
An Invitation to Conversation

Dear churches, dear UN agencies, dear networks of people living with HIV and other partners

We write to you as a group of theologians and practitioners, from five continents and many church traditions, some of us living with HIV. In January 2008, we came together to reflect on the theological issues that have arisen, for us and those around us, in our work on HIV prevention. This book describes the conversation that took place during those days, and invites you, our readers, to enter into that conversation and take it forward.

‘Why just *prevention*?’ you may ask. We know that HIV prevention is inextricably linked with the availability of treatment, care and support, and that the two are mutually reinforcing. As we write, though, it is an inescapable truth that for every two people who start on HIV treatment, five people are becoming infected with the virus.² Vital as it is, access to treatment is therefore not enough. It has become clear that halting the spread of the epidemic will not be achieved without reassessing the focus on HIV prevention, especially in relation to marginalized people.

However, theological conversations between believers from different religious traditions are not easy. Christian theologians can differ quite fundamentally. We were no exception: we disagreed frequently. On one thing, though, we were unanimous. As theologians, ethicists and church practitioners, we share a profound awareness of the power of faith to motivate the organizations, groups and individuals that make up our communities. We are deeply conscious of the need for people of faith (that is, the huge

² UNAIDS Global Report 2008

majority of this globe's inhabitants) to find meaning in what happens to them and in the way they live their lives. We believe that our Christian churches and church-related organizations have the capacity to bring to the HIV response a distinctive set of values, a commitment to care and support, a tradition of compassion, a sustainable presence in communities, and a longstanding history of informed practice.

This book is the result of a *theological* conversation. However, discussions of public issues must, inevitably, involve input and understanding coming from a variety of disciplines. Thus, our understandings of the HIV pandemic are (appropriately) informed by epidemiologists and biologists, sociologists and physicians, anthropologists and psychologists, politicians and economists, people living with HIV or AIDS and community leaders. It is hardly necessary to state that all of these frameworks have a contribution to make to the ability of faith communities to mobilize, to engage more actively in HIV prevention and to challenge stigma. It is in the context of these *empirical* conceptual frameworks that *theological* and *ethical* reflection has to take place.

It is that specifically theological, ethical and ecclesiological territory that our conversations have sought to claim, explore and map: an exercise, we hope, that will make a substantial and focused contribution to the wider, interdisciplinary discussion on HIV prevention that informs global, local and individual responses to the epidemic.

To UN agencies, networks of people living with HIV and other partners, we would say...

The international community, which was formerly fairly skeptical about the contribution of faith communities, is becoming increasingly aware of the important role that faith plays in the process of development and change. The UNAIDS program principles of effective HIV prevention, which are set out on p.9, are designed to provide a globally relevant, contextually adaptable framework for people's work.³ We would point out

³ Intensifying HIV Prevention: UNAIDS Policy Position Paper (2005)

that there is no specific mention of faith among these principles, in spite of the acknowledged role of religious belief and of faith communities in motivating behaviour, and in spite of the involvement of people of faith in the paper's development.

Otherwise, in our theological reflection we have found no conflict with these basic and important principles. The focus on human rights and on gender equality resonates with the powerful theme of justice that flows through our Scriptures and our traditions. Today, a growing number of theologians are exploring theological and ethical approaches that are based on human rights, and in particular, on gender equality. Theological discourses on justice would suggest, further, that rights also imply responsibilities.

Next, we would wish to affirm the focus on the importance of context. Today, both Catholic and Protestant theologians emphasize the importance of theologies and church cultures that relate to local contexts: a belief summed up in the theological notion of 'enculturation'. We would urge that 'faith' or 'religion' be named, within UN principles, as important dimensions of culture and society.

In all our traditions, we find ethical support for the principle that responses must be evidence-informed, effective and comprehensive. In this, we are accountable to our fellow human beings. But people of faith also acknowledge their accountability to God, and this may be an important factor in motivating them to become contributors to evidence-based responses.

The UNAIDS principles resonate particularly with Christian understandings of compassionate care. For us, the concept of 'compassion' has a particular theological significance, which includes an emphasis on the importance of long-term and sustained commitment that is modeled on God's faithful and compassionate commitment to God's people. In Jesus Christ, who suffers alongside us, we find a non-stigmatizing dimension of shared suffering that frees Christian understandings of 'compassion' from the 'us and them' baggage that often accompanies the notion of 'pity'.

Churches and Christian organizations have particularly important contributions to make in terms of community participation. Of all local forms of organization, faith communities are often the strongest, most effective, and most clearly embedded in family and neighborhood life. Christian community is rooted in the theological concept of *koinonia*, which can be summed up as the ideal of a community whose members worship together, care for each other and give hospitality to strangers. While we admit that churches do not always live up to this ideal, we would nevertheless claim that Christian community at its best has a powerful contribution to make to the overall response to the epidemic.

To our churches, church-related organizations and fellow Christians we would say...

Historically, in some places we have been at the forefront of compassionate care and support for sick people. Some of us were involved from the earliest days in the response to HIV and AIDS. Some churches and church-related organizations have been innovators in home based care for families affected by HIV; care for orphans and vulnerable children in homes and extended families; education in schools, hospitals, clinics and youth groups; hospital and clinical care; and the encouragement of voluntary testing and counselling. More recently, religious groups have engaged in the provision of antiretroviral treatment for HIV. Some of us have also been involved in advocacy to influence funding priorities and public policy, promote access to anti-retroviral drugs and services, and play a role in political decision-making. Although we have much to repent, we have - over time - become more aware that we and many of our members are living with HIV, and have made strenuous (though often insufficient) efforts to address HIV-related stigma.

That said, many of us have found ourselves uncomfortable in facing up to the challenge of prevention. For the fact is that one cannot hold an honest discussion about HIV prevention without touching issues that may themselves be connected with profound beliefs about what God is like, how people should behave, and what kind of community

the Church should be. These may include issues of gender and sex, sexuality and sin, the use of drugs, and encounters with individuals and communities whose existence we find it easier to ignore. For people of faith, such theological, ethical and ecclesiological challenges can involve venturing beyond long-established comfort zones into new and unsettling horizons of reflection and encounter, dialogue and spiritual insight.

This book, therefore, is about preventing HIV, why it is difficult, and about the contribution Christian theology makes, could make and sometimes fails to make to that task. The hope is that it will support, encourage and resource churches in their engagement with HIV prevention, outline some starting points for Christian reflection on HIV prevention, and suggest future avenues for research and study.

And about ourselves...

All the individuals in the list that follows are happy to be recorded as having participated in the discussions that led to the publication of this book. Not surprisingly, there were many things about which we did not agree. From such a group, you would not expect unanimity: and indeed consensus is not what you will find in these pages. Instead, what you will find here is a sincere determination to engage with a series of challenges that people of faith (not just Christians) find particularly difficult. You will also find a commitment to reaching a better understanding of why differences arise, and to establishing common ground on a subject (HIV prevention) that has often proved painfully divisive.

It is not as representatives of particular churches or organizations that our names appear here, but as concerned individuals who are deeply involved, professionally or personally or both, in the challenges of prevention. Inclusion does not imply that any of us agrees with every word of the text: that was never the object of the exercise. What we do endorse is a commitment to honest, faithful, respectful listening that leads to being able to name, understand and live with difference and, as a result, to claim that common ground

which is an essential basis for a coherent, integrated conversation about HIV prevention. Our invitation to you, the reader, is to take up this challenge and to continue the conversation in your own context and within your own communities.

Yours in Christ Jesus,

Canon Gideon Byamugisha Baguma, Goodwill Ambassador on HIV and AIDS, Christian Aid, Uganda

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UNAIDS

The Principles of Effective HIV Prevention

- All HIV prevention efforts/programmes must have as their fundamental basis the promotion, protection and respect of human rights including gender equality.
- HIV prevention programmes must be differentiated and locally-adapted to relevant epidemiological, economic, social and cultural contexts in which they are implanted.
- HIV prevention actions must be evidence-informed, based on what is known and proven to be effective, and investment to expand the evidence base should be strengthened.
- HIV prevention programmes must be comprehensive in scope, using the full range of policy and programmatic interventions known to be effective.
- HIV prevention is for life; therefore, both delivery of existing interventions as well as research and development of new technologies require a long-term and sustained effort, recognizing that results will only be seen over the longer term and need to be maintained.
- HIV prevention programming must be at a coverage, scale and intensity that are enough to make a critical difference.
- Community participation of those for whom HIV prevention programmes are planned is critical for their impact.

Intensifying HIV Prevention: UNAIDS Policy Position Paper (2005)
<http://www.unaids.org/en/KnowledgeCentre/Resources/PolicyGuidance/UmbrellaPolicies>

Note: These 'UNAIDS Principles of Effective HIV Prevention', referred to on page 2, are foundational ones for global responses to the epidemic, and a starting point for our own thinking on prevention. We should point out, however, that there is no specific mention of faith among these principles, in spite of the acknowledged role of religious belief and of faith communities in motivating behaviour.

Chapter 1

Theology and HIV prevention: the discourse of life

Epidemics are moments of truth when both knowledge and power are unveiled.

— Neville Hicks quoting Didier Fassin⁴

For public health and other secular disciplines, the HIV epidemic has proved to be something of a *kairos* moment: a moment of opportunity, not to be lost, when new insights can lead to new ways of thinking, working and relating to others. This has also proved true for Christian theology, and for global understandings of the role that faith communities play or could play in the response to major public health issues. The present volume seeks to identify some of the theological insights that have emerged from this *kairos* experience, and to suggest ways in which the challenges they present can be empowering ones. For it may be that the theological truths ‘unveiled’ by the challenge of HIV prevention are ones that will change our churches for ever.

