanic and 1 percent are Asian and Pacific Islanders. As we write, figures for those with AIDS vary slightly (not substantially), depending on the

source. See *AIDS: Sexual Behavior and Intravenous Drug Use*, Charles F. Turner, Heather G. Miller and Lincoln E. Moses, eds. (Washington, D.C.: National Academy Press, 1989).

- 73 percent are homosexual and bisexual men
- 17 percent are IV drug users
- 3 percent are those without a well-defined risk factor
- 1 percent are children
- 1.6 percent were infected by blood transfusions
- 1 percent are hemophiliacs
- 1 percent are heterosexuals exposed to those in risk categories

9. See "The Epidemiology of AIDS in the U.S.," *Scientific American* October 1988) 72-81; and "Prevalence of HIV Infection Among Intravenous Drug Users in the United States," *Journal of the American Medical Association* 261 (1989) 2677-2684. Newborn children of HIV-seropositive women carry the maternal antibody to HIV, even though the infants themselves may not be infected. The maternal antibodies disappear from the infant's blood after a time if the baby is not infected. The Institute of Medicine/National Academy of Sciences 1988 report estimated that there is a 30-50 percent risk of perinatal HIV transmission from an infected mother to her child.

10. "Report from Montreal: The Fifth International AIDS Conference," *AIDS Commentary*, Bernard McNamara, M.D., ed. (Los Angeles: Design Alliance to Combat AIDS [DAC], 1989). Dr. Jonathan Mann, chief of the World Health Organization's AIDS Campaign, spoke of the epidemic's history in the first eight years during which its existence was known. He indicated that between 5 and 10 million people have been infected worldwide. He said that half were in Africa, 40 percent in America, less than 10 percent in Europe and only a tiny fraction in Asia and the Pacific Islands. Mann further spoke of a disturbing change, namely, that the epidemic is exploding in countries such as Thailand, where viral infections have multiplied twenty-fold among intravenous drug users and more than tenfold among prostitutes. He indicated that in West Africa the epidemic is spreading swiftly in many of this continent's larger cities. As another example, in Brazil, a new urban epidemic of cocaine injection has caused a threefold rise in AIDS infections; and in Spain and Italy infections originating in drug abuse now account for more than 60 percent of all AIDS cases. By the turn of this century, Mann said, at least 6 million people will have the disease or will have died from it. The startling numbers of homeless people infected with the HIV virus in a number of major American cities reflect the high number of intravenous drug abusers and young homosexual runaway men among the homeless population. At the present time, nowhere in the world is the AIDS epidemic more devastating than in New York City.

11. Researchers indicate that people who were over forty years old when infected are four to eight times as likely to develop AIDS within seven years as people who were under twenty. People who are older progress to AIDS at a significantly greater rate than teenagers or young adults. In addition, Richard P. Keeling, president of the American College Health Association, has recently said: "We are more disturbed than heartened. Because of patterns of sexual activity and drug abuse among college students, it is possible that there could be further significant spread of HIV in this population." See the *New York Times* (May 21, 1989) 16; and the *Washington Post* (May 23, 1989) A5. Although researchers have learned a great deal about how HIV spreads, they are still struggling with some extremely important questions. For example, why are the patterns of AIDS virus infectivity so different in Africa and North America? In Africa, almost all of the cases occur in heterosexuals, affecting men and women equally; in North America, the disease primarily strikes male homosexuals. Recent studies indicate that lack of circumcision alone increased the likelihood of AIDS infection some five- to eightfold, whereas a history of genital ulcers alone increased it four- to fivefold. See "Circumcision May Protect Against the AIDS Virus," *Science* 245 (1989) 470-471.

12. "The Epidemiology of AIDS in the U.S.," William L. Heyward and James W. Curran, *Scientific American* (October 1988) 72-81. An additional complication concerns the mysterious mutations of the AIDS virus. Up to now, researchers have encountered over two hundred. Although there is scientific controversy regarding these mutations, it is clear that the family of human retroviruses is on the increase.

13. *AIDS: Living and Dying With Hope*, Walter J. Smith, SJ (New York: Paulist Press, 1988) 1-16. Two technical terms are frequently used in discussions of epidemic diseases: *incidence* and *prevalence*. Incidence denotes the rate of occurrence of new infections per unit of time (e.g., per year). Thus, an incidence of .03 per year in some group means that new infections occurred in 3 percent of the group during the year in question. Prevalence denotes that proportion of a group that is currently infected. A prevalence of .10 means that 10 percent of the group is currently infected. The retrovirus responsible for AIDS infects and leads to the death of T helper cells, with resultant dysfunction of the immune system. It was originally referred to as *Human T-cell Lymphotropic Virus Type III* (HTLV-III) and more clumsily as HTLV-LAV-III (*lymphadenopathy-associated virus*). Most literature now follows the usage of the International Committee on the Taxonomy of Viruses: *Human Immunodeficiency Virus* (HIV).

14. See National Research Council, *AIDS: Sexual Behavior and Intravenous Drug Use* (Washington, D.C.: National Academy Press, 1989). See also I:5 in this paper.

15. In their *Statement on AIDS*, the Canadian bishops stated, "[W]e must do all we can to overcome [fear] because there is danger that fear will sap the energies we need to face this disease" (*Origins* 19 [1989] 25-27, citation at 25-26).

16. *Gaudium et Spes* (December 7, 1965) n.1.

17. *New York Times* (May 1989) A5.

18. John Paul II, *On the Christian Meaning of Human Suffering*, (Washington, D.C.: USCC Office for Publishing and Promotion Services, 1984) n. 29. The pope emphasized this same point in speaking to the United States Catholic health-care leaders in 1987.

Besides your professional contribution and your human sensitivities toward all affected by this disease, you are called to show love and compassion of Christ and his Church. As you courageously affirm and implement your moral obligation and social responsibility to help those who suffer, you are, individually and collectively, living out the parable of the Good Samaritan (see Luke 10: 30-37) (*Unity in the Work of Service: John Paul II on the Occasion of His Second Pastoral Visit to the United States* [Washington, D.C.: USCC Office for Publishing and Promotion Services, 1987] p. 103).

19. See Karol Wojtyla, *Love and Responsibility* (New York: Farrar, 1981) 202.

Tenderness...springs from awareness of the inner state of another person (and indirectly of that person's external situation, which conditions his inner state) and whoever feels it actively seeks to communicate his feeling of close involvement with the other person and his situation. This closeness is the result of an emotional commitment: That sentiment enables us to feel close to another "I"...Hence also the need actively to communicate the feeling of closeness, so that tenderness shows itself in certain outward actions which of their very nature reflect their inner approximation to another "I."

20. *Unity in the Work of Service*, p. 185.

21. See *Gaudium et Spes*, especially chapter II, and *Mulieris Dignitatem*, n. 7.

22. Scripture teaches that love of God cannot be separated from love of neighbor: "If there is any other commandment, it is summed up in this saying, 'You shall love thy neighbor as yourself' (Romans 13:9-10; 1 John 4:20).

23. Pope John Paul II has addressed this point on various occasions: see *L'Osservatore Romano*, 10 September 1979; 17 September 1979; 24 September 1979; 1 October 1979; 15 October 1979; 29 October 1979; 5 November 1979; 12 November 1979; 19 November 1979; 26 November 1979; 17 December 1979; 24 December 1979; 7 January 1980; 14 January 1980; 21 January 1980; 4 February 1980; 11 February 1980; 18 February 1980; 25 February 1980; 10 March 1980; 17 March 1980; 31 March 1980; 21 April 1980; 28 April 1980; 5 May 1980; 19 May 1980; 2 June 1980; 23 June 1980; 30 June 1980; 28 July 1980; 4 August 1980; 11 August 1980; 25 August 1980; 1 September 1980; 8 September 1980; 15 September 1980; 22 September 1980; 29 September 1980; 6 October 1980; 13 October 1980; 20 October 1980; 27 October 1980; 3 November 1980; 10 November 1980; 17 November 1980; 8 December 1980; 15 December 1980; 29 December 1980; 12 January 1981; 19 January 1981; 2 February 1981; 9 February 1981; 16 February 1981; 23 March 1981; 6 April 1981; and 13 April 1981; and "On Human Sexuality and Personhood," February 20, 1981, cited in James V. Schall, SJ, ed., *Sacred in All Its Forms*, 287-290.

24. Cardinal Joseph Ratzinger has spoken to this same point:

In a society which seems increasingly to downgrade the value of chastity, conjugal fidelity and temperance, and to be preoccupied sometimes almost exclusively with physical health and temporal well-being, the church's responsibility is to give that kind of witness which is proper to her, namely an unequivocal witness of effective and unreserved solidarity with those who are suffering and, at the same time, a witness of defense of the dignity of human sexuality which can only be realized within the context of moral law (*Origins* 18 (1981) 117-118; citation at 118).

25. "The Los Angeles Youth Assembly and Teleconference," John Paul II, *Origins* 17 (1987) citation at 275.

26. See "Parents Disturbed by TV Content" and "Dating is Strongest Peer Pressure Among Teens," Princeton Religion Research Center, *Emerging Trends* 11(1989)1-3; 5. See also Pontifical Council for Social Communications, *Pornography and Violence in the Communications Media: A Pastoral Response* (May 7, 1989) (Washington, D.C.: USCC Office for Publishing and Promotion Services, 1989).

27. *Unity in the Work of Service*, p. 63.

28. See "All You Need Is Love," James J. DiGiacomo, *America* 156 (1987)126-129; and "Dating is Strongest Peer Pressure Among Teens," Princeton Religion Research Center, *Emerging Trends* 11 (1989) 5.

29. See the Pennsylvania Catholic Bishops, *To Love and To Be Loved* (Harrisburg: Pennsylvania Catholic Conference, 1989).

30. "Given the very high background rate of HIV it is clear that relapses from safe sex, however occasional, constitute a threat to the health of gay men in San Francisco and other cities" (Dawn Garcia, "Unsafe Sex Practices," *San Francisco Chronicle* [March 11, 1989]). The article reported on a study by Ron Stall and Maria Ekstrand released in February 1989 by the Center for AIDS Prevention Studies at the University of California-San Francisco, which reported that relapses into "unsafe" sex practices are increasing among gay men. Their study of 453 men showed a decline of 59 percent in high-risk sexual behavior between 1984 and 1987; 15.7 percent of those studied had at least one incident of relapse into "unsafe" sex practices.

31. Congregation for the Doctrine of the Faith, *Persona Humana* (December 29, 1975) n. 8.

32. Congregation for the Doctrine of the Faith, *Letter to the Bishops of the Catholic Church on the Pastoral Care of Homosexual Persons* (October 1, 1986) n. 3. This document importantly teaches that:

From this multifaceted approach there are numerous advantages to be gained, not the least of which is the realization that a homosexual person, as every human being, deeply needs to be nourished at many different levels simultaneously. The human person, made in the image and likeness of God, can hardly be adequately described by a reductionist reference to his or her sexual orientation. Everyone living on the face of the earth has personal problems and difficulties, but challenges to growth, strengths, talents and gifts as well. Today the Church provides a badly needed context for the care of the human person when she refuses to consider the person as a "heterosexual" or a "homosexual" and insists that every person has a fundamental identity: the creature of God, and by grace, His child and heir to eternal life (n. 16).

Homosexual activity has been one of the main transmitters of HIV virus. In this light, it is of critical importance to heed the Church's teaching regarding homosexual activity, which affirms the basic complementarity of the sexes and the intrinsic "spousal significance" of the human body.

33. NCCB Committee on Pastoral Research and Practices, *Principles to Guide Confessors in Questions of Homosexuality* (Washington, D.C.: USCC Office for Publishing and Promotion Services, 1973) pp. 9, 11:

The confessor should encourage the person to form stable relationships with persons of both sexes...Two other elements which should be stressed are regular access to spiritual direction and the formation of a stable friendship with at least one person. One of the greatest difficulties for the homosexual is the formation of such a friendship...If a homosexual has progressed under the direction of a confessor, but in the effort to develop a stable relationship with a given person has occasionally fallen into a sin of impurity, he should be absolved and instructed to take measures to avoid the elements which lead to sin without breaking off a friendship which has helped him grow as a person. If the relationship, however, has reached a stage where the homosexual is not able to avoid overt actions, he should be admonished to break off the relationship.

34. "AIDS and IV Drug Use," Don C. Jarlais and Samuel R. Friedman, *Science* 245 (1989) 578. A correlation between the use of volatile amyl and butyl nitrites (poppers) and the development of Kaposi's sarcoma has also been demonstrated. Although not directly linked to AIDS, alcohol, marijuana, cocaine, and amphetamines have been demonstrated to be immunosuppressant, and their use may accelerate disease progression from HIV infection to AIDS.

35. In 1972, Pope Paul VI pointed out this urgent need: "It is indispensable to mobilize public opinion through clear and precise information on the nature and true and deadly consequences of drug abuse, about those misunderstandings which are circulating on its presumed harmlessness and on its beneficial influences" (Insegnamenti di Paolo VI 10 (1972) 1286). Pope John Paul II has also spoken of this contemporary scourge:

Neither alarmism nor over-simplification serve to confront drug abuse. Rather, what is effective is an effort to know the individual and understand his interior world; to lead him to the discovery, or rediscovery, of his own dignity as man; to help him to revive and nurture those personal resources that drugs have buried, by reactivating the mechanisms of the will and directing them toward certain and noble ideals ("The Evil of Drugs," John Paul II, *The Pope Speaks* 29 (1984) 356-359: citation at 357.).

36. See "Recommendations for Control and Prevention of *Human Immunodeficiency Virus*(HIV) Infection in Intravenous Drug Users," Philip W. Brickner, M.D., et al., *Perspective: Annals of Internal Medicine* 110 (1989) 833-837. Despite the lack of data on the number of female prostitutes, available data suggest that the majority of prostitutes who have become infected with HIV in the United States have not become infected through sexual behavior. Most AIDS cases among women in the United States have occurred in women who use IV drugs. Although it is seldom possible to disentangle

completely the effects of sexual transmission from drug-related transmission, the fact that there are relatively few women with HIV infection who are not IV drug users suggests that shared injection equipment-rather than sexual activity-has been the most significant transmission factor among female prostitutes. Medical advances are only just beginning to develop programs for polysubstance abusers.

37. Milton C. Weinstein, and others, "Cost Effectiveness Analysis of AIDS Prevention," in Charles F. Turner and others, eds., *AIDS: Sexual Behavior and Intravenous Drug Use* (Washington, D.C.: National Research Council, 1989) 498. See "Can You Rely on Condoms?" *Consumer Reports* 157 (1989) 135-140.

38. See *Gaudium et Spes*, II, chapter 1, for a precise presentation of the Church's teaching on the nobility of marriage and the family; also John Paul II, *Familiaris Consortio* (*Community of the Family*) (November 22, 1981).

39. See "National Federation of Catholic Physicians' Guilds Proposed Position Paper: Statement on Prevention of AIDS By Condoms," *Linacre Quarterly* 55 (1988) 12-15; *The Many Faces of AIDS; and AIDS: A Catholic Educational Approach* (Washington, D.C.: National Catholic Educational Association, 1988).

40. In August 1989, the National Institutes of Health announced that new studies have found that AZT is effective in slowing the development of AIDS in people who have not yet contracted the disease but who exhibit its earliest signs. The studies also found that people with early symptoms of HIV infection not only can benefit from AZT but also suffer far fewer of the toxic side effects that mark the use of the drug among people with AIDS. This research, conducted by a division of the National Institutes of Health, shows that AZT dramatically slows the multiplication of HIV virus in people with mild symptoms of the disease, such as diarrhea, thrush, or a chronic rash. Until this time, AZT was thought to be effective only in patients with more advanced cases of AIDS. This study, called Protocol 019, has several implications:

1. All those who may have been infected with HIV should undergo immediate testing for the virus. This counsel rests on certain clear assumptions: the growing accuracy of the HIV test; increased guarantees of confidentiality; the growth of proper counseling both before and after the test; the enactment of effective city, state, and federal antidiscrimination laws.
2. AZT treatment now costs \$8,000.00 per person per year, and other drugs and diagnostic tests are needed in the treatment of HIV/AIDS sufferers. It is thus crucial to provide financial and medical resources to assist persons with the HIV disease.

41. "Ethical Issues Involved in the Growing AIDS Crisis," *Council Report: The Journal of the American Medical Association* 259 (1988). We recall the 1987 determination by the Council on Ethical and Judicial Affairs of the American Medical Association that refusing treatment to the afflicted is unethical. Also, Dr. Edmund Pellegrino, director of the Kennedy Institute of Ethics, has stated: "A medical need in itself constitutes a moral claim on those equipped to help." This echoes John Paul's words to the Catholic Health Association in Phoenix in 1987, when he spoke of "your moral obligation and social responsibility to help those who suffer" from AIDS and said: "You are called to show the love and compassion of Christ and his Church."

42. The 1988 meeting of the American Medical Association stated: "The Board recommends continued support for adequate funding for all aspects of this epidemic including education, research and patient care" (Proceedings, 210).

43. Cited in the *Los Angeles Tidings* (May 26, 1989) 1. The *Statement of the Holy See on the International Year of the Disabled* also affirms:

The first principle . . . is that the disabled person (whether the disability be the result of a congenital handicap, chronic illness or accident, or from mental or physical deficiency, and whatever the severity of the disability) is a fully human

subject with the corresponding innate, sacred and inviolable rights . . . This principle, which stems from the upright conscience of humanity, must be made the inviolable basis of legislation and society (Origins 10 [1981] citation at 747).

44. See Betty Clare Moffat, *When Someone You Love Has AIDS* (New Jersey: IBS Press, 1986); Barbara Peabody, *The Screaming Room* (Avon: Oak Tree Publications, 1986); Walter J. Smith, SJ, *AIDS: Living and Dying with Hope* (New York: Paulist Press, 1988) and William C. Spohn, SJ, "The Moral Dimension of AIDS," *Theological Studies* 49 (1988) 89-109. See also, *Shadow on the Family: AIDS in Religious Life*, The Catholic Health Association, Conference of Major Superiors of Men, 1988; and *The Gospel Alive*, The Catholic Health Association and the Conference of Major Religious Superiors of Men's Institutes (St. Louis: The Catholic Health Association, 1988).

45. See James Childress, "An Ethical Framework for Assessing Policies to Screen for Antibodies to HIV," *AIDS and Public Policy Journal* 2 (1987) 28-31. It may be appropriate for seminaries and religious communities to screen for the HIV antibody. In regard to candidates for the priesthood, Canon 241:1 is pertinent:

The diocesan bishop is to admit to the major seminary only those who are judged capable of dedicating themselves permanently to the sacred ministries in light of their human, moral, spiritual and intellectual characteristics, their physical and psychological health and their proper motivation (*Code of Canon Law*, Latin-English Edition, Canon Law Society of America).

The point here is not to automatically exclude a candidate who is HIV-positive but rather to discern carefully this person's present health situation as well as future health prospects and thus to make an overall moral assessment of an individual's capacity to carry out ministerial responsibilities. Canon 642 is relevant in terms of admission to a religious community:

Superiors are to be vigilant about admitting only those who, besides the required age, have health, suitable character and sufficient qualities of maturity to embrace the particular life of the institute

46. The 1983 document of the National Conference of Catholic Bishops, *Pastoral Care of the Sick: Rites of Anointing and Viaticum* is instructive to this point: "Although closely linked with the human condition, sickness cannot as a general rule be regarded as a punishment inflicted on each individual for personal sins" (The Rites of the Catholic Church [New York: Pueblo Publishing Company, 1983] 593-740; citation at n. 2).

47. "The Cross of Suffering," John Paul II, July 8, 1980, cited in ISchall, op. cit., 106-111; citation at 108. See also "The Mystery of Life and Death," John Paul II, *Origins* 15 (1985-1986) 415-417.

48. Pope John Paul II has explained: "Suffering has a special value in the eyes of the Church. It is something good, before which the Church bows down in reverence with all the depth of her faith in the redemption..." (*On the Christian Meaning of Human Suffering*, nn. 1-8).

49. "Every Human Death: A Reflection of the Death of Christ," John Paul II, *L'Osservatore Romano* 15 (1985) 3-4; citation at 4.

50. See also "Death and Eternity," John Paul II, *L'Osservatore Romano* 45 (1988) 5. See also, Psalm 27:1-4.

51. Paul VI, *On Christian Joy* (Washington, D.C.: USCC Office for Publishing and Promotion Services, 1975) n. 8.

A Global Catholic Perspective:

The Church's Response to AIDS (2001)

Based on a presentation by Msgr. Robert Vitillo
(Los Angeles Archdiocese Religious Education Congress, Anaheim, California, 2001)

At the very heart of Catholic teaching is the premise of the dignity of each and every human person who has been created in the image of God. Catholic Church leaders re-affirmed this teaching by refuting the conclusions reached by a very small minority of religious leaders and by many in the general public which falsely assert that AIDS might be God's punishment for those who have not observed divine laws. Thus, Cardinal Arnz wrote in 1988 to the members of the Catholic Church in Sao Paulo, Brazil:

And it is Jesus himself, through his words and actions, who teaches us the path which must be taken. It is enough for us to read into the concrete situation of today the parable of the Good Samaritan and the cure of the leper. It is not for us to question WHY or HOW the illness was contracted.

Catholics believe that they have been mandated by Jesus Christ to reach out in solidarity and in non-judgmental compassion to all people, but especially to those who are most in need and to those who have been alienated by others in society. Pope John Paul II reinforced this belief, during his pastoral visit to Uganda in 1993, when he said:

The church feels particularly close to those who are suffering in mind and body, whatever their social or economic condition or their religious affiliation...This loving concern, essential to her mission, finds concrete expression not only in the establishment of her many hospitals, clinics, and dispensaries, but also and above all in the physical and spiritual care provided by her priests and religious and by the many lay men and women-doctors, nurses, and other health care professionals-whom she sets forth as examples to civil society for their selfless devotion to others.

Catholic leaders and the believing community as a whole have translated their theories about the Church's role as educator in the field of HIV/AIDS prevention into practical, everyday actions. In Zimbabwe, for example, the National Catholic Development Commission produced a brochure, *AIDS and the Christian*, which highlights five steps to be taken by Catholics in response to HIV/AIDS: know the facts, respect God's law, love faithfully, protect yourself and your family and have compassion on sufferers.

Many Catholic Church-sponsored educational efforts make a special commitment to educate young people before they begin sexual activity or before they establish harmful patterns of sexual behavior or of drug and alcohol use. In Uganda, a Catholic sister has developed guidelines for teaching about sexuality and human relationships, *An Education for Life Series*. In several countries of Africa, Anti-AIDS clubs have been founded by the Catholic Church and organizations of other faith traditions. In these groups, young people commit themselves to learn the facts related to HIV/AIDS and to reinforce their learning activity with peer social support and by offering assistance to those who are already ill from, or dying of, AIDS. In the Philippines and Chile, national and local Catholic social service agencies have organized educational exhibits about HIV/AIDS for students in primary and secondary schools as well as in universities.

In many countries of the Southern Hemisphere, faith-based organizations take responsibility for more than one half of the infrastructure for health care. Very often, these church-sponsored services are the only ones to reach out beyond the capital cities and the more populated areas. In places where an elevated HIV-infection rate can be noted, Catholic hospitals and clinics have faced many new burdens. In response to resource shortages, overcrowding, and staff "burnout," numerous Catholic health facilities, most especially those located in Africa and Latin America, have developed mobile home care programs which dispatch staff and trained volunteers to assist people in caring for family members who have AIDS in their own homes. The volunteers do not require sophisticated training; frequently, they are catechists, village health workers, or local parishioners.

In addition to programs with a direct medical focus, church-related organizations have been called upon to provide psychological and social support to persons with HIV/AIDS and to their families and loved ones. Such responses include:

- Initiating economic development opportunities for HIV-infected persons who have lost employment and social insurance benefits;
- Nurturing and educating thousands of children whose parents have either died or have become severely incapacitated as a result of HIV-related illnesses;
- Caring for elderly persons who are surviving their adult children and thus are unable to rely on the traditional systems of family care.

The Catholic Church's response to the pandemic of HIV/AIDS has not been formulated without hesitation and conflict. The leaders and faithful of our Church – as their counterparts in all of society--have expressed hesitation, fear and prejudice in the face of the pandemic. On the other hand, our Church has offered a valiant and valuable response to those affected by HIV/AIDS. Its teaching about the pandemic have been rooted in the values of fidelity and responsibility in relationships as well as in respect for the human person from which it draws its very mission and mandate. Catholic-sponsored services to those affected by HIV/AIDS have reached far and wide and generously made available resources to peoples and regions long forgotten by governments and the rest of the society. The Church's spiritual support to those living with HIV will grow and evolve together with the needs of people as they journey in search of ultimate fulfillment in God.

Ethical Issues Related to Preventing the Further Spread of HIV:

Teachings and Actions of the Catholic Church (2012)

Rev. Msgr. Robert J. Vitillo
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Published in *AIDS: 30 Years Down the Line ... Faith-based Reflections about the Epidemic in Africa*, Paterne Am Mombé, SJ, Agbonkhianmehge E. Orobator, SJ, and Danielle Vella (eds.) Nairobi: Paulines Publications Africa, 2012, ISBN 9966-08-690-0, pp 349-360.

Ethical Issues Related to Prevention of HIV Transmission through Sexual Means

With regard to the prevention of HIV by sexual means, rather than focus on a narrow or mechanistic view of HIV prevention education, the Catholic Church continues to promote and encourage sexual relationships that are based upon mutual respect for God-given dignity and mutual responsibility within the context of a permanent and faithful marital relationship between one man and one woman. Thus Pope Benedict XVI articulated the need for a comprehensive and transformative approach to HIV prevention:

The God of Jesus Christ must be known, believed in and loved, and hearts must be converted if progress is to be made on social issues and reconciliation is to begin, and if – for example – AIDS is to be combated by realistically facing its deeper causes and the sick are to be given the loving care they need. Social issues and the Gospel are inseparable. When we bring people only knowledge, ability, technical competence and tools, we bring them too little.¹

Many AIDS educators and activists find it difficult to accept the Church's focus on the deeper realities of life and love; they have preferred to engage in the search for a "quick fix" in HIV prevention.

