1. A new commitment

It is now twenty years since HIV/AIDS came out of the shadows. Then, church facilities were among the first to respond to the challenge. Ever since, churches have been deeply involved, with the Catholic Church alone supporting around 25% of all HIV/AIDS care worldwide. But the epidemic continues to escalate, accompanied by complaints that religious organizations do more harm than good when it comes to HIV prevention.

In the past, church hierarchies have tended to react defensively to such accusations. Today though, Christians are dying, clergy are dying, church leaders are dying. AIDS is not just happening ‘out there’, and to ‘other people’: at every level, the Church itself is living with and affected by HIV. In recent months, therefore, church leaders have organized a series of consultations designed to revisit their record on HIV/AIDS, and see how they can address the issue more effectively. Anglicans, Roman Catholics, Lutherans, Presbyterians, Methodists, the Salvation Army, the various ecumenical bodies, the united churches of North India, Thailand and elsewhere: church leaders of Africa meeting ecumenically with northern partners, the leaders of the Salvation Army in Africa: they have all issued statements acknowledging past failure and committing themselves to change. HIV/AIDS, they say, is nothing like the world has known: for this epidemic, now, the old ways just won’t work.

The question is, what next? Churches are complex organizations, and archbishops and bishops are pastors to all their people. The church, particularly in poor countries, has many other problems, and few of its leaders are in a position to drop everything else and focus on AIDS. They hesitate to say so publicly, but privately many admit that they don’t know what to do, they don’t know where to start, and they are afraid that if they say anything it may be the wrong thing. The aim of this article is to throw some light on the challenges facing church leaders, as they grapple with the consequences of this new commitment.

2. Saving lives, saving souls

Churches are justly proud of their caring record. However, this caring role has generally been conducted not by the congregations of the faithful, but by professional people doing the job on the churches’ behalf. It is a matter of history that the Church has tended to separate its life-saving mission from its soul-saving one. Thus church leaders may raise money for clinics, orphan programmes or hospices, sit on their governing boards, or visit regularly and give the work their blessing: but apart from that, the organization may carry on quietly with its caring role without much interface with local congregations.

Today, though, it is at local church level that the main burden and challenges of the HIV epidemic are felt. This is where the Church exercises its pastoral ministry, where long-term Christian formation takes place, where Christian community is built, where people are brought to God and souls are saved. The caring church and the healing community: they are different models or paradigms, often using
different vocabularies, different concepts, and different tests for truth. What is the goal: prevention of disease, or salvation? Which is the problem: the virus or the sin? Which is more to be feared, death or damnation? Should responses be interventionist (pharmaceuticals, condoms) or moral (abstinence, faithfulness)? When people complain that the churches contribute to the rapid spread of HIV, then it is this second model, the soul-saving church and its leaders, that they have in mind. That is what leaders mean when they confess that they and their churches have ‘contributed to death’.

3. Silence and stigma: the biggest enemies

The biggest obstacle to HIV prevention is now generally acknowledged to be the stigmatisation of people living with or affected by HIV/AIDS, and the silence and denial it causes. Clergy with HIV have been dismissed from their jobs, shunned, and forced to marry again if they are widowed. Religious leaders have “added to the misery of people living with HIV/AIDS by condemning them as ‘wrong-doers’ or ‘sinners’,” says a Ugandan study. People with HIV and their families have been excluded from churches, publicly exposed, refused pastoral care and funeral rites, and in extreme cases have been killed. Without a word from the churches, orphans have been thrown out of their homes, accused of being cursed, and either excluded from school or made to sit separately with other ‘AIDS kids’. Few people are willing to state that a relative has died of AIDS, and one study showed that less than one in ten home-care volunteers will admit that the person they are caring for has HIV/AIDS. One result is great suffering for people who are known to have HIV and their families. Another is massive reluctance, among people who fear they are infected, to come for help or to take steps to avoid passing the virus on. Even in situations where antiretroviral treatment is available for pregnant women, mothers are often so afraid of stigmatisation that they will risk having an HIV-positive baby rather than come for testing themselves.

‘For the churches,’ said one group of church leaders, ‘the most powerful contribution we can make to combating HIV transmission is the eradication of stigma and discrimination: a key that will, we believe, open the door for all those who dream of a viable and achievable way of living with HIV/AIDS and preventing the spread of the virus.’

For church leaders, this may offer a way forward. Of course home-based care, youth education and so on are important. Adequate resources are essential, and it is vital that the individuals responsible for them have high enough institutional status to make them happen. Combating stigma, on the other hand, involves highly personal commitment, and the courage to take a public stand. When leaders do this, the stories spread like wildfire and HIV/AIDS may literally take on a new meaning in people’s minds. One Ugandan Anglican bishop admitted publicly that his son died of AIDS, and thus brought about a sea change in the willingness of ordinary church-people to talk about it. A Catholic archbishop from the Caribbean was so angry when he heard his priests had refused to visit a woman with an AIDS-related illness that he visited her himself on a daily basis, and personally conducted her funeral mass in his cathedral. In the Anglican Church of the Province of Southern Africa, in 2001, all the bishops were voluntarily tested for HIV. Today in Uganda, when the Anglican priest Gideon Byamugisha risked scandal and discrimination by coming out and living openly with HIV, the Church of Uganda made him a Canon.

