Catholic Responses to AIDS in Southern Africa
Catholic Responses to AIDS in Southern Africa

EDITED BY
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Southern African Catholic Bishops’ Conference

IN COLLABORATION WITH

GRACE & TRUTH
St. Joseph's Theological Institute
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Worldwide, Southern Africa has been the region most affected by HIV and AIDS. In 2011 it was estimated that about 10% of the population was HIV positive. But a much higher percentage of the population has been affected by the consequences of infection. Many have had to deal with the care and support of family and friends infected by HIV. Many others have been affected by the loss of parents or other significant others as a result of AIDS related deaths. This includes up to 2 million “AIDS orphans.”

The Catholic Church in Southern Africa has been one of the principal players in the response to this crisis. From a relatively slow beginning in the 1980s it had become a major provider of health care and information on HIV prevention by the early 21st century. This book examines both the pastoral outreach and the theological motivation for this involvement.

Despite a pastoral response in health care and social outreach quite out of proportion to the size of the Church in this region, the Catholic Church is largely viewed by society as having a negative impact on the scourge. A simple Google search of “AIDS and Catholic Church” reveals (apart from Catholic Church sites) an almost entirely negative set of comments focusing on only one thing: condoms. That such a single minded universal scapegoating dominates is a sad reflection on the manipulation of truth in the modern world. It shows how control of the means of production in information technology creates hegemony based on secularist philosophical approaches to libertarianism in sexual freedom. The reality is much wider and much more nuanced than this prejudice. This book hopes to play a small role in redressing the balance.

During 2013, a conference on the response of the Catholic Church to HIV and AIDS was held at St Joseph's Theological Institute, Cedara KwaZulu-Natal. This book brings together papers presented at the conference together with some significant documents of the Catholic Magisterium in Southern Africa and beyond written during the course of the last 30 years. The book is divided into three sections. The first section is reproduced, with permission, from Grace and Truth Volume 30 No. 2
Section 1 Catholic Pastoral Responses to AIDS in Southern Africa

In the first article, Alison Munro OP, Director of the Southern African Catholic Bishops' Conference AIDS Office discusses the history of this response from the perspective of the AIDS Office. In a wide ranging and seminal article she constructs the history of the response of the Catholic Church in Southern Africa. A small but effective beginning which caught the eye of funding agencies led to a synergy between the growth of funders and the rapid emergence of grass roots programmes in treatment, care, prevention and solutions for those affected such as orphans and vulnerable others.

Wilfred Cardinal Napier OFM, Archbishop of Durban, presents an overview of Catholic responses to HIV and AIDS within an urban local Church examining the particular challenges and responses that the urban context requires. He also discusses the changes made as a result of experience gained.

Kevin Dowling CSsR, Bishop of Rustenburg, discusses the challenges and responses to HIV and AIDS within a rural local Church. His article examines issues such as the lack of resources in rural areas and the ongoing consequences of migration into informal settlements around the platinum mines.

Ruth Stark and Marisa Wilke focus on the growth, development and challenges presented by the rapid growth of the Antiretroviral Treatment (ART) Programme of the Catholic Bishops in Southern Africa which at one time was one of the largest ART programmes in the region. They also discuss challenges and new opportunities for the programme as the government responds more effectively.

Susan Rakoczy IHM examines the place of Spiritual Direction in the context of HIV and AIDS based on her study of spiritual directors in the South African context.

Raymond Mwangala OMI examines the impact of HIV and AIDS in Catholic Theological Education. From his study of courses, modules and student groups responding to HIV and AIDS at St Joseph's Theological Institute he argues for a greater insertion of the study of social phenomena such as this into the theological curriculum.

Alison Munro OP, in a second article, presents her research on the
question of HIV testing of candidates for the Priesthood and Religious Life in Dioceses and Religious Institutes. She argues for a system that respects individuals and communities based on transparent procedures for testing and policies regarding the acceptance or rejection of candidates.

In a final article based on the immense contribution of Religious Sisters to the Church's grassroots response to HIV and AIDS, Melanie O'Connor HF situates this particular response within the wider contribution of Religious Sisters to health care in South Africa.

Section 2 Catholic Theological Reflections on AIDS in Southern Africa and beyond

The articles in section 2 focus on theological reflection. This is an area which is widely underrepresented in worldwide discourse on HIV and AIDS, a fact that has led to many misunderstandings and a lot of prejudice. Most of the articles have a special reference to Catholic theological teaching but others widen the discussion.

The first two articles situate the Southern African response within the wider African and then global contexts. In the first article Michael Czerny SJ examines the global Catholic responses to HIV and AIDS since the discovery of HIV. He shows how witness to truth, effective pastoral action, and competent educational, medical and social services within a holistic approach define the characteristics of this ecclesial response.

In the second article Agbonkhianmeghe E. Orobator SJ examines Catholic responses to HIV/AIDS in Africa within the theological category of conversion. He shows how the trajectory of these responses stretches from denial and resistance to conversion and engagement via moments of stigmatization and marginalization as well as compassion and care for people living with AIDS.

The third article examines the controversial theological category of sin and its application to HIV and AIDS within the framework of inculturation in urban Africa. It promotes the need for the construction of systematic theological models which can inform pastoral action and ministry. Here the method is deliberately applied to the prevention of HIV and AIDS using the theological category of "sin", an area which is so unpopular amongst secular and naturalist interlocutors yet essential for theology. The model presented uses Biblical Theology and
Theological Anthropology incorporating local cultural models found in the urban African contexts and an Ecclesiology of HIV prevention.

Chris Grzelak SCJ examines Interreligious Dialogue and Collaboration in the struggle against HIV/AIDS between the Catholic Church and other religions in South Africa. He posits the theological truth that the idea of working together for a common good of humanity has today become a founding principle for interreligious dialogue. His study shows that there is little formal dialogue on HIV/AIDS in South Africa between Catholics and other believers. Nevertheless there is evidence of informal interfaith contacts and cooperation on HIV/AIDS, mainly through faith-based and nongovernmental organizations.

Charles Ryan SPA examines the 'Condom Controversy' from the time of the identification of HIV and AIDS to the present. He clarifies traditional moral teaching on the question of condom use and sinful behaviour within the Southern African context. He notes that throughout the AIDS pandemic the official position of the Catholic Church remained basically unchanged until 2010 when Pope Benedict XVI appeared to adopt a more lenient attitude to the use of condoms. This paper will explore the reactions to the Pope's 2010 statement and see whether they constitute a change in the Church's position on condoms.

Clifford Madondo examines the phenomenon of community based volunteers who are often at the forefront of grassroots ministries to HIV positive and AIDS patients. Using the ecclesio-genesis theories of Leonardo Boff, he examines the question whether community-based volunteers, understood as a Religious Health Asset due to their faith and/or religious solidarity and vibrancy, can be considered a new form of being church emerging in a time of HIV and AIDS.

Finally Philippe Denis OP poses the question Does HIV and AIDS change the faith in local communities? And conversely does Christianity – as well as the other religions – have an impact on the evolution of the HIV/AIDS epidemic in Africa? Using the methodology of oral history he attempts to provide some answers to these questions. Without ignoring the current debate on the relationship between HIV/AIDS and religion in Africa, the paper focuses on “voices from below”, those of men and women infected and affected by HIV/AIDS and involved in daily efforts to cope with the disease.
Section 3 Selected texts from the Magisterium of the SACBC Region

The Southern African Catholic Bishops’ Conference has issued a relatively large number of documents and statements on issues surrounding HIV and AIDS. Most of these are available at the SACBC AIDS Office website: http://aidsoffice.sacbc.org.za/. It was considered important to reproduce some of the main documents in this book.

These reflect the important messages Catholic Church leaders wished to make during the course of the last twenty five years. They include two formal Pastoral statements by the Southern African Catholic Bishops’ Conference (1990; 2001). There are also two formal messages from the Symposium of Episcopal Conferences of Africa and Madagascar (2001; 2003).

Other statements relate to specific issues. In 2003 the SACBC AIDS Office endorsed the Treatment Action Campaign (TAC) civil disobedience campaign against the government lack of response to HIV and AIDS in South Africa. In 2004 the SACBC called for greater cooperation between State and Church in assisting people with HIV and AIDS. In the same year the Church announced a R 16 million contribution to fight HIV and AIDS. In 2005 the Catholic Bishops announced the launch of their antiretroviral programmes in 22 sites in Southern Africa. In 2006 Catholic and Jewish leaders announced collaboration in the fight against AIDS.

Finally two messages of individual bishops are included for their importance in promoting international collaboration (Dowling) and promoting local commitment by fighting against stigma and providing care for people with AIDS (Tlhagale).

I would like to thank Sr Alison Munro OP my co-editor who has worked tirelessly in much of the proof reading and copyediting of the text of this book. Thanks also to Jo Peltzer of Cosmic creations for the copy editing and cover design and to Mariannhill Press for the speed and efficiency in the printing of the book.

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General Editor

St Joseph's Theological Institute
Cedara, KwaZulu-Natal
January 2014.
Together with being well known and popular, the parable of The Good Samaritan remains an expression of concrete love.