Education toward responsible inter-personal relationships is understood by the Church to be essential component of HIV Prevention Education. Thus through her teaching, the Church seeks:

- to uphold and defend integrity, mutual fidelity and responsibility in relationships,
- to accompany people as they strive to correctly form their consciences and seek to discern God's will in the day-to-day demands of life in community,
- above all, to affirm the value of every human life, and stand with and protect those whose survival is in any way threatened or compromised.

Pope John Paul II reassured young people that it was both "normal" and better to wait for true love that is expressed through receiving the sacrament of matrimony and then is consummated in lifelong sexual relationship, on a lifelong and exclusive basis, within the context of marriage.² Many young people express the desire to hear such messages and be reinforced for their efforts to remain sexually abstinent before marriage.

The Catholic Church sponsors excellent educational programmes designed to prevent the sexual transmission of HIV. Curricula have been developed for all levels Catholic education in schools and parishes – to help young people learn about their bodies, about the drive to develop strong and even intimate relationships with others, and about the need to develop discipline and maturity in those relationships so that they will not become manipulative or exploitative. The most consistent message of such education programmes is that sexual activity is to be restricted to faithful marriages and that, before or outside marriage, abstinence can and should be practiced.

The advocacy of the Catholic Church and of other people who support traditional values regarding the exercise of sexual activity within lifelong marriage has helped many public health and HIV education to re-think their strategies and to include messages about abstinence and faithfulness within their programmes for prevention HIV.

¹ Pope Benedict XVI, Homily in Munich, 20 September 2006, http://www.vatican.va/holy_father/benedict_xvi/homilies/2006/documents/hf_ben-xvi_hom_20060910_neue-messe-munich_en.html

² *Documentation Catholique*, No. 2068, 21 March 1993, p. 262.

Catholic and other religious leaders express concern about promotion of condoms. Their objections include concerns about promoting sexual activity outside marriage. The strong and public positions taken by the Church against promoting condom use have led some AIDS educators, some governments, health care professionals, and the media to perceive the Catholic Church as obstructing efforts to prevent the spread of HIV and, therefore, as “promoting death”.

Let us examine more deeply the Church’s teaching about prevention of the sexual transmission of HIV. First we must note that the issue of HIV prevention was not considered in *Humanae Vitae* since, when this encyclical was written in 1968, the world was not yet aware of the HIV pandemic. The encyclical deals with use of condoms – but only within the context of contraception. Martin Rhonheimer³ writes on this topic as follows:

The teaching of the Church is not about condoms or similar physical or chemical devices, but about marital love and the essentially marital meaning of human sexuality. It affirms that, if married people have a serious reason not to have children, they should modify their sexual behaviour by – at least periodic – abstinence from sexual acts. To avoid destroying both the unitive and the procreative meaning of sexual acts and therefore the fullness of mutual self-giving, they must not prevent the sexual act from being fertile while carrying on having sex.⁴

He then proceeds to review some pastoral applications of the Church’s teaching to specific case situations:

What do I, as a Catholic priest, tell Aids-infected promiscuous people or homosexuals who are using condoms? I will try to help them to live an upright and well-ordered sexual life. But I will not tell them not to use condoms. I simply will not talk to them about this and assume that if they choose to have sex they will at least keep a sense of responsibility. With such an attitude I fully respect the Catholic Church’s teaching on contraception.

This is not a plea for ‘exceptions’ to the norm prohibiting contraception. The norm about contraception applies without exception; the contraceptive choice is intrinsically evil. But it obviously applies only to contraceptive acts, as defined by *Humanae Vitae*, which embody a contraceptive choice. Not every act in which a device is used which from a purely physical point of view is “contraceptive” is, from a moral point of view, a contraceptive act falling under the norm taught by *Humanae Vitae*.

Equally, a married man who is HIV-infected and uses the condom to protect his wife from infection is not acting to render procreation impossible, but to prevent infection. If conception is prevented, this will be an – unintentional – side-effect and will not therefore shape the moral meaning of the act as a contraceptive act. There may be other reasons to warn against the use of a condom in such a case, or to advise total continence, but these will not be because of the Church’s teaching on contraception but for pastoral or simply prudential reasons – the risk, for example, of the condom not working. Of course, this last argument does not apply to promiscuous people, because even if condoms do not always work, their use will help to reduce the evil consequences of morally evil behaviour.⁵

There is clear consensus among Church leaders on the norm and value of abstinence outside marriage as well as of mutual, life-long fidelity within marriage. On the other hand, there appears to be a diversity of opinions, among some members of the hierarchy, with regard to information and education about HIV prevention for those who do not share the Catholic tradition or who will not or cannot remain faithful to its teaching.

Some Bishops’ Conferences, such as that of New Zealand, made a decision to avoid collaboration with any government-sponsored and other programs that focus exclusively on condom promotion and do not take a comprehensive approach to prevention. The bishops of Papua, New Guinea, on the other hand, saw complementary roles for Church and government in HIV and AIDS education, while, at the same time, encouraging Catholics to remain faithful to the Church’s teaching concerning abstinence and marital fidelity as the only acceptable ways to prevent HIV transmission.

³ Martin Rhonheimer is professor of ethics and political philosophy at the Pontifical University of the Holy Cross in Rome.

⁴ Martin Rhonheimer, “The Truth about Condoms,” *The Tablet*, 07 October 2004.

⁵ *Ibid.*

In 1987, the Bishop of the Catholic Diocese of Cleveland (USA) noted that information might be given about condom use as a possible HIV prevention technique for those who do not follow Catholic Church teaching, by following the steps outlined below:

- Explain the meaning of human sexuality in the context of marriage and Catholic teaching;
- Discuss the normative value of pre-marital abstinence and marital chastity;
- Acknowledge that 'many people who are not Catholic would not share these teachings about sexuality and marriage' and are unable or unwilling to practice chastity;
- Explicitly present the medical facts about AIDS;
- *In discussing with those who disagree with Church teaching on sexual behavior, "you are to inform them of a fact, from medical science, that condoms are recommended to protect against AIDS! This is information 'about' condoms; it is not a recommendation 'for' condoms."*⁶

The Primacy of Conscience in Moral Decision-Making

The Bishops of Chad spoke of the Church's responsibility to uphold the teaching of the Church with regard to conjugal fidelity and chastity but also recognized the role of the conscience as the "ultimate moral rule". In an approach similar to that taken by the members of the Southern African Catholic Bishops' Conference,⁷ they left to the intimate space of the marital relationship the decision about how best to prevent the spread of HIV from one marital spouse to the other: "Because 'no one is bound to do the impossible', spouses cannot be asked to abstain from sexual intercourse; we therefore understand that a person, through love, may be led to use the condom to protect himself/herself or to protect his/her partner."⁸

The Fathers of Vatican Council II spoke of conscience as the "most secret core" and "sanctuary" of the human person.⁹ The Catechism of the Catholic Church (1778) says:

Conscience is a judgment of reason whereby the human person recognizes the moral quality of a concrete act that he is going to perform, is in the process of performing, or has already completed. In all he says and does, man is obliged to follow faithfully what he knows to be just and right. It is by the judgment of his conscience that man perceives and recognizes the prescriptions of the divine law.¹⁰

While still known as Father Joseph Ratzinger, Pope Benedict XVI offered a theological reflection on the "supremacy" of conscience in his commentary on the Vatican II documents¹¹. If the person's decision is to be made with freedom, responsibility, and truth, this "sovereign" conscience needs to be well-formed, in the light of the Scriptures and the Church's teaching. In order to attain and maintain an "enlightened" conscience, the person needs formation and encouragement at each stage of life in order to make good decisions appropriate to her/his age and particular situation.

From the perspective of his new office, Pope Benedict XVI took the opportunity to further advance reflection on the topic of HIV prevention in a unique and creative manner – by sharing his views with the German journalist Peter Seewald. It is this author's belief that Pope Benedict provided, through his comments, a clear articulation of the Church's insistence on placing the human person at the centre of the HIV prevention and treatment debates.

Roots of the Pope's Comments in the Seewald Book¹²:

⁶ Most Rev. Anthony M. Pilla, Bishop of Cleveland, Pastoral Letter, 3 April 1987, "Statement on Developing an Approach by the Church to AIDS Education," *Origins* 16, 1987, pp. 692-693.

⁷ See "Is Universal Access to Antiretroviral Treatment a Myth or a Reality? Some Experiences of the Catholic Church in South Africa," by Alison Munro, pp 321-332.

⁸ The Bishops of Chad Statement on AIDS, October 2002

⁹ *The Documents of Vatican II*, "Pastoral Constitution on the Church in the Modern World (*Gaudium et spes*)", par. 16 New York: Herder and Herder, 1966.

¹⁰ <http://www.vatican.va/archive/catechism/p3s1c1a6.htm>

¹¹ Herbert Vormgrimer, ed. *Commentary on the Documents of Vatican II*, Vol. v, (Turnbridge Wells: Burns & Oates; New York: Herder & Herder, 1967): p. 134.

¹² Unless otherwise noted the quotes from the Pope Benedict XVI were published in *Light of the World: The Pope, the Church, and the Signs of the Times – a Conversation with Peter Seewald*, (Ignatius Press, San Francisco, 2010): pp. 117-119.

The full significance of the comments on HIV prevention articulated by Pope Benedict XVI during his interviews with the German journalist Peter Seewald ran the risk of being overshadowed by an exclusive focus, by the media and even by some public health experts, on condom use as the “only” or even as “the most important” strategy for HIV prevention. This situation is somewhat ironic since it was the same “fixation” about which the Pope expressed frustration regarding reactions to his comments during his trip to Africa in March 2009: “The media coverage completely ignored the rest of the trip to Africa on account of a single statement.”

So, instead of trusting the media’s slant on what the Pope said – both on the trip to Cameroon and in the interview book – let us first examine the Holy Father’s own words on the papal trip to Africa in 2009 – it may be surprising to note that his focus was not exclusively centred on condoms or on “quick fix” solutions to HIV prevention. Much to the contrary, Pope Benedict XVI praised the Church’s engagement in the global and local responses to the pandemic; acknowledged the need for funding but also warned that money alone could not solve the problem; appealed for a “human” approach to HIV prevention and expressed concern that mere promotion and supply of commodities could worsen rather than lessen the spread of the virus. He insisted that the solution must include two elements: promoting a “new way of behaving toward others” and urged a “true friendship to those who are suffering” and a “willingness to make sacrifices and to practice self-denial, to be alongside the suffering.”¹³

In the Seewald interview, the Holy Father began where he left off during the flight to Africa, by acknowledging and affirming the strong role of the Church in response to this pandemic. With these words, he also acknowledged the urgency of the pandemic and the need to assist people living with or affected by HIV: “We must stand close to the people, we must guide and help them; and we must do this before and after they contract the disease.”

He re-asserted that his remarks on the plane trip to Africa were not intended as a “general statement about condom use” but rather as a caution that we cannot solve the problem by distributing condoms. This is not to deny, however, the importance of Pope Benedict’s specific reference to the fact that, “in certain cases”, the use of the condom as a means of preventing the transmission of HIV could be a “first step” in assuming a more moral, responsible behaviour that could gradually mature into behaviour that would conform to the teaching of the Catholic Church with regard to sexual activity – namely, that it be restricted to lifelong and mutually faithful marriage between one man and one woman.

Clarification by the Papal Spokesman, Fr. Federico Lombardi, SJ

The Pope’s spokesperson, Fr. Federico Lombardi, SJ, emphasized the Pope’s statement that he was not taking up a “position on condoms in general” and highlighted the Pope’s observation that, in the secular context of HIV prevention strategies, A & B (“Abstain” and “Be Faithful”) often are overshadowed by the “C” of condom promotion. He summarized the particular contribution of the Pope during this interview as helping “us [to] clarify and more deeply understand a long-debated question. His is an original contribution, because, on the one hand, it remains faithful to moral principles and transparently refutes illusory paths such as that of ‘faith in condoms’; on the other hand, however, it manifests a comprehensive and far-sighted vision, attentive to recognising the small steps (though only initial and still confused) of an often spiritually- and culturally-impoverished humanity, toward a more human and responsible exercise of sexuality”.

He maintained that the Pope’s comments did not “reform or change Church teaching but reaffirmed it, placing it in the perspective of human sexuality as an expression of love and responsibility.” He asserted that the Pope considered “an exceptional circumstance in which the exercise of sexuality represents a real threat to another person’s life” and acknowledged that “[i]n such a case ... the use of a condom ... can be ‘a first act of responsibility’, rather than not using it and exposing the other person to a mortal risk. Fr. Lombardi also pointed out that “[m]any moral theologians and authoritative ecclesiastical figures have supported and support similar positions.”¹⁴

Note of the Congregation for the Doctrine of the Faith on the Trivialization of Sexuality Regarding certain interpretations of “Light of the World”

¹³ Interview of Benedict XVI during Flight to Cameroon on 17 March 2009, http://www.vatican.va/holy_father/benedict_xvi/speeches/2009/march/documents/hf_ben-xvi_spe_20090317_africa-interview_en.html

¹⁴ Vatican Information Service, “Note by Fr. Lombardi concerning a new book on the Pope,” November 21, 2010, VIS 20101122 (630).

Shortly after the publication of the Seewald book, the Congregation for the Doctrine of the Faith developed a Doctrinal Note to guard against any possible misinterpretations of the Holy Father's statement and in order to clarify his intention to promote rediscovery of the "beauty of the divine gift of human sexuality and, in this way, to avoid the cheapening of sexuality which is common today." The Congregation also maintained that the Holy Father in no way intended to change the traditional teaching of the Church in relation to sexuality.

Most especially, the Congregation emphasized that no one could to "deduce from the words of Benedict XVI that it is somehow legitimate to use condoms to avoid an unwanted pregnancy" - that would be "completely arbitrary and in no way justified." The Congregation acknowledged, as did the Pope, that "... those involved in prostitution who are HIV positive and who seek to diminish the risk of contagion by the use of a condom may be taking the first step in respecting the life of another- even if the evil of prostitution remains in all its gravity." Finally, the Congregation encouraged "the Catholic faithful and the agencies of the Catholic Church" to be "close to those affected," "care for those who are sick," and "encourage all people to live in abstinence and fidelity within marriage".¹⁵

What are the practical implications of these more recent considerations by Pope Benedict XVI for Catholic Church-inspired organizations engaged in HIV Prevention, Treatment, Care and Support?

The question of practical implications for Catholic Church-inspired organisations is not addressed directly in the Pope's comments. Organisations already promoting the HIV prevention strategies of sexual abstinence outside marriage and permanent and mutual fidelity within marriage (when both spouses are not living with the virus) can continue to do so with additional assurance from the Holy Father. Those providing pastoral or medical care and counselling to persons living with or vulnerable to HIV infection can be guided by the insights offered by the Pope with regard to HIV prevention, including his point that, in certain cases, the use of a condom might represent a "first step" toward more responsible sexual behaviour.¹⁶

Contribution of the Church in Africa to Re-focus the HIV Prevention Debate

The bishops of Africa, gathered, during 2009, in Synod with the Holy Father, for the Second Special Assembly for Africa, contributed to the HIV prevention debate by re-focusing attention on durable solutions that respect the dignity of the human person and moral norms and responsibility:

This Synod, with the Holy Father, Pope Benedict XVI, seriously warns that the problem cannot be overcome by the distribution of prophylactics. We appeal to all who are genuinely interested in arresting the sexual transmission of HIV/AIDS to recognize the success already obtained by programs that propose abstinence among those not yet married, and fidelity among the married. Such a course of action not only offers the best protection against the spread of this disease but is also in harmony with Christian morality.¹⁷

These same bishops made a particular appeal with regard to HIV prevention: "We address ourselves particularly to you, the youth. Let no one deceive you into thinking that you cannot control yourselves. Yes, you can, with the grace of God."¹⁸

In his Apostolic Exhortation grounded on this same Synod, *Africae Munus*, Pope Benedict XVI, offered his own comprehensive and profound guidance on this complex topic:

¹⁵ Congregation for the Doctrine of the Faith *Note on the banalization of sexuality, Regarding certain interpretations of "Light of the World"*, 21 December 2011,

http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20101221_luce-del-mondo_en.html

¹⁶ In this regard, cf. Doctrinal Note of the Congregation of the Faith, *op. cit.*: "in the battle against AIDS, the Catholic faithful and the agencies of the Catholic Church should be close to those affected, should care for the sick and should encourage all people to live abstinence before and fidelity within marriage."

¹⁷ Second Extraordinary Assembly for Africa of the Synod of Bishops, *Africa: Arise and Walk!* Final Message (Vatican, October 2009), http://www.vatican.va/roman_curia/synod/documents/rc_synod_doc_20091023_message-synod_en.html

¹⁸ *Ibid.*

The problem of AIDS, in particular, clearly calls for a medical and pharmaceutical response. This is not enough, however: the problem goes deeper. Above all, it is an ethical problem. The change of behaviour that it requires – for example, sexual abstinence, rejection of sexual promiscuity, fidelity within marriage – ultimately involves the question of integral development, which demands a global approach and a global response from the Church. For if it is to be effective, the prevention of AIDS must be based on a sex education that is itself grounded in an anthropology anchored in the natural law and enlightened by the word of God and the Church's teaching.¹⁹

Conclusion:

Hopefully, I have been able to communicate the depth of concern and the careful and nuanced reflection offered by Church teaching and tradition with regard to preventing the further spread of HIV. Not wishing to be perceived as “obstructionist”, the Church nevertheless feels compelled to raise questions related to prevention strategies that may be expedient in the short-term but, because they are superficial or incomplete, do not encourage risk avoidance rather than mere risk reduction and/or that do not facilitate the deeper resolution of inner conflicts that led to drug use in the first place. Far from being “anti-science”, the Church encourages, in the words of Pope Benedict XVI related to climate change during his address to the United Nations General Assembly, “adopting a scientific method that is truly respectful of ethical imperatives.”²⁰

¹ *Ibid.*

¹ Pope Benedict XVI, Post-Synodal Apostolic Exhortation *Africae Munus*, given at Ouidah, Benin, 19 November 2011, paragraph 72, http://www.vatican.va/holy_father/benedict_xvi/apost_exhortations/documents/hf_ben-xvi_exh_20111119_africae-munus_en.html

¹ Pope Benedict XVI, Address to the 62nd Session of the United Nations, 95th Plenary Meeting, 18 April 2008.

¹⁹ Pope Benedict XVI, Post-Synodal Apostolic Exhortation *Africae Munus*, given at Ouidah, Benin, 19 November 2011, paragraph 72, http://www.vatican.va/holy_father/benedict_xvi/apost_exhortations/documents/hf_ben-xvi_exh_20111119_africae-munus_en.html

²⁰ Pope Benedict XVI, Address to the 62nd Session of the United Nations, 95th Plenary Meeting, 18 April 2008.

A Witness to Truth and Solidarity: The Catholic Church Response to HIV and AIDS in Sub-Saharan Africa (2012)

by
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As Pope Benedict XVI has said on several occasions, the Catholic Church is “second to none” in effective action to prevent the further transmission of HIV, mitigate the impact of the present epidemic, and provide person-centered and holistic approach to those living with or affected by HIV and AIDS.²¹ Thus it seems only right and just that any reflection on the more than thirty-year history and impact of the HIV pandemic, particularly in sub-Saharan Africa, should include an overview of the Catholic Church response to this crisis. It is the firm conviction of this writer that the distinguishing characteristic of this ecclesial response can be found in the Church’s witness to truth and solidarity during this “time of HIV and AIDS”.

2001 – an Urgent Cry for Global Solidarity in Response to the HIV Pandemic

In 2001, when Member States convened, at United Nations Headquarters, for the General Assembly Special Session on HIV/AIDS, the world was losing the struggle against HIV:

- The number of people living with HIV was increasing,
- The epidemic was reversing decades of development progress in sub-Saharan Africa, threatening stability and security, and exacerbating global inequity in health.
- Antiretroviral medicines, which revolutionized the HIV response in high-income countries, were virtually unavailable in the most severely affected countries and total resources spent on HIV activities in low- and middle-income countries amounted to only about 10% of the 2009 level of spending for this same purpose.²²

The 2001 Special Session resulted in a Political Declaration that included time-bound targets in the response. It encouraged the establishment of a major global health financing institution—the Global Fund to Fight AIDS, Tuberculosis and Malaria. Pledging additional steps to strengthen the response, UN Member States embraced a complementary set of commitments in the 2006 Political Declaration on HIV/AIDS, including the pledge to achieve universal access to HIV prevention, treatment, care and support.

2011 – at the Crossroads of the Global HIV Response

²¹ Cf., for example the comments of Pope Benedict XVI during his flight to Cameroon on 17 March 2009: “... I think that the most efficient, most truly present player in the fight against AIDS is the Catholic Church herself, with her movements and her various organizations.”

http://www.vatican.va/holy_father/benedict_xvi/speeches/2009/march/documents/hf_ben-xvi_spe_20090317_africa-interview_en.html

and his re-affirmation of these points in *Light of the World: The Pope, the Church, and the Signs of the Times - A Conversation with Peter Seewald* (2010), San Francisco: Ignatius Press, 2010, ISBN # 9781586176068, pp. 117-119.

²²Report of the UN Secretary General to the 65th Session of the UN General Assembly, *Implementation of the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS Uniting for universal access: towards zero new HIV infections, zero discrimination and zero AIDS-related*, 31 March 2011.

World leaders gathered once again at UN Headquarters, in June 2011, in order to assess progress toward reaching the Universal Access goal. They noted much progress: global HIV incidence was declining, access to treatment was expanding, and a global movement had been mobilized to respect and protect the dignity of all affected by HIV. They affirmed that the HIV response had changed our world, elevating global inequity in health onto the political agenda and placing people at the centre of health and development efforts. They cautioned, however, that such accomplishments might be in grave jeopardy since aid fatigue and an enduring global economic downturn were posing a threat to future support for essential initiatives.²³

The Catholic Church, in fact, already had anticipated the articulation of the above-cited concern. In a 2011 study conducted the Catholic HIV/AIDS Network (CHAN)²⁴, it was found that funding cuts and flat-lining by international donors, including by the USA government's PEPFAR and the Global Fund to Fight AIDS, TB and Malaria, had caused the following impact for Catholic organizations providing treatment, care, and support in developing countries:

- All organizations had experienced some degree of flat-lining or budget cuts
- Issues with drug adherence, supply chain, access and adequate nutritional support
- Staff and volunteer cuts, especially in providing psychosocial support, services to orphans and vulnerable children (OVC), and prevention education
- No new clients could enroll in ART; some were lost to follow-up

A Closer Look at Present Trends in the Pandemic²⁵

Sub-Saharan Africa remains the region most heavily affected by HIV. In 2010, about 68% of all people living with HIV resided in sub-Saharan Africa, a region with only 12% of the global population. Sub-Saharan Africa also accounted for 70% of new HIV infections in 2010. The epidemic continues to be most severe in southern Africa, with South Africa having more people living with HIV (an estimated 5.6 million) than any other country in the world.

During 2010, almost half of the deaths from AIDS-related illnesses occurred in Southern Africa. Since 1998, AIDS-related illnesses have claimed at least one million lives annually in sub-Saharan Africa since 1998. The actual number of such deaths, however, has steadily decreased in recent years, since antiretroviral therapy has become more widely available in the region.

By 2010, the total number of new HIV infections in sub-Saharan Africa had decreased by more than 26%, down to 1.9 million, from an estimated 2.6 million in 1997, at which time the epidemic reached its height. In 22 sub-Saharan countries, research shows that, between 2001 and 2009, HIV incidence declined by more than 25%. This includes some of the world's largest epidemics in Ethiopia, Nigeria, South Africa, Zambia and Zimbabwe. The annual HIV incidence in South Africa, though still high, dropped by a third between 2001 and 2009 from 2.4% to 1.5%. Similarly, the epidemics in Botswana, Namibia and Zambia appear to be declining. The epidemics in Lesotho, Mozambique, and Swaziland seem to be leveling off, albeit at unacceptably high levels.

In Southern Africa, there has been significant progress in reducing the number of new infections and impact of HIV among children younger than 15 years of age. In 2009, 32% fewer children were newly infected when compared to the situation in 2004 and 26% fewer AIDS-related deaths occurred among children. Approximately 890 children became newly infected with HIV in Botswana during 2007, significantly less than 4600 in 1999. South Africa is one of the few countries in the world where child and maternal mortality has risen since the 1990s. AIDS-related deaths represent the largest cause of maternal mortality in South Africa and account for 35% of deaths in children younger than five years of age.

²³ *Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS*, Resolution adopted by the United Nations General Assembly on 10 June 2011, 65th Session, Agenda Item 10, A/Res/65/277.

²⁴ "The Impact of HIV and AIDS Funding Cuts on Catholic Organizations," A study by Catholic HIV/AIDS Network, released in June 2011.

²⁵ *UNAIDS World AIDS Day Report 2011: How to get to zero – faster, smarter, better* Joint United Nations Program on HIV/AIDS (UNAIDS), ISBN: 978-92-9173-904-2 | UNAIDS / JC2216E, November 2011, Geneva, Switzerland.

The Impact of HIV and AIDS on Society and Development

The massive effects of HIV on the populace of sub-Saharan Africa already are both well-known and documented. They include premature loss of life, skills, and livelihood; disruption of family harmony; exacerbation of poverty; “blaming the victim” in the form of discrimination against or marginalization of those living with or affected by HIV.