Language can be a potent tool for stigmatising and excluding. Leaders should watch their own language in talking or writing about HIV/AIDS, and ban the language of ‘us’ and ‘them’ in the documents produced by their churches. The fact is that when churches stigmatise and exclude people living with HIV/AIDS, they are discriminating against their own body, and the whole Church loses credibility. HIV positive pastors and others have the potential to be the most powerful of resource-people in combating stigma and discrimination. Church leaders could take positive
steps to encourage them to come out and live openly with the virus, rather than stigmatising them, excluding them, or denying their existence.

“The churches are impossible to work with,” a WHO regional director told me, “because they have so many agendas that are actively hostile to HIV prevention.” There is a belief, among people working in the field of HIV/AIDS prevention, that the stereotypic religious leader is a conservative moralist who deplores any form of sexual behaviour that takes place outside the context of monogamous, heterosexual marriage. He (our stereotypic leader is always a ‘he’) particularly disapproves of the condom (which most professionals regard as a key resource in controlling the spread of HIV), and creates obstacles to effective sex education in schools and youth clubs.

These stereotypes can sabotage efforts to find a distinctive, credible and publicly respected role for churches and other faith-based organizations within the overall task of reducing HIV transmission. Today, church leaders have expressed their determination to work for transformation within their churches. Maybe the time has come for those on the outside, who complain about churches being impossible to work with, to revisit negative attitudes towards religious institutions, and engage them as partners in breaking the silence.

4. Chastity or common sense?

The Church’s traditional message is one of abstinence before marriage and monogamy after it. Over much of the globe, though, abstinence and monogamy are not the norm, and HIV/AIDS is evidence of this. What does this mean for the Church?

Chastity and marriage, say social anthropologists, were originally connected with rules governing property, particularly women-as-property, and societies reinforced these property rules by means of religious codes. Hence abstaining from sex before marriage and being faithful to spouses afterwards is what most cultures officially expect. In practice, this is often a fiction and most people know it. Thus the chastity and abstinence scenario becomes a kind of parallel reality: intended for public consumption, backed by social and religious sanctions, and designed to conceal the real facts. This is bad news for public health planning, which depends on addressing what is really going on, not what people wish were true. It is also bad news for the church, which cannot be successful in combating transmission of HIV until it engages with the moral contradictions implicit in this reality gap.

When cultural norms contradict religious teaching, especially in the case of something as near to home as sexual behaviour, then culture generally wins. Being one of a group or community means conforming to the gender expectations implicit in your own culture. For young people, this may mean being sweet and innocent if you are a girl, or macho and assertive if you are a boy. Moral lectures are almost irrelevant: it is virtually impossible for individuals, especially young people, to stand against the social mores of their peers. Behaviour change starts with an acknowledgement of what really happens, and it takes place at the level (and in the company) of ones peers and one’s own community. This represents a real minefield for church leaders, who fear that ‘accepting the reality of people’s lives’ will mean waterering down traditional teaching, and undermining their advocacy of faithful sexual relationships. It is naïve to imagine that churches will reconstruct their ethical teaching with the sole object of enabling people to avoid sexual infection. In this situation, what is the distinctive contribution the Church can make?

First, its message should not contradict the public health message. Nevertheless, it is not necessarily the same as the public health message. Loving, truthful, non-exploitive relationships are at the heart of the gospel. What church leaders could do is to ask others working in the field of HIV prevention to support them in focusing on what is already at the heart of the gospel message, which is the
importance, for human growth and happiness, of relationships that embody the values of life, hope and truth. In return, churches might agree to stop picking and choosing which bits of the public health message they want to deliver, stop condemning the use of condoms when these will save lives, and stop undermining prevention efforts by those who promote them.

5. Church leadership and national strategy

Over much of the globe, faith-based organizations have considerable moral and political clout. In some countries they have advocated for better statutory reproductive health or testing services, or more humane treatment of people with HIV/AIDS. In South Africa, churches have been active in the campaign for medication to prevent mother to child transmission of HIV, and two successive Anglican Archbishops have risked censure by the stand they have taken on AIDS.