More than 30 years ago, HIV/AIDS became part of our vocabulary and our daily lives and remains so until today.

From the very beginning the Catholic Church, like the good Samaritan, felt it could not look the other way or “pass by on the other side” but expressed that compassion that is able to change some else's life.

The history of these more than 30 years shows that there was never a single answer to the pandemic. HIV kept challenging us all the time to find new answers to make possible Jesus' “go and do the same”.

When we started training people to do home based care we discovered how strong stigma was and how difficult it became to identify HIV positive people. It seemed we all had it and at the same time no one had it.

We started burying young people every week. In 2001 half of the people who died in my parish were younger than I, and I was only 40 years old. We desperately needed to make sure we would educate for life and not for death.

In areas where one person of every three was HIV+, there was no family who was not unaffected by HIV/AIDS. Supporting those infected and affected, helping discordant couples, helping the helpers - those home-based carers who were struggling to cope with a disease that was taking away the people they were caring for - became also part of our response.

We suddenly found ourselves with thousands of orphans and as a Church we wanted to make sure that they'd experience God's love and

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1. Apostolic Administrator of Ingwavuma and SACBC Liaison Bishop for AIDS.
never lose hope in the future. At the same time we worked to reduce the transmission of the virus from mother to child.

We struggled with denial and statements from the political leadership that delayed the much needed help and had the power to destroy years of AIDS awareness.

ARV therapy appeared as a sign of hope but costs were huge and it seemed impossible to access it. But it was clearly a matter of life and death. So some lobbied the US government making sure our countries would benefit from the ARV therapy.

I personally believe that the creation of the SACBC AIDS office was God's gift. We would as Church not have been able to do so much for so many without it. I clearly saw it as a priest and later on as a bishop. We could count on our people at every step of the journey but we would have never obtained the resources that were needed in so many cases.

This book is about a Church that never stops being the Good Samaritan. This book is about thousands and thousands of people who felt compassion, who stood at the side of those suffering, who bent, who healed, who generously put their lives at the service of those who needed it most. They did it silently. They still do. It is about the power of a faith that believes “nothing is impossible to God”.

I believe that HIV/AIDS has challenged us like no other disease. It has given us no rest. Our journey is not yet over.
PART 1
Catholic Pastoral Responses to AIDS in Southern Africa
RESPONSE OF THE CATHOLIC CHURCH TO AIDS: AN SACBC AIDS OFFICE PERSPECTIVE

Alison Munro OP

The SACBC AIDS Office helped to put the Catholic Church's response to AIDS on the map. After initial hostility towards the Church, it has come to be recognised as a valuable partner in local communities. Major grants from 2000 helped expand the response to AIDS, supporting pastoral and spiritual care, prevention, home based care, TB screening, treatment, care of orphans and vulnerable children, and orphan housing programmes. Home based care of the sick and dying was initially the major response in an estimated 70% of the projects. The Church's treatment programme became one of the biggest NGO treatment programmes in South Africa. Thousands of children orphaned and made vulnerable by AIDS have been assisted since 2000. In 2010 the AIDS Office began its houses for orphans programme.

THE SACBC AIDS OFFICE

Establishment of the SACBC AIDS Office

The Southern African Catholic Bishops' Conference (SACBC) established an AIDS Desk in the early 1990s initially as part of the SACBC Department of Healthcare and Education, and then on its own. Different people staffed it over approximately eight years. There were however some difficulties, not least of which was the lack of the necessary funding to support the AIDS response of the Church in thirty dioceses and four countries, including Namibia which in 1994 formed its own episcopal conference.

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2. SACBC Archives: Bishop Hugh Slattery attended a Vatican AIDS consultation in Rome in 1987. The Department of Health Care and Education of the SACBC was represented at the Fourth International Conference on AIDS in 1989 and organised the first SACBC AIDS consultation in March 1990.
3. SACBC Archives: The first AIDS co-ordinator served from September 1992 to mid 1995, the second from mid 1996 to early 1997. CATHCA was asked in June 1998 to take over temporary management of the SACBC AIDS response.
For one year Catholic Health Care (CATHCA) temporarily managed the SACBC response, convening an AIDS summit in Pretoria in 1998, and organising a study day for the bishops in early 1999. After the study day Bishops Cawcutt and Dowling re-established formally the Catholic Church's AIDS response at SACBC level in conjunction with three associate bodies, CATHCA, the Catholic Institute of Education (CIE), and the Development and Welfare Association (DWA), and other members. Before the end of 1999 the promise of a significant amount of money to begin addressing AIDS was on the horizon: US $ 5 million from the Catholic Medical Mission Board (CMMB) over a five year period.

From 2000: An office of the SACBC

What the bishops of the SACBC clarified from the start is that they wanted their AIDS response in an office of the Conference itself, with accountability through the secretary general. There were some discussions in the initial year at management committee level about the new SACBC AIDS Office becoming an associate body, but the Bishops' Conference did not approve the suggestion. The naming of the office was also important. Given the pressure that there was to have it understood as an office within the conference it was decided to call it the SACBC AIDS Office.

NPO, PBO and VAT registrations

It took some years for the SACBC to approve the SACBC AIDS Office being registered as a Non Profit Organisation (NPO). This was a critical step in enabling the AIDS Office to seek funding from South African and

4. Catholic Healthcare (CATHCA), Catholic Institute of Education (CIE), Development and Welfare Association (DWA), now called Siyabhabha Trust are associate bodies of the SACBC, each with its own board and funding sources.
5. SACBC Archives: Bishop Dowling and Archbishop Tlhagale signed the agreement with CMMB in New York, February 2000.
6. Offices of the SACBC have liaison bishops who do not necessarily belong to the SACBC administrative board. The SACBC Secretary General ensures that the concerns/issues of the various offices are raised at the SACBC administrative board.
7. SACBC Archives: There were several different names prior to 2000 according to meeting minutes/reports.
8. Offices of the SACBC are directly under the SACBC and are not usually able to register as separate entities in civil law.
other donors outside the traditional Catholic partner base. Following this it was also registered as a Public Benefit Organisation (PBO) giving the SACBC AIDS Office tax exempt status.

Value Added Tax (VAT) vendor registration became necessary during the PEPFAR-funded period, initially to claim VAT refunds on drugs and laboratory services, and from 2008 to claim on other payments. Some refunds later formed part of the income of the AIDS Office itself.

Staff

The AIDS Office was staffed for the first six months by one person, but by the beginning of 2001 there were five staff members. Over the years as additional funding became available and more programmes were implemented new staff members were employed, making their contribution to combating the spread of HIV and gaining experience, and then sometimes moving on to similar work in other organisations where salaries were often higher than they were at the SACBC. Increases in the AIDS Office salaries could only be made in line with overall SACBC policies and salary structures. For some years SACBC salaries were not market-related, resulting at times in a high staff turnover in the SACBC AIDS Office. In time the SACBC itself put in place new salary scales.

Some staff members left the AIDS Office for various organisations, some of them PEPFAR-funded, often doing very similar work to what they had been doing at the SACBC. Others joined or re-joined AIDS and other community-based projects within dioceses. The-on-the-job training provided by the AIDS Office, as well as the training opportunities that were provided in the field by donors and partner organisations ensured numerous opportunities for people to develop professionally.

A number of AIDS Office staff who had previously been candidates to the priesthood or religious life were employed over the years. Some saw the AIDS Office as a step from the seminary into the world of work, and the AIDS Office recognised a role it could play in this transition. One woman was married to an ex-seminarian, and a couple of others had

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9. The US Government through its embassy in Pretoria signed an agreement with the South African Revenue Services providing for VAT exemption on PEPFAR-funded payments. PEPFAR is an acronym for President's Emergency Plan for AIDS Relief, a US Government funded AIDS programme, originally in fifteen countries.

10. PEPFAR committed major funding to South Africa from 2004.
considered joining religious life. Gaining work experience was important, but so too was being involved in the Church's work of service.

**AIDS Office supervisory, management, allocations meetings, liaison bishops**

A supervisory committee was set up. It was chaired by Bishop Dowling and comprised staff from the three associate bodies that had helped in the re-establishment of the SACBC AIDS Office. It met initially on a monthly basis from 2000 to assist the co-ordinator (who was at the time the only staff member) with the writing of project proposals, the engaging of donor organisations and the approving of support for the projects in the dioceses requesting assistance for their AIDS work. Existing responses to AIDS within the Catholic network were identified, and new projects started. In time it became clearer where responses needed to be concentrated. The work of the supervisory committee was later taken over by the staff of the SACBC AIDS Office.

The original management board, involving four bishops, initially met quarterly, but the number of meetings was later reduced. When the management board structure was changed, the new board consisted of five members: two bishops, the secretary general, the associate secretary general and the director of the AIDS Office. The first two bishops on this board were Nubuasah and Potocnak, followed by Ponce de Leon and Dziuba.