Life expectancy has fallen dramatically in Southern Africa – mostly as a result of widespread HIV infection and early death due to AIDS-related illnesses. As a result of the HIV epidemic raging in a number of countries in Southern Africa, all progress (between 1960 and 1995) in increasing life expectancy has been overturned, and has decreased to between 30 and 40 years of age in Botswana, Swaziland, Zambia, and Zimbabwe. At the present time, life expectancy in Sub-Saharan Africa is the same as it was in tenth century Europe. On the other hand, life expectancy continues to increase in other regions, such as Western Europe and Asia.

Among the poor, women tend to be the most poor because they generally have less access to education, information, and skills training. In some cultures, women have no right to work or to own or inherit land or property in their own name. Women cannot negotiate, still less refuse sexual relations in or outside marriage. Yet these same women often are blamed as “vectors of disease” when HIV is first identified in their respective families.

Young people are located at the center of the epidemic in terms of transmission, vulnerability, impact, and potential for change. In many regions of the world, both in-school and out-of-school youth lack access to HIV education programs. Although young people are at the center of transmission, they rarely receive the primary share of the increasing resources available for HIV treatment and prevention.

Despite the declines in new HIV infections among adults and adult prevalence worldwide and increasing access to anti-retroviral treatment, the total number of children aged 0–17 years who have lost their parents due to HIV, most regrettably, has increased from 14.6 million in 2005 to 16.6 million in 2009. Almost 90% of such orphans live in sub-Saharan Africa. Six countries—Kenya, Nigeria, South Africa, Uganda, United Republic of Tanzania, and Zimbabwe—count more than 9 million AIDS orphans, of which more than 2.5 million are found in Nigeria alone. In four countries, more than 10% of all children aged 0–17 years have lost one or two parents due to HIV; they are Zimbabwe (16%), Lesotho (13%), and Botswana and Swaziland (12%).²⁶ Especially when both parents have died, a child may become head of the household, assuming enormous burdens at an early age. Orphaned girls generally are more likely to drop out of school than are their male counterparts.²⁷

In order to achieve a more comprehensive analysis of this pandemic, however, we cannot limit our attention to its impact alone but also must acknowledge the major “drivers” influencing its spread. The fact is that the dissemination of HIV is intimately linked to situations that affront human dignity, including structural injustice, extreme poverty, the lack of distributive justice, lack of access to adequate nutrition and basic health care, prejudice, inequity between men and women, human trafficking, sexual abuse, and sexual commerce. All these affronts on human dignity, and many others, may diminish the control one can exert over her/his intimate relationships and the general state of health and psychosocial wellbeing among both individuals and families.²⁸

The Catholic Church’s Leadership Response to AIDS in Africa

The Catholic Church hierarchy on this continent has taken very seriously its responsibility to teach that appropriate education, service, and pastoral attention should be extended to those living with or affected by HIV and AIDS. Between 1987 and 2003, various Episcopal Conferences in Africa prepared some sixty letters, messages,

²⁶ UNAIDS Report on the Global AIDS Epidemic, 2010, p. 110.

²⁷ UNAIDS Report on the Global AIDS Epidemic, 2008.

²⁸ Cf. Michael J. Kelly, S.J., *HIV and AIDS: A Justice Perspective*, Lusaka, Zambia: Jesuit Centre for Theological Reflection, April 2006, for a detailed analysis of the dynamics that underlie the destructive interaction between the pandemic and poverty as both make their impact on poor people and families.

communiqués, and statements about HIV and AIDS. These declarations urgently admonished clergy, as well as religious and lay pastoral workers, to open the doors of ecclesial communities, and most especially the sacramental life of the Church, to those living with this virus and their families.

The Bishops of Uganda urged support for people facing the challenge of the HIV epidemic:

We encourage the formation of support groups, within our Christian communities and parishes, which will reach out to the people and families in need, especially the orphans. We need to read the signs of the times, and respond with courage. Christians in general, and those with a special vocation in particular, should be caring for the people with AIDS, and assisting their families and friends to cope with this tragic disease.²⁹

At the Plenary Assembly of the Symposium of Episcopal Conferences of Africa and Madagascar (SECAM), held in Dakar, in October 2003, a collection of these statements was issued under the title, *Our Prayer is Always Full of Hope*, and the collection is available from Paulines Publications Africa.

During the same Plenary Assembly, the bishop members of SECAM developed an Action Plan to enable the Church in Africa to react more quickly, more comprehensively, and more compassionately, to the pandemic. They committed the Church in Africa to:

- Provide access to care and treatment, and advocate vigorously for access among those excluded through poverty and structural injustices;
- Ensure that Church institutions and services respond appropriately to the needs of people living with HIV and AIDS;
- Advocate for policies that support them adequately and assure a life of dignity;
- Focus on the particular vulnerability of girls and the heavy burden borne by women;
- Advocate for the implementation of governmental commitments.³⁰

Such concern among the bishops of Africa was motivated both by their direct interaction with those so affected and by the deep preoccupation about this situation articulated on many occasions by then-Pope John Paul II. In his Apostolic Exhortation, *Ecclesia in Africa*, he included the pandemic among the most debilitating and unjust challenges confronting African people and demanded a response rooted in charity and justice:

A compassionate ear must also be lent to the anguished cries of the poor nations asking for help in areas of particular importance: malnutrition, the widespread deterioration in the standard of living, the insufficiency of means for educating the young, the lack of elementary health and social services with the resulting persistence of endemic diseases, the spread of the terrible scourge of AIDS, the heavy and often unbearable burden of international debt, the horror of fratricidal wars fomented by unscrupulous arms trafficking, the shameful and pitiable spectacle of refugees and displaced persons.³¹

Blessed John Paul II then launched a passionate appeal for solidarity from the entire human family:

The battle against AIDS ought to be everyone's battle. Echoing the voice of the Synod Fathers, I too ask pastoral workers to bring to their brothers and sisters affected by AIDS all possible material, moral and

²⁹ Bishops of Uganda, Pastoral Letter on AIDS, 1989.

³⁰ *The Church in Africa in Face of The HIV/AIDS Pandemic: "Our prayer is always full of hope"*, Message issued by the Plenary Council of the Symposium of Episcopal Conferences of Africa and Madagascar, (SECAM), Dakar, 7 October 2003.

³¹ Pope John Paul II, Post-Synodal Apostolic Exhortation *Ecclesia*, given at Yaoundé, in Cameroon, on 14 September 1995, #114, http://www.vatican.va/holy_father/john_paul_ii/apost_exhortations/documents/hf_jp-ii_exh_14091995_ecclesia-in-africa_en.html

spiritual comfort. I urgently ask the world's scientists and political leaders, moved by the love and respect due to every human person, to use every means available in order to put an end to this scourge.³²

The 2nd Special Assembly for Africa of the Synod of Bishops made a special appeal for worldwide solidarity to sustain and strengthen the service response of the Church:

“The Synod asks international agencies to acknowledge Church institutions and movements and support them while respecting their specificity. The Church urgently recommends that current research into treatments be expanded so as to eradicate this severe affliction. We plead for sustained support to meet the needs of many for assistance...”³³

In his own Apostolic Exhortation, entitled *Africae Munus*, following the Second Extraordinary Session for Africa of the Synod of Bishops, Pope Benedict XVI linked the Church response to the greatest “killer” pandemics with the moral imperative handed down by Jesus Himself:

In the spirit of the Beatitudes, preferential attention is to be given to the poor, the hungry, the sick – for example, those with AIDS, tuberculosis or malaria – to the stranger, the disadvantaged, the prisoner, the immigrant who is looked down upon, the refugee or displaced person (cf. *Mt* 25:31-46). The response to these people’s needs ... depends on everyone. Africa expects this attention from the whole human family as from herself.³⁴

The Church’s Response to the Additional Burden of Care and Support of People Living with HIV

The Church’s response to HIV goes far beyond the written and spoken word of hierarchical leaders; it is rooted in the daily ministry and services provided by countless members of the clergy, religious orders, professional staff, and faithful lay volunteers. This wide array of services includes education, health care, social care, emergency response, income-generating activities, and integral human development.

Working through the diocesan and parish systems, coordinated by the AIDS Office of the Southern African Catholic Bishops Conference, and originally funded by the pharmaceutical company, Bristol-Myers Squibb, the Catholic Medical Mission Board and other Catholic funding agencies, the Catholic Church in this five-country area scaled up service provision by the replication of small programs rooted in and responsive to the needs expressed by local communities. The range of services developed under this initiative included: Prevention, Care, Treatment, Services for Orphans and Vulnerable Children, Advocacy, Capacity Building, Interfaith Involvement, Theological Reflection.³⁵ At the present time, SACBC is the second largest provider of antiretroviral treatment in Southern Africa.

No discussion of the Church’s engagement in services to people living with HIV/AIDS could ever be completed without special mention of the loving service provided by religious congregations. During 2007 and 2008, the Unions of Superiors General of Religious Orders of Priests, Brothers, and Sisters conducted a mapping exercise to evaluate the scale of efforts being made by religious orders and to assess the challenges faced by their members as they strive to be more responsive to such needs. Some 446 respondents detailed the HIV/AIDS services being sponsored by their respective institutes:

³² Ibid, paragraph 115.

³³ Message of the 2nd Special Assembly for Africa of the Synod of Bishops, 2009, #31.

³⁴ Pope Benedict XVI, Post-Synodal^[SEP] Apostolic Exhortation^[SEP] *Africae Munus*, given at Ouidah, Benin, 19 November 2011, paragraph 72, http://www.vatican.va/holy_father/benedict_xvi/apost_exhortations/documents/hf_ben-xvi_exh_20111119_africae-munus_en.html

³⁵ *A Faith-Based Response to HIV in Southern Africa: The Choose to Care Initiative*, Best Practice Collection, Geneva, Switzerland: UNAIDS, December 2006.

- Information/education activities reached a total of 3,925,304 individuals, with a mean number of nearly 15,000 beneficiaries for each responding organization;
- Care and support services reached 348,169 individuals. These services included nutrition, palliative care, home-, hospital-, and clinic-based care, alternative medicine-based care;
- Anti-retroviral treatment services were reported to have been delivered to 90,154 individuals during the 12 months prior to the survey.³⁶

What about HIV prevention?

During the International AIDS Conference, held in Vienna in July 2010, scientists and other experts seemed to turn from their previous and almost exclusive focus on promoting condom use to encouragement of a more comprehensive prevention strategy, including education, change in behavior, new strategies and technology, and vaccines. They made the claim that “Existing strategies have failed to contain the global HIV pandemic.”³⁷

Scientific evidence has demonstrated that sexual behavior change is both possible and feasible. In its 2011 Report on the state of the HIV epidemic, UNAIDS reported that, in countries with generalized epidemics, such as those found in sub-Saharan Africa, a combination of behavior changes, including reduction in the number of sexual partners and delay in the age of sexual debut, have reduced new infections (incidence) in several countries. HIV incidence in urban Zimbabwe, for example, fell from an extremely high peak of almost 6% in 1991 to less than 1% in 2010.³⁸ Eleven country reports received by UNAIDS indicated significant decreases in the percentage of young men with multiple sexual partners and eighteen countries reported significant declines, during 2010, in the percentage of young women and men who had engaged in sexual intercourse before their 15th birthday.³⁹

There now appears to be little scientific doubt that, with specific educational components and provision of quality-controlled surgery, and with appropriate follow-up, male circumcision reliably reduces the risk of HIV acquisition by 50%-60%, benefiting these men and their future female partners.⁴⁰

At the 2010 International AIDS Conference, much discussion was held about on the topic of anti-retroviral treatment as prevention – thus recognizing that treatment stops HIV replication, reduces the amount of virus in the blood and sexual fluids and can result in a sharp reduction in HIV transmission. This concept received further confirmation on 26 May 2011, when Dr. Anthony Fauci of the National Institutes of Health in the USA announced the results of the HPTN 052 Study, conducted in 13 sites in Botswana, Brazil, India, Kenya, Malawi, South Africa, Thailand, United States of America, and Zimbabwe. The study demonstrated that early treatment (when an infected person has a CD4 Cell count of 350 – 550 reduced the possibility of sexual transmission to an uninfected partner by 96% when compared to the transmission rate in the delayed arm of the study among which treatment was started once CD4 Cell count was less than 250.⁴¹

³⁶ *In Loving Service: A Global Analysis of the Commitment of Religious Institutes against HIV and AIDS* (2008), Bologna, Italy: EMI dell Coop. SERMIS.

³⁷ Julio Montaner, MD, Plenary Session at the XVIII International AIDS Conference, Vienna, July 2010.

³⁸ UNAIDS, *World AIDS Day Report 2011*, p. 14.

³⁹ *Ibid.* p. 17.

⁴⁰ Beginning in 1986, numerous reports began to document an inverse relationship between heterosexual HIV transmission and the presence of male circumcision in a population. More than 30 cross-sectional and 14 prospective studies suggested a protective effect of circumcision on transmission, ranging from 48%-88%. However, a randomized, controlled, prospective trial comparing immediate circumcision with delayed circumcision was needed to prove that there was a direct protective effect from this procedure. Three such trials (in Kenya, Uganda, and South Africa) were conducted in recent years. For further information, cf <http://www.who.int/hiv/topics/malecircumcision/en/index.html>

⁴¹ Presentation by Anthony S. Fauci, M.D. Director, National Institute of Allergy and Infectious Diseases, National Institutes of Health, Bethesda, MD 20892, USA, May 25, 2011.
Catholic HIV/AIDS Ministry, Archdiocese of Los Angeles, HIV/AIDS Resources 2020

Significant increases in antiretroviral therapy coverage have occurred in sub-Saharan Africa, with a 20% increase (or of 1.35 million people) between 2009 and 2010 alone. It is estimated that at least 6.6 million people in low- and middle-income countries are receiving HIV treatment. In low- and middle-income countries 47% of the 14.2 million eligible people living with HIV were on antiretroviral therapy at the end of 2010, compared to 39% at the end of 2009.

Universal access to treatment (defined as 80%, or greater coverage) has been achieved in Botswana, Namibia and Rwanda, while Swaziland and Zambia have achieved coverage levels between 70% and 80%. UNAIDS reports that, in cities and villages of sub-Saharan Africa, the introduction of HIV treatment has reduced AIDS-related mortality to a dramatic degree. It is further estimated that, since 1995, in low- and middle-income countries throughout the world, treatment has averted 2.5 million AIDS deaths.

In recent years, global consensus has been formed to strive toward the elimination of new HIV infections among infants and to keep HIV-positive mothers and children alive and healthy. In this regard, a major step was taken with the launch, in June 2011, of *The Global Plan Towards The Elimination Of New HIV Infections Among Children By 2015 And Keeping Their Mothers Alive* by UNAIDS and PEPFAR (U.S.A. government global health programme). The Plan calls for the “elimination of mother-to-child transmission of HIV by 2015” by aiming to ensure that less than 5% of children born to women living with HIV become HIV-positive themselves. When compared to the situation in 2009, this will lead to a 90% reduction of new HIV infections among infants. The Plan focuses on outreach and provision of early diagnosis and antiretroviral treatment to pregnant women living with HIV and their children, mainly in the 22 countries most affected by the disease⁴².

What does the Church in Africa say about HIV prevention?

In brief, upon reading that HIV experts finally recognize the need for multi-pronged HIV prevention strategies and thus have expanded their vision beyond an almost exclusive focus on promoting and distributing condoms, one might conclude that the secular world is finally catching up to the Church’s constant teaching on HIV prevention. The Bishops of Africa have taught that responsible behavior and “harm avoidance” (rather than settling for mere “harm reduction”), in conformity with the definitive teaching of the Church, is the effective and value-based way to promote HIV prevention efforts. Thus they declared in 2003:

“Let’s change behavior”

Besides teaching the morality of the Church and sharing her moral convictions with civil society, and besides informing and alerting people to the dangers of HIV-infection: **we want to educate appropriately and promote those changes in attitude and behavior** which value abstinence and self-control before marriage and fidelity within marriage. We want to become involved in affective and sexual education for life, to help young people and couples discover the wonder of their sexuality and their reproductive capacities. Out of such wonder and respect flow a responsible sexuality and method of managing fertility in mutual respect between the man and the woman.⁴³

In November 2000, Bishop Maurice E. Piat, C.S.Sp., Bishop of Port-Louis, Mauritius, articulated the Church’s teaching about restricting sexual activity to marriage as follows:

“The Catholic Church makes her contribution to the struggle against AIDS and against maladies that are sexually transmitted with the means that are her own, by appealing to what is most noble in the human being: one’s conscience. Indeed, what allows a person to become truly responsible is to learn how to reflect on his behavior, to know how to control himself and to become free by being honest in relation to the moral values of life. By reflecting on his sexual behaviors and by confronting moral values, each one is

⁴² Angola, Botswana, Burundi, Cameroon, Chad, Côte d’Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, India, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Swaziland, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

⁴³ “Our Prayer is Always Full of Hope” – Message of Bishops of Africa and Madagascar, October 2003.

called to become more human by being inspired by the meaning of love, fidelity and chastity. Chastity is precisely the virtue of the successful integration of sexuality in the life of a person (*Catechism of the Catholic Church*, no. 2337).

At the same time, he urged those who do not abide by Church teaching to take means to reduce the risk of sexual transmission of HIV.⁴⁴

The Southern African Bishops' Conference recognized the need for discordant couples to discern how best to prevent the transmission of HIV from an infected to an uninfected spouse. They urged them pursue such discernment from the context of their unique and intimate marital relationship but also to be guided by the Church's Teaching and pastoral care as they arrived at a well conscience:

"There are couples where one of the parties is living with HIV/AIDS ... The Church accepts that everyone has the right to defend one's life against mortal danger. This would include using the appropriate means and course of action. Similarly, where one spouse is infected with HIV/AIDS they must listen to their consciences. They are the only ones who can choose the appropriate means in order to defend themselves against the infection. Decisions of such an intimate nature should be made by both husband and wife as equal and loving partners."⁴⁵

Debate on HIV prevention, and on the specific contribution of Church teaching to this debate, cannot be approached in simple or brief fashion. It requires a disposition to accept the invitation of Jesus to go "into the deep"⁴⁶ ("Duc in altum") with an open and humble spirit of study and meditation *Magisterium* and Tradition of the Church, which is alive and active, not only in Africa, but also at the Universal level. In an effort to promote additional reflection on this issue, an additional chapter on *Ethical Issues Related to HIV Prevention* will be offered in this book.

Pastoral and Spiritual Care: Unique to the HIV Response of the Church

Persons Living with HIV (PLWHIV) in South Africa have given testimony of their great need for pastoral and spiritual support:

"PLEASE DO NOT JUDGE ME – GET CLOSE TO ME- KNOW ME – SUPPORT ME

"We start by thanking all those pastors, church leaders and others in the church, who have faithfully supported us (People Living with HIV and AIDS) in the churches and the communities: Those who have allowed us to find our purpose in life and our place in the church ... The sad truth is that out of the millions infected with HIV, very few hear about this great Love of God."⁴⁷

In the same "hearing", People Living with HIV/AIDS, addressed the following requests to pastoral leaders:

- Be a true reflection of Christ – for if Christ walked the earth today he would respond to the needs of people living with HIV and AIDS.
- Be the light of the world, drawing people with HIV to you, not making them to feel guilty and ashamed. We should be drawn to the church.

⁴⁴ Bishop Maurice E. Piat, C.S.SP., Bishop of Port-Louis, Mauritius, 27 November 2000, in *Speak Out on HIV & AIDS*, Revised Edition, Nairobi, Kenya: Paulines Publications Africa, 2006, pp. 70-71.

⁴⁵ *A Message of Hope from the Catholic Bishops to the People of God in South Africa, Botswana, and Swaziland*, 30 July 2001.

⁴⁶ Luke 5:4

⁴⁷ Ms. Anna Ntombela, At Research Feedback meeting, "Churches and HIV/AIDS," Pietermaritzburg Agency for Christian Awareness, 23 November 2004.

- Preach and live the gospel.
- We would like the church to be at the frontline in educating people about HIV and AIDS.
- Talk about sex and sexuality in church, for God created sex. Teach about the right context of sex.
- Set an example by going for the test; **WALK OUR WALK** and know how we really feel.
- Support our initiative as people living with HIV.⁴⁸

During the Second Special Session for Africa of the Synod of Bishops, the Synod Fathers spoke of three kinds of Pastoral Ministry to people living with or affected by HIV:

- Pastoral care which offers those living with HIV and AIDS access to medication, food, counseling for a change in behavior and a life without stigma;
- Pastoral care which offers orphaned children, widows and widowers a genuine hope of a life without stigma and discrimination;
- Pastoral support which helps couples living with an infected spouse to inform and form their consciences, so that they might choose what is right, with full responsibility for the greater good of each other, their union and their family.⁴⁹

The Southern African Bishops offered words of hope and consolation to their sisters and brothers living with HIV:

“Do not despair – you are not abandoned by Christ nor by us. When you find yourself in a hopeless situation on account of AIDS, Jesus, your brother, remains right next to you and never abandons you. We encourage your families and communities to accept you with love and to stand by you. We urge them not to abandon you but to continue Christ’s mission of mercy, compassion, and love. The Church loves you, welcomes you and reaches out to you in many ways.”⁵⁰

The Catholic Church: A Key Stakeholder in the African Response to HIV and AIDS

In 2003, the Southern Catholic Bishops Conference (SACBC) joined other co-sponsors of the previously-mentioned “Choose to Care Initiative” to engage the Department of Sociology at the University of Pretoria to serve as an independent evaluator of the overall initiative as well as of the 61 projects participating in the programme at that particular time. The evaluators drew the following summary conclusion:

... [D]uring the recent past, as the effects of HIV/AIDS within the congregations and communities of the Church have become progressively more evident, the Catholic Church has emerged as an increasingly central role-player in a range of initiatives to combat the pandemic (SACBC Evaluation, University of Pretoria, 2003).

The Executive Director of UNAIDS, Mr. Michel Sidibé, arrived professed a similar view when he addressed a 2009 conference, held in Rome, on the need for intensified action to eliminate Paediatric HIV infection:

... My friends, we in the AIDS movement look to the Church for leadership. The Church’s uncompromising position on the need for social justice—to do what is right— and on the inherent dignity of individuals, inspires us to champion for universal access to comprehensive HIV prevention, treatment, care and support as a moral imperative.”⁵¹

⁴⁸ Ibid.

⁴⁹ Second Special Assembly for Africa, Synod of Bishops, List of Propositions, #51, 23 October 2009, http://www.vatican.va/roman_curia/synod/documents/rc_synod_doc_20091023_elenco-prop-finali_en.html

⁵⁰ Southern Africa Catholic Bishops Conference Pastoral Letter on AIDS, July 30, 2001

⁵¹ Michel Sidibé, "Virtual elimination of vertical transmission of HIV – a moral imperative of our era," Address to a Conference on “Access to early testing and treatment for children living with HIV or HIV/TB and to prevention of Catholic HIV/AIDS Ministry, Archdiocese of Los Angeles, HIV/AIDS Resources 2020

The response of the Catholic Church to HIV and AIDS in Africa, and throughout the world, has been rooted in two central pillars of Church Teaching: Truth and Solidarity. In *Africae Munus*, Pope Benedict XVI renewed the commitment of the Catholic Church to continue its engagement to accompany those living with or affected by HIV in conformity with its basic mission as Teacher, Servant, and Pastor:

As the Synod Fathers stressed, the Church is resolutely engaged in the fight against infirmities, disease and the great pandemics ... bring Jesus' compassionate love to those who suffer! Be patient, stand firm and do not lose heart! ... As far as pandemics are concerned, while financial and material resources remain indispensable, seek also constantly to form and inform people, especially the young.⁵²

¹ Michel Sidibé, "Virtual elimination of vertical transmission of HIV – a moral imperative of our era," Address to a Conference on "Access to early testing and treatment for children living with HIV or HIV/TB and to prevention of mother-to-child transmission of HIV" co-sponsored by *Caritas Internationalis* and the US Embassy to the Holy See, 14 October 2009.

¹ Pope Benedict XVI, *Africae Munus*, #140.

mother-to-child transmission of HIV" co-sponsored by *Caritas Internationalis* and the US Embassy to the Holy See, 14 October 2009.

² Pope Benedict XVI, *Africae Munus*, #140.

