

# **FAITH AND AIDS IN ZAMBIA**

by

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## DEDICATION

To the people of Zambia who continue to show such magnificent spirit in their faith-ful response to HIV and AIDS.

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## INTRODUCTION

There has been so very much written about HIV/AIDS in Zambia in the past few years. (Almost too much, one might say!) So just what is the purpose then, what is the value, of putting out yet another set of essays on this serious problem that *infects* so many Zambians and *affects* everyone living in Zambia?

The answer to that critical question can easily be seen by the reader of this small pamphlet. Michael J. Kelly, a Jesuit priest with a distinguished record of many years as an educator and in recent years as a researcher and activist on HIV/AIDS, presents in these essays a very holistic view of the disease, its causes and consequences, and offers a series of socio-economic and religious responses to its challenges.

Father Kelly writes as a Zambian citizen (over fifty years in this country) and a Catholic priest with a deep love of the people and hence a passion to see the problem of HIV/AIDS dealt with more urgently and effectively by the Zambian government, international agencies, civil society, churches, families and individuals.

These essays have appeared in the *Bulletin* of the Jesuit Centre for Theological Reflection (JCTR) over the past few years. The purpose of bringing them together in one small pamphlet is to provide a readily accessible educational tool for use by NGOs, church leaders and members, health practitioners, political leaders and ordinary citizens. It is hoped that the ideas presented here will prompt deeper reflection and greater action in an intelligent and effective fashion.

In reading these essays, not everyone may agree with the analysis and recommendations made here. So the questions then are: why do you disagree and what do you propose as alternatives? If the pamphlet stirs this sort of discussion and response, it will have well served its purpose, the purpose of serving the people of Zambia and people all over Africa.

Some study questions are offered at the close of this pamphlet, to help deepen the reflections and widen the responses. There are also some prayers, to strengthen our faithful actions for the future.

The JCTR will be very pleased to hear reader's reactions to this pamphlet, part of our mission of "promoting faith and justice."

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## Chapter One

# BASIC CHALLENGES TO OUR CHRISTIAN FAITH

St. Matthew's Gospel applies to the massacre of the Holy Innocents the words of the prophet Jeremiah about the afflictions of Israel: *A voice is heard in Ramah, lamenting and weeping bitterly. It is Rachel weeping for her children, refusing to be comforted for her children, because they are no more* (Matthew 2: 18).

These words capture very well the sorrow and agony that HIV/AIDS means for those who live with it or who are members of affected families. Throughout Malawi and Zambia, families and communities have the sad experience of this lamentation and bitter weeping. We know elderly parents who cannot be comforted for their children who died in the prime of young womanhood or manhood, because they are no more. We know young children who refuse to be comforted for their parents or siblings, because they are no more.

The stark realism of Fridah Cubby's story tells it all:

When my mother was sick, I looked after her. One day she was very ill and I found a taxi to take her to the hospital. She died in the taxi on the way to the hospital. Before she died, she said goodbye and kissed me. I really loved my mother. I still love her. I miss her very much.

Fridah is from Kitwe. She was eight years old when her mother died.

## WHY? WHY? WHY?

Similar tragic bereavements occurring daily throughout the country force the difficult questions: Why did this happen to an innocent child? Why is this happening now? Why me? Why is my family being hit so hard? What has gone wrong in our community, in our country? What have I done to deserve this?

On a scale that we have never known before, our people are swaying forwards and backwards through the various phases of managing their grief and loss. As they do so, their experiences of the dehumanising suffering of HIV/AIDS and the emptiness, poverty and difficulties that it leaves behind force from them—and from us—the most heart-rending of all laments: My God, my God, why have you forsaken me?

## PROBLEM OF EVIL

Have we been forsaken by God? Does God care? How can a good God allow this kind of thing? What wrong have we done?

These are very basic questions that HIV/AIDS raises. Very powerfully and urgently, *the disease forces us to confront in its starkest form the problem of evil*: how can we reconcile faith in a good, loving and all-powerful God with the evil of HIV/AIDS and the immense suffering it brings to innocent persons, especially children?

Our problem is very similar to that faced by the author of the Book of Job: if God is good and all-loving, he could not want this suffering; if God is all-powerful, he could stop it;

that being so, then why does he not do something about it? Or is it that I have gone wrong somewhere and I have only myself to blame?

## **AIDS IS NOT A SIN**

In a world with AIDS, the same Book of Job offers a critically important answer to the last question. When all the talking was ended, God vindicated Job and condemned the comforters who alleged that Job must have sinned. In effect, what God was saying was that Job's many sufferings were not the result of sin. They were definitely not a sign of divine punishment or God's displeasure!

Likewise, we must be very firm in rejecting any tendency to associate HIV/AIDS with sin or punishment by God. The Catholic Bishops of Kenya put it very clearly when they said in one of their pastoral statements that looking at AIDS patients as sinners condemned by God is a wicked distortion of the truth. *AIDS is a sickness. It is not a sin.* It is not a punishment that comes from God. To say that it is, is a wicked distortion of the truth.

## **GOD IS PRESENT IN THE PERSON WITH AIDS**

Saying that AIDS is not a punishment from God is some help, especially in the face of so many judgmental and stigmatising attitudes. But we need to go further. An incident that occurred in one of the concentration camps set up by Nazi Germany can help. The story is told by Eli Weisel, an inmate in one of the camps and subsequently the recipient of the Nobel Peace Prize for his work in witnessing to what occurred. He describes what happened when the camp authorities hanged two Jewish men and a youth in front of all the assembled prisoners:

The men died quickly, but the death throes of the youth lasted for half an hour. "Where is God? Where is he?" someone asked behind me. As the youth still hung in torment in the noose after a long time, I heard the man call again, "Where is God now?" And I heard a voice within myself answer, "Where is he? He is there, he is hanging there on the gallows."

In our crisis of HIV/AIDS, that is the faith we need. We need to have the vision to be able to see and say: God is here in this suffering person. In this worn, emaciated body, racked with pain and unable to control the diarrhoea, God is present. This person is a member of Christ's body. In this sick and suffering person Christ continues to suffer, because the body of Christ has AIDS.

## **CLOSENESS OF GOD IN PHYSICAL SUFFERING AND DEATH**

If we are to come to grips with this we need to recall what is at the basis of our Christian faith. Our most fundamental belief is that the greatest good the world has ever known was accomplished by great physical suffering followed by physical death.

As Jesus hung on the cross, a shuddering "worm and no man", moaning in pain, God seemed very far away. Yet, God was probably never closer to humanity than at the very moment that Jesus felt most abandoned on the Cross. At that moment, God gave an unqualified Yes to the person and mission of Jesus and overcame the evil of suffering, pain and death. As his Son endured unspeakable humiliations, suffering and death, God became

powerfully and eternally involved with human suffering and every effort to overcome it. God entered into solidarity with every suffering person and with those who care for them.

The lifting up of Jesus in mockery, pain and death led to his affirmation by God, the outpouring of the Spirit, the life of the resurrection. The grinding down of our brothers and sisters in the humiliations, suffering and death brought by AIDS (and other sicknesses) leads to God's affirming both them and all who minister to them. God is with them because he is there—he must be there—where anyone suffers. He is not remote but is a very near and compassionate God, in solidarity of identification with those experiencing the suffering, in a solidarity of community with those who take steps to relieve or prevent it.

## **RESISTING THE EVIL OF AIDS**

This picture of the suffering of AIDS as a kind of re-enactment of God's powerfully sympathetic and transforming presence to His Son on the Cross should not blind us to the fact that HIV/AIDS is evil and can never be condoned. God does not condone it, but in fact strongly resists it and all other forms of human suffering.

God's resistance to the evil of AIDS is shown in two ways. First, in the way God works with the infected person to overcome the suffering, and if it cannot be overcome, to transform it. And second, in the way God works with those who care for the infected, to enable them to overcome or transform the suffering that is being experienced.

Pain and suffering in a dying person are terrible things. They tear the heart out of us, leaving us numb and desperate and frustrated. But we also know that in some instances, perhaps in more than we actually realise, the suffering person eventually passes to a new stage of peace and acceptance. They may not be able to put the words to it, but deep within themselves they are confident that God's wish for them will be fulfilled, that they have life and have it to the full. They know—they just know—that their Redeemer lives and that in their poor scarred flesh they shall see God.

## **AIDS CHALLENGES OUR FAITH THAT DOES JUSTICE**

*But if the body of Christ has AIDS, then we all have AIDS.* St. Paul tells us that we are Christ's body so that "if one part is hurt, then all the parts share its pain" (1 Corinthians 12: 26). Somehow, we all share in the condition of the infected person. HIV/AIDS is our personal problem and responsibility, not the problem of other people "out there". And our responsibility is to minister in compassionate solidarity to those who are infected, doing what we can to mitigate their pain, help them transform their sufferings, and bring it about that there will be less of this evil in our world.

That is a major challenge that HIV/AIDS poses for our practical faith, our faith that does justice. Confronted by what is occurring in our communities and families, we have to learn how to give lived expression in our lives to our belief in the words of the Vatican Council: "The joys and hopes, the griefs and anguishes of the people of our time, especially of those who are poor or afflicted in any way, are the joys and hopes, the griefs and anguishes of the followers of Christ as well." So if the first challenge that HIV/AIDS presents to our faith is how to reconcile this terrible evil with our utter conviction of the goodness of God, the second challenge asks us what we are doing about it. Are we bringing life and hope and the experience of God to those who are infected or affected? What are we doing to stop this disease and to roll it back? As members of the AIDS-infected body of Christ the one thing we cannot do is to stand idly by, doing nothing.

## Chapter Two

# ETHICAL AND THEOLOGICAL CHALLENGES

## HIV/AIDS AND LIFE

HIV/AIDS is about many things. Clearly it is about suffering and healing, dying and death. But it is also about sex and living and originating new life. For very many, especially women, it is about coping and managing on an inadequate or non-existent income. For others, it is about caring for children who have no one to look after them, while at the same time it is about caring for old people whose adult children are no more.

Together, the disease and the epidemic that has resulted from it cover almost every aspect of human life. As they do so, they give rise to a whole host of ethical and theological questions. In many cases, HIV/AIDS highlights and magnifies the ethical implications of existing situations, such as widespread poverty or the unjust treatment and exploitation of women. In other cases, HIV/AIDS raises new issues with ethical dimensions, such as in the areas of stigma and discrimination or access to antiretroviral drugs (ARVs). In many circumstances, responding to these issues implies two judgements that tend to strengthen each other:

- This should not be, it is unethical.
- This must be changed, it makes the HIV/AIDS situation worse.

