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INTRODUCTION

The heavy toll that HIV/AIDS has taken on human lives and its socio-economic impact on several nations has made it an issue of global concern. Sub-Saharan Africa, which has just over 10% of the world's population, now has over 60% of all HIV infections in the world. In 2005, an estimated 3.2 million people in the region became newly infected, while 2.4 million adults and children died of AIDS (UNAIDS· 2005). The worst hit countries are in Southern Africa, characterized as the 'epicenter of the global AIDS epidemic' (Ibid). There, some national prevalence rates are over 30% (Botswana, Zimbabwe, Lesotho, and Swaziland). While Nigeria's prevalence rate of 5.0% (FMOH 2003) is lower than those of many other African countries, it nonetheless represents a higher number of infections due to its large population of 137 million people. Presently, Nigeria has the third largest number of infected people in the world (3.5 – 3.8 million) after India and South Africa (UNAIDS 2005).

Although the first reported AIDS case in Nigeria was in 1986, government did not seriously commit itself to battling the virus until over a decade later. This was largely

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due to the lack of interest demonstrated by Nigerian military rulers on the issue of HIV/AIDS. Active governmental response only started in 2000 when a multi-sectoral approach was inaugurated. This response has been stepped up dramatically since 2003 with what appears to be a stronger political commitment on the part of the country's leadership. Meanwhile, government has repeatedly called on faith-based organizations, among other groups and stake-holders to support its anti-HIV/AIDS crusade.

This study analyses the response of the Christian section of the Nigerian faith community to this call and to the reality of the epidemic around them. It observes that while some Christian organizations and churches have started to respond positively to the situation by showing concern and by devising meaningful interventions, others are still very judgmental and uninvolved. The paradigm of 'spiritual capital' is used here to capture the uniquely faith-based nature of the spiritual resource that underlies this positive response emanating from the faith community. Although this spiritual capital cannot be measured in precise scientific terms, its impact on its beneficiaries is nonetheless profound and transformative. And when placed within the wider multi-sectoral response to the HIV/AIDS crisis, it represents an invaluable contribution of the faith community in complementing the efforts of other secular groups. While this study calls on other Christian bodies and congregations to shed their prejudices and join in the anti-HIV/AIDS battle, it also emphasizes the necessity for faith groups to cooperate and network with other bodies involved in the same cause.

This work is divided into five parts. The first part provides a background of the Nigerian HIV/AIDS situation. The second discusses the concept of 'Spiritual Capital' and its applicability to the Christian fight against HIV/AIDS.

The third accounts for the change in attitude of some churches from silence to concern. The next segment analyses three levels of Christian involvement in the anti-AIDS battle, namely, the prevention campaign, the provision of care and support, and the mitigation of the socio-political and economic impact of the epidemic using three case studies. Next is an assessment of the effectiveness of these interventions and a conclusion that highlights the benefits of networking and cooperation with other stakeholders even as more Christian bodies join the anti-AIDS battle.

THE NIGERIAN HIV/AIDS SITUATION

Since 1986 when the first HIV case was reported in Nigeria, the virus has spread gradually. The first national sero-prevalence sentinel survey carried out in 1991 recorded a prevalence rate of 1.8%. In 1996, this rose to 4.5% and peaked at 5.8% in 2001. The last survey carried out in 2003 gave a prevalence of 5.0% (FMOH 2003). This last rate may not necessarily indicate a reduction in the epidemic until it is confirmed by another survey. Moreover, the observation of UNAIDS about the nature of the African AIDS epidemic appears to hold true for Nigeria. According to the 2004 UNAIDS Report, "the AIDS epidemics coursing through this region [sub-Saharan Africa] are highly varied .... It is therefore inaccurate to speak of a single 'African' epidemic ...." (UNAIDS: AIDS Epidemic Update 2004). What this implies is that the national prevalence rates do not reflect the intensity of the epidemic in particular states of the Nigerian federation. The 2003 sentinel survey revealed pockets of intense epidemics in some states. For example, while the national prevalence was 5.0%, Cross Rivers State had 12.0%, Benue State 9.3% and the Federal Capital Territory (FCT) had 8.4%. In fact,

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

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

The third phase, which could be dated from 2000 roughly, corresponded with the inauguration of democracy in Nigeria (1999 till date). Under the leadership of President Olusegun Obasanjo, a multi-sectoral approach to the management of HIV/AIDS was inaugurated in 2000 (even though it had been endorsed in 1997). This was followed by the establishment of a Presidential Committee

on AIDS and a National Action Committee on AIDS (NACA) with nationwide branches. A three-year HIV/AIDS Emergency Action Plan was initiated in 2001 and implemented in partnership with NGOs, Community-based Organizations (CBOs), Faith-based Organizations (FBOs), and People Living with HIV/AIDS (PLWHAs). The Emergency Plan was succeeded in 2005 by a five-year strategic plan (2005-2009). Due to the increasing political commitment to the HIV/AIDS cause, Nigeria began to attract technical and financial support from several international donors such as UNAIDS, Family Health International (FHI), United States Agency for International Development (USAIDS), the World Bank, and the Global Fund to Fight AIDS, Malaria and Tuberculosis and lately, the US President's Emergency Plan for AIDS Relief (PEPFAR).