Early on in the new AIDS Office it became evident that the SACBC agencies which formed its supervisory committee had interest on occasion in supporting particular projects that formed part of their own existing networks. The AIDS Office allocations committee was

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11. The three associate bodies were: Catholic Institute of Education (CIE), Development and Welfare Association (DWA) and CATHCA. These associate bodies of the SACBC have all contributed through their own work to the Church's response to AIDS.


13. SACBC Archives: Nubuasah was elected by the SACBC as liaison bishop, serving two three-year terms 2003-2009. The 2009 elections were postponed to 2010; at the time there were several vacant dioceses in the SACBC, hence the extra year. Potocnak (liaison bishop for CATHCA) was appointed by the SACBC when the AIDS Office was registered as an NPO in 2008, and two bishops were needed on the new management board. Ponce de Leon was elected by the SACBC as liaison bishop, Dziuba (liaison bishop for CATHCA) was appointed by the SACBC from 2010-2012. Both began second terms in 2013.
established to address potential and actual conflicts of interest among the associate bodies regarding the funding of projects. This committee, an expansion of the supervisory committee, included people from outside SACBC structures. Initially the AIDS Office, through the allocations committee, had almost complete discretion over which projects could be funded and at what level. Later on as donor requirements changed this became more difficult.

The role of the SACBC liaison bishop to the AIDS Office was always valued, and between 2000 and 2012, three different bishops held the position: Dowling, Nubuasah and Ponce de Leon. Each was very supportive and committed to the Office, willing to be engaged and to take initiative, and to ensure that other bishops were kept abreast of developments. Each of them also represented the Church at various national, continental or international events engaging Church and Church leaders on AIDS.

THE ROLE OF FUNDING PARTNERS

Prior to 2000 there had been some funding from both Misereor and CAFOD, and even a grant from the South African Department of Health and Population Development. The funding supported the salary of the co-ordinator, limited travel and a few small grants to some diocesan projects. A grant of R 60 000 in 2000 from the SACBC Lenten Appeal established the new SACBC AIDS Office, helping unlock access to subsequent funding. From 2000 funding requests were submitted to various Catholic donor agencies, traditionally the partners of the SACBC. Not all applications were successful. Some agencies had already committed funding elsewhere or AIDS was not a priority issue. It is also noted that some funding agencies, both Catholic and other, also approached the SACBC AIDS Office at different times, requesting

14. A liaison bishop for each associate body, department and office of the SACBC is elected at the SACBC plenary session every three years.
15. Misereor is the development agency of the German Bishops' Conference, CAFOD, the Catholic Fund for Overseas Development of England and Wales.
16. The SACBC allocates money from the annual Lenten Appeal to various works/projects of the SACBC and in the dioceses. Catholic donor organisations had requested commitment from the SACBC itself to its AIDS Office before making further funding available.
proposals to support the Church's work.  

**Catholic Medical Mission Board, and Bristol Myers Squibb: Secure the Future**

*Catholic Medical Mission Board (CMMB)* funding was the first to enable the SACBC AIDS Office to support the response to AIDS in the different dioceses. CMMB, already in a partnership with Bristol Myers Squibb (BMS), in the *Secure the Future* programme, signed an agreement with the SACBC in February 2000, committing to a grant of US $1 million a year for five years. BMS had committed US $100 million over five years to South Africa, Swaziland, Botswana, Namibia and Lesotho. According to the agreement between BMS and CMMB money had to be spent in all five countries, but not all CMMB funding could reach Church-affiliated projects because of the BMS criteria and the co-funding arrangements. The AIDS Office soon found it could not accept this condition and requested that the terms of the agreement be revised. The terms were re-negotiated at a most difficult meeting near Cape Town in September 2000 when the American partners finally accepted that the SACBC, represented by Bishops Dowling and Cawcutt, and the two AIDS Office staff, was ready to withdraw from the agreement.

**Catholic Relief Services**

Catholic Relief Services (CRS), the development arm of the US Conference of Catholic Bishops headquartered in Baltimore, USA,

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17. SACBC Archives: The Ford Foundation was referred to the SACBC AIDS Office by Catholic AIDS Action in Namibia, and requested a proposal. Fr Charles Kuppelwieser of St Joseph's/Sizonani, Bronkhorstspruit in the Archdiocese of Pretoria referred Project Support Group (PSG) to the AIDS Office.

18. The Catholic Medical Mission Board (CMMB) is a US NGO, Bristol Myers Squibb (BMS) a major pharmaceutical company.

19. The Secure the Future Program of Bristol-Myers Squibb, its flagship philanthropic programme, aimed to develop and replicate innovative and sustainable solutions for vulnerable populations infected and affected by HIV and AIDS in sub-Saharan Africa.

20. SACBC Archives: The criteria included scientific research and technical business plans, beyond what ordinary Church projects could reasonably be expected to do.
established itself in South Africa in early 2000. Traditionally, the work of CRS has been emergency relief and disaster management. However CRS wished to commit to an AIDS response, a new emergency in Southern Africa. In September 2000 the first CRS assessment took place across South Africa engaging all the Church projects providing assistance around AIDS at local level. The assessment results provided the framework for CRS involvement around justice and peace, advocacy, and AIDS. The second assessment in 2003 emphasized subsidiarity at project level. A third grant supporting fewer projects because of changing economic realities ended in the latter part of 2013. It is noted that CRS has supported the AIDS Office since 2000 and its total funding commitment has exceeded that of any other donor other than PEPFAR: R 37 million between 2000 and December 2012. A new agreement was negotiated in 2013, supporting orphaned and vulnerable children.

**PEPFAR Antiretroviral Treatment and Orphan and Vulnerable Children (ART and OVC)**

In 2003 Bishop Dowling and Sr Alison Munro, through Catholic Relief Services (CRS), Baltimore, did some advocacy in Washington ahead of the approval of the President's Emergency Plan for AIDS Relief (PEPFAR) legislation which initially made major AIDS funding available in 15 countries. CRS was awarded a grant to provide ARV treatment in nine countries, eight of them in Africa, one of them South Africa. The AIDS Office became the major implementing partner of CRS in South Africa for this grant for five years. The AIDS Office also accessed OVC funding. In the PEPFAR II period the CRS grant was transferred to the SACBC AIDS Office which has managed a combined PEPFAR treatment and orphans and vulnerable children’s grant since 2009. Over the nine years to December 2012 the grant totalled over R700 million.\(^{21}\)

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\(^{21}\) At the height of treatment programme the AIDS Office paid R 5 million per month just for ARV drugs.
Other funders

Prior to 2000, the Catholic Fund for Overseas Development of England and Wales *(CAFOD)* had been dissatisfied with the SACBC response to AIDS and had frozen its funding. Eventually it allowed the funding to be used from mid June 2000. In time *CAFOD*, *Trócaire* and *Cordaid*, already partners of various SACBC agencies and dioceses, committed funding to the AIDS Office and to the support of diocesan projects. In addition, *Mensen met een Missie*, *Missio Aachen* and *Misereor* supported a number of training programmes. These included workshops given throughout the Conference region on Catholic Social Teaching and AIDS, on pastoral care training for clergy and on care for caregivers retreats. In addition a theological conference was also supported. Together these six agencies contributed over R 13 million in funding.

*The Ford Foundation* supported home-based care and treatment in the dioceses of Dundee and Ingwavuma. The *Department of Health* of the South African Government currently supports home-based care in some priority health districts. *Project Support Group (PSG)* supported home-based care in South Africa, Swaziland and Lesotho. It was initially based in Zimbabwe, and later moved to South Africa from where it operated until its grants with the Dutch Government and NORAD (Norway) ended. Some of PSG's other partner organisation were health desks and AIDS offices of a few Catholic Bishops' Conferences in Africa.

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22. SACBC Archives: The dissatisfaction related to the SACBC's handling of staff issues in the AIDS Office, its temporary closing of the office, and its seeming lack of commitment to the fight against AIDS.

23. Trócaire is the official overseas development agency of the Catholic Church in Ireland. Cordaid is a Dutch Catholic development agency.

24. Mensen met een Missie is a Dutch Catholic NGO associated with religious orders and congregations, Missio Aachen and Missio Munich form the International Catholic Mission Society in Germany. Misereor is the International Development Agency of the Catholic Church in Germany.

25. The Ford Foundation is United States based private foundation promoting social change and development worldwide. The "priority health districts" in South Africa are those with a high prevalence of HIV, compounded by poverty and unemployment. The South African Department of Health expects NGOs receiving funding to deliver services in these areas.

26. SACBC Archives: PSG requested the SACBC AIDS Office to oversee its grants to Lesotho and Swaziland which were separate from its grant to South Africa.
Together these contributed R17 million. NORAD, the Norwegian Agency for Development Cooperation is a directorate under the Norwegian Ministry of Foreign Affairs.

The Sternsinger are German children carol-singers whose donations support children. Kindermissionswerk is part of the Pontifical Mission Aid Society in Germany.

Together these donors contributed R5.6 million between 2010 and 2012.

University Research Co., LLC (URC), affiliated with Center for Human Services, a US nonprofit organization, was awarded a USAID/PEPFAR grant to work on TB in collaboration with the DOH. URC has a Pretoria Office.

