PASTORAL COUNSELLING AND THEOLOGICAL REFLECTION IN A TIME OF AIDS
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Munro, Pearson, et al

Continuing the Mission of Jesus

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The Catholic Church, it seems to me, is an organisation that is willing to get involved in the messiness of life. This is certainly the case when one looks at the arena of the AIDS pandemic where we can readily see the Church's commitment to addressing a problem

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which has grown to such a magnitude that one could be forgiven for thinking that it may never go away. The Church and other so-called faith-based organizations[1] bring an enormous commitment to the fight against AIDS, yet very few resources in the grand scheme of things other than an army of people of faith who recognise their own personal call to try and make some difference. It is, I think, the faith commitment of people that defines their response to AIDS as somewhat and somehow different from the response of people who are employed to do a job in a non faith-based setting such as a government department or the private sector.

Since January 2000, the Catholic Church has attempted to co-ordinate its response to AIDS in South Africa, Swaziland and Botswana through the Southern African Catholic Bishops' Conference (SACBC) AIDS Office.[2] The AIDS Office Management Committee meets twice annually. Two Bishops, representatives of key Church agencies of the SACBC, and representatives of the Church's AIDS programmes in Botswana, Lesotho, Namibia and Swaziland set policy and oversee the programme. Four times annually the smaller allocations and supervisory committee makes decisions on allocations of funding to various SACBC projects, and deals with issues related to the response to AIDS of the Catholic Church in Southern Africa. It has been helpful to have an allocations committee, both to maintain transparency and to involve people from outside the SACBC structures.

The SACBC is recognised as a body which is doing something in the arena of AIDS.[3] This is a point to be noted in the public sphere where there are many opinions, not all of them positive and helpful, about the role of the Church in the fight against AIDS. As the co-ordinator of that programme, I recognise many gaps and shortcomings, many of them not easily wished away or remedied. And yet it seems to me that part of what we are about is taking leaps of faith and thinking on our feet. That said, however, it is also true that the overall picture has changed, and the Church is better positioned than just a few short years ago to plan its response and to act accordingly. The Church, like every organisation in Southern Africa, needs resources, skills and organizational development.

It is often said, with more than an element of truth, that at least part of the strength of the response of the Catholic Church, has to do with its very structure, including dioceses, parishes and sodalities.[4] What is decided at the level of headquarters can in fact be cascaded down to extremely remote areas. Nonetheless this obviously needs working on, and hence the critical role played by diocesan AIDS committees and co-ordinators, as well as by key personnel at the project level. In August 2004, the SACBC Plenary

[1] I have an aversion to the phrase "faith-based organization (FBO)" as a description of the Catholic Church, but for the purposes of discussion in the public arena, it is perhaps tolerable.
[2] The SACBC territory covers twenty-nine dioceses in Botswana, Swaziland and South Africa. The SACBC headquarters in Pretoria houses some of its departments, offices and associate bodies that oversee the Church's work at a regional level.
[3] Cf. Adri Vermeer and Hugo Tempelman, eds., *Health Care in Rural South Africa: An Innovative Approach*, Amsterdam: VU University Press, 2006, especially part III: "Southern African Catholic Bishops' Conference – AIDS Office (Pretoria)."
[4] Sodalities are groupings of people (e.g., the Women of St Anne, the Sacred Heart Men) who perform particular works of charity within a parish or a diocese.

Session of the Bishops adopted a resolution to strengthen the work on AIDS within dioceses by ensuring that committees and co-ordinators are in place at the diocesan level.

Some External Relationships

AIDS has catapulted the Church into arenas it may not otherwise have voluntarily chosen, and hence some strange bedfellows have emerged as collaborators. Donor funding brings its own dynamics with an array of people wanting to play their part and have their say. How does the Church maintain its identity and take its stand on certain issues about which it feels passionate (e.g., the option for the poor) and at the same time not get hooked into agendas it finds impossible to follow? Some of the most difficult negotiations I have had with funders highlight issues around global donor agendas and politics as opposed, e.g., to the social teachings of the Church. A difficult decision is sometimes whether or not to accept donor funding if it comes with unbearable conditions. In some ways it would seem to me that the Church responding to AIDS comes of age in an arena where it is dependent on external resources and, at the same time, confident of its own strengths and outreach to the very communities which often would otherwise fall through the cracks.

For example, the Treatment Action Campaign (TAC) has kept one of the SACBC staff as part of its national executive structures, though in a position somewhat scaled-down from that held by the SACBC previously when it had a dedicated advocacy officer. TAC and the AIDS Law Project worked on submissions to a parliamentary portfolio committee on the proposed new Health Charter in 2005, and continue to monitor the progress of the proposed amendments in the committee. These submissions have been endorsed by the SACBC, and more work is to be done in this area. The SACBC does not endorse everything that TAC calls for, yet by and large the relationship has been mutually beneficial.

Another example: For the past three years I have served on SANAC, the South African National AIDS Council, holding the portfolio of religious sector representative. A beleaguered organization if ever there was one. It was founded to advise government on AIDS, and its members are official representatives of various government departments and of civil society. Although its secretariat has been improved, it remains a rather toothless body, too tied until now to the Department of Health. It has not yet, five years into its existence, ratified its own terms of reference and mandate. It has acted as the Country Coordinating Mechanism (CCM) for proposals to the Global Fund, but has not been successful in advising government, in calling government and civil society to task around the implementation of the national strategic plan, or indeed in revising and updating the plan. Currently under the new deputy president of South Africa, there are moves to address these serious concerns, but it is too early yet to suggest whether there will be any meaningful change.

Relationships with various national bodies show a mixed bag, some of them very beneficial, others not so helpful. These bodies include faith-based organisations, different NGOs, and a number of government departments, at the national, provincial and local

levels. Clearly the Catholic Church does need to work with other players, but it is equally evident that we need to choose strategic alliances that move the agenda forward. This is as true at the national level as it is for projects within provinces or local government areas.

Pastoral and Theological Concerns

Theology and theological development have not kept pace with the progression of AIDS in sub-Saharan Africa. Too often the debate gets bogged down around the condom issue, and people get hooked into mindless and endless arguments about the Church's role in the spread of the disease because of its stance on condoms. Debates about the Church and condoms usually reach no constructive conclusion because, among other things, people confuse teaching on contraception with messages about preventing disease.

Gospel truths and the Catholic teachings may not be watered down, says the Church, if we are to hold sway in a world which does not like rules or being told what to do. On the other side, Church people often take too hard a stand which on occasion proves ill-informed about scientific facts, and which appears to close the door on meaningful discussion about the socio-economic and political context in which AIDS flourishes. This hard line appears to some people to protect the sanctity of marriage and the ideal of no sexual relations outside marriage at the expense of people involved in sexual relationships but not married for any number of different reasons, including abuse, prostitution, and casual relationships. Surely this debate points to another more serious situation, that of the reality of the world in which we live, where structural sin and systems need redressing – perhaps even more so than the personal choices which individuals make in the circumstances of their own lives. This is not to deny that social circumstances and personal options are clearly and often closely related.

There have been forceful demands for spiritual and pastoral support for caregivers and volunteers who often bear the brunt of the work. Many people in Church projects have availed themselves of opportunities for a pastoral or spiritual retreat for caregivers, a time-out to prevent burn-out. Many have benefited, some of whom perhaps would never have dreamed of a retreat. Key aspects of such retreats include the opportunity to be quiet, to be in a group where stories can safely be told, to have time for prayer and reflection, and to build relationships among caregivers. Sharing is happening across denominational boundaries, sometimes even on an interfaith level, and people are being supported and cared for. What happens on such occasions at grassroots levels does not so easily happen at other levels in the different Churches. I feel very strongly that AIDS occasions opportunities for building the local church, albeit across denominational boundaries, which we sometimes miss. My own experience of interfaith and ecumenical AIDS work reveals some of the real difficulties experienced at the leadership level where doctrinal and territorial positions often get in the way of real collaboration, and points as well to the meaningful collaboration that can occur at the grassroots level between ordinary people. Theological positions can sometimes become blurred, but relationships are built.

The Symposium of Episcopal Conferences of Africa and Madagascar (SECAM) statement in 2003 committed the Catholic bishops of the continent to a full range of programmes to fight AIDS: through education in theological institutions and parishes; in the area of prevention and care; in the raising of children orphaned by AIDS.[5] The SACBC's *A Message of Hope* of 2001 includes much that can be done within the pastoral arena.[6] Some unfortunate phrasing regarding condom use led to its being widely attacked in the media. This is regrettable since its positive contribution regarding the position on condom use by discordant couples went almost unnoticed.[7]

The pastoral plan of the SACBC reminds us that we are a *Community Serving Humanity*. All people are created in God's image and likeness. Everyone is worthy of human dignity and respect. The Gospel of Jesus challenges us to work for the common good, to be mediators of compassion and justice, to bring consolation and healing, to become a welcoming and sacramental community. Ours is a sacramental Church, and receive the sacraments we must. Those of reconciliation and the healing of the sick are particularly pertinent here. People are hungry for healing, but often afraid to make their needs known because of real and perceived stigma and discrimination.

Clearly the task of evangelisation is not on hold because of AIDS; on the contrary, the call is more urgent, especially when we remember that AIDS itself is not the problem but rather a symptom of many problems in our society. The social teachings of the Church provide a foundation for the response to AIDS. The Church's social teachings, called by one writer "the Church's best kept secret," are being increasingly recognized as underpinning the work of the Church in society, and supporting its mission to evangelize. The late John Paul II commissioned the recently published compendium of the Church's social teaching.[8]

Many more women than men are involved in care and support, not unexpectedly perhaps when one considers traditional gender roles in society. Of course men are also involved in the caring professions, though possibly less at the informal than at a professional level. There are Bishops and priests who become totally involved in supporting parishioners who do the work of home-based care and raising affected children, and who engage themselves actively in the pastoral care of those touched by AIDS. Some clergy struggle in this regard, perhaps because of issues related to AIDS in their own lives and in their families, perhaps also because of issues around stigma and discrimination, sexuality and death. Moreover their theological and philosophical training has often prepared them inadequately to deal with some of the unconventional issues that confront them. I would like to suggest that the heart of the challenge to clergy as ministers of the Gospel is in the very arena of pastoral and spiritual care to people infected and affected by AIDS. Across the country I encounter people clamouring for spiritual support from their priests and

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[5] Catholic Bishops of Africa and Madagascar, *Speak out on HIV & AIDS*, revised edition, Nairobi: Paulines Publications Africa, 2006, pp. 108-113. Among some eighty pastoral statements on AIDS in this collection, SECAM's of 2003 is one of the few not to highlight the condom issue.
[6] *Speak out*, pp. 82-84.
[7] This applies to discordant couples (one spouse being HIV+, the other negative) and also to infected couples (both spouses being HIV+).
[8] *Compendium of the Social Doctrine of the Church*, Nairobi, Paulines Publications Africa, 2004.

pastors, not knowing always how to ask for such support, especially in a climate of real and perceived stigma and discrimination. Much is to be done if we are truly to claim that we bring the compassion of Jesus to those whom we serve.

In 2004, the All Africa Conference Sister to Sister (AACSS), facilitated in part by the SACBC, brought together over eighty religious sisters from several African countries. The sisters dared to look at how AIDS is affecting communities of celibate religious women. Some sisters told stories of the love and compassion they were able to bring to those among them living with AIDS. Others told sad stories of stigma and fear in communities, and of some sister's lonely death. Committed to their ministry within their congregations, often to AIDS ministry, sisters are torn apart by the experiences of their own families suffering the effects of AIDS. The AACSS continues to meet regionally and locally, and supports its members facing the reality of AIDS in their own ranks, in their families, and in the wider community.[9] Clergy have also died of AIDS-related causes, but the silence that prevails in society too often prevails among their confreres and in their parishes as well.

Religious congregations are disproportionately involved in the response to AIDS, perhaps not surprisingly since it has always been their charism to respond to the needs around them. Were one to subtract religious women in South Africa and elsewhere across the continent from the equation, the response to AIDS in the Catholic Church would look very different. The religious are often wonderfully supported by a cadre of volunteers, many of them HIV+ themselves. One such group of volunteers are retired Catholic nurses, a formidable group in their own right, who have seen the need to roll up their sleeves again and get down to work.

Ethics, and some other questions

Twenty-five years into the pandemic, we are more sober in our thinking and more realistic about the challenges facing society on every front than was the case in the past. Some questions do not go away:

- How does the Church view the notion of sustainable development and carry it forward – as opposed to the more familiar welfare model?
- How do we decide who may receive treatment, 'a slice of the pie,' when there are insufficient resources to go around?
- Under what conditions is it acceptable to accept donor funding? When not, and why not?
- How does the Church view working relationships with government departments, NGOs and faith-based organisations with whom we have traditionally had few or no dealings?

[9] Visit www.allafrica-sistertosister.org A plan is being mooted to organise something similar for clergy and religious men affected by AIDS.

- Can people who are not really employed in Church projects or anywhere else be enlisted as unpaid volunteers in the fight against AIDS? Is it ethical to engage their services?
- Is ecumenical and interfaith dialogue fostered by grass-root collaboration around AIDS? Does such dialogue further or hinder the global AIDS agenda, or the Church's?
- Do poor workplace AIDS policies, or the complete lack of them, provide a breeding ground for stigma and discrimination even in Church organisations?
- Why is theology not keeping pace with the explosive pandemic? How relevant is theology in a world of AIDS?[10]
- What should the Church be saying about the use of condoms, rather than what it seems to be saying right now, bearing in mind that there is no monolithic position held by Catholics, with merely a few dissenting voices? The situation is more complex than many suppose, the opinions quite varied.

The list could be extended….

The media in my experience have helped shape the ethical debate, not very usefully from the viewpoint of the Catholic Church. Every time Bishops make a statement related to AIDS, journalists want to engage us around condoms. Except, of course, they have a position and want the Church to fit into it. I have found some journalists unbelievably manipulative. The Church teaches the sanctity of sex within the commitment of marriage. Our Christian responsibility includes education, it seems to me, regarding the correct facts concerning condoms. Only with an informed conscience about what the Church teaches and about what is scientifically known about the prevention of HIV infection, are people able to make mature and responsible choices, and if necessary to make changes in their life-style. One theme that has come to the fore in this debate is the importance of conscience in Catholic theology.

The ethical debate needs to be developed beyond issues of personal morality and how one deals with sexuality, to include a better understanding of how one's personal choices are shaped by circumstances and contexts, and by global issues. A case in point is that of wide access to ARV therapy, something valuable and desirable in itself, and yet fraught with problems if people cannot make informed choices and take responsibility for their treatment. Those who have problems with alcohol, or who prefer to receive social disability grants (which help to support more people than just the individual) rather than treatment, have had to be turned away by Church programmes. Some who were receiving disability grants have found themselves cut off, once they started getting better, and subsequently defaulted on treatment in order to have grants reinstated.

When the SACBC first embarked on treatment in 2004, we expected a focus on ethical issues such as deciding who would qualify for the limited number of drugs available, how to target women rather than men, how to handle concerns in counselling around possible

[10] But see Stuart C. Bate, O.M.I., *Responsibility in a Time of AIDS: A Pastoral Response by Catholic Theologians and AIDS Activists in Southern Africa*, Pietermaritzburg: Cluster Publications, 2003.

foetal abnormalities resulting from ARV treatment in pregnant women. Pregnant women do indeed need special consideration, and particular drugs if they go on treatment. About two-thirds of the people on treatment in Church programmes are in fact women. They have not been specially targeted, but some of them have been identified in ante-natal programmes for the prevention of mother to child transmission (PMTCT).

One concern that caused me sleepless nights before we embarked on the SACBC programme was how the Church would share responsibility for drug resistance in South Africa if we did not get our counselling right from day one. Everybody going on treatment needs to understand that they can continue to transmit HIV or be re-infected by someone else. Treatment literacy and/or adherence counselling is vital in preparing people to receive treatment if they are to be helped not to default.

The Church supports research to discover a vaccine against AIDS and a cure for it. One of the people on the vaccine trial being conducted in KwaZulu Natal and at Chris Hani Baragwanath Hospital is a Catholic priest.

Prevention

Preventing infection is the ultimate key to turning around and halting the HIV pandemic in the face of, as yet, no vaccine and no cure, and anti-retroviral drugs that prolong life but do not provide a cure. Work in the arena of prevention is the weak point of any AIDS programme – and the Church's work is no exception. Stories of success in Uganda and elsewhere are often misleading and ill-informed. My experience of the Uganda story is that facts related to it are used selectively to illustrate a point that needs to be proven, e.g., that the rate of infection came down because condoms were used or were not needed. Worldwide the number of infected people continues to rise. Even without doing any serious research, one has only to look at the AIDS Barometer in the *Mail and Guardian* every week to note this disturbing fact. And this in spite of all the education programmes and awareness campaigns, to say nothing of the distribution of millions of condoms. If nothing else, AIDS has shown us that we actually know very little of how people behave sexually with one another and, despite knowledge and information of the potential dangers, why they take the kinds of risks they take. In addition, we are witnessing extremely high rates of rape and sexual abuse throughout Africa, of children as well as of adults. We do know that many people are infected unwittingly and in circumstances of forced sex, but not all people are ignorant.

Education for Life, an abstinence-based prevention programme especially for young people, originally developed in Uganda, has been adapted and scaled up across the SACBC territory; the AIDS Office supports EFL workshops in various dioceses. A criticism sometimes levelled at this programme is that it is abstinence-based, considered unrealistic by some. Young people are assisted with the skills they need to handle the often difficult situations in which they find themselves, and to make choices that are life-giving rather than harmful to themselves and others. A number of dioceses have trained facilitators, and many young people have been reached. Talking about sexuality remains a problematic area. It is a taboo in many cultures, and not easily handled. On top of that

many people, perhaps especially young people, claim that they are bored by and weary of AIDS messages. School children today are in general better informed than were their counterparts just a few years ago. They can quite easily educate their parents about matters that could often have adults shying away in embarrassment. Knowledge needs to be applied, and people need to make choices regarding their behaviour. Sometimes they do not make those choices because "it can't happen to me".

ACTS (the Association of Catholic Tertiary Students) has done an enormous amount of work in educating its membership in Catholic teaching and in life skills in general. It has promoted the ABCD campaign – "Abstinence, Be faithful, be Careful, or you are in Danger" -- stressing abstinence, fidelity and choice as means of avoiding danger and death. One of its strengths is that it is seen to be youth-driven, sometimes with great zeal. When I once facilitated a discussion in a mixed parish group, I was struck by the enthusiasm of a particular student advocating the ABCD campaign and being somewhat intolerant of what I would have considered a more pastoral approach to people in difficult daily circumstances. On the other hand, an informal study by the SACBC national youth chaplain, documented only for internal use, gives rise to serious concerns. Alarming behaviours around exposure to HIV infection continue to occur among leaders of Catholic tertiary students who have undergone various kinds of training, and who have committed themselves to abstinence before marriage. Many admit to having had several different partners, and to failing to ensure that they are not at risk of infection. How, we may ask, is the Church's teaching being heard by some young people who see themselves as committed members? What are informed young people doing to protect themselves from possible infection?

I am sometimes amazed, in workshops and among different groups, how people latch on to mosquito bites or scratches on their arms or legs, and wonder whether they can be infected. I suppose it is a form of denial, a red herring that stops everyone from looking at the real issues at hand.

Care and Support

The backbone of the response of the Catholic Church to AIDS is undoubtedly care of the sick and the dying, and increasingly the care of children affected by AIDS. Precedents are to be found in our Judaeo-Christian heritage and throughout the history of the Church. I estimate that two-thirds of the work done in Catholic projects throughout our SACBC territory, and probably beyond it as well, has to do with care. People are cared for in their own homes, in hospices and step-down facilities, and in day-care centres. From hospitals, clinics and hospices, and sometimes from simple buildings in informal settlements[11] or diocesan offices, the work of home-based caregivers is planned and monitored. Ordinary people with no specialised nursing training come forward or are recruited for training, and over time become the key personnel in these programmes. Some of them in certain provinces receive a stipend from the government; some are poached by the government

[11] Migrating from rural to urban areas across South Africa in search of employment, people squat in shack dwellings because of the lack of proper housing.

or other programmes once they are trained; many others volunteer their services, receiving very little by way of remuneration.

A colleague has embarked on PhD studies to examine why the home-based care programmes of the Church are as successful as they are, compared with programmes run by a particular province which are not working well. The study could touch on:

- The faith commitment and dedication of religious sisters, retired nurses and others who head Church programmes or work in them.
- The fact that remuneration is not necessarily the key factor.
- How people in Church projects see themselves as doing the work of the Church, or as helping the Church to do its work.
- The fact that caregivers often belong to the local community they serve.
- How bishops and clergy support the ministry of care in the local dioceses and parishes.
- The fact that Church sodalities or the Catholic Women's League support the caring ministry undertaken by their members.

It is a well-known fact that many programmes working with children affected by AIDS originated in home-based care programmes. Over the years the SACBC has seen an increase in the numbers of projects responding to the needs of orphans and vulnerable children (OVC). It is hoped that additional funding will ensure continued scaling up over the coming years, in terms of numbers of children to be reached as well as in support services offered to them. These services currently include assistance with accessing social grants, assistance in foster care programmes, training in psycho-social support to children, assistance with food parcels, support allowing children to stay in school, support for children in child-headed households, and so on. Projects continually need to be assisted with tapping into the various sources of assistance potentially available to OVC and their care givers. A number of local faith-based organisations and the diocesan and parish projects within the SACBC network have increasingly been able to access the social grants that are available for OVC from the Department of Social Development. There has been a decided improvement in this regard and, while children continue to fall through the cracks in the region as a whole, it is also true to say that many more children are being helped. A number of Church projects are working directly with the Department of Home Affairs to make birth certificates and identity documents available; these are necessary before applications can be made for social grants. Some projects put the priority on foster care, and children are accompanied through the necessary court system. In one project, a religious sister from Argentina, overcoming all sorts of cultural and language barriers, is at the forefront in her diocese regarding the placement of children in foster care.