Areas of ethical and theological challenge presented by HIV/AIDS would include:

1. Protecting truth, and excluding denial and stigma
2. Remedying the status of women and correcting gender imbalances
3. Doing something about the sinful conditions of the unjust distribution of wealth, widespread poverty, and oppressive globalisation
4. Ensuring the protection of human rights that are threatened by HIV/AIDS
5. Understanding sexuality and dealing with its practice
6. Reconciling the demands of confidentiality with those of the public good
7. Ensuring the comprehensive practice of personal and communal responsibility both to and by those who are HIV infected
8. Balancing the competing demands of AIDS treatment and HIV prevention when it comes to the allocation of resources.

A few of these issues are dealt with below.

## STATUS OF WOMEN AND REMEDYING GENDER IMBALANCES

HIV/AIDS has a disproportionate effect on the lives of women. On physiological and health grounds they are at greater risk of becoming infected with the virus. On social and economic grounds they are more vulnerable to infection. And when HIV/AIDS is present in a household, women are likely to carry the larger share of the burden and to be more extensively affected.

There can be little doubt that HIV/AIDS is increasingly becoming a disease with the face of a woman or girl. In the words of Stephen Lewis, the UN Secretary-General's Special

Envoy for HIV/AIDS in Africa, “The pandemic is now, conclusively and irreversibly, a ferocious assault on women and girls worldwide”.

Theologically this is not as it should be. Scripture tells us that “male and female God made them. In his own image and likeness God made them.” There is no question here of one being subordinate to the other, of one carrying a heavier burden than the other. There is no theological reason for the concentration of AIDS among women.

Neither is the “feminization of AIDS” ethically right. The Universal Declaration on Human Rights affirms that “all human beings are born free and equal in dignity and rights”. But until such time as women’s full dignity as human persons and their full equality with men is proclaimed and practised in every walk and stage of life, this article will remain a pipedream. Humanity will remain out of harmony with its best aspirations. It will not be true to itself.

Meanwhile, women and girls will remain at the epicentre of the HIV/AIDS epidemic. The relationship of respect, mutuality and equality between women and men will continue to be violated. In practice, the inherent human dignity of women will be denied. An unethical approach will be maintained and HIV/AIDS will continue to flourish.

## **POVERTY**

HIV/AIDS has never been a democratic disease. Although in its early days it occurred more among the better off, it settled down fairly quickly to targeting the poor and vulnerable. The poor are at higher risk of HIV infection; the poor are more vulnerable to HIV infection; and the disease makes the poor poorer. In circumstances of personal poverty and underdevelopment, HIV transmission occurs more easily while the period of HIV infection prior to the emergence of clinical AIDS tends to be shorter.

Circumstances over which they have virtually no control put the poor at higher risk of HIV infection. Such circumstances include a greater likelihood of untreated STIs; absence of information on their own HIV status or that of their sexual partner; the increased possibility of high-risk behaviour because of difficulties in accessing and storing condoms correctly as well as major constraints in using them properly; and economic pressures to resort to the sale of sex to generate household income.

In addition, many factors that are almost entirely outside their control make the poor more vulnerable to infection. Long prior to HIV infection, their immune system may be weakened because of their low health and nutritional status, their limited access to health care, their inability to meet the costs involved in accessing health services, and their increased exposure to other health hazards, such as malaria, TB, or gastro-intestinal problems. The poor constitute the majority of those who migrate from place to place in seek of work and better living conditions. But only too often they replace joblessness, overcrowding, poor housing, inadequate sanitation, and poor health and educational facilities with similar situations elsewhere. In this way, they carry the burden of their HIV vulnerability with them. Clearly this is not the way things should be for forty percent and more of humanity. God did not make the world so that things should be like this.

Equally clearly, the continuation of such a situation will not serve to roll back HIV/AIDS. The concentration of wealth in the top 5–10 percent of a society; half-hearted poverty reduction programmes; the application of globalisation measures in ways that are to the disadvantage of poorer countries; the continued siphoning off of financial resources to debt repayments; the brain drain that eats away the human capacity of poor countries; maximising

profits at all costs; corruption and cronyism at all levels; the mismanagement, poor governance, and poor and unconcerned leadership that is crippling the potential of many poor countries; the concentration of efforts and resources on the retention of political power; internal and international conflicts and wars—all play their part in maintaining the poverty of peoples and thereby all play their part in maintaining or worsening the HIV/AIDS situation.

Each one of these situations is unethical, it is not as it should be. Each serves to maintain the unethical situation of mass poverty in a world plentifully supplied with means and resources. Each contributes unethically to the prolongation of the wretchedness of HIV/AIDS.

## UNDERSTANDING OF SEXUALITY

Sexual contact is the commonest means of HIV transmission, accounting globally for about 90 percent of cases. Because of this, the understanding of sexuality and the ethics of sexual practice and customs play a critical role in approaches to HIV prevention.

Sexuality is a drive for intimacy, union, relationships, wholeness. It expresses the need a human person feels to find completeness and real fulfilment by handing the self over in some enduring commitment to another person. Sexuality is never casual, neutral, unimportant, or just recreational. It goes beyond genitality and body-to-body contacts. Instead, it stresses person-to-person interchange. What sexuality prizes most highly is interaction with the other as a person.

In many cases, the personal as well as the physical contacts of true sexuality are freely agreed upon. But much sexual contact is also forced—physically and/or psychologically—especially on the young and on women and girls. In addition, many societies debase the true meaning of sexuality through the different standards and expectations they have for men and boys on the one hand and for women and girls on the other.

The '*machismo*' image found in many societies is a caricature of true sexuality, reducing it to physical sex activity and male dominance, prowess and control. Likewise, what can be called the '*feminismo*' image is also a caricature in the way it portrays sexuality in a girl or woman as docile, submissive, yielding, and accepting of whatever comes from the male, whether sexual advances, decisions, economic power, or gifts. Neither approach can give expression to the love, care, intimacy, and joy that characterise true sexuality.

This immediately raises questions about the way sexuality is portrayed in the media and anti-HIV messages. Too often these seem to reduce sexuality almost to a commodity that can be traded (usually by women and girls). To the extent that they do so, they foster wrong thinking and ensure failure to promote appropriate life-affirming behaviour.

HIV/AIDS raises other difficult ethical and pastoral questions in the area of sexuality:

- Can we continue to acquiesce in double sexual standards for men and women, especially as manifested in '*machismo*' and '*feminismo*'? What can we do to change these double standards?
- As church people, are we giving a lead in speaking against these double standards and in promoting positive attitudes to sexuality?
- What are we doing in our school programmes to ensure that young people develop a proper understanding of human sexuality and the right attitudes to it?

- Can we continue to tolerate attitudes and practices that relegate homosexuals and lesbians to the margins of society? Is it right that homosexuality should be a criminal offence?
- Can we continue, in our communities and churches, to overlook the fact that so many children suffer sexual violence, in silence and in their families?

Our thinking in these areas should be guided by three questions. Is this right? Does it make the HIV/AIDS situation better or worse? What would have been the Lord's reaction to the practice or situation? Our answers may well show that, like Abraham, we are being challenged to journey into new and unexplored territories of belief and practice.

## **REDUCING THE RISK OF HIV TRANSMISSION**

The ideal situation would be to see an end to every form of sexual behaviour that puts an individual at risk of becoming infected with HIV. In practice, however, it must be acknowledged that such forms of behaviour seem certain to continue. In spite of the risk of HIV transmission, our Christian communities, like the rest of the world, will almost certainly continue to see instances of early sex, pre-marital sex, casual sex, drug or alcohol induced sex, commercial sex, sex with multiple partners, extra-marital sex, bisexual activities, and homosexual activities. Many of these increase the risk of HIV infection. There is also the tragedy of many married women becoming HIV infected through their fidelity to husbands who themselves are not faithful.

Such situations make it necessary to consider what can be done in circumstances like these to reduce the likelihood of HIV transmission.

Where there is the possibility that sexual activity might involve the risk of becoming infected with HIV or transmitting the disease, the experts propose four harm-reducing practices:

- Reduction in the number of sexual partners. Ideally this would find expression in fidelity to one partner in a stable union.
- Delay or postponement of sexual activity. Ideally this would find expression in abstinence and the avoidance of sexual intercourse outside of a stable married union.
- Sexual activity without penetrative intercourse.
- The consistent and proper use of a condom.

## **PRIORITY OF ABSTINENCE AND FIDELITY**

Together with those from other faiths and religions, the Catholic Church has been outstanding for the consistent and forceful way it has promoted the first two options, abstinence before marriage and mutual fidelity within marriage. Abstaining from penetrative sex and remaining mutually faithful in a relationship where both parties are HIV negative are the only sure ways of preventing HIV transmission. The insistence of the Church on these principles has kept them prominent in people's thinking. The Church's insight here also corresponds to what the majority of people see as being best in human behaviour.

Clearly abstinence and fidelity are the most desirable course of action. They are also the course of action adopted by most people. This is shown by the fact that even in the countries most severely affected by HIV, *three-quarters and more of the people are not infected*, implying the likelihood that a very large percentage do in fact abstain from risky sexual

activity and/or live in mutual fidelity in the safe union of a marriage where neither partner is infected with HIV.

Apart from the way they match up to the highest ideals in human sexual practice, abstinence and fidelity have a further merit. They represent really substantive behaviour changes (or the maintenance of intrinsically valuable human behaviours). Hence they are more likely to be sustained than the more superficial behaviour change involved in condom use. Like good driving, abstinence and fidelity come from internal values that have developed good practices. Like using a safety belt, condom use is an externally applied protection for emergency situations.

## CONDOM USE

But while abstinence and fidelity remain the ideal (and the practice of very many), a place has to be found for the other two options (non-penetrative sex and condom use). Hence it is necessary to ask whether they can be upheld on moral grounds. The answer is that they can, with the ethical justification for these practices, and for advocating them, lying in the *principle of the lesser evil* (and for married couples, in the *principle of double effect*).

The principle of the lesser evil states that if an individual contemplates placing an action that involves the violation of more than one ethical principle, it is lawful (and in certain circumstances even obligatory) to modify the action in a way that will reduce the violations. For example, if an individual is determined to carry out a robbery with violence, it is legitimate to counsel that, whatever else may happen, violence should be avoided.

In the case of high-risk sexual activity, there may be two evils—the wrong use of sex and the danger of transmitting (or acquiring) a potentially life-threatening infection. The first evil violates chastity. The second violates justice by posing a threat to the health or life of an individual. The principle of the lesser evil states that if sexual activity is to take place in these circumstances it should be performed in such a way that the danger of transmitting HIV is eliminated or at any rate reduced. Since the condom reduces this risk, its use can be advocated.

The ethically wrong use of sex remains, but without a condom the action would add the further ethically wrong dimension of putting oneself or another person at risk of HIV infection. In the recent words of a consultor to the Vatican's Congregation for the Doctrine of the Faith, in contexts such as this, "The problem is not condoms. The problem is disordered sexuality".

Even more direct and forthright were the comments of Belgian Cardinal Godfried Danneels in a television interview on 11 January 2004: "When someone is HIV-positive and his partner says 'I want to have [sexual] relations with you,' then he does not have to do it. But if he does, he has to use a condom. Otherwise he will commit a sin." In the view of this senior Cardinal, condom use is not only morally lawful but, where HIV is present, is morally required.

