
Essay 1

Prophetic discourse in a time of AIDS

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When I was asked to write about ‘prophetic discourse’ for this collection, I was conflicted as to whether the term ‘prophetic’ is helpful in describing or in providing guidance for the task of preventing the spread of HIV and AIDS in our world today. Prophetic discourse has many meanings, even when it is located paradigmatically in the traditions of the biblical prophets. These prophets were individuals who were called and commissioned by God, usually to deliver a message to God’s people: as Cathleen Kaveny notes in her new work on the values and dangers of prophetic language in contemporary ethical and political contexts.¹ The divine message frequently took the form of social critique and reform. ‘The prophet,’ Abraham Heschel maintained, ‘was an individual who said “No” to his society, condemning its habits and assumptions, its complacency [and] waywardness . . . His fundamental objective was to reconcile [human persons with] God.’²

¹ Cathleen M Kaveny analyses the meanings of ‘prophetic’ in her ‘Prophecy and Casuistry: Abortion, Torture, and Moral Discourse’, *Villanova Law Review* 51 (2005): 499-579. In drawing on biblical scholars and ethicists, she is trying to get to the heart of the matter, so that ‘prophetic’ can resonate with the persons and ministries of the Hebrew Bible/Old Testament prophets yet take on different nuances as it is relevant today.

² Abraham J. Heschel, *The Prophets*, vol. 1 (1969), as cited in Kaveny, 506.

Since biblical times, though, individuals and groups have engaged in 'prophetic' discourse without claiming to be prophets in the Hebrew Bible or Old Testament sense – without, that is, claiming to have a message or a commission actually and directly from God. Like the biblical prophets, however, their language and rhetoric typically express religious or moral indictments; they address basic moral concerns; their appeal is to the 'heart' not only the 'head'; and they offer a vision of a future that is better than the present.³ Prophetic discourse, therefore, does not issue in what today we would call 'dialogue'; it aims for changes of heart just by the power of its message.

Insofar as these characterizations of prophetic discourse are accurate, I have some reservations about its usefulness as a primary form of advocacy regarding HIV and AIDS prevention. Integrating multiple approaches to prevention, and mediating disagreements about both means and ends, require more than indictments, more than 'conversation-stoppers', more (though not less) than appeals to the heart. Nonetheless, because HIV and AIDS prevention must ultimately address some of the most profound issues in human life and experience, there is perhaps inevitably the need and the potential for it to become prophetic. No one in biblical times simply 'decided' to be prophetic; nor can that be done today. What we can do, however, is to shape the aims and actions of prevention in ways that awaken and change people in response to the HIV and AIDS pandemic.

Insofar as those who work at prevention can do this, they may indeed 'find' themselves to have been and to be prophetic. What I offer here, then, are three considerations for the use of prophetic discourse in relation to HIV and AIDS prevention if it is indeed to be 'prophetic'. These considerations relate first to context, then to manner, and finally to content for such discourse.

³ See James M. Gustafson, *Varieties of Moral Discourse: Prophetic, Narrative, Ethical, and Policy* (1988), as cited in Kaveny, 502-507.

1. Context

Prophetic discourse tends to arise in contexts where needs are massive and injustice reigns. Surely the AIDS pandemic is the result of as well as the generator of such contexts. We have sisters and brothers everywhere who are threatened with grave illness, or who are already sick unto death. Lives are disrupted; families are devastated; and ordinary hopes are challenged in every way. I need not detail the multi-layered and interlinked problems of which we are already starkly aware. Justice issues abound – from those embedded in aspects of globalization, to those rigidified in gendered and sexual patterns of relationships; from local and international poverty and the sufferings it spawns, to the terrible racial, geographical, and class imbalances in access to life-saving medicines.

HIV Prevalence

For those struggling on all fronts against HIV and AIDS, the *AIDS Epidemic Update* published in December 2007 by UNAIDS and WHO offers good news.⁴ The number of people living with HIV worldwide appears to have levelled off; the number of new HIV infections is estimated to have peaked in the late 1990s and to have gone down in 2007. At first glance, this makes it look as if prevention has worked, at least to some degree, and the raging fires of the pandemic may have been contained. At second glance, the news is confusing and not good enough.⁵ It is confusing because it may reflect better methods of epidemiological and demographic research, but not any real decline in prevalence. It is not good enough because, however the facts are presented, it remains the case that in 2007 at least 33.2 million people were living with HIV; 2.1 million people died of AIDS; and 2.5 million more people were

⁴ *AIDS Epidemic Update* (Geneva: Joint United Nations Programme on HIV/AIDS and World Health Organization, December 2007), downloaded November 20, 2007, from http://www.unaids.org/en/HIV_data/2007EpiUpdate/default.asp.

⁵ The accompanying UNAIDS Fact Sheet maintains that the downward revisions are 'due mainly to improved methodology, better surveillance, and changes in key epidemiological assumptions.' This presumably means that earlier estimates were somewhat inflated because of less adequate epidemiological and demographic research.

newly infected. For those who have experienced the pandemic in the Global South, particularly sub-Saharan Africa, news of reduced prevalence and incidence is important, but it does not change the concrete experience of a situation that remains dire. When a Kenyan woman with whom I worked heard of the decline in HIV prevalence suggested by the new report, she shook her head in puzzlement and said simply, 'It may be because we all have died'.

World Church

The context for prophetic discourse regarding HIV prevention encompasses not only societies but churches. Biblical prophets, after all, spoke more to the people to whom they belonged than to other peoples who might be oppressing them. There is no doubt that churches (as well as temples and mosques) have been in the forefront of responses to HIV and AIDS – in some countries providing more than forty per cent of the care of the sick and dying, and also making important strides in education, counselling, and multiple forms of support. More, of course, is needed. As context for prophetic discourse, however, perhaps the most important element undergirding any widespread response from religious traditions and institutions is the developing self-understanding of their own reality. For the Christian churches, in particular, this involves new insight into the meaning of Christianity as 'world church'. Unfortunately, many Christians still understand 'world church' to mean that the Christian gospel has been taken to the far corners of the world. But ours is a time when the concept of 'world church' has a different content and provides a different call. Now more and more Christians recognize that the Christian gospel was never meant to be only or even primarily a Western European or North American gospel exported like the rest of Western culture to other parts of the world. At last we must all realize that God's self-revelation can not only be *received* in every language and culture, but *given*, spoken out of every language and culture. We stifle its possibilities when any one culture claims nearly total control over its forms.

Two consequences follow from a growing understanding of what it means to be 'world church'. The first of these is tied to the fact that the

church has not always thought about itself in this way. In the past, *Western* Christianity exported teachings (in relation, for example, to sexuality and the status of women) that are part of the problem now with HIV and AIDS in formerly missionary countries. The imposition of attitudes and practices shaped by Western culture had the effect of destabilizing traditional cultures in, for example, Africa. These attitudes and practices now intermingle confusedly with traditional practices and with modern secular (and largely Western) practices, all together contributing to the spread of HIV and reinforcing stigma and shame. Recognizing this gives a wake-up call to all Christians to re-examine certain teachings and attitudes, in the light of what is needed to stop the relentless sickness and dying. Insofar as some teachings of the church are part of the problem, we are all responsible for part of the remedy.

The second consequence of developing understandings of what it means to be 'world church' is or can be a growing clarity among all Christians – whether in Africa or Europe or China or the USA - that they are *all equal* sharers in the one life of the church, partakers in the one Life of the Spirit of God. All are therefore called to bear the burdens of one another when the church in one part of the world is in dire need. If the church has AIDS, if the Body of Christ has AIDS, then no Christian is spared this devastation. Insofar as AIDS is a problem for the churches of Africa (or of Australia, East Asia, Europe, or the USA), it is a problem for us all. The gospel comes to us and is received by us – all together across this world; and it calls us not just to assist one another but to stand in solidarity with all, especially with those who are most vulnerable or who suffer the most. This truth characterizes the context for prophetic discourse, the context in which co-believers need a prophetic word of challenge as well as comfort.

2. Manner of Prophetic Discourse

I turn now to my second consideration, what I have called the 'manner' of engaging in prophetic discourse. What I offer here are somewhat bare statements, assertions rather than full arguments. I do not assume they are all self-evident; but I place them on the table in a way that suggests that they are at least plausible.

First, although prophets are known for their clarion calls to repentance, their social criticism, and even their condemnations, their success depends on whether they also *energize and offer hope*.⁶ The biblical prophets spoke out of and back into their own communities. Their words were born in humility yet conviction; they aimed finally not at condemnation but at reminding the people of a future dependent upon common memories, shared hopes, and present actions. The community for prophets in the context of HIV and AIDS is the human community as well as the community of the church.

Second, prophetic discourse in a time of AIDS cannot arrogate to itself sole platforms, silencing other voices, as if it alone were sufficient. Indeed, the effectiveness of prophetic discourse today, especially in the context of HIV prevention, may well depend on its respect for and inclusion of other modes of discourse – for example, social analysis, empirical evidence, and practical reasoning. In a context where no one has yet succeeded in finding the perfect policy, the certain remedy, prophets do well to *call for dialogue* and not simply obedience.

Third, it is not so very difficult to awaken many people to the demands of the dire situation of HIV and AIDS in the world. What follows this awakening, however, is difficult indeed. For, when compassion stirs, it can be overwhelmed by the problem of ‘too much or too little’. As it did for Elijah, the mountain can appear too high; or as Naaman saw it, the Jordan River can appear too lowly. In the face of the ‘mountain’ of HIV and AIDS, prevention can appear too great and intractable a problem; and whatever is ‘at hand’ to do can seem too little. Numbness threatens at every turn. Prophetic discourse, therefore, must safeguard its speakers and hearers from the despair that calls them to the broom tree, and the skepticism that scorns a little river in a strange land. It must, therefore, include the *specification of concrete ways*, or particular actions that are present enough and possible for persons and groups to undertake.

⁶ See Walter Brueggemann's *The Prophetic Imagination* (Philadelphia: Fortress Press, 1978), 14.

Fourth and last, prophets are shaped by their own experience. But just whose is the experience that is needed to engage in prophetic discourse in a time of AIDS? Gustavo Gutierrez once asked: can theology be done by the poor?⁷ Do oppressed and believing people have a right to think and to speak? Is it not the poor themselves who can re-imagine and re-appropriate the gospel? There is of course no telling from where prophets may arise, yet the question must be pondered: whoever should bring a prophetic word to the context of HIV or AIDS, should not those who are most grievously infected and affected be among them? Are their insights into the non-necessity of the present situation needed if prophetic discourse is to make a difference? If so, how shall they find their voice, and with whom can they stand as they prophesy before the powers of the church and the world?

3. Content of Prophetic Discourse in a Time of AIDS

I come, finally, to a consideration of the content of prophetic discourse, especially as it relates to advocacy for prevention. Let me begin by saying that we already have prophetic individuals and organizations among us, and I have no intention of trying either to replicate or substitute for the hard work as well as eloquent prophecy they have given us. I refer to the contributions of, for example, Michael Kelly, Robert Vitillo, Alison Munro, Kevin Dowling, Musa Dube, and many others who have pondered the requirements for HIV prevention in the light of concrete needs as well as the large picture. I refer also to the programmatic designs for prevention through reduction of risks and remediation of vulnerabilities that have been developed by, for example, the World Council of Churches, the Ecumenical Advocacy Alliance, CAFOD, Caritas Internationalis, Catholic Relief Services, as well as UNAIDS and the World Health Organization.⁸ Many of these efforts and documents have been made available to us

⁷ Gustavo Gutierrez, "The Voice of the Poor in the Church," in Catholic Theological Society of America, *Proceedings* 33 (33rd Convention, 1978), 30-34.

⁸ See especially *HIV Prevention From the Perspective of A Faith-Based Development Agency*, (London: Catholic Agency for Overseas Development [CAFOD], 2004); *Framework for Action: The HIV and AIDS Campaign, 2005-2008*, Geneva: Ecumenical Advocacy Alliance [EAA], 2005), esp. Goal II; "Intensifying HIV Prevention," (Geneva: UNAIDS, 2005); *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*, (Geneva: UNAIDS, 2007).

prior to our gathering here for this consultation. All together, they reinforce the need for specificity yet integration and coordination; and they complement one another by providing essential pieces to what would otherwise be an incomplete view.

As I said, I do not want to repeat, and certainly not supplant, these efforts. What I will do is much simpler, more suggestive than programmatic, yet signalling something about the content for prophetic discourse in a time of AIDS. I propose, therefore, three somewhat disparate observations.

The first has to do with the approach to prophetic discourse modelled by the prophets in the Hebrew Bible/Old Testament. They begin by articulating their own and their people's *grief* – the primary announcement that 'things are not right'.⁹ The substance of what these prophets say is not primarily a reprimand, but an articulation of sorrow and grieving over death. Theirs is a grief lodged in stories of human suffering. This is the kind of suffering that goes on for generations. It is 'a voice heard in Rama weeping' (Jer.31:15); peoples subjugated by peoples; women violated in their very persons; and everywhere relentless dying.¹⁰ In the Christian Scriptures and New Testament Jesus, too, spoke of this kind of suffering: 'Can you drink the cup that I will drink?' (Mark 10:38). The cup images the suffering of all persons, hence all kinds of sufferings. But at the heart of the image are the sufferings that are the consequence of injustice – the sufferings that do not have to be, the sufferings that cry out for an end not in death but in change.

Prophetic discourse concerned with the AIDS pandemic can begin also in nothing other than grief. It begins with the real stories of real persons and families and villages and cities and churches and nations. From these narratives, social criticism must follow, if much of the suffering does not have to be. 'No more,' the prophets must cry. 'No more' to false judgements, stereotyping, blaming and shaming; 'no more' to exploitation, indifference, domination; 'no more' to conditions of un-

⁹ See Brueggemann, 20-21, and *passim*.

¹⁰ See Margaret A. Farley, *Compassionate Respect* (New York: Paulist Press, 2002), 69-71.

freedom and the denial of dignity and rights; 'no more' to infection, sickness and dying that do not have to be. And hearers will not despair as long as the prophets can imagine with them the 'next step', the 'new possibility' that will bring change.