Some projects need relatively minimal support from the SACBC because they have various systems in place, sound management practices and committed staff. Sometimes what is needed is encouragement, a pointing in the direction of various resources that will complement what is already happening, a request to them in turn to assist newer initiatives, e.g., with opportunities for training or for learning horizontally from more

experienced organisations. While the SACBC AIDS Office has always supported the projects that make up its network, it is clear that ongoing accompaniment, the facilitation of various kinds of training, and assistance with problem-solving of one kind or another are continually in demand. What is also true is that SACBC project managers themselves are better able than perhaps was the case in the past to take lessons learned in one setting into another, and to point people to the resources and training they need. People often feel less isolated than previously.

The prevention, care and support programme is now in its seventh year, but in some aspects it can be said just to have begun. Among the reasons for this:

- New projects continually become part of the SACBC network as dioceses scale up their responses.
- Staff and volunteers change. On occasion, changes around project co-ordination have been problematic, e.g., when a project founder moves on, leaving an unprepared or ill-equipped successor.
- In prevention programmes in particular, there is a sense of always being at the beginning with new groups of young people coming onto the scene.
- Bigger programmes have expanded to include new forms of outreach.
- Some projects have changed focus to accommodate key aspects of the challenge in their geographic area, e.g., moving from a feeding scheme into a programme of psycho-social support for children.
- Church leadership wishes to replicate something working in one area of a diocese somewhere else where perhaps nothing has been done, or where there has been no adequate response from the Church or from anyone else.
- Training and building-up capacity are a never-completed task; training needs have to be met over and over again as new arrivals replace trained people who leave. De-briefing of caregivers is constantly needed.

The Church programme faces a number of challenges. In home-based care projects, there are concerns about the availability of funding; they have been encouraged to look for sources of funding other than the SACBC and especially to knock on the doors of their local and provincial governments. The workloads of the caregivers have increased, yet they are not always properly supervised or monitored, and patient care is sometimes compromised. From small-scale home-based care to antiretroviral treatment is quite a leap: projects have been forced to become professional, accountable and transparent. Sharing of skills and resources between projects and accessing resources and qualified staff demands energy. Some projects are working in isolation, lacking ecumenical collaboration and networking.

Treatment

The SACBC AIDS Office entered a new phase of its own operations with the introduction of treatment at selected sites in early 2004. These sites had clearly scaled up their response, and have been challenged to operate in a more professional and accountable manner than was seen in the past. Other sites, not designated for treatment

for various reasons including budget constraints, capacity problems, access to other ARV sites, or poor infrastructure, have been targeted for treatment literacy training. In effect, some of these projects are better positioned to assist people to access treatment where it is now available at certain clinics and government hospitals. Treatment is an area in which the SACBC can claim a proud record – even though it must also be said that the price paid has been high. All the difficulties experienced by the country as a whole in getting a treatment programme off the ground have been experienced in the Church. Plus some extra, given that very few of our sites are clinics or operate as a hospital.

Funding opportunities opened up which have allowed the SACBC to build on its own track record. The ARV programme in particular has called for a "thinking on our feet" approach because of the sheer logistics of getting such a big programme[12] off the ground and the enormous number of difficulties associated with it, most of which could not have been anticipated ahead of time. Very promising right now are signs that some provinces are ready to begin taking on the referrals of people on treatment. This will mean in effect that the Church has assisted with the initiation of treatment for certain people who for a number of reasons were unable to access it in other settings.

Swaziland and Botswana have interesting aspects to their treatment programmes supported through the SACBC. In Swaziland the government has received Global AIDS Fund money for treatment, and this money pays for all drugs. The extra support provided through the SACBC allows additional people to be treated, especially in remote rural areas. Doctors and nurses go to the patients, rather than expecting them to reach the hospital which in their condition is often impossible. Drugs in our Francistown (Botswana) project are provided to foreigners who do not qualify to receive treatment through the Botswana government. Some of the patients in this area are from Zimbabwe or South Africa. In this diocese there is a good working relationship with the United Nations High Commission for Refugees (UNHCR). In a project in Kwazulu-Natal, a number of SACBC patients have been transferred to another programme. Others are now part of a public clinic rollout, having first been stabilised at an SACBC site. In three other SACBC projects, the South African government is providing the drugs and laboratory tests, while the Church continues to accompany and support the patients. This model is one we hope to see replicated.

In 2006, the second ARV conference brought about 80 people together from the different ARV projects. They received clinical and medical updates around treatment, and shared their own experiences of running a project. There were workshops on keeping statistics and records, and aspects of monitoring and evaluation, all of which are necessary in accounting for the use of PEPFAR (President's Emergency Plan for AIDS Relief) money from the USA. In 2004, two researchers from the University of Utrecht began a longitudinal study looking at the psycho-social effects of treatment on children receiving ARVs. The study is being monitored by the Universities of Utrecht and Pretoria, and conducted in various sites that form part of the SACBC network.

[12] By mid-2006, there were more than 8,000 people on treatment in SACBC programmes in South Africa. In addition there are patients on treatment in Botswana and Swaziland, also supported through the SACBC.

Some of my favourite stories focus on the fact that people are given another chance in life because someone cares:

- Little Bongani at school for the first time ever as ARV therapy is allowing his immune system to be re-constituted.
- The first patient to receive ARV treatment at a particular site is now one of the best adherence counsellors.
- One of my colleagues attributes his recovery only in part to ARV therapy. He is convinced that the love and support given him by Bishops of the SACBC and others speeded up his return to health when he believed he was at death's door.

Despite the successes, my question is whether the Church should remain in a treatment programme in the long run. My inclination is "No", even though the work of doing treatment literacy and accompanying people may well remain a core function of Church projects. My reasons for this emanate from my experience over four years. The sheer cost of keeping people on treatment is beyond any Church programme unless it is financially supported from outside. In our reality, where most of our treatment sites are attached to home-based care projects, there is insufficient medical back-up for the treatment of various opportunistic infections and other complications. So while the Church has helped to get Southern Africa's treatment programmes off the ground, in the final analysis the Church cannot take on what is in fact the responsibility of the state and the private sector.

Some conclusions

I believe we are seeing AIDS work increasingly *mainstreamed* into the daily life of the Church rather than being an added extra. This is of course not true everywhere, and definitely not in places where AIDS does not 'appear' to be a problem. Some people, in the Church as well as in larger society, continue to deny that AIDS affects them in any way. But with commitment and passion, diocesan and parish projects with few resources provide a vision and hope for people living with HIV in rural and urban communities. Quality of care is seen as key.

Religious communities, especially those of women, are in the vanguard of the Church's response to AIDS. Much more commitment and leadership is needed from other Church structures. AIDS commissions are working within existing structures, through diocesan pastoral councils and deaneries. Many parishes are becoming involved in AIDS ministry. Programmes are adapted and localised according to the needs of the diocese/parish.

Catholic health programmes have generally been independent of local government and various civil society organizations, but now are learning to cooperate and partner with them. Catholic schools implement the life skills policy of the National Department of Education, with additional components related to the Church's teaching. Diocesan AIDS co-ordinators have conducted meetings with youth chaplains to discuss and plan youth prevention programmes.

It is clearly irresponsible, in my view, for anyone to suggest that the Catholic Church is responsible for killing people because of its perceived monolithic stance on the use of condoms. The message nonetheless is clear: what individual Church leaders say, even more so than ordinary Catholics, needs to be factually correct (and this applies to an understanding of the teachings of Catholic moral theology as well as to scientific or medical findings) and not emotionally laden or proclaimed from 'the moral high ground'.

Stigma and discrimination continue to exist, but in many areas are being eroded. In some instances this can be considered a benefit of having people on treatment.

In much the same way that we can view the socio-economic circumstances of the country through an AIDS lens, so too can we view what is happening in the Church from this point of view. I believe that the Church and its theology are challenged to look at patriarchy and issues around gender relations, catechesis, engagement of men in the response to AIDS, the Church's credibility in matching word and action, theological reflection, and an understanding of informed conscience, to name but a few areas for ongoing reflection and study.

HIV/AIDS and Catholic Social Thought

Fr Peter-John Pearson
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The great corpus of social thought in the modern Catholic tradition can easily be seen as a prophetic response to the heinous myth that some people, and the group differs in every age, are dispensable and insignificant and unworthy of even basic respect.

For Leo XIII and Benedict XV it was the exploited workers of Europe, for Pius XII it was the haunting conflicts of the continent that he loved, for John XXIII and Paul VI it was the peoples of the developing world under the yoke of colonialism, exploited and oppressed, marginalised in every way; it was the spectre of the cold war and the arms race and elusiveness of world peace. For John Paul II it was poverty, the environment and the lack of respect for life especially the lives of the unborn, the aged and the terminally ill, gender issues and violence..…….and the litany is virtually endless. But the point to bear in mind is that always, very consistently, the social teachings were there as beacons of hope for those bowed down under the harrow of injustice, as reminders that those areas of structural sin could and should be resisted and reversed and that justice, freedom and participation are the core values of our life together, that the respect for and enhancement of human dignity is absolutely non negotiable and that needless suffering is not a part of

[13] Paper presented at Pastoral Counselling and Theological Reflection in a Time of AIDS conferences, Pretoria and Durban, May 2007

God's plan for society. In recent years this teaching has manifested itself also as a fundamental option for the poor and for those who suffer.

From John XXIII on, all the popes were insistent that we allow the signs of the times to shape and hallow our ministries, those memorable words 'that to serve the world as Christ did, the Church has always the duty to scrutinise the signs of the times and to interpret them in the light of the Gospel'[14] are still imperative and inspiring.

In our times the overarching signs of the time are indeed the scourge of poverty, the rampant pandemic of HIV/AIDS, the extreme vulnerability of women and children in situations of domestic violence and the scandalous disregard for human life. Into these situations which describe the lives of millions, as before, so now even more urgently must the Church witness to the possibility of thinking differently, of pondering/reflecting and strategising out of the box, about these key signs of our times, of developing a moral imagination which can re-describe our world and transform our environments so that a human flourishing can take place.

The following statistics bears out this prioritising of HIV/AIDS as a primary sign of the time.

Almost one third of South Africans (30%) now cite AIDS as one of the three most important problems facing the country that the government ought to address, virtually the same 31% who cite issues of crime and security. Only job creation and unemployment out distance these two issues, selected by 77%. Public focus on AIDS as a public problem has increased substantially over the past few years, moving from less than 1% in 1999 to 13% in 2000 to 26% in 2002 and 30% in 2004/5.[15]

This is also doubly interesting when one considers the following:
'If there is anything positive to take from these figures, it might be that the popular constituency calling for increased levels of government commitment of resources to fighting HIV/AIDS is growing. Since 2002 there has been a sharp jump in the proportions of South Africans willing to divert government resources from other key development areas, like housing and education, to fight HIV/AIDS. 56% of all South Africans now support this position, compared to 40% in 2002.[16]

The scale of the epidemic is even more graphic when we consider the following:

- An estimated 930,000-1.1 million adults and children died of AIDS related illnesses in Southern Africa in 2005, 1/3 of all AIDS related deaths globally.
- SA's AIDS epidemic-one of the most intense in the world- shows no evidence of decline, statistics suggest an estimated 5.5m people were living with HIV/AIDS

[14] Flannery, A. The Documents of Vatican II. Gaudium et Spes. #4.
[15] AfroBarometer. 'Briefing Paper: Aids & Public Opinion in SA.' 10th March, 2005.
[16] *ibid*. p.4.

> in 2005. An estimated 18.8% of adults (15-49 years) were living with AIDS in 2005.[17]

These two statistics are so devastating in their impact that they obviously call for drastic action; it challenges us to raise the theological category of resistance as the appropriate response to this untold suffering.

> 'For many theologians, resistance is the appropriate response to suffering. Schillebeeckx names such resistance to suffering as 'negative contrast experiences,' experiences of negativity on both a personal and social level which cause human beings to be critical of human suffering and to act against that suffering, in anticipation of a better future. Metz also advocates a resistance to suffering and describes this resistance theologically. Using a phase from Peter Rottlander he writes that the sole content of Christianity's universal responsibility is 'that there is no suffering in the world that does not concern us.'[18]

We must 'acknowledge, resist and remove suffering' is clearly the core of Metz's teaching and is also the emergent values in the ongoing reflections on the HIV/AIDS pandemic. It is also congruent with the prophetic values of the social teachings of the Church in its engagement with sites of suffering.

HIV/AIDS then, is not only a category of real physical suffering but with that is the truth of the pandemic being exacerbated by the suffering also in the socio economic domain. In the Catholic social tradition, resistance is also the trigger for resurrection, for the release of new life and the fulfilling of hope. Thus to foreground this social category of resistance is indeed to bring to the HIV/AIDS debate a measure of hope and positivity which is not necessarily present in other discourses. Daniel Louw says, in this regard:

> 'In this regard one can view the resurrection of Christ as the final critique of God on death, suffering and stigmatising. Resurrection hope is about the death of death, about the fact that every form of rejection, stigmatisation and isolation has been finally deleted by God. People suffering from HIV virus should therefore be empowered to start to live life despite the reality of the virus. The pastoral question then is how to live your positive status in terms of realistic hope.'[19]

So once again in this pandemic, this crises of unbelievable proportion the social teachings of the Church is able to leverage hope in a dark situation and offer a positive reading of the human condition in the midst of untold suffering.

Catholic social thought is also instructive in terms of its dynamic/its methodology, a dynamic which calls for an expanding of one's vision of history and society.

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[17] A Faith-Based Response to HIV/Aids in Southern Africa: The Choose to Care Initiative. UNAids October 2006. p.7.
[18] Cimperman, M. 'When God's People have HIV/AIDS.' Orbis Publications. New York. 2005. p.20.
[19] Louw, D. 'The HIV Pandemic from the perspective of *Theologia Resurrectionis*.' Journal of Theology for Southern Africa. v. 126. November 2000. p.104.

What does expanding one's vision of history require of us, or put differently how in social teachings talk do we journey to the place of solidarity with those who suffer and at the same time resist suffering?
Three responses are historically part of that journey.

- The first requirement is a stance of openness as we become aware of the historical and social realities that render people vulnerable to injustice, suffering, exploitation and in this case HIV/AIDS.
- The second requirement is to name our locus for structural transformation. Here we are seeing with our eyes open, allowing this reality to permeate and critically and creatively engage our faith.
- The third requirement is active engagement in the process of transformation.[20]

Lisa Sowle Cahill in her contribution to James Keenan's book brings the historical and social realities of the pandemic and its structural agents of transmission into conversation with the resources of Catholic social thought. She focuses on the common good as an avenue for dynamic engagement with local and global signs of the times. Cahill acknowledges that the individual behaviours upon which HIV infection depends, particularly sexual contact and IV drug use, must be addressed. However she believes that more attention must be focussed on the social conditions that influence behaviours as well as the social circumstances which can promote change in behaviour patterns. She writes poignantly about 'survival strategies' which people living in poverty are often forced to adopt, which expose them to health risks such as HIV/AIDS. In addition to gender and economic issues she also discusses the justice lacking in the 'interlocking local and global economic systems that disrupt traditional societies, displace economic and educational infrastructures and cut off access to the kind of prevention and treatment of diseases whose efficacy in Europe and USA is well established.[21]

The social teachings of the Church has always had as its focus the structures of society that hinder people from living a fully human life.

Cahill's remarks are similar to R.G. Parker secretary general of the Brazilian Interdisciplinary AIDS Association, who said:

> 'To more fully comprehend the consequences of HIV/Aids infection, of the sexual stigma and discrimination so often faced by gay men and sex workers, of the gender power relations and gender oppression so often faced by women or the social and economic marginalisation faced by the poor.'[22]

It is clear that poverty, unjust economic systems, unemployment and a host of unfair social arrangements exacerbate the pandemic enormously especially because survival strategies are often predicated on sexual favours; but poverty also renders it impossible

[20] ibid. p.28.
[21] Keenan, J. (ed.) 'Catholic Ethicists on HIV/AIDA Prevention.' Continuum Publications. New York. 2000. pp. 76-84
[22] *ibid.* p.12.

for those living with the virus to take advantage of the exorbitantly priced drugs and thus are deprived of treatment in a time when HIV/AIDS is increasingly treatable. This is clearly an injustice of monumental proportions and contrary to the key principle of the social teachings of the Church, namely, the fundamental option for the poor.

This principle is indeed 'a many and splendoured thing.' Its core lies in the primacy/ privilege it accords the poor in making certain that the poor have access to the resources that lead to 'human flourishing.' This directs things as basic as choices for public expenditure for example in the realm of treatment. But it has also become associated with the poor challenging injustices, it is about 'the victimised people themselves being allowed and empowered to speak out and act on their own behalf. It is the only way they can overcome the sense of helplessness and dependency that is a fundamental part of their situation.'[23]

Edwin Cameron sees this dynamic present in the formation and then the challenges mounted by TAC.[24] He recognises the dynamic in the stories of making anti retrovirals more available to the poor, in claiming space for generic brands of medicines and in contesting the law of patents; all of which gradually opened the space for access for the poor. He sees it also in the courageous stories of ordinary people who took on pharmaceutical companies. He remembers and celebrates the courage of Hazel Tau, Christopher Moroka and Nontsikelelo Zwedala in their litigation against the giants of the industry such as GlaxoSmithKline and Boehringer Ingelheim.[25]

Church support and pastoral accompaniment for these initiatives and indeed for the litigants are clearly expressions of the fundamental option for the poor and creative ways of extending this accompaniment should be encouraged.

Alison Munro points to the initiatives in Southern Africa, around care and support for the most vulnerable, especially children and orphans as examples of the application of this principle as indeed are the sterling efforts at advocacy around social grants for vulnerable children.[26]

To try to reverse the pandemic without also resisting and reversing the appalling landscape of social inequality and poverty is an exercise in denialism and futility. This synergy is captured powerfully in the Millennium Development Goals which arose out of the Millennium Summit in 2000.

The summit declared a commitment to stop and begin to reverse the spread of HIV/AIDS by 2015 but it further linked inextricably to the other fundamental goals of 'halving poverty, ensuring primary school education for all, promoting gender equality and

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[23] Dorr, D. 'Poor: Preferential Option.' in Dwyer, J. 'The New Dictionary of Catholic Social Thought.' The Liturgical Press. 1994. p.755.
[24] Treatment Action Campaign, the best known advocacy body in South Africa around AIDS-related issues.
[25] Cameron, E. 'Witness to AIDS.' Tafelberg Publishers. 2005. pp. 157-184.
[26] Munro, A. 'Catholic Social Teaching Guides the Church's Response to AIDS.' Pretoria. October 2006. p.1.

empowering women and reducing child mortality while improving maternal health. The 2001 Declaration is a response to unequal socioeconomic development opportunities, economic deprivation and gender inequality in many parts of the world. It concludes that (in this age of AIDS) 'many of the worlds more marginalised countries also need long term international solidarity, co operation and financial support. More equitable investment and trade flows can help ensure that global economic progress also profits the world's poor.[27]

In the discussion around HIV/AIDS, the dynamic of the social teachings of the Church would hold out that AIDS does indeed have environmental triggers, that poor healthcare, poverty, malnutrition and adverse living conditions hasten and prolong the onset of all diseases including AIDS and that most of Africa's pathologies are rooted in poverty. A social teachings approach would conclude that broad, social, political and communal responses to the causes and management of all Africa's pathologies is the correct way forward together with medicine and science, in partnership, in new synergies.

Closely linked to this key principle are the principles of the common good and justice which we are also challenged to apply to the world of HIV/AIDS. About 6million people in the developing world live with HIV/AIDS and need access to treatment now. Of these less than 8% (1/2 million) currently have access to medication. Within the developing world this varies from as high as 84% across Latin America to little more than 2% across Africa. Since more than two thirds of those living with HIV/AIDS live in Africa this means that more than six million poor people are dying of AIDS unnecessarily given that the medicine that can manage the disease is available.[28]
The possibility of managing the disease is virtually nil for many of those six million purely on the grounds of accessibility, sustainability and affordability. For us believers though it is useful to keep in mind Lisa Sowle Cahill's earlier reminder.

> 'The common good is inherently connected to another key tenet of the Catholic tradition-justice-which is the association of persons in community according to relationships and structures that serve the common good of all. The principle asserts that every member of society has a right of participation in the common good, claiming rights and fulfilling duties; the ultimate purpose of the common good is to enhance the well being of every single member of society as well as society as a whole. The common good includes both the material and the social aspects of human flourishing.'[29]

Pope Benedict XVI has two important insights into the virtue of justice in the public domain.

> 'In applying its social doctrine the Church does not seek to make this teaching prevail in political life. Rather the Church wishes to help form consciences in

[27] UNAIDS. 'Report on the Global HIV/Aids Epidemic.' New York. 2002. p.61.
[28] Cameron, supra. P.174.
[29] Quoted in Cimperman supra p.32.