But to say that condom use can be morally justified in certain circumstances does not mean that it is right to distribute condoms indiscriminately. And it is very far from saying that it is all right to have sex provided you use a condom. Handing out condoms to every passer-by as though they were sweets is irresponsible and unethical. Efforts should be made to ensure that those who are to have access to this safety device have had an opportunity to develop some understanding that abstinence and fidelity are usually the better moral choice.

They should also be helped to know that while the condom offers a large measure of protection against HIV infection, it is not necessarily one hundred percent effective.

In this whole discussion, then, ethical concern for the truth requires that all parties accept the truth of a number of statements, namely that:

- abstinence and fidelity are the only totally effective ways of avoiding HIV infection;
- abstinence and fidelity are the most desirable (and usually the most culturally acceptable) ways of avoiding HIV transmission;
- condom use can be morally justified;
- there may be circumstances where condom use is morally required; and
- for a variety of reasons condom use may fail to prevent HIV transmission.

## **CONCLUSION**

When convening the Second Vatican Council, Pope John XXIII called for the windows of the Church to be opened, so that the light of the Holy Spirit might have a better chance to shine in dark corners. At this time of HIV/AIDS, each one of us needs to open the windows of our hearts to let the light of God's Spirit of truth shine within us. We all need the light of the Holy Spirit to know what is right in our present circumstances.

Likewise, we need the strength of the Spirit, the Comforter, the One-Who-Strengthens, to say and do what we see to be right with regard to promoting the full equality and dignity of women, making a meaningful onslaught on poverty, and fostering a more joyful acceptance of God's great gift of sexuality. In these ways we will serve people better, we will promote life-saving responses to the HIV/AIDS epidemic, and we will embody better in ourselves the bountiful God whom Scripture represents as Father, Mother and Spouse.

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## Chapter Three

# REFLECTIONS ON INTERNATIONAL EXPERIENCES

## I: Impacts, Attitudes and Knowledge

During 2003, my work in the area of HIV/AIDS and education brought me to many parts of the world. I covered at least 120,000 miles and spent more than 250 hours in the air, travelling to workshops, conferences and meetings in Africa, Asia, the Caribbean, Europe and the United States. As I developed material for my own presentations, heard other people speak, and discussed issues with concerned women and men from all walks of life, this travel meant two things for me. It confirmed some of my existing perceptions and it gave me new insights into HIV/AIDS. This set of articles shares some reflections arising from both.

### FEATURES OF THE EPIDEMIC

My overwhelming experience was of a problem that was fundamentally the same everywhere. It was obviously much larger in size in Southern and Eastern Africa, but the basic features were similar wherever it occurred.

Wherever I went I found the same story of HIV/AIDS hitting hardest at the weakest in society. The major sufferers were women, children, the poor, prisoners, hard drug users, men who have sex with men. Everywhere there was concern about how prevalent the disease was among the young and what could be done to protect them.

In countries where transmission occurs mainly because of the way drug users share needles, it was mostly young men who were infected. But in all other countries, the disease was much more prevalent among young women. In Zambia, for every two young men (aged 15–24) who are infected there are somewhat more than five young women in the same age group, while in Malawi the proportion is somewhat less.

Everywhere the message was that the epidemic was destroying homes, families and economies. In infected families, incomes were falling and the ability to cope was being stretched to breaking point.

Countries and communities had adopted many strategies for responding to the disease as it affected the health and activities of individuals, and for responding to the epidemic as it affected whole sectors of society. But there was almost a sense of futility about these responses. The overall impression was one of disarray, inadequate understanding, and piecemeal response. People seemed to be timid, confused, uncertain, feeling that they were powerless, wanting to do something constructive but not quite sure what. Stephen Lewis (the UN Secretary-General's special envoy for HIV/AIDS in Africa) spoke to African religious leaders in 2002 about "a curious and distressing lull in the battle, a cumulative feeling of inertia rather than energy, of marking time". That sums up accurately the situation as I saw it in various parts of the world.

## **SILENCE, STIGMA AND DISCRIMINATION**

Almost universally, the disease seems to be shrouded in a thick cloak of silence and practical denial. To some extent silence and denial are a protective human response to situations that are excessively stressful. Years ago, the poet, T. S. Elliott, reminded us that “humankind cannot bear too much reality”. But trying to cover up the existence of AIDS, as occurs worldwide in families, communities, and countries, will never lead to mastery over the disease or its impacts. In fact, denial and silence are ways of suppressing or distorting truth. They do not fit in well with the Lord’s promise that “the truth will set you free”.

Likewise, stigma and discrimination are rampant across the globe. Essentially, stigma occurs when I make a negative judgement about another person because that person differs from me in a way that I disapprove. Because of this, I reject, discredit, disregard or under-rate the person and try to keep him or her at some social distance. Stigma is irrational and harmful, but very powerful in supporting the roll-out of every aspect of HIV/AIDS. As with denial and silence, it distorts the truth and makes an individual disinclined to seek the truth.

Even as recently as January 2004, a report on conditions in the United States stated that stigma and ignorance continue to hound people living with HIV/AIDS, through denial of medical treatment, violations of privacy, deprivation of parental rights, workplace discrimination and not being admitted to nursing homes or residential facilities. In Nairobi, government schools discriminated against children who were HIV positive by refusing to admit them. Thankfully, however, this discrimination ended on 9<sup>th</sup> January 2004 when Nyumbani Orphanage (founded and run by Fr. Angelo D’Agostino, S.J.) secured an agreement in the Nairobi High Court under which public primary schools would admit such children.

One common and almost universal manifestation of this stigma is the attempt to dissociate oneself from HIV/AIDS, to see it as somebody else’s problem and not one’s own. Depending on one’s perspective, the disease is envisaged as something affecting commercial sex workers, men who have sex with men, the poor, women, migrant workers, injecting drug users, and so forth. There is much less readiness to see that it is something that affects everybody, a situation for which everybody has a responsibility. If we look into our own hearts we will very likely see the way we too have tended to treat HIV and AIDS as something affecting people “out there” and not something that belongs to us intimately and personally.

The prophet Isaiah saw the very opposite of this stigma (and the accompanying discrimination) in the Suffering Messiah: “Ours were the afflictions he bore, ours the sorrows he carried. But we, we thought of him as someone punished, struck by God and brought low.”

Much stigma seems to arise from the almost universal tendency to associate HIV infection with immoral sexual practices, homosexuality, and injecting drug use—and in condemning the sin, people also condemn the sinner. As a person from Grenada put it, “it was felt that (you) deserved what you got by being gay or promiscuous or just bad”. Strangely, however, in many parts (including Zambia and neighbouring countries), widespread support and care for people living with HIV/AIDS co-exists with stigma and discrimination. Thankfully, when the need is great, the Good Spirit of compassion acts more powerfully in human affairs than the evil spirit of condemnation.

## **HIV/AIDS-RELATED KNOWLEDGE**

There is great variation within countries in people's knowledge of HIV/AIDS. In India more than half of the urban residents seem to know something about the disease, but it is different in the rural areas, with their large populations. Here, considerably less than half may never even have heard of HIV or AIDS. In general terms, where prevalence is high, most have heard of AIDS, but where it is low, more than half may never have heard of it.

There is much ignorance, however, on how HIV is transmitted and how to protect oneself against infection. For example, a participant at a high level meeting in Thailand showed little understanding of the way HIV is passed from one person to another when she asked whether it is safe to use a scissors that had previously been used to cut the nails or hair of an HIV-infected person. Also, a very large number of people either do not know or deny the possibility that a healthy-looking person could be HIV-positive. In Tajikistan only 8% of teenage girls knew that a healthy-looking person could have HIV, while in neighbouring Kazakhstan, only 12% knew that abstinence from sexual intercourse protects against infection.

But even in Zambia, where the prevalence level is high, less than half the women know that abstinence can protect against infection; only one-third of the men know that being faithful to an uninfected partner can protect them; and almost 40% of both men and women do not know that a person who has HIV can look healthy. Clearly there is still a great need for education campaigns that will overcome what could be lethal ignorance.

## **II: Women, Child Abuse, Sexuality**

### **WOMEN AND GIRLS**

Some system of patriarchy, with men in a dominant decision-making role, seems to be almost universal. In many Caribbean countries, there are almost twice as many young women as men in universities and women occupy highly prestigious positions. But the same women say that the decisions about when and how to have sex are made by their boy-friends and husbands, not by themselves. This seems to be common across the world. Even though they may be empowered in other ways, relatively few women or girls seem to be free to make critical decisions that affect their own lives.

Almost every country that I visited could speak of the different sexual expectations for women and men. Women were expected to be docile, submissive, accepting, unquestioning, and not well versed in sexual matters. South American countries have begun to use the word "marianismo" to refer to this, but this is neither reverent to Our Lady nor true to the proactive, caring woman of the Visitation and Magnificat. It is for this reason that I have coined the word "feminismo" to refer to the passive, subordinate role that so many cultures ascribe to women, particularly in the sexual sphere.

On the other hand, sexual experience and having many sexual partners (usually one after the other) is often seen as a matter of male prestige. The "macho" image is strong and universal. It is taken for granted in very many societies that boys should have many girlfriends, whereas a girl should 'stick to one boy'. These different sexual expectations put huge pressures on the young people, whatever their sex, to act accordingly, and for many the outcome is increased exposure to the risk of HIV infection.

Almost every country seems to be following the road we have travelled in Africa where HIV/AIDS is becoming more and more a woman's disease. Historically, the disease started among men and clearly it is transmitted mostly by men. But women and girls are the ones who bear the brunt. Physiologically, socially and economically they are more vulnerable to infection and are at higher risk. As a result, more and more of them are becoming infected—everywhere. Globally, more than half of those who are HIV-infected are women. In Malawi, 56% of the infections are found among women, and in Zambia 59%. In addition to carrying their own burden of HIV infection, women and girls continue to have the major responsibility of caring for others who are infected, holding homes together and making ends meet.

Very clearly the “feminization of poverty” and the distinctive “feminine face of oppression,” phenomena to which the Jesuit 34<sup>th</sup> General Congregation referred in 1995, are now being made worse by the “feminization of HIV/AIDS”. The vulnerability and predicament of women are overwhelming. Globally, gender relations are at the epicentre of the epidemic, but little is being done to address the problem. This is a major challenge that none of us can ignore.

## **CASUAL AND COMMERCIAL SEX**

Casual and commercial sex are found everywhere. They seem to be a normal feature of life for a large proportion of men and women. In cultures that allow more freedom to men than to women, it may be considered acceptable even for married men to have sex with commercial sex workers. These attitudes and practices lead readily to the man becoming HIV-infected and subsequently bringing the infection to his wife.