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

In January 2006, government announced free treatments and its plans to extend ARVs to a total of 250,000 people within a six-month period[2].

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

Initial public response to HIV/AIDS in Nigeria was also characterized by denial. It was regarded as a disease of 'white people' and of 'homosexuals'. As more people tested positive to the virus, the idea started to make the rounds that it was a disease of the sexually 'promiscuous' and 'immoral'. This fueled the stigmatization of PLWHAs, which in turn found expression in several acts of discrimination. While it is true that about 85% of HIV infections in Nigeria are contracted through heterosexual activities, government and NGOs have continued to enlighten the populace on other sources of infection such as the sharing of unsterilised piercing instruments and needles, transfusion of infected blood and mother-to-child transmission. As public awareness campaigns were intensified, A few members of the literate public began to change their attitude to PLWHAs, but the general situation in the country is still one of stigmatization and discrimination. Many PLWHAs have defied this by publicly announcing their HIV status, thus breaking the

silence surrounding the infection[3]. Such individuals have subsequently spearheaded the formation of strong PLWHA support groups through which they collectively fight for their rights and lobby the government to pay more attention to issues relating to HIV/AIDS such as the discouragement of discrimination and the provision of ARVs. These groups have become strong advocacy instruments and they include: Network of People Living with HIV/AIDS in Nigeria (NEPWAN), Positive Action for Treatment Access (PATA), AIDS Alliance of Nigeria (AAN), and Positive Life Association of Nigeria (PLAN).

SPIRITUAL CAPITAL

The concept of spiritual capital recently emerged in Western social science literature as an analytical tool with which to investigate the complex role of religion in human communities. While the investigation was first concerned with what experts called 'religious capital' (Iannaccone 1990), research efforts gradually gravitated from ritual measures of religion (such as church affiliation, frequency of prayer, church attendance etc) to considerations of intrinsic spirituality. This shift also coincided with debates on the difference between 'religiosity' and 'spirituality' (Marler and Hadaway 2002). Meanwhile, the question of the impact of religion, faith or spirituality on the lives of the disadvantaged and sick also caught the attention of public health experts. Lynne Friedli (2001), for example, worked on the role of faith communities in promoting mental health. These latter concerns have become increasingly relevant in the context of HIV/AIDS with the necessity to involve various communities in a multi-sectoral battle against the epidemic (Phiri et al 2003; Dube and Kanyoro 2004).

With these developments, scholars, appropriating the logic and language of social capital, began to view faith and its accoutrements as a form of spiritual capital, while at the same time sensitive to the peculiarity of the spiritual context. This has given rise to several definitions of spiritual capital, which range from those that emphasize its materialist connotations to those that bemoan its intangible nature. There is even a novel definition offered by Zohar and Marshall (2005) that has no connection with religion or any belief system, but is purely a secular discourse in which spirituality is seen as "meaning, values and fundamental purposes". On the other hand, in a trenchant discussion of the works of Pierre Bourdieu on religion, Bradford Verter constructed a model for spiritual capital even though the latter did not use that particular terminology. According to this model, spiritual capital is a "widely diffused commodity, governed by complex patterns of production, distribution, exchange and consumption" (Verter 2003:158). It exists in three states: the embodied state, the objectified state, and the institutionalized state; it interacts with other forms of capital, has a labor value and is considered a 'valuable asset' if strategically invested. While the language here is that of economics with a marketplace orientation, the focus is thus inevitably materialistic and individualistic. The consequence of this is to make this model of spiritual capital unrecognizable in other cultural contexts where sharp lines are drawn between economic and spiritual matters.

Robert Woodberry, in an approach that is not totally devoid of economic undertones, considers spiritual capital a useful metaphor that presents religion as a resource from which people draw to meet several challenges such as sickness, political oppression, ethical choices or social

problems (Woodberry 2003). As a spiritual resource, the contents of spiritual capital vary from one culture to another. These may include: moral teaching, experiences of the divine, conviction of 'sin', and the power inherent in religious rituals such as the Catholic Eucharist etc. These elements are hard to explain with existing theoretical concepts. Woodberry is however optimistic that important insights could be yielded if scholars are able to develop tools for spiritual 'accounting' with 'appropriate nuance and recognition of the complexity of, and barriers to the quantification of those aspects of life that are intractably intangible' (Woodberry 2003).

Apart from religious capital, social capital is another form of symbolic capital that resonates with spiritual capital. Social capital has been defined by many scholars such as Bourdieu, Coleman, Putnam and several others. Despite variations in details of application, the consensus is growing in the literature that social capital represents the quantity and quality of resources (individual, group or community) that individuals can access through membership in social networks or other social structures (Portes 1998; Iannaccone 2003). This implies that social capital inheres in the relations among persons, and like other forms of capital, it facilitates productive activity. These social relations are held together by trust and shared ethical values (Fukuyama 1995). In the USA, Putnam has identified faith communities in which people worship together, as the single most important repository of social capital (Putnam 2000). This has led to several studies of the manner in which American Christian denominations and other religious organizations have generated and dispensed social capital.