> political life and to stimulate greater insights into the authentic requirements of justice and a readiness to act accordingly…..'
>
> 'The Church must not seek to replace the state, yet at the same time she cannot and must not remain on the sidelines in the fight for justice.'[30]

To set store by the virtue of justice is also a way of taking sides in competing claims. Writing in the spirit of the social teachings of the Church, Karen Lebacqz says that justice has to do with fulfilling the demands of relationships.' Jeffrey Weeks says that justice demands not only the avoidance of unnecessary pain, but fostering care and responsibility for the other.'[31]

Catholic social thought has increasingly used need as a basic criterion for justice. In the light of these insights, justice is a critical criterion for determining the appropriate place for Christians to take their stand on difficult questions such as the arguments around government spending on HIV/AIDS.

Edwin Cameron points to the debates and political battles around the widening of access to treatment in resource poor areas. Strong voices have suggested that life saving anti retrovirals and treatment on a mass scale was not feasible. There are suggestions that a strong argument could be made for short courses to prevent mother to child transmission but anything more than that would end up increasing the budget by R15b. Calls instead have been made to improve hospice care (and death) rather than treatment and recovery. The prevention rather than treatment campaign has found a steady following. Another argument has been that this large expenditure on treatment would threaten to undermine the country's sound economic fundamentals. Others have raised the triage approach.

He writes that a 'further truth is that the scepticism espoused sometimes seems to be compounded by the unexpressed reluctance some of its proponents feel in endorsing treatment options for those who have AIDS. The unspoken assumption is that their plight is their own fault and that they therefore do not deserve treatment.'[32]

All of these expediencies are for one reason or the other tempting and often exonerate us from engagement and from committing ourselves to the long haul that is the terrain of the social teachings. It is expedient and ideological to take a view, and at other times not to: but the imperatives force us to take prophetic stances in keeping with our traditions.

Using some of the insights of the category of justice, in the face of these deeply fiscal arguments, Paul Farmer explains how we use cost effectiveness as a rationale to cut back health benefits to the poor. 'Yet the poor are more likely to be sick than the non poor. In this way we miss our chance to heal. In this setting we are told of scarce resources, we

[30] Benedict XVI. Deus Caritas Est. #28a.
[31] Quoted in Cimperman supra p. 53
[32] Cameron supra p.196.

imperil the health safety net. In the name of expedience we miss our chance to be humane and compassionate.'[33]

The 'law of graduality' considers justice a growth process. Actions can evolve from just preventing wrong to doing good for the good of all. Cimperman quotes Burgraeves as holding that the minimum for sexual ethics is the no harm principle. For a sex worker justice minimally requires clients to use condoms so as to prevent HIV and to protect her as she earns money to provide for herself and her family. Justice on a larger scale seeks out alternative sources of income for women so that their human dignity need not be compromised by the sale of their bodies. [34]

Cimperman considers this and in talking about the virtues in a time HIV/AIDS, points to four markers with regard to justice that help to ground our thinking practically.

- A critical knowledge of global structures and issues. For example large chunks of the debates in this sector have been around profits and patents in the great pharmaceutical companies.
- Attentiveness to the needs of the person on the margins, we have heard so often of the need for listening, for accompaniment, for reflection and for support.
- Interior discipline and the business of caring for ourselves.
- Active creative engagement.[35]

In the final analysis justice must open up and deepen our own opportunities to be humane and compassionate. I am often struck by the frequency with which we use the word 'remember', especially at the Eucharist. It is the opposite not only of forgetfulness, but also of dismember, to pull apart, to destroy. To remember is to put back together again, to make things whole. The quest for justice accentuates this challenge.

In our times and on our continent both understandings of remembering need to be actualised, yes to put together in ways that serve the cause of justice, but also not to forget, because the experiences of people are meaningful. It is little wonder then that Edwin Cameron uses the quote from Primo Levi.

> 'For the survivors remembering is a duty. They do not want to forget and they do not want the world to forget, because they understand that their experiences were not meaningless.[36]

A few weeks ago I was in Rwanda with its traumatic recent history still everywhere in evidence and in making the pilgrimage through the poignant Genocide Memorial/Museum I was struck again by the fact that one of the ways in which we remain open to the Gospel and open to the signs of the time and how we do social

[33] Ibid p.197
[34] Cimperman. supra pp.56-57
[35] Ibid.
[36] ibid. dedication page.

teachings, is indeed to look at what we remember, what narratives we tell and how we respond in solidarity. Johan Baptist Metz spoke of dangerous memories, memories which continually disrupt the smooth processes of reason, and in so disrupting, save it from a catastrophic self absorption. The understanding of memory that shaped Metz's theology was based on two pivotal experiences in his own life, namely experiencing his company of soldiers wiped out during a fierce battle in World War II and learning theology which never faced the haunting memory of the Holocaust. Metz said very famously that we must not lose sight of the truth of history as we seek to see the God of history at work in history. In other words, an attentiveness to the victims, to the underside of history, allows us in the spirit of the social teachings to also make room for a resurfacing of alternate discourses, of fresh creative approaches, of, as I said in the introduction to this paper, new ways of re describing and of remembering, ways of being held accountable to, and honouring, the dead and the martyred, to the victims of war and genocide, to the victims of HIV/AIDS and those who died needlessly while we argued about the causal link between the virus and AIDS.

Dr. Mamphela Ramphele described the official sanction given to the scepticism about the cause of AIDs as 'irresponsibility that borders on criminality.' She went on to say: 'If this aberrant and distressing interlude has delayed the implementation of life saving measures to halt the spread of HIV and to curtail its effects, then history will not judge this comment excessive.'

The social teaching of the Church allows for creative discourses to emerge, it creates the space for the truth to be told (in love) and for creating prophetic action which brings healing and hope to the downtrodden.

Again I return to Edwin Cameron's book. He says in his closing paragraph.

> "Africa needs healing. That healing lies within the power of our own actions. In inviting us to deal with the losses it has already inflicted, and, more importantly, in enjoining us to avoid future losses that our own capacity to action make unnecessary, AIDS beckons us to the fullness and power of our own humanity. It is not an invitation that we should avoid or should refuse."

AIDS, ETHICS AND CONSCIENCE

Fr Charles P. Ryan, St Joseph's Theological Institute, Hilton[37]

HIV/AIDS is primarily a community health problem. Unfortunately, from its first identification the virus assumed an unprecedented moral dimension, especially in the religious domain. HIV status is almost always related to sexual activity. Many religious traditions have an ambiguous, if not downright antagonistic, attitude to human sexuality – an attitude which is not in any way compatible with authentic religion, but which continues to plague the actions and image of religion and religious leadership.

The post-sexual-revolution (and post-Christian) culture, which is often described as 'Western', inheriting, as it does, a lip service to Christian morality, is equally plagued by an embarrassment about sexuality – while at the same time advocating a very liberated, if not promiscuous, lifestyle. Finally, in Africa at least, the extremely rigid discipline about sexual activity that characterized most traditional cultures provides a fertile setting in modern Africa for the all-pervasive assumption that a HIV-positive person is 'guilty'. The negative attitude to sexuality survives even when the traditional cultures are virtually replaced by an urban culture.

I propose to give clear reasons for a Christian to dispose, once for all, of the need to judge HIV–positive persons, so as to liberate our discussion for the REAL moral issues arising from the present pandemic. I have written elsewhere[38] on this topic, but considering the ongoing stigmatization of AIDS victims, and the ongoing pervasive moralistic image of Church leaders and members, it bears repetition, at least in summary:

1. Christ clearly instructed his followers not to judge others – "Judge not so that you may not be judged."[39]
2. Christ did give his Church a teaching role – "Go, teach all nations…"[40] - which must surely include teaching about morality, but teaching about morality and judging the consciences of people are two very distinct things. Unfortunately, it appears that many religious leaders and 'religiously-motivated people' accept the

[37] Paper presented at Pastoral Counselling and Theological Reflection in a Time of AIDS conferences, Pretoria and Durban, May 2007
[38] See, for example, Bate, Stuart C.2003,Responsibility in Time of AIDS, Pietermaritzburg, pp.2-19
[39] Matt, 7 :1-5
[40] Matt, 28:19

notion that a moral teacher must also be the judge. Christ's warning about judging others is self-righteously forgotten!

3. The moral climate and value system of modern society in Southern Africa is not only tolerant of extra-marital activity, but virtually demands it.
4. Young people, and the very high percentage of morally immature 'chronological adults' in modern society, will inevitably conform to the sexual mores of their environment, and will accept those mores as 'moral'.
5. It does not take much imagination to realize that the environment in which we all live is saturated with the message that not only encourages 'recreational sexual activity' but makes it virtually compulsory.
6. For there to be serious sin, there must be grave matter, full knowledge and full consent. While in no way suggesting that promiscuous sexual activity is not extremely harmful to individuals and society at large, an awareness of the immaturity of the average youth and adult, combined with the pressures from the highly-effective media-ruled society, makes it clear that those who are sexually active outside the confines of marriage (even if they are active in a Christian community) are rarely guilty of serious sin. In other words, there is grave matter, but the possibility of full knowledge and full consent is very low.
7. Looking at the matter from the perspective of the supremacy of Conscience[41] we must also be open to the possibility that even when consent is complete, the conscience of the individual may not be in unison with the well-known teaching of the Church on sexual matters. In which case, again, there is no sin.
8. Accepting that the Church teaching on sexuality is wise and beneficial, each sexually active member of our Church or society at large, who does not conform to the Church teaching is not evidence of the pervasiveness of sin but of the failure of the Church to teach effectively and credibly on sexual matters[42].

There is no scriptural or theological justification for the moralistic posture being taken by a large segment of Church leadership, because, as I have elsewhere summarized, ***No one deserves to have AIDS***.[43] Unfortunately, the preoccupation with sexual 'malpractices' dissipates the energy we should employ in addressing the huge amount of suffering and other related moral issues.

The Real, but Obscured, Moral Issues related to AIDS

I have argued that the pre-occupation of many 'religious' and 'ethical' people with the assumed guilt of HIV-positive people has actually distracted the Church and Society from the real moral issues that arise in the context of the epidemic. I present some of those issues, with a suggestion of the values that are involved and the appropriate ethical conclusions:

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[41] "Above the Pope as an expression of the binding claim of Church authority stands one's own conscience, which has to be obeyed first of all, if need be against the demands of Church authority" Joseph Ratzinger, 1968

[42] Pope Benedict's Encyclical on sexuality – "Deus Amor Est", December 25, 2005 – is a heartening example of positive and credible teaching on sexuality, but many say it is 'too little, too late'.

[43] Bate, S.C.(ed.) op. cit. p.10

1. ***Prioritizing allocation of resources and personnel.*** South Africa is dealing with a crisis where about five million of its population are infected with HIV – a condition that is preventable but incurable. Here is not the right setting for dramatizing the magnitude of the disaster, but 'unprecedented in human history' is an understatement. There can be no dispute that the mission of the followers of Christ is to assist those who are in need, especially those who cannot help themselves. There has been an improvement in the roll-out of ART[44] by public authorities, although the response in that area is far from adequate. The availability of care for those who are affected by the tragic deaths, adequate and appropriate nursing care for those who already at the full-blown AIDS stage and the provision of ART and other assistance (including financial) for those who have not succeeded in benefiting from the government interventions is massively inadequate.[45] We are frequently reminded that the Catholic Church is doing more than any other NGO to help AIDS victims, but comparisons are not relevant. The question is 'Are we doing enough?" and I suggest that the answer is an emphatic NO. The moralizing tone of our response is such that we feel that anything we do in this context is 'heroic'. The Church is going about its normal day-to-day activities as if we are not living in a time of unprecedented tragedy. Is this an acceptable response from the followers of him who said: "Whatever you do to the least of my brothers you do to me"?[46] The Church must maintain a high level of advocacy in motivating government and society to respond proportionately to the AIDS disaster. The Church must also be a witness to proportionate response to a disaster, in her compassionate care for those who have less chance of receiving help.
2. ***Allocation of Scarce Resources:*** The Church has access to a limited supply of ARVs[47] and other material assistance (most of which, interestingly, is financed from overseas). In every instance a decision must be taken when the demand exceeds the supply – whom to help and whom to leave, effectively, to die. In many cases there is an assumption that the resources should be used where there is most hope of success, or to members of our own church, or even – judgmentally – to those whose lifestyle is least 'reprehensive'. What has happened to the theology of the 'preferential option for the poor' especially when the term 'poor' can not be equated with the 'good-living poor' or the 'productive poor' or the 'Christian poor'? Is it not appropriate to re-examine our policies in this matter?
3. ***The Case of the Notorious Condom!*** In the 'Message of Hope' the Bishops of Southern Africa[48] concede the option of using some measure to protect a married

[44] Antiretroviral Therapy
[45] The fact that there are no reliable statistics for those who are not receiving assistance is, in itself, a pointer to apathy.
[46] While regretting the disproportionate level of response of the Church at large one can only rejoice at the extraordinary heroism of a few. The recent death of Sister Anne in rescuing AIDS sufferers is a greater witness than all of the moralizing statements of church leaders.
[47] Antiretroviral medication
[48] *A Message of Hope,* statement from the Plenary Session of the Southern African Bishops' Conference, Pretoria, July 30, 2001.

partner when the other is HIV positive. This concession is not widely known, and, in some cases has been revoked. However, there are other similarly challenging situations. A woman who takes ARVs and becomes pregnant has a high risk of giving birth to a seriously deformed child. Not to get pregnant is the obviously moral option in such a case. In many cases the woman has no option but to continue to be sexually active, in which case should she not be advised to use a condom? The possibility of a deformed child is a scientific fact. The protection offered by using a condom is a scientific fact. I see no moral problem about making this scientific information available to the patient and allowing her to make a decision herself. Even the Principle of Double Effect permits giving information to someone, even if it is foreseen that it will be used negatively, when there are proportionate grounds for giving the information. Surely, the same also applies to giving information to sexually-active unmarried persons.

4. ***Confidentiality***: It is interesting to note than on many moral issues the Church accepts the decisions of secular legal authorities. This applies to matters like the determination of the time of death, the right of parents to prevent blood transfusions, the right to terminate life-support systems etc. Whatever the suitability of the previous instances, I suggest that the issue of confidentiality must be re-addressed in the context of HIV/AIDS. Granted that stigmatization of HIV patients is illegal as well as totally un-Christian, its existence must also be recognized as a fact of present-day life in Southern Africa. The basic principle is that only the patient has the right to access to information about his/her health etc. and that the medical practitioner may use that information only to the extent that it is in the interest of the patient. How, then do we justify having "AIDS Clinics" where a patient entering is automatically identified as being HIV positive? This is both a form of discrimination and an encouragement to stigmatization. Given, also, that there are other medical conditions which are less dangerous than HIV that are 'statutorily notifiable', is it sufficient to invoke government non-action on notification as justification for never warning partners or potential partners? It appears to be standard for medical practitioners to give a coded warning to other potential care-givers about HIV status. Why must that end within the medical facility? How, in practice, do we maintain the dignity that each person must be accorded and, at the same time, give appropriate protection to society?

While there are NO scriptural or theological arguments to justify a moralistic response to the AIDS pandemic, there ARE powerful arguments that point the Church towards a massive, compassionate, non-discriminating mobilization of her own personnel and financial resources to render assistance to God's children who are suffering in one of humankind's greatest disasters. An ongoing advocacy programme must also be maintained.

Theological education and formation in the era of AIDS

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Introduction

AIDS is rampant in sub-Saharan Africa. And it is not AIDS alone. Africa is affected in a disproportional measure by tuberculosis, malaria, infant mortality, and violence. All of this causes a lot of suffering for its victims, their relatives, the society, and economy to name but a few sectors. It calls for reactions by individuals, governments, communities, families and the Church.

Attribution of guilt, shame and the fear of stigma often prevent a life promoting response. Sufferers feel left alone by their cultural and religious community. One gets reactions that regard AIDS as being the consequence of sin or offer a somehow arrogant judgement along the lines of "we told you before" [50]. At the same time church-communities miss the opportunity of being witness to a different way of dealing with suffering.

All of this is in stark contrast to the approach that Jesus took. Instead of following the judgemental route he chastised it (Lk 13:1-5). It would be worthwhile to tap and explore in deeper ways the perception of suffering as an event in which "the works of God might be made visible" (Jn 9:3). Looking at this is a responsibility of the church to break through barriers of silence, attribution of guilt and subsequent stigmatization, and the further resulting limitation of life. It has the resources that could lead to a powerful actualization of the belief: "If, then, we have died with Christ, we believe that we shall also live with him" (Rom 6:8).

An enormous but not necessarily daunting task for theological education and formation emerges. It affects most of the theological disciplines. Education and formation help to develop a genuinely Christian response to any crisis – in this case the AIDS pandemic. Theology on the academic level is called to reflect on the issues and to provide proper initial and ongoing formation to agents at the local level. It serves to help the grass root

[49] Paper presented at Pastoral Counselling and Theological Reflection in a Time of AIDS Conferences, Pretoria and Durban, May 2007

[50] Ryan, C. 2003 : 5 AIDS and responsibility: the Catholic tradition, in *Responsibility in a time of AIDS: A pastoral response by Catholic theologians and AIDS activists in Southern Africa,* edited by SC Bate, Pretoria: SACBC AIDS Office, 2-18.

level develop local theologies that can aptly react to their local challenge. The *educational* part addresses the reflective aspect within the different theological disciplines. It needs to go far beyond the approach of the Penny Catechism which by and large has the danger of promoting Petty Catholicism. The *formation* part builds on this by developing human and spiritual formation. It would provide the launching pad for appropriate reaction and action. It could have a tremendous effect on both, the sufferer as well as the community experiencing, interpreting, and reacting to whatever crisis. Theological education and formation share in the tension between the already and not yet in the process of actualization; while succeeding to some degree they also miss out on what could happen; they need to address proper and comprehensive Christian initiation. The following sections will indicate what is happening and what needs to be addressed. This includes contextually fitting education that leads to human, moral, spiritual, and liturgical formation no matter whether the educational background of the people is based on traditional cultural wisdom or academics. Such formation does not happen in the void. It is community based and alert to the cultural issues that are part of it.

Community formation

Ryan [51] assumes "that a very high percentage of humanity *never reaches moral maturity* and therefore will always conform to the conventions and the environment upon which they are emotionally dependent."[52] This makes it understandable that mere imperatives in bishops' letters, papal writings and homilies directed at behaviour will not work. To work on relationships in communities on which one emotionally depends appears as an optimal choice.

Christian education and formation does and needs to address the issues of community building. This is sometimes misunderstood and even rejected as a fashionable, technical or practical matter. Community building with the intention of serving or enhancing humanity is essential for the living of Christian values. Ryan [53] points for example at the failure of Christian communities to communicate an authentic appreciation of the beauty of chastity and the lack of providing a societal environment where it can be lived. The communal environment on which one emotionally depends can in many respects become a liberating one. Concrete experience is essential in human formation [54]. Sofield reflects on experiences that trigger beliefs, that in turn trigger feelings, that in turn trigger action. It is a systematic process where one step builds on the other.

If one appreciates this approach it becomes clear why mere appeals to action will scarcely work. They are neither backed up by feelings, nor interpretation, nor by experience. Likewise a mere appeal to feelings will falter and remain sentimental if it is not backed up by experience and a certain understanding. One needs to work on experiences and their understanding first. An ideal environment for this is a community (on which one is

[51] Ryan 2003 : 7, ibid
[52] Ryan 2003 : 7, ibid
[53] Ibid
[54] cf. Sofield, L, Hammet, R & Juliano, C. 1998. *Building community: Christian, caring, vital.* Notre Dame: Ave Maria Press, 43-44

"emotionally dependent") where diverse people develop an intimate relationship with Christ and try to translate it into their lives.

Integration into community

An important step for integration into the community is a proper process of initiation. Entering and going through a "rite of passage" a person leaves this process significantly changed. The *RCIA* (Rite of Christian Initiation of Adults) is meant to provide such a process. An "initiating" practice that focuses more on learning catechism is a long away from an approach that opens one up for a change of spirituality and world view through experiences. The scrutinies at the time of immediate preparation for the sacraments of initiation are meant to witness to the tremendous change that faith – acquired and deepened in the rite of passage - can bring to peoples' lives. It hopefully results in the best form of self-actualization possible. Rohr[55] reflects on the important educational and formative role of rites of initiation that help to handle and not abuse one's power.

The mere fact that scrutinies often go unnoticed speaks volumes. It may be an indication that the rite of formative initiation is not done in the way it is supposed to be: as a community based initiation into an intimate relationship with Christ. The *Lumko* book for the *RCIA* (Hirmer 1986)[56] actually is an attempt to present a communicative and community based process of initiation. The educational reflection is available but the formational practice appears as deficient. This must inevitably have consequences for the subsequent Christian life-practice of the formally but not formatively "initiated" – as the initially mentioned negative reactions to AIDS indicate.

Formation through role-models

Education and formation need role-models or "significant others", people who have gone through the initiation process and who provide credible witness; this assumes particular importance in a context with dysfunctional or often non-existing core-families. Such role-models can be a powerful tool for education and formation. "*We need models of higher development around us to move forward*" [57]. Kamaara[58] points out with her research in Kenya that some 80% of the interviewed youth name as actual source for information about sex the mass media and some 24% the parents. However, some 90% name their parents as *preferred* source. Religious leaders are the next preferred by some 62% (contrasted by an actual role 15%). Such preference deserves a response.