REPSSI is a regional non-profit organisation working to lessen the (psychosocial) impact of poverty, conflict, HIV and AIDS among children and youth across East and Southern Africa.

Family Health International (FHI) supported orphans and vulnerable children for five years, spending a total of R13 million. The initial contact with FHI was made by the SACBC AIDS Office in New York at the time of the 75th anniversary celebrations of the Catholic Medical Mission Board. FHI was PEPFAR-funded, and organisations in Zambia and Namibia, as well as the SACBC AIDS Office were sub-recipients of the funding.

Ausaid gave a grant to Siyabhabha Trust and to the SACBC AIDS Office, as a sub-recipient. Policy Project provided support for various

27. Together these contributed R17 million. NORAD, the Norwegian Agency for Development Cooperation is a directorate under the Norwegian Ministry of Foreign Affairs.
28. The Sternsinger are German children carol-singers whose donations support children. Kindermissionswerk is part of the Pontifical Mission Aid Society in Germany.
29. Together these donors contributed R5.6 million between 2010 and 2012.
30. University Research Co., LLC (URC), affiliated with Center for Human Services, a US nonprofit organization, was awarded a USAID/PEPFAR grant to work on TB in collaboration with the DOH. URC has a Pretoria Office.
training workshops and retreats for caregivers. The Belgian Embassy grant of R2 million, awarded to the Centre for the Study of AIDS at the University of Pretoria, for work in the Catholic Church, was implemented by the SACBC AIDS Office and Siyabhabha Trust. It provided capacity building and training to address AIDS in five dioceses.

The SACBC AIDS Office managed a Department of Health (DOH) grant awarded to the National Religious Association for Social Development (NRASD). The grant was given to train faith leaders on how to address AIDS within faith communities. The NRASD requested that the SACBC AIDS Office oversee the implementation of the grant. NRASD retained overall responsibility for financial and other reports. A Finnish Embassy grant awarded to the NRASD was also managed by the AIDS Office. The SACBC AIDS Office is currently a sub-recipient of funding (R 8.3 million between 2010 and 2011) from The Global Fund to NRASD, together with other church organisations and some NGOs for several home-based care and orphan projects.

Decrease in funding

South Africa is increasingly expected by donor organisations and foreign governments to take control of its own AIDS problem, and be less dependent on outside resources. Changes have been seen in donor funding commitments since at least 2005. Donor organisations have established new priorities for themselves, geographically and thematically. Commitments were made to elsewhere in Africa or to Eastern Europe, and AIDS in South Africa was no longer seen as a priority. In the Mbeki years of AIDS denial, and when PEPFAR made its commitment to fighting AIDS, PEPFAR was spending more in South Africa than was the Department of Health. Over the past few years this scenario has changed and the Department of Health's budget commitment by far exceeds that of PEPFAR. After the initial period of

34. SACBC Archives: Policy Project, operating out of Cape Town, was a sub-recipient of PEPFAR funding, and approached the SACBC AIDS Office to implement various training workshops. The amount was R 600 000.
35. Together the amount was almost R 1 million.
36. The Global Fund is an international financing institution dedicated to attracting and disbursing resources to address HIV and AIDS, TB and malaria.
the *AIDSRelief* treatment programme there were budget cuts in the award to the SACBC, part of the winding down of the PEPFAR programme towards its end in May 2013.\(^{37}\) It is however hoped that a no-cost extension will be made, enabling at least part of it to continue for a further year.

**PROGRAMMES**

**Prevention**

The Department of Health originally promoted condom use as a means of HIV prevention, suggesting that there was little else one needed to do not to become infected. Its position in later years was different, with more emphasis on the *A* (*Abstinence*) and *B* (*Be faithful*) of the *ABC* message. The question of HIV prevention has been emotive, provoking endless debates which cannot be resolved because of the differing positions people take, for or against condoms. In some quarters the Church's stance on condom use was seen as fuelling the spread of HIV. People at grassroots often did not have the tools to deal with the conflicting messages. It sometimes felt as though work around prevention was an Achilles' heel of the Church's response at a time when so much good was being done in the area of home-based care, and later in the field of treatment. In more recent years the DOH has been willing to work with SACBC-affiliated projects, even if not everywhere, despite the Church's known position on condom use.

The Ugandan programme, *Education for Life*, was adapted for the Southern African situation and accepted by the SACBC as one of the programmes targeting youth.\(^{38}\) Other programmes included *Love Waits*, and *Love Matters*, initiatives of dioceses and agencies working with youth, and the *ABCD Campaign* of the Association of Catholic Tertiary Students.\(^{39}\) The SACBC AIDS Office helped support these various initiatives, none of which can be said to have brought down infection

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37. *AIDSRelief* is the nine-country ART programme of the CRS-led consortium funded through the President's Emergency Plan for AIDS Relief (PEPFAR).

38. *Education for Life* is a life-skills programme targeting young people, and drawing on Gospel teachings and values.

39. The *ABCD Campaign*: A for Abstain, B for Beware, C for Change your life, and D for Danger if you do not change your life.
rates. Yet, it is also to be noted that when rates of HIV infection were finally seen to be decreasing in South Africa, it was among youth (rather than in adults in their thirties and older) that more condoms were being used, and that numbers of concurrent partners were reduced.\textsuperscript{40}

The AIDS Office was approached in 2010 by the Pretoria office of the \textit{Centers for Disease Control and Prevention (CDC)} which manages the PEPFAR-funded programmes in South Africa on behalf of the US government, and asked to consider doing medical male circumcision in one province. It was decided not to accept the proposed funding. The amount was too much, the target number of people impossibly high and none of the projects was willing to accept these conditions.\textsuperscript{41}

\textbf{Home-based care, hospice work, TB screening}

The care and support of the sick and dying is a gospel mandate the Church has always taken seriously. Home-based care was the major response of the Church to AIDS at diocesan and project level prior to the receipt of major donor funding from 2000. Before treatment became a reality in 2004 it was estimated by the SACBC AIDS Office that 70\% of the projects in the network were providing home-based care services. In some dioceses hospices were established or expanded to accommodate people dying of AIDS-related sicknesses, giving them the chance to die with dignity. Training was initially done by the religious sisters and nurses who had spear-headed different projects. More formal training in accredited syllabuses in HIV/AIDS/TB management came later. Home visits are an important way of supporting patients at household level, identifying household members in need of follow up care, and identifying orphans and vulnerable children. Clearly those who serve the least of Jesus' brothers and sisters serve him. In one study conducted by the SACBC AIDS Office (Munro 2006b), caregivers asked why they were doing the work they did, often with little financial reward beyond a stipend, provided answers recognising this call: “I do it because I am part of the Church and that is our work” and “I do it because it is in my heart...”. While home-based care no longer has the same level of

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urgency around AIDS it formerly had because of the wider availability of treatment, it remains a critical component of community and diocesan health care work, helping identify patients in need of various services and appropriate referrals.

**Treatment**

The Church's treatment programme began in five places towards the end of 2003 with Cordaid funding at a time when treatment was available only in the private sector to those who could afford it. It is a measure of faith that it began at all. In the first place only a relatively small amount of money was at hand. Secondly, most Church sites were not primary health care clinics and were without the necessary infrastructure. And thirdly, the AIDS Office itself did not have the clinical expertise needed. Despite this we went ahead and in fact scaled up from the second half of 2004 with the advent of PEPFAR funding received through the CRS AIDSRelief grant. Soon the programme was delivering services at 22 sites and their various satellite centres. It thus became the biggest programme of the SACBC and one of the biggest NGO treatment programmes in South Africa (Viljoen 2013b).

A major challenge was dealing with the CRS Consortium partners, some of them clinical practitioners from sophisticated research institutes in the USA, but unfamiliar with logistics of home-based care projects turned into treatment sites, and with resource-poor settings. Getting training and systems in place was demanding enough without the unrealistic expectations of “experts”, who also expected to be paid exorbitant salaries, far above those paid to local South African staff, from the grant. Bishop Dowling and Fr Menatsi, secretary general of the SACBC, were part of the AIDS Office negotiations requesting CRS to withdraw the services of Consortium partners from the programme. The SACBC programme continued to draw on the South African expertise that had initially helped establish it.

Over the grant period more than 45 000 people were initiated on treatment. The current phase in PEPFAR-funded programmes is one of “transition” of patients and services to the DOH. Some Church treatment sites have closed, or will close, while continuing to offer home-based care, TB screening and hospice services, and ensuring that patients in need of treatment are referred to appropriate DOH facilities.
Some Church sites, victims of funding cuts or lacking the human capital to re-direct their AIDS effort and diversify their funding source, may not be able to continue. Some of the Church treatment sites will continue in collaboration with the DOH (Viljoen 2013b).

The effectiveness of the AIDS Office treatment programme over a ten-year period lies in direct service delivery and in local management. That “the 'Romans' pray over the drugs before giving them to patients...”\(^{42}\) is indeed only one reason why services at Church sites are so valued by patients. The effort related to building the treatment programme from nothing was tremendous. Ironically the effort needed to establish agreements with the DOH ensuring that all patients continue to receive services beyond PEPFAR funding is as challenging.