My second observation is that while prophets must speak to their own communities, the work of preventing the spread of HIV also crosses borders; it has become essentially *multi-cultural and interfaith*. Cross-cultural work has always been difficult, and so very many mistakes have been made in attempting it in the past. Therefore prophetic discourse may include in its task the bridging of what have been insurmountable divides – cultural, racial, gender, geographic, religious, class. New forms of learning and acting are required. Prophetic discourses of healing and hope challenge partnerships based on domination and submission; they foster partnerships based on mutual respect, a search for mutual understanding, and trust in interdependence. Prophetic discourse can embody the learnings that: (a) it is not possible simply to transplant the beliefs and practices of one culture into another; (b) no one culture should stand in general judgment of other cultures; and yet (c) not anyone can unreflectively and unconditionally respect every cultural practice – whether their own or another's; hence (d) people from diverse cultures can stand in solidarity with those who critique, in their own culture or another, practices from which people die; and (e) all peoples have responsibilities, each for the other and for all. Prophets of prevention must tell the stories that articulate and bring into being the hopes of peoples, the possibilities of their coming together to weep over similarly recognized tragedies, to laugh over similarly recognized incongruities, to stand in awe of one another, and to labour for common goals.

My third observation is about aspects of advocacy for HIV prevention that are most commonly accepted as controversial. As many others have noted, the controversies are not only about the use of condoms or needle exchange; they go much deeper. As a primary example, I focus here on issues of *sexuality*. As growing numbers of African women theologians are saying: the traditions of world religions in which many of them stand must find better ways to address problems of sexual-

ized stigma, discrimination, and gender bias. The favoured response of religious leaders has all too often been simply and vehemently to reiterate strong moral rules which, if they are adhered to, may guard people against risks from sexual activities. Ironically, the sheer repetition of traditional moral rules has frequently served only to heighten the shame and the stigma associated with AIDS, and to promote misplaced judgments on individuals and groups (especially women). The perpetuation of a morality based predominantly on taboos (which by definition are non-reflective) reinforces the sort of divine punishment motif that the book of Job was against, and it ignores the genuine requirements of justice and truth in sexual relationships.

The AIDS crisis, as I have indicated above, presents a clear situation in which faith traditions must address their own traditional teachings about sexuality, and they must rethink the gender bias that remains deep within their teachings and practices. It would be naive to think that cultural patterns that make women vulnerable to AIDS are not influenced by world religions (and vice versa) whose presence is longstanding in their countries. Fundamentalism takes varied forms, but many of them are dangerous to the health of women. Questions must be pressed about the role of patriarchal religions in making women invisible – even though women’s responsibilities are massive, and their own agency can be crucial and strong.

I long ago came to the conviction that the sexual sphere of human life must be governed not by taboos but by considerations of justice. I have also become convinced that what justice means in the sexual sphere is not very different from what justice means in other spheres of human life, whether social, political, or economic. Questions of same-sex relationships, or of condoms, or of marital relationships, are questions of justice, and they must be measured by the criteria of justice that govern human relationships more generally. These are not isolated and individualistic questions; they go to the very roots of morality – including Christian morality.¹¹ The question to be asked is not whether

¹¹ See Margaret A. Farley, *Just Love: A Framework for Christian Sexual Ethics* (New York: Continuum, 2006) for an explanation of what I can only allude to here.

this or that sexual act in the abstract is morally good, but rather, when is sexual expression appropriate, morally good and just, in a relationship of any kind. With what kinds of motives, under what sorts of circumstances, in what forms of relationships, do we render our sexual selves to one another in ways that are good, true, right, and just?

Prophetic discourse regarding HIV/AIDS prevention must incorporate new understandings of human sexuality and the requirements of justice. Norms for sexual relationships and activities must take into account the concrete reality of human persons, particularly their capacities for freedom and relationality. It is only within a new framework (with of course roots in the tradition, although not clearly recognized in the tradition) that human sexuality as a whole can be understood, and specific questions such as the justifiability of the use of condoms can be resolved.¹²

A sexual ethic that remains too much in the form of a morality of taboo has led to an interpretation and rejection of some means of HIV and AIDS prevention—in particular, the use of condoms—because they are considered forms of contraception. This, however, misses (somewhat tragically) the point that their use in this context has nothing to do with a contraceptive goal; it has only to do with preventing people from dying.¹³ I applaud the work of scholars like James Keenan on issues of condom use.¹⁴ His appeals to well entrenched principles in the Christian tradition (such as material cooperation, toleration, epikeia and double effect) are extremely important and, in my view, sound. Yet we must go further. Issues of condom use cannot be reduced to questions of ‘lesser evil’, or even of ‘double effect’. They arise only because larger frameworks for Christian sexual ethics have not been challenged – as they must be. My own proposal in this regard is that justice-norms for sexual relationships include requirements to treat

¹² See Farley, 2006, op. cit

¹³ Condoms are a necessary strategy, and should not raise a moral problem as such. They are a necessary, but not sufficient strategy. This is an issue that is both exaggerated and underplayed, to the detriment of many efforts at HIV and AIDS prevention.

¹⁴ See James F. Keenan, ed., *Catholic Ethicists and HIV/AIDS Prevention* (New York: Continuum, 2002).

individuals as ends in themselves, and to do no unjust harm; they also require, more specifically, free consent on the part of both partners, as well as mutuality, equality, some level of commitment, and fruitfulness in some form (though not necessarily biological children). Finally there is a requirement of social justice regarding the rights of persons in their sexual choices and in relation to human society in general.¹⁵

Let me conclude by saying that if religious traditions have anything at all to say to situations like the AIDS pandemic, they must speak of God; and they must speak of human responsibilities to one another in relation to God. Words of hope and deeds of love will be 'true' insofar as they are shaped by accuracy of understandings of the situation and plausibility in identification of claims of justice. The great human and religious goals of mutual respect, solidarity, fairness, compassion, come slowly. But in some contexts, where responses to human suffering become urgent, where abandonment and death make slow progress 'too late', the role of prophetic discourse expands.

¹⁵ See Farley 2006, *op. cit.* especially chapters 5-7.

Essay 2

The need for comprehensive multi-faceted interventions

Johannes Petrus Heath

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1. No magic bullet

In my five years with the African Network of Religious Leaders living with or personally affected by HIV and AIDS (ANERELA+), I have found that there are some issues that are so central to the network's identity that we deal with them on a daily basis. First, for example, it has always been a core focus of the mission of ANERELA+ to challenge stigma, shame, denial, discrimination, inaction and mis-action (a combination that has come to be known as SSDDIM). Second, prevention (including the development of effective prevention messages) remains a constant concern of ANERELA+ and its members. Neither of these issues has been resolved. In 2007, 2.5 million people were newly infected with HIV. Prevention messages and strategies are not getting across as effectively as they need to, and even something as uncontroversial as treatment to prevent mother to child transmission (PMTCT) is only reaching 11 per cent of the women who need it.

The long-term character of these challenges, and the relatively minor progress we have made over the years, act as a warning to any of us who are expecting that the current process or any other will yield quick-fix solutions to the challenge of HIV prevention. On the contrary

(and it pains me to share this with you): *there is no magic bullet*. HIV prevention is a complex and nuanced challenge, which strikes at the heart of human identity, family relationships and community life. This paper, therefore, will address four separate and distinct factors that contribute to the challenges facing prevention. They are:

- prevention messages;
- factors that increase vulnerability;
- the small proportion of people, who are living with HIV, who know their status;
- the complexity of the challenges involved in changing behavior.

The stigma that surrounds HIV and AIDS is a cross-cutting issue, undermining responses to all four of these challenges, and helping to explain why they have proved so intractable. And that is why the first issue I mentioned, in the opening paragraph of this paper, was stigma.

2. Prevention messages

ANERELA+ has long argued that one of the main problems with HIV prevention is that it tends to focus on sex, sex and sex again. This presents a problem for most religious groups, who tend to have major difficulties in talking about sex. One example of this is the widespread and well-advertised use of the ABC approach to prevention, with its descending order of acceptability. What this approach seems to say is: ‘**A**bstain, since no sex is the best sex; or if you can’t abstain, then at least **B**e faithful; if you refuse to be faithful then at least have the decency to use a **C**ondom’.

In practice, there are a variety of problems with the ABC approach. First, it intensifies that stigma round HIV and AIDS by focusing only on sex. Second, it leads people into a false sense of security, since the message becomes: ‘As long as you are in a faithful relationship you have no need to worry – you are safe from HIV’. Sadly this is not the case. Dr. Hannu Harponen, who works and teaches in Uganda, analyzes information relating to the most common modes of trans-

mission of HIV. The current figures in Uganda, he says, suggest that the highest area of transmission is within marriage: 42 per cent of all new infections of HIV in Uganda happen within the sanctity and safety of the marriage bed. That means that the riskiest behavior possible in Uganda at the moment is marriage. It is therefore worth looking at what we mean by risk.

My friend and fellow member of ANERELA+, Canon Gideon Byamugisha, who is also a contributor to this volume, has stressed that there is a major difference between risky *behavior* and a risky *environment*. What this essentially means is that if you find yourself in an environment with a high HIV prevalence, behavior that in other circumstances would have been considered safe, suddenly takes on a new risk. Therefore, if you focus only on one element in the transmission chain, without giving full information about all factors, you give people misinformation, and they are not able to judge the risk for themselves. If the aim is to prevent HIV transmission, it is pointless to speak about being faithful in a sexual relationship until after people have learned the importance of knowing their own and each other's HIV status. That information makes it possible for them to take informed decisions as to how best to protect yourself and your loved ones.

3. The SAVE approach

It is for these reasons that ANERELA+ developed the SAVE approach to HIV prevention. This stands for four key principles.

S = Safer practice

When speaking about safer practices we try to address all avenues of HIV transmission. Factors that reduce the risk of HIV transmission would include PMTCT; post-exposure prophylaxis (PEP); abstinence, but also the delay of sexual début; mutual fidelity within a committed relationship; the use of vaginal microbicides; needle exchange; oral substitution therapy; male circumcision; use of condoms; clean and safe blood for transfusion; and sterile implements – not just for hospital or clinic-based surgery but also for cultural scarification.

A = Available medical interventions

One of the most effective prevention methods is the use of antiretroviral therapies (ARVs). This is because where the viral load of the person living with HIV is reduced to undetectable the chances of transmission drop to less than 1 in 25,000. But this is not the only medical intervention we are talking about. There is a need for effective treatment of opportunistic infections, and also all other sexually transmitted infections (STIs). In addition to this, good nutrition may be regarded as a medical intervention. Medical interventions also include the crucial (and seldom provided) access to all necessary blood tests. Without adequate monitoring of the efficacy of ARVs through viral load tests, a person could have developed an undetected drug resistance, compromising not only have their own health but also the health of their sexual partner. The availability of viral load tests for babies is also important. The majority of babies who die from HIV die before they are two years old, because the diagnostic tool most commonly used is the CD4 test, which cannot determine whether a baby is HIV positive until the infant is 18 months old. With a viral load test this can be done at birth.

V = Voluntary Counselling and Testing (VCT)

It is crucial that all people know their HIV status. We need to move from 'AIDS Friendly Congregations' to 'Congregations that know their HIV Status'. Whether this happens through VCT or Provider-initiated testing is less important than getting people to know their HIV status.

E = Empowerment

One of the single biggest challenges we face in increasing the impact of our HIV prevention messages is the limited capacity of many people to respond. For example, it is no good telling a woman to use protection in her sexual relationship if we do not also help her to overcome clearly defined gender inequalities in her domestic, religious or cultural environment that prevent her from doing so. Further, most information about HIV prevention comes in written form when in many areas there are still high levels of illiteracy and, even when people can read, many of the publications use stigmatizing, misleading or often incorrect language. These two examples of the need for empowerment bring me to the next of our four key challenges to prevention.

4. Factors that increase vulnerability

In October 2007 an 'Open Space Meeting' was held in Amsterdam to discuss the global architecture of the response to HIV and AIDS. One of the most significant impacts of that meeting for me was a model put forward by Gracia Violeta Ross Quiroga relating to the streams of vulnerability. In her model, Gracia postulated a landscape that increased people's vulnerability generally. The features of this landscape are:

- laws/ legal framework;
- poverty;
- marginalization;
- conflicts;
- gender inequalities;
- migration;
- violence (sexual, psychological, physical);
- economic imbalances;
- lack of education;
- homophobia;
- racism.

In this model these factors of vulnerability are like the streams of magma that flow together to form the pressure release we know as a volcano. As soon as the pressure rises to a certain level it will explode. The current explosion of this volcano is HIV and AIDS. If we manage by some means to plug this volcano called HIV and AIDS it will simply bubble up and explode in a different place. The only effective long-term solution is to dry up the flow of magma, and that can only happen if we effectively deal with the factors that increase people's vulnerability.

Let me give some examples of how this works. In January 2008 forty people living with HIV came together for the HIV+ Monaco conference. We were there to look at the advocacy agenda around HIV not only leading up to the International AIDS Conference to be held in Mexico City in August the same year, but to take us beyond Mexico. Four themes for advocacy were identified:

- positive prevention;
- universal access to treatment, support and care;
- rights to sexual and reproductive health;
- discrimination and criminalization.

Throughout the conference it was stressed that none of these themes are stand-alone. All are strongly interrelated. You cannot talk about positive prevention without the availability of ‘universal access to treatment, care and support’, for treatment is an integral part of prevention. We also need to stress the need for these same services to be judged by universal standards (hence the advocacy slogan: ‘universal access – universal standards’).

The need for universal standards seems so obvious. And yet it is not universally accepted. I will give just two examples. The first comes from the ANERELA+ chapter in Nigeria, where we have just sadly lost our coordinator. One of the reasons was that in Nigeria, as in the rest of Africa, viral load tests are not provided. In Boniface’s case what this meant was that even though he was taking his medication correctly and consistently he had developed a resistance to the medication and nobody could pick it up because not all the necessary tests were available. This has left a family without a father, increasing the vulnerability of the whole family.

A second example would be the whole issue of criminalization. In some countries the transmission of HIV is being criminalized. Firstly this means that sexual health is a burden being placed only on the person who is HIV positive. But more worryingly, in countries where this is the case a trend is emerging where people are resisting going forward to be tested for HIV, in the knowledge that they cannot be held responsible for transmission if they do not know their HIV status.

5. At best 15 per cent of people living with HIV know it

The single largest contributory factor to challenging HIV transmission is that about 85 per cent of people living with HIV don’t know it. This means that they continue their lives as normal, believing themselves

to be immune from the HIV that is all around them. The majority of people only go to test for HIV when they are already seriously sick. In most cases this means that they would have been living with HIV for some eight to ten years already. In that time there are a number of people who could have been put at risk of HIV infection simply because they did not know. One of the commitments which people living positively with HIV are always ready to make is: 'HIV stops here!' This is positive prevention in action – but it is impossible to enact when you don't know your HIV status, or if you do not have access to the medication, nutrition, care and support which helps you to live positively.