In this chapter, therefore, we consider the unique contribution that theology is able to make to the dialogue on HIV prevention, and also its limitations (*Theology and certainty*). The next section (*Some theological difficulties*) names some of the challenges that present themselves when people from different theological traditions do theology

⁴ Didier Fassin: *When Bodies Remember: experiences and politics of AIDS in South Africa* (Berkeley: University of California Press, 2007) p.129.

together. In the section entitled *'Doing' theology*, we look at some of the specific difficulties Christian theologians have confronted in their efforts to 'do' theology in relation to HIV and AIDS.

The discussions that led to this book generated various suggestions about the kinds of action that might flow from them. Some of these suggestions appear at the beginning of Part Three. We believe, though, that readers and groups of readers will wish to come to their own conclusions. Therefore this chapter (like Chapters 2, 3 and 4) ends with a challenge to its readers to reflect on the implications of what has been said and find ways of moving from reflection to action in their own particular context.

1. Theology and certainty

What does it mean to talk about HIV prevention from the standpoint of Christian theology? The opening letter pointed out the need for our discussions to be informed by those secular disciplines through which the epidemic is understood, and the evidence base from which they derive their authority. Also of great importance, as a source and validating tool in all discussion, is actual experience (especially the experience of people who are themselves living with or affected by HIV).

Most would agree that Christians are called to participate in efforts to care for communities and individuals living with HIV, to help prevent new HIV infections and new HIV epidemics, to reduce unnecessary deaths and to slow down existing epidemics. In countries where the epidemic is concentrated within particular populations, there are still opportunities to limit its spread and to protect those vulnerable to infection. It is against this background that we approach the task of identifying the specific and vital contribution that theological and scriptural reflection can make to our response to an epidemic that has been so copiously described through the lenses of other discourses and disciplines.

One of theology's functions – which this volume is designed in part to address – is to resist the temptation to take refuge in certainties. With so much knowledge now available, it is all too easy to say, as one participant put it: 'Don't ask me to think about it, just give me the answer'. We

then become a society in which research may be driven by the need to prove oneself right rather than by a longing to arrive at the (possibly unwelcome, possibly complex) truth. When this extends to our reading of the Bible, we risk embracing an over-simplistic, insufficiently nuanced understanding of the ways of God.

Such differences were frequently encountered in the course of the discussions that led to the writing of this book. Theological discussion between Christians who read the Bible as literal and incontrovertible truth and those (on the other hand) who take a more contextualized or historical view can prove painful for both groups. Different traditions have different views of how the Scriptures are to be applied to contemporary issues, views that may be held with such absolute conviction that dialogue becomes a threatening experience. In this publication, we have tried to indicate differences in theological approach and enable them to be heard. At the same time, we have insisted (as the participants in the consultation insisted) that dialogue is not just possible but essential, that differing views are held in good faith and should be heard, and that there is, at the end of the journey, theological common ground on which we may all find firm footing.

It's not easy though. On the one hand, it can give one a sense of peace and security to believe there is a set of unquestionable truths, and that one knows the answers; on the other hand, the theological issues raised by HIV prevention are complex ones, not open to easy solutions, and difficult to address from the standpoint of religious and scriptural certainty. Equally, Christians who take a more nuanced and contextual view may be accused of losing the power and uniqueness of the gospel message by adapting and accommodating too much to the world.

When churches make statements or advocate particular theological and ethical positions, they cannot expect – however strongly they believe they are in possession of revealed truth – that they will be immune from questioning, nor can they expect their truths (however self-evident they appear) to be unquestioningly accepted by others. We are therefore struggling, in these pages, to develop a theological approach to HIV prevention that is sufficiently flexible and broad-ranging to be capable

of making an accessible contribution to the overall response to the epidemic at global, local and personal level.

2. Some theological difficulties

This has not been easy. For some, HIV prevention was a simple question of morals. For others, it was a public health problem, a gender problem, a social justice problem. In sharing these views, profound questions were raised about the nature of God. 'Is our image of God one of vengeance and punishment,' comes the question, 'or is it an image of love and life?'

The answer is, of course, that some religious groups or traditions stress the punitive character they attribute to God, and others place emphasis on God's life giving, liberating characteristics. Increasingly, therefore, the issue becomes a contextual one, as it becomes clear that particular social and economic contexts raise particular questions. The problem is that apparently simple, obvious solutions often ignore the dynamics of culture, and the social or gender roles it imposes, leading to answers which assume that everyone has the capacity to control what happens to them. We will return to these discussions, in greater detail, in future chapters.

Christians from different traditions may also have different understandings about God's saving action in the world, and therefore about the role of the Church in mission. Is the world irredeemably lost until it is saved for Christ by His Church? Or is the world already the location of divine action, which the Church is called to discern and celebrate? These questions go to the core of our understanding of mission today.

3. 'Doing' theology

In 'doing' theology in relation to HIV prevention, one of the biggest problems is the tendency to cloak important issues in silence and denial. An effective response to the HIV epidemic demands that we focus on issues on which Christian tradition has long been uncomfortable. In particular, these include gender inequality, violence, drugs, sex and

sexuality: all of them issues that many religious people find (in practice) impossible to speak of. Marriage, preparation for it and what happens within it have also proved to be difficult terrain for Christian theology to enter. Further, becoming infected with HIV, living with HIV, being treated for HIV, and also preventing HIV are all highly physical experiences: and yet, although celebrating the fact that they are called to be the Body of Christ on earth, churches have often been silent or highly ambivalent about *actual* human bodies and their functions.

A further set of issues surrounds the relationship between institutional churches and marginalized populations such as injecting drug users, commercial sex workers, prison populations and men who have sex with men: all of whom have regularly found themselves excluded or judged (or both) by mainstream religion.

Two major theological images kept re-emerging in the course of these discussions. The first is the idea of 'right relationships', which will be discussed at length in future chapters. The second is the concept of life and death, and the absolute conviction that a Christian orientation towards HIV and AIDS must involve not just a *theology* of life, but also a wholehearted *celebration* of life. As one of the participants in the Johannesburg conversations put it: 'In the end, religion is about love and life. We need to be vigilant in ensuring that our own beliefs or values reflect this'

Right relationships, love and life? These positive, non-judgmental, celebratory and profoundly *biblical* themes give us the space we need to see the awkward, apparently intractable issues in clearer perspective. Sex and sexuality are within the discourse of life; ideas of gender and of right relationships place the discussion within the discourse of justice. Furthermore, these themes are ones that have the capacity to energize Christian contributions to the overall global, communal and personal response to the HIV epidemic. In the words of a participant: 'The discourse of death (as in public health when risk reduction or mortality figures are being discussed) and the discourse on sexuality (which you hear even if it is unspoken in many churches) is, in the end, *less effective* than the discourse of life'.

4. Questions for discussion

- a. What does it mean to think theologically in the context of HIV prevention?
- b. Have you experienced discussions when there has been a fundamental disagreement about any of the controversial issues discussed in this chapter?
- c. What value does Christian theology add to the various dialogues around HIV prevention? What would be lost if we abandoned our search for a distinctively Christian contribution to these dialogues?
- d. How far should effectiveness be a criterion in evaluating a particular theological approach to HIV prevention? What other criteria could there be?

Chapter 2

HIV prevention at global and national levels

While the form of an epidemic is influenced by the type and virulence of the pathogen, the question of who is affected, and with what consequences, will reflect the ideologies, social and political structure and economic organization of the populations among whom the pathogen exists.

— Neville Hicks

The aim of this chapter is identify and explore some of the theological issues encountered in responding to the HIV epidemic at global and national levels. The chapter opens with a brief summary of the challenges and difficulties that were identified, and goes on to suggest some theological themes that are notably relevant to this discussion. These are:

- justice;
- prophetic courage;
- Christian solidarity and the common good.

Therefore the chapter ends with a challenge to its readers to reflect on the theological implications of the international and national issues that they themselves encounter in moving from reflection to action in their own particular context. Recommendations from participants appear in Part Three, in the section headed ‘From Conversation to Action’.

1. Challenges at global and national level

A major and much-publicized challenge to HIV prevention has been the lack of progress towards achieving universal access to HIV pre-

vention, treatment, care and support, coupled with the urgent need for the resources to make services more freely available to people who need them most. Progress towards meeting the Millennium Development Goals has been slow, and there has been a lack of political will at national level to honor international commitments. Most national governments have failed to meet their commitments to the United Nations or to the Global Fund to Fight AIDS, Tuberculosis and Malaria. When resources are available, they are not always used as efficiently as they could be, because stakeholders at country level have insufficient capacity, or are unable to harmonize or prioritize their efforts.

New methods of HIV prevention, treatment, and diagnosis are needed. In particular, there is an urgent need for effective, affordable, convenient, female-controlled prevention methods. These have not so far been a priority, and until very recently there has been little urgency about efforts to make them so. Medicines are still beyond the reach of the majority who need them, and while some countries have used the TRIPS⁵ agreement to launch successful challenges against inequalities in the availability and pricing of medicines, others have lacked the capacity to take advantage of the flexibilities that exist within the agreement.

There has been insufficient progress towards the ending of discrimination against people living with HIV: a view based on continued evidence of the lack of access to health services and employment, of travel restrictions on people living with HIV and of the criminalization of HIV transmission. This is accompanied by a failure to observe human rights principles in relation to those key populations who are particularly at risk of HIV – for one reason of another - especially vulnerable to transmission.