For several years the SACBC AIDS Office was able to support a small non-PEPFAR treatment programme in the Vicariate of Francistown, serving foreigners unable to access Botswana government treatment.

**Orphaned and Vulnerable Children**

Children orphaned and made vulnerable by AIDS are often identified in home-based care programmes by caregivers ministering to sick and dying patients. The SACBC AIDS Office observed in earlier years that the local Church responded to orphans initially and particularly through feeding schemes and soup kitchens. More comprehensive and holistic services were more challenging to implement and monitor. These included after-school programmes, helping children to access health, education and social services, household economic strengthening and registration for social grants and paralegal services. This was often difficult for local people, themselves struggling to meet their basic needs. It necessitated ongoing training of child care workers in a variety of psycho-social, educational and health care skills. Some child care workers have received formal qualifications in child care work; others have pursued study in early childhood development. Thousands of children have been assisted since 2000. While some have made a great success of their lives, overcoming their disadvantaged backgrounds, others remain vulnerable in the often harsh realities of their socio-economic circumstances.

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42. An AIDS Office staff member was told by a patient at a site that the prayer of nursing staff before they gave him his treatment had definitely contributed to his healing.
The first major conference on orphans and vulnerable children organised by the SACBC AIDS Office was hosted jointly with HopeHIV in 2003 in Bronkhorstspruit, Gauteng. It brought together 185 delegates from several African countries, highlighting the churches’ response to vulnerable children (Dowling 2003). Several studies of the Church’s OVC programme were conducted, some as part of research into the AIDS work of the Church, some looking specifically at the response in local contexts. They include the CAFOD-commissioned “To live a decent life” (Marcus 2008), conducted in South Africa and Swaziland, but part of a wider study covering several countries; and the FHI and CDC commissioned studies evaluating the Church’s OVC work across its PEPFAR-funded projects (Khulisa 2008; Byenkya, Pillay, Ofi 2011). Every study highlighted strengths and weaknesses, and made recommendations on future action. And every study was a reminder of the reality that many more children would fall through the cracks without the support of Church and NGOs, given that government services often do not reach those who need them.

In 2010 the SACBC AIDS Office was approached by the Dutch NGO Homeplan (Viljoen 2013a) about the construction of simple two-roomed houses for orphans living in inadequate shelters. Thus was born the Houses for Orphans programme of the SACBC AIDS Office, supported also by Kindermissionswerk and an anonymous donor. Approximately 145 houses had been completed by the end of 2012 in eight dioceses, half of them in the Vicariate of Ingwavuma in northern Kwa Zulu-Natal. Simple criteria were used for identifying who would benefit from the scheme: personnel at local level in the dioceses and at existing projects working with orphans identified the children and grandparents caring for children most in need of a house. Permission was sought from the local chief to build on tribal land. Local people appreciate that the most needy families have been identified as beneficiaries. In one instance a two-roomed house was added to a one-roomed house in which twenty-six orphaned children were living with their grandparents.

Training, technical assistance, mentoring, good governance

There has been great investment in training for project level staff. This training included home-based care, TB screening, the clinical management of treatment, counselling, adherence monitoring, peer education, micro-finance, play therapy, bereavement counselling as well as project and financial management. It targeted many people from the various dioceses and projects. Challenges have included the time commitments for people running programmes, the finances needed, levels of literacy and/or prior learning. Sometimes prior training and its related experience has served as a credit towards recognised accredited training. A constant challenge across all projects has been the reality of trained people moving elsewhere. The upside of this reality is that many people trained in Church projects have been able to acquire DOH and other salaried positions.

The treatment programme saw training in ART management for clinical and nursing personnel, conducted by local professionals. Some nursing staff acquired dispensing licences to meet South African pharmacy and drug dispensing regulations. Subsequently some nurses also completed the nurse-initiated management of anti-retroviral therapy (NIMART) training, becoming qualified to initiate patients on treatment in the absence of a doctor. Counsellors and adherence monitors were trained to work with patients around HIV transmission, prevention and adherence issues.

Child-care workers often started off as volunteers in home-based care projects and projects serving orphaned and vulnerable children. Non-professional child-care workers underwent training in psycho-social support, in helping children accept their HIV status and the need for treatment, in auxiliary social work, in bereavement counselling and play therapy. A number of child-care workers underwent professional training through the National Association of Child Care Workers.

44. Adherence monitoring is the follow-up of individual patients to help ensure that they remain adherent to ARV treatment.

45. NIMART, nurse initiated management of ART, is evidence of “task-shifting” of tasks traditionally associated with doctors to nurses. Many ART clinics in South Africa are run in the absence of doctors.
The National Association of Child Care Workers is a registered non-profit organization promoting optimal standards of care for orphaned, vulnerable and at-risk children and youth. See www.naccw.org.za, accessed March 2013

Ongoing financial management training through the AIDS Office has utilised the services of internal auditors and compliance officers, its own and others, to assist AIDS projects with accountability in relation to donor funds. Financial training covers everything from basic bookkeeping and filing, to adherence to regulations governing US funding. The internal auditors of Catholic Relief Services (CRS) helped greatly in this regard, providing much of the initial in-service training.

In the AIDS Office experience, the best projects have been those run by, or overseen by, dioceses and religious congregations, involving committed boards or management committees. Many boards have provided support and encouragement, ensuring an important oversight role. Other projects have suffered under weak boards that have not been able to take the decisive action sometimes needed. Some boards have been unavailable, some too interfering at project level. On several occasions the AIDS Office was called upon, sometimes to persuade individual board members to become more involved in a supportive role, and at others to allow more freedom to projects to do their work without interference.

Both Rural Development Support Programme, an associate body of the SACBC, and Donor Support Solutions, provided a number of training workshops to board members, diocesan AIDS committees, and project staff on the principles and the practice of good governance. Such workshops were conducted in individual dioceses as well as regionally, and in all three SACBC countries.

46. The National Association of Child Care Workers is a registered non-profit organization promoting optimal standards of care for orphaned, vulnerable and at-risk children and youth. See www.naccw.org.za, accessed March 2013
47. SACBC Archives: The report noted poor financial management practices in some projects.
48. RDSP, an associate body of the SACBC, provides training and skills-building particularly in rural dioceses and rural church projects. Donor Support Solutions assists NGOs with training around governance and financial management.
PARTNERSHIPS, PUBLICATIONS, STUDIES

Partnerships and collaboration

The SACBC AIDS Office helped to put the Catholic Church's response to AIDS on the map (Munro 2002; Munro, Viljoen, Brennan 2003; Munro 2007). When the Office was started there was lot of antipathy, even hostility, around the Catholic Church's response to AIDS. Over time the Church has come to be recognised as a valuable partner in local communities, doing what others have not always been prepared to do. There was also a perception that Church agencies weren't able to report accurately or run professional services. Certainly there have been weaknesses in this area, and some of these continue. Yet some of the partner projects of the SACBC AIDS Office have accomplished a great deal. Some funders asked the AIDS Office to provide ART services even where the capacity of Church projects was insufficiently developed to meet grant requirements; elsewhere, too, the AIDS Office put supportive measures in place, and took on in the Pretoria office as many of the burdens around reporting requirements as possible.49

Some SACBC AIDS Office partnerships

Over the years the SACBC AIDS Office has recognised the need to work with a variety of organisations, developing collaborative partnerships for the sake of beneficiaries as well as for the improvement of services. There is no way that the Church can act alone in the fight against AIDS. Some of these partnerships have been challenging and not always easy to negotiate.

The AIDS Office has provided one of the religious sector representatives on SANAC, the South African National AIDS Council, in the era of government denial of the seriousness of AIDS and afterwards. Since 2001 the AIDS Office has provided a religious sector representative on the National Committee for Children with AIDS in collaboration with the Department of Social Development. Some diocesan and parish projects supporting orphaned and vulnerable children receive grants or

49. Examples of these measures include: having projects provide monthly financial and statistical reports, visiting the projects to check on all accountability-related issues and putting corrective measures in place where needed, organising training for boards and staff, providing for project staff to visit stronger projects.
subsidies from their provincial Department of Social Development. Some diocesan projects also have representation on provincial or local committees for children with AIDS.

*University of Utrecht* students from the Departments of Education and Psychology conducted research towards Bachelors, Honours or Masters degrees in the SACBC AIDS Office partner projects over some years. One longitudinal study examined the effects of HIV infection in children on treatment (Wierda et al 2008). Volunteers from other organisations have been helped with placements in various AIDS projects.

The AIDS Office collaborates with various *SACBC and diocesan agencies*. The AIDS Office Director is an ex officio member of CATHCA's board, with CATHCA in turn serving on the original supervisory and management committees of the AIDS Office from 1999, and later on the allocations committee.