In a very recent work, Heidi Unruh and Ronald Sider (2005) explore the religious dynamics of church-

based community ministries in the USA and its implication for religious social activism. While there is thus an increasing optimism on the social capital potential of churches, there has also been an awareness of the fact that the production of social action is not the primary duty of the church. In the words of Don Browning:

> It is dangerous to think of churches in terms of social capital. Churches are carriers of religious stories that reveal God's will and grace. Salvation, not the increase of social capital is the primary purpose of churches and their narratives .... Christians do not live the Christian life to produce social capital but it appears that increased social capital is a long-term, secondary consequence of Christian life (Quoted in Coleman 2003).

The flip side of the warning contained in the above passage is that there is a lot going on in churches that cannot be captured by the concept of social capital. Therefore the need for another interpretive grid has brought to the fore the concept of spiritual capital. The usefulness of the concept of spiritual capital could also be seen in the opportunity it offers to address another major limitation of the social capital concept. Alejandro Portes identified four negative consequences of social capital, principal among which is the exclusion of outsiders from the social networks that breed social capital. In his words, "the strong ties that bring benefits to members of a group commonly enable it to bar others from access" (Portes 1998: 15).

Because spiritual capital transcends the boundaries of social networks and is focused on 'outreach', it therefore holds the promise of reaching out to people who do not necessarily belong in the churches' traditional orbit.

Spiritual capital is here conceived as a vital resource generated within the faith-based community and dispensed to others within and outside it. This resource is an assemblage of spiritual gifts, pneumatic endowments and charismata, experiences of the divine, power evoked by religious rituals and other virtues in a person's demeanor that enhance the discharge of his or her responsibility as a good Christian or (if a leader) as a faithful leader. The major anchor here is faith in God, which could be demonstrated as overt acts of service or covert acts of personal piety. While this resource could be perceived at the personal level, it could also be seen as a collective grace located within the faith-based community. Spiritual capital is derivable from a major source, namely, through encounters of the divine mediated through acts of worship, prayer, meditation or study of the Scriptures. This could range from experiences garnered during personal devotions to collective encounters in a congregational context. Like other forms of capital, it takes time to accumulate, but unlike them, the more it is dispensed, the more it is replenished.

Despite the optimism of scholars like Woodberry that 'accounting' tools for measuring spiritual capital might someday be devised, its major characteristic remains its unquantifiable and intangible nature. Thus, while the intensity and variety of its manifestation continue to evade clinical measurements, a starting point for social scientists keen on 'quantification' might be to evaluate other socio-economic activities enhanced by a person's encounter with spiritual capital. Alternatively, its impact on a section of

society in terms of improved mental (and physical?) health might also be studied. At the experiential level, spiritual capital produces fulfillment in persons and congregations that have shared their own stock with others, and it is most 'visible' (read experienced) when it flows as acts of Christian service or ministry to others. Another effect of spiritual capital when dispensed through ministry acts to others is healing – emotional, mental (and in some cases), physical healing. It creates a feeling of wholesomeness and its beneficiaries can thereafter meaningfully access social networks from which they might have hitherto been excluded.

A major limitation on the concept of spiritual capital is when it is conceived as grace to be dispensed as a matter of duty (obligation), and not driven by love. This 'obligation mentality' creates an 'us' versus 'them' dichotomy, which may reduce Christian service into a mechanical and patronizing exercise. A way out is to adopt a theological anthropology that celebrates the dignity of all human beings whether or not they are inside the church, and also adopt a humble and loving attitude in dealing with them (Cimperman 2005). Another potential abuse of spiritual capital is 'simony', which is the act of merchandising spiritual gifts, and using them for personal profit. This is an act of 'squandering', and spiritual capital thus poorly invested may lead to personal ruin (Verter 2003: 169; cf Woodberry 2003: 3).

These shortcomings notwithstanding, the concept of spiritual capital is particularly relevant in our analysis of the reaction of some Christian bodies in Nigeria to the HIV/AIDS epidemic because the vast number of people suffering from the infection need a touch of affective care and love, which the church claims it possesses but which has not been forthcoming from the legalistic structures of

religious capital. Moreover, when applied to Nigeria, the concept of spiritual capital becomes highly nuanced depending on which Christian groups are being examined. For example, while mainline churches generally emphasise love and care as spiritual virtues to be dispensed, Pentecostals/Charismatics on the other hand, generally emphasize divine or faith healing, spectacular demonstrations of 'Holy Ghost' power and its 'anointing'. This, however, is not an attempt at stereotyping. The pendulum sometimes swings either way. The focus here is to assess the quality of Christian service that flows out of the spiritual reservoir of the faith community free of dogmatic fetters. Thus while the concept of spiritual capital has been previously utilized in the context of Western studies, it is here applied to Nigeria, a developing nation, characterized by poverty, in which almost four million people are infected by the HIV virus, and where churches are becoming increasingly popular.