Although gender inequality and gender-based violence are now generally known to increase vulnerability to HIV transmission, few

⁵ The WTO agreement on Trade Related Aspects of Intellectual Property Rights 1994, see www.wto.org/english/tratop_e/trips_e/trips_e.htm

governments have effective legislation in place to overcome them. Though national governments may give verbal support to international statements on gender, this support is often limited to rhetoric, foundering on the fatalistic view that gender violence and gender inequity are in practice unavoidable.

Global poverty and increasing food shortages are often cited as being among the factors that drive people to engage in activities that put them at risk of contracting HIV. If this is true, then it means that poverty should be seen as both a *driver* of HIV transmission, and also a *consequence* of HIV: an observation that has relevance for national resourcing of HIV prevention, and also for personal struggles for survival.⁶ Furthermore, conflict, war, and violence result in the breakdown of social and economic structures, the creation of mobile groups of fighting men, and often also a collapse of traditional value systems.

2. Justice

Issues of justice are woven into the agenda of HIV prevention at every level. Unequal access to HIV treatment is an obvious example, connected as it is with the power differentials that govern the mechanisms for the allocation of resources and the difficulty often faced by people living with HIV in accessing health services. Further justice issues include the discrimination faced by people living with HIV and their families and survivors, recent trends towards the criminalization of HIV transmission, the disproportionate effect the epidemic appears to have on poor people, and the marginalization of population groups that are particularly vulnerable to HIV.

International responses to the epidemic have, from the beginning, adopted a human rights approach that is underpinned by the concept of justice. Dominant public health responses, too, have often

⁶ For a detailed discussion of the role of poverty in HIV transmission, see the following link (p2, sub-head 'HIV and Poverty'): http://data.unaids.org/pub/InformationNote/2008/response_reassessing_hiv_prevention_science_en.pdf

been informed by a well-founded awareness of the danger of increasing stigmatization and thus driving the epidemic underground. This creates a strong and potentially fruitful synergy between – on the one hand – secular approaches and, on the other hand, those faith-based responses that are rooted in the powerful strand of justice that runs through our scriptures.

Speaking through the prophet Amos, God says: ‘Let justice flow down like waters and righteousness like an ever-flowing stream’. (Amos 5:24) Biblical concepts of justice are premised upon the covenant that God made with the children of Israel, of which Christ is the fulfillment. We are all equally loved by God, and it is through us, as God’s children, that this love is to be acted out. Our relationships with each other, the world and with God cannot be grounded in love if they are not also grounded in justice. This message is absolutely central one in both the Old and the New Testaments, calling for fair treatment of our fellow human beings, resistance to the exploitation of the environment, hospitality to the stranger and care of the vulnerable and marginalized.

We are urging here, therefore, that principles of justice should underpin any kind of strategic thinking and planning about responses to HIV prevention, not just at the level of public discourse, but also in the context of interpersonal and community-based relationships. Justice issues are all around us: in the steady progress of globalization, in the gender injustice that is often inherent in sexual relationships, in local and international poverty and the suffering it causes and in the scandal of unequal access to life-saving medicines. The biblical concept of justice is a key area for theological and practical engagement with the HIV epidemic and a useful reference point for a theologically-based advocacy strategy. It is also one key contribution that Christians can bring to global and national dialogues on HIV prevention.

3. Prophetic courage

A greater commitment to justice is a key requirement at every level in the dialogue about HIV prevention. But how, exactly, is the call

for justice to be articulated? And how can we help people to hear it? For it takes more than preaching, condemnation and moralizing to deliver the wake-up call that will persuade Christians to re-examine their teachings in the light of the sickness and dying, the stigma and the discrimination that characterize the HIV epidemic.

The word 'prophetic' is often used loosely today, but the concept of the prophet is nevertheless an important one. As Margaret Farley says later in this book, prophetic discourse tends to arise in contexts where 'needs are massive and injustice reigns'.⁷ Prophets express religious or moral indictments; they address basic moral concerns; they appeal not only to the head but to the heart as well; and they may offer a vision of a transformed future that is better than the present.

Prophetic discourse, therefore, is not what we, today, would label 'dialogue'. On the contrary, it is a discourse that calls, through the power and the passion of its message, for people to 'turn to God'. It grieves over the world and invites us to lament its pain. It speaks of hope in the context of a concern for some of the most profound issues in human relationships, emotions and experience.

Churches have an important role in such prophetic discourse. It is at the level of faith, often, that people engage with the big issues of life and death, pain and loss, passion and hope. It is in prayer and liturgy that they find the opportunities to lament. But prophecy is not the mere repetition of moral rules. Nor is the prophetic role one that we choose for ourselves: it is one to which we are called by God. As with the prophet Amos, the message of prophecy is not *our* message but *God's* message.⁸

Furthermore, prophetic discourse is not merely challenging to its audience. On the contrary, it is often, also, deeply challenging to the prophet him or herself, confronting the person with truths that are

⁷ See Essay 1, p.59

⁸ See above, under Justice, p.20

difficult to accept. So when churches challenge themselves, their leaders and their governments to a change of heart that will enable them to address HIV prevention more energetically and honestly, they may find that they themselves are also profoundly and painfully challenged by the experience. For example, an individual exploring the issue of stigma and discrimination in his or her community will inevitably expose stigmatizing assumptions in their own heart. It is not possible for the prophet to address the issue of HIV prevention without leaving his or her comfort zone and confronting the taboos that surround issues of sex and sexuality.

It is painful, though, to come to the realization that aspects of one's morality are based mainly on taboo, and serve only to reinforce the idea of 'divine punishment', which has made such a pernicious contribution to the response to HIV and AIDS. Similarly, Christian men and women are often made deeply uncomfortable by their first experience of 'seeing' gender injustice or the invisibility of women that is associated with patriarchal religion.

Traditionally, then, the prophetic task is to challenge and disrupt, to expose hypocrisy and denial, and to identify what is not 'true'. The priestly task, on the other hand, is to maintain or conserve. These two main strands in Christian tradition (the prophetic and the priestly) both have huge contributions to make to the response to AIDS. The role of the 'prophet' should be seen as complementing that of the 'priest'. 'Prophet' and 'priest' are both aspects of Christian identity and of the Body of Christ.⁹

4. Christian solidarity and the common good

The idea of 'the common good' (which dates back over two thousand years) implies the promotion of social systems, institutions, and environments that operate to the benefit of all people. A central plank of

⁹ For broader discussion of the prophetic, priestly and wisdom aspects of Christian identity, see Curran, C, 'Enda McDonagh's Moral Theology' in Hogan, L (ed), *Between Poetry and Politics*, Dublin Columba Press 2003, p.206 ff.

Catholic social teaching, this notion has a critical place in discussions of social policy today, especially over issues like access to health services or the sustainability of the environment. In such contexts, the 'ethics of the common good' may be seen as being opposed to the 'ethics of individual rights': an opposition that frequently underpins the different approaches people bring to matters of social policy.

Such questions are particularly relevant in the context of HIV prevention at global and national levels. For deep within a Christian concept of the common good is the recognition that each person is created and held in being by God, and therefore has intrinsic dignity and value. Both Scripture and Christian tradition affirm the relational character of human flourishing and human goodness, and the moral responsibility of human beings to promote the interests of those who do not have access to the systems upon which such flourishing depends. It is not enough to say: 'so long as I and my family are OK then I have done what I need to do'. On the contrary, individual rights must be seen in the context of a shared common good and this, in turn, requires of Christians that they attend to the interests of groups and individuals who are excluded from the benefits of society.

In Catholic social teaching, the idea of *the common good* is connected with the three further principles of *solidarity*, *subsidiarity* and most recently, '*the preferential option for the poor*'. Solidarity demands that we take the side of those who are not benefiting from systems. The idea of subsidiarity demands that decision-making and information-gathering are located as close as possible to the people those decisions affect. This is a key principle for churches addressing HIV prevention, since councils and synods may have very little exposure to the real concerns, fears and dreams of grass-roots families, neighborhoods and communities. The option for the poor implies that when there are choices to be made, they should favor interests of the poor and powerless.

The idea of the common good is fundamental to the theological concept of Church described by St Paul in his first letter to the Corinthians.

The Church is the Body of Christ (1 Cor. 12:12-14): a global, transnational community, called to be the visible Body of Christ in our world today. As churches, we differ from each other in many respects, and we disagree on some issues. We are all, however, part of one Body, and therefore we are interdependent. For within this Body, there is no hierarchy of body parts: and when one part hurts, the whole body feels the pain. How then can we fail to see that the HIV prevention needs of one are dependent on the prevention needs of all?

A further implication of the 'ethics of the common good' is its insistence on the relationality of human living and flourishing. Within communities and families, the way we organize ourselves and the way we treat one another should be informed by 'common good' thinking. In the end, the rights of individuals are inextricably bound up with an understanding that they are also the rights of others.

In a globalizing world, the Church itself is called to be an icon of what it means to take seriously the idea of the common good. At the most basic level, it is not acceptable to God that some should eat while others starve. Thus Christians and Christian communities are called to support the equitable sharing of resources and ensure universal access to effective services. They are called to stand against the poverty and suffering that makes HIV prevention so much more difficult. They are called to combat HIV-related stigma and discrimination, and to become the kind of inclusive communities that bring into being the Body of Christ we are constantly in the process of becoming.

5. Questions for discussion

- a. What issues of justice have you identified in your own work with HIV or AIDS? Do you find echoes of these in (a) the Old Testament and (b) the Gospel narratives?
- b. Who are the prophetic voices in the global and national dialogue about HIV prevention today? What difficulties do prophets encounter in terms of HIV prevention?
- c. What would be the consequences, in terms of HIV prevention, if the world were genuinely to embrace the concept of 'the common good'? What might stop that happening? And what can you do about it?