By contrast, negative reactions from influential religious authorities can torpedo national policy and turn public health planning into a battleground. In Latin America and in parts of Africa, certain churches have gone out of their way to undermine public strategies, disassociating themselves from national campaigns on the grounds that they advocated condoms or promoted sex education in schools. They have disseminated false information in order to prove their points, withheld vital information about prevention, and used language in manipulative and inaccurate ways. “AIDS is caused by adultery,” states a council of churches document on HIV and youth. “Using condoms results in disabled babies,” thunders an Archbishop⁵. The credibility of the whole church is compromised when its leaders are allowed to get away publicly with lies and manipulative propaganda. So church leaders will need training, they will need commitment, they will need great honesty, they will need support from their peers, and they will need to be in close touch with the experience of grassroots groups in their own churches.

6. Training and theological formation

Transformation, though, will not happen by itself. A new generation of leaders is now determined to do things differently. The problem is that most of us are busy. We loathe institutional change, and when it is forced on us, we can’t wait for things to calm down so that we all can go back to normal again. In the wilderness, the children of Israel longed for the security of the old oppression, rather than the Promised Land with its uncertain future. It is not easy to be a leader in such times, mainly because the task of motivating change calls leaders to a personal involvement, a willingness to be open about their own thoughts and difficulties, and a sustained commitment to lasting change. Otherwise, unlike Moses, they are not going to carry their people with them.

Much will depend on training, and many leaders are now trying to include HIV/AIDS, in culturally sensitive ways, in clergy formation and theological education. However, transformation is not just a matter of producing resources and running workshops; not just to do with helping clergy to relate their liturgy and worship, bible studies and preaching to what is really going on in people’s lives. The fact is that tackling stigmatisation, discrimination and denial may involve a paradigm change in the way people think about the values that underpin their faith, and that will be painful. That was what Jesus tried to do, and as a result they killed him.

When the Salvation Army pioneered Christian responses to the HIV/AIDS epidemic, they didn’t realise that this was going to lead to a radical transformation in the style and culture of their leadership. In the past, the aim of leaders was to direct and provide. Facing AIDS has entailed a new approach, characterised by facilitation and participation. The emphasis now is on mutual learning and capacity development, rather than expert-to-recipient or top-down relationships⁶. This, they find, is bringing about a whole new relationship between local communities and church hierarchies, the new challenge being to find models of church leadership that are capable of responding to authority located at local level.
For example, top-down, male dominated religious hierarchies reinforce those very cultural mindsets that make it so difficult for women and young people to take responsibility for their own behaviour. People living with or affected by HIV/AIDS have a vital leadership role to play, but highly moralistic religious cultures can make this impossible. To clergy who enjoy the authority they have as preachers and community leaders, it comes as a shock when they are called on to develop, instead, the skills of enabling, facilitating, community organizing and leadership sharing. Thus church leaders may discover that what was needed was not more direction from above, but new structures that allowed their hierarchy to respond to the needs at the level of the local community.

7. How can I help?

An unpopular but necessary role for leaders is the mobilization of resources. For such help, poor churches may call on rich ones, or on church-related agencies in richer countries. It is crucial that cash does not come with strings attached that will stifle emerging patterns of leadership. Further, churches in the North should beware of the danger of judging another culture according to the criteria of their own. Africa is the worst hit continent. Leaders of northern churches could go with open hearts and minds. Don’t send someone else. Pay a visit to a brother or sister church leader and say, ‘I am here to share your journey, so show me how I can help.’

Church leaders get lonely, too. Recent high-level consultations have brought them together, inspired them and given them hope. Back in one’s own environment, though, the old problems re-surface, and new hope can quickly evaporate. Between leaders working for change, shared prayer, networking and communication is essential. We are not talking about nuts and bolts (although that comes into it): we are talking about the future of our churches, and the relationships they embody locally, nationally and internationally. We look at our sons and daughters, and maybe our grandchildren, and we want them to grow up and become good, responsible adults. For that to happen, for the church of tomorrow to exist at all, then our children must stay alive: a challenge that may involve the charismatic leadership of a Moses, the wisdom of a Solomon, the prophetic voice of a second Isaiah, and the hypocrisy-hating, non-stigmatizing, saving ministry of Jesus.

(Endnotes)
1 Vatican Pontifical Council for Health Care
7 AIDS policy statement 1998, London Salvation Army

(Credits)
Photo: Caption 1070: Yannik Noah, for magazine ad to promote UNAIDS bracelet.
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*Inclusion of persons in photos should not be construed as indicating their health status.
Gillian Paterson is a writer and consultant who is engaged in ongoing research on how churches are combatting HIV/AIDS-related stigma and discrimination. She is the author of Love in a Time of AIDS, Geneva, WCC Risk, 1996 (US edition is Women in the Time of AIDS, Maryknoll Orbis, 1997); and AIDS and the African Churches, London, Christian Aid, 2002, as well as numerous other articles.

As part of her ongoing work in this field, Ms. Paterson is interested to hear from you about your own experience, and to find ways of sharing ideas and thinking more widely. Please get in touch with her at stigmamail@aol.com and let her know how you have used this discussion paper.

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