III. General Information about HIV/AIDS



Key Points and Facts in the Chronology of the HIV/AIDS Pandemic

- **Summer 1981:** First reports of *Pneumocystis carinii* (now called *Pneumocystis jirovecii*) pneumonia, Kaposi's sarcoma and other unusual infections clustered in Los Angeles, New York City, San Francisco. Similar illnesses soon reported in injecting drug users, blood transfusion recipients, and in sexual partners or babies of persons with immunodeficiency illnesses. A new medical term, *Acquired Immunodeficiency Syndrome* (AIDS), is coined to describe these illnesses.
- **Late 1983/Early 1984:** Isolation of the virus that causes AIDS, which becomes known as *Human Immunodeficiency Virus-1* (HIV-1) or in most cases, simply as HIV.
- **1985:** Introduction of the first HIV-1 antibody test in the U.S, which enables the testing of blood products before transfusion, and evaluation of persons for presence of HIV infection.
- **1985-86:** AZT (Zidovudine, Retrovir) is studied and approved as first drug for treatment of AIDS.
- **1993-95:** HIV infection becomes the leading cause of death in the U.S. among persons between 25-44 years of age.
- **1994:** AZT is shown to reduce mother-to-infant HIV transmission during pregnancy to less than 10%.
- **1995-96:** Introduction of combination anti-retroviral drug therapy, including a new class of drugs called protease inhibitors, known as the “anti-HIV cocktail” or as *highly active anti-retroviral therapy* (HAART).
- **1995-96:** New technical approaches to measuring the levels of HIV present in the blood of persons living with HIV (“HIV viral load”) provides a direct means of evaluating success or failure of interventions or treatments.
- **1996-97:** First declines in the U.S. in the number of AIDS deaths (25% decrease in 1996, 42% additional decrease in 1997). On the average, a 20-year-old HIV-infected person in the U.S. is expected to live to the age of 39.
- **2000:** Durban Declaration signed by thousands of scientists and doctors: “*HIV causes AIDS. Curbing the spread of this virus must remain the first step towards eliminating this devastating disease.*”
- **2001:** United Nations Declaration of Commitment on HIV/AIDS: “*...to address the problem of HIV/AIDS in all its aspects and to secure a global commitment to combat it in a comprehensive manner...*”
- **2003-2007:** Approval of new categories of drugs in the U.S. for treatment of HIV that include fusion, entry, and integrase inhibitors.
- **2006:** 95% decrease in mother-to-infant HIV infections in the U.S. since 1992; overall risk of mother-to-infant HIV infection estimated to be <2%
- **2011:** “Treatment as Prevention” study demonstrates for the first time that if an HIV-infected person is on anti-retroviral treatment, the risk of passing HIV to his/her uninfected sexual partner is reduced by 96%.
- **2011:** United Nations *Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS*
- **2011:** Rates of new HIV infections worldwide decreased by 20% compared to 2001
- **2014:** Achievement of “15 by 15” global target to provide anti-retroviral therapy to 15 million people by 2015
- **2015:** HIV diagnosis rates in the U.S. remained stable between 2009-2013; men who have sex with men, young adults, racial/ethnic minorities, and individuals living in the South continue to bear a disproportionate burden of HIV
- **2016:** The Second Durban Declaration: *Access Equity Rights—Now!*

- **2017:** 79-80% decrease in HIV/AIDS death rates for black/African Americans in U.S. between 1999 and 2015
- **2018:** In the U.S., estimated 36,400 new HIV infections (about 100 per day), 1.2 million people aged 13 and older living with HIV; estimated about 45% of young people (13-24 years) living with HIV were unaware of their infection
- **2019:** Scientists develop ways to measure the number of cells that make up the “HIV reservoir”, a pool of chronically HIV-infected cells which is the major obstacle to completely ridding the body of HIV with treatments
- **2019:** New HIV infections worldwide have been reduced by 40% since the peak in 1998; Joint United Nations Programme on HIV/AIDS (UNAIDS) worldwide estimates in 2019:
 - 1.7 million people newly infected with HIV (150,000 under the age of 15 years); around 5500 young women (age 15-24) become infected with HIV each week
 - 38 million people living with HIV infection (1.8 million under the age of 15 years)
 - 25.4 million people living with HIV, including 85% of HIV-infected pregnant women, had access to anti-retroviral therapy (compared to less than 1 million in 2000)
 - 690,000 AIDS-related deaths (32.7 million deaths since the beginning of the epidemic)
- **2020:** In a large study within the Kaiser Healthcare system in the U.S., a 21 year old man without HIV was predicted to live to the age of 86, while a 21 year old man with HIV was predicted to live to the age of 77; if the man with HIV started antiretroviral therapy at a high CD4 T cell count (above 500), he would be predicted to live to the age of 87.
- **2020:** estimated that COVID1-19 disruptions to generic HIV medicine production and distribution could lead to 500,000 additional AIDS-related deaths, and more than doubling of mother-to-child transmission in some countries

Compiled/updated by E.C. Breen, Ph.D., April 2017, August 2020, from:

American Red Cross, www.redcross.org

Centers for Disease Control and Prevention, www.cdc.gov

HIV.gov, www.hiv.gov

International AIDS Society, www.iasociety.org

Joint United Nations Programme on HIV/AIDS, www.unaids.org

Marcus JL et al, Conference on Retroviruses and Opportunistic Infections, abstract 151, March 2020

NAM aidsmap, www.aidsmap.com/news/mar-2020

Owen, J., et al, *Kuby Immunology*, 7th Ed., 2013, W.H. Freeman and Company, New York.

Punt, J., et al, *Kuby Immunology*, 8th Ed., 2019, W.H. Freeman and Company, New York.

U.S. Department of Health and Human Services, www.hhs.org

For a detailed timeline of HIV & AIDS in the U.S. up to 2019, please see:
<https://www.hiv.gov/hiv-basics/overview/history/hiv-and-aids-timeline>

About HIV & AIDS (from HIV Basics, HIV.gov)

WHAT ARE HIV AND AIDS?



What is HIV?

HIV (*human immunodeficiency virus*) is a virus that attacks cells that help the body fight infection, making a person more vulnerable to other infections and diseases. It is spread by contact with certain bodily fluids of a person with HIV, most commonly during unprotected sex (sex without a condom or HIV medicine to prevent or treat HIV), or through sharing injection drug equipment.

If left untreated, HIV can lead to the disease AIDS (*acquired immunodeficiency syndrome*).

The human body can't get rid of HIV and no effective HIV cure exists. So, once you have HIV, you have it for life.

However, by taking HIV medicine (called antiretroviral therapy or ART), people with HIV can live long and healthy lives and prevent transmitting HIV to their sexual partners.

What is AIDS?

AIDS is the late stage of HIV infection that occurs when the body's immune system is badly damaged because of the virus.

In the U.S., most people with HIV do not develop AIDS because taking HIV medicine every day as prescribed stops the progression of the disease.

A person with HIV is considered to have progressed to AIDS when:

- the number of their CD4 cells falls below 200 cells per cubic millimeter of blood (200 cells/mm³). (In someone with a healthy immune system, CD4 counts are between 500 and 1,600 cells/mm³.) OR
- they develop one or more opportunistic infections regardless of their CD4 count.

Without HIV medicine, people with AIDS typically survive about 3 years. Once someone has a dangerous opportunistic illness, life expectancy without treatment falls to about 1 year. HIV medicine can still help people at this stage of HIV infection, and it can even be lifesaving. But people who start ART soon after they get HIV experience more benefits—that's why HIV testing is so important.

THINK YOU'VE BEEN EXPOSED TO HIV?

Get tested **as soon as possible!**



Find an HIV testing site near you:
Locator.HIV.gov



GET TESTED FOR HIV...

CDC recommends that **everyone** between the ages of 13 and 64 get tested **at least once**.

People with certain risk factors should get tested more often.



Find an HIV testing site near you:
Locator.HIV.gov





Treatment with HIV medicines can **prevent HIV from developing into AIDS.**

How Do I Know If I Have HIV?

The only way to know for sure if you have HIV is to **get tested**. Testing is relatively simple. You can ask your health care provider for an HIV test. Many medical clinics, substance abuse programs, community health centers, and hospitals offer them too. You can also buy a home testing kit at a pharmacy or online.

To find an HIV testing location near you, use the HIV Services Locator (Locator.HIV.gov).

HIV self-testing is also an option. Self-testing allows people to take an HIV test and find out their result in their own home or other private location. You can buy a self-test kit at a pharmacy or online. Some health departments or community-based organizations also provide self-test kits for free.

HOW IS HIV TRANSMITTED?

How Do You Get or Transmit HIV?

You can only get HIV by coming into direct contact with certain body fluids from a person with HIV who has a detectable viral load. These fluids are: blood, semen (*cum*) and pre-seminal fluid, rectal fluids, vaginal fluids, breast milk. For transmission to occur, the HIV in these fluids must get into the bloodstream of an HIV-negative person through a mucous membrane (found in the rectum, vagina, mouth, or tip of the penis); open cuts or sores; or by direct injection.

People with HIV who take HIV medicine daily as prescribed and get and keep an undetectable viral load have effectively no risk of sexually transmitting HIV to their HIV-negative partners.

How Is HIV Spread from Person to Person?

HIV can only be spread through specific activities. In the United States, the most common ways are:

- **Having vaginal or anal sex with someone who has HIV** without using a condom or taking medicines to prevent or treat HIV. Anal sex is riskier than vaginal sex.
- **Sharing injection drug equipment (“works”), such as needles,** with someone who has HIV.

Less common ways are:

- **From mother to child during pregnancy, birth, or breastfeeding.** However, the use of HIV medicines and other strategies have helped lower the risk of mother-to-child transmission of HIV to 1% or less in the United States.
- **Getting stuck with an HIV-contaminated needle** or other sharp object. This is a risk mainly for health care workers. The risk is very low.

HIV is spread only in extremely rare cases by:

- **Having oral sex.** But in general, the chance that an HIV-negative person will get HIV from oral sex with an HIV-positive partner is extremely low.
- **Receiving blood transfusions, blood products, or organ/tissue transplants that are contaminated with HIV.** The risk is extremely small these days because of rigorous testing of the U.S. blood supply and donated organs and tissues.
- **Being bitten by a person with HIV.** Each of the very small number of documented cases has involved severe trauma with extensive tissue damage and the presence of blood. There is no risk of transmission if the skin is not broken.
- **Contact between broken skin, wounds, or mucous membranes and HIV-infected blood or blood-contaminated body fluids.**
- **Deep, open-mouth kissing if both partners have sores or bleeding gums and blood from the HIV-positive partner gets into the bloodstream of the HIV-negative partner.** HIV is not spread through saliva.
- **Eating food that has been pre-chewed by a person with HIV.** The contamination occurs when infected blood from a caregiver’s mouth mixes with food while chewing. The only known cases are among infants.

Does HIV Viral Load Affect Getting or Transmitting HIV?

Yes. Viral load is the amount of HIV in the blood of someone who has HIV. Taking HIV medicine (called antiretroviral therapy or ART) daily as prescribed can make the viral load very low—so low that a test can’t detect it (this is called an undetectable viral load).

People with HIV who take HIV medicine daily as prescribed and get and keep an undetectable viral load have effectively no risk of transmitting HIV to an HIV-negative partner through sex.

HIV medicine is a powerful tool for preventing sexual transmission of HIV. But it works only as long as the HIV-positive partner gets and keeps an undetectable viral load. Not everyone taking HIV medicine has an undetectable viral load. To stay undetectable, people with HIV must take HIV medicine every day as prescribed and visit their healthcare provider regularly to get a viral load test.

Ways HIV Cannot Be Spread

HIV is **not** spread by:

- Air or water
- Mosquitoes, ticks or other insects
- Saliva, tears, or sweat that is not mixed with the blood of a person with HIV
- Shaking hands; hugging; sharing toilets; sharing dishes, silverware, or drinking glasses; or engaging in closed-mouth or “social” kissing with a person with HIV
- Drinking fountains
- Other sexual activities that don’t involve the exchange of body fluids (for example, touching).

HIV can’t be passed through healthy, unbroken skin.

WHO IS AT RISK FOR HIV?

HIV can affect anyone regardless of sexual orientation, race, ethnicity, gender or age. However, certain groups are at higher risk for HIV and merit special consideration because of particular risk factors.

Is the Risk of HIV Different for Different People?

Some groups of people in the United States are more likely to get HIV than others because of many factors, including the status of their sex partners, their risk behaviors, and where they live.

When you live in a community where many people have HIV infection, the chances of having sex or sharing needles or other injection equipment with someone who has HIV are higher. You can use CDC’s *HIV, STD, hepatitis, and tuberculosis Atlas Plus* to see the percentage of people with HIV (“prevalence”) in different US communities. Within any community, the prevalence of HIV can vary among different populations.

Gay and bisexual men have the largest number of new diagnoses in the United States. Blacks/African Americans and Hispanics/Latinos are disproportionately affected by HIV compared to other racial and ethnic groups. Also, transgender women who have sex with men are among the groups at highest risk for HIV infection, and injection drug users remain at significant risk for getting HIV.

Risky behaviors, like having anal or vaginal sex without using a condom or taking medicines to prevent or treat HIV, and sharing needles or syringes play a big role in HIV transmission. Anal sex is the highest-risk sexual behavior. If you don’t have HIV, being a receptive partner (or bottom) for

anal sex is the highest-risk sexual activity for getting HIV. If you do have HIV, being the insertive partner (or top) for anal sex is the highest-risk sexual activity for transmitting HIV.

SYMPTOMS OF HIV

How Can You Tell If You Have HIV?

The only way to know for sure if you have HIV is to get tested. You can't rely on symptoms to tell whether you have HIV.

Knowing your HIV status gives you powerful information so you can take steps to keep yourself and your partner(s) healthy:

- **If you test positive**, you can take medicine to treat HIV. By taking HIV medicine daily as prescribed, you can make the amount of HIV in your blood (your viral load) very low—so low that a test can't detect it (called an undetectable viral load). Getting and keeping an undetectable viral load is the best thing you can do to stay healthy. If your viral load stays undetectable, you have effectively no risk of transmitting HIV to an HIV-negative partner through sex.
- **If you test negative**, there are more HIV prevention tools available today than ever before.
- **If you are pregnant**, you should be tested for HIV so that you can begin treatment if you're HIV-positive. If an HIV-positive woman is treated for HIV early in her pregnancy, the risk of transmitting HIV to her baby can be very low.

Use the HIV Services Locator to find an HIV testing site near you (Locator.HIV.gov).

What Are the Symptoms of HIV?

There are several symptoms of HIV. Not everyone will have the same symptoms. It depends on the person and what stage of the disease they are in.

Below are the three stages of HIV and some of the symptoms people may experience.

Stage 1: Acute HIV Infection

Within 2 to 4 weeks after infection with HIV, about two-thirds of people will have a flu-like illness. This is the body's natural response to HIV infection.

Flu-like symptoms can include: fever, chills, rash, night sweats, muscle aches, sore throat, fatigue, swollen lymph nodes, mouth ulcers. These symptoms can last anywhere from a few days to several weeks. But some people do not have any symptoms at all during this early stage of HIV.

Don't assume you have HIV just because you have any of these symptoms—they can be similar to those caused by other illnesses. **But if you think you may have been exposed to HIV, get an HIV test.**

After you get tested, be sure to learn your test results. If you're HIV-positive, see a doctor as soon as possible so you can start treatment with HIV medicine. **And be aware: when you are in the early**

stage of infection, you are at very high risk of transmitting HIV to others. It is important to take steps to reduce your risk of transmission.

Stage 2: Clinical Latency

In this stage, the virus still multiplies, but at very low levels. People in this stage may not feel sick or have any symptoms. This stage is also called **chronic HIV infection**.

Without HIV treatment, people can stay in this stage for 10 or 15 years, but some move through this stage faster.

If you take HIV medicine every day, exactly as prescribed and get and keep an undetectable viral load, you can protect your health and have effectively no risk of transmitting HIV to your sexual partner(s).

But if your viral load is detectable, you **can** transmit HIV during this stage, even when you have no symptoms. It's important to see your health care provider regularly to get your viral load checked.

Stage 3: AIDS

If you have HIV and you are not on HIV treatment, eventually the virus will weaken your body's immune system and you will progress to AIDS (*acquired immunodeficiency syndrome*). This is the late stage of HIV infection.

Symptoms of AIDS can include: rapid weight loss, recurring fever or profuse night sweats, extreme and unexplained tiredness, prolonged swelling of the lymph glands in the armpits, groin, or neck, diarrhea that lasts for more than a week, sores of the mouth, anus, or genitals, pneumonia, red, brown, pink, or purplish blotches on or under the skin or inside the mouth, nose, or eyelids, memory loss, depression, and other neurologic disorders.

Each of these symptoms can also be related to other illnesses. The only way to know for sure if you have HIV is to get tested. If you are HIV-positive, a health care provider will diagnose if your HIV has progressed to stage 3 (AIDS) based on certain medical criteria.

Many of the severe symptoms and illnesses of HIV disease come from the opportunistic infections that occur because your body's immune system has been damaged. See your health care provider if you are experiencing any of these symptoms.

ADDITIONAL HIV INFORMATION AND RESOURCES ARE AVAILABLE AT HIV.GOV,
<https://www.hiv.gov/hiv-basics>

INCLUDING:

OVERVIEW

- ABOUT HIV & AIDS
- DATA & TRENDS
- HISTORY
- MAKING A DIFFERENCE

HIV PREVENTION

- USING HIV MEDICATION TO REDUCE RISK
- REDUCING SEXUAL RISK
- REDUCING RISK FROM ALCOHOL & DRUG USE
- REDUCING MOTHER-TO-CHILD RISK
- POTENTIAL FUTURE OPTIONS

HIV TESTING

- LEARN ABOUT HIV TESTING
- JUST DIAGNOSED: WHAT'S NEXT?

STARTING HIV CARE

- FIND A PROVIDER
- GETTING READY FOR YOUR FIRST VISIT

STAYING IN HIV CARE

- PROVIDER VISITS AND LAB TESTS
- HIV TREATMENT
- OTHER RELATED HEALTH ISSUES

LIVING WELL WITH HIV

- TAKING CARE OF YOURSELF
- YOUR LEGAL RIGHTS

Information accessed at <https://www.hiv.gov/hiv-basics>, August 2020

Psychosocial Needs of HIV Patients

by

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From: ***HIV Manual, Third Edition***

Stanley Ho Centre for Emerging Infectious Diseases

The Chinese University of Hong Kong

and

Centre for Health Protection

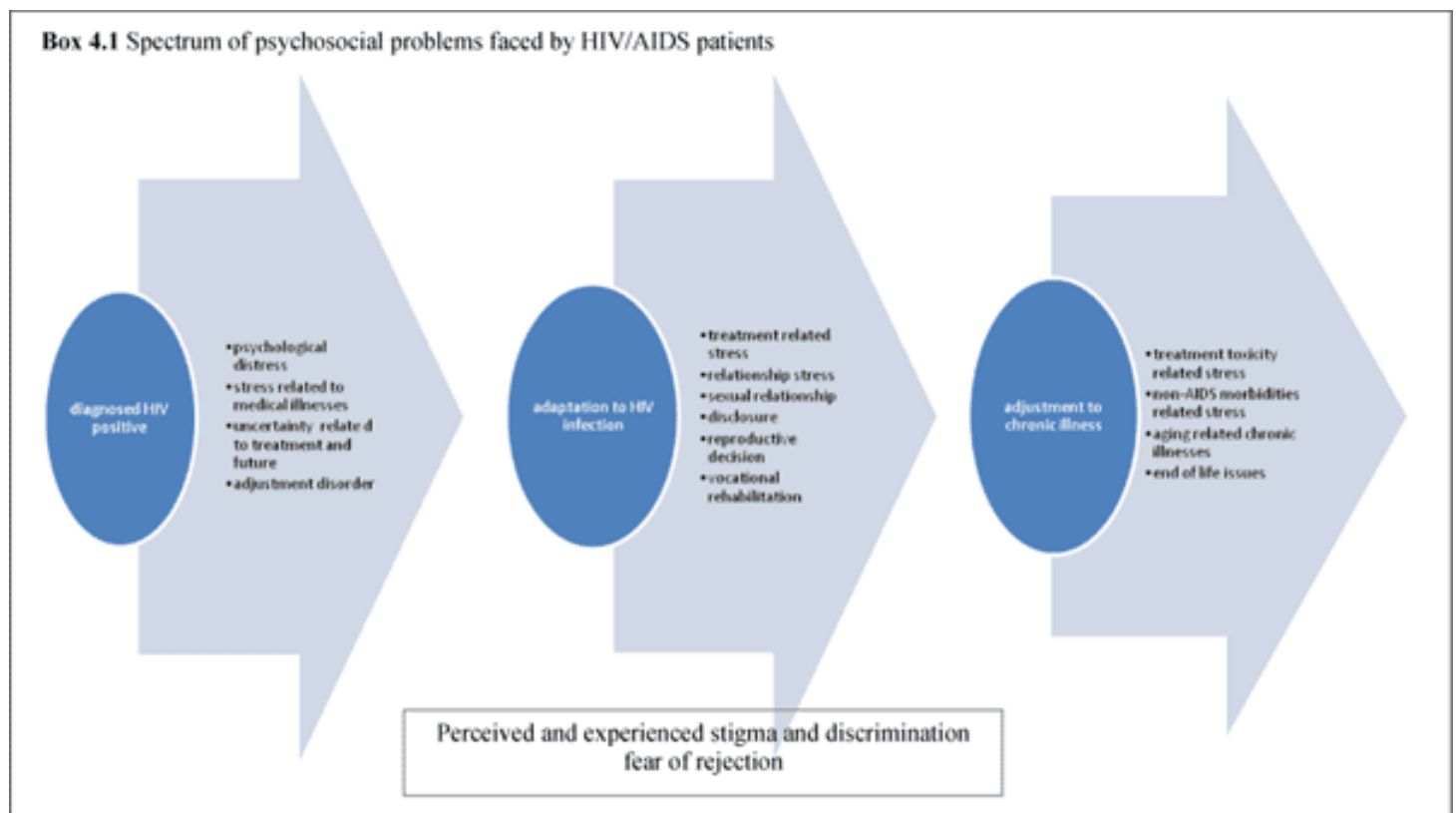
Department of Health

Hong Kong Special Administrative Region Government

<http://www.hivmanual.hk/index.html> (last updated 8 October 2015)

Introduction

Thirty years into the AIDS epidemic, revolutionary improvement in medical treatment of HIV/AIDS has converted the once life-threatening terminal illness into a manageable chronic disease. This is witnessed in Hong Kong as much as it is in other developed countries. Medical advances have not only prolonged life of HIV-infected individuals, but have brought about drastic changes in the nature of concerns and issues among patients and their significant others. These include prevention of HIV transmission; challenge to maintain ongoing perfect drug adherence; treatment toxicity despite maximum viral suppression; reproductive decisions; aging related to chronic illnesses and increasing non-AIDS morbidities and mortalities among HIV infected individuals. All these issues are often associated with a range of psychosocial sequel that must be addressed throughout all stages of the infection. Psychological support is therefore critical for helping individuals, couples, and families affected by HIV to cope with their emotions and psychosocial needs.



Research in Hong Kong suggested that physical health and social discrimination were the most "difficult aspects" of the life of PLWHA (people living with HIV/AIDS). In real life, they have to tackle a broad spectrum of challenges which

vary with different stages and time points of the disease, many of which with a locally specific context (Box 4.1). Awareness of these unique psychosocial needs is crucial in effecting timely and appropriate interventions.

Receiving the bad news - psychosocial impacts of an HIV diagnosis

Newly diagnosed HIV-infected patients may have little knowledge or distorted picture about HIV disease. There is an apparent need to clarify the myths and misunderstanding of management of HIV infection. Foremost are accurate facts and knowledge about HIV and its available treatment.

Patients may show a variety of reactions upon receiving the bad news. The most common responses include shock, disbelief, denial, fear and anxiety, depression and guilt. In addition, some may express a sense of uncertainty. They worry about health deterioration and a shortened life span. Therefore, a strong sense of foreshortened future and despair is common. Prevalence of depression and psychological distress are elevated among PLWHA.

Disclosure of HIV diagnosis is often a difficult decision. Like other patients, PLWHA have right to confidentiality. They would also need to understand that they have the obligation to disclose their HIV diagnosis to those with whom they have had unprotected sexual contact and/or shared needle voluntarily. Disclosure of HIV diagnosis is frequently identified as a stressor by newly diagnosed patients. The sense of guilt and fear of abandonment and stigma are the common barriers to disclosures of HIV status.

From a social angle, ill health resulting from HIV-infection is likely to affect the working capacity of newly diagnosed patients especially when they are already in an advanced stage of disease. Financial concerns and difficulties are often brought up at this stage. Some patients could be the breadwinners or the major care takers of their families. Therefore, a series of practical social issues, such as children care and financial needs have to be addressed in the initial phase.

Psychological needs of HIV/AIDS patients when physical health becomes stabilized

In order to live an adaptive life despite HIV infection, patients need to negotiate between the demands of chronic illness and their goals of living a "normal" life. In order to enjoy sustainable physical health, social support and financial independence, patients have to work on a number of areas that require persistent efforts. These are treatment-related stress as well as relationships with significant others.

Treatment-related stress

People on Highly Active Antiretroviral Therapy (HAART) are required to maintain good adherence to therapy throughout their lives. Long-term adherence to HAART is a real challenge as non-adherence would result in sub-optimal viral suppression, which may lead to treatment failure. On the other hand, patients with good drug adherence may also be challenged by either transient (diarrhea and nausea) or longer lasting (lipodystrophy, dyslipidemia, neuropathy) side effects. Some of these, though distressing, can be treated and are reversible, for example, fatigue, insomnia, diarrhea, nausea and stomach upset. Other side effects, for example, lipodystrophy, often cannot be completely removed. Drastic changes in physical appearance often cause despair and constant fear of exposure of their HIV status. Moreover, PLWHA are challenged with long term drug toxicities of HAART and a broad range of aging associated co-morbidities despite maximum viral suppression. These include dyslipidemia, insulin resistance or diabetes, atherosclerotic cardiovascular and cerebrovascular diseases, hepatotoxicity, nephrotoxicity, osteoporosis, non-AIDS cancers and cognitive impairment. To counteract the burden of these co-morbidities, health care workers may facilitate patients to weigh the efficacy of antiretroviral therapy against its toxicities; and encourage diminishing risk factors that contributes to aging and toxicity related co-morbidities, such as quit smoking, healthy eating, control obesity and regular exercises.

Apparently though HAART is effective in prolonging life, it also brings about side effects and adverse psychosocial consequences that lead to either discontinuation or poor adherence. Drug adherence is often influenced by patient-related factors. Some non-adherent patients understand poorly the relationship between adherence, viral load, and disease progression. Mood, psychological well-being, and a person's lifestyle are also factors pertaining to adherence to HAART. Treatment interruption may be related to fatigue and lack of confidence in treatment, fear of toxicities and inconvenience to carry HIV medicine for travel. Study has indicated a decreasing trend of adherence over time. On the other hand, patients with poor drug adherence were more likely to default follow up; while stable drug adherence could partly be related to patients' awareness of the importance of adherence to long-term treatment success.