There is good collaboration between the AIDS Office and the *Mariannhill Mission Press* around the design and management of the AIDS Office website. The SACBC AIDS Office worked with the *Catholic Parliamentary Office (CPLO)* on Catholic Social teaching workshops, and in the preparation of the *Catholic-Jewish Dialogue* hosted in Cape Town in 2006 (Vitillo 2006). Dialogue and partnership between the Church and Judaism can happen around the themes of social teaching and outreach to those on the margins of society as evidenced by AIDS, despite other challenges. The SACBC AIDS Office collaborates with Jews in the National Religious Association for Social Development and in the World Conference of Religions for Peace.

The Director of the AIDS Office served on the *Anglican HIV and AIDS Trust* for some time at the invitation of the late Bishop David Beetge. An AIDS Office staff member is on the board of *CMMB (SA)*. Where possible, and depending on donor funding, CMMB (SA) programmes are implemented at SACBC affiliated sites. Different staff members have participated in or served on various diocesan and other AIDS committees, helping to support local level ownership of projects and working with management boards and committees around effective structures and good governance issues. Several dioceses and projects have been assisted with training around governance, NPO registration and the writing of funding proposals.

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Staff members have participated, also with CRS, at national, provincial and district level in various regular meetings of the Department of Health and the Department of Social Development concerning the establishment and ongoing management of treatment sites, the delivery of home-based care services, the management of TB, and the care of orphaned and vulnerable children. (Wilke 2012; Stark and Munro 2005 and 2006).

The SACBC AIDS Office Director was invited by the religious sector representative of UNAIDS to join a UNAIDS scenario planning for Africa series of workshops held consecutively in Tunis, Addis Ababa, Dakar and Johannesburg. The technicalities of scenario planning seem just that, technicalities rather than implementation of programmes on the ground. The AIDS Office participated in an evangelical conference hosted by Franklin Graham in Washington in 2002. It was in fact a political event, not an event underpinned by Catholic Social Teaching. But what was striking was the number of Catholics from Africa involved in the response to AIDS.

The AIDS Office has hosted various delegations of bishops including those from Germany, India and the United States on study visits related to the Church's response to AIDS (Nubuasah 2006). There was also a follow-up to the visit of German bishops, a German Exposure-Dialogue programme of parliamentarians and church agencies. Numerous US government officials and PEPFAR officials have come to observe how PEPFAR money is being spent. CRS-affiliated AIDSRelief teams from the Zambian and Kenyan Bishops' Conferences have come, as have church project staff working on AIDS in various African countries. Exposure visits have also been arranged for Homeplan (Viljoen 2013a) donors wanting to participate in their own building project.

Publications

The AIDS Office made a contribution to Grace and Truth in 2001 (Munro 2001) on the HIV testing of seminarians and candidates for religious life, a highly contentious issue, originally addressed by Catholics as early as the late 1980s in the USA and Britain. At that time there was no treatment for AIDS, and so perhaps some of the arguments against admission of HIV+
candidates are understandable. In 2012 the SACBC AIDS Office addressed the same theme at the request of the Leadership Conference for Consecrated Life showing that the arguments for and against testing remained very similar to what they had always been. What is important is that dioceses and congregations need to have policies in place, and not be reactive to individual situations.

Numerous articles and papers by bishops, AIDS Office staff and others involved in AIDS Office conferences and workshops have been presented and/or published over the years locally and internationally. Some of the themes covered are:

- The effect of changed funding priorities in the light of the global economic crisis on the work and programmes of the SACBC AIDS Office; sustainability of programmes (Munro 2012c).

- The ethical challenges faced by the Church in its AIDS treatment programme (Ryan 2007).

- The response of the Church to AIDS in Southern Africa (Munro 2004a; Munro 2005a; Munro 2007; Viljoen 2001; Parry 2005).

- The challenges of meeting the demands around attaining universal access to AIDS services, including treatment (Munro 2012a; Munro 2013a).

- The increase of gender violence against women and girls in the context of AIDS (Munro 2013b).

- The work of the Church with children orphaned and made vulnerable by AIDS (Dowling 2004; Munro 2006a; Munro 2012b).

- The role of diocesan AIDS co-ordinators, the role of priests, and the challenges (Munro 2004b; Wuestenberg 2007).

- The spiritual needs of people affected by AIDS; pastoral and theological response to AIDS (Viljoen 2003; Dowling 2005; Phalana 2007; Tlhagale 2006).

Catholic Social Teaching and AIDS (Munro 2006b; Munro 2008b; Pearson 2007.)

AIDS, the responsibility of State, Church, Society (Dowling 2003; Munro 2004b; Munro 2006d).

Church in partnership (Nubuasah 2010).

**Studies**

Many studies of the AIDS Office have been commissioned by donors or requested by the AIDS Office itself. The first independent evaluation of the SACBC AIDS Office programmes was conducted by Professor Stuart Bate, then at St Augustine College (Bate 2002). It was followed by a Pretoria University study commissioned by CMMB (Barolsky 2003). Research on the early stages of the Church's ARV treatment programme was conducted by the University of Pretoria in 2004 at the request of Cordaid, highlighting the home-based care settings scaled up to accommodate treatment services (De Waal 2008). Further studies of the treatment data and programme were undertaken by Professor Robin Wood and colleagues through the University of Cape Town (Wood 2008; Morrow et al 2012); by Boston College (Ahonkhai 2012); by the University of the Witwatersrand (McCarthy 2009); and by the SACBC AIDS Office (Stark and Munro 2005; Stark and Munro 2006).

A UNAIDS best practice study of the SACBC AIDS Office programme, authored by Fr Bob Vitillo of Caritas Internationalis, was published in 2006 (UNAIDS Best Practice Collection, 2006). *Health Care in Rural South Africa* published by the University of Utrecht devoted a considerable section to the work of the SACBC AIDS Office in the dioceses (Vermeer and Tempelman 2008). An evaluation of the SACBC AIDS Office was conducted by Georgetown University, at the request of Cordaid (Brady et al, 2008). Various studies of the orphan programme were conducted through the National Research Foundation, CAFOD, PEPFAR (Marcus 2008; Khulisa 2008; Byenkya 2011). A PhD thesis awarded by the University of the Free State examined models of care at four treatment sites of the SACBC (Wilke 2012).
THEOLOGICAL REFLECTION

Theological reflection and pastoral response

The theological conference hosted by the AIDS Office, St Augustine College and the Catholic Theological Society remains one of the major theological responses to AIDS in South Africa. Catholic tradition, prevention, care, African cultural issues, the media, and cultural healing were some of the themes addressed. Two publications on the theme Responsibility in Time of AIDS emanated from the conference (Bate 2003; Prior and Munro 2003).

Clergy workshops on a pastoral responses to AIDS involved theologians and clergy active in the fight against AIDS (Pearson 2007; Phalana 2007; Wuestenburg 2007). We sometimes noted the fear and reluctance of some clergy to become involved in pastoral work around AIDS because of having to deal with so many deaths, particularly of young people, their own personal experiences of AIDS among family and friends, and discomfort around responding to sickness. Questions about how pastoral work, prayer and the sacraments help mediate the love and forgiveness of God in the lives of those seeking healing need constantly to be addressed, not side-stepped. Supported by Misereor, the SACBC AIDS Office, in collaboration with Lumko and CPLO, conducted a consultation and series of workshops on Catholic Social Teaching and AIDS, among clergy and others. The consultation highlighted how people engage with the principles of Catholic Social Teaching, reaching out beyond the boundaries of the Church to those in need. Retreats for caregivers and project personnel have been an ongoing feature of the AIDS Office programmes.

The AIDS Office was represented at a conference of women theologians including members of the Circle of Concerned African Women theologians at Yale University, on the AIDS questions of Africa. Subsequently, the Office helped establish the All Africa Conference Sister to Sister in Southern Africa, bringing together sisters of different

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53. The workshops aimed at updating clergy regarding AIDS information and helping them recognise how they could become more pastorally involved with patients and their families, and in the support of caregivers providing services. Sometimes because of AIDS-related issues in their own families some of the clergy are reluctant to become involved at parish/project level.

54. Lumko is an agency of the SACBC, providing pastoral and catechetical training in the dioceses.
Catholic Religious Congregations affected by AIDS and providing a forum in which they could share their stories. Some congregations readily embraced their members who were HIV positive and dying (before the availability of treatment), while in others there was the same kind of denial, stigma and discrimination that was prevalent in the wider society, with members being sent home to their families to die, or being shunned by community members (Munro 2004a; Munro 2006c). The Conference no longer formally operates in Southern Africa, but sisters continue their AIDS ministry in local settings.

**Pastoral statements**

The original SACBC pastoral statement on AIDS was made in January 1990 before the pandemic exploded in South Africa. The SACBC pastoral statement, *A Message of Hope*, in mid 2001, made provision for the use of condoms by discordant couples. With most of the SACBC bishops absent from South Africa at an IMBISA Meeting (Inter Regional Meeting of the Bishops of Southern Africa) after the statement was issued, the AIDS Office had to deal with the anger and opinions of the media: they and almost everyone else wanted the Church to say that the general use of condoms was permitted. Individual bishops issued pastoral statements and approved diocesan AIDS policies in their own dioceses from 2000. The Symposium of the Episcopal Conferences of Africa and Madagascar (SECAM) pastoral statement on AIDS issued at the SECAM plenary session held in Senegal, 2003, *Our Prayer is always full of Hope*, did however not make reference to condom use, one of the few bishops' statements of the time not to do so. A proposed new SACBC pastoral statement in 2007 was not written.