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FROM SILENCE TO CONCERN

The current concern shown by some churches about the deepening HIV/AIDS situation in the country did not develop overnight. It was prefaced by an initial denial, which transformed to stigmatization, and later softened to concern. In the early 1990s, when more cases of the infection were identified, religious leaders began to preach against it, characterizing it as the disease of 'sexual sinners'. In a 1994 study, I.O. Orubuloye et al reported that both Christian and Muslim leaders in Nigeria regarded AIDS as a divine punishment for 'sexual transgressions' (Orubuloye 1994; Chepkwony 2004:56-59). By the end of the decade, a handful of churches had had a rethink about their stance and were already favorably disposed to the cause of the infected. Meanwhile, others had become quite

vociferous in their condemnation of PLWHAs. A common practice among both mainline and Pentecostal churches at this time was to demand HIV-free medical certificates from intending couples before their marriages were solemnized (Guardian [Lagos], May 1, 2000; May 1, 2001). This act of institutional discrimination further reinforced the stigma associated with HIV/AIDS in the society as the doors of many churches were closed to PLWHAs. It also strengthened the dichotomy between 'saints' and 'sinners' (cf. Kamaara 2004: 42-46).

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

Three major developments however, made several churches to soften their hard position on the issue of HIV/AIDS within the last five years. First, church leaders

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

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

congregation. A brief introduction to each of them is contained in the following paragraphs.

HWWN is a subsidiary of Hope Worldwide, which is an international, faith-based NGO affiliated with the International Churches of Christ (ICOC) with headquarters in Los Angeles, California. The Hope network got to Africa in 1991 and by 2005 had branches in twenty-five African countries (HWW 2005). HWWN was incorporated in 1996 and has since established its presence in eight states of the federation with Lagos as its headquarters. The Lagos branch of the International Churches of Christ, called the Lagos Christian Church (LCC) coordinates other ICOC branches in Nigeria and mobilizes congregational support for the activities of HWWN. The main thrust of the activities of HWWN is to battle HIV/AIDS.

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

The Catholic Church is the oldest Christian denomination in Nigeria, having first been introduced in the 15th century to Warri, in the Niger Delta. However, it was in the 19th century that it became firmly established.

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

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

AREAS OF CHRISTIAN INTERVENTION

Prevention Campaign

FBO strategies for preventing further spread of HIV rest on three legs. First is the reduction of stigma and the breaking of the silence in the churches. Second is the creation of awareness within churches, while the third is the promotion of behavioral change. The first two are closely

related, and in fact go hand in hand. The first few years of RAPAC's existence, for instance, were spent organizing sensitization seminars to educate first the pastors, and later the laity on the reality of HIV/AIDS. RAPAC campaigned against stigmatization of PLWHAs in the church by invoking the love of Christ and appealing to members to demonstrate Christian virtues in their dealings with the infected (Adeboye 2006). Discrimination against PLWHAs was most effective in small settings such as the home fellowship and cell groups, and within very small congregations where people knew one another well. The following experience of Sister Agnes (not real name) who is a 'worker' (an active member) in an RCCG parish illustrates the point:

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

The LCC on its own part, also raised awareness about HIV/AIDS in its congregation by educating members on how the virus is contracted, how it could be avoided and treated. However, all these amounted to nothing more than intellectual awareness. What actually broke the ice in the

LCC was the personal testimony of members living with HIV, who had been flown in from a sister church in South Africa to train counselors for the church in Lagos. This singular act gave the virus a human face. It transferred HIV/AIDS from a nebulous, distant infection to an undeniable personal reality. The Catholic Church also started by training clergy in eight Dioceses to create awareness about HIV/AIDS, and to enable the priests initiate discussions on it from the pulpit. Local Parish Action Committees on AIDS (PACAs) also organized seminars and invited resource persons to educate parishioners on HIV/AIDS

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

device. While the LCC frowns on pre-marital sex and does not promote condom use among the youth in the church, HWWN openly advocates it among the youth with whom it works outside the church.

The attitude of HWWN to condom use is quite understandable because, of the three groups it is the only one that has taken its prevention campaign beyond the church congregation to public schools. It is also part of an international FBO that has considerable experience in HIV/AIDS work in the wider society. In 2001, HWWN started a prevention program in eleven tertiary institutions in Lagos State with funding from USAID and FHI. This was scaled up in 2003 to include all Senior Secondary Schools in Epe Local Government Area of Lagos State (HWWN 2005). It is within this context that it proclaimed the condom message. RAPAC, on the other hand provides sexuality education within the RCCG, and in other churches to which it is invited. The aim of this sexuality education is to equip adolescents and teens with skills that they need to practice abstinence. It also seeks to foster effective parent/child education. The approach of the RCCG is also to mainstream HIV/AIDS into existing church programs. Church drama groups disseminate information on HIV/AIDS during performances. Modules on HIV/AIDS have also been built into the syllabus of the RCCG Bible College (cf. Dube 2003). And during large convocations of the RCCG held at the international headquarters – the Redemption Camp- RAPAC mounts information stands where it gives out literature on HIV/AIDS and offers interpersonal counseling (Adeboye 2006). There is also a media campaign in which the General Overseer of the RCCG, E.A. Adeboye, appears on national television in a three-minute advert, giving tips on

HIV prevention and appealing to the public to rise up and kick out the virus from the nation.