Parts of India and Nepal experience massive and unceasing migration of men in search of work. What is coming to light now is the extent to which along with their earnings these migrant workers bring home HIV. Similarly, at the Durban AIDS Conference in July 2000 an African mother stated that as far as becoming infected with HIV was concerned, the most risky thing a young African woman could do was to get married, because of the likelihood that her husband would infect her.

But there is another and more tragic side to commercial and even casual sex. It is that this may be the only way available to many women for supporting themselves and their children. For them it is a business and a livelihood. Our stigmatising attitudes make it difficult for us to see deeper than the woman waiting at the street corner. We fail to see that, when the motley is taken off, the person beneath is a tired, harassed, caring, concerned, loving mother doing the only thing she is able to do for the support of her children (and all too often of her husband as well). For her, sex is not pleasurable or glamorous. Neither does she see it as a moral issue. For her, it is a matter of life and death, a survival strategy for herself and her children.

Because of the risk of HIV infection, there is much focus on reducing or controlling casual and commercial sex. This has taken many forms. Uganda has been successful in reducing HIV prevalence largely because of the promotion of what they call ‘zero grazing’—a man ‘tethered’ to his wife and never roaming away from her to another woman (like a cow or goat tied to a tree and grazing only on the grass within reach).

“Safer sex” is the mainstay of the response of many international organizations. By this they mean any physical sexual activity other than unprotected (without a condom) penetrative sexual intercourse. It is worth noting that in the year 2000 the official Vatican newspaper *L'Osservatore Romano* carried an article from a high level Vatican official in

which he stated that Thailand's requirement that condoms be used within its thriving sex industry had particularly good results and in the circumstances was actually a lesser evil.

A third approach is the legalisation of the sex industry. This generally entails the registration of commercial sex workers and the licensing of brothels. Dakar in Senegal is regarded as one of the largest commercial sex centres in Africa, but the rate of HIV transmission in Senegal is less than one percent. Among the factors influencing this low rate are the high level of selenium in the soil, and hence in people's diet, and the practical agreement of the government, Islamic and Catholic authorities that they would all speak with one voice, each advocating the line that was in agreement with its own teaching, and none disagreeing in public with the line that the others might take.

But a significant factor that can be cited as accounting for this low rate in Senegal is legislation that registered sex workers are required to have regular medical examinations, including examinations for sexually transmitted infections and HIV/AIDS, and are prohibited from practising their trade if they do not have a medical card showing that they are free of infection. While this may speak well for concerns about public health, it is a sad comment on how women are viewed. It seems to treat them as merchandise to be suitably packaged before sale, commodities that can be trafficked if they are in the right condition.

## **VIOLENCE AND CHILD ABUSE**

It was distressing when travelling to learn that violence with potential to transmit HIV was so universally common. Three forms were spoken about almost everywhere: rape, the sexual abuse of children, and forced sex among prisoners. Human Rights Watch has drawn attention to the varied abuses of women's human rights in many parts of the world. These include rape within and outside of marriage and other sexual violence and coercion (often abetted by poverty, domestic violence, and unequal property and inheritance rights).

Sexual abuse of children also seems to be nearly universal. As Catholics we are greatly distressed when we hear about the abuse of children by priests and religious in the United States, Ireland, England, and even here among us in Africa. The very sad fact is that the abuse of children is very widespread, with the majority of acts of abuse being committed by a family member or trusted adult. The increasing evidence of incest involving children is stunning. One wonders whether this is something new in the world, or whether it has always been with us.

Violence and sexual abuse within schools, especially where there is a large proportion of male teachers, are also very common. South Africa has found that one half of all schoolgirls are forced to have sex against their will, one third of them by teachers. Across the world, millions of girls—many orphaned by AIDS or otherwise without parental care—suffer in silence as their societies fail to provide basic protection from sexual assault that would lessen their vulnerability to HIV/AIDS.

Zambia is one of the few countries that has a strong HIV/AIDS prevention programme for prisoners—"In But Free", a community-based programme of the Copperbelt University and the Zambia Prison Service. Among other things, the need for the programme arises because of the unprotected sex that occurs between male prisoners. This is not allowed, of course, but everybody knows that it happens. Prison systems in other countries experience the same problem, especially where prisons are crowded. Some of the sexual activity is consensual, but much is forced, particularly on more recent and younger prisoners.

The system carries dangers for the prisoners, that they will contract HIV from one another, and for the wider public, that when the prisoners are released they will spread HIV among their family and friends. It has been said that Russia's severely overcrowded prison system, and its practice of decongesting them periodically by releasing large numbers of prisoners, act like a carburetor for HIV, pumping high concentrations of the infection out into the general population.

In all three cases—rape, the sexual abuse of children, and forced sex among prisoners—those who are violated are often afraid to report what has happened to them. They fear they will get the blame and be punished. They feel ashamed of what has happened. They feel that their very violation has made them detestable and outcast. Many of them bear the scars of shame, fear, self-stigma and low self-esteem for the rest of their lives.

## **SEXUAL ORIENTATION**

Writing from Japan in 1549, St. Francis Xavier observed that homosexuality was reasonably common. Were he alive today, he could say the same for very many other countries. Homosexual activity seems to occur in all societies, even though in many it is almost a taboo topic. Homophobia—abhorrence of a sexual relationship between two people of the same sex, but mostly that between men, and discrimination against the participants—ensures that much that is related to homosexual activity remains underground. Many cultures deny that it occurs among their members, and in many countries (such as India and Zambia) homosexual acts are against the law.

But HIV/AIDS is unmasking the hidden reality. Those at the highest risk of contracting or transmitting HIV are men who have sex with men, and these have been brought under the spotlight by the spread of HIV/AIDS. Along one dimension, this has contributed very strongly to the stigma and discrimination associated with being HIV positive. Being sick with the disease is seen as suggesting that one may be homosexual, and once that association is there the homophobia quickly follows.

Along another dimension, the spread of AIDS is revealing how common homosexuality is in all parts of the world. Even societies like those in many parts of the Caribbean or Africa are recognising that homosexual sex has old roots and is fairly commonly practised. In many cases, however, what is going on does not come to light because the man has also contracted a regular marriage and appears as an ordinary husband and father.

Possibly even more surprising is the way HIV/AIDS is revealing how common bisexuality is—married men in a stable union, with a good wife and loving children, “once in a while” having sex with other men. Bisexuality also shows itself among men who have sex with men because they are cut off from the possibility of a female sexual partner due to living in mostly single-sex situations—miners, migrant farm workers, refugees, prisoners, boarding school students—but who will revert to sex with women when they leave these situations.

The masking of homosexual activity through a regular marriage, and the practice of bisexuality, both increase the possibility of HIV transmission. There is the challenge of dealing with this. But there is an even deeper challenge. This is the challenge of opening up the Gospel message to every person, regardless of sexual orientation.

Theologians seem to be facing up to that challenge as they grapple with such difficult questions as “How can we ensure that the Gospel is good news for every person, irrespective of sexual orientation?” or “How can we ensure that Christ's message is a

message of liberation, that boosts self-affirmation and self-esteem, for a person who has found fulfilling personal identity in the acceptance of his or her homosexual or lesbian orientation?"

In all parts of the world, HIV/AIDS is bringing more and more homosexual and lesbian individuals out into the open. As it does so, it calls for much re-consideration of attitudes. There is need for every door to be opened so that those who are oriented towards persons of the opposite sex do not break the crushed reed or quench the wavering flame in those whose sexual orientation is different.

### **III: Education, Treatment, Nutrition**

#### **ROLE OF EDUCATION**

Every country seems to recognize the importance of education in the response to HIV/AIDS. But most countries have been slow in organizing their education systems to work in the threefold area of HIV prevention, care and support for infected and affected persons, and mitigation of the impacts of the disease on the education sector itself. Namibia and Zambia have had a head-start in this, but even these countries still have a long way to go.

When countries think of responding to HIV/AIDS through education, the first thing they usually think of is putting some form of AIDS education into the curriculum. This is only natural, because ministries of education feel comfortable when they are dealing with curriculum and teaching matters. But in fact the impact of education on HIV seems to have very little to do with teaching about HIV/AIDS.

In a rural area in Uganda, HIV testing was conducted annually over a period of more than ten years. What was found was that for those with secondary education HIV prevalence fell steadily from 12% in 1991 to less than 2% in 2001; for those with primary education it fell from 12% to 6%; and for those with no education it did not fall, but fluctuated around 12%. This occurred at a time when the education being provided in schools was not very good and when HIV/AIDS did not receive very much attention in the school curriculum

This shows that the more education the less HIV. It seems that it was the fact of being through school that made the difference, and not education about HIV or AIDS as such. Something similar has been found in Zambia: a girl who dropped out of school was three times more likely to be HIV positive than her age-mate who remained in school. What seems to be happening is that school education somehow opens a person up to taking in and acting on information from other sources, including information about the disease and how to protect oneself against it.

But the beneficial effects of education are now being seen more widely. In Zambia, the percentage of those who know that a healthy-looking person can have HIV rises steadily with the level of education. So also does the percentage of those who know more than one way of protecting themselves against HIV infection, the percentage of those who know where to go for an HIV test, and the percentage of those who have actually had an HIV test. On every measure that has been taken, those with primary education come out better than those with no education, those with secondary better than those with primary, and those with tertiary better than those with secondary. Clearly education counts, and the difference is more than in knowledge, since being educated is linked with going for HIV testing, something that requires action.

## CONCERNS ABOUT AIDS AND SEXUALITY EDUCATION

It was remarkable to hear people in Phnom Penh, Jakarta, Bangkok, Almaty, Nairobi, Kingston, Windhoek and elsewhere expressing the same fears and doubts about AIDS and sexuality education that were being expressed in Malawi and Zambia. In any of these places you could close your eyes and think you were at a workshop in Mangochi or Kafue!

Seven principal issues kept coming up everywhere:

1. Teachers are not comfortable with this area and hence they try to avoid having to teach it.
2. Such teaching as there may be is confined to the biological and examinable aspects, but avoids dealing with issues of behaviour.
3. Very few teachers are prepared to deal with sexuality, relationships and the formation of attitudes.
4. There is no comprehensive training or preparation of teachers for work in this area.
5. There is a great shortage of suitable books and teaching materials.
6. Teachers fear that if they go into any detail in this area they will be accused by parents of wanting to seduce some of the children or lead them into bad practices.
7. Parents and community leaders fear that teaching children about sexuality and safer sex may promote promiscuity.

On the last point, it is worth noting that there is abundant evidence, from Africa as well as from other parts of the world, that teaching about sexuality and safer sex—even very explicit teaching—does not lead to promiscuity. On the contrary it is associated with the deferment of sexual activity, more extended periods of abstinence, greater partner stability, and fewer unwanted pregnancies.