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55. SACBC Archives. See also Section 3 of this book.
57. The Symposium of the Episcopal Conferences of Africa and Madagascar (SECAM) pastoral statement on AIDS issued at the SECAM plenary session held in Senegal, 2003, *Our Prayer is always full of Hope*, did however not make reference to condom use, one of the few bishops' statements of the time not to do so. A proposed new SACBC pastoral statement in 2007 was not written.
59. The expectations were not clearly defined, and the idea was dropped.
Some ethical and pastoral questions

Stigma and denial are painful: that of the individual patient who till his/her death denies HIV, that of family members who refuse to consider that HIV might be the underlying cause of sickness, that of the medical practitioners who call for all sorts of tests, not naming what they know to be the problem. The SACBC AIDS Office was not immune to the ambivalence and denial South Africa experienced in the Mbeki years with the government's refusal to put integrated AIDS programmes and infrastructure into place. People in Church projects said: “We don't know what to think. Mbeki says one thing, the Church says something else, and the media says a third. Who is to be believed? What should we do?”

The condom issue became something of a non-issue in the AIDS Office, with a policy of informing people of the Church's teaching on sexual practices outside marriage and on the efficacy of condom use, leaving them to make their own decisions. The DOH, despite wanting family planning services and condom distribution as part of comprehensive services offered at Church ARV sites it supports, has accepted this position. The questions raised by medical male circumcision are similar to those raised by condom use when it comes to behaviour-related issues with some people believing that once circumcised they need no longer take precautions around their sexual behaviour.

The AIDS Office faced ethical questions in the ARV treatment programme. It was clear that there would be long term funding issues given that treatment is for life. We had to recognise the realities of patients defaulting on treatment sometimes for cultural reasons with the potential consequence of introducing drug resistance. It was necessary to deal with pregnancy issues in HIV+ women. Finally there was the ever present reality that some people continue to engage in risky sexual behaviours despite their HIV status.

THE FUTURE

Inspired by the Mission of Jesus Christ, the SACBC AIDS Office exists to respond to the HIV and AIDS pandemic by serving marginalized and vulnerable people.60

Thirty years ago when HIV was discovered no one could have envisaged the devastating effects it would have on sub-Saharan Africa in particular. South Africa lost time in addressing the pandemic because of other agendas including the ending of the apartheid regime and the birth of the new South Africa. Then there was the lack of political will to recognise the reality unfolding. The Church was not unaffected, and was slow off the mark. Today the urgency around home-based care and of getting people on to treatment has changed. The DOH has more programmes in place than was the case ten years ago. HIV and AIDS is still an issue, but with different issues of urgency. Too many people still do not have access to health services and too many children are falling through the cracks. The call to the Church moving forward is to intensify its care for those on the margins of society. Our mission is not yet accomplished.
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In 2012 the Church in the Archdiocese of Durban marked 25 years of responding to the AIDS pandemic. Initially there were two concerns: 1) to love and care for those infected and affected by HIV/AIDS; and 2) to get people to take responsibility for their moral and sexual behaviour. Initially we focused on educating people about the virus and its social impact and about the Church's moral and practical teaching. The Church's response today has developed considerably from what it was twenty five years ago. The Archdiocese has developed a threefold approach to care, prevention and dealing with HIV within the broader framework of healthcare.

In 1982, the first case of AIDS in South Africa was reported. The first deaths from AIDS in South Africa occurred in 1985.

The Archdiocese of Durban's response to AIDS began as early as 1987 under the leadership of Archbishop Hurley and a small group of interested people. This was in response to the warnings given by Fr. Ted Rogers at a presentation in Durban that the AIDS epidemic was not going to go away any day soon.

Fr. Ted Rogers had established an AIDS programme in Zimbabwe at the start of the epidemic and he could already see its social impact on communities there and beyond. While everyone else was focusing on the medical aspect, Fr. Ted was concerned about the social ramifications. So, right from the beginning he advised interest groups to target youth.

Soon after that presentation, Archbishop Hurley gathered together people with interest, knowledge and skills to discuss what the Church should and could do. Those were to be the founding members of Archdiocese of Durban AIDS Care Committee, later known as Catholic Archdiocese of Durban AIDS Care Commission (CADACC).

The question asked of the AIDS Care Committee was: What should the Church be doing about AIDS, which was so brand new a disease that even the scientists were struggling with it? It soon became clear that the answer lay in the Church doing what it does best, and in the specific areas of its competence, namely morality and charitable care.
THE APPROACH ADOPTED IN THE BEGINNING – EDUCATION AND AWARENESS

This was partly to respond to the government's message, which at the time went no further than "Use a condom". Abstinence and faithfulness were never even mentioned. As a result one of the first tasks of the Committee was to set out in brief notes the Catholic Church's stance on HIV and AIDS. Those made clear two concerns of the Church: 1) to love and care for those infected and affected by HIV/AIDS, who were being shunned, rejected, stigmatized and 2) to get people to take responsibility for their moral and sexual behaviour. Thus, from the beginning the Church in the Archdiocese of Durban preached the message of giving love and care, never judging.

A starting point was to educate people a) about the virus and its social impact b) about the Church's moral and practical teaching, which was to be done at deanery level, in the hope that it would cascade down to parishes.

OUTCOMES AND CHALLENGES

It took two years to complete the education process in the deaneries – mainly because the wrong people were sent from the parishes to deanery meetings. As AIDS was seen as a medical problem, parishioners with medical expertise were being sent. In fact the Church wanted and needed to deal with the AIDS from a spiritual perspective drawing on its Social Teaching.

It was also easier getting traditionally 'White' parishes to become engaged than 'Black' parishes. People heard the Church's message but did not engage with it. There was just too much stigma and fear. People were petrified to care for family members, and those who were infected were petrified that their status would be disclosed.

As the epidemic grew, the urgency of speaking to people about their sexuality became acute, but a major problem was that people in the Church (including the priests) were uncomfortable doing this. Priests in particular were needed for counselling and spiritual support.

That is when Archbishop Hurley, as Chairman of the AIDS Care Committee, told the priests that every one of them had to weigh up the consequences of the family or the couple not being able to protect
themselves from HIV, and that they had to start talking about it, and encourage people into faithful relationships. In other words, priests too needed to be trained regarding how to deal with the epidemic.

**THE APPROACH CHANGED – FROM EDUCATION TO PROVIDING CARE AND SUPPORT**

Unfortunately the epidemic continued to grow, and so in the early 1990's CADACC’s approach changed by necessity from education to providing care and support to those infected and affected by HIV or AIDS.

In 1995, CADACC opened its first Home Based Care (HBC) programme called *Sinosizo* (isiZulu for "we help"). The vision was for Sinosizo to work with people (communities) at parish level and help set up HBC projects throughout the Archdiocese. Whereas before all the work being done was by the committee members on a voluntary basis, it now became necessary for the committee to establish itself as a formal organization in order to fundraise for full time staff and for the necessary resources and equipment. Sinosizo was soon working in 18 of the most under-resourced and impoverished communities in Durban and surrounding areas. It wasn't long before Sinosizo became a leading faith based organization in the HIV field, using this experience also to become a HBC training organization.

**OUTCOMES AND CHALLENGES**

However, there was still much stigma and people were very fearful, so it was difficult to motivate parishes and communities to establish their own projects. Consequently, the approach remained an 'outside in' one, with Sinosizo running the project from outside the community but using volunteers from the community.

Around that time, the government began its programme to educate communities about HIV. It employed people to hand out leaflets from door to door. Unfortunately it did not consult the NGOs already providing practical care and support in the field and as a result many of the HBC volunteers left HBC projects to become paid HIV educators. Many HBC projects had to close leaving families without support or
care. Holding government accountable became a new reality for the committee.

**APPROACH ADAPTS AGAIN TO INCLUDE OVC CARE, TREATMENT AND FOCUS ON YOUTH AND PREVENTION**

By the year 2000, communities were still very much in denial despite the visible signs of the AIDS pandemic, and mixed messages from Government did not help. The care for orphans and vulnerable children was becoming desperate as parents died in large numbers. What was needed was a programme to deal with the psychosocial, physical and spiritual needs of orphaned and traumatised children. Focus on youth and prevention also became more urgent.

CADACC's response was to expand the HBC programme to include an OVC (orphans and vulnerable children) programme and to create another two separate programmes - one to help mobilise parishes and parish communities to respond with their own projects to the ever-increasing need for care; and the other to help youth with information and support. *Education for Life*, a training programme, was adopted as the approach to reach out to the youth.