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

Treatment and Care

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

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

institutions (medical, educational etc). And according to the Church, "members of staff of Catholic institutions who become HIV infected or develop AIDS shall retain their rights to employment" (Catholic HIV Policy 2002).

Post-test counseling is also very crucial because it assists the individual concerned to overcome stigmatization and to make good choices about himself and the society. Will he embrace grief and dejection or live positively with the infection? Will he wallow in self-pity or join the community's battle against HIV? Will he take responsible steps to prevent infecting others or go crazy with anger and try to pass on the infection? These are some of the issues raised during counseling sessions (cf. Nussbaum 2005). The churches give hope to PLWHAs and help them to accept their sero-status, and adjust their lifestyles accordingly in terms of diet, hygiene, and healthy habits. The realization that this type of counseling requires special skills has made the churches to train their leaders in order to meet this challenge. Apart from the medical staff in the Catholic institutions, Parish Catechists and marriage counselors are also trained to undertake pre- and post-test counseling[9]. RAPAC has also trained several pastors in the RCCG as HIV/AIDS counselors[10]. In the LCC, all the evangelists (church leaders) are certified HIV/AIDS counselors[11]. Furthermore, in 2001, HWWN commenced counseling services at nine government hospitals in Lagos State.

The question of whether or not PLWHAs should declare their status publicly is another choice which counselors assist them to make. It is only in the Abuja Diocese of the Catholic Church that several individuals have stepped forward to declare their status. And this was made possible also because of the existence of strong support groups. However, the same cannot be said of the

remaining 48 Dioceses of the church[12]. In the RCCG, the first clergy to declare his HIV status was Assistant Pastor Pat Matemilola in 2000 (Matemilola 2005). The support he experienced in his parish has created a social space for others within the same assembly to disclose their HIV positive status. Matemilola is now the National Coordinator of the Network of People Living with HIV/AIDS in Nigeria (NEPWAN). There is also the case of Rolake Odetoyinbo, the first Nigerian woman to go public about her HIV positive status, and a member of the RCCG. Rolake later became an AIDS treatment activist and heads an NGO called Positive Action for Treatment Access (PATA)[13]. In addition to a weekly show on national. television on HIV/AIDS, she also writes a weekly column titled "In Moments Like This: Living with HIV" in the *Sunday Punch*, Nigeria's most widely read newspaper. This brings us to the role of support groups. While the Catholic HIV/AIDS Policy has detailed recommendations on the composition and role of support groups, in practice, only a handful of such groups are functional as is evident in the Abuja case cited above. HWWN has over ten support groups in Lagos with a membership of about 500 PLWHAs and PABAs. RAPAC even has fewer than ten.

In the area of pastoral care, the three FBOs have continued to reach out to PLWHAs mainly through the use of volunteers from their respective congregations. RAPAC has volunteers who pay home visits to PLWHAs, pray with them and offer them encouragement from the Bible. They also distribute material donations (food items, clothing, household supplies) collected by the church to the PLWHAs (Adeboye 2006). In the LCC, 'Benevolence' Sunday services are conducted to raise material donations for PLWHAs within and outside the church[14], while the Catholic Church allows all Dioceses to organize second

Collections in all Parishes once a year for HIV/AIDS Programs. This is in addition to budgetary provisions in each Diocese to support HIV/AIDS activities (cf. Bate 2003).

The bio-medical treatment of PLWHAs is also a matter of great concern to the FBOs. Under the PMTCT initiative, HWWN provides free ARV treatment for HIV positive expectant mothers and their babies, as well as free replacement feeding for the babies for the first year to prevent transmission through breast-feeding (HWWN 2005). In 2005, 700 women benefited from this scheme. HWWN also provides free medical consultations and free treatment of opportunistic infections to other PLWHAs. It works from its bases in the nine government hospitals with which it is affiliated[15]. Because of its wider network of health institutions, the Catholic Church is able to reach out to a greater number of people although it does not give free ARV treatment. Its philosophy of health care is to establish "a continuum of care between home, community and health institution to meet medical and psychological needs of people living with HIV/AIDS" (Catholic HIV/AIDS Policy 2002). It treats, among other things, opportunistic infections for which it charges moderate fees.

The RCCG has only a handful of health institutions that can treat HIV/AIDS cases, so most of the time, it refers patients to other government and mission hospitals. Majority of its own health institutions are designated 'maternity centers', which specialize in deliveries and child care. However, RAPAC has been able to donate ARVs and medical equipment to many government hospitals in Lagos through the Med-Share Program of the North American Chapter of the African Missions of the RCCG started in 2004 (Adeboye 2006). What this group of RCCG members in North America does is to solicit for donations of drugs

and medical equipment from companies in the USA and Canada, which they send to RAPAC to distribute in Nigeria and to other RCCG mission fields in other parts of Africa. RAPAC then donates Nigeria's share of the medical supplies, especially ARVs to government hospitals since it does not dispense directly to patients. Although, given the immense needs of the nation, these donations amount to a very small fraction, they nonetheless assist in a little way. It is also common in the RCCG and in the other two FBOs to find intra-church associations and societies covering the cost of ARVs for some groups of PLWHAs they have identified. Again, home based care (HBC) is also promoted by these FBOs that train volunteers in the administration of home care and sends them out in teams to visit and care for sick PLWHAs in their community.