Role-models, as the community itself, provide avenues for experience that can be evaluated. Consequently sponsors and god-parents are assigned a very special role in the *RCIA*; yet it frequently appears that they are chosen for reasons other than the proper reasons and are seldom properly prepared for their task. Theologically rooted formation needs to be concerned about the providers of religious formation because much of the

[55] Rohr 2004:15
[56] Hirmer 1986
[57] Rohr 2004 :19
[58] Kamaara 2005:74)

Christian alternative in dealing with issues like that of HIV/AIDS is at stake. It will need the development of discernment processes for communities to determine their leaders in the formation of faith, including the ordained ones.

Catechetical formation

Catechetical formation happens in many ways. Kamaara (2005:112)[59] names various methods fitting for the catechesis of different age groups, among others story telling, watching and analysing video tapes, role plays, and in class experiences. The latter builds on – constructed – experience. *Our Journey Together* [60] takes consequently life situations – albeit virtual ones – as point of departure. Knowing about the power of experience others build for instance their confirmation courses expressly and even exclusively on experience gathered through exposure to "real projects" which could be hospices, development projects, orphanages and the like. Experiences made there, interpreted in the light of faith, lead to new insights, attitudes and practice. It requires special skills on the side of the catechetical leaders, at best being role-models. They must be initiated and formed into their faith and so be able to search self-assuredly together with their course-participants for a faith based understanding of real life.

Their formation and training is a special challenge for pastoral agents. They must be enabled to accompany and animate these key-witnesses of faith. The context based initiation that is needed will hopefully allow the initiates to give an account to their fellow people about the most probably counter-cultural approach to issues such as encountering HIV/AIDS positive people.

Biblical formation

The introduction of Gospel-Sharing methods like the Seven Step Method by Lumko-Institute contributed tremendously to familiarizing the laity with the scriptures within the Catholic Church. Course material for introducing such methods explores their spiritual depth [61]. Some formators unfortunately tend to rush such initiating process and thereby obstruct its far reaching potential.

Nürnberger [62] proposes an evolutionary approach towards reading the bible, acknowledging the development that major theological perceptions or concepts underwent when responding to changes in their context – critiquing and keeping them at the same time relevant. Such a method, tested in practice at grass roots level, can be of significant help for people to adjust to development and new challenges creatively in a biblically rooted manner.

While Nürnberger concentrates on the development in the trajectory of time, both the reader-response and narrative methodology focus on and open the eyes for the experience

[59] Kamaara 2005 :112
[60] Hirmer 1986
[61] cf Hirmer 1991
[62] Nuernberger 2002 and 2004

of reading and for the dynamics within a story. Biblical stories present a critical and encouraging potential for change without denying the often inevitable hazardous reaction to such change. Amazing dynamics can be discovered in the stories around Jericho (Lk 18:35-19:10). While a blind man gains sight and a seeing one sees Jesus the initially jubilant crowd starts grumbling because a sinner becomes a son of Abraham and the house of a sinner becomes a house of salvation. The use of a respective methodology at *Dei Verbum* courses in Harare and Caritas courses in Maputo found a positive response. It showed that these methods work with empowering effect for people who have not received formal theological training.

West's and Zengele's report [63] reads like a case-study of this. They describe Bible study as means for well-being, regaining dignity and empowerment. Their group of HIV/AIDS positive people, *Siyaphila* (we are alive), drew strength from Gospels where Jesus took sides with victims of stigma. The story of Job 3 is firstly experienced by the reader as devastating and then on reflection, the reader is given a new, life-giving insight. Life and faith came together, incurable diseases were seen in a new light. Topics that were otherwise avoided could be dealt with, taboos were broken. A judgemental attitude was overcome. Corporate study gave everybody a voice. Action was taken.

What is described here comes close to the tradition of *lectio divina* and the four senses of scripture: looking at the example of Jesus in the literal sense, putting it into practice in the moral sense, identifying one's own spiritual journey with the scripture in the allegorical sense and immersing and identifying with the text in the unitive sense[64]. Purification happens on the crucial allegorical level when confronting the darker side of our personality, e.g. deeply seated prejudices. This includes getting rid of "the emotional damage that has been done to us from the moment we were conceived until now" [65].

The examples indicate that existing methods of biblical education can enhance human and spiritual formation. Biblical texts open up for an encounter and real dialogue that allows for change. The challenge for pastoral agents is the translation of the material into the local context and its application. On a personal note I can say that it was only ongoing formation that brought me into contact with these methods which were not around at the time of my own training. Ongoing formation is as essential for pastoral agents as it is for any real professionals.

Cultural formation

Introducing *The African Bible* (1999) with its commentary as a tool for interpretation a facilitator once chose the stories of creation to make her point. Working with the commentary she emphasised the biblical view of gender equality (in Gen 1&2). She received strong criticism from the male participants rebuking her talking about things "in which they were the experts". A cultural clash about gender-roles developed.

[63] West and Zengele 2006 : check page
[64] Keating 2005 : 47-60
[65] Ibid 2005 :50

Benn [66] stresses that the cultural world-views of people have to be taken seriously. This calls in our context for instance for scrutinizing the ways of explaining the experience of death. One can give "medical" reasons, but also understand it as a curse, or attribute it to the power of ancestors, at times connected with witch-hunting and sorcery. The reflections of the pastoral statement of the SACBC (Southern African Catholic Bishops' Conference) "Ancestor religion and Christian faith" [67] and the subsequent address by Bishop Bucher to the SACBC plenary [68] are criticizing the culturally legitimized abuse of power. They would need a backup with practical, catechetical and homiletic steps to address such issues.

Similarly the issue of culturally based gender inequality needs attention. Though Kamaara (2003:44)[69] observes changes with regard to authority and the previously strong appreciation of male offspring, she also notes that girls are often forced into sexual activity since they don't have the right to say "no" (:76)[70]. A girl, raped by her uncle, can be regarded as available (cf. Davis 2003:67)[71]. With examples changing in varying contexts Kamaara (2003:100[72]) pleads for developing a theological anthropology of gender justice. Biblical development in the New Testament could serve as a paradigm for such change.

Culture needs a respectful but critical change. "If anything, the AIDS epidemic demonstrates the fallibility of all human cultures – African cultures included" (Maluleke in Benn 2002:11)[73]. Cultures are changing and rightly do so – for the sake of maintaining life. Cultures are eventually about "how life is done". Romantic traditionalism that strives to keep up cultural observances that are actually obsolete - and life threatening - violates actually the very culture it claims to preserve.

The attempts towards an African renaissance will have to be looked at with caution. The first renaissance was paid for by others than its beneficiaries. One will have to avoid making others pay the price: women, ostracised people, and the sick. What is needed is the further development of culture-sensitive tools (e.g. Prior & Munro 2003)[74] for a theological sound Christian guidance in the cultural development that takes place anyway and often in an unreflected manner. Gospel values could contribute in this way tremendously in dealing with issues such as AIDS.

Formation of conscience

[66] Benn 2002 :11
[67] SACBC 2006
[68] Bucher 2007
[69] Kamaara 2003 :100
[70] Kamaara 2003 : 76
[71] Davis 2003 :67
[72] Kamaara 2003 : 100
[73] Maluleke in Benn 2002 : 11
[74] Prior and Munro 2003

"The conscience must be educated in order that it become the *informed* conscience desired by Catholic teaching" (Rose 2003:56)[75]. Many people - young people as well as grown ups - appear as morally not mature, lacking knowledge and freedom (cf. Ryan 2003:9)[76]. Hence the process of initiating and integrating a person into a life-supporting community should include the formation of conscience. It should not aim at absorbing imperatives but help developing mature and informed decision makers that are able to judge situations and actions. The fundamental option of who one wants to be and familiarity with the related values are part of such process (cf. Gula 1989:75-88)[77]. Respective decision making takes into account the object chosen, the intention and the circumstances or the context (cf. Catechism of the Catholic Church, CCC 1750)[78]. When making decisions an initiated person (with a fundamental option) with a knowledgeable conscience (this includes the use of resources that inform competently about issues such as AIDS) is more likely to take seriously into account the statements and guidelines of bishops and popes as mentioned above. Conviction is likely to prevent their quick discarding of them for flimsy reasons. The longing for guidance was indicated above; a mature conscience will arrive at its decisions accordingly. This could allay fears that conscientious decision making could be somewhat arbitrary or moody.

Such an approach needs attention in education and formation. Initiation within the RCIA often appears at best as aiming at linking life and faith in exploring faith. The capacity for moral judgements is scarcely dealt with as is the spiritual life – apart from hints at Gospel sharing. A "lectionary based" approach for the RCIA as well as a "lectionary based" ongoing formation – and catechesis for children for that matter – are likely to miss such essential aspects of human and spiritual growth in a systematic way due to the random selection and piece-meal presentation of readings provided for the Sunday liturgy. Material for ethical and moral formation exists [79]. It may need a proper contextualization for the African context and grounding in the various cultural contexts.

Proper moral formation could give an answer to the persistent question about the use of condoms in the prevention of AIDS. A thoroughly informed conscience of truly initiated Christians will be able to make a morally accountable decision based on all sources of information, the context and the intentions. The challenge will be to form such consciences in a broad approach. In the process of their own initiation individuals hopefully become competent agents and thus role-models for others. Such an approach respects human dignity. It expects a more mature response than just being told what to do.

The challenge for theological formation on all levels is to safeguard such formational long-term process. As a general process being detached from the immediate theme of AIDS needs not to be a disadvantage at all. Ryan [80] suggests separating the

[75] Rose 2003 : 56
[76] cf Ryan 2003 :9
[77] cf Gula 1989 : 75-88
[78] cf Catechism of the Catholic Church, CCC 1750
[79] cf Crawford Hodapp 2002
[80] Ryan 2003 :14

compassionate response to AIDS from a comprehensive and positive formation in sexual morality in order to avoid the impression of being judgemental. The building of conscience in such long term process goes hand in hand with the development of a mature and composed spirituality.

Spiritual formation

Spirituality is not the domain of a few full-time pastoral workers or of monastic life. Rolheiser[81] states that everybody has a spirituality that directs one's energies. The question is how to channel such energies. Spirituality allows for vitality and integration[82]. One has to form spiritual identity for coping with problems and to feel well again when one's wellbeing is threatened. Eventually it allows for the response to the quest for meaning and purpose.

There are many possible ways to arrive at this point. One of them is by means of contemplative or centering prayer)[83]. It is related to the *lectio divina*. With its simple four steps it has the power of leading into the spiritual state of unity with God and of freeing from all forms of alienation: alienation from ourselves, from God, from others and from exploited creation (Pennington 2001:122-123). Such spirituality positions one in the situation of experiencing unity: "that they may all be one, as you, Father, are in me and I in you" (Jn 17:21). Such beatific experience of the intimate union with God allows real solidarity with all the others to whom it is likewise offered.
Proper spiritual initiation will help for a comprehensive understanding of healing (cf. Bate 2003:161). The Greek words words *sozo* (**σώζω**) and *therapeuo* (**θεραπεύω**) are often translated by "cure". But they don't mean a medical cure at all. *Sozo* refers to the whole person and not to its single members or organs. The whole person is healed, rescued or attains integrity. Also *therapeuo* exceeds medical treatment that may fail and eventually will fail anyway. Jesus acts with *dynamis*, a power that is not miraculous, as often translated, but means control over all powers. That is exactly where e.g. *lectio divina* and *centering prayer* and proper initiation want to lead to: to attribute power only to God.

This has consequences. We are not dealing with vain considerations for pious people but with the essentials of life. Van der Ven (1996:177) finds "a certain degree of empirical support for a critical-political spirituality" based on meditative practice. The – albeit not extreme – difference in commitment augurs well for emphasising spiritual aspects in education and subsequent formation especially in the formation of pastoral agents. They would miss out on an essential part of their ministry if ill equipped for animating the spiritual practice of their people. Moreover, Van der Ven's research indicates a connection between the level of (general) formation and the actual practice of meditation. Enhancing both education and spiritual formation has certainly the potential in mediating and supporting new attitudes in critical matters such as AIDS.

[81] Rolheiser 1999 : 6
[82] Rolheiser 1999 : 11
[83] cf Pennington 2001

Initiation into coping

The description by West and Zengele (2006) of the *Siyaphila* project makes one associate it with a rite of passage. Since HIV positive people are not natural experts in matters of AIDS they need a certain kind of initiation – in order to come out of the liminal space with a new and transformed approach to life. The aim of this group is mental health and peace. This means among others learning to live positively with the virus and planning for the future (West & Zengele 2006:54).

Unfortunately the impression prevails that quite a number of people still maintain a "traditional theological approach" which makes HIV positive people feel ill at ease in a parish. What richness would such a group bring into a parish, sharing its spiritual journey as one can share on the power of faith in the scrutinies of the RCIA.

Initiation rites help in the maturing process to which belong the capability to cope, and to cultivate one's use of power as well as the strength of letting go: "*All great spirituality is about letting go*" (Rohr 2004:5). This helps to accept oneself as one really is. Stripping the false self and acquiring such ability would mean a lot for those who are HIV/AIDS positive: letting go for instance of the fear of stigma on the side of the sufferer and being as one is in the presence of God; letting go of prejudices and even cherished feelings of superiority on the part of others, being united through Christ with all the others in fundamental solidarity.

Such a spiritual approach could go hand in hand with overcoming the devastating effect of a theology of retribution (cf. Haddad 2006:86) which comes along with its woeful sibling, the prosperity cult: be good and you get something, be bad, and you'll get something, too. Both are denigrating God and his dynamic power, and playing with the attraction of the false self. A restitutive theology and spirituality would ask what can be re-instituted to lead to full integration and wellbeing.

Here lie great challenges for the education and formation on the level of the pastoral agents. One can suspect that their formation for becoming spiritual leaders who are able to assist their people to some degree on such spiritual journey needs further development. Neglecting this aspect would endanger crucial dimensions of faith and proclamation that can bring about true healing to people.

Liturgical formation

After primary (for children) and secondary (for youth and adolescents) religious formation, it is religious practice that influences religious convictions. Liturgy was identified as "the greatest source of religious experience" (Van der Ven 1996:182). It may even be tapped for the religious formation of children who otherwise in some rural context may have no regular access to catechesis. Properly prepared liturgy can form the consciousness and consciences by providing genuine experiences.

Fragomeni, who teaches liturgy at the Catholic Theological Union in Chicago, builds much on the dynamics of liturgy as experience. In a symbolic or metaphoric event, eyes, ears, touch, smell, and taste arouse meanings. This triggers imagination. As one imagines so one becomes. As one becomes so one desires. As one desires so one values. As one values so one decides. As one decides so one behaves. As one behaves so one relates. As one relates so one constructs networks of meaningful exchange.

Imagine these dynamics as working! A powerful tool emerges that goes far beyond any form of rubricism. The construction of a new world in which many issues can be dealt with differently appears at the horizon.

The challenge is to find ways and provide communication to educate and provide ongoing formation for an appealing celebration of the liturgy that is formative. This powerful tool appears as often underestimated and underutilized.

Formation for social commitment

One could finally ask whether all this is really relevant, in particular whether it is relevant to translate spiritual initiation and growth into action. Comprehensive theological education and formation will have to deal with one of the "best kept secrets" of the Church, its social teaching. Despite the availability of quite some practical material in the area of the SACBC there are complaints about little practical action. This appears, again, as a challenge for the motivational force to own the teaching and translate it into one's own context. There may also be some insufficiently addressed issues with regard to the contextualization and application of existing material as well as the designing of one's own material.

The principles of the social teaching such as subsidiarity, participation and solidarity (cf. Pontifical Council for Justice and Peace 2004:104-112) leave no doubt that commitment in the social realm is not at all reserved to specialists but poses a challenge to each and everybody. Of course, to be able to apply them they should be reflected upon and joyfully owned. A step towards this would be their inclusion into a comprehensive process of initial and ongoing initiation.

Conclusion

Facing the bubonic plague Luther was asking not so much "why" but "for what purpose is this happening?" (cf. Scriba 2006:78). Looking at the crisis of HIV/AIDS we know that it is not the only one. I hold that it does not require a specific approach and then another one for the next looming crisis. Rather it alerts us to general deficits and opportunities for being prepared and having the lamps of our faith, conviction, values and the underlying spirituality prepared (cf. Mt 25:1-13). This can allow us to react creatively in a life-orientated manner and let Paul's conviction become an experience: "If, then, we have died with Christ, we believe that we shall also live with him" (Rom 6:8).
Theological education and formation faces many challenges. The communal, catechetical, biblical, cultural, moral, spiritual, liturgical, and social aspects are

interrelated. They need to be integrated in many areas. This includes the training of future pastoral agents and the ongoing formation of the existing ones. They are meant not to be mere "consumers" in these areas but animators who are trained to initiate others into them. This is demanding for their education and formation. It needs a rethink of pastoral planning and programmes and the respective materials for communities.
For this it could be beneficial to have some sort of institute that – with sufficiently diverse staff – serves as a think tank to accompany and animate the activities at the grass root level in a competent manner.

This is, of course, a general challenge. It is not limited to cope with AIDS alone. But it will affect in far-reaching ways the coping also with this pandemic. It will eventually benefit all in a "unitive" spirituality that enhances solidarity among all, in the case of HIV/AIDS between the "negative" and the "positive".

There is nothing specifically new about this approach. The saints are an example of people who internalised a Christian spiritual approach comprehensively in many of the above mentioned fields without focussing on single issues. Their education and formation succeeded in enabling them to respond to challenges that they were confronted with without prior workshops and specific training. They were alert to their environment and addressed the issues such as poverty, leprosy or poor education and acted efficiently. They became role-models that taught others.

The implications of such a spiritual change are tremendous. The challenges coming ahead with global warming will demand much more of matured spirituality, attitude and mindset. The track on which the challenge of AIDS can put all of us may be a blessing in disguise: To be better prepared as fully initiated believers for any issue that actually affects the life and survival of humankind, even as a whole.

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OUR PASTORAL RESPONSE TO THE HIV/AIDS PANDEMIC

Fr Victor Phalana, Archdiocese of Pretoria[84]

Introduction

Bridgette Syamalevwe RIP, from Zambia has this to say: "I am neither a statistic nor an object of curiosity… People living with HIV/AIDS are people like everyone else. They are neither to be discriminated against nor condemned. It is by listening to people living with HIV/AIDS that Africa will learn how to act well to prevent HIV/AIDS. We no longer think HIV/AIDS is the fault of rape victims, sex workers, or homosexuals. HIV/AIDS is our reality, and we can only change the situation if we treat the illness and those who are suffering from it with a sense of value and dignity".

Allow me to quote our theologian from Botswana, Dr Musa Dube who said: "For many of our members are infected, sick, dead or dying of HIV/AIDS. And because if one has it, we all have it. It means that Jesus Christ himself has AIDS, for the Church is the Body of Christ (1Cor 12:27). It is my contention therefore, that we do not have to wait until judgement day to hear Jesus saying: "Look at me, I have AIDS." Do we love him any less? Do we worship him? Are we holier than him? In this HIV/AIDS era, our greatest theological challenge is to grasp that Jesus is the face of every individual who is suffering with HIV/AIDS and who is threatened by this disease. Whenever and whoever and wherever a person is stigmatized, isolated, and rejected because of the HIV/AIDS status, the Church needs to grasp that Jesus himself is discriminated and rejected".

Pope John Paul II has made frequent and emotional appeals to avoid discriminatory treatment of people living with HIV and AIDS. In his visit to AIDS patients in the United States (1989), he held out the unconditional love of God as the guideline to be followed: "God loves you all, without distinction, without limit… he loves those of you who are sick, those suffering from AIDS. He loves the friends and relatives of the sick and those who care for them. He loves all with an unconditional and everlasting love."

In 2001, the Bishops of Southern Africa said: "AIDS must never be considered as a punishment from God. He wants us to be healthy and not to die from AIDS. It is for us a sign of our times, challenging all people to inner transformation and to the following of Christ in his ministry of healing, mercy and love".

In 2002, the bishops of Chad said: We sometimes hear people say that AIDS is a punishment from God. This belief sometimes prompts us to point fingers at people, to stigmatize, to isolate our brothers and sisters who suffer from AIDS. Many people say

[84] Paper presented at Pastoral Counselling and Theological Reflection in A Time of AIDS Conferences, Pretoria and Durban, May 2007

that they are sick 'through their own fault', or because they have sinned. In the Gospel of John, to a question put to Him on the origin of evil, concerning a person who was born blind, Jesus answers: Neither this man nor his parents sinned…" (John 9:3). Indeed God loves the man to the extent that He cannot contradict his act of love. He cannot call Himself Love and at the same time want the suffering and the death of this man…! AIDS is not therefore a punishment from God.

Pastoral response to AIDS in the African context

For a period of 20 years now, Africa has been experiencing the brunt of the AIDS pandemic. The Church in sub-Saharan Africa is called upon to appreciate and respond decisively to the AIDS pandemic as she feels more than ever its devastating impact. We need to understand the successes of countries like Senegal, Uganda and perhaps Botswana, to find out what they are doing to overcome this pandemic. We need to recall the experiences of Africans in our traditional societies, to find out what they did in the face of danger and how they overcame crises.

Let us remember that in Africa people used look after the sick and the dying out of love and generosity and not to make personal gain out of them. The dying were accompanied and cared for, so that if they were to die, they would die in dignity. We must continue to remind our people that an HIV infected person has a right to a life of dignity and to medical care and treatment. Those who are living with AIDS must be supported and given hope and compassion. Our people are still hiding their patients. Those who are infected do not want to go for tests and they do not want to disclose to anyone. They even hide it from their partners and from their family members.