Supportive care to retain patients in care is of paramount importance in effective drug adherence program. Drug adherence monitoring effort should be consistent even when the condition of patients is stable, CD4 on rising trend and viral load undetectable.

Relationships and sexual behaviors

PLWHA may start to reengage in romantic relationships and sexual activities when their physical conditions become stable. Sexuality becomes an important issue of concern. Studies in western countries revealed that around one third of PLWHA continue to practice unprotected sex which might put uninfected individuals at risk. These behaviors could be related to the lack of knowledge and skills in safer sex practice. In addition, these could be linked with anxiety arising from concern about disclosure and fear of rejection, false interpretation of "undetectable viral load" as nonexistent transmission risk, irrational association of condom use with HIV and sexually transmitted diseases as well as the lack of negotiation power. Emotional distress, such as depression and hostility also correspond with risky sexual behaviors among PLWHA. They shall be supported with counselling tailored to their needs in sexual health and relationships.

Spouses/Partners and family members of PLWHA often have great concerns, worries and a sense of burden after learning the HIV diagnosis of their beloved ones. It can be difficult for them to solicit social support and seek empathy from their social network or other family members. Caregivers, who are mainly spouses/partners, may have reduced life satisfaction or even feel burnout in the course of taking care of their loved ones. Support and counselling to spouses/partners and family members is an important part of the holistic care in management of HIV disease.

Child bearing issues

Given the prolonged life expectancy and stable health condition of HIV infected individuals; there are increasing desire for child bearing options among HIV infected and affected couples in recent years. The HIV transmission risk to babies could be reduced to below 1% through the use of HAART in prevention of mother-to-child transmission (PMTCT) programme. Health care workers should provide preconception counselling for all women of childbearing at intake and ongoing follow up visits. Sexual health counselling on contraception and reproduction decisions are needed in order to facilitate decision making. In meeting these complex medical and psychosocial needs, a comprehensive HIV care approach for couples is essential.

Towards the end of life

Although AIDS specific mortality has declined, serious co-morbidity has continued to occur in relation to poor drug adherence, progressive viral resistance, and unmanageable drug toxicities. In addition, other chronic diseases will emerge as life expectancy increases, and thus a fluctuating yet ultimately downward course of HIV disease is expected. The principle of palliative care should apply at the last stage of illness. Decision making about risk and benefit of various therapies, such as chemotherapy; withdrawal of HAART after evident treatment failure and the decision on the use of artificial feeding are scenarios that involve assessment of patients' preferences and wishes. The objective of palliative care is to focus attention on comfort, relief of suffering, and quality of life through the end of illness.

PLWHA and their families as well as friends have to face many losses in the course of illness. They have to deal with the loss of job, the threat of health and life insurance, the change in close interpersonal relationships and the fear of rejection of friends, and the partners/spouses. In face of multiple losses, one may develop feelings of helplessness, anger and guilt. The most devastating loss is the death of spouses/partners or friends to AIDS. PLWHA may even have to face multiple losses because the death of friends and co-patients to AIDS would bring traumatic impact to them and even reduce their confidence and hope for successful treatment. Support to family includes psychological preparation for possible deterioration, counselling on decision process about "end of life" issues and bereavement counselling.

Psychosocial interventions in HIV/AIDS

Since the stressors faced by PLWHA are multiple and chronic in nature, a multidisciplinary team approach has to be adopted in order to cater for the various psychosocial needs of PLWHA. Case management is a client centered form of care that connects clients with medical, psychosocial and supportive service. This is an effective model that promotes adaptive coping of patients suffering from chronic diseases and HIV infection, in which a case manager takes up a facilitative role in management. In Hong Kong, case managers are often HIV clinic nurses and case workers of AIDS related non-governmental organizations (NGOs).

Psychosocial assessment of newly diagnosed HIV-infected patients

The initial counselling and intake assessment given to newly diagnosed patients is of paramount importance. The objective of the intake assessment is to understand the needs and current functioning in each aspect of life, such as occupational functioning, social functioning, and source of supports. After this initial assessment, an agenda is set up to prioritize areas of needs and services required. Referrals to other professionals, including, clinical psychologist, social worker and dietitian may be necessary. Knowledge about HIV infection and their current health status is reinforced, while myths and misunderstandings are clarified, and realistic expectations are set with patients. Other relevant information, such as that on mental health, substance use, skills in independent living, are also provided. A supportive and non-judgmental attitude of the health care workers during the first encounter with the newly diagnosed HIV positive patients is crucial in order to build rapport and establish partnership of care between each other. Patients are encouraged to discuss openly and frankly with the health care workers about their concerns and worries.

Psychological assessment and intervention

Research in Hong Kong and elsewhere gave similar findings that depressed mood is very common among PLWHA.¹⁸ Although they may not be afflicted with clinical affective disorders, many of them experience significant levels of distress. Some PLWHA would need psychological assessment and intervention for evaluation of mood, and management of stress. Psychological intervention helps patients deal with various mood and anxiety problems and learn adaptive coping skills. Psychological intervention can be in the form of individual treatment and group treatment. Individual treatment involves individualized treatment plan for the issues a person and the counsellor/psychologist identifies during assessment. On the other hand, group treatment delivers intervention in the form of group with a specific topic and theme.

PLWHA support groups and caregivers led support groups

Patient support groups provide a forum to share feelings and experiences with each other, share information on treatment and resources, thereby lessening feelings of isolation and being neglected. PLWHA are given an opportunity to discuss HIV-related issues openly within the support groups, which may otherwise not be available in other contexts of daily life. In Hong Kong, patient support groups are formed at specialist clinics where patients receive medical treatment. Various NGOs also form groups and provide mutual support among patients.

Cognitive-behavioural group treatment

Cognitive-behavioural group treatment is widely applied to patients of various mental and medical problems. It has been reported that cognitive-behavioural group could be effective in improving the quality of life and mood in HIV-infected patients in Hong Kong.¹⁹ Typically, these interventions involve groups of 6-8 participants which are led by one or two psychotherapist. These groups usually meet weekly for 2-3 months. Most cognitive behavioural groups involve cognitive restructuring of maladaptive thoughts, provision of knowledge on stress responses, relaxation exercises, health behaviour change, and discussion on constructive coping skills. The aims are to reduce distress of participants and to promote their efficacy in dealing with stress related to HIV illness.

Counselling on drug adherence

One of the important principles in drug adherence counselling is that patients should be involved in treatment decision process. Drug adherence counselling is covered in Chapter 11.

Positive prevention - counselling on safer sex

Intervention activities directed towards HIV positive infected individuals is also known as positive prevention.²⁰ The development of rapport and regular contacts with HIV patients are the pre-requisites for effective safer sex promotion in HIV patients. Recent study indicates that antiretroviral therapy was linked with 96% reduction of sexual transmission to HIV negative partners as well as improved health outcome among HIV infected patients.²¹ It is important for health care workers to consider retaining patient in care for access to treatment as essential strategy in effective behavioral risk reduction programme. Prevention targeting HIV positive is discussed in Chapter B7.

The social interface

The ultimate objective of psychosocial care is not only for prolonging survival of patients, but to assist them to attain quality of life and to enable them to reintegrate back to society. In the course of treatment, health care workers have to identify barriers to independent living, and offer appropriate assistance to achieve the aim. For example, PLWHA

may also need vocational rehabilitation in order to resume independent living. Moreover, they can be empowered by full understanding of their own health progress and treatment updates.

It is important to note that HIV-related social stigmas have never disappeared. Social stigma can be a form of chronic stress for HIV/AIDS patients. In addition, fear of stigmatisation and discrimination would stop people from disclosing their diagnosis to friends and family members, while the burden and stressors of HIV are all kept to the infected individuals. Some people develop internal stigmas. They believe that their disease is a form of punishment and the disease constrains every aspect of their lives. Some patients may avoid social contacts and do not seek social support since they believe that they are not worthy of respect and care from anyone. As a result, some PLWHA may live in despair and in constant fear of rejection, and yet lack social support that they need.

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Further reading

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Joint Statement by UN human rights experts* on the occasion of the High-Level Meeting on ending AIDS by 2030 (2016)

On the occasion of the High-Level Meeting on ending AIDS by 2030, to take place in New York from 8 to 10 June 2016, a group of international human rights experts call on States to seize the opportunity to recommit to and ensure the full respect, protection and fulfillment of human rights in the efforts to end the AIDS epidemic by 2030.

Unprecedented health response with human rights at the core

Driven by the urgency of the right to life and powered by the Millennium Development Goal to halt and begin to reverse the AIDS epidemic, the global response to HIV succeeded in reducing the number of new HIV infections by 35% since 2000. In sub-Saharan Africa, the region most affected by the epidemic, new infections declined by 41% between 2000 and 2014. The world has moved from no treatment access in 1996 to 15 million people with access to treatment in 2015.

The AIDS response has demonstrated the importance and feasibility of overcoming entrenched socio-political, gender-related and legal barriers that block effective responses to HIV, to both enable better health and to advance human rights. Two decades after the introduction of the International Guidelines on HIV/AIDS and Human Rights, a Human Rights Council Resolution 30/8 (2015) has reaffirmed that the full realization of human rights and fundamental freedoms for all is essential to the global AIDS response².

Participation and meaningful involvement of key populations

The human rights principles of non-discrimination, equality, participation, access to justice and accountability, have been crucial in making the AIDS response effective. Since the GIPA principles, Greater Involvement of People Living with HIV/AIDS, the meaningful participation of civil society and key populations, in particular at the community level, has been a vital tool in enabling an effective response these past decades.

Using the language and power of human rights, people living with HIV and human rights defenders have secured important legal and judicial victories against HIV-related discrimination and human rights violations. Their demands for social justice have led to increased access to medicines, law reform and the inclusion of human rights programmes in HIV responses.

However, human rights defenders, including those living with HIV/AIDS, working to advance social justice and secure rights in the AIDS response across the world still face stigma, discrimination and violence. States should publically recognize the importance of their work, and must do more to ensure safe and enabling environments for defenders to operate. Human rights defenders and civil society should be ensured safe and reprisals-free access and participation not only in the UN and other multilateral fora but also at regional, national and local levels. If individuals and organizations cannot safely demand their own human rights and the rights of others living with HIV/AIDS, the full enjoyment of their rights, including their right to health, will be severely undermined.

AIDS is an unfinished business

Effectively realizing the right to health in the global AIDS response means not only securing access to health care but equally addressing the underlying determinants of health, in particular discrimination and stigma. Social inequalities and exclusion shape health outcomes and contribute to the increasing disease burden borne by marginalized groups. In addition, a health condition such as HIV/AIDS may involve exposure to compounded forms of discrimination that reinforce existing inequalities.

The HIV epidemic continues to be a metaphor for great inequalities within and between countries. Specific populations and communities – often the most fragile and marginalized – continue to be left out and bear the brunt of the epidemic. HIV-related discrimination and violence faced by certain sectors of the population make it more likely that they will end up living in situations of poverty. And those who come from deprived socioeconomic backgrounds are often subject to multiple forms of discrimination, which make it extremely difficult to lift themselves out of poverty.

Key populations at higher risk of HIV, have disproportionately high rates of HIV infection and yet, have poorer access to essential HIV services: people who inject drugs are 24 times more likely to acquire HIV, sex workers are 10 times more likely to acquire HIV, men who have sex with men, who globally are 24 times more likely to acquire HIV than adults in the general population, transgender people, who are 18 times more likely to acquire HIV, and prisoners, who are five times more likely to be living with HIV than adults in the general population.

The epidemic continues to be attended by human rights violations fueled by discrimination, violence, punitive laws, policies and practices. HIV-related discrimination is often deeply interwoven with other forms of discrimination based on gender, race, disability, drug use, sexual orientation and gender identity, immigration status, being a sex worker, prisoner or former prisoner.

Ending the AIDS epidemic in a way that leaves no one behind requires bold policies and reforms that reach out to populations that are deeply marginalized and criminalized. However, in certain parts of the world, we continue to witness a trend towards the opposite—with increased criminalization and exclusion of key populations, fueling stigma and violence against them.

Discrimination in healthcare settings

The enjoyment of the highest attainable standard of health is a fundamental human right that includes non-discriminatory, affordable and acceptable access to quality health care services, goods and facilities. Yet, around the world, even where healthcare services are in place, people face various forms of discrimination and violence in relation to health care.

Punitive laws, policies, and practices impede, and sometimes altogether bar, the disadvantaged and marginalized from accessing information, as well as health goods and services that are critical to the prevention, treatment, and care of HIV. There is a large body of evidence which clearly demonstrates that punitive frameworks drive people away from health services, particularly those who are most in need.

Evidence also shows that healthcare settings are among the most frequent environments where people experience HIV-related stigma, discrimination, and even violence. One in eight people living with HIV report having been denied health care. Some of the most common manifestations of discrimination in health care include denial of health care and unjust barriers in service provision; inferior quality of care; disrespect, abuse, and other forms of mistreatment; extreme violations of autonomy and bodily integrity such as forced abortions and sterilizations; undue third party authorizations for accessing services; mandatory treatment; and compulsory detention.

This discrimination is an unacceptable breach of human rights and, moreover, negatively affects public health outcomes. Health care settings should prohibit HIV mandatory testing or treatment; respect patient privacy and confidentiality; link those affected to additional services or support networks; educate and support their workforce to provide quality care in a safe and non-judgmental way; set up grievance mechanisms to ensure redress and accountability; and ensure the participation of those affected in health-related policies and programmes that affect them.

Gender inequalities and HIV/AIDS

Globally, women and girls are still the most affected by the AIDS epidemic and women living with HIV generally report higher levels of stigma, discrimination and violence than men living with HIV. For instance, adolescent girls and young women account for one in four new HIV infections in sub-Saharan Africa. Young women who experience intimate partner violence are 50% more likely to acquire HIV than women who have not³.

Legal barriers, such as third party authorization to access health services, harmful cultural practices, and forced or early marriage, prevents many adolescents and young women from accessing their rights to sexual and reproductive health⁴. This in turn can lead to higher levels of unsafe abortion; unwanted pregnancies; and HIV infection. Laws that recognize adolescent girls' autonomy and bodily integrity and protect their confidentiality encourage and empower adolescents to seek and demand the services and information required to protect themselves.

A variety of discriminatory practices occur in reproductive health settings affecting women living with HIV. For example, pregnancy-related discrimination includes inaccurate information, inappropriate treatment or failure to provide care during labor, and forced or coerced sterilization. This discrimination can have particularly detrimental effects on women's health

and the efforts to eliminate mother to child transmission of HIV, as women who have faced HIV-related stigma and discrimination are less likely to access pre- and post-natal treatment and care.

Violence against women, harmful gender stereotypes and multiple and intersectional forms of discrimination based on sex and gender lead to the violation of women's sexual and reproductive health rights. The ability of women and girls to protect themselves from HIV continues to be compromised by gender inequalities, including unequal legal, economic and social status, insufficient access to education, health care and services, including for sexual and reproductive health, inability to exercise sexual and reproductive rights as well as all forms of discrimination and violence in the public and private spheres, including sexual violence and exploitation.

Drug policy and access to harm reduction services

The SDGs include an ambitious global target to end AIDS by 2030 but this target requires governments to stand up against the stigma, discrimination and criminalization that have driven the spread of HIV for decades, and embrace evidence- and rights-based responses.

People who inject drugs are among those who have been left furthest behind by the global response to HIV. While people who inject drugs are at increased risk of contracting the virus because they lack access to safe injecting equipment and evidence-based health services; at the core of their suffering is the pernicious stigma associated with drug use, and the focus on highly punitive policies of criminalization as the primary means of addressing drug issues at the global level. Women who inject drugs experience higher infection risk factors and are exposed to greater risks of violence and discrimination in prisons, the community and in health care settings. This has only served to fuel the epidemic among drug users, and it is unsurprising that the world has missed the previous target of halving HIV among people who inject drugs by 2015 – by a staggering 80%.

Responding to the HIV risks linked to unsafe injecting is crucial if we hope to end AIDS. We know risks can be minimized, even avoided altogether, by providing access to harm reduction services – such as sterile needles and syringes, and opiate substitution medications such as methadone⁵. Recent studies show that HIV-related deaths and new HIV infections could be cut by over 90% by 2030 if just 7.5% of the global funding for drug enforcement were redirected to scaling-up harm reduction⁶. Yet, despite this fact, many governments continue to neglect or even oppose harm reduction programmes, and instead opt to pursue outdated, unscientific policies of abstinence and criminalization as their main response.

We know harm reduction works. It saves lives. It saves money. It promotes rights. The high Level Meeting on AIDS provides an excellent occasion to get things right when it comes to addressing the global response to HIV. States must commit to removing the punitive frameworks that fuel mass incarceration, HIV epidemics, and negative health outcomes⁷. They must adopt a new target to prevent HIV among people who inject drugs, and they must commit to ensuring availability and access to treatment informed by evidence and delivered within a human rights framework, including by ensuring unfettered access to opioid substitution treatment and scaling up funding of harm reduction programmes.

An opportunity to be seized: leave no-one behind

The full realization of human rights in the response to HIV/AIDS is therefore crucial to ending the epidemic by 2030 as committed in the 2030 Agenda for Sustainable Development. Ending AIDS is not just critical to realizing health for all. It will also advance and depend on progress in many of the Sustainable Development Goals such as gender equality, peace, justice and inclusive institutions and partnerships for the goals.

The High Level Meeting on ending AIDS by 2030 represents a critical opportunity for advancing the highest attainable standard of health. To end AIDS, human rights obligations and political commitments need to be translated into concrete strategies, programmes and actions at global, regional and country levels.

We call on States to:

1. remove punitive laws, policies and practices, including overly broad criminalization of HIV transmission, third-party notification requirements, mandatory testing and others that block key populations' access to healthcare services, goods and information;

2. prevent and address violence against key populations;
3. increase human rights and legal literacy for people living with, at risk of and affected by HIV, and provide access to legal services for them to challenge violations of human rights;
4. eliminate HIV and key populations-related stigma and discrimination in all settings, especially health-care, workplace and educational settings;
5. eliminate discrimination and violence against women and girls, including gender-based, sexual and intimate partner violence, harmful traditional and customary practices, abuse, rape and other forms of sexual violence, and ensure that they can access comprehensive sexual and reproductive health information, education, and services;
6. adopt a new target to prevent HIV among people who inject drugs, and commit to ensuring availability and access to evidence-based treatment, including harm reduction programmes and include a gender perspective which recognizes the unique needs of women;
7. strengthen human rights capacities of law makers, law enforcement and the judiciary; and health care workers;
8. ensure health services meet the right to health framework criteria of availability, accessibility, acceptability and quality and are delivered without discrimination;
9. promote and protect human rights defenders working on HIV-related issues, including those working with criminalized populations; and
10. establish and strengthen redress and accountability mechanisms.

We have an historic opportunity not to be missed: to put an end to AIDS within our lifetime. The international community has made great progress in the fight to end HIV/AIDS, but there remain great challenges ahead and important work to be done. The present challenge is to reach the many who are still being left behind.

Notes:

1. The UN Special Rapporteurs on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health; on the situation of human rights defenders; on extreme poverty and human rights; on violence against women, its causes and consequences; and the Working Group on discrimination against women in law and in practice.
2. See report on the Panel discussion held in March 2016 on the progress and challenges in addressing human rights issues in the context of efforts to end the HIV/AIDS epidemic by 2030 ([A/HRC/32/35](#)).
3. UNAIDS, Gap Report (2014).
4. UNDP 'Background Paper: Strategy Meeting to Advance the Findings and Recommendations of the Global Commission on HIV and the Law on Young Women and Girls' (2015).
5. [Case Information Sheet](#): Kurmanayevskiy et al v Russia; International Centre on Human Rights and Drug Policy and the Canadian HIV/AIDS Legal Network (2016).
6. [The Case for a Harm Reduction Decade](#): progress, potential, and paradigm shifts (Harm Reduction International, March 2016).
7. See [Joint open letter of the Rapporteur on the right to health and other experts](#) with occasion of UNGA Special session on world drug problem, April 2016.

- See more at:

<http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20053&LangID=E#sthash.M37SzoXU.dpuf>

IV: Pastoral Care Resources



Pastoral Care Guidelines for persons with HIV/AIDS

Los Angeles Archdiocese HIV/AIDS MINISTRY

Fr. Chris Ponnet, Director Catholic HIV/AIDS Ministry Los Angeles Archdiocese

1. Let the individual set the agenda.

Many of us like to be in control of everything, including the direction of our conversations. This approach can sabotage our best efforts. The earlier you are in your relationship with the person you are counseling, the more s/he needs to control the issues that are discussed. If you begin a relationship by making demands of the HIV/AIDS-positive person such as his/her immediate repentance, notification of family/partner(s), and acceptance of death, you are being, at best, unfair and unhelpful. At worst, you are being destructive.

2. Confidentiality is a must.

We must keep the trust people place in us. Disclosing one's HIV/AIDS status is often a difficult decision. It means becoming vulnerable and trusting another with a secret. Pastoral visitors are not free to tell others the secrets entrusted to us. We do not tell spouses, church committees, pastors, or friends. If we break confidentiality, we may hurt the one who trusted us so much that s/he never reaches out for help again. We may also be violating the law.

3. Do not ask how someone contracted the virus.

We do not ask someone who has cancer, lupus, or suffered a heart attack how she or he got sick, so why should we ask that of someone with HIV/AIDS? When people tell us their HIV/AIDS status, they are usually dealing with the present and future more than the past. There may be lifestyle issues that need to be discussed at a future time, but our initial reaction needs to be compassion - not questioning.

4. Avoid the "Blame Game."

Spending time blaming people who are HIV/AIDS positive for their illness distracts from the most important issues. The truth is that we have all done things in our lives that involved risk. For the most part, we have been spared many of the worst potential consequences of those acts. We are hypocritical when we blame others if they suffer the severe consequences of their acts. The "blame game" hinders us from effectively providing pastoral care to those who need it.

5. Compassion is the key.

Compassion is being a channel of God's grace and coming to the side of one who is hurting. We suspend judgment and focus on the needs of others. Compassion is shown in gentleness, kindness, acceptance, and love. Pastoral care that lacks compassion is not helpful. Compassion is the way of Jesus.

6. Confront your own fears.

Fear leads some pastors and churches to reject people infected/affected by HIV/AIDS. They may refuse to visit or care for them. We must confront our fears with facts, put judgment and prejudice behind us, and get on with the privilege of ministry. It is important to get accurate medical information.

7. Focus on life, not death.

A person infected with HIV/AIDS will eventually die. So will a person who is not infected by HIV/AIDS. None of us knows when death will arrive. Therefore, our focus needs to be on how we will live the rest of our lives. Focusing only on death gives the impression that we have given up hope and are just waiting for the person to die. Focusing on life declares that the person has a lot of living yet to do.

8. Communicate hope.

Every moment lived with meaning and faithfulness is a moment lived in hope. New medications are extending the lives of persons infected with HIV/AIDS. A cure may be found. Prayer and medication can help move us into hope. Spirituality calls us to hope and to live each day of our lives fully.

9. Affirm the worth of the person.

All people are created in the image of God. All people inherently have great dignity and eternal worth. God's grace has gone out to all people. God calls all people to a life filled with power, love, joy, and service to others. "God so loved the world," (John 3:16) means that there are no second-class people. We must embody the message of love in the Gospel.

10. Feel free to show emotion.

A diagnosis of HIV/AIDS can stimulate concerns about death, prolonged illness, lack of control of our lives, financial stability, transmission of the disease, prejudice, and more. Providing good pastoral care requires that we confront these issues and become aware of our own emotions about them. We must be careful, however, to respond to the needs of the person and not our own anxiety, fear, and pity. Our role is to be a pastor to them, not the reverse. Be emotionally present. Feel free to appropriately cry, laugh, or express other emotions when visiting.

11. Remember to touch.

One of the tragedies of HIV/AIDS infection is that many people are reluctant to touch someone who is HIV/AIDS-positive. Some of this hesitation is due to irrational fears about contracting HIV/AIDS through casual contact. Others hesitate because they do not accept the HIV/AIDS-positive person or the lifestyle he or she is believed to have. Whatever the reason, refusing to touch someone who wants to be touched sends the message that we are not emotionally present for the person or that we do not accept the person. We must also be sensitive to times when a person does not want to be touched for any reason or cannot be touched because of a physical condition. Our willingness to touch shows our willingness to care.

12. Look for the stages of grief.

People who are infected/affected by HIV/AIDS wrestle with grief. They may deal with shock, denial, anger, bargaining, depression, and acceptance. People go through these stages in differing periods of time and may bounce back and forth between stages. People will grieve over their HIV/AIDS status, an HIV/AIDS diagnosis, the loss of a job, becoming symptomatic, the loss of their future, the death of their friends, and the anticipation of their own death. Our job is not necessarily to move people through these stages but to be present to them in the stage they are presently in.

13. Be aware of psychosocial issues.

Those infected with, or affected by, HIV/AIDS deal with a variety of issues such as social isolation, rejection by friends and family, prolonged periods of illness, fear of what tomorrow will bring, the sometimes negative reactions of the religious community, reproductive decisions, guilt, and grieving. As givers of pastoral care, we need to recognize these issues and help people as they work their way through them. We also need to educate our community about HIV/AIDS so that it may respond supportively.

14. Expressions of spirituality vary from person to person.

People experience God in various ways. Some people express their faith emotionally; others are quiet and contemplative. Some people enjoy singing; others prefer to listen. Some belong to a particular religious group; others do not. Some are very sure about their spiritual direction; others are searching and have a lot of questions. Such differences are not bad. They demonstrate unique ways God reaches out to each of us.

Since religious expressions differ, we must not require everyone to experience God the way that we do. We cannot assume that we know another person's spirituality just because we know that person is

infected/affected by HIV/AIDS. We must be present as pastoral guides who help people to find their own way on their spiritual journey.