Perhaps, the most unique service/care rendered by these FBOs is in the area of mental health promotion and restoration of hope to PLWHAs. Mental health is here defined as "the emotional and spiritual resilience which enables us to enjoy life and to survive pain, suffering and disappointment. It is a positive sense of well-being and an underlying belief in our own and others' dignity and worth" (Friedli 2001:56). Thus mental health promotion aims to "strengthen individuals and increase emotional resilience through interventions designed to promote self-esteem, life and coping skills; communicating, negotiating, relationship and parenting; skills to improve the capacity to cope with life events, transitions and stresses such as parenting, bereavement, redundancy, unemployment, retirement" (Ibid). To this list one could add the trauma and stress of living with HIV/AIDS and the burden of having to care for a loved one who has the virus. This last category describes the experience of PABAs. That the faith community has been able to devise fruitful interventions to address these

needs shows that not only does it promote mental health; it also provides spiritual therapy for mental health problems such as depression and stress. In fact, research has shown that many people with mental health problems (that were not even related to HIV/AIDS) have found great support within their congregation and have found prayers, worship, religious belief and belonging to a religious community both helpful and affirming (Ellison and Levin 1998). The 'testimony' of Rolake Odetoyinbo quoted below illustrates this point well. In December 2000,

> My parents, my younger brother and I went to the Redemption Camp [of the RCCG] for the Holy Ghost Festival [tagged] VICTORY AT LAST .... [There,] I cried my heart out to God and begged Him to heal me .... God heard my cries and healed my broken heart and mended my life .... The last time I took the HIV test, the virus was still in my bloodstream but I know God permitted this for a purpose. My healing is a settled matter, but while I await the physical manifestation, I will use this to the glory of God, to bring hope and joy to those in similar circumstances (Odetoyinbo 2004).

Closely related to this is the issue of faith healing as it applies to the RCCG. The church believes that God can cure HIV/AIDS and prays regularly for the healing of

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

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

Mitigation of the Impact of HIV/AIDS

In working to assuage the impact of HIV/AIDS on the society, the FBOs in focus have concentrated their energies on the care of Orphans and Vulnerable Children

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

Other forms of support for OVCs in the care of HWWN include: nutritional assistance (food donations), counseling and free medical treatment for the children and their caregivers. The children also enjoy regular home visits from HWWN volunteers, who organize them into several clubs and what HWWN calls the "Children's Parliament" where they receive feedback from the children on how to further improve their lot. Not all OVCs under HWWN benefit form educational scholarships. Some are enrolled under the Life Skill Development Program which commenced in 2004. This is a training institution located at the HWWN headquarters in Lagos where skills like leatherworks, bead-making, textile crafts (weaving, dyeing), pottery and ceramics are taught to the children to

enable them become financially independent[18]. In collaboration with HWW South Africa, HWWN developed appropriate child survival booklets which address issues such as children's rights and income generation. HWWN has no corresponding scheme specifically targeted at widows. But as caregivers to OVCs, many widows benefit from the free medical treatment and nutritional support from HWWN. Within LCC, AIDS widows are classified as PABAs and this qualifies them for pastoral care and support. They also benefit from existing church schemes for general widows[19].

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

In the RCCG, there were several welfare schemes for orphans even before the HIV/AIDS ministry was inaugurated. The only Orphanage operated by the church (Heritage Home) does not discriminate against AIDS orphans. Apart from the RCCG central scholarship scheme, there are also parallel programs at the Provincial, Area, and Parish levels, which cater for the needs of indigent children, and into which OVCs are also brought. As is the

case in the Catholic Church, existing 'ministries', which reach out to widows at all levels (Provincial, Area, and Parish) also attend to AIDS widows. Some of the schemes seek to empower the women economically by giving them vocational training and granting them soft loans to establish small businesses. Widow support groups also provide fellowship opportunities for the women. Examples of these include the Tabitha Fellowship in Lagos Province 2 and 'Heads High' Ministry in Lagos Province 7 of the RCCG.

Another way of mitigating the impact of HIV/AIDS on the society is by confronting poverty. Poverty is to be seen here, not just as a contributory cause to the spread of HIV/AIDS, but also as a major consequence of the epidemic. There thus appears to be a dialectical relationship between the two because while poverty pushes people into high risk groups like sex workers and drug users, the aftermath of AIDS reinforces poverty and creates new strands of lack, which in turn exposes many to greater risks of infection. The churches seem to have recognized this vicious cycle and have strengthened 'ministries' targeted at the high risk groups. The case of the RCCG illustrates this. Its Christ Against Drug Abuse Ministry (CADAM) rehabilitates drug users while its Holistic Ministry is directed at commercial sex workers. The relevance of these two ministries in the context of current HIV/AIDS campaigns cannot be overemphasized. Individuals converted from drugs and sex work are taught new skills and assisted to establish small businesses of their own, while taking care of those that are already HIV positive among them.