## TREATMENT

Every country seemed to want more antiretroviral (ARV) treatment for people infected with HIV. But those dealing with the situation were not always aware of some of the limitations and constraints of ARV treatment. HIV infection cannot be cured, not even by the best kind of ARV treatment. The treatment suppresses the activity of the virus in the body, but never eliminates it. Hence, the treatment, once started, must be continued for the remainder of one's life. Many people did not seem to know this.

By November 2005, 44,000 people were receiving free ARV treatment in Zambia. The plans are to extend this to 100,000, while in Malawi there are plans to provide treatment to 50,000 people. But as Zambia's former Minister of Health, Brian Chituwo, pointed out, these plans will succeed only if greater emphasis is placed on planning and preparation; information, education and communication; training; extending laboratory capacity; getting the drugs in good condition to the people who need them when they need them; and ongoing medical monitoring of those who are taking the drugs. There did not seem to be much international attention to these vital details. Instead, many people seemed to think of ARVs almost as they would of Panadol, as something that can be dispensed simply and easily, without much prior planning or subsequent monitoring.

There also seemed to be a fairly widespread lack of awareness that ARV treatment may not keep a person in good health indefinitely. Most people seemed to overlook the possibility that over time the virus might become resistant to the particular ARV drug being taken by an individual. This is because as it replicates within the body, HIV does not have the ability to

make sure that each one of the billions of new copies that it produces every day is an exact replica of the original. The variations to which this leads result in a large number of departures from the original. Some of these may be immune to the ARV drug being used and in a classic example of the “survival of the fittest” may go on to multiply in the body, until eventually the drug no longer has the effect of suppressing the activity of the virus.

The grave lesson from international experience, therefore, is that there should be much more realism in ARV expectations. The drugs can work wonders and where possible should be administered (under good medical supervision) to those whose medical condition shows that they need them. But they are not the silver bullet that will solve the whole problem. At best they are only one part of the answer to HIV/AIDS.

## **NUTRITION, AND MICRONUTRIENT DEFICIENCY**

Nutrition is integral to a complete response to HIV/AIDS. Improved nutrition can protect against becoming infected with HIV and extend the number of years between HIV infection and the development of AIDS. Moreover, enhancing nutritional status is necessary before treatment with ARVs can start—if the individual’s nutritional status is poor, the ARVs might do more harm than good.

There seemed to be fairly widespread understanding of the importance of nutrition in itself, but efforts to link it to the control of HIV and AIDS were quite limited. There seemed to be very little appreciation that effective teaching of nutrition, including ways of achieving it (through the involvement of agricultural advisors, better use of school gardens, and community participation), was something that could be of extraordinary value to school learners when they left school, and was also something that the majority of parents and communities would support wholeheartedly.

If most people seemed to place the relevance of nutrition to HIV/AIDS control on their back burners, this was even more true regarding the role played by a balanced intake of micronutrients. Educators seemed to have very little knowledge on this, preferring to leave the matter in the hands of public health specialists.

## **NEED FOR A BALANCED APPROACH**

The relevance of both of these areas in the response to HIV/AIDS seems to have been overwhelmed by an approach to HIV control that places almost all the emphasis on the management of sexual behaviour. The narrow focus on the acknowledged link between sexual behaviour and HIV transmission has had several unfortunate effects. It has fuelled moralisation and stigma. It has diverted attention from the importance of nutrition and an adequate supply of micronutrients. It has not paid adequate attention to the role played by the disempowerment of women, widespread personal poverty, and the structural poverty in many societies. In all these ways the focus on sexual activity has been somewhat superficial and, as a result, largely ineffective in stemming HIV transmission. Too much attention has been paid to the symptoms and the superficial causes, but not nearly enough to underlying factors and causes.

## **IV: The Role of Religion**

### **ROLE OF ORGANIZED RELIGION**

It was encouraging to see increasing recognition in so many different parts of the world of the positive role that organized religion plays in responding to HIV/AIDS. The Christian Churches and Islam are seen as being of major importance in Africa, while in South-East Asia the Buddhist communities and monasteries work strenuously with many Catholic and Protestant bodies in the struggle against the epidemic.

The Catholic Church is recognized as being the world's largest provider of AIDS care, accounting for more than 25% of the global support and care for those infected or affected. Universally there is praise and appreciation for the work the Church and its members do in caring for the sick, especially through home-based care, and in responding to the needs of orphans and vulnerable children.

The position on condom use is almost always a sticking point, for both Catholics and Muslims. Some Catholic spokespersons do not show much familiarity with traditional moral principles and hence they are very forthright in saying that condom use is always immoral. The media seize on these statements and often caricature the whole Catholic involvement with HIV/AIDS as opposition to condom use. This in turn makes the Catholic media and many bishops even more sensitive and anxious, and so the problem grows larger. For instance, in November 2003, the editor of a Catholic newspaper in Trinidad censored a reference made in a draft article by one of its staff reporters to a statement from the Bishops of Chad, because the Bishops acknowledged that it might be lawful for a married couple, one of whom was HIV positive, to use condoms.

The tragedy is that while the debate over the morality of condom use absorbs the energy, resources and wider concerns of many on both sides, recognition is growing in secular circles of the importance of promoting abstinence and fidelity as successful ways of preventing HIV transmission. In Uganda, condom use certainly played some role in reducing HIV transmission. But the Ugandan success was essentially due to staying faithful to one partner. Next came abstinence, showing itself in a delay in sexual activity by young people. With only 8% of Ugandans saying that they use condoms consistently, it seems that although it played a role, condom use was not highly significant in the Ugandan achievement.

### **INCREASING PUBLIC RECOGNITION**

A further development is the way international conferences have changed in recent years in the provision they make for religious perspectives on HIV/AIDS. Before the formal opening of the 13th ICASA held in Nairobi in September 2003, time was allocated for special presentations on behalf of the Catholic, Anglican and Muslim faiths, while the main programme made provision on a couple of occasions for discussions on faith-based initiatives. Previous conferences had never done anything like this. The Catholic presence at the Nairobi ICASA was also highlighted by a special Mass for delegates, celebrated by the Archbishop of Nairobi, and followed by a reception.

Another example of the increasing recognition of the major role that organized religion plays in the struggle with HIV/AIDS is the way international statements and resolutions are increasingly calling on religious leaders to spearhead aspects of the campaign. Thus, a high level meeting on the orphans challenge, convened in 2002 by Nelson Mandela, called on religious organizations to make even better use of their potential for breaking the silence,

stopping the stigma, and mobilising action to prevent HIV and promote care for orphans, vulnerable children and families affected by HIV/AIDS.

## **INCREASING INTER-FAITH DIALOGUE AND COOPERATION**

Responding to HIV/AIDS has been significant for the faith communities themselves in the way it has stimulated them to work together. The epidemic has promoted ecumenical and inter-faith dialogue, with Christian communities of all faiths collaborating with one another and with their Muslim, Jewish, Buddhist and other counterparts in work aimed at HIV prevention, the care and support of the infected and affected, and the mitigation of the impacts of the epidemic. As an example, with leadership from the Muslim community, women from all faiths in Uganda—Catholic, Protestant, Pentecostal and Muslim—meet regularly as groups for fellowship and to develop their self-respect as women.

In addition to this dialogue of action, the epidemic has fostered the dialogue of theological exchange where the faith communities endeavour to appreciate better the religious and social approaches of other religious heritages. Some of this is being achieved through the World Conference of Religions for Peace (WCRP), a partnership involving major religious bodies and communities (including several Catholic religious congregations) that seeks to mobilize the moral and social resources of religious people to address their shared problems. Among other things, WCRP has helped launch the Hope for African Children Initiative (HACI), a programme for the millions of children affected by HIV/AIDS in Africa.

## **WHAT THE WORLD EXPECTS FROM ORGANIZED RELIGION**

Clearly, then, the international community is coming to recognize that, as the largest and best-organized set of civil institutions in the world today, religious communities are uniquely well equipped to meet the challenges of responding to HIV/AIDS.

Increasing expectations accompany this growth in recognition. These expectations would like to see the Churches and other faith communities:

- Providing more public and coordinated leadership, within countries and regions, in the struggle against the epidemic.
- Coming out loud and clear in every possible way about HIV/AIDS, and overcoming silence or denial, among their own personnel, in their members and in their teaching.
- Adamantly rejecting every utterance, pronouncement or practice that carries any connotation of stigma or discrimination, and working hard to ensure that stigma and discrimination never find a home in any member of their faith communities.
- Pouring their enormous human resources into the major tasks of eliminating poverty and ending the subjugation of women (recognizing the sea-change this will mean for many of their internal structures and practices).
- Recognising the dimensions of the orphans challenge and mobilising their communities for a massive response to it in humane and practical ways.
- Galvanizing their members into even further action for the reduction of HIV transmission, the provision of care and support for those infected or affected, and the mitigation of the impacts of the disease and epidemic.
- Working in cooperation and harmony with one another, the representatives of local cultures, civic personnel, and local, national and international leaders.

- Maintaining a multidimensional response to HIV/AIDS at the top of their agenda and as an integral element in their seminary and other training programmes.

It is significant and encouraging to note that the message issued by Symposium of Episcopal Conferences of Africa and Madagascar (SECAM) for World AIDS Day, 1<sup>st</sup> December 2003, responded to many of these expectations. (See appendix to this pamphlet.) What remains now is to see the establishment of the Africa-wide HIV/AIDS service that SECAM intends to set up for the implementation of its plan of action.

## **HELP US TO HOPE**

Finally, we could say that what the world looks for perhaps more than anything else, and what those living with HIV/AIDS need above all, is hope. This should be real hope, costly perhaps for the infected and affected, but costly also for the healthy and wealthy. The deepest roots of this hope lie in the death and resurrection of Jesus Christ. As the Irish theologian, Father Enda McDonagh, has said, “This hope cost the all-powerful and privileged God the life of his only-begotten Son”. But it also saw God confirm the Son’s complete self-emptying by raising him up—as he likewise will raise every person living with HIV/AIDS.

If it is to provide this hope, and to experience it within itself, the Church cannot stand apart. It can no longer see HIV/AIDS as infecting and affecting people “out there”. It must identify and acknowledge that it too is infected. It must proclaim in word and deed that the Body of Christ has AIDS—for in Father McDonagh’s words, “Only a Church with AIDS can speak effectively and provide hope in a world with AIDS”.

## Chapter Four

### WHY SO MUCH HIV AND AIDS IN ZAMBIA?

In Zambia approximately one in every 12 persons has HIV or AIDS. In Ghana it is one in every 60. In Great Britain it is one in every 1,900. Why are there such great differences? In particular, why are Zambia and other countries in Eastern and Southern Africa so badly affected?

There is also another puzzling feature. In Zambia and elsewhere in Africa the survival time from initial HIV infection to death usually ranges from five to seven years.

In the United States, however, people with HIV can live in good health for more than a decade, while some live for as long as 15 years without becoming ill with AIDS-related sicknesses. (This is how it was before the anti-retroviral drugs came into use. Access to these drugs in countries has extended the life prospects of persons with HIV to an extent that is very considerable, though not yet accurately known). Again, one asks why it should be so.