15. Avoid saying, “I know how you feel.”

Even if we have had similar situations, we cannot completely understand how anyone else is experiencing a particular situation. More helpful responses might be: "You are in pain," "I am sorry," "I would like to be supportive of you," "It sounds like this is a difficult time for you," "What can I do to help?" and "How do you feel?" Sometimes a quiet hug is appropriate and needed.

16. Get educated.

To give helpful, consistent pastoral care, educate yourself about HIV/AIDS infection. Learn the basic facts about modes of transmission, progression of the infection, common illnesses and medications, and the psychosocial issues that surround HIV/AIDS.

By becoming educated about HIV/AIDS, you communicate to people with the virus that you care about them. You can find out about HIV/AIDS in many ways: books, tapes, seminars, volunteer opportunities, HIV/AIDS hotlines, American Red Cross programs, denominational resources, hospitals, and more.

However you choose to become educated, do it today.

17. Pastoral care is usually a long process.

We cannot heal every wound and solve every problem in one visit. Pastoral care with someone whose life has been touched by HIV/AIDS requires time, patience, and the development of a relationship. Our role is to come alongside of people and support them, to be present with them. It is not to answer every question and give a solution to every problem. We must be patient as people work through grief and the myriad other life issues.

18. Know your limits.

HIV/AIDS brings us into contact with issues such as counseling, bio-ethics, living wills, medical treatment, grief, guilt, stress reduction, and nutrition. None of us can adequately deal with all these issues. We must realize when we have reached our limits and be humble enough to refer to an appropriate professional person.

19. Every situation can be used by God for growth as God's people.

God meets us in the people we encounter. People living with HIV/AIDS, through the issues they raise, help us confront fear, death, frustration, impatience, prejudice, and spirituality. Accompanying them through these issues can be mutually beneficial. We must be open to growth.

20. Doctrine and dogma do not substitute for sharing and love.

We all operate within the structure of a religious organization. That does not mean, however, that all we have to offer is that structure. We must add to that framework caring, personal sharing, and love. Unless we become personally involved, we will fail to show God's love to others and fail to follow the example of Jesus.

“For those who are ill, the Church offers the Sacrament of the Anointing of the Sick, together with the Sacrament of Penance and the Eucharist...For family members, as well as health-care workers, these same Sacramental sources of grace provides the inner strength and needed hope that the world cannot give.”
U.S. Bishops, Called to Compassion and Responsibility (VI, 4)

Guidelines for Sacraments and Pastoral Ministry

Office of Catholic HIV/AIDS Ministry, Los Angeles Archdiocese Fr. Chris Ponnet Director

HIV/AIDS infection has been a major public health problem not only in the United States, but also throughout the world. Today it is well established that HIV/AIDS occur throughout the population, irrespective of gender or sexual orientation.

These guidelines deal with pastoral care for those who are living with or dying from HIV/AIDS disease. Through such care, the Church carries out in the world the work of our Lord, God, and Savior Jesus Christ, who is gracious and loves all people, who ate with sinners and publicans, who healed the sick and forgave sins. The pastoral situation before us is sickness and its consequences, not the causes of the sickness.

These Guidelines in no way abrogate any pastor’s right or obligation to guide those under his care according to the moral teaching of the Church, nor do they imply any endorsement of secular organizations or programs providing care for persons infected or affected by HIV/AIDS. Instead, they emphasize pastors’ obligations to remember that there is no one who lives and does not sin. This truth compels us to put compassion before judgment. We believe that illness is a sign in the world that – as St. Paul reminds us – “for all have sinned, and fall short of the glory of God.” (Romans 3:23)

Theological and Philosophical Assumptions:

- HIV/AIDS infected and HIV/AIDS-affected persons who are baptized children of God retain all of their rights to participate in the life of the Church.
- HIV/AIDS -infected persons are welcome and encouraged to participate in all parish, diocesan, and other Church-related services, celebrations, meetings, and activities.
- HIV/AIDS -positive status by itself does not permit clergy or laity to make any unreasonable judgment or presupposition about a person’s sexual orientation, activities, or possible means of infection.

Sacrament of Reconciliation and Confidentiality:

- In accord with the Church’s tradition, priests need no reminder that the seal of the Sacrament of Reconciliation is inviolable (c. 983) and that no information learned in confession, either from a person infected with HIV/AIDS or from HIV/AIDS-affected persons, can ever be divulged. Nor may information learned in confession be used in any way that might harm the penitent (c. 984).
- Strict secrecy and confidentiality also bind clergy and other Church ministers in the extra-Sacramental forum. HIV/AIDS infected persons should have complete confidence that in private conference they can reveal their medical condition and related information to a priest, deacon or other parish minister and so receive pastoral guidance and advice without fear of a breach of confidentiality.
- This secrecy and confidentiality also applies when HIV/AIDS -affected persons (family and friends) discuss such matters in private conference with clergy and other parish ministers. Church teaching calls us to compassion, accompanying those who suffer solidarity with the marginalized and offering mercy to fellow sinners. Clergy, along with all pastoral care givers, should take advantage of local opportunities – classes, workshops, seminars, etc. – to develop their awareness of HIV/AIDS disease.

Eucharist:

- There is no evidence that HIV/AIDS can be transmitted by the usual method of distributing and receiving the Precious Body and Blood of Christ our Savior. When the Communion cup is shared the usual sanitary precautions should continue to be used.
- The Eucharist itself is a symbol of our mutual vulnerability in the fellowship of Christ's Body. In a time when those among us who have HIV/AIDS are often shunned because of ignorance and fear, the community of the faithful has an opportunity to exercise its ministry of healing and love by drawing all people, regardless of HIV/AIDS status or state of health, together around the Eucharistic table. This banquet of love becomes a powerful sign of solidarity with those who suffer.

Marriage:

- Couples preparing for marriage should be educated about the various ways in which one may contract HIV/AIDS. Since most states do not now require blood testing for HIV/AIDS, pastoral personnel conducting marriage preparations should ask persons planning to marry if they may have been in a situation of possible infection (sexual encounter, questionable blood transfusion, sharing of intravenous drug needles). If there is any possibility of infection, they should be encouraged to receive counseling and testing as part of their preparation for happy, healthy, and holy married life.
- An HIV/AIDS-infected person must carefully assess his or her desire to marry in the wider context of the demands of a truly Christ-like love. When both parties to a proposed marriage are aware of the HIV/AIDS infection in one or both and still desire to marry, the clergy should discuss with them the moral difficulties presented by their situation. Each case should be examined separately.
- Canon law specifies that a marriage contracted by fraud is invalid. If a member of the clergy or other parish minister conducting marriage preparation learns that an HIV/AIDS-infected person is withholding this information from his/her prospective spouse, the exchange of vows cannot be celebrated in the Church because the prospective spouse has a canonical right to that information. Even if the prospective partner is aware of the HIV/AIDS infection, no wedding date can be scheduled or promised without consulting the Matrimonial Tribunal in order to make sure that all fundamental moral responsibilities as well as appropriate canonical requirements can be met.
- A married person who discovers that he or she is HIV/AIDS -infected has the moral obligation to inform his or her spouse of this condition and to use every responsible, morally licit means to prevent the spread of the infection. Clergy should be knowledgeable about the Church's authentic moral teaching in this area so that they are pastoral to counsel couples in the fulfillment of their responsibilities and in dealing with the difficulties of the situation.
- Clergy should be prepared to provide appropriate and informed pastoral ministry to sexually active single people, grounded in the Church's moral teaching and oriented toward healthy and responsible conduct of Chastity. When condoms are considered it must be in light of church teaching, conscience and the distinction between use for birth control and disease control.

Holy Orders and Religious Vows:

- If any clergy of the diocese, priest or deacon or monk, secular or religious, becomes HIV/AIDS -infected, he is responsible for informing the Bishop, either directly or through his religious superior, about the presence of the infection so that he can receive proper medical and pastoral care.
- Guiding thoughts for one considering ordination for those who discover they are HIV/AIDS infected:
 - a) As with any serious medical condition, the candidate has an obligation to the church and to his bishop/religious superior to manifest the gravity of the situation. He is presenting himself for service on behalf of the church. He does not enjoy a "right" to ordination, and the church has traditionally articulated the following criteria for admission to orders: normal intelligence, sound moral character, right intention, and good health. The church has an expectation that the candidate will be able to fulfill the demands and requirements of ministry. Accordingly, the candidate has a moral obligation to disclose

his medical condition so that those charged with his future can make a reasonable assessment whether or not to issue a call to orders. He may choose to leave the seminary.

- b) The spiritual director should urge the candidate to have a thorough medical Examination and the results must be revealed to his superiors. An underlying medical condition, in and of itself, is not the issue for disqualification from orders. Rather, it is the overall context, both diagnosis and prognosis for the future that must be considered. Ordination is not a private matter so the People of God who call persons into ministry have a need to know the health of candidates for ordination.

Sacrament of the Sick:

- Insofar as their health permits, HIV/AIDS -infected clergy should be permitted and encouraged to continue their ministry in an appropriate, sensitive, and convenient way. Like all ministries, such continued ministry can be a powerful sign and reminder that all of us are imperfect tools God uses to do His work.
- HIV/AIDS -infected persons face serious health situations. With or without serious symptoms, all should be encouraged to receive the Sacrament of the Sick, which may be repeated at reasonable intervals as in the case of any illness.
- The usual procedure for anointing the sick presents no danger of infection to the priest administering the Sacrament. If he has any questions in this regard, he should consult with a competent physician.

Rite of Christian Burial:

- Persons who die of HIV/AIDS -related causes have the right to Christian burial. If cremation is chosen instead of burial, the funeral service can be celebrated with the body or the cremated remains present in the church or in the funeral home. If it is a funeral mass, it is celebrated in the parish church. If the body is cremated without the funeral service, the clergy should encourage the family at minimum to observe the usual custom of memorial services and/or liturgical commemorations at the traditional times. It is the mind of the church that cremated remains should not be scattered at sea or anywhere. The entire remains of the person should be buried or placed in a sacred place. If there is time, the clergy and the responsible persons (family or friends) should make all these and other necessary funeral arrangements before the time of death and in cooperation with the chosen funeral home. Pastoral ministers should be aware of the special circumstances that often are connected with HIV-related deaths, and make every effort to make grief/bereavement counseling available.

Education:

- Every pastoral institution of the diocese should be aware of the likelihood of having to deal with HIV/AIDS disease within its community. These institutions should make concrete and practical efforts to inform and educate their members about HIV/AIDS disease from the medical, social, and ecclesiastical/theological perspectives. As much as possible, every aspect of the parish, including religious education, youth groups, ladies' societies, men's clubs, social organizations, prayer and study groups, should be involved in the informational and educational preparation.
- Every effort must be made to respect the privacy and the rights of HIV/AIDS -infected persons and the HIV/AIDS -affected persons. Clergy must be especially careful not to try to silence people who wish to speak out or work for HIV/AIDS awareness. Clergy have the responsibility to guide such efforts for the good of the whole parish by finding appropriate occasions, activities, and organizations where this work can be done.

Catechetical Guidelines for Parish HIV/AIDS Programs

Archdiocese of Los Angeles Office of Religious Education

All concern for the sick and suffering is part of the Church's life and mission. The Church has always understood herself to be charged by Christ with the care of the poor, the weak, the defenseless, the suffering and those who mourn. Today you are faced with the present crisis of immense proportions: that of AIDS. You are called to show the love and compassion of Christ and his Church. As you courageously affirm and implement your moral obligation and social responsibility to help those who suffer, you are, individually and collectively, living out the parable of the Good Samaritan (cf. Lk 10:30-32) . . . To be "neighbor" is to express love, solidarity and service, and to exclude selfishness, discrimination and neglect.

Pope John Paul II, Mission Dolores Basilica, San Francisco, September 17, 1987

People with AIDS provide us with an opportunity to be with the suffering, to be compassionate toward those whom we might otherwise fear, to bring strength and courage both to those who face the prospect of dying as well as to their loved ones. For the Christian, people with AIDS must not become occasions for stereotyping or prejudice, for anger or recrimination, for rejection or isolation, for injustice or condemnation.

Pope John Paul II, Phoenix, Arizona, September 14, 1987

Preamble:

God's love for us as our Father is a strong and faithful love, a love that is full of mercy, a love that enables us to hope. It is also true to say that God loves us as a Mother. God's love is tender and merciful, patient and full of understanding. The love of God is so great that it goes beyond the limits of human language, beyond the grasp of artistic expression, beyond human understanding. God loves without distinction, without limit. God loves those of you who are sick, those who are suffering from AIDS. God loves the relatives and friends of the sick and those who care for them. God loves us all with an unconditional and everlasting love.

HIV/AIDS Catechesis General Guidelines:

1. HIV/AIDS catechesis must reflect the church's teaching concerning sexual expression, chastity, sanctity of marriage and morality.
2. HIV/AIDS catechesis must be taught within the context of humanity, personal worth and dignity of the individual, which is inherent in all Catholic teachings.
3. HIV/AIDS catechesis should be addressed to the total parish population.
4. HIV/AIDS catechesis should be seen as a part of a total educational approach to human sexuality and Christian morality.
5. Parents, as the primary educators of their children, should be educated about HIV/AIDS so that they may be involved with the education of their children on this topic. They also have the right to know what their children will study, and how it will be taught. The right of parents to remove their children from HIV/AIDS catechesis must at all times be respected. Pastors would be encouraged to speak with parents about their concerns regarding church teachings.
6. Catechesis for HIV/AIDS must be done in a way appropriate to the age of the persons involved.
7. All those who will be involved in providing HIV/AIDS catechesis should be provided with a thorough in-service. Teacher in-services should include:
 - understanding of the Church's moral teachings

- knowledge of these guidelines and the U. S. Bishops' documents
- medical knowledge
- cultural implications of HIV/AIDS
- age appropriate methods
- culturally appropriate methods
- pastoral care for people with HIV/AIDS
- procedures to follow in emergencies
- When inviting a presenter for HIV/AIDS catechesis to speak in the parish, it is recommended that one would check references, review outlines and prepared remarks and even hear the presenter in advance.

HIV/AIDS Catechesis Curriculum Guidelines:

8. All HIV/AIDS catechesis should be reflective and respectful of cultural differences. Catechists should be aware of varying cultural factors that will affect their catechetical efforts.
9. The curriculum, "AIDS: A Catholic Educational Approach," reflects current knowledge concerning HIV/AIDS catechesis. An informed user of this resource will remain updated and make appropriate choices about proper emphasis of items, depending on the setting. Certain items of the curriculum may lend themselves to an improper interpretation if overemphasized. Transparency Masters will sometimes use inappropriate terminology when discussing HIV/AIDS, such as "Catching AIDS". When using a master, take care to make the necessary changes with appropriate terminology, such as "Exposure to the HIV Virus", or "Infection with the HIV Virus." As this curriculum is used, additional items may become apparent. The catechist must be alert to these types of issues. This curriculum will continue to be updated as new information and material become available. The Archdiocese will develop a list of speakers qualified to make presentations in the parish setting concerning HIV/AIDS Catechesis. This list may be obtained from the Diocesan Office of Religious Education.

HIV/AIDS Catechesis Media Guidelines:

10. Care must be taken when using media for HIV/AIDS catechesis. Media should never take the place of the catechesis. (A list of media resources may be obtained from the Diocesan Office of Religious Education.)
11. The catechist needs to preview all materials before using them. Questions for evaluating HIV/AIDS Media include:
 - Are the media appropriate for the audience and the purpose of the presentation?
 - Are the medical facts accurate?
 - Is the content presented in an unbiased manner or are stereotypes perpetuated?
 - Are the media consistent with the Church's teaching on sexual morality in general and on the response to HIV/AIDS in particular?
 - Do the media present accurate information empowering the viewer to make responsible behavior choices?

Suggested Materials for Presentations

OPENING PRAYER

Where there is charity and wisdom, there is neither fear nor ignorance.

Where there is patience and humility, there is neither anger nor disturbance.

Where there is poverty with joy, there is neither greed nor avarice.

Where there is rest and meditation, there is neither anxiety nor restlessness.

Where there is fear of the Lord to guard an entrance,
there the enemy cannot have a place to enter.

Where there is a heart full of mercy and discernment,
there is neither excess nor hardness of heart.



Catholic HIV/AIDS Ministry Vision Statement

- We are called to be compassionate of all those living with HIV/AIDS.
- We are called to love those with HIV/AIDS, recognizing that HIV/AIDS is not a punishment from God, but rather that God is present and loving and a source of strength for all who are suffering.
- We are called to uphold the dignity of human life and commit ourselves to cherish each person living with HIV/AIDS.
- We are called to be instruments of the reign of God and as Church we commit ourselves to build a community of faith and love, which includes those living with HIV/AIDS.

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## A Global Catholic Perspective: The Church's Response to AIDS

Based on a speech by Rev. Msgr. Robert J. Vitillo

(Msgr. Vitillo works for Caritas Internationalis as both Head of Delegation to the United Nations in Geneva and Special Advisor on HIV/AIDS and Health. Msgr. Vitillo is a trained social worker and psychotherapist.)

Catholic leaders and the believing community as a whole have translated their theories about the Church's role as educator in the field of HIV/AIDS prevention into practical, everyday actions.

In Zimbabwe, for example, the National Catholic Development Commission produced a brochure, AIDS and the Christian, which highlights five steps to be taken by Catholics in response to HIV/AIDS:

1. Know the facts,
2. Respect God's law,
3. Love faithfully,
4. Protect yourself and your family and,

## 5. Have compassion on sufferers.

In many countries of the Southern Hemisphere, faith-based organizations take responsibility for more than one half of the infrastructure for health care. Very often, these church-sponsored services are the only ones to reach out beyond the capital cities and the more populated areas. In places where an elevated HIV-infection rate can be noted, Catholic hospitals and clinics have faced many new burdens. In response to resource shortages, overcrowding, and staff “burnout,” numerous Catholic health facilities, most especially those located in Africa and Latin America, have developed mobile home care programs which dispatch staff and trained volunteers to assist people in caring for family members who have AIDS in their own homes. The volunteers do not require sophisticated training; frequently, **they are catechists**, village health workers, or **local parishioners**.

In addition to programs with a direct medical focus, church-related organizations have been called upon to provide psychological and social support to persons with HIV/AIDS and to their families and loved ones. Such responses include:

- Initiating economic development opportunities for HIV-infected persons who have lost employment and social insurance benefits;
- Nurturing and educating thousands of children whose parents have either died or have become severely incapacitated as a result of HIV-related illnesses;
- Caring for elderly persons who are surviving their adult children and thus are unable to rely on the traditional systems of family care.

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The Vatican

All concern for the sick and suffering is part of the Church’s life and mission. The Church has always understood herself to be charged by Christ with the care of the poor, the weak, the defenseless, the suffering and those who mourn. Today you are faced with the present crisis of immense proportions: that of AIDS. You are called to show the love and compassion of Christ and his Church. As you courageously affirm and implement your moral obligation and social responsibility to help those who suffer, you are, individually and collectively, living out the parable of the Good Samaritan (cf. Lk 10:30-32) . . . To be “neighbor” is to express love, solidarity and service, and to exclude selfishness, discrimination and neglect. (*Pope John Paul II, Mission Dolores Basilica, San Francisco, September 17, 1987*)

People with AIDS provide us with an opportunity to be with the suffering, to be compassionate toward those whom we might otherwise fear, to bring strength and courage both to those who face the prospect of dying as well as to their loved ones. For the Christian, people with AIDS must not become occasions for stereotyping or prejudice, for anger or recrimination, for rejection or isolation, for injustice or condemnation. (*Pope John Paul II, Phoenix, Arizona, September 14, 1987*)

2008 “Pope Benedict XVI appealed for solidarity with those living with and otherwise affected by HIV/AIDS throughout the world. (Pope Benedict XVI, Message to African Bishops of South Africa 2005) There is an urgent need to reach out and mobilize the Catholic community and the general public to fight the HIV/AIDS crisis...We invite you to encourage the faithful under your charge to join their prayers with others in the hope that an end to this epidemic will soon be realized.” Most Reverend José H. Gómez Chairman, Committee on Cultural Diversity in the Church

“The international experts tell us on this World AIDS Day 2014 that we must “close the gap” between the “haves” and “have-nots” in the global response to AIDS. We can accomplish this lofty goal by opening our hearts in solidarity and in the search for the common good. We can ‘close the gap’ by challenging and changing the structures that prevent some 25 million adults and children from access to life-saving anti-retroviral medications.” Caritas International Vatican Statement

August 2006 “The dignity of the individual plays a central role in the social doctrine of the Church. In fact, that is the basis also of its vision for society. Nowadays this includes the persons living with HIV/AIDS, so that this caring presence of the Church is incarnated into many different forms and covers a whole range of activities addressing the different aspects of the needs and the problems of the society.” August 2006 HIV/AIDS AND ITS EFFECTS ON REFUGEE SITUATIONS IN A CHRISTIAN PERSPECTIVE by Archbishop Agostino MARCHETTO Secretary of the Pontifical Council for the Pastoral Care of Migrants and Itinerant People

World AIDS Day December 1 2016 “Millions of persons are living with this disease, and only half of them have access to life-saving therapies. I invite you to pray for them and for their loved ones and to promote solidarity, because even the poorest can benefit from diagnosis and appropriate care. Finally, I call upon all to adopt responsible behavior to prevent further spread of this disease.” Pope Francis

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## **Pastoral Care**

Ministering to people with HIV/AIDS and those whose families are touched by HIV/AIDS may differ in some ways from ministering to people with most other illnesses. The HIV/AIDS crisis often provides a forum for stereotyping and prejudice, anger and recrimination, rejection and isolation, injustice and condemnation. The social stigma and harsh social judgments associated with HIV/AIDS, coupled with the high incidence of fear and ignorance about this condition, set this ministry apart. It is the unique challenge of the Church to support and respond to all of the challenges created by the HIV/AIDS pandemic, and particularly those that are spiritual.

“Christ’s compassion toward the sick and his many healings of every kind of infirmity are resplendent signs that God has visited his people and that the kingdom of God is close at hand. Jesus has the power not only to heal, but also to forgive sins, he has come to heal the whole man, soul and body; he is the physician the sick have need of. His compassion toward all who suffer goes so far that he identifies himself with them: I was sick and you visited me. His preferential love for the sick has not ceased through the centuries to draw the very special attention of Christians toward all those who suffer in body and soul. It is the source of tireless efforts to comfort them.” (Catholic Catechism, #1503)

**Outreach Activity** - AIDS quilts are made to honor the memory of those who have died from the complication of AIDS. You may choose to create a panel privately as a personal memorial to someone you’ve loved, but we encourage you to follow the traditions of old fashioned sewing and quilting bees, by including friends, family, and co-workers. (The AIDS Memorial quilt: [http: www.aidsquilt.org](http://www.aidsquilt.org))

## **Theological and Pastoral Assumptions Fr. Chris Ponnet, Director Office of Catholic HIV/AIDS Ministry, Los Angeles Archdiocese**

- We share a consistent life ethic: We believe in the dignity of each person. This speaks of a God who accompanies all people on their life journey, not a God who abandons them. Catholic social justice teaching is a frame of reference.
- Human sexuality is good and beautiful. It is a gift that we must use responsibly.
- Freedom of conscience and choice are companions to responsibility.
- Jesus’ message of hope and the promise of the Kingdom to come are directed at the most marginalized in society. This is the radical justice of the Gospels.

The Catholic Church itself is one of the biggest global health providers. It runs thousands of hospitals and dispensaries as well as houses for people who are elderly, chronically ill or who have physical or learning disabilities.

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RESOURCES: Caritas Internationalis, UNAIDS, and U.S. Centers for Disease Control

Caritas Internationalis is the global confederation of 164 Catholic organizations working on behalf of the poor. It is the arm through which the Church delivers its moral mission to help the most vulnerable and excluded people, whatever their religion or race.

Since 1987, Caritas Internationalis has taken a lead role in promoting just and compassionate care to people living with HIV/AIDS. The disease has now claimed the lives of more than 30 million people – many in the poorest corners of the world. But there is good news – deaths have fallen by 30% and more people than ever before have access to medicines. The battle against HIV/AIDS is far from over. (Caritas Internationalis <http://www.caritas.org>)

HIV/AIDS is one of the many programs supported by Caritas Internationalis - Since 1990, CCUSA Disaster Operations have coordinated the Catholic Church's response to thousands of disasters; the 9/11 Terrorist Attacks, the 2005 Hurricane Season, the 2010 Gulf Coast Oil Disaster, the 2011 Spring Storms and most recently, the impact of Superstorm Sandy. For every dollar donated to Catholic Charities agencies approximately 90 cents goes directly to programs and services across the country that serve over 10 million people each year regardless of their religious, social or economic backgrounds. (Caritas Internationalis <http://www.caritas.org>)

Joint United Nations Programme on HIV/AIDS (UNAIDS, www.unaids.org) 2019 worldwide estimates:

New HIV infections/year reduced by 40% since peak in 1998

1.8 million people newly infected with HIV (150,000 among children <15 years of age)

38 million people living with HIV infection, 1.8 million of those in children (<15 years of age)

690,000 AIDS-related deaths (32.7 million deaths since the start of the epidemic)

U.S. Centers for Disease Control and Prevention (www.cdc.gov) 2018 U.S. estimates:

36,400 new HIV infections (about 100 per day)

1.2 million people aged 13 and older living with HIV

About 45% of young people (13-24 years) living with HIV were unaware of their infection

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## About HIV & AIDS (from HIV Basics, HIV.gov)

(Abbreviated version; see section III above and HIV.gov website for more details)



**HIV (*human immunodeficiency virus*) is a virus that attacks cells that help the body fight infection, making a person more vulnerable to other infections and diseases. If left untreated, HIV can lead to the disease AIDS (*acquired immunodeficiency syndrome*).**

AIDS is the late stage of HIV infection that occurs when the body's immune system is badly damaged because of the virus. The human body can't get rid of HIV and no effective HIV cure exists. So, once you have HIV, you have it for life. However, by taking HIV medicine (called antiretroviral therapy or ART), people with HIV can live long and healthy lives and prevent transmitting HIV to their sexual partners.