Some of the factors preventing people from being tested are:

- *Gender inequality:* a wife is afraid either to go and get tested or to ask her husband to get tested because she might get kicked out of the home if found to be HIV positive even though it is likely that it is her husband who infected her.
- *Stigma, discrimination and criminalization:* one example is that in prisons people are fearful of going to be tested. They are afraid that the 'authorities' will get to know, other inmates will find out, and they will either be isolated or even in danger of their lives.
- *Lack of access to treatment, care and support:* where these are not available there may seem little incentive to know your HIV status because the only thing you will receive is rejection.
- *Travel restrictions:* it is better not to test for HIV because then you don't have to lie about your HIV status to get a visa.

You can see quite clearly that one of the main reasons for people not going to find out their HIV status is the fear of rejection, isolation, discrimination and all that goes with this. If we are truly to overcome this

hurdle to HIV prevention we will have to work harder at levelling the playing fields.

6. The complex challenges of behavior change

One of the biggest challenges to our prevention messages is the all too human belief: 'I'm immune, it can't happen to me!'. For example, I may believe that I need not worry about testing before I get married because it could not happen to me; or that HIV only affects young people so I need not worry because I am older; or that HIV only affects black people, so I need not worry because I am white; or that HIV only affects gay men, so I need not worry because I am heterosexual. In each of these examples, a sense of invulnerability has become our individual barrier to making the right decisions. One of the biggest challenges of HIV prevention is to help people understand that they are vulnerable to HIV *simply because they are human*. (It is, after all, the *human* immunodeficiency virus we are talking about.)

I think it was Antony de Mello, amongst others, who said that the most futile thing we as humans could try to do was change settled patterns of behavior. As human beings, we should seek – rather - to enter deeper into the heart of God, deepen our relationship with God, and then it would be God who changed within us that which God wanted changed. From a spiritual perspective I have always found this helpful. If I were able to change myself, or to save myself, there would have been no need for Jesus to come and save me.

This may also help explain why behavior change is so difficult for people. I believe that the answer to this challenge is to help people into adopting the right behaviors from the start: which would mean engaging more in teaching about HIV and AIDS, sex, sexuality and so on, not just in Sunday schools and confirmation classes, but also in Bible studies, sermons and any and all forums of teaching open to us.

The pressure to encourage young people to develop desirable patterns of behavior from the start does not absolve us from working harder towards helping not only ourselves but other people to alter existing

patterns of behavior. The key to challenging behavior, though, is not to be judgemental but rather compassionate and accepting, helping people to see their immeasurable value in the sight of God. It is not truly possible for me to love myself until I can fully accept God's unconditional love for me; it is not truly possible to show love to our neighbour - with all that that would entail in HIV prevention and positive living - without first accepting and living the 'love of self' which an acceptance of God's love would mean.

In conclusion, I hope that, if I have done nothing else, I have been able to highlight for you the reality that there is no magic bullet. Rather, HIV is a complex issue that demands of us comprehensive and multi-faceted interventions. One of the participants in the Open Space Meeting described civil society thus: 'We are a tropical forest, not a formal, planted garden'. For me, from my place within the faith community's response to HIV, this means that we don't all have to do everything, but we do all have to do something.

It is also more useful if our interventions complement each other. If I believe in a tree with a bird in it, but you prefer a tree without a bird, that does not mean you should chop down my tree or that I should chop down yours - there is not only room but also a necessity for both trees in this tropical forest of ours. For me this remains one of the main strengths of a prevention message like SAVE. Within safer practices there may be some interventions that from your particular faith perspective you cannot endorse, but you can still teach about the safer practices you believe in, and so together we can speak about SAVE rather than attacking each other on our different approaches. Dr Peter Piot of UNAIDS has said: 'We will not overcome HIV without the support of faith communities'. Our contribution as faith communities to overcoming the effects of HIV on people's lives is not only valuable but it is crucial to the eventual success. And, as we further develop and refine our individual and collective responses to HIV prevention, it would be useful for us to bear in mind one very important thing:

HIV is a virus, not a moral condition.

Essay 3

Behavior change and the role of the Church: towards reducing and eliminating risk

Peter Okaalet

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1. No magic bullet

The HIV epidemic has challenged our faith in medical science (which often seems to have a cure or a vaccine for everything), and also in some of those traditional moralities and ways of life that – in all parts of the world – have been relied on to keep communities and their members safe from harm. For HIV prevention, neither medicine nor tradition can offer a ‘magic bullet’. None of the new prevention methods currently being tested is likely to be a hundred per cent effective, and all will need to be used in combination with existing approaches if they are to reduce the global burden of HIV and AIDS.

Interventions that support HIV prevention include behavior change programmes, HIV testing, condoms, male circumcision, treatment of other sexually transmitted infections, and the few female-initiated HIV prevention methods that are currently available. And yet despite all the energy that has gone into the promotion and implementation of these, the number of new cases of HIV continues to rise. Before we come to reflect on the role of the Church in this dilemma, it is important to consider why this is.

2. Drivers of the epidemic

In this paper, I want to look at three sets of factors that may be said to 'drive' the HIV epidemic. These may be grouped under the headings of *biological* drivers, *behavioral* drivers and *cultural* drivers. (Those important drivers that make women particularly vulnerable are addressed below.)

'Biological drivers' are factors that increase the risk that a given act or episode may lead to HIV transmission. These include the presence of other sexually transmitted infection, pregnancy or an immature or injured genital tract. HIV is more easily sexually transmitted at some stages in the infection's progress: for example, during the months immediately following the acquisition of the virus, when the viral load is high. It seems that some viral sub-types are more readily transmitted. Without appropriate medication, HIV can be transmitted from the mother to her child during pregnancy and delivery. And malnutrition makes individuals more susceptible to infection.

'Behavioral drivers' are connected with individual risky behavior. People put themselves at risk of infection if they have unprotected sex or multiple sexual partners. Intergenerational sex carries a high risk of transmission, as does early marriage or early sexual debut (or first sexual experience), and also 'sex in exchange for money'. Alcohol abuse can lead to risky sex or drug taking; so can injecting drug use. Situations of violence against women or children can be thought of as carrying a high risk of HIV transmission.

By 'cultural drivers' I am seeking to identify practices that are so much taken for granted in particular groups or communities that they come to seem like an immutable part of a cultural identity. In my own African context, cultural drivers that place people at particular risk of HIV transmission include wife inheritance, inter-generational sex, cleansing ceremonies and female genital mutilation (FGM). Dry sex and other risky practices lead to increase in the likelihood of transmission of HIV. A particularly explosive set of factors can be present in areas where polygamy is common.

These lists of drivers are not exhaustive. The point of the exercise is rather to point out that our individual efforts to contain the epidemic are always conducted in a context which is either *hostile* or *welcoming* towards HIV transmission, and that these hostile or welcoming factors (which may vary from context to context) need to be part of any effective approach to HIV prevention.

3. Women and girls

In some severely affected regions, says ex-UN special envoy Stephen Lewis, the HIV epidemic has caused ‘carnage among women and girls’.¹ 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.

Worldwide, about 46 per cent of HIV positive individuals are women. In Africa, HIV prevalence among women is around sixty per cent and, among men, about forty per cent. In addition, women do most of the work of caring for people living with HIV or dying from AIDS; further, they have responsibility for keeping families together, or caring for their own or other people’s orphaned children when parents die.

In spite of this, they have more limited access to information than men; the ‘ABC’ prevention model is no real help to them in avoiding contracting HIV; violence against women seems to be increasing; and there is evidence from all parts of the world that HIV positive women are more heavily stigmatized than men. While public policy often has men in mind as its default target, the sentinel surveys, on which national and international data are based, are carried out at antenatal clinics, and therefore tell us only about women.

And yet women and girls – who are uniquely vulnerable to HIV, both biologically and culturally – may nevertheless find it impossible, in a

¹ Stephen Lewis, press interview following a visit to Southern Africa, March 2006
<http://www.un.org/apps/news/story.asp?NewsID=17847&Cr=hiv&Cr1=aids>

particular context, to protect themselves. With all the billions of dollars that have been spent on the development of treatments and vaccines, it is outrageous that there is still no cheap, effective, easy-to-use prevention option available to women.

There are many cultural factors that make women particularly vulnerable. Women are under huge pressure to keep their marriages together at all costs. Men are free (and often expected) to have sexual relationships outside marriage, but women may not. Many perceive sexually transmitted infections as women's diseases. And, in many cultures, women face taboos on talking about sex and on using the kind of language that is impossible to avoid in talking about HIV prevention.

Women and girls may be *uniquely* vulnerable, but they are not *unavoidably* vulnerable. In 2005, at the 14th ICASA meeting in Abuja, Nigeria, Dr Joy Ezeilo spoke of the possibilities for legislative intervention to support female-initiated prevention options, namely:

- address poverty: it fuels AIDS, and vice-versa
- promote legislation that covers 'behavior'
- make sure that VCT programmes are linked to the availability of antiretroviral treatments (ART)
- governments should follow the 'three stage processes' with respect to the making of laws:
 - Stage 1: formulation and promulgation;
 - Stage 2: implementation;
 - Stage 3: evaluation.²

4. Understanding the Church

So where does this leave the Church? Indeed what may we say 'drives' the Church, in this era of HIV? And how do those drivers (or modifiers) of 'church' behaviour and culture also end up driving or modifying the

² Dr. Joy Ezeilo, Plenary Presentation, "HIV/AIDS, Gender and Human Rights: How Far is Africa" (14th ICASA meeting, Abuja, Nigeria, December 2005)

behaviour of individuals? Let me outline some general principles that I hope we can agree on.

First, the Church exists to honor God. It is not an HIV project, nor is it there to honor a set of donors.

Second, the wish to bring care and prevention into the context of the Church's relation with its Maker should not be seen as a dualistic approach, or one that involves a split between sacred and secular.

Third, the Church does have a role in shaping the attitudes and behaviour of its members, both by its example, and by promoting understanding of context and values.

Fourth, faith has huge significance, not just in Africa but elsewhere too. This makes it a powerful source of support for those affected by the need for change, and a powerhouse in generating prayer and messages of hope.

So what is the Church?

In Africa, where I come from, the Christian church is growing steadily, and developing an independent African identity. Moreover, we now have on the continent a group of churches that fall under the umbrella of 'African Independent (or Instituted) Churches', indicating that they are not affiliated to the so-called 'mainstream' group of churches that brought Christianity to sub-Saharan Africa. We need to take these into account, too, as we seek to define and reach out to the 'Church' in Africa.

We think of the church in a variety of ways, or through a range of different 'lenses'. We may think of it sacramentally, as 'the Body of Christ' (1 Cor.12: 27). Or maybe for us it is the congregation to which we belong. Or perhaps we think of it as an administrative, co-ordinating body that 'leads' the faithful or adjudicates on matters of faith. We may encounter it as a Christian community-based organization, a development service or an NGO supported by a Christian church or group of churches. But whichever of these institutional 'models' we have in mind when

we talk about 'church', they all have one characteristic: they are there to stay. NGOs pack up their work after programmes finish; churches will never leave the community.

The Church, by virtue of its longstanding, multifaceted presence, has a great potential for supporting people in responding to issues that are of critical (maybe life and death) importance to them. Churches shape people's attitudes and they provide services. They have the capacity to influence the powerful. They bring people together in prayer. They engage in ministries that are often prophetic. Because they are always there, they are able to walk with people on their life's journey: a journey that cannot be hurried; one in which there is, for everything, a season. Above all, the Church is committed to its people; not just some people, but all people, regularly leaving the ninety-nine behind to go and search for the one lost sheep. (John 10:1-18)

5. The role of the Church in reducing risk

So what, specifically, can the Church contribute to the process of HIV prevention?

It can sensitize people to the existence of HIV and the risks it presents, and it can share with them its educational messages. Most important, it can give to people that most empowering of gifts, namely accurate, scientific, correct information. It can do this through pulpit ministries and preaching, through music, dance and drama, and through songs and testimonies. It can encourage people to talk openly about sex, without which effective HIV education is impossible. It can use the Bible study materials that are currently available. It can and must involve people who are themselves living with or affected by HIV or AIDS. It can make it clear that saying 'no' to AIDS is a lifelong commitment. 'HIV prevention is for life' it must say.

Further, Christian churches (like other religions) are value-based institutions. HIV prevention is not just a matter of finding the appropriate technical interventions: it is to do with the values people

hold, and the effectiveness with which these are handed on to young people. Celibacy and abstinence outside marriage and mutual faithfulness in marriage are the most reliable forms of HIV prevention; they are also part of church teaching. It is because we believe that every human being is made in the image of God that we seek to eliminate stigma and discrimination and to include people living with HIV and AIDS (PLWHA) at leadership level.

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 sex and sexuality not to be shrouded in embarrassed and guilty silence. 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)

6. What is an 'AIDS-competent Church'?

With all this in mind, we should now be in a position to consider the question: what, then, is an 'AIDS-competent Church'?

An AIDS-competent Church is first and foremost one that turns its back on denial and acknowledges the reality and enormity of the problem of AIDS. It is a Church that knows its own strengths and weaknesses, and uses its strengths as a starting point for a scaled up response. It is a Church that recognizes vulnerability and risk and works to reduce them. It is a learning Church that listens and shares; a Church that has zero tolerance for stigma and discrimination; a Church in whose ministry people living with HIV or AIDS are playing a central part. It is a Church that is living out its full potential, both as an organization and as a congregation.

We are returning, therefore, to the image of the Church as the Body of Christ responding to HIV and AIDS. We must become listening churches with *large ears* – quick to hear the challenges of the people; compassionate churches with *warm hearts*; churches with *quick feet*

that respond rapidly to need; and touching churches with *anointed hands*. In the Body of Christ, churches will have *loud voices*, raised on behalf of the marginalized. They will be research-oriented: churches with *sharp minds*, seeking for truth, asking relevant questions, and seeking relevant answers.

For that reason, we use the word 'CRITICAL' as an acronym for the kind of holistic approach that must characterize an AIDS-competent church in any particular context. In Africa, which is my home, a 'critical' approach brings together the following:

- **Community** – how it influences our society;
- **Religion** – how it imbues our actions;
- **Involvement** – what it means for us;
- **Technical capacity** – what it means in a global health crisis;
- **Infrastructure** – what challenges us in rural and urban Africa and elsewhere;
- **Capital** – why it is more than money;
- **Access** – how globalization can pull Africa forward;
- **Leadership** – what is necessary for success at all levels: local, national, regional and international.