Chapter 3

HIV prevention at community level

Families, communities and nations which stigmatize people who are living with or affected by HIV or AIDS are not just stigmatizing individuals: they are in practice silencing the whole dialogue, within the community, from which a culture of prevention might grow and develop.

— Gideon Byamugisha, in *Essay 4*, p.92

The aim of this chapter is to explore those theological and ethical dilemmas that have been particularly encountered in the context of community responses to HIV prevention. An initial summary is followed by a discussion of five challenges that Christians, Christian practitioners and theologians have struggled with in their attempts to respond theologically to the epidemic. They are:

- community as the context for HIV prevention;
- communities that stigmatize;
- compassionate care, compassionate prevention;
- Christian leadership and compassionate practice;
- power and scapegoating.

The theological issues discussed below (community, compassion, leadership and power) are also relevant at global and personal levels. They are grouped together here in an effort to make the material more user-friendly for those who want to construct their own discussions in a way that reflects most conveniently the requirements of their own situations. The chapter ends with a series of questions that could be used in discussion. And again, the practical recommendations of participants in this investigation will be found, for those who are interested, at the beginning of Part Three of this book.

1. Challenges at community level

Some of the challenges identified in this reflection relate to inequalities of power in church and society, and to the cultures of many churches and the communities they serve. Sometimes these are to do with communication. For example, leaders do not always think to share their theological thinking on HIV prevention with parishioners, even where such thinking is going on within church leadership circles. There may be limited contact with people affected by the epidemic, so that decisions about resource distribution are taken without their input. This serves to increase the vulnerability of the very people whose voices are least audible in society, who may also be those who are at risk of contracting HIV.

Further challenges relate to the hierarchical, male character of some church leadership. Increasing numbers of church leaders are uncomfortable about collaborating with systems and norms that reinforce the subordinate roles of poor people and women and girls. They may be reluctant to address crucial issues of gender, sexual orientation, race, and economic and social marginalization. In particular, church leaders are often hesitant about addressing violence against women, feeling that this is an intrusion on areas of people's lives that should be private. Prevailing theological constructs of masculinity and femininity make it more difficult for leaders to urge men to take responsibility for HIV prevention, or to reflect on why it is so difficult for women to co-determine the terms of their sexual relationships. Discomfort with gender-related conflict may lead to reconciliation efforts not undertaken, which in turn serves to increase existing vulnerabilities among women and girls. Preaching and liturgy may (explicitly or by implication) stigmatize or exclude the very groups and individuals who are most at risk of HIV infection.

A further challenge is the silence and denial that often surrounds the issue of HIV, making it impossible for members of communities to develop informed and effective approaches to prevention. As Gideon Byamugisha points out in the quotation that opens this chapter, communities which stigmatize people living with HIV 'are in practice silencing

the whole dialogue, within the community, from which a culture of prevention might grow and develop'. This silence is most evident, and perhaps most damaging, where sex and sexuality are concerned.

A further, connected area of discomfort surrounds the issue of sin, and how communities deal with individuals their members regard as sinners. Stigma, fear of stigma, and the specter of possible exclusion from one's own community are powerful reasons for failures to seek help or change behaviour. Churches can play an important role in creating non-stigmatizing and inclusive models of community. But if they are to do so, then they need theologians and ethicists to confront issues of sin, sex and sexuality: issues which have lain at the root of the moralization and judgementalism for which religion has gained such an adverse reputation in terms of the global response to HIV prevention.

2. Community as the context for prevention

We use the word 'community' a lot, but it is not at all clear what we mean by it. Is it a place 'where two or three are gathered together'? Can any form of human association be classified as 'community'? Is my community defined by my city, my neighborhood, my church, or my extended family? Or is it defined by something else entirely? Do I belong to more than one community, each with its own social and cultural norms: such as my peer-group and my workplace? *Gideon Byamugisha, in Essay 4, p.91*

It is helpful to try and define the various communities of which we are members, because it is at the level of those communities that we encounter the factors that make HIV prevention *difficult*, and also those which make it *possible*. As Gideon Byamugisha puts it, the first question is how community activity can be scaled up if the challenges are to be addressed. The second question is: what (other) community activities need to be scaled *down* if that is to happen? Scaling up HIV prevention involves the empowerment of individuals to behave in a risk-free or less risky ways; and it also involves a careful analysis of the risk-increasing (and also risk-reducing) factors that are at work in our communities.

The idea of community is absolutely central to our faith: a principle it is not always easy for people in highly individualistic cultures to accept. In the Old Testament, the message of God's unconditional love was given not to an individual, but to a community, the people of God. In spite of its shortcomings, God has faith in the community, and also in the individual's capacity (and right) to live in community and to flourish. It is through God's love for us, and belief in us, as communities of faith, that we are enabled to have faith in one another, to accept our diversity, and to be welcoming to individuals. The prophets had strong warnings for communities that become so closed and exclusive that they turn away the stranger and the outcast, or fail to hear the voice of God when it comes from an unexpected source.

In the Gospels, Jesus does not reject existing models of community, or the cultures they represent. He accepts in full the Law around which God called the Jewish community into being.¹⁰ In other ways, though, Jesus challenges and defies community values. Those whom he healed are either outcasts or people on the fringes of those communities. 'Being healed' involves more than a physical 'cure': it involves reintegration of the healed person into the community, and it also involves a shift in the way the community sees itself. In the story of the woman accused of adultery, Jesus rejects the hypocrisy that enables community opinion to separate sinners from non-sinners. (John 7:53-8:11) He does not condone sin, but points to its ubiquity in society. All of us are sinners; but all of us, equally, may be forgiven.

3. Communities that stigmatize

'The task of faith communities and their leadership,' says Lisandro Orlov, 'is to develop transforming responses to the issue of stigma and discrimination, and also recognize that many times we have promoted them.'¹¹ The word 'stigma' comes from the marks that were branded (or burned) onto the bodies of slaves, providing a visible sign that they were unworthy to be included in human community. Today, the brand-

¹⁰ See the essays by Lisandro Orlov (Essay 7) and Robin Gill (Essay 6) in Part Two

¹¹ See Essay 7, p.122

ing or labeling is usually related to some perceived physical, psychological or moral condition believed to render the individual unworthy of full inclusion in the community. We may stigmatize those we regard as impure, unclean or dangerous, those who are different from ourselves or live in different ways, or those who are simply strangers. In the process we construct damaging stereotypes and perpetuate injustice and discrimination: which are made possible because of the link between stigma and the misuse of power to exclude vulnerable, marginalized people or discriminate against them.

In relation to HIV, Orlov speaks of 'the stigma and discrimination, which transform a medical diagnosis into a moral judgment'. This in turn leads to what has been termed 'self-stigma', which occurs when the despised condition or characteristic causes the person to internalize their outsider status and to end up feeling ashamed, inferior, and on those grounds unworthy of acceptance by others. Fear of stigmatization prevents people from seeking to know their HIV status, and discourages them from seeking help or changing behavior. Therefore they do not take advantage of care, treatment and support services until it becomes too late for interventions to be effective, and they may also fail to take measures to prevent further transmission of HIV.

The stigmatization of people living with HIV relates to a long tradition of Biblical interpretation that has been used to justify the stigmatization of people of color, Jews, slaves, women (as witches) and people with leprosy. Jesus, by contrast, seemed almost to seek out these stigmatized ones, not just as recipients of his healing ministry but also as his friends. On the Cross, He took on the full force of human stigmatization in his own body, and He redeemed it. It is easy to forget that the Cross itself (which has become the symbol of our faith) was, at the time of Jesus, the consummate 'stigma', the ultimate symbol of the world's rejection.

Christ is the living Word, and our Scriptures give witness to that fact. The Scriptures are also the route by which we can explore what the Word of God means, both to ourselves as individuals and for the communities of which we are a part. Traditions and forms of biblical interpretation can help or hinder people who are struggling to hear God's voice and

interpret God's will for them through the Scriptures. However hard we work at HIV prevention, we are undermining our efforts if we then use the Scriptures to oppress or stigmatize people who are affected by or vulnerable to HIV. Communities struggling with these issues have found themselves helped by scholarship that unlocks new meanings by giving a greater awareness of the historical and cultural worldview of biblical authors: a worldview that may be very different from our own.

However, it is in living ways that the Spirit of God speaks to the churches today, and brings them into authentic encounters with the living Word of God. For many Christians, the HIV epidemic has been one of these 'contexts of encounter'. We have listened to personal experiences of HIV and AIDS, and we have found that crucial questions arising from those experiences must be answered not only in the light of God's Word testified to in Scripture, or God's Word interpreted in the traditions of the Church, but also in the light of God's living presence and action in the lives of God's people today.

Thus we have found ourselves reading Scripture through very different lenses. Who, today, are the blind men, the 'maniacs', the people with leprosy, the women who are hemorrhaging or who have bent backs? Who are the women of passion who pour ointment over the Lord's feet or shout after Him in the street to help an epileptic child? Who are the 'women taken in adultery'? And also: who are the community members who judge, isolate and condemn?

Stigma, of course, exists within global and national responses to the HIV epidemic, and can also be a powerful factor in interpersonal relationships and individual responses. But it is at the level of human community that stigma and discrimination are perhaps most accessible to the saving, redeeming and totally non-stigmatizing love of Christ.

4. Compassionate care, compassionate prevention

'Become compassionate communities,' we are told. And yet it is not always clear what is meant by the word 'compassionate'. For example, one can feel 'passion' for a lover, one's work or even for chocolate.