There are three possible reasons for these differences. First it could have something to do with the virus itself. Second, it could have something to do with the way HIV is transmitted, that is, with behaviour patterns. Finally, it could be because of the social conditions affecting individuals who contract HIV. Let us look at each of these possibilities.

#### DIFFERENCES IN THE VIRUS

There are different types and sub-types of HIV. The sub-type that is ravaging Zambia and this part of the world is different from the sub-type that predominates in West Africa, and both are different from the sub-type that is encountered in the United States.

One could ask whether the HIV virus that infects people here can be transmitted more easily than the type that occurs in other parts of the world. This is certainly part of the answer, as there is evidence that the HIV sub-type that is prevalent in Zambia and Southern Africa tends to be more easily transmitted and aggressive than that which is found elsewhere.

But although this is part of the answer it does not in itself account for the very high levels of HIV and AIDS that are experienced here compared with other parts of the world.

#### DIFFERENCES IN SEXUAL ACTIVITY

A second possibility is that behaviour patterns in Zambia and neighbouring countries differ from those in other parts. If it is true that hetero-sexual behaviour is what causes most of the HIV transmission here, this possibility, if true, would imply that the pattern of sexual behaviour here differs from what is found elsewhere.

A different pattern in sexual behaviour could mean either that in Zambia and neighbouring countries there is more of the risky sexual activity that leaves one open to possible HIV infection, or simply that more sexual activity occurs here than in other parts of the world. If either of these were true, then a higher level of promiscuity would go a long way towards explaining the high levels of HIV and AIDS that we are experiencing.

But sexual behaviour alone cannot explain the differences in the way HIV has spread in Eastern and Southern Africa compared with the rest of the world. There is no evidence that promiscuity in Zambia or in the neighbouring countries is higher than elsewhere. In fact, all the evidence indicates that when it comes to promiscuity countries tend to be very similar.

Careful studies have shown that risky sexual behaviour patterns, such as high rates of partner change, frequency of contacts with sex workers, or keeping several sexual partners “going” at the same time, are just as likely in West Africa, where HIV prevalence is low, as in Ndola, where it is high.

In the United Kingdom, 27% of men report having sex with a non-regular partner, the very same as in Zambia. But the HIV prevalence rate in Zambia is almost 200 times higher than in the UK. Something other than the pattern of sexual behaviour must be leading to such a difference.

That differences in sexual behaviour do not fully explain why HIV infection has spread so rapidly in Zambia is also borne out by evidence about rates of mother-to-child transmission. In Africa, 25–40 percent of infants born to HIV-positive mothers are likely to be HIV infected; in Europe, in the absence of treatment, this is the case with only 14 percent of infants and in the United States with 17–25 percent.

In this case there is a complete absence of any form of sexual behaviour. Yet a new-born infant of an HIV-positive mother in Zambia is two to three more vulnerable to HIV infection than an infant in similar circumstances in the developed world.

Clearly this has nothing to do with promiscuity. Instead, it is telling us that for some reason an infant born in Zambia, or Africa, is intrinsically at considerable risk of contracting HIV. The Zambian infant is more likely than the US or European infant to contract HIV infection.

But this is so not only for infants. Almost everybody living in Africa is somehow more susceptible to HIV infection than those living in other parts of the world. This is not entirely because of the type of virus. And it is not because of excessive or uniquely high-risk sexual behaviour.

This marked difference in rates of infection is because of the third reason: there is something in the condition of those living in Zambia, and elsewhere in Africa, that makes them very vulnerable to HIV infection.

## **NUTRITION, HEALTH, AND HYGIENE**

Specifically, the nutrition, health, and hygiene conditions of those living in Africa make them particularly susceptible to HIV infection, in the same way that they are particularly susceptible to infection from other viruses and bacteria (such as those that cause cholera, a disease that has tended to flourish across the same period that HIV infections grew).

There are four health-related conditions in Zambia that go a long way to explaining why this is so. They are under-nutrition (or malnutrition), deficiencies in micronutrients, carrying a heavy load of parasites and worms, and untreated sexually transmitted infections (STIs). Unsafe water and sanitary conditions also play a role.

## **1. The Role of Malnutrition**

The extent of malnutrition has been highlighted in many governmental, non-governmental and international reports. Data indicates that about 60% of the children are malnourished, up from 47% in the early 1990s. More than half the Zambian children are stunted and almost 25% are underweight.

These facts make two things clear. First, back in the early 1990s malnutrition rates among children were already extremely high, and second, the position has since grown considerably worse.

Many of the children who experienced malnutrition in the late 80s and early 90s are today's adults. Now aged 15 and above, they are among the ones most severely affected by HIV. A very large proportion of these have experienced chronic malnutrition throughout their lives. They seldom had enough calories and proteins to sustain active growth and a life of work. For many this situation continues.

Malnutrition weakens a person's immune system. First, it weakens the body's initial lines of defence, the skin and the mucus membranes. The healthy skin of an adequately nourished person effectively blocks the admission of a virus while the mucus engulfs and carries away any that may be admitted.

In a malnourished person, these systems are not able to block infection in the way they should. The frequency with which a malnourished person develops sores on the lips or infections in the eyes shows us this quite clearly.

Second, malnutrition reduces the ability of blood cells and bone marrow to produce the immune response that is needed to cope with an infection—any infection. Of particular relevance to HIV is the fact that protein deficiency leads to a reduction in the size and weight of the thymus, the gland that produces the all-important protective T-cells.

This being the case, it comes as no surprise to learn that when nutrition levels decrease, HIV prevalence levels increase. Across countries, increases in HIV prevalence are strongly associated with falling consumption of proteins and calories: the more severe the deterioration in nutrition, the higher the HIV prevalence rate.

## **2. Micronutrient Deficiency**

Micronutrients are essential nutrients which the human body cannot manufacture but which it needs in only small amounts for the efficient functioning of the brain and the proper operation of the immune system. Deficiencies of even the small amounts that are required increase a person's vulnerability to infection.

In Zambia, iron deficiency (which leads to anaemia) is so common that it is believed to affect almost all school children and up to half of the adults. Iron is essential in promoting resistance to infection. Zinc deficiency, which is also widespread, also reduces resistance to infection and impairs the self-healing power of the skin and tissues.

But the most serious condition—and one that is very widely experienced—is vitamin A deficiency. Inadequacy of vitamin A impairs the body's immune system in three ways—by weakening the skin and mucus membranes, by reducing the ability of bone marrow to

produce protective cells, and by reducing the ability of blood-cells to provide the necessary protection.

Children who lack vitamin A may be in danger of blindness, because their systems cannot protect the mucus membranes that surround the eyes. The night-blindness that is endemic in the North-Western, Western and Luapula Provinces is a manifestation of extensive vitamin A deficiency, but the problem occurs in other areas of the country also, especially during the dry season.

Iron and vitamin A deficiencies occur because of the shortage of these micronutrients in the diet. They also occur because diarrhoea, frequently caused by unsanitary conditions and contaminated water, flushes them out of the system.

Both sets of circumstances combine to leave a large proportion of the people in Zambia, and elsewhere in tropical Africa, with chronically impaired immune systems that are dangerously susceptible to infection by any virus or bacterium that might come along, HIV included.

### **3. The Load of Parasites and Worms**

Malaria is the most widespread disease that afflicts Africa. Of the 300–500 million annual cases of malaria worldwide, more than 90% occur in tropical Africa. Although certain drugs take away malaria symptoms, they do not kill all the parasites that may remain in the body's system (and that can lead to renewed bouts of fever). There are other parasites also.

Bilharzia is almost endemic in Zambia, with very high rates occurring in individuals who come into contact with a combination of slow-moving or stagnant water and water-borne vegetation. In addition roundworms, whipworms, hookworms, and amoebae are very widespread, with many individuals carrying several of these at the same time.

This parasite load undermines nutrition and increases the need for micronutrients. The simple reason is that if they are to survive within the body the parasites must draw their sustenance from their human host. Millions of people in Africa are sharing their meagre intake of foodstuffs and micronutrients with billions of parasites. This impact on nutrition and micronutrient supply further weakens the natural defence systems of infected persons, leaving them more vulnerable to infection.

In addition, parasites have another negative effect. They keep the immune system in a perpetual state of alertness in an effort to ward off the infections to which the parasites may give rise. This reduces the immune system's ability to identify and react to newly introduced parasites, almost as a piece of elastic loses its elasticity if it is kept tightly stretched all the time.

The exhausted immune system fails to spot new invaders or is incapable of mounting the response needed to protect the body. The result is greater susceptibility to infection, particularly by a relatively new virus such as HIV.

### **4. Sexually Transmitted Infections**

It has been recognised for a long time that sexually transmitted infections (STIs) facilitate the transmission of HIV. However the type of STI is also important. The United States of America reports about 12 million new STI cases annually, yet there are only about one

million HIV positive cases in the US. The high incidence of STIs is not accompanied by an equally high incidence of HIV infection.

This is related to the fact that the STIs that commonly occur in the United States do not cause ulcers in the genital area. It is different, however, in Africa where a very common STI is chancroid. This causes genital ulcers. Moreover, this and other genital ulcer conditions occur most commonly where the scarcity of water makes it hard to maintain personal hygiene, a situation that is all too familiar in both rural and urban Zambia.

Susceptibility to genital ulcers is also increased by malnutrition and vitamin A deficiency, especially when there is a combination of these, because of the way these two conditions weaken the skin and mucus membranes. When there are genital ulcers, the risk of HIV transmission becomes five to ten times greater than otherwise.

What makes this situation worse is that many people do not know that they have an STI, many who do know do not look for treatment (because of shame or because of costs associated with going to a clinic or doctor), and many who look for treatment cannot get it (because clinics or health centres do not have the necessary medications).

## **WHAT SHOULD BE DONE?**

It is clear from the above that there are two major explanations for the amount of HIV and AIDS in Zambia. Sexual behaviour is one explanation. The second is the nutrition, health, and hygiene status of those who engage in sexual behaviour. Both must be taken into account. Neither one alone tells the whole story.

Addressing one without addressing the other is a recipe for failure. A policy that focuses narrowly on behaviour change, but does not simultaneously focus on improving the general nutrition, health, and hygiene conditions of people, will not succeed in stemming the HIV epidemic.

This underlines the importance of taking the broad view of HIV and AIDS, especially by seeing the epidemic in the context of poverty. President Mbeki of South Africa has drawn much criticism for the way he has linked HIV and AIDS to poverty, but his views in this regard received international endorsement when a special session of the United Nations General Assembly unanimously agreed that “poverty, underdevelopment and illiteracy are among the principal contributing factors to the spread of HIV/AIDS” .