7. The need for and role of HIV and AIDS curricula in theological education

The Church has continued to offer the much needed mitigation. At a meeting in Kampala, Uganda in April 1994, church leaders from across Africa developed biblical principles and guidelines to help the Church take action to meet the challenges presented by the HIV and AIDS pandemic. Whereas their perspective of HIV and AIDS may have changed since then, the principles they proposed seem to endure. In the *Kampala Declaration*, the church leaders affirmed:

The Church is [God's] instrument to proclaim and promote life. [...] We believe that God has called us at this unique moment in history to be instruments of His hope and eternal life. His life and hope may yet be seen even when sickness consumes our bodies and a virus saps the strength of those we love.

We plead for God's people to:

- engage in dialogue at all social and structural levels;
- wrestle with the issues, so that we might understand and apply principles of truth in a way that will bring about appropriate change [which] must include some traditional cultural practices as well as some modern trends that affect the family.

We are watchmen standing in the gap and stewards of the hope of God offered in Christ. The pain and alienation of AIDS compel us to show and offer the fullness and wholeness that is found in Him alone. In this, our time of weakness, may the rule of Christ's love bring healing to the nations.³

One of the recommendations coming out of the all Africa church leaders' consultation on AIDS⁴ organized by WCC in 2001 was that participants needed to develop HIV and AIDS curricula for Christian theological institutions. Theological and Bible colleges in Africa, after all, are the breeding grounds for pastors and clergy. MAP International, the organization that I work with, for example responded to that cry by developing *Choosing Hope: Eight HIV and AIDS Curriculum Modules*, targeting theological and Bible schools in Africa.

Choosing Hope: Eight HIV and AIDS Curriculum Modules

1. Understanding hope through knowing facts about HIV and AIDS
2. Discovering hope in the HIV epidemic through our Biblical foundation
3. Spreading hope through mobilising the church to HIV and AIDS ministries

³ *AIDS in Africa: The Church's Opportunity* (Nairobi: MAP International, 1996).

⁴ World Council of Churches, *The Ecumenical Response to HIV/AIDS in Africa: Plan of Action*, Geneva WCC 2001

4. Developing hope through changing feelings and attitudes about HIV and AIDS
5. Sharing hope through pastoral care to families and communities affected by HIV and AIDS
6. Offering hope through HIV and AIDS pastoral counselling
7. Giving hope to parents and youth for AIDS-free living
8. Ministering hope through home-based care to people with AIDS.

*MAP International*⁵

It is important for users of these modules, and ultimately for the recipients of these teachings, to interpret and fit these teachings into their own cultural, organizational, economic and educational context, under the authority of Scripture.

Over the years, other organizations and institutions – including the World Council of Churches (WCC), the Ecumenical HIV and AIDS Initiative in Africa (EHAIA) and the University of KwaZulu Natal (UKZN) – have developed further materials for use in theological institutions and Bible colleges.

Equipping would-be clergy and pastors in theological institutions with HIV and AIDS knowledge and skills, prior to their posting and eventual work in their respective congregations and communities, is mandatory. This, I believe, will go a long way in shaping effective responses to the pandemic at grassroots level – and possible change of behavior – for the good of all.

8. Individual factors

In this last section, I want to say a word about individual, personal responses to the challenge of HIV prevention. We need help; we need

⁵ *Choosing Hope: Eight HIV and AIDS Curriculum Modules* (Nairobi: MAP International, 2003).

companions on the journey; we need our families and faith communities; but at the end of the day, with God's help, we must each of us take responsibility for ourselves.

Dr Creflo Dollar has proposed that we see our own behaviour in the context of eight factors that determine our individual behaviour and destiny.⁶ They are:

- the *words* we listen to or read: whether it's media, books or the Bible;
- our *attitudes* and whether they are conformed to the mind of Christ (Phil.2:5-11);
- our *emotions* and the extent to which they are influenced by external or internal factors;
- the way we make *decisions*: whether they are motivated by spur-of-the-moment impulses or long-term goals and values;
- our *actions* and whether these promote or reduce the risk of contracting or transmitting HIV;
- our *habits*: the company we keep, and what needs to change;
- our *character*, including an assessment of who we are, or what others say about us;
- our final *destination*: the goal towards which our life's journey is taking us.

But this struggle is valueless without the One who is the Founder and Head of the Church. 'Without me,' said Jesus, 'you can do nothing.' (John 15:5) Jesus had no servants, yet they called Him Master. He had no degree, yet they called Him Teacher. He had no medicine, yet they called Him Healer. He had no army, yet kings feared Him. He won no military battles, yet He conquered the world. He committed no crime, yet they crucified Him. He was buried in a tomb, yet He lives today...

⁶ Dr. Creflo Dollar, *Interview*, CBN, January 2008

So – finally - we should never forget that it is in families and communities and human relationships, not in the solitude of one's own heart, that the task of HIV prevention is lost or won. As the UNGASS Commitment of 2001 put it:

'AIDS is not over...until it is over for everyone...!'

Essay 4

Risk-increasing context or individual behavior?

Gideon Byamugisha

The Reverend Canon Gideon Byamugisha is the Goodwill Ambassador on HIV and AIDS for Sudan, Eastern Africa and The Horn, Christian AID (UK) and also member of ANRELA+ (the African Network of Religious Leaders living with or personally affected by HIV and AIDS).

1. The real question

You see the trouble we are in, how Jerusalem lies in ruins with its gates burnt. Come let us rebuild the walls of Jerusalem, so that we may no longer suffer disgrace. *Nehemiah 2:17*

In talking about HIV prevention, the question we have to ask is: 'Why do people get HIV?'. Why, with all that we know, and all the billions of words that have been said or published on the subject, does the challenge of HIV transmission remain so intractable? How come the world, in its wisdom, has not found a way to stop AIDS? How can we 'rebuild the walls of Jerusalem', and say a decisive 'No!' to the 'disgrace' that is suffered by those who live in it?

I am suggesting in this paper that one important answer lies in the way we see and understand the issue of HIV transmission, and what the virus has come to mean. Because how we see and understand the epidemic affects the kinds of responses we try to encourage. It affects the way we see our own place in the epidemic. And it affects where we lay the responsibility for change.

So the question we have to ask is: in talking about prevention, should we be asking about individual behavior, over which a man or woman, boy or girl may have or may not have a measure of control (given the socio-economic, cultural, educational, political, psychological, motivational, service and skill factors surrounding him or her)? Or are we talking about the overall environment in which the man or woman, boy or girl find themselves - the environment that either makes safe behaviors and practices easier to adopt and to maintain or makes them difficult to adopt and to maintain? Should we be addressing risky *behavior*, or should we be addressing risk-increasing *contexts* or should we be giving both risky behavior and risky environments equal attention?

I want to suggest that it is not possible to try and answer this question without first understanding something about stigma (or what the prophet Nehemiah calls 'disgrace'); that is, without first learning to perceive the way stigma sabotages and silences honest dialogue about the contextual dimensions of HIV transmission, and the way it paralyzes people who fear that they themselves or one or more loved ones may have HIV.

One difficulty about HIV prevention is that only about 15 per cent of all HIV positive people know their status. Because of the fear of the possibility of facing a quick agonizing death or else of being stigmatized, rejected, discriminated against, isolated or abandoned, many do not want to know. Many of those who dare to know are, for the same reasons, very hesitant to disclose their HIV positive status. Those who venture to disclose do so too late for effective HIV prevention, care and treatment to take place: often because they do not seek help until it is too late for medical interventions to make a difference in blocking new HIV transmissions and in preventing and postponing death.

Fear of stigma leads to individual and collective denial that there is a problem. As a result, people who secretly fear they may be HIV positive (and societies which have sufficient reasons to believe that they could be at risk) do not take measures to prevent the virus being transmit-

ted from one person to the other. This includes, for example, pregnant women, who may fear stigma more than they fear the possibility of transmitting the virus to an unborn child, as well as nations/communities which may fear loss of pride and business more than they fear the possibility of losing millions of people to a disease that is, in the absence of stigma, preventable and manageable.

Families, communities and nations which stigmatize those 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.

Societal stigma may be based on the irrational fear of contagion, or on concern about resources: which can be dealt with on a rational, factual basis. It may be based on an association between HIV infection and behavior, judged by community members to be 'immoral', or 'deviant', such as sex before or outside marriage, prostitution, drug abuse or homosexuality. AIDS may be associated with lack of faith in God and God's miracle healing powers; with inability to pray or pray well; or with punishment for sin, more especially sex-related sins.

An understanding of the sources and manifestations of stigma at individual, family, local community, national and global level is crucial to the argument of this paper. Stigma leads people and societies to make simplistic moral judgements, devoid of serious reflection and analysis, about people's capacity for behavior change. Seen through the lens of stigma, which arises out of connecting HIV infection with sexual immorality, looseness and debased-ness, the possible reality that someone could have *'failed to change to safe behavior'* is quickly and inaccurately translated into the perception that they have *'refused to change to safe behavior'*. But the key difference is that a *failure* to change is the result of constraining variables within someone's socio-economic, cultural, educational and political *environment*. In order to understand why this is the case, it is necessary to initiate an exploration of what we mean by 'community'.

2. What is community?

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, or my neighborhood, or 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?

The objective of this reflection on ‘community’ is for members of a community to learn to:

- appreciate and reduce their individual and collective risk and vulnerability to HIV;
- promote positive prevention among individuals, families, communities and nations living with HIV;
- integrate HIV and AIDS related issues in liturgy and worship in such a way as to facilitate (or enhance) theological reflection, task-focused praying and practical action for accelerated HIV prevention;
- reflect on how such a church/community praxis can be strengthened and scaled up for increased HIV prevention.

So before we can define what we mean by a ‘risk-increasing community’ or start discussing what risks are carried by the culture of our own communities, we need to be sure that we know what we are talking about, and that we are all talking about the same thing. And, having done that, we need to reflect – in the context of the particular community with which we are concerned - on the community practices, traditions, values, attitudes and happenings that add to the problems of HIV and how these can be used to change situations in community. The question is: how can community activity be scaled up to address the challenges? And in addressing

that question, one must also ask oneself: what (other) community activities need to be scaled *down* if that is to happen?

Of course every community is unique; but also there are a number of community level factors that can help explain the rapid spread of HIV, or the difficulty of containing the epidemic. Any review of factors influencing individual or collective community competence or incompetence in HIV prevention should therefore reflect the following:

- a) *The availability or scarcity of accurate, adequate and unbiased information* regarding HIV and AIDS and how HIV is and is not spread; information about all possible modes of transmission and all possible means of prevention; and what individuals, families, communities and nations can do to minimise risk and contain HIV.
- b) *The attitudes of community members* towards both HIV and to people living with the virus. Are they positive or negative, empowering or disempowering? Do they encourage vigilance and spirited action for accelerated HIV prevention, care and treatment; or do they cause paralysing fear, stigma, shame, denial, discrimination, inaction or mis-action? Do they foster openness, counselling, testing, sero-status disclosure and positive prevention; or do they foster the kinds of rejection, harassment, mistreatment and discrimination that drive the epidemic underground?
- c) *The presence or absence of skills* for self-protection among community members. Do community members know how to negotiate abstinence or safe sex with their current or potential sexual partners? Do they know how to store, use and dispose of condoms correctly? Are they able to read and check their expiry dates? Do they have the competence, self-belief and self-motivation to demand VCT, safe injections, safe circumcision, safe blood transfusion or the enrolment of women into mother to child transmission prevention programmes?

- d) *The availability or scarcity of health related services for self-protection.* Are HIV prevention services available, and if so, are they accessible? Examples include voluntary counselling and testing (VCT), treatment to prevent mother to child transmission (PMTCT), condom supply, safe maternity and delivery services, safe surgery, safe dentistry, safe blood transfusion and safe circumcision.
- e) *The presence or absence of supportive environments.* Examples would be those that make safe behavior and practices widely acceptable, popular, easy to adopt and routine, while making unsafe behavior unacceptable, unpopular, difficult to practice and rare. Factors in this would be psychological, socio-economic, spiritual, cultural, educational or political; they would be expressed in family, local community, national and global level policies, and in programmes and partnerships aimed at bringing about safer, healthier, fairer and more prosperous relationships.
- f) *The amount of HIV circulating in the community.* The HIV prevalence in a certain community may determine whether individual behavior or practice (which may appear to be 'acceptable', 'lawful' or 'right') is actually, in that context, 'unsafe'. On the other hand, local prevalence may determine whether a behavior or practice regarded as 'unlawful', 'unacceptable' or 'wrong' by the community is actually 'low-risk' or 'risk-free'.
- g) *The community members' frequency or infrequency of exposure to HIV* through unsafe sex, unsafe maternity and child delivery services, unsafe circumcision, unsafe injections and other skin piercing, penetrating or cutting practices and other happenings (voluntary or involuntary) that take place at community level.
- h) *The condition of sexual organs,* for example the absence or presence of sores, cuts, abrasions, whether a man has been circumcised or not and whether the sexual organs (especially of the girls) have matured to withstand/manage the wear and tear during sex.

- i) *The gender of the community member at risk of infection (positive men are more efficient transmitters of HIV to women than positive women are to men).*
- j) *The general health and competence of immune system and other variables of the members at risk.*¹

From the above, we are now in position to appreciate what is meant by an 'HIV risk-prone' or 'vulnerable' community where members do not just *refuse* to adopt safer and healthier behaviors and practices but in most cases *fail* due to the environmental factors at play in the context of accurate information acquisition, appropriate attitudes formation, skills building and service provision for effective self-protection against HIV and AIDS.

3. Contextualising HIV and AIDS prevention in the Diocese of Namirembe, Uganda

In the final section of this paper, I am going to focus on the context I know best, which is the church community in the Anglican Diocese of Namirembe, in Uganda. Here we have found that scaling up HIV and AIDS prevention involves both the empowerment of individuals to behave in a risk-free or less risky way and a careful analysis of the risk-increasing (and also risk-reducing) factors that are at work in our communities.