**You can only get HIV by coming into direct contact with certain body fluids from a person with HIV** who has a detectable viral load. These fluids are: blood, semen and pre-seminal fluid, rectal fluids, vaginal fluids, breast milk. For transmission to occur, the HIV in these fluids must get into the bloodstream of an HIV-negative person through a mucous membrane (found in the rectum, vagina, mouth, or tip of the penis); open cuts or sores; or by direct injection.

HIV can only be spread through specific activities. In the United States, the most common ways are having vaginal or anal sex with someone who has HIV, and sharing injection drug equipment ("works"), such as needles, with someone who has HIV. Less common ways are from mother to child during pregnancy, birth, or breastfeeding. The use of HIV medicines and other strategies have helped lower the risk of mother-to-child transmission of HIV to 1% or less in the United States.

People with HIV who take HIV medicine daily as prescribed, and get and keep an undetectable viral load, have effectively no risk of transmitting HIV to an HIV-negative partner through sex.

**The only way to know for sure if you have HIV is to get tested.** You can ask your health care provider for an HIV test. Many medical clinics, substance abuse programs, community health centers, and hospitals offer them too. You can also buy a home testing kit at a pharmacy or online.



To find an HIV testing location near you, use the HIV Services Locator (Locator.HIV.gov).

**THINK YOU'VE BEEN EXPOSED TO HIV?**

Get tested **as soon as possible!**



Find an HIV testing site near you:  
[Locator.HIV.gov](https://locator.hiv.gov)



**GET TESTED FOR HIV...**

CDC recommends that **everyone** between the ages of 13 and 64 get tested **at least once**.

People with certain risk factors should get tested more often.



Find an HIV testing site near you:  
[Locator.HIV.gov](https://locator.hiv.gov)





Treatment with HIV medicines can **prevent HIV from developing into AIDS.**

**After you get tested, be sure to learn your test results.** Knowing your HIV status gives you powerful information so you can take steps to keep yourself and your partner and/or baby healthy:

- **If you test positive**, see a doctor as soon as possible so you can take medicine to treat HIV. By taking HIV medicine daily as prescribed, you can make the amount of HIV in your blood (your viral load) very low—so low that a test can't detect it (called an undetectable viral load). Getting and keeping an undetectable viral load is the best thing you can do to stay healthy.
- **If you are pregnant**, you should be tested for HIV so that you can begin treatment if you're HIV-positive. If an HIV-positive woman is treated for HIV early in her pregnancy, the risk of transmitting HIV to her baby can be very low.

There are three stages of HIV infection: (1) acute HIV infection, (2) Clinical latency (also called chronic HIV infection), and (3) AIDS (*acquired immunodeficiency syndrome*).

During acute HIV infection (first 4 weeks or more after infection), be aware that you are at very high risk of transmitting HIV to others. If you think you may have been exposed to HIV, get an HIV test.

Without HIV treatment, people can stay in the chronic HIV infection stage for 10 or 15 years, but some move through this stage faster. If you take HIV medicine every day, exactly as prescribed and get and keep an undetectable viral load, you can protect your health. It's important to see your health care provider regularly to get your viral load checked.

**If you have HIV and you are not on HIV treatment, eventually the virus will weaken your body's immune system and you will progress to AIDS**, which has many severe symptoms and illnesses. This is the late stage of HIV infection.

**ADDITIONAL HIV INFORMATION AND RESOURCES ARE AVAILABLE AT HIV.GOV,**  
<https://www.hiv.gov/hiv-basics>

## **Pastoral Care Guidelines for persons with HIV/AIDS**

*Adapted from "Guidelines for the Giving of Pastoral Care to Those Persons who are Infected/affected by HIV/AIDS" by Rev. Don Nations, Archdiocesan AIDS Resource Manual, Portland, Oregon.*

- 1. Let the individual set the agenda.**
- 2. Confidentiality is a must.**
- 3. Do not ask how someone contracted the virus.**
- 4. Avoid the "Blame Game."**
- 5. Compassion is the key.**
- 6. Confront your own fears.**
- 7. Focus on life, not death.**
- 8. Communicate hope.**
- 9. Affirm the worth of the person.**
- 10. Feel free to show emotion.**
- 11. Remember to touch.**
- 12. Look for the stages of grief.**
- 13. Be aware of psychosocial issues.**
- 14. Expressions of spirituality vary from person to person.**
- 15. Avoid saying, "I know how you feel."**
- 16. Get educated.**
- 17. Pastoral care is usually a long process.**
- 18. Know your limits.**
- 19. Every situation can be used by God for growth as God's people.**
- 20. Doctrine and dogma do not substitute for sharing and love.**

HIV/AIDS has also raised awareness of discrimination and injustice. We as church must condemn as immoral any discrimination in word or action. We come today to seek forgiveness if we--as individuals or as church--are guilty of homophobia, sexism or racism. We commit to the spirituality of our Psalm--asking to see the face of God--especially in those who are ill.

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Discussion:

- Discuss how God is present in pain and death.
- Discussion of your faith, hopes and beliefs.
- Some suggestions for following up on this presentation with community action.

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## **CLOSING PRAYER**

### **MOTHER OF GOD, LIGHT IN ALL DARKNESS**

Mother of God, Light in All Darkness,

Shelter Him, our flame of hope,  
With your tender hands.

And in our times of dread and nightmares,  
Let Him be our dream of comfort.

And in our times of physical pain and  
Suffering,  
Let Him be our healer.

And in our times of separation from God and  
One another let Him be our communion.

AMEN.



# What would Jesus do?

## Summary Handout for teachers/preachers

Fr. Chris Ponnet, Director Catholic HIV/AIDS Ministry Los Angeles Archdiocese



HIV/AIDS poses new challenges for those with HIV/AIDS, as well as their friends. When someone you know becomes ill, especially with a serious illness like HIV/AIDS, you may feel helpless or inadequate. If this person is a good friend you may say, "Just call if you need anything". Then, out of fear or insecurity, you may dread the call if it comes. Here are some thoughts and suggestions that may help you:

1. Try not to avoid your friend. Be there – it instills hope
2. Touch your friend. A simple squeeze of the hand or a hug shows you care.
3. Call and ask if it is okay to come for a visit. Let your friend make the decision
4. Respond to your friend's emotions. Weeping and laughing is okay.
5. Call and say you would like to bring a favorite dish. Ask. Share a meal.
6. Go for a walk or outing, but ask about and know your friend's limitations.
7. Offer to help answer any correspondence.
8. Call your friend and find out if anything is needed from the store-make a list.
9. Celebrate holidays and life with your friend by offering to decorate the room
10. Check in with your friend's family, lover, care-partner, or roommate.
11. Your friend may be a parent. Ask about the children. Offer to bring them to visit.
12. Be creative by bring books, periodicals, taped music, a poster for the wall, etc.
13. It is okay to ask about the illness, but be sensitive. Do not pressure.
14. Like everybody else a person with HIV/AIDS can have both good and bad days.
15. You do not always have to talk. It is okay to sit together.
16. Can you take your friend somewhere? Transportation may be needed
17. Tell your friend how good he/she looks, but only if it is realistic. Never lie.
18. Encourage your friend to make decisions. Illness can cause a loss of control.
19. Tell your friend what you would like to do to help. Keep any promises you make.
20. Be prepared for your friend to get angry with you for "no obvious reason".
21. Keep your friend up to date on mutual friends and other common interests.
22. What is in the news? Discuss current events. Help keep your friend connected.
22. Offer to do household chores, perhaps taking out the laundry, etc.
23. Send a card that says simply "I care!"
24. If your friend is religious, ask if you could pray together.
25. Do not lecture or direct your anger at your friend.
26. Help your friend understand any feeling of blame regarding the illness.
27. Remember that by being a friend or lover you are also a part of the family.
26. Do not confuse acceptance of the illness with defeat.
27. Do not allow your friend or the care partner to become isolated.
31. Talk about the future with your friend...tomorrow, next week, next year.
32. Bring a positive attitude. It is catching.
33. Practice active listening with a focus on the patient's story and concerns.

# HIV/AIDS Retreat Format

Fr. Chris Ponnet, Director Catholic HIV/AIDS Ministry Los Angeles Archdiocese



The general retreat model that follows gives you a framework, but must be planned in the context of the group that will participate. Always include stories, sacred texts, quiet and ritual, opportunities to share food, play games, and non-structured interaction. You can include additional presentations, meditation experiences, and holistic health options such as yoga, Taize chant or massage.

## **Preparation activities:**

- Form a retreat team that is diverse, committed and realistic.
- Be clear about the focus, theme and expectations for the retreat.
- Have a realistic budget that takes into account the location, medical, transportation and food expenses.
- The spiritual preparation of the team is just as important as arranging the logistics. The team should meet to pray, listen in stillness to God in all phases of planning.

## **Some helpful tips from people who have conducted these retreats:**

- Team members must participate in a retreat before they can join the team
- Understand that opportunities for rest and fellowship are essential.
- Provide spiritual guides or “buddies” for retreat participants.
- Remember that the team’s goal is to provide time for the participants to reflect on their spiritual needs, not to produce “dramatic moments.”
- Trust the Spirit. If the team and participants listen to the Lord, all will fall into place.

The schedule that follows is designed for a three-day retreat. The components can be shortened for a one-day experience or additional ones can be added for a longer retreat.

## **First Night: Theme setting, listening in quiet to the Spirit.**

- Help participants settle into their rooms. (1 hour)
- Begin with introductions, perhaps a “get to know you” experience. (45 – 60 minutes)
- First formal session: stress retreat theme and the need to listen to the Spirit. Follow with a closing ritual. (1 ½ hours)

## **Second Day:**

- Breakfast. (1 hour)
- First formal session, followed by quiet time for personal reflection and small group discussions. (2 – 2 ½ hours)
- Lunch, followed by afternoon quiet or rest time. (3 hours)
- Second formal session (discussion of medical or spiritual issues). (2 hours)
- Dinner, followed by third formal session and evening activity (e.g., movie, dance).

## **Third Day:**

- Breakfast. (1 hour)
- Formal session on retreat theme and a call to action. (2 – 2 ½ hours).
- Lunch, clean up and departure.

# Model for an Interfaith Service

Fr. Chris Ponnet, Director Catholic HIV/AIDS Ministry Los Angeles Archdiocese



## **Hospitality and greeting: (15 Minutes)**

Serve Refreshments

## **Welcome: (10 Minutes)**

Gathering Song and/or Liturgical Movement

The presider welcomes participants and introduces themes for the service. He or she may introduce any co-sponsors and should also mention the confidential nature of the service.

## **Opening Prayer by leader: (10 Minutes)**

Based on an agreed theme, the Opening Prayer gives focus to the evening. It honors the inclusive nature of the gathering. It can be followed by music or a brief guided meditation.

## **Reading: (20 Minutes)**

The reading should focus on healing, God's love, or life and death. The presider should select a scripture (*e.g.*, the parable of the Good Samaritan, the story of Martha and Mary or Sunday scripture) or perhaps something from the US Bishops' *Call to Compassion* or a document drafted by another congregation's leadership. A brief period of meditation can follow. Participants can then be encouraged to share thoughts about the struggles of those living with HIV/AIDS or memories of those who have died.

## **Litany for the Living: (15 Minutes)**

This is a time to honor the dead. Participants can form a "circle of memory" for those who have died and now live with God.

## **Closing Prayer: (15 Minutes)**

## **Reception:**

Serve additional refreshments. Have materials on hand for support groups, suggested reading lists, etc. Encourage participants to share phone numbers with one another and to sign a contact sheet that parish can use for follow up contacts after the service.

# WORSHIP RESOURCES: HIV/AIDS

## Awareness/Anointing of the Sick Mass

Fr. Chris Ponnet, Director Catholic HIV/AIDS Ministry Los Angeles Archdiocese



The HIV/AIDS Awareness Mass could include such specific items as greeting those living with HIV or AIDS or making special mention in petitions of those living with HIV/AIDS. An after Mass reception could include an information table, a holy hour with a place to put names of those who are living with or who have died of AIDS. The Mass could also be followed by another special event such as a candlelight procession.

Plan to have the ministry team available both before and after Mass to answer questions, distribute information, and offer prayer and support to those who might ask for it.

The Mass will be more meaningful if some concrete actions are taken to heighten awareness of HIV/AIDS. Some examples are:

- Distribute HIV/AIDS ribbons for people to wear.
- Display some panels from an AIDS Quilt.
- Have cards or notes available for people to sign to send to those who are ill. This can be done with the assistance of a local hospice or home health agency.
- Have some options available for follow up activities for those who might be interested. Perhaps a representative from the Red Cross or a hospice could provide information about becoming a volunteer.
- Arrange for a speaker to provide more information and have the date and time ready to announce during the Mass.

### Prayer Suggestions:

*Numbers indicate location in the Catholic Sacramentary. Additional prayers can be found in the Ritual Book.*

- **Liturgy:** Mass of the Holy Spirit (No. 7)
- **Eucharistic Prayer:** Jesus the Compassion of God (IV, Various Needs and Occasions)
- **Preface:** Holy Spirit (No. 34, 37, 40, 41)

■

These Mass texts are taken from *Pastoral Care of the Sick: Rites of Anointing and Viaticum* (1983 edition), nos. 131-148. Other prayers and rites are given there.

### Opening Prayer

Father you raised your Son's cross as the sign of victory and life.

May all who share in his suffering find in these Sacraments a source of fresh courage and healing.

We ask this through our Lord Jesus Christ, your Son, who lives and reigns with you and the Holy Spirit, one God forever and ever.

### **Or:**

God of Compassion, you take every family under your care and know our physical and spiritual needs.

Transform our weakness by the strength of your grace and confirm us in your covenant so that we may grow in faith and love.

We ask this through our Lord Jesus Christ, your Son, who lives and reigns with you and the Holy Spirit, One God forever and ever.

The liturgy of anointing follows the homily.

*Prayer Over the Gifts*

Merciful God, as these simple gifts of bread and wine will be transformed into the risen Lord, so may he unite our suffering with his and cause us to rise to new life.

We ask this through Christ Our Lord.

**Or:**

Lord, we bring you these gifts, to become the health-giving body and blood of your Son.

In his name heal the ills which afflict us and restore to us the joy of life renewed.

We ask this through Christ our Lord.

*Preface*

V. The Lord be with you.

R. And also with you.

V. Lift up your hearts.

R. We lift them up to the Lord.

V. Let us give thanks to the Lord Our God.

R. It is right to give him thanks and praise.

Father, all-powerful and ever-living God, we do well always and everywhere to give you thanks, for you have revealed to us in Christ the healer your unfailing power and steadfast compassion.

In the splendor of his rising your Son conquered suffering and death and bequeathed to us his promise of a new and glorious world, where no bodily pain will afflict us and no anguish of spirit.

Through your gift of the Spirit, you bless us, even now, with comfort and healing, strength and hope, forgiveness and peace.

In this supreme Sacrament of your love you give us the risen body of your Son: a pattern of what we shall become when he returns again at the end of time.

In gladness and joy we unite with the angels and saints in the great canticle of creation,

As we say (sing):

Holy, holy, holy Lord, God of power and might heaven and earth are full of your glory. Hosanna in the highest. Blessed is he who comes in the name of the Lord. Hosanna in the highest.

*Special Intercessions:*

*When Eucharistic Prayer I is used, the special form of "Father, accept this offering..." is said:*

Father, accept this offering from your whole family, and especially from those who ask for healing of body, mind and spirit. Grant us your peace in this life, save us from final damnation, and count us among those you have chosen.

*When Eucharistic Prayer II is used, after the words "and all the clergy," there is added:*

Remember also those who ask for healing in the name of your Son, that they may never cease to praise you for the wonders of your power.

*When Eucharistic Prayer III is used, after the words "the family you have gathered here," there is added:*

Hear especially the prayers of those who ask for healing in the name of your Son, that they may never cease to praise you for the wonders of your power.



Prayer After Communion:

Merciful God, in celebrating these mysteries your people have received the gifts of unity and peace.

Heal the afflicted and make them whole in the name of your only Son, who lives and reigns forever and ever.

**Or:**

Lord, through these Sacraments you offer us the gift of healing. May this grace bear fruit among us and make us strong in your service.

We ask this through Christ our Lord.

Solemn Blessing:

*Then the priest blesses the sick person and others present, using one of the following:*

May the God of consolation bless you in every way and grant you hope all the days of your life. R. AMEN.

May God restore you to health and grant you salvation. R. AMEN.

May God fill your heart with peace and lead you to eternal life. R. AMEN.

May almighty God bless you, the Father, and Son, and the Holy Spirit. R. AMEN.

**Or:**

May the blessing of almighty God, the Father, and the Son, and the Holy Spirit come upon you and remain with you forever. R. AMEN.

Dismissal:

*The deacon (or the priest) then dismisses the people and commends the sick to their care. He may use these or similar words:*

Go in the peace of Christ, to serve him in the sick and in all that need your love.

**Music:**

On Eagles' Wings (Michael Joncas)

Only In God (John Michael Talbot)

Be Not Afraid (Bob Dufford)

Remember Your Love (Darryl Ducote, Gary Daigle)

I will Rise Again (David Haas)

I have Loved You (Michael Joncas)

**Prayers:**

- Merciful God, as these simple gifts of bread and wine will be transformed into the risen Lord, so may he unite our suffering with his and cause us to rise to new life. We ask this through Christ Our Lord.
- Father, all-powerful and ever-living God, we do well always and everywhere to give you thanks, for you have revealed to us in Christ the healer your unfailing power and steadfast Compassion. In the splendor of His rising, your Son conquered suffering and death and bequeathed to us his promise of a new and glorious world, where no bodily pain will afflict us and we will experience no anguish of spirit. Through your gift of the Spirit, you bless us, even now, with comfort and healing, strength, hope, forgiveness, and peace. In this supreme Sacrament of your love you give us the risen body of your Son: a pattern of what we shall become when he returns again at the end of time.
- Merciful God, in celebrating these mysteries your people have received the gifts of unity and peace. Heal the afflicted and make them whole in the name of your only Son, who lives and reigns forever and ever.
- May the God of consolation bless you in every way and grant you hope all the days of your life. AMEN  
May God restore you to health and grant you salvation. AMEN.  
May God fill your heart with peace and lead you to eternal life. AMEN.  
May almighty God bless you, the Father, and Son, and the Holy Spirit. AMEN.

### **Penitential Rite:**

**Leader:** We must acknowledge that the hope now breaking forth for those living with HIV/AIDS through new treatments is both gratifying and thrilling. But we must confess that it is also tragically true that such hope is as yet stillborn for those in much of the developing world.

**People:** The body of Christ has AIDS. Lord, have mercy.

**Leader:** We have seen our sisters and brothers naked and hungry and oppressed due to their HIV antibody status, their color and their economic status both in our society and around the world. And we have too often failed to see Christ in them, much less clothed, fed or liberated them.

**People:** The body of Christ has AIDS. Christ, have mercy.

**Leader:** We have known for years precisely what must be said and done to help people change from behaviors that spread HIV infection, but in our timidity and fear, we have too often failed to tell these truths in love, which can spare our sons and daughters from the scourge of AIDS. **People:** The body of Christ has AIDS. Lord, have mercy.

### **Bible Readings:**

**Hope:** Psalms 22,62, 131, 139; Isaiah 41: 25-31 and 42: 1-9; Matthew 12:15-21

**Light:** Psalms 27; 42:8-43:5; Matthew 5:13-16; Mark 8:16-18

**Healing:** Luke 5:12-14; 6:36-38; 7:11-17; 1 Corinthians 12:12-26

**Children of Light:** Ephesians 8: 14, 19-20; Matthew 8:5-13; 18:1-4; Mark 5:21-23, 35

### **Non-Biblical Readings:**

"Mommy, I want you to know everything. Like how tall I am today, that I really did good with my shot, that I am going home from the hospital, and that I am starting kindergarten next week. I am going to wear my dress that has the flowers on it and is black on my first day of school. Most of all, Mommy, I want you to know that I miss you and that I think about you all the time. I miss you the most when I am crying. I wish I could fly up there to the sky to be with you. I know that you are not sick anymore and I hope that you are happy." *Cassie, age 5*

"I often wonder what will happen to my family because of AIDS. I wish my sister would be all right, but I know she may not be. I wish my mother would start relaxing and not jump to conclusions about my sister so quickly. I wish my mother would continue to feel well. I wish I did not have to lie about my sister's and my mother's health . . . I wish I could just tell the truth." *Melissa, age 13*

The spiritual life of the minister, formed and trained in a school of prayer, is the core of spiritual leadership. When we have lost the vision, we have nothing to show; when we have forgotten the word of God, we have nothing to remember; when we have buried the blueprint of our life, we have nothing to build. But when we keep in touch with the life-giving spirit within us, we can lead people out of their captivity and become hope-giving guides. *Pg. 72 The Living Reminder, Henri Nouwen*

What I would like to leave behind is a simple prayer that each of you may find what I have found—God's special gift to us all: the gift of peace. When we are at peace, we find the freedom to be most fully who we are, even in the worst of times. We let go of what is nonessential and embrace what is essential. We empty ourselves so that God may more fully work within us. And we become instruments in the hands of the Lord...

*Pg.152-153 The Gift of Peace, Joseph Cardinal Bernardin*

### **Prayers of the Faithful:**

**Presider:** My brothers and sister, with faith let us ask the Lord to hear our prayers for those who have come forward.

**Lector:** Lord, through this holy anointing, come and comfort those standing among us with your love and mercy. **ALL:** LORD, hear our prayer.

**Lector:** Free them from all harms. LORD...

**Lector** Relieve the sufferings of all the sick. LORD...

**Lector** Assist all those dedicated to the care of the sick. LORD...

**Lector** Free all from sin and temptation. LORD....

**Lector:** Give life and health to all standing as we lay hands in your name. LORD...

### **Blessing of Holy Oil:**

**Celebrant:** Praise to you, almighty God and Father. You sent your Son to live among us and bring us salvation. BLESSED BE GOD.

**Celebrant** Praise to you, Lord Jesus Christ, the Father's only Son. You humbled yourself to share in our humanity, and you desired to cure all our illness. BLESSED BE GOD.

**Celebrant** Praise to you, God the Holy Spirit, the Consoler. You heal our sickness, with your mighty power. BLESSED BE GOD.

**Celebrant** Lord God, with faith in you our sisters and brothers will be anointed with this holy oil. Ease their sufferings and strengthen them in their weakness. We ask this through Christ our Lord. AMEN.

### **"Who will Break the Silence?"**

*Balm in Gilead (Black Church Week of Prayer)*

O God, be present with us and hear our cries.

We, your people, have been in exile so long. **Response:** Have Mercy O God.

We, your people with HIV/AIDS, have been in exile too long. **Response:** Have Mercy O God.

We mourn our friends and lovers, sisters and brothers. **Response:** Have Mercy O God.

We have been our people lame and blind, weeping and silenced. **Response:** Have Mercy O God.

Mothers are sick and babies are dying; families scattered and men alone. **Response:** Have Mercy O God.

O People, hear God's call. Come with weeping into my presence; I am your God and I will have mercy.

**Response:** Thanks be to God!

Come from far and near; I am your God and I will have mercy. **Response:** Thanks be to God!

Come with singing into my presence; I am your God and I will have mercy. **Response:** Thanks be to God!

Come to be refreshed and filled; I am your God and I will have mercy. **Response:** Thanks be to God!

Come with dancing into my presence; I am your God and I will have mercy. **Response:** Thanks be to God!

### **Sample Homily**

Today throughout the world, HIV/AIDS is a focus of prayer and education.

We gather in prayer to support those living with this virus within our community, families, and the world. We gather to honor the memory of those who have died.

In faith we know that *nothing can separate us from the Love of Christ*. As St. Paul says to us today, *God is Faithful*. Illness of body tends to make us ask questions: where is God? Is God here when I feel alone and abandoned? Where is my life going? What might I change when I get well?

HIV/AIDS has also raised awareness of discrimination and injustice. We as church must condemn as immoral any discrimination in word or action. We come today to seek forgiveness if we--as individuals or as church--are guilty of homophobia, sexism or racism. We commit to the spirituality of our Psalm--asking to see the face of God--especially in those who are ill.

Jesus calls us during this Advent season to be watchful and ready. HIV/AIDS has made us a watchful and ready community--watchful for the cure, waiting for the vaccine, longing for God's direction and the church community to respond. HIV/AIDS has made us a people watchful and ready for death and resurrection--watchful at bedsides, ready to embrace, watchful of the light of resurrection and ready for eternal peace.

*“The Church offers all its members the rich treasury of grace through its Sacramental life. These encounters with Christ in forgiveness, healing, and the restoration of the life of grace are profound moments of conversion and renewal. We encourage all who minister in the Church to bring the full Sacramental life of Christ to those who need to be touched by his healing hand.”*

*US Bishops, **Call to Compassion and Responsibility** (VI, 4)*

**Prepare the Community for your Parish or School Services:**

It is helpful to prepare the community for special liturgies by mentioning them in homilies and parish bulletins a few weeks ahead of time. The following are ideas and suggestions to help your parish make these services your own.

**Pulpit Announcements regarding Archdiocesan Activities:**

1. HIV/AIDS is one killer of our young people. There is information in today's bulletin about our Archdiocese's outreach activities. There are also flyers in the back of the church that provide additional information about the Los Angeles Archdiocese HIV/AIDS Ministry.
2. HIV/AIDS is a medical pandemic. The U. S. Bishops have made clear statements that our Christian response to this virus demands compassion and action to end discrimination against those who suffer from it. The Los Angeles Archdiocese AIDS Council offers training for those persons wishing to lead support groups. It also provides retreats and information speakers for groups as well as spiritual directors for one on one support. The Council staffs retreats for those suffering from HIV and AIDS and links with thousands praying for a cure. Please see today's bulletin for more information about this service.