The need now is for ever more determined and holistic reduction. Anti-AIDS programmes should not be stand-alone activities that focus almost exclusively on the virus and on sexual behaviour. Instead, they should be firmly rooted where they belong, within a poverty-eradication framework that gives prominence to programmes that

- expand employment,
- safeguard the ability of every person to meet essential nutritional requirements,
- improve the provision of primary health care,
- ensure that clinics and health centres are adequately stocked with essential drugs and that the infrastructure is in place to make these freely available to those in need,
- provide quality basic education to every child and young person, and
- ensure safe, accessible and hygienic water and sanitation systems.

Anybody who promotes programmes like these is promoting the struggle against HIV and AIDS.

## WHO IS RESPONSIBLE?

There has been a considerable amount of research in the past few years that links economic reform programmes promoted in Africa with the spread of AIDS. Indeed, some of this research directly indicts the Structural Adjustment Programmes (SAP) imposed by the IMF and World Bank as an indirect cause of the socio-economic vulnerability of children to HIV. I believe that this argument should be widened.

The IMF's own evaluation of the SAP in Zambia shows the way SAP measures were accompanied by an increase in malnutrition, a decrease in the value of health services, and an extension in cost recovery for the limited health services that were available (at a time when drought and badly sequenced SAP measures made it impossible for large numbers to pay any costs).

In the light of what was said earlier in this article, this worsening of the health situation in the first half of the 1990s has made a major contribution to the high levels of HIV and AIDS being experienced today. Since HIV and AIDS first came on the scene in 1981 sufficient attention has not been paid to ensuring health care, medical supplies, water and sanitary infrastructure, and food security. This neglect has left the people of Zambia very susceptible to infections of all sorts, HIV included.

A weakened people were easy targets for an insidious, complex, patient, and virtually indestructible virus such as HIV. Much of the blame lies within Zambia—with bad governance, poor policies, mismanagement of financial resources, corruption and the diversion of funds. Much also lies outside Zambia—with the economic measures imposed by the international financial institutions.

Is there any possibility that the perpetrators of what is now a national catastrophe will be brought to book? Or will the people of Zambia have to impoverish themselves even more by borrowing in order to deal with a situation for which both leaders and lenders must bear considerable responsibility?

[Much of this article is drawn from a paper presented by Professor Eileen Stillwaggon, University of Gettysburg, USA, at the Durban International AIDS Conference in July 2000. A more developed version of this paper and related materials appears in Professor Stillwaggon's book *AIDS and the Ecology of Poverty*, published by Oxford University Press in October 2005.]

## Appendix

**THE CHURCH IN AFRICA IN FACE OF THE HIV/AIDS PANDEMIC***“Our prayer is always full of hope”***2003 Message Issued by****Symposium of Episcopal Conferences of Africa and Madagascar (SECAM)**

Dear brothers and sisters in the faith,

Dear friends, fellow believers and all people of good will,

*“Grace to you and peace from God our Father and the Lord Jesus Christ!”* (1 Corinthians. 1:3).

We, Cardinals, Archbishops and Bishops of Africa and Madagascar greet you in faith and with warm affection. Gathered in the 13<sup>th</sup> Plenary Assembly of our Bishops Conferences of Africa and Madagascar (SECAM), we have taken up the AIDS pandemic and its horrible consequences. In doing so we have been very close to you, our dear brothers and sisters who are infected and affected by HIV/AIDS, and also to you who have been moved to join in the fight against the scourge of AIDS.

**I We are in solidarity**

*“For just as the body is one, and has many members, and all the members of the body, though many are one body, so it is with Christ”* (1 Corinthians 12:12).

This eloquent image expresses well the solidarity that we feel towards all who suffer, but especially towards you our Christian brothers and sisters, who are one single body, with millions who make up the communities of Africa and Madagascar. It is on you that we call to join together in confronting the pandemic whose gravity no one can ignore.

May this solidarity be matched by a keen awareness of the seriousness of the threat facing us. Millions of lives have already been lost prematurely, whole families dismembered and untold numbers of children orphaned and/or infected by HIV. And it is they above all who need protection, nurture, housing, education and adult parents.

**II Let's be true to ourselves**

As heads of our Christian communities, we commit ourselves to making available our Church's resources be they our educational and healthcare institutions or social services. We will work closely with all funders who are disposed to support and work with Christian and faith-based organisations. We are open to partnerships with them and others who are happy to put their resources to work in the struggle, and do so knowing well that we work according to our Gospel convictions. For “Man does not live by bread alone, but by every word that issues from the mouth of God” (Matthew 4: 4).

The morality we teach in God's name seeks to respect and affirm human life which gets its value and dignity from the fact that it is the inviolable gift from our Father who creates every human being and calls everyone to the fullness of life. Therefore abstinence and fidelity are not only the best way to avoid becoming infected by HIV or infecting others, but

even more are they the best way of ensuring progress towards lifelong happiness and true fulfilment.

*“Never give in then, brothers and sisters, never admit defeat; keep on working at the Lord’s work always, knowing that, in the Lord, you cannot be labouring in vain” (1 Corinthians 15: 58).*

### **III Let’s change behaviour**

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

This type of education can only be undertaken effectively with the active collaboration of lay men and women who not only speak about principles of morality but also, as youth and as couples, give living testimony that fidelity to these moral principles yields a humanising and fulfilling affective and sexual life. Such education also contributes to promoting healthy and stable families, and these are the best prevention against AIDS. Organizations<sup>1</sup> which specialise in such education for young people and for couples exist throughout Africa and are having a small but gratifying degree of success. We give them the support and encouragement they deserve.

### **IV Let’s be responsible**

The solidarity that we spoke of earlier binds us to joint responsibility in tackling the global and complex challenges facing us: interminable and recurrent wars, conflicts and violence in which rape is often used as a weapon, not just psychologically violent but physically destructive through HIV/AIDS!

We have also come to realise that poverty goes hand in hand with HIV and AIDS. It concerns us that our already fragile economies should be further weakened with much of the trained labour force lost to HIV and AIDS. Poverty facilitates the transmission of HIV, makes adequate treatment unaffordable, accelerates death from HIV-related illness and multiplies the social impact of the epidemic.

In all these senses, *“Let all the parts [of the one body] feel the same concern for one another” (1 Corinthians 12:25)*. This solidarity among us and this fidelity to our faith, this resolve to change behaviour and assume our entire responsibility for the future of our continent, now take concrete form in the following Plan of Action. We pass it on so that you can also make it yours.

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<sup>1</sup> Education for Life, Youth Alive, Action Familiare, Pro Vita

## PLAN OF ACTION

We, Cardinals, Archbishops and Bishops of SECAM, propose to the members of the clergy, brothers and sisters in religious life, to the faithful and all people of good will, the following plan of action:<sup>2</sup>

### ***I. In solidarity with you, we commit ourselves to:***

1. Utilise and increase the human, material, and financial resources dedicated to address the situation of HIV and AIDS in our communities, and to identify focal points in parishes, dioceses, and national Episcopal conferences in order to assist with gathering information and development of programme strategies. In this same effort, we are committed to coordinating our efforts at the continental level in the struggle against the pandemic.
2. Make sure that the health services of the Church, the social services and the educational institutions respond appropriately to the needs of those who are ill with AIDS.
3. Focus on the particular vulnerability of girls and the heavy burden on women in the context of the HIV pandemic in Africa.
4. Advocate vigorously for access to treatment for those who are prevented from obtaining it through poverty and structural injustices.
5. Involve those who are knowledgeable about traditional medicines and other natural remedies in research into means of struggling against AIDS.

### ***II. Faithful to our Gospel convictions, with you we commit ourselves to:***

1. Collaborate with other Christian confessions and with people of other faiths working in their respective communities to support those affected and infected by HIV/AIDS.
2. Promote closer partnerships with civil society, the business sector, governments, the United Nations, international and intergovernmental agencies, and particularly with organisations of people living with HIV and AIDS, in order to increase the capacity for care and support, without diluting our evangelical convictions.

### ***III. Facing the serious threat of AIDS, with you we are committed to:***

1. Promote changes of mentality, attitude and behaviour necessary for confronting the challenge of the pandemic.
2. Work tirelessly to eradicate stigma and discrimination and to challenge any social, religious, cultural and political norms and practices which perpetuate such stigma and discrimination.
3. Play a major role in eradicating the damaging myths of stigma and discrimination by facilitating Voluntary Counselling and Testing (VCT) so that those who are infected might benefit from the care and support they need. This will also help better to control mother-to-child transmission.
4. Advocate with government at all levels and with inter-governmental organizations to establish policy priorities that adequately support those affected by HIV and AIDS, that provide access to care and treatment and a life of dignity for people living with HIV and AIDS, and that implement the commitments made at various inter-governmental meetings.

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<sup>2</sup> These recommendations are partly based on the Plan of Action prepared at the African Religious Leaders Assembly on Children and HIV/AIDS, Nairobi, 9-12 June 2002, and on the Proposed HIV/AIDS Plan of Action prepared at the SECAM Meeting of Secretaries General, Johannesburg, 24-27 October 2002.

**IV. In shared responsibility with you, we commit ourselves to:**

1. Develop educational programmes which integrate the theme of HIV/AIDS in theology and religious formation. These programmes will also include moral principles and practical skills for promoting healthy relationships and a well-integrated sexuality.
2. Promote and deepen theological reflection on the virtues of compassion, love, healing, reconciliation, and hope, all of which are capable of confronting the judgement, shame, and fear that so often are associated with HIV and AIDS.
3. Organize workshops at the regional, national, diocesan and parish levels in order to increase accurate knowledge and sensitivity around all HIV and AIDS-related issues relevant to our Church.
4. Encourage people living with HIV/AIDS or affected by it to become actively involved, in our local communities, as resource persons in the struggle against the pandemic.

**V. Finally, as Pastors of the Church Family of God in Africa in a time of AIDS, we want to:**

1. Train clergy, religious, and committed laity to accompany people living with and affected by HIV and AIDS with prayer and spiritual counselling.
2. Provide doctrinal, spiritual and social formation, and the best possible professional training, for those willing to become involved in caring for and accompanying those who are living with and affected by HIV/AIDS.
3. Welcome people living with HIV and AIDS in a warm, non-judgemental and compassionate manner in our churches and ensure them a "place at the table of the Lord."
4. Provide the sacraments and sacramentals, as appropriate and requested, to Catholics living with the virus.
5. Put into action the challenge addressed by our Holy Father Pope John Paul II to the Church in our continent through his Apostolic Exhortation, *Ecclesia in Africa*:

*"The battle against AIDS ought to be everyone's battle. Echoing the voice of the Synod Fathers, I too ask pastoral workers to bring to their brothers and sisters affected by AIDS all possible material, moral and spiritual comfort. I urgently ask the world's scientists and political leaders, moved by the love and respect due to every human person, to use every means available in order to put an end to this scourge."<sup>3</sup>*

We intend to create an HIV/AIDS service on the Continental level in order to assist us in implementing our Plan of Action.