Prophetic Action

In Africa, the Church must take a prophetic stance and redefine and transform some cultural practices and free them from patriarchy. The Church must identify all structures and symbols which alienate women and perpetuate their domination. The Church needs to address the place of women in society. Women are heavily affected by this pandemic. Besides the physiological and anatomical reasons which make them more vulnerable, there are also relational and socio-economic reasons. Why is it that there tends to be some tolerance of male unfaithfulness, and that fidelity is not seen as a value for both men and women. Some of the sayings like*: Monna ke selepe*... "a man is an axe and he can be used on all kinds of trees" and over emphasis on female virginity while not much emphasis is placed on virginity as far as boys are concerned attests to this. The Gospel demands fidelity from men and women alike.

The prophetic stance of the Church must be seen when the Church speaks out against sexual violence against women and children. The abuse of male power and male privilege is to be challenged as one of the greatest evils facing Church and society, and must be acknowledged as one of the ways responsible for the spread of AIDS. The most vulnerable people, those who become easy targets are children and poor women. Some of them are used as sexual slaves, while virgins are rumored to be a cure for AIDS. We are

all suffering and are affected by the AIDS pandemic: men and women. We have men who are faithful, disciplined and moral. They must be acknowledged and supported. We must not fall into the temptation of 'male bashing' which has become fashionable in Southern Africa today. The Church must speak out against irresponsible sexual behaviour by women and girls as well. Do we justify and defend sin committed by women because of socio-economic conditions? We must speak out and be prophetic in the face of sin and immorality, but at the same time, whenever there is a link between HIV/AIDS and sinful behaviour, we must continue to show mercy, acceptance and compassion. The suffering, the immorality and the sin of the person concerned, must be met with pity and kindness, (Mk 3:1-6; Lk 7:36-50). We must not be afraid to enter those situations where there is pain, brokenness, fear and guilt. We come in as prophets who speak the truth and who allow the light of Christ to shine on those dark areas. We must, at the same time, be agents of Divine Mercy.

The Church in Africa is asked to continue to challenge the global economic systems which continue to relegate Africa to the bottom of the economic ladder. Grinding poverty in the rural areas and in the cities contributes to the spread of AIDS. In most cases, those who are infected do not have access to clean water, good nutrition, primary health care and sanitation. This obviously makes them more vulnerable to disease. Living in a poverty stricken area exposes people to health risks. Young men who are unemployed and frustrated seek some solace in drugs and illicit sexual behaviour. Poverty fuels the sex industry in which young women use their bodies for economic survival. For some of them it is a matter of putting food on the table while for others it is a matter of getting money for education and some other basic needs.

A prophetic church must speak out in those cases where families are ostracized because of the presence of an infected member. We want to call upon the African spirit of solidarity. We must find solutions together and act together to alleviate pain and suffering. Where is the extended family? It is their role to care for the vulnerable members and those who are marginalized by society. Where are our Small Christian Communities in the face of HIV/AIDS. In most SCC's, it is life as usual. They still focus on themselves and on finances and have forgotten their social responsibility.

Youth and Formation

In view of the prevalent incidence of premarital sex among the youth, the church can look once more on the way traditional African societies imparted knowledge and led their children and youth to responsible behaviour. The youths used to receive moral teachings and values through myths, riddles, proverbs and parables. They were assisted to move gently from one stage of growth to another. Why are we not using our schools and our catechetical classes for this? There are times when our youth are taken away into seclusion; men with boys, women with girls, giving them lessons about the facts of life, the value of self-discipline, etc. Our formation of the youth under our care must deal with sexual health education, behaviour change, peer pressure, the church's teaching on abstinence, the delaying of sexual intercourse before marriage, fidelity within marriage and HIV counseling.

Compassion

A priest from one of the African countries shared with me a situation where a bishop refused to preside at a funeral of a religious sister who died of an AIDS related illness. He had nothing to do with her and she was buried from home, not from the convent where she lived most of her young life and her consecration. The religious community and the bishop had already judged and condemned her as unworthy of a proper catholic burial. Who are we to judge? Christ calls us to be compassionate. This is a call for us to be near those who suffer and mourn and to give them our support and our prayers. Those who are HIV positive are usually lonely and rejected. They are discriminated against and stigmatized. Jesus touched lepers and cured them (Mt 8:1-3). We can come to those who suffer and give them warmth, love and care as the Lord taught us to be compassionate (Lk 6:36). We must always respect their personhood and refrain from marginalizing them and seeing ourselves as better than them. We can give them time to deal with their emotions, especially their depression and anger. Our role is that of the Good Samaritan who helped the wounded man and did not leave him to die unattended (Lk 10:29-37). His attitude to the wounded man was different from the one of the Levite and the Priest, who only saw a dying man; a man who was half-dead and someone who could defile them and make them unclean. The Good Samaritan saw a man who was half-alive, someone who could be helped to live. That is why he had compassion on the victim, and bound his wounds, pouring wine and oil on them; he then set him on his own beast and brought him to an inn and took care of him.

We can encourage all those who live with AIDS to live a healthy life, through sport, diet and medical treatment. We can also pray for supernatural healing for them. In Mark 16:17, Jesus says: "And these signs shall follow all who believe: they shall lay hands upon the sick, who will recover." Jesus is the healer of mind, body and soul. He can mend our broken bodies. God has no hands but ours. We need to believe in Him and help the sick to face pain and to allow the healing power of the Lord to help them. Some of those we minister to will be healed spiritually, others emotionally and others physically. It is God's choice. We ask and God will respond freely and generously. It is our task to encourage them to come closer to God in faith and trust. We must assure them of God's love and care. We must love them and pray with them but with the knowledge we have of how HI virus is transmitted, we need to be careful and not expose ourselves and risk contracting the disease.

> "Compassion asks us to enter where it hurts, in places of pain in order to share brokenness, fear, confusion and anguish. Compassion invites us to mourn with those who mourn, keep company with those who are lonely, to be weak with the weak, to be vulnerable with the wounded, in other words, to be immersed in the human condition so as to lift them up to a better way of life. Compassion is not an accidental feeling that is expressed in a moment of weakness, but our way of life. Compassion is an abiding feeling and attitude towards others; it is much more than general kindness or tender-heartedness. Through compassion, our

humaneness grows into its fullness and fully immerses itself in the condition of being human".[85]

Compassion means that those who are caring for others must also take care of themselves. AIDS patients do not need our pity. They need our love and must be treated normally. It is our pity which can lead them to further depression. Compassion teaches us to love and where necessary to challenge them, for example if they refuse to cooperate with the care-givers and/or are taking advantage of their availability and service. Compassion teaches us to know when to love with 'tough love'. A love that helps patients to play their part in the process of care and treatment.

The role of small Christian Communities and sodalities

We are fortunate to have Small Christian Communities and sodalities in our Church. While they contribute a lot in spiritual growth and personal holiness, they still fail in their apostolate. They are at times not able to keep a balance between faith and action. In most cases they are irrelevant to the context and to the situation where they are. We have the break the culture of silence and denial. Help the people to address issues which affect them in their daily life and reflect on them in the light of the Gospel. From reflection we plan for action. We must then take decisions and act or implement those decisions, inspired by prayer, the Eucharist and the Word. Prayer leads to action. We cannot continue with business as usual, spending all our time and energies discussing who we are to bury or not to bury; who we will or will not baptize and worrying all the time about girls wearing mini-skirts! 'Rome is burning' as they saying goes. Let us not bury our heads in the sand. Let us have a holistic attitude towards life and all pastoral challenges. Let us also learn to prioritize issues since we cannot do everything at once. A pastoral strategy is necessary. We must also raise awareness of all the issues we regard as important in our Sunday liturgies, our meetings and various gatherings.

What can we do?

- Firstly get tested. Pastors will give more people courage to get tested when they see you getting tested. You do not have to reveal your status to anyone; but at least you will know and take the necessary steps. It will be helpful and priests and religious who are HIV positive can declare their status and be ready to minister to each other and to the society at large.
- As pastors and spiritual directors, give comfort through prayers, counseling, physical touch for assurance and acceptance and by being present.
- Understand where a sick person is, in his or her 'stages of grief'. Is the person still on the level of denial, is he or she on the level of anger or fear or bargaining or have they accepted. Listen to them and do not pretend you know or understand where they are and how they feel. Do not presume you know. Move with them at their pace. Respect the process. Guide them gently.
- We are at times afraid of talking about death. I remember in those cases where I personally got involved; it was always difficult to talk about death. Find a way to

[85] C. Drago, *Healing and Compassion,* 9Bombay: Paulines Publications, 2001, pp16-19.

introduce this issue, and help them to be at peace with dying. Help them to make the necessary preparations, like the writing of wills, saying goodbye to loved ones and receiving sacraments. Do not encourage them to stay on the level of denial. Give them hope. Help them to live each day to the full. Whether a person has 5 days, 5 months or 5 years to live, let them live the sacrament of the present moment. Each second and each day counts.

- Yes we do pray for the sick and for the dying. God is the only one who knows the full circumstances. In his infinite wisdom, he might realize that the long-term greater well-being of the person is better served in some other way than by responding to our request for immediate and miraculous healing with a straight yes. I am convinced that God does always hear our prayers and acts on them. God's response might result in an amazing cure, which none of the doctors thought possible. On other occasions, help might come through being given strength to live and to persevere through bad times, one might be given the ability to come to terms with the inevitable. God has many responses to prayers, ranging from a straight 'yes', through 'yes but not yet', or 'yes, but not in that way', through to a straight 'no'. God always hears and gives an answer, an answer best suited to our longer-term betterment. God's thoughts are not our thoughts. Pray and still give God the freedom to answer. Listen to God's answer and move on.
- We are called upon to be trustworthy. Confidentiality must never be broken when we minister to those who are HIV positive. I have a case where a girl I know has just fallen in love with a person who is HIV positive. I care about both of them. I called the man in question and made him aware of the situation and begged him to find a way of disclosing his status to the girl. I do not know if he did. I plan to challenge him to do so and perhaps I might even threaten him to do so. He cannot be left to infect an innocent person simply because he is afraid that if he discloses, she might leave him. I told him that once he gets assurance from her that she is committed to him, they could both go for counseling and let her discover his status in a safe environment, where there is counseling and support.
- Do not judge. We want to feel as is we are better or morally superior to those who are HIV positive. You do not know how a person was infected. It is not for you to know. Do not be overly curious. A bishop, in one of the African countries refused to bury a nun who died of some AIDS related sickness. Fortunately some of the priests took over and gave him a very good funeral indeed. AIDS is a human issue; it is a sickness, not a sin.
- Do not forget the family. They are affected and need a lot of support. They have their fears. They are at times embarrassed. They feel humiliated and let down by an infected family member. Understand their plight. They look at the implications of this situation, financially and relationally. Listen and help them to deal with those practical issues and to forget their pain and focus on the infected member.
- Keep on recruiting support and volunteers. Give them spiritual formation and assistance. Give them some stipend. Give them a time for prayer and sharing. Raise funds for HIV/AIDS work. Let the resources we have in our parishes and missions assist the community and address our plight.

- Motivate those who are infected, to know that it is not the end. They can live positively with HIV and AIDS. They must do what they are advised to do in the clinics. They are always told to keep positive, keep working and avoid worry. They must keep healthy relationships but must avoid alcohol, drugs and harmful substances. They must keep their daily hygiene, bathing, washing hair and teeth, washing their clothes and bedding, etc. They must exercise regularly and also have enough rest. They must avoid re-infection with HIV virus and infection with STDs. They must take their medication regularly and visit their clinics faithfully. They must eat healthy food and also devise and keep a healthy spiritual life.
- Let the person hear God through you. Let them encounter the compassionate Jesus through you. Be there for them and also give time for yourself, to deal with your own emotions and pain, your guilt and fears. You may cry with them if it is appropriate to do so, but give yourself time to heal and to receive strength so that you can strengthen them.
- *Lastly, do not simply watch and sympathize, - get involved!!!*

Intervening around HIV and AIDS related Stigma

Centre for the Study of AIDS, Pretoria

Faith based organisations (FBOs) have an important role to play with regards to the HIV/AIDS epidemic. They have usually been involved in caring for those living with HIV or AIDS. FBOs also have an important role to play in addressing stigma within the FBO and the community as some of the roots of stigma lie in moral issues. We have seen that stigma is involved with sexuality and moral values and issues related to death. FBOs can address these issues. They also have a role to play in changing the attitudes of people from one of fear and rejection to one of caring and support.

Suggestions for interventions in faith based organisations

Develop good policies

(a) Discuss the issue of confidentiality

Confidentiality is a challenge within many faith groups. The issue of how to handle confidential information, while being able to encourage the support of fellow faith members, needs to be openly discussed and possible solutions developed. Some reference group members suggested that faith leaders should 'not collude with silence' but should respect confidentiality if requested. Those entrusted with privileged confidential information should not disclose people's HIV-positive status without their consent.

(b) Develop guidelines on confidentiality

Within the faith-based context, sharing personal information about community members is seen as acceptable and supportive. Members of faith-based organisations often seek and receive support from their faith community through, for example, prayer. In the context of HIV/AIDS confidentiality is extremely important. This can however often create a dilemma in an environment where personal information is freely shared. In an HIV/AIDS-supportive environment, disclosure is encouraged and it breaks the silence. Often disclosure and open communication can reduce the associated shame of the disease. It also allows a PLHA to tap into existing support services. However, in many instances faith-based organisations are not HIV/AIDS-supportive. Rather, they are characterised by stigma to the extent that PLHAs may find themselves ostracised by their religious community. This has serious implications for the way in which faith leaders, in particular, need to try to balance respecting the confidentiality of a PLHA's status and ensuring support through the congregation.

Faith leaders in the Siyam'kela research were particularly critical of how their faith groups deal with PLHA disclosure. There are no written confidentiality policies to guide faith leaders within groups included in this study, with the exception of the policy in the Roman Catholic Church related to the confidentiality of confession.

There is a need to develop guidelines that will assist faith leaders, as well as faith community members on how to appropriately deal with HIV/AIDS and related stigma. These guidelines should cover how to:

- maintain confidentiality of HIV status
- manage disclosure
- provide appropriate support to those that are infected and affected by HIV/AIDS.

The guidelines should be developed in consultation with PLHAs.

(c) Mainstream HIV/AIDS stigma and guideline policies

HIV/AIDS and stigma-reduction standards should be mainstreamed. A de-stigmatising approach to incorporating HIV/AIDS in all pastoral services e.g. funerals, pre-marital counselling, confirmation, baptism, etc., should be spelt out in policy development. This will ensure that stigma-mitigation is taken seriously and addressed in various aspects of faith.

Build leadership

There are several challenges facing faith leaders. It appears to some people that some faith leaders are unable to provide the kind of spiritual support and guidance required by the faith-community members. This is generally perceived to be the result of:

- Faith leaders being ill equipped to deal with people who turn to them for advice and support on issues related to sex and safer sex practices without taking a high moral ground
- A sense of denial by some faith leaders that HIV/AIDS is a problem within their faith communities. This research found that this was especially prevalent in middle-class Christian and Islamic faiths.

The following is recommended:

(a) Provide ongoing capacity building of faith leaders in stigma mitigation

The skills of the leadership need to be built up in order to effectively create and share anti-stigma messages and take responsibility for the stigma-reduction process. Training should include:

- Theological and ethical reflection on HIV/AIDS

- Sensitising faith and opinion leaders to HIV/AIDS stigma by focusing on how stigma develops and the consequences to PLHAs the faith community and society
- Exploring faith leaders' attitudes and prejudices and how these feed to HIV/AIDS stigma

(b) Encourage leadership to take responsibility.

It is strongly recommended that leadership take responsibility for HIV/AIDS stigma mitigation. This would not only include driving the process but also monitoring the implementation of stigma-mitigation policies.

(c) Foster leadership commitment and involvement

The active involvement of faith leaders is highly recommended in efforts to create a stigma-free environment and should include participation in stigma-reduction interventions and message creation. This would require faith leaders to be the face of the campaign, set the scene and be role models.

Such interventions could, for example, include forming support groups for those living with and affected by HIV/AIDS and should not only be limited to material support and care.

(d) Include PLHAs in positions of leadership

It is recommended that faith-based organisations consider appointing faith leaders openly living with HIV/AIDS. These leaders could be positive role models and advocates for a stigma-free environment.

Assess levels of stigma

It is suggested that before planning a programme to address HIV/AIDS stigma faith leaders initiate a faith community-wide stigma assessment to gauge the extent of the problem, identify local barriers to stigma-mitigation as well as highlight factors enhancing mitigation. Assessment may include a survey within the faith community to learn more about members' perceptions of PLHAs and HIV/AIDS. The audit will allow faith leaders to better understand the levels of stigma within their faith community and identify critical issues that need to be addressed. The assessment and the resulted stigma-mitigation interventions should be conducted in consultation with the faith community.

Involve PLHAs to a greater extent

The principle of the Greater Involvement of People Living with HIVIAIDS (commonly referred to as the GIPA principle) should be applied to faith-based organisations. The GIPA principle encourages organisations to involve PLHAs in addressing the pandemic and to act as HIV/AIDS advocates for positive living. PLHAs have unique experiences and expertise that should be used as a resource. PLHAs' experience and insights could be used in the:

- development of HIV/AIDS-related policies and programmes
- delivery of programmes

- monitoring and implementation of programmes.

By involving PLHAs the faith-based organisation's policies will be more likely to reflect the concerns of members who are living with HIV, as well as give credibility to the HIV/AIDS interventions. PLHAs could also be effective spokespersons for stigma-mitigation efforts.
The use of faith members living with HIV/AIDS as positive role models will demonstrate that the environment is supportive of PLHAs. Such role modeling will also begin to de-stigmatise the disease.

It is suggested that PLHAs be trained in:
- Theological reflection on HIV/AIDS
- Issues of stigma
- Knowledge of rights and the pastoral standards within the faith community
- Awareness of the possibilities for redress
- Awareness of the services and care offered by the faith community and partner organisations
- Advocacy, empowerment on advocating the role of the faith community in creating a non-stigmatising environment.

Deliver appropriate prevention messages

There is a need to move away from understanding HIV/AIDS in terms of judgement of people's behaviour, values and lifestyles. HIV/AIDS should not be used as an opportunity to teach about the consequences of 'immoral' behaviour. Faith leaders should rather spread the message of acceptance and support.

Raise awareness in faith communities

Faith communities should be sensitised to HIV/AIDS stigma, how it functions and consequences to PLHAs, the faith group and society. This could be done by adding to existing HIV/AIDS awareness-raising actiVities.

Move beyond providing information only

Many studies have shown that information alone does not necessarily change behaviour. In addressing stigma, interventions should refer back to models that have rather focused on changing attitudes. Awareness-raising workshops should be conducted and should include a session on unpacking underlying assumptions and beliefs that are closely linked to HIV/AIDS stigma. This would look at diversity issues: racism, sexism, and issues relating to class. A skilled facilitator is necessary to run these sessions.

Mainstream stigma-mitigation messages

It is important that stigma-mitigation should not only be limited to annual events, for

example World AIDS Day. It is suggested that stigma-mitigation should be integrated to other faith-based activities, e.g. Holy Communion, Sunday services, etc. Innovation is required to de-moralise HIV/AIDS. For example, a faith group may display a big sign outside their church or mosque welcoming everyone, including PLHAs.

Use non-stereotypical images and concepts of PLHAs

When sharing HIV/AIDS prevention messages within a faith group. These messages need to be representative of the HIV/AIDS epidemic and not use stereotypical images or concepts, such as depicting PLHAs as frail and sickly or HIV/AIDS as affecting gay men only. Such images contribute to feelings of hopelessness and the perception that PLHAs should be avoided. They also encourage people who do not associate themselves with the stereotypical images to feel immune to the disease and not respond to prevention messages.

Images and concepts that should be avoided include:

- those focusing on high-risk groups (e.g. truck drivers. sex workers, drug users) instead of on high-risk behaviour (e.g. unprotected sex, sharing syringes)
- images of PLHAs as 'promiscuous' and 'immoral', and as a danger to members of the faith community
- images of PLHAs 'at death's door'
- images of PLHAs as unable to live fulfilling lives because of their HIV-positive status
- understanding of HIV/AIDS as a 'scourge' or plague
- understanding of some PLHAs as innocent, which implies that some PLHAs deserve to be infected
- the language of 'us and them'.

HIV/AIDS prevention messages should rather:

- focus on risk behaviour and not on risk groups
- show that HIV/AIDS does affect all people - all ages, cultures, genders and sexual orientations
- use positive language that is inclusive and sensitive - for example, using the term people living with HIV/AIDS instead of AIDS victims.

Monitor interventions for their sensitivity in relation to stigma

It is important that all HIV/AIDS interventions are monitored for their sensitivity in relation to stigma so that such interventions do not contradict the other messages being created within the faith group.

Adopt an inclusive approach

HIV/AIDS is often depicted as a disease affecting the poor, black, prisoners, women, homosexuals, sex workers or promiscuous heterosexuals. This perpetuates the idea that people who do not belong to these categories are not susceptible to infection, which, in turn may encourage risk behaviour in these groups. This "othering" perception subsequently leads to stigmatisation of the groups perceived as risky. It is an important step in stigma reduction to see the whole body of the church as having HIV/AIDS. In this way HIV/AIDS will stop being the problem of just individual PLHAs, and become the responsibility of the entire religious community. This approach creates inclusiveness and breaks down stigma.