***For a non-Eucharistic Service:*** Next Sunday we will have a special interfaith service at *(time)* to support those living with and/or affected by HIV/AIDS and honor the memory of those who have died. We invite you to join us as we respond with prayer, education and action.

***For a Mass of the Anointing of the Sick:*** “Who is my neighbor?” is the question put to us in the Bible. Next Saturday at *(time)* our AIDS Ministry will host an Anointing Mass for the elderly, for all who are ill, and for those preparing for surgery. In addition, information about HIV/AIDS will be available after Mass. Please join us.



# How to Create an AIDS Quilt Panel

Fr. Chris Ponnet, Director & Renee Stampolis, Catholic HIV/AIDS Ministry, Los Angeles Archdiocese

AIDS quilts are made in honor memory of those who have died from the complication of AIDS. You do not have to be a professional artist or a sewing expert to create a moving personal tribute. It doesn't matter if you use paint or fine needlework; any remembrance is appropriate. You may choose to create a panel privately as a personal memorial to someone you've loved, but we encourage you to follow the traditions of old fashioned sewing and quilting bees, by including friends, family, and co-workers.

## Design the panel:

- Include the name of the friend or loved one you are remembering.
- Feel free to include additional information such as the dates of birth and death, and a hometown.
- Please limit each panel to one individual.

## Choose your materials:

- Remember that the Quilt is folded and unfolded many times, so durability is crucial.
- A medium-weight, non-stretch fabric such as cotton duck or poplin works best.
- Your design can be vertical or horizontal, but the finished, hemmed panel must be 3 feet by 6 feet (90cm X 180cm)-no more and no less!
- When you cut the fabric, leave an extra 2-3 inches on each side for a hem.
- If you cannot hem it yourself, we will do it for you.
- Batting for the panels is not necessary, but backing is recommended. Backing helps to keep panels clean when they are laid out on the ground. It also helps retain the shape of the fabric.

## Construct your panel (suggested techniques):

- Applique: Sew fabric letters and small mementos onto the background fabric. Do not rely on glue. It will not last.
- Paint: Brush on textile paint or colorfast dye, or use an indelible ink pen. No "puffy" paint; it is too sticky.
- Stencil: Trace your design on to the fabric with a pencil, lift the stencil, then use a brush to apply textile paint or indelible markers.
- Collage: Make sure that whatever materials you add to the panel will not tear the fabric (avoid glass and sequins for this reason), and be sure to avoid very bulky objects.
- Photos: The best way to include photos or letters is to photocopy them onto iron-on transfers, iron them onto 100% cotton fabric and sew that fabric to the panel. You may also put the photo in clear plastic vinyl and sew it to the panel (off-center so it avoids the fold).

**Please take the time** to write a one or two-page letter about the person you have remembered. The letter might include your relationship to him/her, how he or she would like to be remembered, and a favorite memory. If you can, send us a photograph with the letter for our archives. Be sure to include a panel-maker information card with your letter.

**The NAMES Project Foundation:** 204 14th St. NW, Atlanta, GA 30318-5304  
404-688-5500, 404-688-5552  
[www.aidsquilt.org](http://www.aidsquilt.org)

Updated 1.2017

# **SAMPLE HOMILY FOR WORLD AIDS DAY WEEKEND & FIRST SUNDAY OF ADVENT/ WORLD AIDS DAY DEC 1st**

(Isaiah 2:1-5; Ps 122, Romans 13: 11-14; Matthew 24: 37-44)

Fr. Chris Ponnet, Director Catholic HIV/AIDS Ministry Los Angeles Archdiocese

She is a young woman living in fear. She comes to the hospital and clinic with much fear. Her first fear is that her friends at high school will know. She is fearful of the treatment today and the side effects. She is fearful of more pills and she is fearful of dying. She can hardly speak because of the fear. We are called to accompany, to listen, to hold a hand, to bring a message of hope and compassion. She **WAITS** for her friends, her family, her doctors, her church and her cure. With her, we as church live with AIDS. (You might want to use your own story, a testimony of a real person, reference to a testimony after communion or a talk after mass)

Advent is about Waiting and Staying **AWAKE**—with joy. Yet this year we approach Advent in light of the terrorist attack. We have been **AWAKEN** to treasure each moment and the persons in our lives. Those thousands who lost their lives and billions of us as humans affected—were going about life without much reflection—waiting for things like the coffee pot, the subway, the medical report, the next meal, the business reports, the children’s report cards or the next vacation. People now **WAIT** and **AWAKEN** in fear and with the gut experience of not knowing what is coming.

The scriptures remind us that **GOD** has promised: that God **WILL** return, not might, but **GOD** will return. We are called in the second reading to **LIVE** fully knowing that **GOD WILL** return. We are called to treat one another with respect, love, compassion and waiting to encounter **GOD** in the person—**TODAY**.

This weekend throughout the world people honor **WORLD AIDS DAY**. It is a time to remember the millions who have died, the millions living with the virus or with AIDS and the billions affected. We celebrate the interfaith and our own Catholic international, national and local efforts to educate as well as to offer direct assistance—about ¼ of all the funds or efforts over the past 20 years have been done by the Catholic church. But this reality of HIV and AIDS demand of us as a universal church—a local **AND** a global awareness and response. We are asked today to **STAY AWAKE**. (You might look to [AIDS.gov/HIV.gov](http://AIDS.gov/HIV.gov) or [cdc.gov](http://cdc.gov) for the latest facts)

**STAY AWAKE**—to the facts of how this disease is affecting women, children and men. It is affecting all people. It is disproportional in affecting people in economic situations that offer have limited or no health care. It is affecting people of color and married persons as well as single heterosexual or homosexual persons. It is affecting children youth and senior citizens.

**STAY AWAKE**—because the greatest enemy of our to ending HIV/AIDS is silence and fear.

**STAY AWAKE**—so as to offer not words and actions of hatred and discrimination but words and actions of **COMPASSION, SERVICE** and **ADVOCACY**.

**STAY AWAKE**—so as to affirm one another but especially young people in their dignity and in their own coming to terms with their sexuality and addictive needs so as to call us all to responsibility as the second reading speaks: “conducting ourselves properly...putting on the Lord Jesus Christ.”

**STAY AWAKE**—using Advent as a time to not only shop and prepare for expressions of love at Christmas but to come to the Lord in stillness so God may “instruct us in Gods ways, and we may walk in God’s paths.”

**STAY AWAKE**—so that fear does not rule our lives because of terror, war or plagues like HIV/AIDS.

**LET US GO REJOICING TO THE HOUSE OF THE LORD**—because we walk by faith and “in the light of the Lord”. We walk with good medical and global knowledge about HIV/AIDS. We walk with the faces of AIDS in our hearts so we would not think about speaking words of hatred. We walk with the hope for a cure and the truth that each of us **CAN MAKE A DIFFERENCE**. We walk **AWAKEN** and **TRUSTING** like **NOAH** and **JESUS** before us. **STAY AWAKE**.

# **SAMPLE BI-LINGUAL HOMILY WORLD AIDS DAY DEC. 1st / 1<sup>st</sup> SUNDAY OF ADVENT**

Fr. Chris Ponnet, Director Catholic HIV/AIDS Ministry Los Angeles Archdiocese

Today throughout the world HIV/AIDS is a focus of prayer and education.

We gather in prayer to support those living with this virus within our community, families and world and we gather to honor the memory of those who have died.

Today we gather in faith knowing that **NOTHING CAN SEPARATE US FROM THE LOVE OF CHRIST**. As St. Paul says to us today **GOD IS FAITHFUL**. Illness of body tends to make us ask questions: where is God? Is God here when I feel alone and abandoned?

Where is my life going? What might I change when I get well? HIV/AIDS has also raised the question of discrimination and injustice. We as church must continue the work and Christ and the US Bishops who condemned as immoral this discrimination in word or action. We come today to seek forgiveness if we as individuals or as church are guilty of homophobia, sexism or racism. We commit to the spirituality of our Psalm--asking to see the face of God—especially in those who are ill.

Jesus calls us on this first Sunday of Advent to be **WATCHFUL** and **READY**. HIV/AIDS has made us a watchful and ready community—watchful for the cure, waiting for the vaccine, watchful for God's direction and waiting for the church community to respond. HIV/AIDS has made us a people watchful and ready for death and resurrection—watchful at bedsides, ready to embrace, watchful of the light of resurrection and ready for eternal peace.

[Today we join all nations and peoples in committing ourselves to daily prayer—sign up at the side altar with **HEARTS UNITING**. We commit to walking the **POSADA** tonight as we leave this church—to join other faiths in working for the cure. We invite you to sign up at the side altar for more information about our regional AIDS Ministry.] [We commit here at County General to support those living among us with the virus and the work of the 5p21 Clinic]

We go forward with our **FAITHFUL GOD, STRENGTHED 'TIL THE END, WATCHFUL AND READY** for promise of Jesus who is the reason for the sacred season with our universal prayer today for healing of spirit, mind and body.

Hoy en el mundo entero, los grupos de ayuda para el SIDA, se centran en la oracion y formacion, educacion. Nos unimos en oracion para apoyar a todos los que tengan el virus del Sida en nuestra comunidad, en nuestra familia y en el mundo. Tambien recordamos a todos los que han muerto de Sida. Hoy nos unimos en la fe, sabiendo que, como dice Sn. Pablo, **NADA NOS PUEDE SEPARAR DEL AMOR DE CRISTO. DIOS ES FIEL.**

La enfermedad nos hace preguntarnos.

/Donde esta dios? Esta Dios conmigo cuando me siento abandonado?

Hacia donde va mi vida? Que puede cambiar cuando este bien?

La enfermedad del Sida tambien provoca que nos preguntemos acerca de la discriminacion y la injusticia. Nosotros como iglesia debemos continuar el trabajo de Cristo y los Obispos que condenan la discriminacion de palabra o de obra. Hoy pedimos perdon si individualmente o como Iglesia hemos sido



culpables de discriminar a personas de diferente sexo, o raza. Nos comprometemos con la espiritualidad del salmo—pedir ver el rostro de Dios—especialmente en aquellos que se encuentran enfermos.

Jesús, en este primer domingo de Adviento nos llama a estar vigilantes y alerta. La enfermedad del Sida nos ha hecho una comunidad vigilante y alerta. Vigilante para la curación, esperar las vacunas, vigilantes a la venida de Dios y esperando que la comunidad y la iglesia respondan. El Sida nos ha convertido en personas vigilantes para la muerte y la resurrección—vigilantes cerca de la cama del enfermo, listos para el abrazo, vigilantes esperando la luz de la resurrección, listos para la paz eterna.

Hoy nos unimos a todas las naciones y personas del mundo, nos comprometemos a orar todos los días— firmen aquí junto al altar, HEARTS UNITING. Nos comprometemos a caminar en la POSADA cuando salgamos de la iglesia, nos unimos a todas las personas que trabajan para buscar la cura contra el sida.. Los invitamos a buscar más información referente a los ministerios del Sida. Nos comprometemos aquí en el Hospital General para apoyar a los que entre nosotros tienen el virus del sida, quienes trabajan en la clínica 5p21.

Seguimos adelante con nuestra FE EN DIOS FIEL, FORTALECIDOS HASTA EL FIN, VIGILANTES Y LISTOS para la promesa de Jesús quien es la razón en este tiempo sagrado de Adviento con nuestra oración universal, orando para alcanzar la sanación de cuerpo, mente y espíritu.

# V. APPENDIX





## Terms, Definitions, and Calculations Used in CDC HIV Surveillance Publications

<https://www.cdc.gov/hiv/statistics/surveillance/terms.html>

The Centers for Disease Control and Prevention (CDC) collects, analyzes, and disseminates surveillance data on HIV infection and AIDS; these data are the nation's source of timely information on the burden of HIV infection. HIV surveillance data are used by CDC's public health partners in other federal agencies, health departments, nonprofit organizations, and academic institutions to help target prevention efforts, plan for services, and develop policy.

### Background

This fact sheet contains terms, definitions, and methods of calculation that are commonly applied to HIV surveillance data.

Data on HIV infection in the current HIV Surveillance Report reflect the date of diagnosis of HIV infection—not the date of report to CDC.

In the HIV Surveillance Report, CDC publishes data for cases of HIV infection and stage 3 (AIDS). The data include persons with diagnosed HIV infection and those whose infection has been classified as having progressed to stage 3 (AIDS), and have been reported to CDC by state and local health departments through a given point in time. As of April 2008, all 50 states, the District of Columbia, and 6 US dependent areas (American Samoa, Guam, Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands) had implemented confidential name-based HIV infection reporting. Data for the most current year are considered preliminary as they are based on 6 months reporting delay. Due to delays in reporting, CDC recommends allowing for a 12-month reporting delay before including data in trend analyses.

**Adjusted (estimated) data:** The 2015 *HIV Surveillance Report* marked the transition to presenting diagnosis, death, and prevalence data without statistical adjustments for delays in reporting of cases to CDC. CDC periodically assesses the portfolio of the National HIV Surveillance System (NHSS) to determine whether methods and efficiencies in data collection and analysis meet the information needs of the nation. In determining that adjustments for reporting delays were no longer necessary, CDC considered improvements in data quality as a result of the following: availability of additional case information; shorter time for processing duplicates from multiple states; a better system for national data processing. CDC continues to statistically adjust transmission category data by using multiple imputation techniques to account for missing transmission category information in cases reported to CDC.

### Terms, Definitions, and Calculations

#### HIV diagnoses and stage 3 (AIDS) classifications

HIV infection is classified as stage 3 (AIDS) when the immune system of a person infected with HIV becomes severely compromised (measured by CD4 cell count) and/or the person becomes ill with an opportunistic infection. In the absence of treatment, AIDS usually develops 8 to 10 years after initial HIV infection; with early HIV diagnosis and treatment, this may be delayed by many years. With the release of the [\*Revised Surveillance Case Definition for HIV Infection — United States, 2014\*](#), CDC now uses a stage system to describe HIV infection (see Stage of Disease).

**Diagnoses of HIV infection and deaths of persons with diagnosed HIV infection** are the number of persons diagnosed with HIV infection and the number of persons with a diagnosed HIV infection who have died in a given time period, respectively. Note that diagnoses of HIV infection are regardless of stage of disease at diagnosis (that is, persons diagnosed with HIV infection who have not progressed to stage 3 (AIDS); persons who were diagnosed with HIV infection and classified as stage 3 (AIDS) at the same time; and persons who were diagnosed with HIV infection that later received a stage (3) classification. Also note that deaths of persons with a diagnosis of HIV infection may be due to any cause (i.e., the death may or may not be related to HIV infection). Other systems, such as the National Vital Statistics Reports, provide data on HIV infection as a cause of death in the US population.

To provide the reader with a more accurate understanding of the number of persons diagnosed with HIV infection who have died, CDC includes in its surveillance report data on persons diagnosed with HIV infection regardless of the stage of disease at death, which includes persons with infection that may have been classified as stage 3 at the time of death.

**Stage 3 (AIDS) and deaths of persons with infection ever classified as stage 3 (AIDS)** are the number of persons with infection classified as stage 3 (AIDS) and the number of persons with infection ever classified as stage 3 (AIDS) who have died in a given time period, respectively. Note that deaths of persons with infection ever classified as stage 3 can be due to any cause (i.e., the death may or may not be related to HIV infection), and the category is therefore different from the designation deaths due to AIDS.

***Uses of these data:*** Diagnoses of HIV infection (including stage 3 classifications), and death data provide trends of the burden of disease and are useful for tracking the time from a diagnosis of HIV infection to a stage 3 classification or death. Disparities between populations in the time from HIV infection diagnoses to stage 3 classifications or time to death underscore inequities in access to testing and care; this knowledge can help direct resource allocation.

### **HIV incidence**

In general, HIV incidence is expressed as the estimated number of persons newly infected with HIV during a specified time period (e.g., a year), or as a rate calculated by dividing the estimated number of persons newly infected with HIV during a specified time period by the number of persons at risk for HIV infection.

It is important to understand the difference between HIV incidence and new diagnoses of HIV infection. HIV incidence refers to persons newly infected with HIV, whereas individuals newly diagnosed with HIV may have been infected years before being diagnosed.

***Uses of these data:*** Incidence estimates are useful for planning and for allocating of funds, as well as evaluating the impact of prevention programs.

### **Persons living with diagnosed HIV infection or infection ever classified as stage 3 (AIDS)**

These terms denote the number of persons in the 50 states and 6 US dependent areas who have received a diagnosis of HIV infection and are still alive, or the number of persons with infection that has been classified as stage 3, and are still alive.

The data in the HIV Surveillance Report represent the number of persons living with HIV infection who have been diagnosed, have been reported to the HIV surveillance system, and have not been reported as deceased.

### **HIV prevalence**

The number of persons living with HIV disease at a given time regardless of the time of infection, whether the person has received a diagnosis (aware of infection), or the stage of HIV disease. Although prevalence does not indicate how long a person has had a disease, it can be used to estimate the probability that a person selected at random from a population will have the disease. CDC reports prevalence as the number of persons living with HIV infection in a given population at a given time and also reports prevalence rates, calculated per 100,000 population.

**Uses of these data:** Prevalence is useful for planning and resource allocation, as it reflects the number of people currently needing care and treatment services for HIV infection. Prevalence rates are useful for comparing HIV disease between populations and for monitoring trends over time.

### **Rate**

A measure of the frequency of an event compared with the number of persons at risk for the event. Rates are calculated by dividing the number of events (numerator) by the size of the population (denominator) and including a measure of time. When comparing rates between populations, it is typical to standardize the denominator in order to make direct comparisons. This standardization will depend on the magnitude of the local surveillance data—for national data, the population size is most often standardized to 100,000.

- **Incidence rate:** a measure of the frequency with which new cases of illness, injury, or other health condition occur, expressed explicitly per a time frame. Incidence rate is calculated as the number of new cases during a specified period divided either by the average population (usually mid-period) or by the cumulative person-time the population was at risk.
- **Prevalence rate:** the proportion of a population that has a particular disease, injury, other health condition, or attribute at a specified point in time or during a specified period.

### **Percentage**

A proportion of the whole, in which the whole is 100.

### **Proportion**

A portion of a population or a data set, usually expressed as a decimal fraction (e.g., 0.2), a fraction (1/5), or a percentage of the population (20%) or of the data set.

### **Stage of disease**

In April 2014, CDC published the [\*Revised Surveillance Case Definition for HIV Infection — United States, 2014\*](#). This surveillance case definition revises and combines the surveillance case definitions for human immunodeficiency virus (HIV) infection into a single case definition for persons of all ages (i.e., adults and adolescents aged  $\geq 13$  years and children aged 13 years). The revisions were made to address multiple issues, the most important of which was the need to adapt to recent changes in diagnostic criteria.

Laboratory criteria for defining a confirmed case now accommodate new multitest algorithms, including criteria for differentiating between HIV-1 and HIV-2 infection and for recognizing early HIV infection. The surveillance case definition is intended primarily for monitoring the HIV infection burden and planning for prevention and care on a population level, not as a basis for clinical decisions for individual patients.

A confirmed case can be classified in one of five HIV infection stages (0, 1, 2, 3, or unknown):

If there was a negative HIV test within 6 months of the first HIV infection diagnosis, the stage is 0, and remains 0 until 6 months after diagnosis.

- A. Otherwise, if a stage-3-defining opportunistic illness has been diagnosed, the stage is 3.
- B. Otherwise, the stage is determined by the CD4 test immunologic criteria shown in the following table:

**Table. HIV infection stage, based on age-specific CD4+ T-lymphocyte count or CD4+ T-lymphocyte percentage of total lymphocytes\***

| Stage* | Age on date of CD4 T-lymphocyte test |           |                |           |                       |           |
|--------|--------------------------------------|-----------|----------------|-----------|-----------------------|-----------|
|        | <1 year                              |           | 1—5 years      |           | 6 years through adult |           |
|        | Cells/ $\mu$ L                       | %         | Cells/ $\mu$ L | %         | Cells/ $\mu$ L        | %         |
| 1      | $\geq 1,500$                         | $\geq 34$ | $\geq 1,000$   | $\geq 30$ | $\geq 500$            | $\geq 26$ |
| 2      | 750—1,499                            | 26—33     | 500—999        | 22—29     | 200—499               | 14—25     |
| 3      | <750                                 | <26       | <500           | <22       | <200                  | <14       |

\*The stage is based primarily on the CD4+ T-lymphocyte count; the CD4+ T-lymphocyte count takes precedence over the CD4 T-lymphocyte percentage, and the percentage is considered only if the count is missing.

- C. If none of the above apply (e.g., because of missing information on CD4 test results), the stage is U (unknown).

### Transmission category

The term for summarizing the multiple risk factors that a person may have had by selecting the one most likely to have resulted in HIV transmission. For surveillance purposes, persons with more than one reported risk factor are classified in the transmission category listed first in the hierarchy and therefore counted only once. The exception is men who report sexual contact with other men *and* injection drug use; this group makes up a separate transmission category. Due to the large number of cases reported without transmission category information, transmission category data are statistically adjusted using multiple imputation techniques to account for missing transmission category information in cases reported to CDC.

- **Male-to-male sexual contact:** Persons whose transmission category is classified as male-to-male sexual contact include men who had sexual contact with other men (i.e., homosexual contact) and men who had sexual contact with both men and women (i.e., bisexual contact).

- **Heterosexual contact:** Persons whose transmission category is classified as heterosexual contact are persons who had heterosexual contact with a person known to have, or to be at high risk for, HIV infection (e.g., an injection drug user or a man who has sex with men).
- **Injection drug use:** Persons whose transmission category is classified as injection drug use are persons who received an injection, either self-administered or given by another person, of a drug that was not prescribed by a physician for this person. The drug itself is not the source of the HIV infection, but rather the sharing of syringes or other injection equipment (e.g., cookers and cottons), which can result in transmission of bloodborne pathogens, such as HIV.
- **Male-to-male sexual contact and injection drug use:** Persons whose transmission category is classified as male-to-male sexual contact and injection drug use include men who had injected drugs as well as had sexual contact with other men or sexual contact with both men and women.

## Additional Resources

- CDC-INFO 1-800-CDC-INFO (232-4636) <https://wwwn.cdc.gov/dcs/ContactUs/Form>
- CDC HIV Website <https://www.cdc.gov/hiv/default.html>
- CDC *Let's Stop HIV Together* Campaigns <https://www.cdc.gov/stophivtogether/index.html>
- CDC HIV Risk Reduction Tool(BETA) <https://wwwn.cdc.gov/hivrisk/>
- Find Testing Sites Near You <https://gettested.cdc.gov/>

<https://www.cdc.gov/hiv/statistics/surveillance/terms.html> accessed August, 2020

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# **Networking Information**

## **CATHOLIC RESOURCES**

### **Catholic HIV/AIDS Ministry Los Angeles Archdiocese**

1911 Zonal Avenue, Los Angeles, CA 90033

Office/Fr. Chris Ponnet: 323-225-4461 x221; Fax: 323-225-9096

Information: 213-637-7HIV

Spanish language information/Manuel Torres: 323-225-4461 x124

[www.stcamilluscenter.org](http://www.stcamilluscenter.org)

### **Caritas Internationalis**

Palazzo San Calisto Vatican City State V-00120

Reception Desk: + 39 06 698 797 99; Fax: + 39 06 698 872 37

Email: [caritas.internationalis@caritas.va](mailto:caritas.internationalis@caritas.va)

<https://www.caritas.org/>

<https://twitter.com/iamcaritas> <https://www.facebook.com/pages/Caritas/63820026592>

### **Catholic Relief Services**

228 W. Lexington St. Baltimore, Maryland 21201-3443

877-435-7277

Email: [info@crs.org](mailto:info@crs.org)

[www.crs.org](http://www.crs.org)

### **Catholic Charities USA**

1731 King St. Suite 2000 Alexandria VA 22314

703-549-1390

[www.catholiccharitiesusa.org](http://www.catholiccharitiesusa.org)

### **Office of Religious Education, Archdiocese of Los Angeles**

3424 Wilshire Boulevard, 4th floor

Los Angeles, CA 90010-2241

<http://www.la-archdiocese.org/org/ore>

## **COMMUNITY/NATIONAL RESOURCES**

**AIDS Project Los Angeles (APLA) / AIDS WALK** [www.aplahealth.org](http://www.aplahealth.org)

**AIDS Health Foundation (AHF)** [www.aidshealth.org](http://www.aidshealth.org)

**AIDS info (National Institutes of Health)** 1-800-HIV-0440 (1-800-448-0440) <http://www.aidsinfo.nih.gov/>

[twitter.com/AIDSinfo](https://twitter.com/AIDSinfo) [facebook.com/AIDSinfo](https://www.facebook.com/AIDSinfo)

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<https://www.facebook.com/bienestarla/>

**Centers for Disease Control and Prevention** [www.cdc.gov](http://www.cdc.gov)

**CDC-INFO** 800-CDC-INFO (1-800-232-4636) <http://www.cdc.gov/cdc-info/>

<https://twitter.com/CDCgov> <https://www.facebook.com/CDC>

**Joint United Nations Programme on HIV/AIDS** [www.unaids.org](http://www.unaids.org)

<http://twitter.com/unaids> <http://www.facebook.com/UNAIDS>

**Los Angeles AIDS Commission** [www.hiv.lacounty.gov](http://www.hiv.lacounty.gov)

**National HIV Hotline: 800-342-2437**

**U.S. Department of Health and Human Services** [www.hhs.gov](http://www.hhs.gov)