In doing this, we have learned to use the Bible in particular ways, notably as a lens for 'seeing' the reality of our lives in community, by starting with what is actually happening in our midst, and looking for resonance and dissonance between that reality and the Word of God. In doing this, we have discovered that there is a very big difference between what we know as 'acceptable, right, lawful, and faithful' in the eyes of God and what is known as 'safe' in the context of HIV and AIDS. In other words we are discovering and

¹ Science is still exploring the mystery of people who remain negative despite regular exposure to HIV. It is now common scientific knowledge that HIV positive people with undetectable viral loads in their blood systems due to effective and impactful ARV treatment are not able to transmit the virus to others - even if they were to be tempted to.

frustrating the plans of the Evil One, recorded for our awareness, and taking heed of what is written in Nehemiah 4:11: ‘Our enemies said: “They will not know, they will not see until we come in their midst, kill them and cause their work to cease”’

What are we doing in Namirembe to intensify HIV prevention?

We are educating, encouraging and supporting community members to adopt safe practices through:

- community awareness raising workshops, seminars and sermons;
- attitudinal change training events;
- skills building session for behavior change, positive living etc;
- counselling in pre marital and pre/post testing contexts;
- testimonies from HIV positive and personally affected community members;
- interpreting and re-interpreting scriptures to enhance understanding, in particular about sexual relations (see box);
- understanding that, when the Bible teaches: ‘Drink water from your well/cistern’, it does not go ahead to ask the questions: what type of water is in that well/cistern? Is it safe or unsafe water?

We are supporting community members living with or vulnerable to HIV to live positively, to access treatment and care and to participate in HIV prevention programmes and activities, through:

- loving, caring and being church;
- initiating and strengthening church-run and church-sponsored post-HIV-test clubs, home care programmes and referral services;

- campaigning for increased treatment programmes and funds through days of prayers to enhance solidarity;
- offering treatment in church run and church supported clinics and hospitals.

We are encouraging, funding and multiplying voluntary, routine and stigma free counselling and testing by:

- sponsoring mobile counselling and testing services to communities far from testing centres;
- subsidising the cost of HIV tests;
- offering testing and counselling services through church run clinics and hospitals.

We are empowering children, young people, families and communities living with or vulnerable to HIV by:

- running child-to-child peer education, 'Youth Alive', 'Daughters of the King', 'Minus One', programmes in Sunday schools, Youth Fellowships, Mothers' Union, Christian Women Fellowships and activities in parishes;
- giving leadership space to people living with HIV or AIDS;
- participating in national, regional and international action and advocacy agenda for accelerated HIV prevention.

The wise and foolish virgins of today

It is not only sex outside of marriage that is 'foolish' and 'deadly' as Proverbs 5 and 7 teaches. In the context of HIV risk it is *all unprotected sexual intercourse with someone whose HIV status is not known as HIV negative, whether that*

sex is in marriage or outside of it. In the context of Matthew 25:1-13 and in the context of HIV, there can be 'foolish virgins', who marry without testing, who do not insist on condom use in a situation where a spouse's sero-status is not known as HIV negative, who do not guard against other routes of HIV infection beyond sex and who do not advocate for safer, healthier and fairer policies, programmes and practices in their socio-cultural, economic, spiritual and political environments. On the other hand, there are 'wise virgins' who know and appreciate that in the context of HIV risk and vulnerability, 'faithfulness' (as it is rightly taught in Proverbs 5:15) does not always translate into 'safeness' and that, in high HIV prevalence countries and communities, 'acceptable' and 'right' sexual behavior (i.e. having sex in marriage only) in unsafe public health environments may not be right *enough* or safe *enough* to protect someone against all the possible modes of HIV infection and transmission.

We believe that this multifaceted, comprehensive and truthful approach to prevention tackles unsafe, risky and life-reducing environments at family, local community, national and global level. It tackles it just as aggressively as it addresses unsafe, risky and life-reducing behaviors at individual level. In that way it puts into people's heads, hearts and hands the understanding, the skills and the competence they need, as individual men and women, boys and girls, in order to prevent the spread of HIV in their own environments; but, in addition, it will also result in the transformation of risk-increasing cultures into risk-reducing ones in all the sectors, levels and dimensions of our living. And in faith, we say, with the prophet Isaiah:

For I am about to create new heavens and a new earth. The former things shall not be remembered or brought to mind.

— Isaiah 65:17

Essay 5

The virus and the Bible: how living with HIV helps the Church to read it

Adrian Thatcher

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Theologians of all shades of opinion have called on the sources of theology (Bible, tradition, reason and experience) to provide a better understanding of the HIV pandemic. However, anyone sifting through the weight of theological material surrounding HIV in the last two decades may be struck by pervasiveness of negative and moralistic attitudes, both outside and inside the churches, towards people living with HIV. Such attitudes are very deeply rooted; and they will not be removed merely by being ignored. Rather, honest self-critical analysis and charitable confrontation may be required. In this paper I shall attempt two tasks: to explore ways in which particular readings of the Bible and tradition have conspired to oppress people living with HIV or AIDS; and to suggest how we might use these precious resources more wisely in the service of all God's people.

1. What silences need to be broken?

This paper was first delivered at a conference entitled 'Breaking the Silence'. We need, therefore, to ask what silences need to be broken. The theological literature grounded in caring for and ministry to HIV-positive people is full of reports about obstacles that first need to be overcome before caring and ministry can happen effectively. In 2003 UNAIDS initiated

a 'theological workshop' which aimed to identify 'those aspects of Christian theology that endorse or foster stigmatizing attitudes and behaviour towards people living with HIV and AIDS and those around them'.¹ It notes 'Historically the churches have often used the Bible for purposes of exclusion.'² Women's risk of infection is hugely increased by 'extensive theoretical and practical gender inequalities [...] unequal power-relations give women a subordinate position and make them submissive to men'.³

We need to ask how we ever got into this situation: for admission of fault must not stop us from enquiring into the causes of it. For example, a report on religious women in Malawi concluded that 'religious groups do little to nothing to change socially structured gender inequalities'. Religious institutions 'do little to support women' or lighten their 'multiple burdens'. Indeed, women's 'donkey work', as countenanced and indirectly supported by religious attitudes, beliefs, and practices regarding sexual activity, results in at-risk sexual behaviour, primarily sex work, as a means of sheer survival.⁴

That judgment could be made in many other countries. The very firmness of the churches' teaching about abstinence from pre-marital sex and fidelity in marriage, it is claimed, has underlined the false assumption that HIV infection is God's punishment for disobedience to God's law, irrespective of how the virus was contracted.⁵ The Nigerian theologian Teresa Okure compares the HI virus with two other, metaphorical, viruses, which she thinks are even more dangerous (assuming that to be possible): one 'assigns women an inferior status to men in society'; the other is 'global economic injustice'.⁶

¹ *A report of a theological workshop focusing on HIV- and AIDS-related stigma, 8th - 11th Dec. 2003, Windhoek, Namibia* (Geneva: UNAIDS, 2005), p. 11.

² *Ibid* p. 12.

³ Michael J. Kelly, S.J., *HIV and AIDS: A Justice Perspective* (Lusaka, Zambia: Jesuit Centre for Theological Reflection, 2006), p. xiv (and see pp. 26-31).

⁴ Sally H. Rankin, Teri Lindgren, William W. Rankin, Joyce Ng'oma, 'Donkey Work: Women, Religion, and HIV/AIDS in Malawi', *Health Care for Women International*, 26 [4-16], 2005, pp. 14, 13.

⁵ Dorothy Scarborough, 'HIV/AIDS: The Response of the Church', *Journal of Constructive Theology*, 7.1, July 2001 [3-16].

⁶ See Claire Foster, 'Disease, Suffering, and Sin: One Anglican's Perspective', *Christian Bioethics*, 12 [157-63], 2005. p. 160, summarising Okure's essay in J. Gollither ed., *Healing God's Creation: the Global Anglican Congress on the Steward of Creation* (Morehouse: Harrisburg, PA, 2004).

The churches are unanimous (and in my view right) in commending marriage, but marriage (as Isabel Phiri reminds us) 'is also the centre of patriarchy, which constructs the subordinate position of African women'.⁷ We are sadly at fault if, in our enthusiasm for marriage, we do not also celebrate the transition from patriarchal to egalitarian marriage, and let the 'new life in Christ' that we proclaim thoroughly transform our gender inequities.

2. The Bible as a source of suffering

We can no longer suppress the question of why the churches need to overcome so much in their own practice. That is a huge and multifaceted topic. Part of the answer, I shall suggest, is that the Bible and our tradition are heavily incriminated in these multiple oppressions. The powerlessness of wives in relation to their husbands is straightforward biblical teaching, despite the fact that it is a huge source of distress for millions of women. 'Now as the church submits to Christ, so also wives should submit to their husbands in everything.' (Eph.5:24) Tradition colludes with scripture in denying to women an appropriate place in the liturgy, in holy orders or in the episcopate. (1Tim.2:8-15) Exclusion is bad enough for the excluded: but there is worse. When the world perceives the inadequacy of the arguments in favour of retaining an exclusive, penis-endowed priesthood, how can it find the Church attractive, or even fit to be taken seriously? Worse still, how is gender inequality to be tackled at its theological roots when the churches themselves do not practise gender equality (apparently because they do not believe in it)?

Isabel Phiri says: 'The major problem of African Christians is their uncritical reading of the Bible'.⁸ There are readings of the Bible that reinforce these as well as other lamentable policies and practices. Unfortunately these readings have long been the dominant ones. It is time

⁷ Isabel Apawo Phiri, 'HIV/AIDS: An African Theological Response in Mission', *The Ecumenical Review*, 56.4 [422-31], 2004, p. 425.

⁸ *Ibid* p. 427.

that we Protestants (who have been taught that the 'plain sense' of scripture can be read off its pages) should learn to re-think what we do with the Bible.⁹

The literature on HIV shows remarkable attempts to read the Bible differently. In KwaZulu-Natal, for example, a group of women (inspirationally-led by Beverley Haddad) created a 'safe, sequestered' site, away from 'the surveillance and control of patriarchy', where eventually the 'hidden discourse' of rape, violence, poverty and exclusion could percolate through into 'the public domain'. 'Contextual Bible study' was then possible, requiring 'a commitment to read the Bible critically from a particular perspective'.¹⁰ The stories, say, of the rape of Tamar (2 Sam.13:1-22) and of the woman with a haemorrhage (Mk.5:21-43) could then elicit extraordinary theological understanding from the participants themselves.¹¹

As a resource to be utilised in discussion groups and workshops about sexuality and HIV, Manoj Kurian advocates a threefold model for the interpretation of the Bible: 'literal, convenient and contextual'.¹² He finds the simple use of the model helps to relativise literalism and so to articulate responsible interpretation. Hyunju Bae, a Korean woman theologian, describes the 'Janus-faced' function of the Bible in Asia both as a (welcome) source of salvation and liberation, and as a (deeply unhelpful) sourcebook 'to promote the Christian contempt of the indigenous religions and cultures of the "Other"'.¹³ Bae proposes 'a hermeneutics of compassion in detachment [...] which involves a critical assessment of what the Bible did

⁹ Worldwide Anglicanism is currently tearing itself apart over a related issue. To a majority, it seems obvious that scripture forbids homosexual love. To the rest of us, these readings are a betrayal of the Spirit of Christ.

¹⁰ Beverley Haddad, "Living It Out: Faith Resources and Sites as Critical to Participatory Learning with Rural South African Women", *Journal of Feminist Studies in Religion*, Spring 2006, Vol. 22 Issue 1, pp. 136, 145

¹¹ *Ibid* pp. 146-53.

¹² Manoj Kurian, "The HIV and AIDS Pandemic: Changing Perceptions on Sexuality in Faith Communities", *The Ecumenical Review*, 56.4, October 2004 [432-6], p. 435.

¹³ Hyunju Bae, "Dancing around Life: An Asian Woman's Perspective", *The Ecumenical Review*, 56.4, Oct. 2004 [390-403], pp. 390-1.

and does, and a sympathetic retrieval of the meanings one can construct from the creative interpretation' of it.¹⁴ These micro-practices are admirable. They free the Bible from patriarchy. They allow the experience of readers to interrogate the text.

In my forthcoming book, *The Savage Text*, I have charted the misuse of the Bible against minorities.¹⁵ The list includes homosexuals, slaves, people of colour, women, children, witches, the disabled, Jews, and so on. Two brief examples must suffice. The first is the Genesis narrative describing the curse of Ham/Canaan. (Gen. 9:18-27) In 1862 a man born in the United States to freed slaves claimed that the divine curse upon black people was the 'general, almost universal, opinion in the Christian world'. He found it:

...in books written by learned men; and it is repeated in lectures, speeches, sermons, and common conversation. So strong and tenacious is the hold which it has taken upon the mind of Christendom, that it seems almost impossible to uproot it. Indeed, it is an almost foregone conclusion, that the Negro race is an accursed race, weighed down, even to the present, beneath the burden of an ancestral malediction.¹⁶

This is frightening testimony to the power of the Bible, inadequately understood, to endorse outrageous readings that justify unspeakable acts of cruelty, injustice and murder. The second example is the killing spree by the Scottish Presbyterians of witches in Scotland. In this small, under-populated country, between 1590 and 1670, the Protestant Kirk ensured the death of over a thousand victims (not counting hundreds more who killed themselves or died awaiting trial).¹⁷ One of

¹⁴ Bae, *op cit*, p. 391 (author's emphasis).

¹⁵ Adrian Thatcher, *The Savage Text* (Malden, Mass. & Oxford, UK: Blackwell-Wiley: October 2008).

¹⁶ Alexander Crummell, 'The Negro Race Not under a Curse: An Examination of Genesis IX. 25', in *The Future of Africa, being Addresses, Sermons, etc., etc., Delivered in the Republic of Liberia* (New York: 1862), pp. 327-8: cited in Goldenberg, *The Curse of Ham - Race and Slavery in Early Judaism, Christianity, and Islam* (Princeton: Princeton University Press, 2003), p. 176.

¹⁷ And this is a conservative estimate. See Diarmaid MacCulloch, *Reformation: Europe's House Divided - 1490 - 1700* (London: Penguin Books, 2004), pp. 563-75.

the 'drivers' of this persecution was the biblical text: 'Thou shalt not suffer a witch to live'. (Ex.22:18)

The stigmatizing treatment of HIV positive people belongs to a long and sad tradition of biblical exegesis, found in Christianity's darker side, which converts the Bible into a savage text. This counter-Christian tradition lies at the heart of Christianity itself. In addressing it, we need to return to the distinction between – on the one hand – God-the-Word, made flesh in Jesus Christ (Jn.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.

In its most recent attempts to discuss sexuality, the House of Bishops of the Church of England sets out two views of the Bible that co-exist among Anglicans: the *guidebook* view and the *witness* view. Anglicans, they explain, see the Bible 'as providing normative guidance for their sexual conduct'. And they see it this way because of the status they give 'to the Bible as a whole as pointing to Christ, through whom God has revealed to his people what he is like, what he has done for them, and how they should respond to him'. But if the Bible is already our guide, what need do we have of Jesus Christ? That is why the *guidebook* view is finally idolatrous and it becomes necessary to re-establish the *witness* view.