Signed:

Symposium of Episcopal Conferences of Africa and Madagascar (SECAM) in plenary session  
Dakar, Senegal, 7<sup>th</sup> October, 2003.

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<sup>3</sup> Pope John Paul II, *Ecclesia in Africa*, 14 September 1995, #116.

## **AIDS PRAYER: KEEP THE PROMISE!**

*God of our weary years,  
 God of our silent tears  
 O Good and gracious God,  
 In the plan of Your creation,  
 You call us to struggle, to work together,  
 To bring justice to the poor,  
 Comfort to the suffering,  
 Consolation to the old,  
 Hope to the young.*

*O God, we are Your servants.  
 And now, so many of us,  
 And so many all around us,  
 Are suffering with HIV or AIDS.  
 So we come before You now and ask You,  
 If it is Your holy will,  
 To take this suffering away from us,  
 Restore all to health and lead all to know You  
 And Your powerful healing love of body and spirit.*

*We ask you also,  
 to be with those of us who nurse Your sick ones.  
 We are the mothers, fathers, sisters, brothers,  
 children and friends of Your suffering people.  
 It is so hard for us to see those whom we love suffer.  
 Keep us strong in reaching out to others,  
 Especially to the poorest in our midst, the most forgotten.*

*O God, Creator of all of us,  
 Lead us to do whatever it will take,  
 To eradicate this illness from the lives of those  
 Who are touched by it,  
 Both directly and indirectly.  
 Teach us how to bring the changes,  
 Both personal and structural,  
 That will make a difference.*

*Yes, help us to keep the promises that we make,  
 To make a difference, within us and around us.  
 We need your strength, your wisdom, your love.  
 And we trust in all that,  
 Because you are our God,  
 And we are your children.  
 We pray in your name!  
 Amen*

Adaptation of Prayer by composed by  
 National African American Catholic HIV/AIDS Task Force

## AIDS PRAYER SERVICE

### All stand

The prayer leader invites those present to join together in sharing a blessing with all who are sick or suffering:

1. Everyone puts their right hand on their heart and their left hand on the shoulder of the person next to them, to let their compassion flow from one to the other on behalf of all who are sick and suffering.
2. With the right hand still on the heart, each person holds their left arm stretched out in front with palm upwards, to let their compassion flow across the world.
3. Next, each person bows low with both arms stretched towards the ground, to let their compassion flow to the earth and to ask forgiveness for the many ways we have mistreated God's good earth.
4. Finally, each person raises both arms on high, to bless God our Creator, to greet those who have died and gone before us, and to ask a blessing for all those who are infected or affected by illness or loss.

### All say The Lord's Prayer -- Our Father .....

#### Reader 1 AIDS Poem: I am Ashamed

*I am HIV positive – and I am not ashamed of being positive.  
I am just sorry that this virus found a home in me.  
I am not ashamed of being sick.  
I just want to fight HIV without fighting shame and discrimination.  
With my diminished capacity I can take on only one enemy at a time.*

*I am HIV positive and I am so ashamed of my church, my mosque, my temple, for being ashamed of me being positive.  
I have been ostracised, shunned – not because I am not a believer but just because I am positive.  
I am so ashamed of my church, my mosque, my temple.*

*I am HIV positive and I am so ashamed of my family for abandoning me in my time of need.  
I am HIV positive and I am so ashamed of my government for ignoring the pandemic while many of us die every day.  
I am HIV positive and I am so ashamed of our world that sits back while millions die of a disease that can be prevented and treated.*

*I am ashamed. I am so ashamed. I am so, so ashamed*

(Mwangamu wa Kaggia, 2003)

### God's Response

#### Reader 2 Be not afraid

*Do not take fright, do not be afraid of your enemies. Yahweh your God goes in front of you and will be fighting on your side as you saw him fight for you in Egypt. In the wilderness, too,*

*you saw him: how Yahweh carried you as a man carries his child, all along the road you travelled on the way to this place (Deuteronomy 1: 29-31).*

Pause for personal reflection.

Father, we ask you to carry your children who have HIV or AIDS and to help us to fight at their side so that together we may overcome this evil and praise your name.

### **Reader 3 I love you**

*Do not be afraid for I have redeemed you. I have called you by your name, you are mine. For I am Yahweh your God, the Holy One of Israel, your Saviour. You are precious in my eyes and I love you. Do not be afraid, for I am with you (Isaiah. 43: 2-5).*

Pause for personal reflection.

Father, we ask you to fill every person who has HIV or AIDS with the reassurance that they are precious in your eyes, that you love them dearly, so that they may never be afraid, but know always that you have called them by name, that they are yours, that you are always with them.

### **Reader 4 I shall continue to support you**

*In your old age I shall still be the same, when your hair is grey I shall still support you. I have already done so. I have carried you. I shall still support and deliver you (Isaiah 46:4).*

Pause for personal reflection.

Father, we ask you to support the elderly and those with grey hairs, carry them in your arms so that they in their turn may carry their sorrows at the loss of their children and be brave in carrying their new burden of caring for the young.

### **Reader 5 Our hope is in God**

*While I was thinking I have toiled in vain, I have exhausted myself for nothing, all the while my cause was with Yahweh, my reward with my God. I was honoured in the eyes of Yahweh, my God was my strength (Isaiah. 49: 4-5).*

Pause for personal reflection.

Father, save us from being discouraged because of the challenge of confronting AIDS and eradicating poverty. Help us to see that we are not toiling in vain but that our cause is with you, Yahweh God, and help us to share this hope and strength with all our sisters and brothers.

### **Concluding Song**

“Be still and know that I am God...  
I am the Lord that healeth thee...”

## AIDS WAY OF THE CROSS

**Opening Prayer:** "We adore you, O Christ, as you carry your cross along the dusty roads of Zambia. We make the way of the cross in the homes and at the bedsides of those with AIDS. We bless you because through this suffering you have redeemed the world.

**1st Station:** "Jesus is Condemned to Death."

He sits shocked, unable to speak. His hands tremble. Marko has just been told he has AIDS. 'I'm going to die,' he says.

**2nd Station:** "Jesus Takes Up His Cross."

He is weighed down with the knowledge that he has AIDS. How will he tell his family? What will happen to his children? He tells his brother, sells some land, arranges for his children. It's hard. It's a heavy cross Vincent carries.

**3rd Station:** "Jesus Fall for the First Time."

He cannot stand alone. The abscesses are too painful. Peter is too weak. With help he makes it home and to bed where he begins the difficult task of regaining strength, so he can pick up the cross of living with AIDS and continue his journey.

**4th Station:** "Jesus Meets His Mother."

She lies there waiting for her mother to return. Regina has just learned that she has AIDS and is dying. She wants to tell her mother. As they meet, a look of pain and love passes between them. "I have AIDS." Her mother takes her in her arms and they weep.

**5th Station:** "Simon Helps Jesus Carry His Cross."

Richard has so many decisions to make. How can he go on? When his brothers come, he tells them he is too scared to go on. They comfort him, arrange to take him home, plan transport so he can return for treatment.

**6th Station:** "Veronica Wipes the Face of Jesus."

She lies there, too weak to clean herself. Her clothes dirty and soiled because the diarrhea is almost constant now. She's alone. Pushed into a corridor so the smell won't disturb others. A young nurse comes, washes her and changes her clothes. Rose smiles.

**7th Station:** "Jesus Falls the Second Time."

He has begun to have diarrhea and no longer wants to eat. Sleep doesn't come and he's afraid. The illness is getting worse. Peter has to stop work. It's hard to keep living with AIDS.

**8th Station:** "Jesus Meets the Women of Jerusalem."

Jane has no land. Mary has no milk for her baby. Scovia's husband sent her away when he learned she has AIDS. Juliet was put out of her rented room. Betty works in a bar to support her children, providing favors for men to get food for them. The plight of poor women and AIDS. Jesus weeps.

**9th Station: "Jesus Falls the Third Time."**

His head feels as if it's bursting. Nothing brings relief. Peter lies in bed unable even to open his eyes. As the end nears, relatives arrive to move him from his rented room where he suffered alone for many months. One more step along the way.

**10th Station: "Jesus Is Stripped of His Garments."**

They put her out of the house and kept her clothes saying they wouldn't fit her wasted body. They told her to go to her grandmother's to die. Once there, she was again rejected -- stripped of all, even her right to belong. Juliet was returned to the hospital like an unwanted commodity.

**11th Station: "Jesus Is Nailed to the Cross."**

He cannot move. Finds it hard to breathe. Must wait for someone to care for him totally. An AIDS-related brain tumor has nailed James to his bed. His mother keeps watch.

**12th Station: "Jesus Dies on the Cross."**

Rose, Peter, John, Alecha, Kakande, Joseph, William, George, Grace, Paulo, Goretti...Jesus' body is dying of AIDS.

**13th Station: "Jesus Is Taken Down From the Cross."**

The wailing begins. The car reaches the homestead. As men rush forward to carry Paulo's shrouded body, a woman comes from the house. She reaches out to touch the body of her son.

**14th Station: "Jesus Is Placed in the Tomb."**

A grave is dug on hospital land -- only staff for mourners. Her nine-month-old child cries not understanding. The grave is filled. All go away. Rose is dead.

**15th Station: "The Resurrection."**

We wait! We are hopeful.

Adapted from Service by Sister Kay Lawlor, M.M.M., Kitovu Hospital, Masaka, Uganda

## REFLECTION QUESTIONS

1. Do you know anyone – yourself or someone else – who is experiencing HIV or AIDS? Do the articles in this pamphlet offer you any help, guidance, encouragement?
2. Does the existence of HIV/AIDS in our midst raise any theological questions for you, any challenges to your faith?
3. Some people say that HIV/AIDS is caused by sin and that suffering is God's punishment for sinners. What do you say about that?
4. For you, what is the biggest ethical or moral challenge to be faced in dealing with HIV/AIDS? How does your church, your community, help you answer this challenge?
5. What do you think is the best way to deal with the stigma and discrimination associated with HIV/AIDS? Do you have any stories of how this stigma and discrimination takes place and how it can be overcome?
6. Why do women suffer more from HIV/AIDS than men? What does that tell us about our African society, our Christian church, our personal attitudes and practices?
7. What do you think should be done to meet the growing problem of orphans in our society today?
8. Do our young people receive adequate education about sex in our churches, our schools and our traditional society? Do you know of any good programmes that should be used more widely?
9. Some people say that ARVs are the solution to the HIV/AIDS problem now and in the future. Do you agree or disagree with this opinion?
10. Should organised religion – churches, religious groups, clubs, leaders – plan a more active role in the fight against HIV/AIDS? What should be their role?
11. In your own opinion, why is there so much HIV/AIDS in Zambia today? What does that tell us about the kind of responses we should be emphasising to deal with the problem?
12. When you read a pamphlet like this, what is your primary response or reaction and what difference, if any, does it make in your own personal life?