CHRISTIAN INTERVENTIONS: HOW EFFECTIVE?

An objective assessment of the FBO interventions discussed above would help in identifying aspects that

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

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

operation. HWWN, which appears to possess the institutional framework (as an international FBO) to implement the monitoring and evaluation of its interventions has not done much in this regard. Its approach seems to be to get projects off the ground first and allow them time to stabilize before embarking on evaluation.

These three FBOs also suffer similar limitations. These are: lack of funds, inability to eradicate stigmatization of PLWHAs in their congregations, and what I have termed 'structural limitations'. Because their HIV/AIDS interventions utilize existing church networks and structures, FBOs automatically become susceptible to whatever structural or internal problems that plague such networks. Nevertheless, with the tool of comparative analysis, one could attempt some form of assessment based on the relative performance of each of the groups studied here. The Catholic Church is strongest in the area of the provision of medical care due to its widespread health institutions and long tradition of social work. However, it needs to improve its strategies for prevention and mitigation of the impact of HIV/AIDS. RAPAC, on its own part, is strongest in its enlightenment campaigns and pastoral care. It is however, weak in the area of provision of medical care. Its mitigation efforts could also be improved if coordinated centrally. HWWN is strongest in its prevention messages and mitigation efforts. It needs to scale up its activities in the area of medical treatment although what is generally on offer here is better than that of RAPAC.

Perhaps a more productive approach to the issue of performance assessment is to examine how the FBOs have fared in handling specific challenges directly related to the discharge of their duties. The first challenge here is an internal one and is mainly theological. HIV/AIDS touches

on a number of important theological issues, which the churches cannot ignore as long as they are serious about their commitment to the anti-AIDS battle. The most salient issues here are: the role of disease in God's creation; understanding of suffering and death; interpretation of sin and forgiveness; love and acceptance; the concept of sexuality; and gender relations (Weinreich and Benn 2003). All but the last of these concerns have begun to receive varying degrees of attention by the FBOs examined here. Biblical sources of gender inequalities and injustice are still unchallenged by the churches. For example, many churches teach fidelity as part of HIV prevention strategies. But what should a 'faithful' wife do in the case of a spouse who is not only 'unfaithful', but is also unwilling to use the condom after testing positive to HIV? Churches have not empowered married women to negotiate safe sex with their husbands in such cases. Women thus endure 'death-dealing' relationships because most churches do not support divorce. The silence of the church on this has made some feminist theologians to advocate not only a gender-sensitive, multi-sectoral approach to the issue of HIV/AIDS, but also an 'engendered theology' for the church (Haddad 2002; Dube and Maluleke, 2001; Dube 2004).

A faith-based group that has consistently championed the cause of oppressed women especially within the context of HIV/AIDS is the Circle of Concerned African Women Theologians, a pan-African group formed in 1989. In line with its mission of undertaking research and publishing theological literature with special focus on religion and culture, the Circle has over thirty books to its credit. The ones that specifically address HIV/AIDS are: *African Women, HIV/AIDS and Faith Communities* (2003) and *Grant Me Justice! HIV/AIDS and Gender Readings of*

the Bible (2004)[22]. The concern of the authors of the above two books is to present, among other things, new female-friendly interpretations of the Bible that challenge earlier androcentric versions hitherto used to support patriarchal oppression within the church. For the Circle, the fight is still ongoing on behalf of African women who bear the brunt of HIV/AIDS, but for the churches, gender is yet to be mainstreamed into their interventions.

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

Abstinence certainly has its value especially where it leads to late sexual debut among youths. This is a

prevention tool that has been proven to be effective in Uganda, which when combined with other strategies, like condoms and fidelity brought down the national prevalence from 21% in 1991 to 6.1% in 2000 (Green 2003). The idea is that a combination of strategies works best. Thus, religious leaders, even where they will not allow condom use within their constituencies should not disparage its usefulness in other contexts. In the same way, secular activists are to respect churches' position and not downplay the former's emphasis on abstinence and fidelity. This ideal of cooperation and tolerance is succinctly captured in a Christian prevention campaign developed in Tanzania by Father Bernard Joinet, a professor of psychology, called the *Fleet of Hope*.

> Fr Joinet images compare the AIDS pandemic to a flood from which the only escape is to climb on board the *Fleet of Hope*, an inseparable combination of three boats, the *Fidelity*, the *Abstinence* and the *Condom*. It is explained that whereas the government or the UN and NGOs have a responsibility to get people on board, no matter into which boat, groups like churches, tribes or families may urge their members to climb into a specific boat, according to their common shared values. However, the *Abstinence* is not only for monks nor is the *Condom* only for poor sex workers. Everyone may at

> some determined moment have to change from one boat to another to avoid the risk of drowning. A typical example is that of the 'condomizing womanizer' who runs out of stock; he can either drown or board the *Abstinence* until the pharmacy opens the following morning[24].