Christians have used the word 'passion' in a very specific way, to refer to Christ's suffering and crucifixion. It is in this sense that we are using it here. If 'passion' means 'suffering, possibly unto death', then 'compassion' (or 'suffering with') would imply, literally, 'suffering *as if that person's pain were your pain too*'; or as we suggest here, 'not being able to look at the suffering and death of another without suffering yourself and in some sense dying alongside that person'.

Compassion is not the same as pity, which implies an element of condescension towards the person who suffers, as in 'I took pity on her'. Compassion, on the contrary, is never patronizing or condescending. 'Your suffering is my suffering,' it says. And because it implies that one is putting oneself in the place of the sufferer and participating in their pain, then their struggles against injustice or oppression inevitably become one's own struggles too. For compassion demands that one responds. The idea of 'compassion' suggests an intelligent long-term commitment to seeing the person brought back to the fullness of life and restored to their own community: of which the story of the Good Samaritan in Luke 10 provides an exemplar.

The theology of the Body of Christ is relevant here. The Body of Christ is made up of people who are living with or otherwise affected by AIDS, and also of people who are not. But we are all part of the Body of Christ; when one member of that Body suffers, all members suffer; and we are all, therefore, affected by HIV. By virtue of our membership of this Body, therefore, every single one of us is called to live in the presence of the compassionate, 'suffering-alongside' reality of the living Christ.

There is a danger, though, that our attempts at 'Christian compassion' may acquire a self-congratulatory character that emphasizes the sinfulness of the sinner and the holiness of the helper. A response to this difficulty is to 'see' the whole dilemma in a social justice frame. You cannot fight authentically for social justice if you do not feel compassion, or if your efforts to change a particular situation do not include a 'choice to suffer with'. Jesus, after all, wept over Jerusalem, just as he wept with Mary and Martha over the death of their brother Lazarus.

Misunderstandings about the nature of compassion have led, on occasion, to a tension between 'care' and 'prevention'. It is accepted that churches are motivated by compassion to *care for* people living with or personally affected by HIV; and yet the function of compassion in *preventing transmission* of HIV is not always obvious. In practice, the distinction between care and prevention is an artificial one. Effective care involves prevention, just as prevention strategies are more likely to succeed if effective treatment and care are available. Therefore care and support activities and programs are not just targeted on the physical health of individuals: they are (or should be) appropriate responses to those factors that make communities particularly vulnerable to HIV infection. This implies a resistance to poverty, oppression, gender-based discrimination, disempowerment, lack of education, debt that is related to illness, and a culture of silence that prevents the facts about transmission from being widely known.

Is it only within the community of faith that we should exercise compassion? Or does Christian compassion call us to revisit our understanding of the boundaries between the 'world of faith' and the 'outside world'? Christian communities live, unavoidably, with a tension between their understanding of the holiness sought by a community that comes together in the name of Christ, and the call to treat your neighbor as yourself. However inclusive and welcoming we seek to be, however open we are to change, we remain anxious not to lose a sense of community identity, community solidarity and community values. It is a tension that has no easy answers. Perhaps this is where the idea of 'compassion' comes into its own: the idea of 'suffering alongside the sufferer, even unto death', *whoever it is*.

5. Christian leadership and compassionate practice

In the early days of the epidemic, many church leaders believed that Christians (or church members) could not be affected by HIV: it was something that happened outside the 'AIDS-free zone' of the Church. When it became apparent that people living with HIV or AIDS were present in their own congregations or among their clergy, many responded with denial or an insistence on secrecy.

It takes a special kind of leadership to help faith communities to deal with challenges like these. Leaders are charged with conflicting tasks. To members of their flock and to the wider society, they have a duty of compassion (in the sense we have used this word above). But they also have a responsibility to preserve from harm the institution they have been called to serve. From this point of view, the challenges of HIV *prevention* can seem to be more complex ones than those which are presented by care, treatment and support of people already living with and affected by HIV. For one cannot address HIV prevention without also addressing such issues as gender, stigma, denial, marriage, relationship education for young people, sex and sexuality, the messages preached in our churches and the way the Bible is read. It is not irrational to fear that the process of opening up such matters may prove undermining to the identity of the very institutions they are charged to preserve.

It is at this stage that it becomes necessary to go back to one's theological roots. Where is Christ in this epidemic? Just what is the Holy Spirit saying to our churches today, through their experience of responding to the challenges of HIV prevention?

An example of religious leaders facing such a dilemma appears in the gospel story of the woman who had been 'bent over' for eighteen years. (Luke 13:10-17) She comes to Jesus, he lays his hands upon her and 'immediately she stood up straight and began praising God'. The leader of the synagogue objects on the grounds that it is the Sabbath. 'There are six days on which work ought to be done,' he says. 'Come on those days and be cured, and not on the Sabbath day.' This is not an unreasonable point. After eighteen years, one more day is surely no reason for failing to observe the Law. But Jesus' response was to turn on them and accuse them of hypocrisy. In some ways, this may seem unfair. The religious leaders had followed the rules. They had obeyed the Ten Commandments by upholding deeply felt and principled scruples about keeping the Sabbath. The leader of the synagogue had objected to the public flouting of these rules.

What he had not done was to hear the call of God to compassionate action. The point Jesus is making is that the Law and the demands of organized religion become sterile *once the bond between religious practice and compassionate practice has been broken*. The accusation of hypocrisy was one that Jesus directed particularly at religious leaders who had broken this bond.

People who are living with or especially vulnerable to HIV say they are accustomed to finding the bond between faith and compassionate practice broken, both by religious and community leaders, and by church members more widely. Leaders are breaking this bond when they refuse to face up to the prevalence of HIV in their community or church, spread mis-information about the virus or about evidence-informed means of HIV prevention, or turn away from compassionate action. What makes them (and all of us) into hypocrites is that – in the name of faith – we say one thing but do another. What has happened is that in becoming slaves to the Law, we have become deaf to the Gospel of Christ: a state of affairs which challenges faith communities to a living witness to the Gospel they preach or claim to believe.

However, this does not mean giving up on moral standards. In his encounter with the woman accused of adultery (John 7:53-8:11), Jesus is not condoning sinful behaviour or the breaking of the Law. What he does is to confront the crowd with the truth about their own sinfulness; and recognizing the truth of what he is saying, they fade away without speaking. ‘Has no one condemned you?’ Jesus asks. ‘Neither do I condemn you. Go your way, and from now on do not sin again.’

Communities need to find ways of exposing the truth about behaviour that puts their members at risk, which is especially difficult when such behaviour is so deeply embedded in community life that it is taken for granted. Examples might include glorifying predatory male sexual behavior, condoning violence against women and turning a blind eye to the abuse of children. These are all connected with the ways in which we relate to those who are closest to us; and because they often take place within the family or in situations of privacy, it is easy to deny that they are happening. The culture of secrecy that sur-

rounds them makes it unlikely that preaching (which is by its nature public) will have much effect.

Churches' credibility is undermined when there is a gap between what is preached and what is done; between the realities of people's lives and the messages coming from the pulpit or the synod. One of the most difficult challenges facing our church leaders is to break the silence that often surrounds HIV and AIDS. This silence leads to vulnerable people being rendered invisible, and the factors that lead to transmission being too shrouded in taboo to be spoken of. We are all undermined by the failure to make the connection between the rules on the one hand and, on the other, the need for compassionate practice.

6. Power and scapegoating

Churches have an ambiguous record in confronting oppressive power, both in public and institutional life and in private relationships. Some have colluded with political oppressors against the oppressed. Too many have been guilty of the oppression of groups and individuals on grounds of gender, disability, race, disease, caste or sexuality; too many have been silent in the face of violence against these groups. To some extent, the HIV epidemic has disturbed that silence, producing many examples of situations in which an honest focus on HIV prevention has thrown a spotlight on the need for sexual and gender relationships that are equitable and mutually empowering to both sexes: not just in the interests of justice (which has always been the case), but in order to save lives of girls and boys, men and women and their unborn babies.

The Gospel stories show us again and again how worldly powers can be transformed by healing, mutually empowering and saving love. The 'good news' of Jesus is that a new and inclusive community is not 'out there' in some distant future, but already among us or within us. (Luke 17:21) It is a community (or kingdom) that is graced and called to give priority to the needy and the poor, the marginalized and those excluded through gender, race, poverty, drug use, sexual orientation, disability or illness. Especially today, this includes those of us who are living with HIV. Compassion, though, is costly. Do we ever have the right to say to

somebody else: 'Your pain is my pain'? Seeking to establish community after the manner of Jesus involves putting down what power one has. One aspect of this 'putting down of power' is the abandonment of the buffer zone that keeps us safe from the loneliness, rejection, vulnerability and pain of others.

In stigmatizing responses to HIV, we see situations in which the most vulnerable and powerless have become, to some extent, the scapegoats for the rest of the community, carrying the weight of assumed 'sin' that should rightly be shared by all. The challenge to stigmatization and scapegoating comes from the heart of our faith: the theology of the Cross. Jesus' crucifixion is, rather, a call to end all scapegoating and stigmatization. Jesus was without sin. The scandal and folly of the Cross is not the scandal and folly of the crucified, it is that of the crucifiers, the stigmatizers and the scapegoaters. It is a message that has had to be repeated over and over again through the history of the Church, which after all is a communion not just of saints but of sinners.