"All are affected by AIDS, even if all are not infected'. Rev. Colin Jones, Anglican Church

Rethink sexuality

"Responsible sexuality [is] a gift from God, something wonderful, not negative. Sex does not equate to sin. The idea that there is something wrong about sex, we believe that tradition is not a healthy one. I think a challenge is to know how to teach about sex without emphasizing sin."

It is important to move away from a view of sex as sinful. If faith organisations could promote a view of sexuality as healthy and good, it would assist their members to be less judgmental of PLHAs who had contracted the virus sexually. This would in turn reduce HIV/AIDS stigma.

Address judgemental attitudes

Another important promising practice is to develop an alternative to the model of a vindictive and judging God who uses HIV/AIDS as a punishment for human sin. The idea of a compassionate God is to be preferred as it reduces the judgementalism of members of faith groups regarding HIV/AIDS. In this way stigma is also reduced.

The Church often interprets the Bible in a narrow way, and this has to change:

"The Bible is often read and interpreted in such a way to encourage a stigmatising attitude and practice and to rnarginalise people. But we believe that the real story of the Bible is about a God who is inclusive, not exclusive. In the context of stigmatisation what we want to do is to try to reclaim those stories in the Bible that talk of inclusion ... God seeks to redeem creation and humanity, not to condemn it.

"The Church needs to reclaim the teachings of Christ - to use the Bible as a source of reconciliation rather than destruction."

Visibly involve PLHAs

It is crucial for faith organisations to visibly involve PLHAs at every level of their response to the pandemic. It is also important for faith leaders to publicly identify with PLHAs. Such involvement not only helps ensure that faith organisations have an appropriate response to the pandemic, but also reduces stigma among members. Some faith leaders are themselves HIV-positive. PLHAs who are open about their status are crucial to reducing stigma in faith organisations.

"There are indeed clergy living with HIVIAIDS. And there are probably political leaders living with HIVIAIDS. What we need to do is change the climate so that it is possible for people in these leadership positions to come out and identify themselves with people living with HIVIAIDS. That will make a tremendous difference. "

The visibility of faith leaders living with HIV/AIDS will go a considerable way to destigmatising the disease.

Use the church as a resource

The church, even in rural areas, has many resources which could be utilised for HIV/AIDS work.

"Even in the remotest villages there is access to a church ... we can *use these facilities for AlDS work, educating people to spread the message. We can* also *use our resources in the community, for instance, caring for people living with HIVIAIDS by providing home-based care support, and by providing spiritual and emotional support to people. Orphan children are another important area."*

Work in partnership

Another important stigma-mitigation practice is for faith organisations to work together in partnership to address the HIV/AIDS pandemic. This is already happening between the mainstream Christian denominations. However, partnerships needed to be extended to include smaller and traditional African churches, as well as groups representing other faiths.

- Talking about HIV/AIDS in terms of sin is not helpful as it puts PLHAs into a situation of feeling judged.
- In HIV/AIDS it is important to engage in both practical care, as well as reflection at the intellectual and theological levels on the meaning of the disease.
- It is important to speak the message of responsible morality regarding sexual behaviour.
- It is necessary to challenge gender practice in FBOs that disempowers women in order to show people what we want to move towards building strong women who make choices for themselves.

Involve people living with HIV/AIDS

FBO approaches to PLHAs need to be based on a long process of reflection, which starts with finding a sound theology for approaching HIV/AIDS. There is a need for FBOs to return to a close study of religious texts in order to reduce HIV/AIDS stigma.

"The Church will wrestle with theology first, that's the difficult thing. The Church always wants a scriptural message to say: this is about this, what is our response theologically. It then takes an argument and lots of discussion before [the church members] decide to do something. " Rev Dr. Xapile, Memorial Uniting Presbyterian Church.

In the Christian tradition, the gospels are particularly challenging to those who stigmatise PLHAs.

"I think if you read Matthew 25 *you will find it very hard to engage in condemnation* of *people who are HIV-positive... I think in that passage, if there's any judgement, it is not on the people that are infected and affected by HIV/AIDS, an element of judgement Is towards how the church responds to people that are affected by HIVIAIDS."*

Bring together diverse opinions

There is a need to reconcile those in FBOs who have strongly opposing views of the HIV/AIDS pandemic. An important role is played by what can be described as "the ministry of reconciliation" in some Christian churches in alleviating stigma. In practice this means bringing together in a religious service PLHAs and members who engage in stigmatisation in order to build new and healed relationships between them.

Challenge responsibility

Stigma reduction can also occur through making members of faith organisations aware that the HIV/AIDS pandemic is the responsibility of everyone. All are affected. In some Christian churches the extensive involvement of the church in all aspects of HIV/AIDS derived from an understanding of the faith community as part of the body of Christ.

[The faith community is] "*... the body of Christ which means that there is the whole question of us belonging to one another and if one suffers, everyone suffers. There is a call to really carry each other's burdens and be involved."*

Go beyond support groups

The involvement of a FBO must extend beyond the integral inclusion of PLHAs to include a programme for children orphaned by AIDS, emergency food relief for the destitute, condom distribution, and an education and awareness programme. The FBO must also provide a skills-training programme for women in basic homecare and training for health care workers in HIV/AIDS.

Conduct alternative textual analysis

It is important to provide faith leaders with an alternative, non-stigmatising perspective on HIV/AIDS. Such a perspective could be derived to a significant extent from texts from key religious books which support and encourage a caring response to PLHAs in religious groups. Such texts allow leaders and members of faith groups to engage in a more compassionate response to members who are HIV-positive, as they will teach a different perspective to the stigmatising discourse prevalent in many faith groups.

"What is mostly taught is love and that God loves us all. We are children of God, regardless of who we are and what we are. So that is the most important thing that is being taught here – to destigmatise and to love one another." Rev. Martin Nobula, Church of Christ in Southern Africa.

"In the Muslim community the study of compassion addresses the discrimination and prejudice that the Muslim person living with HIV faces. It also addresses the issue of justice ... we cannot be judgemental towards people who have been diagnosed with HIV/AIDS". Positive Muslims

"Our reading can never limit the Qur'an. The Qur'an is miraculous because of its ability to transform the reader. It is not a passive text but has an inexhaustible number of readings, depending on the reader's context. On the contrary, depending on the reader's God consciousness, the text will surface meanings hitherto hidden".

"It is only when we are able to establish the right balance between jalal (a strong sense of justice) and jamal (an unlimited compassion), that we will be able to perhaps display what Allah intended of us – kamal (perfection)".

Challenge internal stigma

Passages from holy texts have the potential to challenge the internalized stigma of PLHAs who are members of faith organisations. Such passages have an enormous power to reduce HIV/AIDS stigma.

"In the midst of the challenges of HIV/AIDS, we can be assured that God still loves us ... God promises to bring good results out of our difficult situations. HIV affects the body but hope is found in the soul".

Pastoral Care in a Time of AIDS: Where are we?

Mary Crewe, Centre for the Study of AIDS, University of Pretoria

This is a very important time to be reflecting upon where we are in this time of AIDS; for it seems that we have reached a serious impasse in our response and that we are floundering in how to sustain the response; and it also seems clear that now more than any time before in the response to HIV and AIDS the human rights and dignity of many people are directly under threat.

I want to introduce this discussion with a quote from Edward Said one of the world's most critical public intellectuals -

> *I've never felt myself to belong to any establishment of any kind and mainstream. I'm interested in mainstreams; I'm jealous of them. I sometimes, occasionally, envy people who belong to them – because I certainly don't – but on the whole I think they are the enemy. I feel that authorities, canon, dogmas, orthodoxies, establishments, are really what we are up against .... They deaden thought*[86].

Using this quote implies nothing about the Catholic Church though some people may think I am using it as a challenge to their stand on many issues. Not at all – I use this quote to highlight the dangers we face as the terrible orthodoxy of the AIDS mainstream is starting to show itself.

What we are confronting now in the AIDS world are the views of people who have positioned themselves as experts in all kind of fields; often with little or scant training in those areas in which they are professional experts. Responses to HIV and AIDS have been mainstreamed in many ways such that it is difficult to challenge or debate them and this is having serious repercussions on our ability to stand back and reflect upon where we are going and what needs to be done.

What we have done is to have mainstreamed the status quo rather than positioning it as something that we should all be actively fighting against. The response to HIV and AIDS has become predictable, bound by formulas – a kind of false community being asserted, a veneration of certain positions and ideas and a deadening or even loss of critical thought, debate, questioning and objections. And to quote Said again

[86] Ali T 2006 Conversations with Edward Said Seagull Books p 104

> *No social system, no historical vision, no theoretical totalisation, no matter how powerful can exhaust all the alternatives or practices that exist within its domain – there is always the opportunity to do something else; to formulate an alternative and not either to remain silent or to capitulate.*[87]

What we seem to have lost in the AIDS response is the power to be asserting the alternative.

I want to use four examples of what I mean to illustrate where I think we are in the AIDS response and to see why it is that I think that we are in danger of neglecting to ensure that we remain vigilant in looking out for people with HIV and AIDS; their families and their community. These four things are

- testing and treatments;
- male circumcision;
- orphans and the elderly and
- young people.

In all cases a particular social orthodoxy has crept into the ways in which we talk about these things and we have watched the mainstreaming of a social and political response that could have very serious consequences as the epidemic matures.

South Africa continues to have the worst epidemic in the world. No matter how it is spun[88]; there has been no real or significant downturn in the rate and pace of the epidemic – some leveling out may occur but there is really no downturn, no dramatic shift and no respite. This epidemic calls for a robust and vigorous response. It calls for commitment and passion. Such an epidemic must open ways for us to ask what have we learned from our past; from the ways in which 20 years ago we have described and understood the epidemic and the ways in which we have chosen to analyze and interpret its impact.

Can a society such as South Africa come to terms with the impact of AIDS and generate a brave, vibrant and robust response? Can we understand the lessons of the past and create a future that protects and supports us all as we negotiate our way through this most fascinating of all epidemics and the many social, political, economic and personal ramifications it has produced and will produce.

For in the end

> *This disease not seldom attacks the rich, but thrives among the poor. But by reason of our common humanity we are all, whether rich or poor, more nearly related here than we are apt to think. The members of the great human family are,*

[87] Ibid 109

[88] The annual ante natal surveys do show slight fall off in infection rates among young people but these are so slight that they cannot be said to show a downturn in HIV infections

in fact, bound by a thousand secret ties of whose existence the world in general little dreams. And he that was never yet connected with his poorer neighbour, by deeds of charity or love, may one day find, when it is too late, that he is connected with him by a bond which may bring them both at once to a common grave. (William Budd 1874 on Typhoid)[89]

What we are seeing now with the current response to HIV and AIDS is a picture of a society that is being ruptured and buckled into an antithesis of the humane, just and dignified society millions struggled for and continue to strive toward. It need not be this way - but at the moment this epidemic is reiterating and intensifying already powerful features of a society with such ferocity that it will require extraordinary boldness and invention to reclaim the future[90].

How is it possible that in the AIDS world various positions, for which there is very little evidence or which clearly violate human rights, come to be taken as comprising authoritative, and therefore to some degree socially determinant, statements about the nature of the world and the ways to address the epidemic?

Testing and treatments

In the realm of testing and treatments what happened was that treatment and access to treatment fell under the spotlight. To access treatment one needs to be tested and so the whole push for 3x5 developed – we must, so the argument went, get all people to know their status.[91]

The object was the test and the focus of debate and energy was on the test. How, the question went, can we get people from diverse social, political, economic and social strata to test, because clearly as the public health argument would go (against any evidence that this is in fact true) it is much better for people to know their status.

The way the test was spoken about was as if it was divorced from any symbolic meaning - indeed testing was set up as the great intervention that would work because the rational idea was that it is better to know (against all the evidence that questions the "know your status" approach as being flawed and counter intuitive in the epidemic) and then be able to access good medical care.

The concept was debated and discussed by people with authority and power – doctors operating from a deeply public health model, steeped in the public health history of violation of individual rights for the general good. Doctors who because they are medical people "know" what is best, and so skillfully did they employ their constructs that it was

[89] Cited in AIDS Review *Buckling* 2005 Hein Marais University of Pretoria p5
[90] Marais H 2005 AIDS Review *Buckling* University of Pretoria p7
[91] See the WHO 3x5 documents and other UN agency implementation plans

almost impossible for the non medic – the community person, indeed the AIDS worker, to challenge this because they did not carry the required social authority.

The strategy then became the provider initiated test which of course very soon slides into the routine offer and from there into the mandatory test – and a clear abuse of and violation of rights[92].

But few were concerned because overwhelmingly the voice of testing was the medical voice; the voice of public health authority and there was it seemed little ground for the non medic – the lawyer, the judge, the teacher or the priest to move. And so embraced by the world bodies – the UN and WHO - the massive 3x5 programme started and then we learned that in the developing world people required less counseling[93]; that the numbers tested mattered[94] and that people who were opposed to testing in this way were portrayed as being unconcerned if people were to die.

A multitude of social, political and economic rights were often rolled aside in this juggernaut of testing and stories abound of domestic violence, and of losing jobs, family support and family homes[95]. But this is swept aside as a side stream, an irritation in the mainstreaming of testing. The oath of medical personnel **"***first do no harm***"** was overlooked as, fuelled by the conservative anti human rights ideology of the Bush administration, money poured in for testing and so we mainstreamed into public health a programme and policy counter-intuitive to the understanding of the epidemic and disrespectful of people's rights, privacy and dignity.

No one denies that treatments and treatment access is a basic and fundamental human right and should be freely and openly available to all people – that is not the point . When people raise concerns and questions about treatment they are not questioning the right to treatments or that people should freely choose to have them; rather they are questioning what comes with it – the very real potential for a reduction in human rights, a reduction in counseling and confidentiality and a reduction of nuanced prevention as everything gets subsumed into VCT and routine offers of a test.

And as we know there has not been a significant reduction in stigma, no massive uptake in testing, no increased adherence to treatment if people can access it – in fact it now seems clear [96]

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[92] See Viljoen F and Crewe M *Testing Times* 2004

[93] The 3x5 document states that due to health infrastructural weakness less counseling will be acceptable in the context of the developing world

[94] The drive for numbers above all else is through the PEPFAR funding requirements as well as other donors

[95] Many of these are anecdotal but many are well documented and some have been dealt with through NGOs in South Africa and in other SADC states

[96] See Crewe M opening plenary address at the Priorities of Care conference as well as the work of Susan Kippax of the Australian Centre for HIV and social research on the medicalisation of prevention

- that testing and treatment will **replace prevention** as people believe they no longer need to take precautions;
- that testing and treatment will **hinder prevention** strategies;
- that people will be **wary of accessing clinics** where routine or opt out testing is offered,
- that testing and treatment will **add to the stigma** of the disease and
- that **treatment cynicism** for those who are positive but excluded will have a detrimental impact on the social nature of the disease.

A huge burden lies on treatment to succeed in ways where others have failed. The urgency of the epidemic and to save lives and the hope that treatment would succeed where prevention seemed to have failed have led to a situation where treatments are assumed to take on all kinds of symbolic powers beyond their actual work in addressing the virus in the body.

1.1.1.1.1 Circumcision

One can have a similar debate about circumcision[97]. Again fuelled by an infection rate panic attack a new intervention seemed to show that circumcision lowered the level of risk in men for infection. The trials (despite being criticized in their methodology) seemed conclusive. The experts were called in to give the social and scientific language – create the concepts and the discourse and the ways in which it is spoken about brooks no dissent. The strategy is to roll out male circumcision at least in the developing world with scant regard for individual choice or autonomy. Indeed examples from Kenya[98] already tell us of discrimination against non- circumcised men and that there is a push to have men presenting with a negative test result to be circumcised.

Very little attention has been paid to the rights of men in this regard – what of cultural, sexual and traditional rights? How will these be ensured and protected ? What of the right to refuse the procedure? What about the rights of parents in terms of decisions about their son's infant health and indeed again what about the act which prohibits surgery for which there is no proven benefit? A lowered rate or risk is not a lowered risk – men will still have to use condoms. And what about the rights of circumcised men who become infected after all. What about the sexual experiences of women?

Circumcision is on its way through the WHO and UNAIDS juggernaut, to be a mainstreamed health intervention that offers no real insights into social and cultural rights and practices or political fall out. So-called protection of rights is disingenuously claimed in the right of patients to choose. None but the most naive are in any doubt about how patients actually have very few rights in the face of medical authority.

[97] The work of i.e. Peter Aggleton and Gary Dowsett and others and the UNAIDS position papers for the debates on the efficacy and value of male circumcision

[98] See the report non circumcised pupils denied access to school and also see the effects of persecution of men in Eastern Europe in the recent ethnic struggles depending on their being circumcised or not

It is also apparent that circumcision is seen as an intervention for *black* men, for Africans. And why? – because of the ways in which the sexual behaviour of black men has been construed and understood by the collective wisdom based on the long tradition of how black African male sexuality has been portrayed and understood. The implicit racism in this intervention is astounding.

As with testing, in male circumcision the dual discourse comes into play. There is concern about "traditional circumcision" because of infection and death, but there is also concern not to upset traditional cultural practices. The call is to regulate and to give clinical standards to traditional circumcision. Once that is done tradition is changed forever – as soon as it is regulated it is a modern practice and a very long standing social and cultural practice will be irreversibly changed. You can't have both – at best you can have the pretence of one and the actuality of the other[99].

1.1.1.1.2 Orphans

Orphans of AIDS constitute what is called the 'fourth wave' of the epidemic – the first being a rising number of new infections, followed by rising HIV prevalence and the third wave of the rising number of AIDS related deaths. How do we tell how many children are orphaned by AIDS – how do we make sense of all the new categories and definitions? The two challenges of course are the need to keep parents alive and of ensuring greater acknowledgement of the rights of young people.

There is a tendency to automatically equate orphanhood with vulnerability, but in the South African context a more elastic definition of orphan needs to be used. Significant proportions of children who are not orphaned live mainly with only one of their parents and both orphans and non orphans are often placed in the care of relatives where they experience a variety of living conditions[100].

What is the mainstreaming dogma we are facing with orphans? It is the belief that there exists a strong enough extended family network able to take in large numbers of children and give them the care, nutrition, socialization, education and support which young people need. All the research shows that households taking in orphans are poorer than households without orphans – and households with orphans also tend to have a greater proportion of elderly people and are usually headed by women. In addition, orphans have been made to occupy a central part in such narratives of insecurity, social breakdown and collapse – they have been cast in the role of the alienated, antisocial and enraged outcasts prone to crime and to violence and worse. Orphans have been positioned as the problem and the question is how does 'normal society' cope with this problem[101]?

What matters in relation to orphans is the failure of society to protect the weak and the largely defenseless against harm and suffering. As Hein Marais has written 'many

[99] See Crewe M *There are a thousand ways to wear a veil* AIDS, Sexuality and Globalisation
[100] See Marais H AIDS Review 2005 *Buckling* for a detailed and expanded discussion of the ways in which society is addressing orphans
[101] Hein Marais *Buckling*

children – far too many – are already falling through the cracks; suffering abuse and neglect at the hands of parents, care givers and extended family. Decades of apartheid corroded the capacity of the family and other social networks to shield children against neglect and abuse. Whether these already battered families can absorb the additional strain of the AIDS epidemic and orphans is moot'. What matters is that there is no public debate about alternatives – the creation of new families, new communities and new ways of living and being. All too often the orthodoxy of the family drowns out the debate about what else might be possible, sustainable and supported[102].

And with scarcely a backward glance we talk about child headed households, children coping and the resilience of the poor as if these were things to be proud about. Child headed households have no place in a caring democratic society; coping is about failure and resilience blocks the ability to flourish. Some people may thrive in adversity but millions are merely abused by it. And equally abused are the orphans at the other end of the scale – the elderly on whom tremendous burdens now fall and yet there is no public outcry about the quality of their lives nor about the failure of society to protect them. It's as if the small numbers who are supported and cared for or who cope make the rest invisible[103].

1.1.1.1.3 The youth

Young people are growing up in a world that is bewildering, exciting and full of challenges through sex, drugs, crime and violence and an education system that seems constantly to fail them. The AIDS epidemic is shaking the foundations of the homes for many young people and the public sector in whose care so many of them are placed through education, health care, social development is itself buckling to the epidemic. But despite this, young people do remain the great hope for the ending of the epidemic, for the care and support of those who are infected as well as for being secure adults in the future. Yet, we are failing them as well. We are failing to recognize and act on the convention of the rights of the child; we offer them mixed messages and we fail to educate them. Ayn Rand believed that

> *The only purpose of education is to teach a student how to live his life - by developing his mind and equipping him to deal with reality. The training he needs is theoretical, i.e., conceptual. He has to be taught to think, to understand, to integrate, to prove. He has to be taught the essentials of the knowledge discovered in the past - and he has to be equipped to acquire further knowledge by his own effort. Ayn Rand*[104]

Of course we need to teach our fellow citizens to deal with reality and this reality of course differs from community to community, from country to country – but the crucial

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[102] Ibid

[103] Ibid – the discussions in *Buckling* on this issue are very complex and detailed and the discussion on orphans in this paper draws almost exclusively from that work

[104] See Crewe M 2006 *Education the forgotten side of prevention* – address at the International AIDS Conference, Toronto 2006

question is how we do this – how do we develop their minds and equip them for this reality? Do we get them to accept the reality – by not challenging the dominant status quo, by not questioning the ways in which culture and tradition feed into and collude with the epidemic or by playing all the old clichés about power and oppression and blaming all the usual suspects? Or do we equip them to think in new ways about who they are, what forces have shaped and will shape their lives and equip them to have powerful imagined futures?