In 1600 the Anglican theologian Richard Hooker found it necessary to combat the bibliolatry (or bible worship) of Puritans who wanted biblical warrant for everything. This included the abolition of Christmas Day, which was a papist feast without biblical warrant. Hooker (rightly) committed himself to the 'witness view'. Both Tes-

¹⁸ House of Bishops' Group on 'Issues in Human Sexuality', *Some issues in human sexuality: A guide to the debate* (London: Church House Publishing, 2003), 2.1.1 and 2.1.2 (p. 37).

taments, he taught, are alike in bearing witness to Christ; where they differ is on how they do it:

So that the general end both of Old and New is one; the difference between them consisting in this, that the Old did make wise by teaching salvation through Christ that *should* come, the New by teaching that Christ the Saviour *is* come.¹⁹

This re-positioning of the Bible in relation to Christ will be difficult to accomplish; but in this 21st century, when the revelation of unbounded love is continually compromised, it is essential that Christians are aware of the need to achieve it. In doing so, I think the contextual Bible study method, or the practice of compassion in detachment, is the right approach. For example, Renita Weems, an elder of the African Methodist Church, describes how African slaves in the United States devised a simple, yet sophisticated hermeneutic. Slave-masters especially feared the revolutionary potential of the scriptures, so knowledge of these was mediated through the slave-masters themselves, and also through black churches which had been specifically set up for the slaves.²⁰ Generally speaking, the slaves were (rightly) wary of any interpretation of the Gospel that oppressed them. Weems explains: 'What the slave-masters did not foresee, however, was that the very material they forbade the slaves from touching and studying with their hands and eyes, the slaves learned to claim and study through the powers of listening and memory.'²¹

For Afro-Americans, continues Weems, 'it is not texts *per se* that function authoritatively. Rather, it is reading strategies, and more precisely, *particular* readings that turn out, in fact, to be authoritative'.²² Faced with the cacophony of Protestant voices proclaiming their competing conversion narratives, the slaves knew that not all of these voices

¹⁹ Richard Hooker, *Ecclesiastical Polity Books I – IV* (ed. E. Rhys), *Volume 1* (London: J.M. Dent, 1907, reprinted 1925, Everyman's Library), 1.14.3, p. 217 (emphasis added).

²⁰ Renita J. Weems, "Reading Her Way through the Struggle: African American Women and the Bible," in Cain Hope Felder (ed.), *Stony the Road We Trod – African American Biblical Interpretation* (Minneapolis: Fortress Press, 1991) [57-80], p.60.

²¹ *Ibid* p.61.

²² *Ibid* p.64.

could be right. Thus, before they could even read the Bible for themselves, their experience led them to the Exodus and other narratives and to a sense of liberation that continues to the present day.

So the Bible has not been read in a Christ-centred manner; and all our churches have (at one time or another) used the Bible for the purposes of exclusion. This is the background to the observation in the theological framework that emerged from the UNAIDS theological workshop on stigma, which said: 'Since God's abiding concern is for our well-being or fullness of life, *no passage from Scripture should be used to diminish this in any other human being*'.²³ 'Readings of the Bible must be Christ-centred,' it goes on to say, 'and linked to the context in which we find ourselves'. The habit of reading the Bible to justify rejection or exclusion is embedded in several types of conservative Christianity, and charitable confrontation with them is inevitable.

3. Tradition as a burden

It will come as no surprise, then, that I propose to treat tradition in a similar way.²⁴ I will take just two examples, and in the final sections suggest a way of handling both the Bible and tradition that better equips us for faithful living.

The first example is the association between sickness and punishment for sin. In the Church of England Book of Common Prayer, The Order for the Visitation of the Sick contains the following exhortation:

Dearly beloved, know this, that Almighty God is the Lord of life and death, and of all things to them pertaining, as youth, strength, health, age, weakness, and sickness. Wherefore, whatsoever your sickness is, *know you certainly, that it is God's visitation*. And for *what cause soever* this sickness is sent unto you; whether it be to *try your patience for the example of others*, and that *your faith* may be found in the day of the Lord *laudable, glorious, and honourable*, to the increase of glory and endless

²³ Weems, *op cit*, p.13 (emphasis added).

²⁴ Many questions are, of course, begged, not least what it is, and how it is thought to develop.

felicity; or else it be sent unto you to correct and amend in you whatsoever doth offend the eyes of your heavenly Father; know you certainly, that if you truly repent you of your sins, and bear your sickness patiently, trusting in God's mercy, for his dear Son Jesus Christ's sake, and render unto him humble thanks for his fatherly visitation, submitting yourself wholly unto his will, it shall turn to your profit, and help you forward in the right way that leadeth unto everlasting life.²⁵

My second example is contraception. According to Christian tradition, contraception is not just *wrong*, but the practice of it is tantamount to *murder*. This doctrine, which is found in Chrysostom,²⁶ Aquinas,²⁷ and in the Roman Catholic canon law *Si aliquis*,²⁸ has been notoriously re-established by new natural law theorists at the present time.²⁹ *Humanae vitae* is actually a liberalization of this tradition, basing the wrongness of contraception not on the charge of murder, but on 'the inseparable connection, established by God, which man on his own initiative may not break, between the unitive significance and the procreative significance which are both inherent to the marriage act'.³⁰ Forty years on from *Humanae vitae*, is it not time to push the development of thinking about contraception a stage further?

But Protestants can't afford to be smug about contraception: Calvin, after all, re-affirmed the condemnation of any form of contraception.³¹ Let's also be clear: the tradition condemns masturbation on similar grounds. Calvin taught that Onan deserved to die for the crime of the unproductive discharge of semen (not simply the practice of *coitus*

²⁵ emphases added

²⁶ St. John Chrysostom, *Homily 24 on the Epistle to the Romans*, PG 60, 626-627. Translation in John T. Noonan, *Contraception: A History of Its Treatment by Catholic Theologians and Canonists* (Cambridge, MA: The Bellknap Press of Harvard University, 1965), p. 96.

²⁷ *Summa contra gentiles*, 3, 122.

²⁸ Text in *Corpus iuris canonici*, eds. A. L. Richter and A. Friedberg (Leipzig: Tauchnitz, 1881), 2, 794.

²⁹ Germain Grisez, John Finnis, Joseph Boyle, and William E. May, "Every Marital Act Ought to Be Open to New Life': Toward a Clearer Understanding," *The Thomist* 52.3 (1988), pp. 365-426.

³⁰ Pope Paul VI, *Humanae vitae* (1968), 12. http://www.vatican.va/holy_father/paul_vi/encyclicals/documents/hf_p-vi_enc_25071968_humanae-vitae_en.html

³¹ John Calvin, *Commentaries on the First Book of Moses Called Genesis*, Ch. 38: 9,10; quoted in Charles D. Provan, *The Bible and Birth Control* (Monongahela, PA: Zimmer Printing, 1989), p. 15.

interruptus).³² Wasted semen? There is more than enough semen in the world! While Calvin uses the Onan narrative to accuse masturbators of a crime worthy of death, the Congregation for the Doctrine of the Faith observe: 'Both the Magisterium of the Church, in the course of a constant tradition, and the moral sense of the faithful have been in no doubt and have firmly maintained that masturbation is an intrinsically and gravely disordered action.'³³ Here is another case of a strand of tradition crying out for further development.

4. The spiral and the score

In the example from the Book of Common Prayer, it should be clear Christian tradition *does* assert the close association of sickness and sin. Sickness is 'God's visitation'. There are reasons why God sends it (known only to God) and they include the learning of exemplary patience, the increase in and witness of faith, and opportunities for repentance and the purgation of sin. On the one hand the association of sickness and sin is defensible: it is, after all, in the Prayer Book! But let us remember that in 1549, when this was written, people believed in evil spirits; they believed that illnesses and all manner of malevolence could strike as the result of a spell, or a stare from an 'evil eye' or the calling up of magic. People had no idea about viruses, no access to the medical understanding which we now take for granted. In those circumstances they would have found genuine comfort in the assurance that God had sent a sickness, that it was not the consequence of a curse or an evil spirit. What these pious authors were doing was to attempt to make theological sense of sickness in a pre-scientific world. On the other hand this prayer is almost useless for pastoral purposes. The conceptual world of their authors is long gone, and cannot conceivably be ours.

³² 'The voluntary spilling of semen *outside of intercourse between a man and a woman* is a monstrous thing. Deliberately to withdraw from coitus in order that semen may fall on the ground is doubly monstrous.' (Provan, *The Bible and Birth Control*, p. 15, emphasis added)

³³ Congregation for the Doctrine of the Faith, *Persona humana: Declaration on Certain Questions concerning Sexual Ethics* (1975), 9. http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19751229_persona-humana_en.html. Reaffirmed in *Catechism of the Catholic Church* (1994), 2352.

In the case of contraception, what has happened is that a tradition intended to promote life has now become an obstacle to survival. Christian approaches to contraception were forged in a time when no one knew how babies were made; a time when sexual intercourse was justified for propagation only (often in periods of intense anxiety about human survival); and a time when Christian concern for living children extended naturally to the unborn. Today, how can a Church which tells the world it is 'pro-life' deny vulnerable people one of the means they need to stay alive? How can it officially deny the pleasure and relief of masturbation, at least to those who are trying to remain free of HIV and to practice pre-marital chastity in accordance with church teaching? Here is another case of the disjunction, not only of conceptual worlds, but of centuries.

5. The spiral...

Joseph Monti, in his splendid work *Arguing about Sex*, advocates a model of doctrinal development which copes well with this obvious disjunction between past and present:

The denominations are forgetting how the obligation of fidelity [to tradition] must be dialectically engaged with the equal obligation of contemporaneity – how Christian life must make sense in its own time, must be truthful and right-making, and promote the good in whatever world we find ourselves.³⁴

Since the Church is a trans-historical body, it spans more than one 'cosmological world', and so cannot remain identified with any particular period, or cultural manifestation of itself, and especially not with our own contemporary world.³⁵ We are not simply passive tradition-receivers but active tradition-makers, as ever-new social, cultural and global problems cause us to examine what we have already received, and to reshape it in the light both of our own questions, and of the

³⁴ Joseph Monti, *Arguing about Sex: The Rhetoric of Christian Sexual Morality* (New York: State University of New York Press, 1995), p. 5.

³⁵ *Ibid* p. 21.

Spirit's guidance, so that it bears the stamp of our own Christian identity when we pass it on to our children to appropriate differently for themselves. Remembering, reading and affirming the Christian tradition is like belonging on:

...an advancing spiral that constantly loops back as a precondition of advancement. This looping remembrance sets a continuity with the past that is internally necessary for the shape of the spiral and its advancement toward an anticipated future. However, when set in motion, such advancing spirals create new and discontinuous centers and radii. With this continuing recombination of the dimensions of continuity and discontinuity that mark historical experience, an historical foundation and model for critical discourse and argument is attained.³⁶

6. ...and the score

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. Derived from the global North, a rather different model of Bible reading may be found in Stephen Barton's question:

What if the Bible is more like the text of a Shakespearean play or the score of a Beethoven symphony, where true interpretation involves *corporate performance and practical enactment*, and where the meaning of the text or score will vary to some degree from one performance to another...?³⁷

The emphasis on 'corporate performance and practical enactment' is easily translatable into different contexts. It highlights our active responsibility for what we do with the Bible, and also the frightful mess that both we and our unrehearsed orchestra or troupe of actors can make of it.

³⁶ Monti, *op cit*, p. 61.

³⁷ Stephen C. Barton, 'Is the Bible Good News for Human Sexuality? Reflections on Method in Biblical Interpretation?', in Adrian Thatcher and Elizabeth Stuart (eds), *Christian Perspectives on Sexuality and Gender* (Leominster, Herefordshire: Gracewing / Grand Rapids MI: Eerdmans: 1996) [4-13], p. 6 (emphasis added).

We, the community of readers, are shaped by scripture and tradition. But we will read our scriptures and our tradition in our present context, and our present context will also shape how we will read scripture and tradition. Being faithful to Christ in the time of HIV entails a 'No' to all those accretions and assumptions that compromise that great love that was poured into the world through His Cross. Looked at against the ebb and flow of history, HIV constitutes one of those discontinuities that renders all theodicies inadequate, and for that very reason requires us to wait afresh upon the Spirit who 'will guide you into all the truth'. (Jn.16:13)

All the critical remarks in this paper are directed towards the removal of obstacles and inhibitors that hinder the full flow of that divine love which the churches are seeking to embody in their ministry and mission among people living with HIV and AIDS. The Chair of the Health Commission of the Catholic Bishops Conference of India said:

All the Catholic healthcare institutions, as we are serving the Lord in the abandoned and afflicted, will admit and care for the people living with HIV or AIDS. As Blessed Teresa of Calcutta used to say, 'a person affected by HIV and AIDS is Jesus among us. How can we say no to Him?'³⁸

Who cannot be moved by that care, not confined to Catholicism, and by the simple yet profound theology that inspires and sustains it? Jesus said 'Truly I tell you: anything you did for one of my brothers here, however insignificant, you did for me.' (Mt.25:40) In ministering to poverty-stricken and sick people, Christians find they are ministering to the Christ who is already with them awaiting recognition. But that is not all. Such people also minister in Christ's name to the theologians, the guardians of traditions, the Church leaders, the biblical interpreters, and all those who cling on to damaging uses of scripture and tradition with little thought of the consequences of what they do.

³⁸ Cited in report of theological workshop (see note 1), p. 23.

Essay 6

Jesus, community compassion and HIV prevention

Robin Gill

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1. Health, healing and the Gospels

Over the last few years I have found the healing stories in the Gospels particularly important in thinking about health care today. They help to point to values and depths that are sometimes overlooked in everyday life. In these stories Jesus shows levels of compassion, care, faith and humility that can, I believe, still inform those working alongside people in need.

Consider, for example, this story recounted in the first chapter of Mark.