Christian communities exist within the broken and breaking landscape of actual human history. Here, power is exercised without compassion. The vulnerable are turned into scapegoats for the sins of the rest. History reveals the natural inclination of communities to stigmatize, exclude, oppress, abuse and judge. The response to HIV prevention challenges us to confront these tendencies, to turn around, and to transform ourselves for our journey towards our eschatological home. It is a home whose characteristics are revealed in our Scriptures, in our traditions, in our own experience and in our God-given capacity to know truth. In this, the churches and their members are stronger if they are not alone, if they can come together with other churches in order to offer prophetic witness to their compassionate God, the God of Jesus Christ and of the whole human family.

7. Questions for discussion

- a. What different 'communities' do you personally belong to? What 'communities' or 'community-like groups' are you aware of in the church or social context with which you are concerned?
- b. This chapter opens with a quotation from Gideon Byamugisha. Relate this to your own experience of HIV prevention.
- c. Is it possible for a community to be 'compassionate' in the sense in which the word is defined in this chapter? What effect might 'becoming more compassionate' have on any of the communities you belong to?
- d. What gives us the right to say to a suffering person: 'Your pain is my pain'?
- e. Where is Christ in this epidemic? Just what is the Holy Spirit saying to our churches today, through their experience of responding to the challenges of HIV prevention?
- f. In your experience, what leadership challenges does HIV prevention present?
- g. What power dynamics (if any) would have to change in your community for effective HIV prevention to take place?

Chapter 4

HIV prevention at the individual level

We Christians will not be faithful if we apply yesterday's answers to today's and tomorrow's questions, especially when they are related to a problem which is as grave as the HIV pandemic.

— Adrian Thatcher in *Essay 5*, p.111

The aim of this chapter is to explore some of the theological challenges faced by individuals in relation to HIV prevention. As in the two previous chapters, we start with a summary of the challenges of this task. Again, there is much overlap between the individual and the community: but that is what could be anticipated, since HIV transmission is so closely related to the context of the individual's relationships, family, culture and peer-group.

We move on to six theological themes that were identified in our consultation as being particularly relevant to individuals (though again, these have a wider relevance). These are:

- sex and drugs, denial and silence;
- word made flesh;
- women and men, boys and girls;
- living more safely;
- vulnerability and the Cross of Christ;
- hope, Christian discipleship and HIV prevention.

1. Challenges at the individual level

Some of the difficulties churches face in addressing HIV prevention stem from their efforts to oversimplify the challenge. They may teach abstinence or faithfulness, or urge the use of condoms in certain situations. They may outline the principles on which Christian marriage should be built. They may preach about (for example) drug use or gender violence or sex between men or early sexual experimentation among young people. These messages, though, are unlikely to be effective if they are based on the assumption that every individual who is at risk is at liberty to control the terms of his or her own sexual encounters, or to cope with the difficult process of behavior change generally. This lack of understanding of individual risk and vulnerability¹² has so often led people and communities to attach moral blame to individuals, without taking into account the context of vulnerability that many live in, the risks that are inherent in the day-to-day environment of their lives, or the power differentials that make it impossible for some people to choose the less risky option.

In the past, teaching about sexuality used to be relatively uncontroversial. The 'do's and don'ts' were fairly clear, even if they were not always observed. Today, almost everywhere, it is much more complicated. There is a gap between traditional preaching and what actually happens in homes and neighborhoods and workplaces and peer

¹² The following definition of risk and vulnerability is taken from the UNAIDS Practical Guidelines for Intensifying HIV Prevention: '**Risk** is defined as the probability that a person may acquire HIV infection. Certain behaviours create, enhance and perpetuate risk. Examples include unprotected sex with a partner whose HIV status is unknown; multiple unprotected sexual partnerships; injecting drug use with contaminated needles and syringes. **Vulnerability** results from a range of factors that reduce the ability of individuals and communities to avoid HIV infection. These may include: (i) personal factors such as the lack of knowledge and skills required to protect oneself and others; (ii) factors pertaining to the quality and coverage of services, such as inaccessibility of services due to distance, cost and other factors (iii) societal factors such as social and cultural norms, practices, beliefs and laws that stigmatize and disempower certain populations, and act as barriers to essential HIV prevention messages. These factors, alone or in combination, may create or exacerbate individual vulnerability and, as a result, collective vulnerability to HIV.' http://data.unaids.org/pub/Manual/2007/20070306_Prevention_Guidelines_Towards_Universal_Access_en.pdf

groups, and this gap is widened by institutional resistance to talking openly about sex and sexuality. The result is that over much of the Christian world one encounters a great gulf between the actual realities of people lives and those that are officially assumed in the context of their churches. This is an important consideration for HIV prevention, since transmission of the virus is connected with *what actually happens between people*, and not *what they would like us to believe* about what happens.

Partly because of the above, church congregations have not always been 'safe spaces' for people living with or personally affected by HIV. Because we are afraid of stigma and moral blame, those of us who are living with HIV may feel that our churches are the last place we would choose to disclose our HIV status. The tragedy of this is that the experience of living with HIV makes a person uniquely well qualified to talk about HIV prevention in down-to-earth, realistic, non-judgmental and unstigmatizing ways. As a result, a valuable contribution to HIV prevention goes largely untapped, and the lives of people living with HIV or AIDS are seriously diminished.¹³

2. Sex and drugs, denial and silence

Humanity is created in the image of God. Since it is through sex that human life is generated, sexuality is to be regarded as a dimension of God's self-giving, and therefore a gift from God. God's love for us is the template for human loving, situated at the very heart of our faith experience, since it is because we are loved by God that we are able to love each other.

These are simple statements: but the problem is that many people do not, in their hearts, believe them. Human loving rarely measures up to our image of the love of God. Sexual activity is often associated with sin or impurity or shame, and Christians may find it almost blasphemous to imagine that God could be present in their love-

¹³ Thanks partly to the work of positive networks such as ANERELA+, GNP+ and ICW, there are increasing numbers of situations where this is not the case.

making. For women and girls, particularly, the connection between sex and sin is a living one in many cultures. And so the one activity (sex) that is, above all others, a transmitter of life becomes instead a transmitter of sickness and death, to be punished by God with a dangerous and possibly deadly disease.

As Peter Okaalet says in Essay 3, it is not because of the need for HIV prevention but 'it is because we believe that sex is part of God's plan for human beings that we want to be able to talk openly in our churches, and for it not to be shrouded in an embarrassed and guilty silence'.¹⁴ In Essay 1, Margaret Farley argues powerfully for Christian churches to develop an ethic of 'just love' within which relationships are governed not by taboos but by considerations of justice. So churches and their members need to develop and articulate theologies of human sexuality that are rooted in justice, wholeness and the idea of loving, truthful relationship. These are the kinds of understandings that flow not from an image of a punitive, judging God, but of a God who delights in human creativity and wants us to have loving human relationships that mirror the humanity of Christ, and the relationship-building power of the Holy Spirit.

Negative views of human sexuality and sex are profoundly unhelpful to the agenda of HIV prevention. For example, the lack of a language for talking about sex makes it impossible for churches to deliver effective messages about HIV prevention. Violent, abusive or exploitive sex is made more likely by the association between sex and sin, or sex and shame, especially in relation to women. When churches are deaf to the cries for help of sexually abused or exploited women and children, it is an affront to justice. They are failing in their duty of compassion when they permit the silence and denial that provide a safe space for violence, exploitation and abuse.

The fact that we are loved by God also makes it important not to engage knowingly in forms of behaviour (sexual or otherwise) that may harm ourselves. We are responsible for our own health as well

¹⁴ Essay 3, p.84

as for that of other people. It is therefore crucial to know what is safe and what is not, and how to protect oneself from harm in the face of a mysterious disease that may lie in the body, dormant and invisible, for many years, and whose presence it is therefore all too easy to deny. Everyone should know their HIV status, says the religious leaders' network INERELA+¹⁵.

In helping individuals to avoid the transmission of HIV, information should therefore be complete, comprehensive and evidence-informed.¹⁶ We have focused mainly on the stigmatization of sex as a barrier to HIV prevention: but there is also a high level of silence and denial surrounding injecting drugs, which in some parts of the world is the major transmission route. Therefore 'knowing about HIV prevention' includes all routes of transmission: via unprotected sex, via blood or blood products, via injecting drug use with non-sterilized needles, via mother-to-child transmission or via breast-feeding. This is the only way that believers can make (or encourage others to make) well-founded judgments about their behavior. It is an abuse of power when churches (or other institutional bodies) withhold or dilute information that may save lives. Embarrassing as it is to talk or write about such matters, it is nevertheless a misuse of moral authority when life-saving information is so wrapped up in euphemistic or judgmental language that the ordinary person cannot understand what it means. It is because we believe in the basic dignity of every man and woman that we seek the elimination of ignorance, illiteracy and poverty. Thus, like Job, we start with information, and we move towards understanding, inspiration, illumination, and wisdom. (Job 28:28)¹⁷

This does not mean that considerations of morality and church teaching should be ignored. What it does mean is that accurate information, openly discussed, is the common starting point from which faith communities can begin to reflect on the moral implica-

¹⁵ The International Network of Religious Leaders living with or personally affected by HIV or AIDS

¹⁶ See Margaret Farley's essay, Essay 1 in Part 2 of this book.

¹⁷ See Peter Okalet in Essay 3, p.84

tions of what has been learned, and to engage in the kind of educated discussion that can inform their reflections on what might be regarded as 'lawful' or 'acceptable' behaviors within their traditions. In terms of HIV prevention, one overriding moral position would be that churches should not endorse sexual practices, behaviors, or cultural customs that might lead to the transmission of HIV or other sexually transmitted infections.