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

Finally, there are several miscellaneous issues of practical concern which could be tackled by a pragmatic deployment of both internal and external resources. First is the neglect of widowers in many intervention programs. The peculiar needs of men infected and affected by HIV/AIDS require special attention. The activities of Rev. Gideon Byamugisha of Uganda in mobilizing religious leaders infected by HIV/AIDS in Sub-Saharan Africa are quite remarkable. But what becomes of widowers that are not religious leaders? Another problem is the concentration

of most intervention efforts in the cities and urban centers while the rural communities suffer relative neglect. This ought to be addressed urgently and a poverty-relief component added to the rural interventions. While it has been observed that the strength of the interventions in the three case studies rests on the use of volunteers, these individuals should not be overworked so as to avoid burnouts. Strategies should be devised to broaden the volunteer base of each FBO. Lastly, the big gap between administrative policy and practice in the execution of intervention programs should be bridged.

RECOMMENDATIONS

In addition to the observations above, the following recommendations are hereby made to assist FBOs in their battle against HIV/AIDS in Nigeria:

1. FBOs should begin to look beyond the ABC campaign and embrace other integrated strategies. Such a holistic approach would include:
    - Empowerment of women and children and other gender sensitive initiatives.
    - Anti-poverty initiatives.
    - Comprehensive sexuality education.
    - Scaling-up of VCT and referral, treatment, care and other prevention efforts.
2. FBOs should dispense affective care in order to reach out effectively to PLWHAs and PABAs. They should understand that the whole body is affected if one member is infected with HIV. There should be no 'holier-than-thou' treatment.

3. For FBO campaign against discrimination and stigmatization to be effective, their must be a re-interpretation of Scriptures in ways that emphasize love, forgiveness, care, and champions the cause of the weak, the sick, the oppressed and the suffering. FBOs cannot insist that HIV/AIDS is the result of sin and expect their members to be sympathetic to the cause of PLWHAs and stop discriminating against them.
4. Church leaders who believe in faith healing should not shy away from offering palliative care to PLWHAs that are not healed. There could be an interface between faith-healing and bio-medical management of HIV/AIDS, where PLWHAs could be encouraged and supported.
5. FBOs should actively denounce cultural practices that enhance the spread of HIV/AIDS, especially in communities where the prevalence of the infection is unusually high e.g. Cross-Rivers State, FCT (Abuja), Benue State etc.
6. RCBs such as the Pentecostal Fellowship of Nigeria (PFN) and Christian Association of Nigeria (CAN) should be more involved in the anti- AIDS battle and mobilize other Christian groups to be a part of it.

CONCLUSION

This study has shown the different areas in which FBOs have been involved in the anti-AIDS crusade in Nigeria. Although they joined the battle late, FBOs have great potentials given their tradition of care (through health institutions), spirit of service, and pastoral care, all of which reach beyond the physical bodies into the emotional and mental health of PLWHAs. A major resource

harnessed for this service is the spiritual capital discussed in this work. While this spiritual resource is hard to gauge, its mobilization and the manner in which challenges surrounding its effective discharge are handled, further point to the fact that the FBOs need to improve their efforts for their reach to be widespread and more incisive. Although the cases studied here highlight Christian interventions, Muslims and traditional healers are also involved in the anti-AIDS crusade at different levels. More research is still needed on this.

This study has also unveiled an interesting paradox in the faith community, namely, that the administration of spiritual capital could be stalled, not by external forces, but by theological bottlenecks generated within the same faith system. This is exemplified by the delayed response of FBOs to the outbreak of HIV/AIDS and the protracted debate on condom use. While secular NGOs responded almost spontaneously to the challenges presented by the epidemic, the faith community was still debating issues of theology – on sin and suffering, on the correct interpretation of disease etc. It took the appeal of government authorities, and the realization that the 'faithful' were not immune from the ravaging epidemic before the reservoir of spiritual capital was opened and dispensed in the HIV/AIDS situation. This shows that spiritual capital, just like other resources (whether symbolic or substantive) has no agency of its own despite its tremendous potential. That is why the concept of religious capital also remains inadequate, due to its legalistic and dogmatic emphasis, in handling the HIV/AIDS issue. Theological rigidity remains an impediment in the administration of spiritual capital. Happily, this contradiction is being addressed as more churches join the anti-AIDS crusade, shedding their prejudices and

reinterpreting and rereading the Scriptures in ways that favor the poor, the suffering, and the sick. However, there is still the need to revisit the issue of women in the faith communities through an 'engendered theology'.

For FBOs that are yet to capitulate on their judgmental stance, the challenge to them is this – Is their own Christianity in words alone and not in deeds? If the Christian message is one of love and sacrifice, what better way exists to demonstrate this love than to reach out to those infected and affected in the present context of death and pain created by HIV/AIDS? While the growing concern in the faith community on HIV/AIDS is welcome, there is need for this concern to be widespread and well-rooted. It is only then that sections of the faith community in Nigeria would not be liable to charges of "Letting them Die" as had been pronounced on some local authorities in South Africa (Campbell 2003). As somebody once said, "the best time for the church to have started dealing with the HIV/AIDS crisis was twenty years ago, but the next best time is now"[25]. And may I add that churches and faith groups that remain insensitive to people's suffering, risk becoming irrelevant in the present dispensation.

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