A leper came to him begging him, and kneeling he said to him, 'If you choose, you can make me clean'. Moved with pity, Jesus stretched out his hand and touched him, and said to him, 'I do choose. Be made clean!'. Immediately the leprosy left him, and he was made clean. After sternly warning him he sent him away at once, saying to him, 'See that you say nothing to anyone; but go, show yourself to the priest, and offer for your cleansing what Moses commanded, as a testimony to them'. But he went out and began to proclaim it freely, and to spread the word, so that Jesus could no longer go into a town openly, but stayed out in the country; and people came to him from every quarter. (Mark 1:40-45)

It was a 'leper' who came to Jesus. Except, of course, he almost certainly was not a 'leper' in any medical sense. *Sara'at* in the Jewish Bible or *lepra* in the New Testament are not simply to be identified with the bacterial infection Hansen's disease, or *elephantiasis graecorum* (which is how leprosy would be identified today).¹ None of the crucial features of Hansen's disease (anaesthetic areas of the skin, painless and progressive ulceration of the extremities, and facial nodules) are ever mentioned in the Bible.² Rather the person who came to Jesus had already been stigmatised by his community as being a 'leper', as someone who should be segregated from the community as being profoundly 'impure'.

This 'leper' came to Jesus 'begging' him and (according to some texts) 'kneeling'. Jesus in response was 'moved with pity/compassion' (some texts have 'anger'). In Mark, unlike the other Gospels, Jesus was again moved with compassion by the sight of the 5000 and then the 4000 lacking food. Compassion (or even anger) here is not just empathy, placing yourself in the position of another, but identifying someone in real need, 'suffering alongside' him and being determined to help him if you possibly can. Compassion is both passionate and focused upon help. It was, after all, the Good Samaritan in Jesus' parable who was also moved with compassion (Luke 10:33), going to some lengths to help the man stripped and beaten by robbers on the road to Jericho.

Then Jesus 'stretched out his hand and touched' the 'leper', showing astonishing disregard for the impurity consequences involved.³ In this he was quite unlike Elisha, who stayed in his house, kept a distance from Naaman the 'leper' outside and gave his command through a messenger.⁴ Compassionate care indeed!

¹ See, for example, Vincent Taylor, *The Gospel According to St Mark* (London: Macmillan, 1959, p. 186); W.D. Davies and Dale C. Allison Jr, *A Critical Commentary on The Gospel According to Saint Matthew*, Vol. II (Edinburgh: T & T Clark, 1991, pp. 10-11); Martin Noth, *Leviticus* (London: SCM Press, 1965, p. 106); and Gordon J. Wenham, *The Book of Leviticus* (London: Hodder and Stoughton, 1979), p. 195.

² S.G. Browne, *Leprosy in the Bible* (London: Christian Medical Fellowship, 1970), p. 8.

³ James D.G. Dunn, 'Jesus and Purity: An Ongoing Debate', *New Testament Studies*, 48, 2002, p. 461.

⁴ See my 'AIDS, Leprosy and the Synoptic Jesus', in ed. Robin Gill *Reflecting Theologically on AIDS: A Global Challenge* (London and Geneva: SCM Press and UNAIDS, 2007), p.110.

In the parallel healing story of the ten lepers, told only in Luke, Jesus used a phrase repeated in other healing stories: 'your faith has made you well'. (Luke 17:19) If compassion and care occur frequently in healing stories then so does faith, sometimes in the sense of 'trust' (particularly trust that Jesus can indeed heal) and other times nearer to 'belief'; and usually the faith of the person to be healed but occasionally the faith of others. Faith in some sense can even be a requirement of healing or, at least, its absence can be an explanation of why healing was not possible. (Mark 6:6)

Characteristically the story of the single 'leper' also involves restraint and humility, or rather a lack of restraint on the part of the one who was healed. Jesus sternly warned him, as he warned others:

'See that you say nothing to anyone'...but he went out and began to proclaim it freely, and to spread the word, so that Jesus could no longer go into a town openly.

Compassion, care, faith and humility run deeply through the healing stories and have much to teach us about good health care.⁵ In addition, like many others, I have come to see strong affinities between the way 'lepers' in the Bible were stigmatized by their local community, but emphatically not by Jesus, and the way that those living with HIV are too often stigmatized today. Of course Hansen's disease and HIV are medically quite different from each other. But at the level of community misperceptions and stigmatization they have much in common. The followers of Jesus manifestly must respond to people living with HIV as Jesus responded to those perceived to be 'lepers', that is, with compassion, care, faith and humility.

2. Community compassion versus community cohesion

All of this I simply assume here. But there is more to be discovered in this story from Mark about *community* compassion. This is after

⁵ See further my *Health Care and Christian Ethics* (Cambridge: Cambridge University Press, 2006).

all a story that exemplifies a central tension within contextual theology. In it, the norms of the local community are simultaneously both challenged and affirmed. The complex requirements of Jewish purity laws are both broken and sustained in a single story. For those biblical scholars who see Jesus as one who overturns Jewish laws, the touching of the impure 'leper' confirms a pattern displayed in Jesus' table fellowship with sinners, breaking the Sabbath and being touched by the woman made impure from menstrual blood. However, for those who see Jesus as a generally observant Jew, there is his command to 'show yourself to the priest, and offer for your cleansing what Moses commanded' as is required in Leviticus 13 and 14. Confusingly the story can be read either way.⁶

My own suggestion is to see this as a story that upholds community norms when they do not conflict with the demands of compassion, that is to say the demands of the Kingdom of God, but to challenge them when they do. Such compassion even takes precedence over strongly held and principled scruples. So Jesus upholds the formal requirements of Leviticus 13 and 14 yet, as a healer 'moved with pity, Jesus stretched out his hand and touched' the 'leper'. The formal requirements of the local community were sustained but the personal practice was quite different.

This pattern is shown even more clearly in the following story, this time from Luke:

Now he was teaching in one of the synagogues on the Sabbath. And just then there appeared a woman with a spirit that had crippled her for eighteen years. She was bent over and was quite unable to stand up straight. When Jesus saw her, he called her over and said, 'Woman, you are set free from your ailment'. When he laid his hands on her, immediately she stood up straight and began praising God. But the leader of the synagogue, indignant because Jesus had cured on the Sabbath, kept saying to the crowd, 'There are six days on which work ought to

⁶ James D.G. Dunn, 'Jesus and Purity: An Ongoing Debate', *New Testament Studies*, 48, 2002, pp. 49-467.

be done; come on those days and be cured, and not on the Sabbath day'. But the Lord answered him and said, 'You hypocrites! Does not each of you on the Sabbath untie his ox or his donkey from the manger, and lead it away to give it water? And ought not this woman, a daughter of Abraham whom Satan bound for eighteen long years, be set free from this bondage on the Sabbath day?'. When he said this, all his opponents were put to shame; and the entire crowd was rejoicing at all the wonderful things that he was doing. (Luke 13:10-17)

Viewed from the synagogue community's perspective, its leader was obviously correct: 'There are six days on which work ought to be done; come on those days and be cured, and not on the Sabbath day'. The woman had been crippled for eighteen years. One more day after all those years would have mattered little in the interests of keeping communal norms about the Sabbath.

Jesus' response was astonishingly sharp: 'You hypocrites!'

In the Synoptic Gospels the charge of hypocrisy is frequently made by Jesus (13 times in Matthew) and is characteristically levelled at the religiously observant and their leaders. In this story the religious leader and his congregation are denounced as hypocrites, as 'actors' who say one thing but do another.⁷ Or, to express this in terms of pastoral theology, they break the relationship between faith and practice. They claim the high ground of religious faith but in the process ignore the accompanying requirements of compassionate practice.

3. Compassion, truth and shame

In the context of HIV, hypocrisy by community leaders has been only too evident. Perhaps it is the hypocrisy of leaders hiding information about prevalence, denying the link between HIV and AIDS, or claiming that HIV only affects the gay community. Or perhaps, and most shocking among religious leaders, it is the denial that their own community and pastors are themselves living with HIV. Communal fidelity and

⁷ See C.F. Evans, *Saint Luke* (London and Philadelphia: SCM Press and Trinity Press, 1990), p. 338.

truth-telling are key components in HIV prevention, yet the record of churches has all too often been riddled with hypocrisy.

If Jesus responded to the vulnerable with compassion, care, faith and humility, he responded to those religious people who ignored their plight with a sharp denunciation of hypocrisy. And 'when he said this, all his opponents were put to shame'.

The issue of 'shame' is especially sensitive in the context of HIV. 'Stigmatization' and 'shame' are closely connected, but they are not always identical. People have a deplorable tendency to stigmatize others, but they can properly feel shame about this tendency and thus about their own behaviour. All too often communities, even Church communities, have seen fit to stigmatize those living with HIV. Stigmatizing (and even shaming) people who cannot undo their condition is particularly cruel and deeply harmful. Those with disabilities have all too often been stigmatized in this way. The history of 'leprosy' demonstrates this all too clearly. Emphatically Jesus did not do that to the woman in this story. Yet he did 'put to shame' the community that had failed to show her compassion.

Perhaps communities that stigmatize those living with HIV, or that condone predatory male sexual behaviour that helps to spread HIV, can appropriately be shamed. This does appear to be possible in the third story, from John:

Early in the morning he came again to the temple. All the people came to him and he sat down and began to teach them. The scribes and the Pharisees brought a woman who had been caught in adultery; and making her stand before all of them, they said to him, 'Teacher, this woman was caught in the very act of committing adultery. Now in the law Moses commanded us to stone such women. Now what do you say?'. They said this to test him, so that they might have some charge to bring against him. Jesus bent down and wrote with his finger on the ground. When they kept on questioning him, he straightened up and said to them, 'Let anyone among you who is without sin be the first to throw a stone at her'. And once again he bent down and wrote on the ground. When they heard it, they went away, one by one, beginning

with the elders; and Jesus was left alone with the woman standing before him. Jesus straightened up and said to her, 'Woman, where are they? Has no one condemned you?'. She said, 'No one, sir'. And Jesus said, 'Neither do I condemn you. Go your way, and from now on do not sin again'. (John 8:2-11).

It is generally recognized that this is indeed an ancient story about Jesus but that it did not originally form a part of the Fourth Gospel.⁸ In the context of understanding compassion it is particularly important although it requires sensitive interpretation.

Once again it is the religiously observant who take the moral high ground but are finally put to shame by Jesus. This time they are not defending the Sabbath. They have found a woman who has apparently flouted sexual norms: 'Teacher, this woman was caught in the very act of committing adultery'. Like many religious communities today, it is sexual activity that is identified as being especially sinful.

In the story Jesus does not deny the role of sin. The woman herself is finally told 'from now on do not sin again'; whatever she has done is not condoned. Yet she is explicitly not condemned by Jesus and everyone else is reminded that they are not 'without sin'. She is not stigmatized as an 'adulterer', but the religious community is apparently shamed, going away 'one by one, beginning with the elders'. They have been challenged by Jesus in public and, as a direct result, put to shame.

In conclusion, taken together, these three stories suggest that Jesus was prepared both to affirm and to challenge religious communities. In them he affirmed communal practices when they did not conflict with the demands of communal compassion, but challenged them sharply when they did. The virtues identified at an individual level in the healing stories (compassion, care, faith and humility) are supplemented at a community level with sharp challenges, or even denunciations.

⁸ C.K. Barrett, *The Gospel According to St John: An Introduction with Commentary and Notes on the Greek Text* (London: SPCK, 1967), pp. 490-3.

In the context of HIV, even Church communities sadly can act badly. If we are to become genuinely compassionate, as Jesus still requires us to be, and indeed if we are to become effective agents in HIV prevention, we still need to be challenged sharply. Fidelity, truth-telling and, above all, compassion should properly be marks of the Church.

Social change and the role of the Church: the people's resources for understanding and reducing vulnerability

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1. A pilgrimage

In this paper, you will not find great proposals: what you will find is passion. For what follows is the story of the pilgrimage of a human rights activist, walked in the context of HIV. This is because my overriding commitment, in the past quarter century, has been to journey together with people and groups who are vulnerable to HIV. It is within this framework that I have discovered a spirituality; and in doing so I have found that another way of looking at reality is possible. I simply want you to take this reflection as a way of opening heart and mind to share what, for me, has been an epiphany of the gospel in the context of the HIV pandemic.

Since its beginning, the HIV epidemic has produced very clear theological divisions within the churches. During these twenty-five years, the voices of leaders and of faith communities have reflected widely differing attitudes and reactions, articulating positions that speak of different theological approaches and, in consequence, of different actions in terms of advocacy, pastoral activity, prevention and care.

For example, there are many people within the faith communities who want to limit the HIV issue exclusively to the medical field. They want

to avoid conflictive issues, and they are not comfortable with alternative (perhaps more faith-related) responses. But for faith communities and their leadership, the HIV issue cannot be mainly a medical one. If it were, then they would not have problem with it. But it has in fact been repeatedly demonstrated that the centre of the debate is not the human immune deficiency virus. There are other viruses and other diseases with similar characteristics, some of which affect an even greater number of people, but the faith communities did not feel the need to do theological reflection (as we are doing) or to respond to them in other unique ways.

Since 1981, when people became aware of the HIV epidemic, it has been repeatedly shown that it is not HIV as a virus, or AIDS as a medically described syndrome, that is the central problem, or the cause of so many divisions and contradictory messages. What makes AIDS different, and brings us together here, is the stigma and discrimination that transform a medical diagnosis into a moral judgement. The task of faith communities and their leadership is to develop transforming responses to the issue of stigma and discrimination, and also recognize that many times we have promoted them.

Churches, therefore, have often found it simpler to work in the area of care than to develop messages on education-for-prevention. But addressing HIV-related stigma requires theological answers. Theology, therefore, has to help us to build a message which is faithful to a renewed hermeneutics of the Scriptures, and which also brings an alternative view of our confessional identities. For theology is a structure of thought related to our idea of God and God's action in the world. A hermeneutic based on this understanding means we can never have a neutral approach to any of the critical issues provoked by the HIV and AIDS epidemic.

2. A theology of glory

I am going to try to classify and to name different ways of doing theology in relation to HIV (and, incidentally, in relation to many other issues).

On one side we have those who want to respond, and to speak about AIDS, but not to get involved with conflictive issues. They may be organizations and individuals who view hospitals supported by faith communities with pride on grounds that a high percentage of beds is occupied by people living with HIV or AIDS; but at the same time, these very organizations and individuals may not take responsibility for the innumerable graves for which they have been responsible in the cemeteries of the world.

It is an unfortunate fact that faith communities and their leadership have frequently been part of the problem rather than part of the solution. Society in general has observed our narrow biblical, theological advocacy and service perspectives, and has concluded that we are more an obstacle than an ally in the achievement of global goals and targets. In recent years, our own documents have openly confessed that we have been very slow, as institutions, in breaking the silence, but very quick, as individuals, in condemning and judging.