All Christian traditions advocate fidelity in marriage. In addition, mutually faithful marriage between uninfected partners is an effective way of avoiding the sexual transmission of HIV between partners. However, it is an unfortunate (and often unacknowledged) truth that many marriages are not mutually faithful, and it is not uncommon for the faithful partner (usually the woman) to find that she has become infected with HIV by an unfaithful husband. This exposes the distinction between what is lawful (that is, consensual sex between married partners) and what is safe (which unprotected sex, consensual or otherwise, may not be). What churches teach in such situations needs to be rooted in justice and respect for people. The rules they make should not support practices that abuse the social, economic or physical vulnerability of individuals, or expose those individuals to harm. If churches are to concern themselves with sex at all, then they must also concern themselves with *safer sex*.

3. Word made flesh

When churches experience difficulty in addressing the issues of sex and sexuality that are raised by HIV prevention, it is a manifestation of the more widespread ambivalence of church tradition towards the human body in general. In relation to HIV prevention, this is a very productive area for theological reflection. For, in Adam and in Jesus, both the Old and the New Testament start with God making real, live, flesh and blood human beings.

What does it mean, in this context, to talk about 'Word made flesh', or to say with conviction: 'the Word became flesh and lived among us'? (John 1:14)

In Essay 5, Adrian Thatcher writes:

We need to return to the distinction between – on the one hand – God-the-Word, made flesh in Jesus Christ (John 1:14) and, on the other hand, the words of the scriptures. God comes into the world, in Person, in the flesh of Christ. That is the Christian faith. It is Christ who is God's Word, and even the well-intentioned habit of speaking devotionally of the Bible as 'the Word of God' obfuscates the pre-eminent position of Jesus Christ as the final and unalterable revelation of the Triune God.¹⁸

Both Scripture and tradition provide vital signposts for our journey through life. We speak with reverence of God's Word contained in Scripture (which is found in books), or God's Word interpreted in the traditions of the Church (which is found in the structures of the Church). But it is in Jesus Christ, the Word made flesh, that we find God's living presence in the lives of God's people today. Because He was real flesh and blood, and because that is the substance of which we too are made, we know that the incarnate Christ, the Word made flesh, is really here in our midst, in our own embodied lives and those of our fellow human beings. Within the incarnation of Christ the whole of our sexual, psychological, biological, emotional and spiritual being is affirmed.

Insights such as the above, emerging from the church's experience of HIV, have led Christians who are involved in the response to this epidemic to question ecclesial traditions and traditions of biblical interpretation that appear to suggest that the human body is somehow not good enough for God: that it is impure, sinful, a source of temptation, lust and greed. Thus many theologians and Christian practitioners, believing that the Spirit really is speaking to the Church through its experience of HIV and AIDS, have found themselves drawn to re-examine Scriptural texts and to re-visit the traditions of interpretation that have led to negative body theologies. This is because we honor our Scriptures and our traditions, through which God's Word, incarnate in our own world and our own time, must be discerned and interpreted by the people of the age.

¹⁸ Essay 5, p.105

4. Women and men, boys and girls

As Peter Okaalet notes in his essay:

It is now generally accepted that the capacity of a culture or community to resist HIV transmission is associated with the position within it of its female members.¹⁹

The part that gender inequality plays in the transmission of HIV has been strongly and repeatedly emphasized in these chapters. Gender inequality has always been an issue of justice and also of development. Rape and gender-based violence have always been regarded (officially) as morally unacceptable. It has always been known that drunkenness can lead to the abuse of women and children. The difference today is that the HIV epidemic has brought about a situation in which these are no longer 'mere' moral issues: they have become a threat to life itself. So the spotlight is on gender as never before, making this a moment of opportunity that should not be missed.

This observation has rightly led to a focus, within prevention debates, on the need for the social and economic empowerment of women, and the need for girls to develop the confidence and the relationship-skills to co-determine the conditions of their sexual encounters: for example, questions of whether, when, where and with whom such encounters take place. Missing from this argument, as participants in the present dialogue pointed out, is the subject of men and boys. In relation to HIV prevention, women and men, boys and girls are all caught in a trap that is made up of apparently immutable constructions of masculinity and femininity, which are reflected in and affirmed by the social and theological construct of masculinity prevailing in all churches and in most societies.

It is sometimes assumed that the answer is marriage. Provided both partners are sero-negative when they marry, the sexual transmission

¹⁹ Peter Okaalet in Essay 3, p.80

of HIV will not occur in a monogamous marriage that is characterized by complete mutual fidelity and the kind of 'just love' that Margaret Farley speaks of.²⁰ This is also the ideal of marriage that all churches would say they believe in, reflecting as it does Christ's unconditional, faithful, generous love for His people and His Church. It may therefore be difficult for Christians to admit that many marriages (perhaps including their own) do not measure up to this ideal.

Christian leaders, at all levels, have the power to influence church thinking about what happens within marriage, and the attitudes and beliefs of people who are preparing for it. For most people, the answer is not to attack the institution of marriage but to focus on the quality of relationships within marriage. However, experience seems to show that a culture of silence exists within most churches when it comes what goes on behind the closed doors of the matrimonial home: a state of affairs that may lead to the home itself becoming a place where abuse may happen with impunity, while children look on and learn that physical violence and verbal abuse are the norm.

It is unrealistic to assume that the Church's responsibility for married people ends once the knot has been tied. It is also over-optimistic to assume that young people will develop healthier approaches to marriage than those which their parents demonstrated while they were growing up. Difficult as it is, marriage preparation should include an opportunity for an honest exploration of what it means to be a man or a woman (and especially, perhaps, a Christian man or woman) in that culture. What gender assumptions do couples have when they enter the marriage? What are the realities of marriage relationships in societies where polygamous marriages are or other forms of concurrent sexual relationships normal? It follows, then, that in order for realistic preparation and support for marriage to happen, there must first be a systematic effort to help the couple understand the systems and cultural influences in which the institution of marriage is placed.

²⁰ See Essay 1, p.66

Malawian theologian Isabel Phiri says, 'The major problem of African Christians is their uncritical reading of the Bible'.²¹ It is not just to African Christians that these remarks could be addressed. Today, increasing numbers of theologians and church leaders have become aware of the dominance of biblical interpretations that create constructions of masculinity and femininity that promote vulnerability to HIV. In Essays 3, 5, 6 and 7, Peter Okaalet, Adrian Thatcher, Robin Gill and Lisandro Orlov all argue this case. In the shadow of HIV, though, African women theologians have been energetic and inspirational in their efforts to read the Bible differently. Thatcher refers particularly to the work coordinated by Beverley Haddad in KwaZulu-Natal,²² where remarkable theological insights have arisen from contextual bible studies of the stories of, say, the rape of Tamar (2 Sam.13:1-22) and of the woman with a haemorrhage (Mk.5:21-43).²³ In a time of HIV and AIDS, such research makes a crucial contribution to our understanding of the relationship between Word-made-flesh and the words of Scripture.

5. Living more safely

When our children are born, our prayer is that they will live safe, healthy and loving lives. But how does one live safely, healthily and lovingly in a time of HIV and AIDS? For some time, the favored answer to this was the much-used prevention acronym ABC (**A**bstinence; **B**eing faithful to one partner for life; **U**sing **C**ondoms). Prevention programs vary in terms of the weight they attach to these three elements. For example, some programs will focus primarily on the promotion of abstinence, or on the ideal of a lifetime's fidelity to one sexual partner. Others (more realistically, they themselves would say; less morally, their opponents would say) will stress the importance of condom use.

²¹ Isabel Apawo Phiri, 'HIV/AIDS: An African Theological Response in Mission', *The Ecumenical Review*, 56.4 [422-31], 2004, p.427.

²² For more detail, see Adrian Thatcher's Essay 5.

²³ Haddad, B, 'We Pray but We Cannot Heal: Theological challenges posed by the HIV/AIDS crisis', *Journal of Theology for Southern Africa*, 125, 2006, 80-90.

As a well-known prevention mantra, 'ABC' has been widely used and energetically defended, mainly because it seems so totally logical. Today, however, it is recognized that 'ABC' has major limitations as a universal recipe for prevention, and does not appear in the UNAIDS programmatic principles for HIV prevention. A brief reflection on these limitations demonstrates some of the points that were made in the previous chapter, dealing with communities. For example, 'ABC' is focused exclusively upon sexual behavior and takes no account of mother to child transmission, transmission through injecting drug use, or transmission in healthcare settings. Further, it implies that people who enter into sexual relationships are always in a position to make choices about how, where and with whom these are conducted: which is manifestly not the case for the majority of the world's women, for young people or for other vulnerable groups. Congolese theologian Ka Mana Kangudie argues that the ABC message is not only useless to women, but also to men who believe that abstinence reduces virility, 'being faithful' reduces male power and vital force and condoms block body tubes and the flow of vital juices and thus masculinity.²⁴

Critiquing both the ABC and the Ka Mana positions, Gideon Byamugisha and Japé Heath²⁵ argue in Essays 4 and 2 for the need to address what is really happening in communities, and not what one would like to believe is happening. Therefore, as an alternative to ABC, ANERELA+ has developed the so-called 'SAVE'²⁶ model, which goes much further towards acknowledging the complexity of HIV prevention, and does take account of the limitations of ABC. SAVE stands for:

- Safer practices (in relation, for example, to sex or injecting);
- Available medication for HIV, for TB or for STIs;

²⁴ Kangudie, Ka Mana, *Les Religions face au VIH / SIDA en Afrique: Discours et Problèmes*, in Congo-Afrique 2007/47

²⁵ Both founder members of ANERELA+, the African Network of Religious Leaders living with or personally affected by HIV or AIDS.

²⁶ See Essay 2, pp.71-72 for a more detailed account of SAVE.