In most AIDS prevention we have turned away from any real theoretical understanding or training through the mistaken belief that AIDS information and messages – AIDS prevention – needs to be simple, that it needs to be uncomplicated and straightforward. In this we have failed to recognize the point Rand makes about education being conceptual, theoretical and something that makes us think, and through this thinking to understand, integrate and work with theory and concepts as well as to have the means to act on this.

We have to realize that this is a fascinating and complex epidemic, playing itself out in widely divergent communities with different pasts and different futures – and it is overlaid with fascinating and complex ideas about tradition and modernity and the impact of globalization[105].

What theoretical or conceptual tools are we developing with young people – how do we recognize this epidemic in all of its complex forms and educate people with the theoretical tools to understand power, hegemony, patronage, choice, freedom and social identity. We need to give people the conceptual and theoretical tools to understand how culture can lock them into positions of inferiority, how culture can be used to collude with the epidemic and how race and class and gender all have webs of interconnectedness beyond mere behavior change.

AIDS education is not about basic facts – it is about having the intellectual skills and the curiosity to use these facts to change the world.

1.1.1.1.4 Conclusion

So in conclusion I think that we are in a precarious state with regards to the epidemic and the response to it. We have sunk into the pedestrian, the banal and the mundane – what has happened to the critical voice, the voice that challenges, the voice that refuses to accept, the voice that asks questions and refuses to accept the-taken-for-granted explanations?

In part this is because the modern world is full of experts and professionals, not so much of intellectuals. Experts and professionals are a great threat to intellectual freedom and intellectual performance – as there is extraordinary pressure on them to commodify their skills and expertise in a field like AIDS[106]. Their role is to sell their wares to the

[105] This whole section draws heavily on the paper given at the Toronto conference
[106] Tariq Ali 2006 *Conversations with Edward Said* Seagull Books UK

establishment – not to say what the alternate to the present impasse is, but rather to maintain the status quo.

The system and the push for mainstreamed responses neither wants to nor in the end can accommodate the person who pushes for alternatives for a different vision – but for us, for you in the Catholic Church with its great traditions of liberation theology and social conscience, it is essential that we seek different and new ways to continue to think about HIV and AIDS. We have made great progress in many fields but we have still not got it right - our role now is increasingly to challenge the experts, to protect the human rights and dignity of all and to ensure that in the panic attack this epidemic creates we do not compromise on integrity, truth and debate.

Dealing with AIDS is not about consensus – it's about rigour, debate, dissent and conflict and it's about challenging all the-taken-for-granted assumptions so that we can truly say that we have done the very best we can to understand this epidemic and the social webs in which it moves. It's about intellectual bravery and always speaking the alternative view, the different take and through challenging the status quo, imaging a future that we would all be proud to inhabit.

The Spirituality of Caring

Archbishop Buti Tlhagale, OMI, Archdiocese of Johannesburg

(Paper presented to the SACBC, 1 November 2006)

Every epoch, every age, has its own markers, its own indicators, its own powerful signs of wretchedness, of misery, of its material and spiritual poverty, its own highs and lows of human progress. Its spirituality, the lived, experienced encounter between God and the community of believers, is determined, nourished and formed by its socio-economic and cultural contexts. For example, in the recent history of Southern Africa, the migratory labour system transgressed the social, moral and spiritual values of most of those who were directly or indirectly caught up in the system. It left in its wake, for those at the receiving end, brokenness, and palpable wretchedness. It tore families asunder creating and maintaining an environment in which infidelity thrived. It stripped men and women of their dignity. It was paradoxically, a viciously exploitative system whose promise of wealth and well being for its labour force was simply a blinding mirage. Men lived in constant fear of being swallowed up by the earth, or dying from diseases that prey on men who work underground. This was yesteryear's chilling marker, not of the sharing of wealth, but of the depravity brought about by poverty. It was an unnerving social commentary on the brutal relationship between power and poverty.

Poverty and HIV-AIDS

Today, it can reasonably be argued that HIV/AIDS is a compellingly powerful marker of human wretchedness. HIV/AIDS relentlessly afflict Frans Fanon's "the wretched of the earth". AIDS can be usefully compared to leprosy in the medieval European society (11`$^{n}$ to 13`^{n} century). Lepers, like AIDS victims, were disproportionately drawn from an economically deprived sector of the population (Peyroux 178). Unlike people living with AIDS, lepers of medieval Europe experienced a diminishment of their civil status. They were consigned to social death by being confined to a leper house or hospital. While social death is apparent in the case of people living with AIDS, legally, their civil status is protected by law in a culture where human rights prevail. But, in spite of the law, human prejudice and stigma weigh heavily against those living with AIDS.

Lepers and AIDS sufferers-compared

Medieval Europe, in speaking about the leper, addressed, not the disease, but the condition of poverty. They were referred to as the miserable, the wretched, the

afflicted or even Lazarus, that biblical figure whose body was covered with sores as he lay before the table of the rich man (Lk. 16.19). The leper was a "living icon of medieval poverty". Today, the majority of people living with HIV/AIDS are virtual icons of poverty especially the millions of orphans left behind by their parents who died of AIDS or who simply abandoned their children upon discovering their HIV/AIDS status. HIV/AIDS is like a vengeful demon that spreads terror among people already ravaged by poverty. This is the demon that defies being called by name. At funerals of people who die of AIDS, the word AIDS is not ever mentioned in spite of the public campaign to acknowledge the reality of AIDS openly (Peyroux 178). In the case of people living with AIDS, their condition of poverty is not highlighted.

Divine and Human Charity

What then should be the attitude of the Christian community in the face of poverty and the poor, in the face of power that fails to take the poor to heart, in the face of AIDS that frequently preys on the "have-not", in the face of the moral dilemmas of our contemporary society?

At the heart of the Gospel message is the call to friendship with God. "I call you friends because I have made known to you everything I have learnt from my Father" (Jn. 15.15). This friendship is realized through obedience to the love command: "Thou shall love thy neighbour as thyself'. (Lev. 19.18; Jas. 2.8). Preference is given to the poor." Has not God chosen the poor in the world to be rich in faith and to be heirs to the kingdom?" (Jas. 2.5). By healing the suffering, by touching lepers (Mk. 1.40), Christ made the sick recipients of divine charity. His interaction was by and large with the downtrodden, the afflicted, the wretched, the marginalized who found themselves at the mercy of the powerful in society. "I tell you solemnly, in so far as you neglected to do this to one of the least of these, you neglected to do it to me" (Mt. 25.45).

Exemplary models

For edifying and exemplary models of interaction between the healthy and the afflicted, again we resort to the spiritual commentary of hagiographers. A new register of interaction had emerged. Lepers became recipients of a kiss from heroic personalities, a gesture of respectful intimacy, of acknowledgment and acceptance in spite of, or perhaps because of, the gross disfigurement and physical mutilation brought about by the ravages of leprosy. St. Martin of Tours (4^{th} Century) kissed a leper at the city gates of Paris to the horror of on-lookers. The afflicted is said to have been instantly healed. This is one model of interaction between the healing saint and the victim of illness.

The other model is when the kiss of a leper by a saintly person is essentially understood as an act of self-abasement, of humility. This aspect of behaviour was highlighted in the narratives of the lives of the medieval saints such as St. Radegund, St. Martin and Matilda, the wife of King Henry I of England. The emphasis in the interaction between the saint and the sufferers fell on their tireless self-mortification and their legendary

devotion to charity to the indigent. In the poor, the afflicted, the wretched, they "saw" the "veiled" face of Christ. They experienced the powerful presence of the divine. Thus, the spotlight in the hagiographer's narrative shifted from the diseased indigent, to the spiritual attitudes of the healthy who deliberately transgressed the socially accepted values by publicly embracing those who were rejected and frowned upon. Diseased indigence became an opportunity for a spiritual about-face for the healthy.

It is perhaps this second model of interaction between the saintly heroes and the lepers who experienced physical decay, that has some relevance for our contemporary society in the face of diseased indigence.

This model focuses on the healthy whose judgmental attitude towards people living with AIDS simply exacerbates the already high levels of anxiety and depression, and drives the sufferers to a low sense of self-esteem, and even to suicidal behaviour. Like the saints of medieval Europe, our contemporary society could also use diseased indigence, people living with AIDS, as a new basis for both personal and community spiritual transformation.

In fact, there is a measure of cover-up, or a playing down, a softening of the diseased indigence by referring to AIDS sufferers as “people living with AIDS” and not AIDS sufferers, or victims of AIDS, or people afflicted with AIDS. In the vernacular language they are commonly called people with the three lettered word” i.e. A.I.D., a self-imposed taboo on the very appellation: AIDS. The disease is palpably feared. It is considered a death sentence.

Like medieval lepers, AIDS victims are thought to be at risk as “trespassers on the terrain of the healthy”. According to hagiographers, lepers of medieval Europe “occupied a highly charged and profoundly ambiguous position in medieval society”. But so too people living with AIDS in our contemporary society. Medieval society construed the continued existence of lepers as at best “a tolerable calamity and, at worst, a pernicious threat to the common good”. But so too AIDS sufferers in today's society.

Unlike in the medieval society, there are no church rites of separation, no exclaustration and no banishment of AIDS sufferers. In the mind of medieval Europe, leprosy was associated with moral decadence, the dissolution of the moral fibre of society, the transgression of the moral values of society. In our contemporary secularizing society, many wish to see AIDS as a morally neutral infliction, not even as a ritual impurity as lepers were perceived to be in medieval Europe. There is a perceptible reluctance to assume moral responsibility for the scourge of AIDS. And yet, the sense of guilt, of shame, is inextricably woven into the common experience of the stigma. Hence the uphill struggle to convince people vulnerable to the disease to test for HIV. AIDS is seen as a certified death sentence and indeed as a death shrouded in shame, hence the denial of its existence in the life of many individuals. Many individual stories record attempts at suicide or even actual cases of suicide. There are many heart-rending stories of bitter divorces and expulsions of AIDS sufferers from their homes, or even total destruction of families. AIDS as a medical condition is not always visible to the naked eye in its early stages, hence the need for testing so as to be able then to resort to medication.

The leprosy of medieval Europe on the other hand, was a chronic, infectious, degenerative disease. Leprosy visibly disfigured the face, the toes, the fingers, the nose. The nose discharged a foul smell. And so, unlike AIDS sufferers, lepers could not hide their predicament. Lepers, tragically reduced to the status of beggars, would ring bells to warn the healthy of their imminent approach. They shouted: tamen, tamen (unclean, unclean).

AIDS in our contemporary society has not yet come to enjoy the status of other chronic diseases such as diabetes, Alzheimer's, high blood pressure etc. The sense of shame is associated with moral guilt even though individual sufferers may be absolutely innocent. The healthy of course, sit in judgement over those who live with the disease in spite of the scriptural injunction: "Do not judge, and you will not be judged, because the amount you measure out is the amount you will be given" (Mt. 7.1).

The focus is to be shifted onto the healthy rather than onto the afflicted. Diseased indigence is an opportunity for the healthy to bear witness, to demonstrate fidelity to the love command. Diseased indigence is ostensibly a radical invitation to the healthy to exercise unrestrained generosity towards those who are desperate for a new lease of life. Those living with HIV-AIDS will genuinely accept their status openly and freely only when the healthy disown their own prejudices and cease to live in a world of denial.

As a community of believers, we too are to seek the face of Christ in the afflicted and to recognize the incomparable worth of the human person. We, as Christians, are invited to be the bearers of the Gospel of life to those who are sorely afflicted. Their cross has to become our cross; we are to become their "keepers", otherwise the basis for our claim to a Christian lifestyle and commitment, is tragically weakened.

Institutions of higher learning, pharmaceuticals, the medical fraternity, the private sector and governments, all have a moral obligation to plough resources into research that will yield results aimed at alleviating the human condition. Poverty and its pernicious effects can be significantly reduced if there is enough political will and genuine commitment to gospel values of empathy, of caring, of sharing, of communities. This country is committed to bankrolling a prestigious project, the 2010 World Cup event to the tune of 15 billion Rand, plainly speaking, to impress the world. The majority of the poor will not be affected by this spectacular display of wealth. The voice of the poor, wretched, the afflicted, is not sufficiently heard in the corridors of power. Not even by those who claim to represent the scum of the earth.

By caring for others, especially the afflicted, the wretched, the indigent, we become what we ought to be, the true disciples of Christ, and by the same token, we simply become more human. And the more human we become, the more Christ-like we become.

The Socio-Economic Impact of HIV and AIDS: A Challenge to the Church

Bishop Kevin Dowling, C.Ss.R, Diocese of Rustenburg

Selina's story is remarkable in many ways because it is so intensely human. Her story invited me to think deeply about the title of this talk *The Socio-Economic Impact of HIV and AIDS: A Challenge to the Church.* Selina was born in the Eastern Cape, and got married there. A son, Thabo, was born to her and her husband. But her husband was sick and died relatively young. Thus began a long and very painful journey for Selina, and I share it with you because one can sense in her story the structural sin that is present in our whole SACBC region in terms of this pandemic and its effects on God's little ones in society, which is indeed a challenge to advocacy and pastoral response by the Church.

As with so many others in the Eastern Cape, Selina, after the death of her husband, migrated to an urban area in a search of a way out of extreme poverty. She ended up, and so many thousands do, in an informal settlement amidst the platinum mines in the diocese where I minister. I met Selina several years ago and she became part of my life as I shared her ongoing struggle to survive.

When I came to know her at the informal settlement I experienced again the systemic or structural issues which are central to the HIV/AIDS pandemic, and why this virus is so prevalent amidst the poorest and most vulnerable of sub-Saharan Africa and its communities. These systemic issues are not confined solely to matters of personal and sexual morality; on the contrary. There are profound ethical and justice questions which have to do with policies created and implemented by human beings and governments, often the elites and powerful of the world, with very little consideration or care for what these policies do to the lives of the poorest and vulnerable of the earth.

Selina was and is a victim of all this. She arrived in the informal settlement and I have heard and experienced her personal story in so many others as well. A PhD student in theology came out from Maynooth University in Ireland to me in order to do research for her thesis on the structural issues around the AIDS pandemic. She spent a couple of weeks in the same shack settlement where Selina lived, and I told her to go round with our team of home-care nurses and make up her own mind. One day I met her there as she returned from a round of visits. She spoke to Tshidi, one of the home-care nurses in my presence: *Tshidi, I came across a young mother in a shack with 3 little kiddies. The mother was from another country. There was nothing in the shack, nothing. I asked if she had any money. No. Did she have any food? Nothing at all. Did she have a job? No, I am an illegal and cannot get an ID document. What are you going to do? I don't know, the woman said. Tshidi, what can she do?* And Tshidi's response was chilling in its

directness: *Like so many here, she must find a boyfriend today (one of the miners working there without their families), and she will get some money to buy food for tomorrow or maybe two days, and then she must find another boyfriend.*

Selina faced the same stark and brutal reality because she was so poor and could not find a job, because there were and are no jobs for people like her. She did the same many times, and ended up sick, infected with the HIV Virus, pregnant, and her little daughter, Karabo, was born also HIV positive. That was not a free choice to engage in what we call survival sex; she had no options at all in life. Her situation was a profound injustice crying out to heaven for redress, and it left Selina a very sick, a very vulnerable and very broken person.

Before the advent of anti-retrovirals Selina became very ill indeed. We had to find someone to care for Karabo and her son Thabo (who is healthy), and Selina was brought to our hospice in-patient unit a couple of minutes walk from where I live. I remember how we fought for her life, of how she was carried to our church with a dying little boy, Omphemetse, because both were too weak to stand or walk. We laid them down on the carpet at the altar for the healing service that morning just before Christmas. Omphemetse did indeed die in the hospice, surrounded by love and care and nursing from our team I visited him, held his hand and prayed for him the day before he died. Selina lived long enough until the anti-retroviral drugs became available. Through the treatment regimen she grew stronger, was released from the hospice, and went back to her settlement for follow-up care.

There she grew stronger under the watchful care of our anti-retroviral team, and received much love, encouragement and support from our team - and I tried to do the same every time I was able to visit her. She was helped especially through praying with others which is part of all that goes on there in our programme, and she attests to how she feels God is close to her. Her daughter Karabo was also placed on the ARV programme, and began to improve. Selina put on weight, came back to fairly normal health, and soon began to run a tuck-shop at the school, and helped out at our clinic by counseling other people and encouraging them by telling her own story. Because of the skills she picked up at our centre there, Selina was able to find a job in town, and now she leaves by taxi each morning with little Karabo. Her future is in God's hands and ours as we strive together to work for a better quality of life.

When one analyses that story, and when one proceeds from this individual story to the actual reality obtaining in all the countries of sub-Saharan Africa, and in the SACBC area in particular, one finds that the single common factor impacting most severely on the pandemic is poverty and its consequences: on the physical level - thousands living in squalid conditions without clean water, proper sanitation and refuse removal, and without adequate and nourishing food; at the emotional, psychological and spiritual level - the same people broken by the stigma, discrimination, rejection and lack of support even from Church members. So they live in loneliness and despair, aching to find a door of hope that will enable them to seek a way out of such unending misery. As I have looked at the tears of despair as a very sick young mother contemplates her very ill baby in a

boiling hot shack in the middle of summer, both of them infected, and wondering what will happen if she dies before the baby, I see so clearly how the structural and systemic issues lead to a profoundly personal suffering with so many aspects and consequences that it is hard to decide what must be prioritised by us as a Church community in terms of finding pastoral responses, and indeed a relevant spirituality for our people.

The reasons behind all this need to be sought through careful analysis leading to advocacy, an advocacy which must play its role as part of pastoral and spiritual care. The statistics which you all know are just so shocking that they numb the mind. Starting with Southern Africa: Zimbabwe 27.5% of the population infected, thousands of them now in South Africa as refugees on the run from police, getting deported, unable to get the asylum they need; Botswana and Swaziland with over 39% of the population infected, a threat to the survival of those nations; over 5.6 million infected in South Africa alone. It is now reliably estimated that 3-4 out of every 100 homes in South Africa are in the care of children with the entire extended family wiped out by the disease and clearly, that number will grow. Again, the figures for children who have lost their mothers are heartbreaking. In July, 2003, it was estimated that 990,000 children under the age of 18 in South Africa had suffered the trauma of losing their mothers to AIDS.

In Sub-Saharan Africa, over 29 million people are infected with the HI Virus, a great majority of whom will certainly die unless there is massive intervention, because they live in poverty and squalor, and are malnourished - therefore open to opportunistic infections of all kinds. What has become a manageable disease in the West because of the availability of ARV drug therapy, proper nourishment through food security and micro-nutrients, and a wide range of support services for the great majority of people in Sub-Saharan Africa, is an experience of stigma and marginalisation, and a passage to a painful, lonely and often horrible death.

To provide you with a simple picture of structural injustice and poverty on the global level, just consider the following facts I sourced from the UNDP Human Development Report 1998 and 1999 and the Ecumenical Coalition for Economic Justice:

- About 1.5 billion people were living in absolute poverty at the beginning of the new millennium. It would take just 5% of the wealth of the richest 225 people in the world to provide food, shelter, basic health care and education for everyone in the world who lacks access to these basic needs.
- The top three billionaires in the world hold assets worth more than the combined GNP of all 48 least developed countries (LDCs), with their population of about 600 million.
- The assets of the 200 richest people (over US$ 1 trillion) are higher than the combined income of 41% of the world's people.
- Just 100 transnational corporations (TNCs), based in the highly industrialised countries are the driving force behind economic globalisation. 70% of all trade takes place within and between TNCs.

- The terms of trade have deteriorated for most of the developing countries. Negative trade balances and falling export earnings have made many of the developing countries more dependent on foreign capital, therefore subject to the control of the politically and economically powerful.

On the basis of the available research, there seems to be little evidence of an improvement in the situation which impacts so negatively on the poor of the world, and more specifically Africa. To bring this macro-picture down to a manageable size, let us consider the case of South Africa. The impression most outsiders have of South Africa, particularly those who have experienced our tourist spots, is that this is a rich and well-resourced country. Poverty on a scale equal to that of other African countries? Surely that is not possible. So, let us take a look at the situation before South Africa's second democratic elections in 1999, and compare that with statistics I have for the year 2004, 10 years after our democratic elections.

Before the 1999 elections in South Africa some surveys were published which highlighted the huge imbalance or disparity in the way resources and wealth are distributed in South Africa. (Researchers use different criteria to compute the poverty datum line). In August 1997, the SA Non-Governmental Organisation Coalition (SANGOCO) reported that 53% of South Africans were living below the R301 per month poverty line, their estimate (NGO matters vol. 2, no 9, p 7).

In May 1998, the Government report *Poverty and Inequality in South Africa* estimated that at least 19 million people, or around 50% of the population, lived below the poverty line which Government calculated then at R353 per month. Government spends R240 billion annually in marginalised areas but little economic activity is actually generated there to enable people to empower themselves and live independently. When such estimates are analysed further, the unmistakable conclusion is that a relatively small number of people hold a hugely disproportionate share of the wealth of the land. This is seen in the so-called Gini Co-efficient. (It has been calculated that South Africa has one of the highest Gini Coefficients in the world: 0.58 [1997] as compared to an average of 0.46 for developing countries, and 0.34 for developed countries). The Gini Coefficient is an economic indicator, and is not difficult to understand. It measures inequality in income distribution in the population of a country. If income in a country like South Africa is perfectly equally distributed among the country's population, the Gini Coefficient would be 0. If all the income goes to just one person, the figure will be 1. So, the higher the figure or percentage between 0 and 1, the greater the inequality in income distribution.