In one way or another we are all theologians. We do theology because we have ideas and convictions about the nature of God and God's action in creation. But this does not mean that it is necessarily good theology. Our fears, cultural limitations, prejudices or political commitments are often stumbling blocks to the permanently open attitude that would free us for a genuine review of our theological and pastoral hermeneutics. Therefore we have to recognize that many times we have been poor theologians, that we have given way to the temptation to usurp God's glory and give the glory to ourselves for our efforts, and that we are prone to take refuge in a theology that shows us a God without paradoxes, a God who fulfils all our expectations of prestige and power.

Those who promote a 'theology of glory' believe that God's nature is modelled on their own patterns of hierarchy, and their own understandings of purity and human wisdom. They believe that the achievement of comfortable circumstances, success, and professional acclaim are signs of God's favour: that God is delighted with them, and therefore rewards their human efforts.

3. A theology of the Cross

In reality, being a good Christian theologian in the context of the HIV epidemic has nothing to do with a theology of glory. Christian theology is, rather, a theology that takes the Cross of Christ (and not our own success) as its fundamental hermeneutic and pastoral tool. It is that cross which allows us to understand the dimension and prophetic depth of living in the context of the HIV epidemic. A theology of the Cross is the antidote to a theology of glory or a theology of prosperity.

The most fundamental text on the theology of the Cross comes in the first letter to the Corinthians. Here the apostle Paul affirms:

For the message 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 discernment of the discerning I will thwart'. [...] God's foolishness is wiser than human wisdom, and God's weakness is stronger than human strength. [...] God chose what is foolish in the world to shame the wise; God chose what is weak in the world to shame the strong. God chose what is low and despised in the world, things that are not, to reduce to nothing things that are, so that no one might boast in the presence of God. He is the source of our life in Christ Jesus, who became for us wisdom from God, and righteousness and sanctification and redemption, in order that, as it is written, 'Let the one who boasts, boast in the Lord'. (1 Cor.1:18-31)

In this fundamental text we have a blueprint for content and methodology for pastoral action. It is a road map for those who want to establish a dialogue and accompany people and groups vulnerable to the HIV epidemic. This text allows us to understand that those women and men who act out a theology of the Cross do so in the belief that the format and ways in which God is manifested and revealed are always paradoxical and hidden to the human understanding.

Webster's New Collegiate Dictionary defines **paradox** as 'contrary to expectation, a tenet contrary to received opinion, a statement that is seemingly contradictory or opposed to common sense and yet is per-

haps true'. Thus, our understanding of the action of the community of faith and its leadership has to be guided by this paradoxical manifestation of a God who is hidden (and therefore to be revealed) in something that is opposite to what one might rationally expect. The HIV epidemic is manifested in those vulnerable to HIV and AIDS. This is our new hermeneutical key, which allows us to put ourselves, and also our actions in the context of the HIV epidemic, into a different perspective, which goes beyond the mere provision of social welfare.

God, therefore, is always hidden in what we consider vulnerable, weak and impure. But from the perspective of a theology of glory we continue to expect God to be revealed amidst thunder and lightning, in the powerful, the magnificent, the miraculous and all that we consider politically correct. So we see that God's manifestation is always a paradox, in the sense that it is something totally contrary to our expectations, contrary and opposed to common sense.

Theologians of glory might express a view that runs something like this: 'God cannot be manifested in that which we consider vulnerable to HIV or to AIDS, because God is mighty, and in God we do not find weakness nor foolishness'. But as we have seen in the passage from Corinthians, to know God as revealed in Jesus of Nazareth is to know God *in all stigmas and all discriminations*. In trying to discern God's will, theologians of the Cross will not speculate on the life of their community of faith or on the circumstances of their own lives. Their attention, rather, will center on the suffering of Jesus Christ for the cause of justice, on his life of passion, and on the communions and friendships that drove him to the cross.

It is not abstinence or monogamy that pleases God. Neither is it the fulfilment of any law. It is faith in the one who died on the cross and who (even when resurrected) shows us that he carries, in his hands and his side, the signs of all stigmas. That is the faith that sanctifies all laws and brings them to fulfilment, leading us to conform our own lives to the life and passion of Jesus of Nazareth. In the context of the HIV epidemic, the core of any message that comes from the faith communities should be that unconditional love which we receive only by grace.

In all honesty, though, we must admit that we are not immune to the theology of glory. We have a tendency, in all our messages about prevention and education, to put our successes and merits in the center. We create messages based on human and individual glory, and on our achievements, because we are afraid of God's paradoxes as revealed by Jesus of Nazareth.

In Jesus, incarnate, crucified and resurrected, God manifests himself as a passion for justice, equity, and promotion of the rights and dignity of all people. God's concern is especially for those stigmatized and excluded by social and cultural considerations. Indeed the cross is a direct consequence of Jesus' friendships, and the people with whom he shared his table. For Jesus' choice of friends was a subversive one. The cross, after all, was a tool of punishment for all those who were considered dangerous or likely to subvert the prevailing political and religious power systems. It was not two thieves who were crucified together with Jesus of Nazareth: it was two men who had been judged to be dangerous to the oppressive social, cultural and religious systems, and to the imperial powers.

When we speak about measures to prevent HIV transmission, we have to remember that God is pleased *only* by that which is in Jesus of Nazareth. *Solo Christo, sola fide, sola gratia* (Christ alone, faith alone, grace alone) must be central in our proposals for prevention, education, advocacy and care in the context of HIV and AIDS. Many of our responses to critical issues presented by the HIV epidemic have clashed with the prevention strategies proposed by society and people living with HIV or AIDS because we have forgotten this centrality of the Cross of Jesus of Nazareth and we have turned non-central and circumstantial elements into dogma.

4. Law and gospel

For faith communities, the issue of HIV prevention has proved a sensitive one. Prevention is one of the conflictive areas involving 'breaking the silence' about certain issues that many people prefer not to talk about. In this, Lutheran theology is helpful. With its bi-

focal view of reality, the distinction between law and gospel could help us address the issue of prevention, allowing us to take different and diverse positions without creating divisions. What this 'bifocal' approach does is to make a basic distinction between law and gospel: as in the distinction between the written law and spirit, between the kingdom or regime of God and the secular kingdom or regime, between faith and deeds, the idea that we are justified but also sinners; and so on. The main thrust of Christian proclamation itself is directed towards preventing the gospel from being transformed into law.

For the law neither redeems nor saves. Rather, the aim of the law, theologically, is to bring all human beings to the humble awareness of their situation of slavery to oppressive systems and to their liberating need of the mediation of Christ. The law is the mirror in which we see ourselves; and under its gaze we always find ourselves in want, knowing that (before God) we have never done enough. That is exactly the aim of the law: to bring the believer to a state of humility, which leads to the arms of that totally undeserved grace which is offered by Jesus, the Christ.

It is interesting to see how the churches' main documents on HIV and AIDS, notably those of the World Council of Churches and of the Lutheran World Federation,¹ start with a confession, by the community of faith, of its own sins. As we contemplate what the law demands, we know that the aim of the law is to help us to see that we cannot be the ones to throw the first stone. That is why the law should never be made a moral code or a paradigm of behaviour: for in the very moment that this happens the redeeming work of Christ loses its centrality and becomes a simple help to what we can do by ourselves.

I would like to rescue a basic text of Luther that can help us in the construction of an educative proposal for the prevention of HIV and AIDS:

¹ WCC, *AIDS and the Churches as a Healing Community*, Geneva WCC 1986; LWF Documentation. *Pastoral Work in Relation to AIDS*, edited by Publication Office, LWF Department of Communication. N°25 September 1988, Geneva.

Be sure [...] that you do not make Christ into a Moses, as if Christ did nothing more than teach and provide examples as the other saints do, as if the gospel were simply a textbook of teachings or laws. [...] You must grasp Christ at a much higher level. Even though this higher level has for a long time been the very best, the preaching of it has been something rare. The chief article and foundation of the gospel is that before you take Christ as an example, you accept and recognize him as a gift, as a present that God has given you and that is your own. [...] See, this is what it means to have a proper grasp of the gospel, that is, of the overwhelming goodness of God, which neither prophet, nor apostle, nor angel was ever able fully to express, and which no heart could adequately fathom or marvel at. This is the great fire of the love of God for us, whereby the heart and conscience become happy, secure, and content. This is what preaching the Christian faith means.²

By understanding the true meaning of the law, the community of faith has the possibility of opening itself to its own conversion. This understanding is the common ground on which to establish human relationships of solidarity. It is also important to distinguish between the theological use of the law (which belongs to God's kingdom) and the civil use of the law (which rules in the secular world). Changes, diversity of opinions and of behaviour are accepted in the secular regime. Many misunderstandings and faulty messages on prevention transmitted by our faith communities have resulted from confusing the law and the gospel and confusing the kingdom of God with the secular kingdom.

In Lutheran theology, the core of Christian action is the announcement and the experience of the gospel; and this consists in opening oneself to receive God's forgiveness and God's reconciliation. In putting ourselves under God's sight, we are justified through faith in Jesus Christ: a justification that is not earned through any action of ours, but by accepting an unconditional gift, offered to everybody, and completely free.

To confuse law and gospel is to take away from the law its 'accusing' function in order to transform it into a moral system that is unrelated

² Luther's Works. *Word and Sacrament* Vol.35 p.117: "A Brief Instruction on what to look for and expect in the gospels" (1521) Philadelphia, Fortress Press 1957.

to the work of Jesus Christ. It is to transform the law into a guide for sinners who try (basically by their own efforts) to adjust themselves to its demands, and receive supplementary help from God in doing so. In this way, we lose the centrality of the promise of salvation, and of justification by the God who liberates us from the accusations of the law, and does so exclusively in Jesus Christ. The radical, saving promise of the gospel is thus transformed into a tool for covering up our deficiencies, and for imagining that we are able to please God through ways which have basically nothing to do with Jesus Christ.

5. Theology of the Cross in the churches' documents on HIV

It is significant that some of the churches' earliest written responses to the HIV epidemic located the issue firmly within the perspective of the theology of the Cross. The first document published by the World Council of Churches (WCC) in 1986 was a fundamental one. It was entitled *AIDS and the Churches as a Healing Community*.³ If it is genuinely to be a healing space, it said, then the Church needs to be truly open to the challenges provoked by the epidemic. Apologetic and conservative positions cannot help us to 'break our own hearts, and repent of inactivity and rigid moralism'. The theology of the Cross paradoxically recognizes that 'the healing community itself needs to be healed by the forgiveness of Christ'.

As people of God who live under the cross of Christ and want to embrace and support individuals and groups vulnerable to HIV, we have to do it 'without barriers, exclusion, hostility or rejection' of any kind. As part of the process of our own healing we need to review our biblical hermeneutics, our confessional identity and our pastoral practices.

Only as we enter into the reality of a theology of the cross, and consequently find God in this paradoxical, hidden way, will we be able to confess, as this WCC document puts it, 'that churches as institutions have been slow to speak and act [but....] that many Christians have

³ World Council of Churches, 1986

been quick to judge and condemn'; or to affirm that because God deals with us in love and mercy, then we are to also and that we are to outlaw simplistic moralizing about those who are living with HIV or AIDS.

In the same way, in its 1988 document entitled *Pastoral Work in Relation to AIDS*,⁴ the Lutheran World Federation (LWF) adopts a perspective from the theology of the Cross. In this publication, LWF declared that 'the Church should [...] open its doors to all, unconditionally [...] irrespective of who they were or what they had done [because] by excluding somebody from the sources of life, the Church becomes guilty of the gravest form of discrimination that exists'.⁵ It says, further, that 'the church should question seriously its own role in developments facilitating the spread of the disease and challenge its own members and the society to take steps to remove discriminatory attitudes and actions prevailing in society'.⁶ These tasks, these aims and this commitment are still pending even twenty years after the adoption of this document by the Lutheran World Federation.

We have to recognize the co-factors that promote the HIV epidemic and become a prophetic voice in denouncing them. One of the roles of faith communities is to advocate for the development of public policies, which brings us into dialogue with governments. We have therefore participated in the follow up to the UNGASS meetings in 2001 and 2006, and the ongoing monitoring of the Millennium Development Goals (MDGs). This is because we recognize that socio-economic structures promote the poverty of certain communities and groups, making them more vulnerable to the epidemic. In consequence, working to eradicate AIDS also involves questioning the structures that produce poverty, illiteracy, prostitution and drug abuse and all forms of inequality. Among those we should include the structures that produce and sustain gender inequity: one of the major factors that favours the spread of the epidemic. This means that empowerment of women

⁴ LWF Documentation. *Pastoral Work in Relation to AIDS*. Edited by Publication Office. LWF Department of Communication. N°25 September 1988. Geneva

⁵ *Ibid*, p. 5

⁶ *Ibid*, p. 5

must have a central place in any prevention proposal. This political commitment should be part of our theology of the Cross and of all crosses that produce injustice.

The LWF document also assumes that 'the body of Christ as a reconciling community must respond affirmatively to the manifold human brokenness'. AIDS, it says, 'challenges us to free ourselves from the bondage of prejudice and self centeredness,' and as the church, to 'become a caring community that sets people free and gives them hope through faith'. More recently, but also from the perspective of the theology of the Cross, the African leaders of the Lutheran communion affirmed:

We commit ourselves to:

- Breaking the silence;
- Confessing and acknowledging that we have too often contributed to stigmatization and discrimination
- Speaking openly and truthfully about human sexuality and HIV/AIDS;
- Remembering that the silence of persons living with HIV/AIDS can be broken when they know they will not be judged, excluded and discriminated;
- Stopping all forms of condemnation and rejection;
- Turning stigma and discrimination into care and counselling;
- Not standing in the way of the use of any effective methods of prevention.⁷

In conclusion, the distinction between law and gospel supports the use of a theology of the Cross as a hermeneutical key which allows us to build an alternative voice in the dialogue about HIV and AIDS, together with the people who are themselves living with HIV and AIDS. Thus the epidemic has become our space to do theology, our mandate

⁷ LWF, *Breaking the Silence: Commitments of the Pan African Lutheran Church Leadership Consultation in Response to the HIV/AIDS Pandemic*, Nairobi 2-6 May 2002.

being the promise of inclusion in the body of Christ to individuals and groups vulnerable to HIV and AIDS. Doing theology is no more an aseptic task. We confess a God who is not beyond the epidemic, not beyond the people living with HIV, and not beyond the stigmatized and excluded. We confess a God who is – paradoxically - right there in the midst of them.