- Voluntary testing and counseling;
- Empowerment of people (especially women and children) who are unable to limit or control their own risk-taking behaviour.

This list, which provides a helpful framework for living safely in a context of HIV, has been accused of lacking the ‘value base’ of ABC. SAVE’s advocates reject that view. Life itself is a value, they say, and a commitment to preserving life is a moral commitment. There has to be life in order for goodness and holiness and faithfulness to flourish. The bizarre thing is that sexual activity, which is where a human life begins, has become (for many in sub-Saharan Africa, at least) a potential source of death. Therefore SAVE is not in itself a recipe for faithful living: it provides a non-judgmental framework, within which loving, faithful lives may be given the chance to happen at all.

For those religious people who fear that SAVE is abandoning crucial moral principles of chastity and fidelity, ANERELA+ states:

The adoption of SAVE does not imply the abandonment of abstinence. The ‘S’, for ‘safer practices’, includes abstinence as well as a wide range of evidence-based HIV prevention interventions. HIV prevention can never be effective without a care component. The SAVE model combines prevention and care components, as well as providing messages to counter stigma.

We are called to promote justice in sexual relationships. And as Farley and others argue in Part 2, justice is premised on the principle of the dignity of every human being. That means we should not treat individuals merely as objects for our use or enjoyment. On the contrary, sexual relationships should be based on mutuality, equality, consent, and a level of commitment to the other person. They should also carry the possibility of fruitfulness in some form, although this would not necessarily be confined to biological children.

This template for relationships takes us back to the gospels. Jesus said, 'You shall love the Lord your God with all your heart, and with all your soul, and with all your mind, and with all your strength... You shall love your neighbor as yourself'. (Mk 12:30-31) In John 13:34, he commanded us to 'love one another as I have loved you'. The realms of marriage or sexual relations are not exempt from these general commands about human relationships, as some would have us believe. In this time of AIDS, we all are called upon to recognize each other as God's beloved children, fully human, equal in dignity, to be treated with respect, and not to be abused and exploited.

6. Vulnerability and the Cross of Christ

As the notes of group discussions record, participants in the consultation noted:

The disputes present in the faith communities are not simply about biblical interpretation, nor simply about sex, but more deeply over the meaning of being a male and female, what or who counts as human, and the broader social contexts which the disease raises up (what Paul calls the principalities and powers of this world) which always afflict the vulnerable.²⁷

Vulnerable means 'easily wounded'; and all cultures have their 'easily wounded' groups. They are vulnerable because they are weak, or sick, or poor, or unable to cope, or have some characteristic that is stigmatized by the majority population. In the world of the Gospels, the vulnerable ones included women, children, the blind, the sick, the disabled, the disfigured, those with leprosy, the unmarried women, and people with mental illnesses. Poverty inserted another layer of vulnerability, because poor people did not have the resources to cope when things went wrong. It was for these vulnerable ones that Jesus had compassion, because He saw that they were 'like sheep without a shepherd'. (Mk. 6:34) It was to them that He brought healing and acceptance.

²⁷ Notes from group discussion, Day 3 of Theological Consultation on HIV Prevention

Today, the populations that are particularly vulnerable to HIV include men who have sex with men, migrants, refugees and asylum-seekers, prisoners, injecting drug users, street children, transgendered people, male and female sex workers, or others who are rendered vulnerable by particular contextual factors. Being a woman adds another layer of vulnerability, and so does the reality of being a usual sexual partner of an individual who falls into the above categories.

If HIV prevention is to be effective, it needs to be appropriately targeted. In contexts where HIV prevalence is more than 15%, as it is in some sub-Saharan African countries, prevention efforts need to be carried out among the general population. On the other hand, it is for these vulnerable groups that HIV prevention efforts are so particularly important in contexts (such as those listed above) where the epidemic is concentrated among certain populations and where prevalence is still low among the general population. This targeting strategy is not just for the sake of individuals, but also for the future trajectory of the epidemic itself in that context.

The problem is that churches have not always tried to understand and respond to these vulnerabilities, and indeed have participated sometimes in their causes. It is rare, in practice, for programmatic Christian responses to AIDS to include practical efforts to work with marginalized populations, although most people will know of shining exceptions to this generalization. This is despite of our claims to be followers of a Savior who embraced the vulnerable, made friends with them, liberated them from stigmatization, and did away with marginalization by becoming vulnerable Himself and dying on the Cross.

Vulnerability, then, becomes a hermeneutical key that unlocks for us a perspective which goes beyond mere social welfare. We find God hidden, paradoxically, in people we consider vulnerable, weak and impure. As Christians, there are two ways in which we respond to this perception. The first is the simple recognition that we are all vulnerable. We are all at risk, however much we say 'It cannot happen to me,' or 'HIV only affects the young, or the unmarried, or the

economically poor, or people in Africa, or women, or non-Christians, or those whose sexual orientation is different from mine or who belong to different communities from mine'. We are all, in a sense, living with HIV, because we live together in a world that condones the marginalization and stigmatization that make some members of the human family so vulnerable.

The second way is to learn to see Christ in what is vulnerable. It is in the Cross of Christ, and in the vulnerability of the Man on the Cross, that we discover the prophetic depth of the theological insights unlocked by the experience of living in the context of the HIV epidemic. St Paul writes:

The word of the cross is foolishness to those who are perishing, but to us who are being saved it is the power of God. For it is written, 'I will destroy the wisdom of the wise, and the cleverness of the clever I will set aside'. (1 Cor. 1:18-19)

This fundamental text offers a road map for those who are living with or affected by HIV. It allows us to understand that God's self-revelation is always paradoxical and hidden to the human understanding. The paradox of the Cross is that it is not, finally, about the emptiness of human plans or the shallowness of human perceptions; and nor is it, finally, about suffering. For the crucifixion was not the end. In the Cross, we find that loving 'even unto death' is, paradoxically, the way to life; so that finally, the message that comes from the Man on the Cross is, simply, that we are loved.

7. Hope, Christian discipleship and HIV prevention

In a world where millions are infected with HIV, millions have died of HIV-related diseases and there seems to be no end in sight, it is all too easy to lose hope. Hope points to the end or goal of our journey and of the Church's journey. Hope offers a vision of what-is-to-come that allows us to reshape the narrative of our lives in the light of both present realities and an anticipated future. Hope enables us to believe in a 'promised land' and gives us a road map for getting there.

As we pointed out in the previous section, this hope is rooted in the life, suffering, death and resurrection of Jesus Christ: it acknowledges the Cross but believes that the Cross is not the end. Thus the reality of AIDS leads us not simply to see death, suffering and stigma, but also to believe in new life, positive living and new possibilities. It energizes us to move beyond a daunting, sometimes discouraging present to a future where things really can be different. In the light of this eschatological hope, we see the HIV prevention agenda not as a multitude of disparate, unconnected and possibly futile efforts, but as an achievable goal that can be reached through the kind of unified agenda (global, national, local, interpersonal and personal) that we are speaking of here.

Fatalism and hopelessness demotivate. They create and then feed on perceptions that we are powerless to change our circumstances. Treatment, care, support, education and prevention programmes are important, of course. But no amount of programmatic intervention is going to succeed without a living hope that a better future is not just *available* but also *achievable*. Therefore hope for an end to HIV will lead us to challenge those structures and systems that create vulnerability, helplessness and despair. In particular, it will lead us to challenge the marginalization, invisibility and hopelessness that add to the vulnerability of those populations and individuals who are most at risk of HIV transmission.

In the overall global, national and local response to the HIV epidemic, the call to become agents of hope is one that faith communities must hear. Most powerfully of all, it is addressed to the Church, which is the community rooted in the living experience of the birth, life, death and resurrection of Christ. Yes, the narrative of our faith includes the Cross: but its culmination is the resurrection, and then the founding of Christian community through the discipleship of a few men and women who had a personal relationship with Jesus. Today, we see Jesus Christ working within communities of disciples, through the power of the Holy Spirit, to bring about a world marked by justice and peace. What does it mean to be one of those disciples?

Christian discipleship brings us to the power structures in our global society and names the realities that deny vulnerable women, men and children the opportunities for human flourishing. Christian discipleship calls our Church communities to re-visit and reclaim aspects of our traditions that have been used in life denying ways. 'I came that they might have life and have it abundantly,' said Jesus (John 10: 10). Christian discipleship, on a personal and interpersonal level, calls us to walk with those who are vulnerable in society as they struggle with realities that place them in danger of infection.

Hope and discipleship come together and allow us to 'imagine into being' a world where the apparently-immutable reality of HIV and AIDS can give way to a vision of a transformed world where we will hear a voice saying:

See, the home of God is among mortals.
He will dwell with them,
they will be His peoples,
and God himself will be with them.
He will wipe every tear from their eyes.
Death will be no more;
Mourning and crying and pain will be no more,
For the first things have passed away. (Rev. 21:3-4)

And like the writer of the Book of Revelation, that great hymn to Christian hope, we will hear the One who is seated on the throne say, 'See, I am making all things new.' (Rev. 21:5)

8. Questions for discussion

- a. In your church community, is it possible for people to talk honestly to each other or to young people about sex and sexuality?
- b. What does it mean to be a man or woman in your society, culture or church? What are the expectations of you, as a man or a woman? Do any of those expectations make it difficult to avoid situations or activities that put women or men at risk of HIV?
- c. Who are the vulnerable people in your church or neighborhood community? Are there vulnerable people in your environment who are marginalized within those communities or who might feel excluded from them?
- d. Why is hope so important a factor in HIV prevention, and what would be the 'good news' that would enable you and the people around you to hope that things might get better?