South Africa's Gini Co-efficient was 0.58 in 1997. In other words, we were 58% along the way towards all the income going to just one person. In recent years, this has grown to 0.69 (2003 UNDP). South Africa, in fact, has one of the highest levels of inequality in income distribution in the world; as a result, one of the highest indicators of a serious imbalance in the sharing of available resources; and, as a further consequence, a huge gap between the relatively small but increasing number of rich and the massive numbers of poor. We precisely mirror the reality which obtains globally.

What was the overall situation in 2004, after celebrating our 10 years of democracy and another round of elections? With the emphasis on poverty reduction and delivery of essential services by Government, perhaps one would expect at least a small improvement in those figures. The analyses show that the Government's delivery programmes have significantly improved some aspects of the lives of the poor, e.g. access to water, electricity and low-cost housing, etc. But government's efforts to improve conditions have not yet reversed the negative trends in poverty, unemployment, inequality.

To summarise the situation, therefore. There can be little doubt that the situation is still as bad today for many millions. The Human Sciences Research Council Report (19 November 2004) stated that 57% of the population was living below the poverty line. That meant that roughly 22 million of our people live in the poorest 40% of households and the researchers reveal, on average, they survive on R144.00 per person per month (e.g. a family of 10 existing on one pension of a grandmother). This is less than the internationally defined level of 1 US dollar a day.[107] The poor survive if they can on small amounts of money, social grants and piece jobs. But last year statistics showed we had 5880 dollar millionaires in the country.

Let me also highlight another factor which makes the situation even more problematic; the increasing number of so-called illegal economic refugees from our neighbouring countries, and from countries to the north. The publication, *Refugees International*, in September 2004, put the figure at 2 million Zimbabwean refugees in South Africa, i.e. 15% of that country's population. The total number of economic refugees is variously estimated at between 4 and 6 million people, a number which will undoubtedly increase. These people cannot access social grants on which to survive because they are illegal and cannot obtain ID documents. How do they survive? That, in itself, as I demonstrated earlier, creates all kinds of social problems and a breakdown in the social fabric and family life, which will also impinge negatively on the overall goals of creating a better future for our population through education. A great challenge for the Southern African region as a whole.

Our political liberation in 1994, important as this was and will always be, can only be translated into real freedom for our people when there is true economic transformation in South Africa. And that highlights the root cause of poverty and inequality in South Africa, as in the rest of Africa and the developing world that the global economic system in which we as a nation state participate is essentially unjust, and until we achieve a more equitable global economic system and sharing of the world's resources, there will be little hope for the poor of our continent. As long as extreme poverty and the exclusion of millions from the possibility of a quality of life which accords with their inherent human dignity persist, there will be a fertile ground for conflict, divisions and war in underdeveloped nations and there will also be fertile ground for the spread of HIV and AIDS in our very midst in Southern Africa.

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[107] (Claudia Hausmann, Poverty and the Current Social Assistance Programmes in South Africa, Applied Fiscal Research Monograph No. 21 [April 2001], 24-25).

The challenge for the Church in South Africa, as elsewhere on the African continent is this: how to advocate for, promote and sustain a democracy that is meaningful to the entire nation; how to advocate for a culture of human rights, personal responsibility for others, and good governance in all our countries so that we can then work for a more just economic system which will create the necessary conditions for development strategies and programmes to work; how to advocate and work for a more just world economic order, a more just economic system in Southern Africa so that the impoverished masses are enabled to journey towards the ideal of Jesus, viz. that all people, but especially the poor, may have life and have it to the full (John 10:10)7 These goals are at the heart of the quest for economic justice, development and peace. That is why all that departments like Justice and Peace with its SADC Trade Desk, the Catholic Parliamentary Liaison Office and so forth, are working with our networks in advocacy initiatives at the European Union, and in the UK and USA, on issues like the international debt, a just trade system, the phasing out of agricultural subsidies in the developed world, and so on. These issues are central to the Church's mission of evangelisation, and not extras, nor should they be considered as being on the margins of pastoral vision and strategies as they so often are in practice.

At the level of our own communities, therefore, our pastoral responses to HIV and AIDS have to be worked out within this actual context of extreme poverty. The situation demands a holistic response. We cannot plan and implement programmes of catechesis and liturgical formation, and other pastoral programmes which are suited to a situation of relative stability and economic security, where people have jobs and live a healthy life-style, and pretend that we can just translate these into situations of extreme poverty. Pastoral Care has to deal with the whole person in their total socio-economic and cultural situation, and to develop responses and practical programmes accordingly. The whole person needs healing, new life and beginnings, which means their total context needs a response from the Church, and above all from us as priests working with our teams, communities, and individuals.

The Church's advocacy and pastoral response, therefore, must be characterised by this holism; we, i.e. the Church as a whole, need to develop projects like skills training, community development programmes, ID/social grant initiatives in the communities, so that people especially vulnerable women and girl children can be given the skills to find a way out of the trap of poverty and personal danger. We need to respond to social and cultural attitudes and practices, to the power dynamics in society and the family, which have an impact on this pandemic, especially in terms of their effect on women and girl-children. We need to extend our personal pastoral skills into working with and empowering teams of people from our communities which can be trained and given nursing, child-care, counselling, and other skills to respond to the emotional and psycho-social needs of orphaned and vulnerable children, and hurting and broken adults, and include in this the spiritual care of sick and affected people. We need to provide for the stress and suffering of our co-workers who face the misery and dying every day, so that they can remain wholesome as people and empowered to continue with their vital work, which will also include the spiritual dimension. We

need, as pastors, to be regularly present in the very reality of poverty and misery so that our knowledge of this disease does not remain theoretical. We need to allow the situation of people to question our assumptions and theological training, and begin again to learn what holistic spiritual and pastoral care in such situations of misery is, in fact, all about. I don't think I will ever stop learning from my experiences with the precious and vulnerable human beings who have been and are God's gift to me in this pandemic.

As a Church and faith community we take our inspiration from the prophet Micah, i.e. with ever greater sincerity and commitment to act justly, love tenderly, and walk humbly with our God (Micah 6: 6 8) - and with our sisters and brothers especially in the marginalised and impoverished communities we serve; to work together to overcome all unjust structures, policies, attitudes and ways of living/acting which diminish and destroy the inalienable right of all people to a quality of life which corresponds to their fundamental dignity as people made in the image of our God.

Working together ecumenically around AIDS

Canon Desmond Lambrecht, Anglican AIDS Trust, Cape Town

Introduction

"As we follow the example of Jesus, in loving and giving, we are likely to find ourselves drawing more deeply than ever before on the wells of God's compassion. Yet we have confidence in his promise that he will 'equip us with everything good for doing his will and working in us what is pleasing to him.' (Hebrews 13:21)

It has been said the Church is the only society that exists primarily for its non-members. Well perhaps we are not entirely unique. But we must remember that so much of Jesus' own ministry was directed to those on the margins of society – the poor, the excluded, disreputable sinners.

HIV/AIDS hits the poor hardest of all. It is also a disease that too often marginalizes and excludes, not least because of its associations with sex. The Church must take much of the blame for the issue of stigmatization, and its attendant problems of fear, denial and silence. Christianity has too often espoused a destructive theology that links sex and sin and guilt and punishment. We must take the lead in overturning these distortions.[108]

Ecumenical response by the World Council of Churches

[108] "The challenge of HIV/AIDS to Christian Theology" – Archbishop Njongonkulu Ndungane

The global epidemic – or "pandemic" – of the Human Immunodeficiency Virus (HIV) and the consequent Acquired Immunodeficiency Syndrome (AIDS) has evoked responses from many national governments, United Nations bodies and non-governmental organizations. There are many reasons for the churches to respond to this challenge and to join hands with the worldwide effort to provide care and support, to reduce vulnerability to HIV and to alleviate the impact of the pandemic.

The pandemic reveals the tragic consequences of personal actions which directly harm others, and of negligence which opens persons to additional risk. It exposes any silence and indifference of the churches, challenging them to be better informed more active and more faithful witnesses to the gospel of reconciliation in their own lives and in their communities.

Increasing numbers of people worldwide are falling sick, suffering physically, emotionally and spiritually – many in abandonment and desolation. Men, women, young people and children are dying; families and communities are severely affected socially and economically, particularly in less affluent countries. The effects of HIV/AIDS are impoverishing people, breaking their hearts, violating their human rights and wreaking havoc on their bodies and spirits.

Jesus Christ demonstrated God's love to all human beings, coming to be present in the midst of human struggle. If the churches are to fulfill their mission they must recognize that HIV/AIDS brings the lives of many people into crisis and that is a crisis which churches must face. The crisis also challenges the churches to re-examine the human conditions which in fact promote the pandemic, and to sharpen their awareness of people's inhumanity to one other, of broken relationships and unjust structures, and of their own complacency and complicity. HIV/AIDS is a sign of the times, calling us to see and to understand.

It was for this reasons that the central committee of the World Council of Churches, meeting in Johannesburg, South Africa, in 1994, mandated the formation of a consultative group to conduct a study on HIV/AIDS that would help the ecumenical movement to shape its response in the three areas of theology and ethics, pastoral care and the church as healing community, and justice and human rights. The study would challenge the churches to be more honest, more faithful and better informed – and to become communities which are safe places for people living with HIV/AIDS.

This process has been in itself an ecumenical journey. People with experience and expertise in various fields related to HIV/AIDS, coming from all continents and many confessions and including some persons living with HIV/AIDS, came together to be a part of this journey.

At various stages of this ecumenical journey members of the consultative group were exposed to the realities of communities and individuals living with HIV/AIDS and working in AIDS-related projects. During these exposure visits – which took place in

South Africa, the USA and India – preliminary findings from the study were shared with local community members, and their comments invited.[109]

This innovative move encourages us to constantly search for God's will in an ever changing world. In the worldwide struggle to find answers to the challenge of HIV/AIDS there are almost every day new discoveries, new information, new responses and new reports on how communities are affected by this pandemic. No report issued at any particular point in time will provide the final answerers to this challenge; it can only be a part of a continuing process. It must also be remembered that issues related to HIV/AIDS are extremely complex and we need extraordinary measures to deal with this pandemic.

Finally, it is the churches themselves which are affected by HIV/AIDS, and their credibility depends on the way in which they respond. They are confronted with people, members of the body of Christ, who not only seek support and solidarity, but who ask "Do you want to be my brother and sister?"[110]

21st Century Challenges

It is critical to explore the relationship between economic, social and cultural variables and the spread of HIV – who becomes infected with the virus and with what spatial distribution. Examples which have been identified as having a casual role in the spread of the virus include gender (more specifically the economic, social and cultural lack of autonomy of women, which places them at risk of infection); poverty and social exclusion (the absence of economic, social and political rights); and labour mobility (which is more than the physical mobility of persons and includes the effects on values and traditional structures associated with the process of modernization). At the core of the problem of transmission of HIV are issues of gender and poverty.

Thus, the classical components of development – transportation systems, labour markets, economic growth, governance, poverty and more – are within the casual framework which determines the patterns and speed of spread of the virus. These components will also be affected by the impact of the spread of the virus, its associated mortality and morbidity and the burden of dependency and social disruption it will create. No longer can the implications of failures to alleviate poverty or success in employment be understood in isolation. All of the components of development affect what happens with the HIV epidemic.

At a recent conference hosted by the Anglican Church of Southern Africa, (TEAM – Towards an effective Anglican mission – April 2007) the following recommendations were adopted.

[109] Facing AIDS – The challenge, the Churches response – WCC Study document

[110] Challenge: Church and people – June 1999

Eight centered on the Millennium Development Goals (MDGs) which was a main focus of the conference - plus two additional ones were developed out of the conference's many discussions, debates and dialogues.

The Millennium Development Goals are "the starting point for a world that reflects God's principals of exclusivity, because of the consensus that exists around them, we have framed our recommendations around the eight objectives," Ndungane said. "However, as the people of God, we are required to do much more" he added. "So in addition to recommendations around the MDGs, we have included others that are critical to advancing the developmental agenda."

The first recommendation is connected to the first MDG of poverty and hunger eradication. "Given that food can be utilized as a weapon of war in various conflicts globally, this body has been emphatic in stating that the Church must exert pressure on governments and international bodies to ensure that food is used for the nourishment and development of our future -- not as a tool of war," We need to contribute to the creation of sustainable food production systems globally.

The second recommendation involves education and acknowledges that schools "have become extended homes and can serve as nodes of social service delivery," "By supporting school feeding programs and strengthening the capacity of educational institutions within our parishes, we can have a very real impact," adding that churches must also advocate for stronger schools and curriculums, and adult literacy programs.

The third recommendation addresses gender, equality and empowerment of women.
Noting that "that girls and women continue to suffer disproportionally from the effects of poverty, disease and hunger, "as a community, we recognize the importance of our sisters, mothers, daughters, aunts, friends and colleagues in living out our mission and in reflecting the vision of humanity illustrated in the Gospels."

"Accordingly, alongside the policies and programs to serve the needs of girls and women - which serve all of our needs, we need a change of mindset, in both men and women, about gender and gender roles, "Therefore, in our dialogues going forward, we have committed to using language that is inclusive of women and non-threatening to men. We will strive to do this not only in our dialogue, but also in our worship."

We are to "examine the Bible, the source of our mission, to speak against patriarchy and to advocate for equality." "We will use scripture to combat domestic violence and sexual abuse," he said, calling for partnerships between women and men. "Not only will we use these resources within our body, but we will advocate in our communities at large for an end to violence against women."

The fourth recommendation addresses child mortality
Noting that "a disproportionate number of our children suffer from malnutrition and hunger leading to an unnecessarily early loss of life," We need to ensure that our youth have the opportunity to grow and develop into all that God has called them to be."

The fifth recommendation addresses maternal health. "In an effort to preserve the lives of our mothers, this assembly has expressed a desire to mobilize constituencies within the Church to raise awareness about maternal health issues,"
"Equipping communities with pertinent maternal health information as soon as possible will be a critical element of our campaign,"

At both local and international levels, we will advocate for improved transportation and health infrastructure within communities," "This will enable women in crisis to reach health facilities in a timely fashion and help to ensure that they receive adequate medical attention once they reach those facilities."

The sixth recommendation addresses HIV/AIDS and other preventable diseases.
"At the national level and in the international arena, a need has been expressed to advocate for education about the prevention, transmission and treatment of HIV and AIDS."

The church must work for improved access to treatment, voluntary counseling and testing, and to enter the debate about intellectual property rights and the dissemination of anti-retroviral drugs. "As we pursue these strategies, however, we will not forget the individuals behind the statistics and figures," he said. "We will remember and serve those orphaned and made vulnerable by this global pandemic. We will advocate for and support the provision of material goods while ensuring that grief counseling and the necessary support are given to families impacted by HIV and AIDS."

The seventh recommendation is around the subject of environmental sustainability
The conference called for Anglicans to advocate for the development of renewable energies as well as a reduction in carbon dioxide emissions and other greenhouse gases. "Additionally, we will hold our various governments and multinational corporations accountable," he said. "Polluting God's creation for the benefit of the few, and to the detriment of the majority, is not something we are prepared to stand silently by and watch."

The eighth recommendation addresses the need for partnerships to accomplish MDGs.
"In all of the goals we endeavor to achieve, you will note that partnerships are a vital and important part of our strategy,'' Partnership is a cross-cutting issue and at congregational level we need to seek new opportunities in working with other FBO's.

Current international partnerships

The Ecumenical Advocacy alliance is a broad international network of churches and Christian organizations cooperating in advocacy on global trade and HIV and AIDS. Within our body are a wealth of resources, expertise and knowledge that we should utilize to the fullest and ecumenical partnerships must be nurtured.

National and local partnerships

- South African Government
- South African National AIDS Council
- SA Christian HIV/AIDS Consultative Process
- CABSA – Christian AIDS Bureau of SA
- CARIS – Christian AIDS Resource and Information Services
- Local ministers fraternal

The ninth recommendation focuses on refugees, internally displaced people, and asylum seekers, "which the Church recognizes as important and central to our mission,"
"In affirming our commitment to the plight of refugees and displaced persons, as a body we are reaffirming our Christian commitment to offer unconditional hospitality and pastoral care to the stranger," he said. "As part of this work, we will develop strategies for communicating the challenges faced by displaced persons to the global media and policy makers while mobilizing resources for their ... emotional and physical care."

The final recommendation expands on the MDG's focus on children.
The conference has articulated the importance of creating networks to address issues of children's rights and welfare, including, but not limited to: child trafficking, child soldiers, gangs, child abuse, suicide, addictions, and other issues,"

That work includes support for orphans and those who adopt them and "a desire to integrate issues of child welfare and full participation of young people into every aspect of church life, from baptism preparation, Christian education, youth groups, and confirmation preparation, to leadership in the church's worship, governance, and public life in order to nurture their full potential,"

The way forward

In many communities, worldwide, this moment is one of crisis and kairos. AIDS is increasing its deadly toll. Parents are dying, so that incomes disappear and there are growing numbers of orphans and desperately poor families. Incomes are further eaten away by the cost of caring for the sick. Young people are at greatest risk. In severely affected regions, our priests, pastors and lay leaders are stretched to breaking point by the increased burden of funerals, the support of dying people and their families, the care of orphans and those who look after them, and their efforts to provide a ministry to the sick. They are aware, meanwhile, that what they are seeing is only the tip of the iceberg. In communities, among church congregations and among clergy themselves, HIV is silently advancing.

In this situation, says a South African priest, "Our theological education and pastoral formation have left us feeling like a cricket team, send out onto the field only to find that the bats we have been given are broken."

In the mysteries of life and death we encounter God: this encounter calls forth trust, hope and awe rather than paralysis and immobilization. The AIDS crisis challenges us profoundly to be the church in deed and in truth: to be the Church as a healing

community. AIDS is heartbreaking, and challenges the churches to break their own hearts, to repent of inactivity and of rigid moralisms. The HIV and AIDS crisis is bringing us together because we are living with HIV and AIDS. We need to share knowledge, understanding and experience from our various religious communities so that our efforts become more and more effective and inclusive. Through this, we will seek to establish a new culture of interfaith cooperation, respecting the uniqueness within our traditions while focusing on our shared values of human dignity and human rights.

Have religious communities done enough to respond to the urgent challenges posed by HIV and AIDS to individuals, communities, and the global human family? We need to acknowledge with much regret that quite often our response has been one of prejudice, ignorance, fear, and judgmental attitudes.

There is an urgent need to build communities that are welcoming, supportive and capable of breaking the silence about HIV and AIDS. Our churches in particular are to become sanctuaries of prayer, reflection, acceptance and care and therefore I humbly offer the following insights as part of your ecumenical response to the pandemic.

- Churches to provide a climate of love, acceptance, and support for those who are vulnerable to, or affected by, HIV/AIDS. This could be expressed by providing space for these concerns to be raised within regular worship, by special worship events.

- Churches could reflect together on the theological basis for their response to the challenges posed by HIV/AIDS

- Churches could reflect together on the ethical issues raised by the pandemic, interpret them in their local context and offer guidance to those confronted by difficult choices.

- Churches could participate in the discussion in society at large of ethical issues posed by HIV/AIDS, and to support their own members who, as health care professionals, face difficult ethical choices in the areas of prevention and care.

Furthermore :

The witness of the churches in relation to immediate effects and causes of HIV/AIDS

- Churches could work for better care for persons affected by HIV/AIDS.
- Churches could give particular attention to the conditions of infants and children affected by the HIV/AIDS pandemic and to seek ways to build a supportive environment.
- We ask the churches to help safeguard the rights of persons affected by HIV/AIDS and to study, develop and promote the human rights of people

living with HIV/AIDS through mechanisms at national and international levels.

- We ask the churches to advocate increased spending by government and medical facilities to find solutions to the problems – medical and social – raised by the pandemic.

The witness of the churches in relation to long-term causes and factors encouraging the spread of HIV/AIDS.

- Churches need to recognize the link between AIDS and poverty, and to advocate measures to promote just and sustainable development.
- Churches need to reflect collectively on situations that increase vulnerability to AIDS such as migrant labour, mass refugee movements and commercial sex activity.
- The full dignity of women and children need to be restored as we provide holistic care and support in our churches.
- Men and youth should form an integral part of educational programs in order to prevent the spread of HIV/AIDS.
- Churches need to explore more fully the gift of human sexuality in the contexts of personal responsibility, relationships family and Christian faith.
- Churches need to address the pandemic of drug use and the role which this plays in the spread of HIV/AIDS and to develop locally relevant responses in terms of care, de-addiction, rehabilitation and prevention.

Conclusion

Albert Nolan remarked that Christian faith cannot be lived in the abstract. We always practice our faith at a particular time and in particular place – in our historical circumstances. The challenge has always been deeply conscious of the political, economic, cultural and church context within which we are called to be disciples of Jesus Christ.

The Christian church is significant in the lives of millions of people throughout Africa. The church is responding to AIDS through treatment, care support and communicating prevention messages. It has reached many through mobilizing large numbers of motivated volunteers. However, much more could be done – more could be reached, with better quality. Unhelpful messages around gender, sexual practice and stigma must be addressed to reduce infection, improve take up of services. The church must rediscover God's call to speak for justice. [111]

As the church we face a huge opportunity to demonstrate unconditional love of Jesus and to reiterate this point let me quote an African proverb. *If you want to go far, then go alone. If you want to go far, then you must go together*

[111] "Working together" –Together we have a voice – TEAR Fund August 2006