In addition, in 2002, the Archdiocese of Durban (AOD) Synod resolved to implement a programme to address the issues of poverty, unemployment and AIDS. This went a long way towards encouraging and supporting parishes to get involved. Shortly thereafter CADACC employed a full time coordinator to support parish responses.

Despite all the care being provided, the number of people dying from AIDS related illnesses was increasing. Treatment was urgently needed, but costs were too high. Fortunately in 2004 Sinosizo was selected by the SACBC AIDS office as one of its Anti-Retroviral (ARV) sites. It was a different model as the site was an HBC project rather than a clinic or hospital but after a few teething problems in the early stages, it proved to be very effective and was later successfully handed over to the Department of Health.

Although parish and parish communities were establishing HBC and OVC projects, many of them were relying on the South African health system to provide the medical expertise and experience. However due to the health system, being so stretched this was a challenge. Fortunately, in
2006, CATHCA approached and offered CADACC a new project called the Parish Nurse project that brought together medical science and faith in the service of the human person. The value of the project is that it utilizes the expertise and experience of retired nurses. This project worked and continues to work well as it offers much needed support and confidence to the parish priest, as well as the organisation.

**APPROACH CHANGES TO ENCOURAGE COMMUNITY AND ORGANISATIONAL DEVELOPMENT**

By 2007, an extensive survey of actual activities in the Archdiocese of Durban was done and it revealed that parishes and communities were realising their own 'social capacity' to organize themselves and care for people living with HIV and AIDS (Dageid, Sliep, Akintola and Duckert 2011). It was clear that the 'outside in' approach adopted before was no longer beneficial, sustainable or even necessary. At this time Government had also developed a National Strategic Plan for fighting AIDS (NSP 2007 – 2011) which focused on access to treatment and care for HIV positive individuals with a strong emphasis on building cooperation between Government and NGOs.

CADACC therefore decided to adopt an approach that encouraged and supported projects to attain NPO (Non-Profit Organisation) status in order for them to access government funding and other resources.

By 2008, the Archdiocese AIDS programme had much going for it. It had:
- Meaningful leadership
- Credibility and a good reputation
- Excellence at providing care and training
- Good models for HBC, OVC and training
- Visibility within most communities
- Resources (including dedicated volunteers)
- And a well 'co-ordinated' response

However, there were still many challenges:
- Accessing funding, especially local funding
- Rewarding volunteers
- Maintaining government partnerships
- Working together with other denominations and faith groups

But most notably it was over 25 years since the discovery of HIV, and
HIV and AIDS rates were still increasing with high levels of HIV and TB coinfection being seen. TB had become the leading cause of death in South Africa. On reflection, despite the decision being made right at the outset for the Church to do what it did best in the specific areas of its competence, namely charitable care and morality, our response seemed to have been predominantly curative and less preventative. It may have been that the provision of care and support was so desperately needed in the early stages that we focused on the most pressing need? But somehow I can't stop thinking that the prevention programme just seemed to be harder to implement, despite it also being part of our area of competence.

**INTO THE FUTURE**

Thirty years on and a new crossroads has been reached where the challenges are different but the scale of the problem is much greater than it was. And to be effective in responding to these challenges and prevent those we anticipate in the future, CADACC has adopted a threefold approach:

1. **We are continuing to empower and build capacity within parish and parish community projects to provide care and support, encouraging them to become NPOs and associative bodies of CADACC.**

2. **We have developed a prevention strategy with the input of a number of stakeholders from all levels within the Archdiocese, focusing on the moral and social teachings of the Catholic Church and are in the process of disseminating this strategy throughout the Archdiocese.**

3. **We have recognized the need to deal with HIV within the broader framework of healthcare that includes care for the aged, TB, cancer, and other concerns, and as such we have helped establish the KwaZulu-Natal Regional Catholic Healthcare committee. Not only is the response broader but it is more collaborative. The purpose of this committee being:**
   - to help improve relations and communication with Government at local and provincial level;
to improve communication and collaboration between Catholic healthcare projects within KwaZulu-Natal Province of South Africa;

- to help form Catholic health care workers in the moral/social teachings of the Church;
- to provide a central point for information gathering and information sharing; and
- to anticipate and pre-empt issues that might be of concern to Catholic health care in the future for example: euthanasia, National Health Insurance (NHI).

Throughout the years, the Archdiocese of Durban AIDS programme has had to constantly adapt its approach in order to face up to the challenges and ever changing needs of the pandemic, and yet maintain its vision as a Church to be a 'Community serving Humanity'.

I hope our experiences will be of some value to you, as we continue to reflect on this challenge to us – the Church.
REFERENCES


AN HIV/AIDS PROGRAMME IN A RURAL CONTEXT

Kevin Dowling CSsR

In South Africa in the 80s and early 90s, the predominant “sign” of the time was the struggle for freedom after years of oppression. But, insidiously and silently, another killer was at work mostly unnoticed. Several factors – the apartheid system and its homelands, dehumanising poverty, forced migration to the cities and mines, among others – created the conditions for a major epidemic which would grow to epic proportions. In the Diocese of Rustenburg, characterised by its predominantly rural nature, but also the unique feature of massive informal settlements spawned by the biggest platinum mines in the world, socio-economic-cultural factors made the HIV pandemic a very complex challenge. But it was also an invitation to recognise the opportunity to empower those very impoverished communities to recognise their richness and potential to create truly life-giving responses for the most vulnerable. This is my story.

“How can I understand a figure or a statistic unless I have held the hand that it represents”? A quote from a certain Dr. J.P. Muliyil – very relevant to the reality of the ravages of the HIV/AIDS pandemic in sub-Saharan Africa in general, and South Africa in particular.

However, that quote brought to my mind another insight or awareness, viz. that we as human beings, as communities, as nations, can be so focussed on one particular “sign of the time” (which we are almost literally touching, 'holding') that we miss seeing another “sign” which is also of great significance, indeed devastating in its consequences, because we are so absorbed in that first particular “sign” which seems so overwhelming at the time.

I think this is true of South Africa and HIV. At least the first 10 years, if not more, of the worldwide HIV pandemic as it emerged and grew in South Africa were lost, as it were, to our consciousness and potential response because we were being overwhelmed by the crushing weight of the dominant “sign of the time” – the increasingly bitter struggle against apartheid from the mid-70s onwards, even right through those CODESA\(^1\) years of political negotiations which were accompanied by

great violence, strife, and murders. Dr. Muliyil's challenging insight was just as relevant to all those years of struggle: unless we had held the hand of the oppressed of our society, the figures and statistics of the numbers killed, maimed and dehumanised in their millions could not be understood.

What a cruel awakening we experienced when a new “sign of the time” became increasingly evident in the post-1994 period. But sadly, our political leadership was very dilatory, and later was trapped in seeming denial, in responding to what this would mean especially for the poorest and most vulnerable in our society which that very political leadership claimed to represent preferentially in terms of the Struggle. What was lacking was an awareness of the actual lived reality of HIV – the hand had not been held by the politicians in general - and a passion that something had to be done immediately.

This passion was magnificently captured by a very great advocate in the struggle to respond to HIV, Dr. Stephen Lewis, UNAIDS envoy, who said this in 2005: “Some experts say we're ahead of the pandemic. Some experts say we're behind the pandemic. Some experts say the pandemic is in its infancy……Whatever the experts, the pandemic engulfs us; in combination with eviscerating poverty, it puts the survival of entire countries at risk….. We can subdue this pandemic, but it will take the collective and uncompromising voices of principle and outrage to make it happen…” Yes – outrage! Real outrage at the suffering and despair of those dying as a result of HIV. I felt such outrage every time I sat with a dying mother in a dreadfully hot shack, sometimes with a dying baby next to her – the systemic injustice which had brought her to this moment, as I looked into eyes which were pools of despair and a face where tears mingled with perspiration, as she whispered to me: “I have no hope”. But outrage is not enough, as Dr. Lewis so clearly saw. It needs a principled response – and what should always guide our response as Church are the person of Jesus, the Gospel, and the principles of Catholic Social Teaching – applied in holistic and relevant programmes in the affected communities.

I gained my own insight because of a personal experience of HIV in 1992 and in the years which followed, and which became a passion in my life. At that time I was very occupied on a weekly, if not daily basis, with multiple crises as a result of atrocities and human rights violations at the
hands of the Bophuthatswana regime in the diocese. These included surviving a protest march in March 1991 when the Bophuthatswana forces opened fire on me and the people with live ammunition, and the blowing up of the church on St. Joseph's Mission in 1992 when I refused the regime's emissaries' demand that I cancel a mass meeting on the mission of liberation movements, unions and civic movements which were banned from meeting in Bophuthatswana.

However, in 1990, 680 farm workers had taken refuge on St. Joseph's Mission where I live because of the oppression of very right-wing farmers in the area, and in 1992 they were able to move to a new resettlement site as a result of a court settlement we managed to secure. This resettlement area was called Boitekong, just north of Rustenburg. Sister Georgina Boswell, a religious sister on the mission and a highly qualified nurse, followed them there, and opened a primary health care clinic in a shack to serve the people who rapidly began to occupy the 41,000 stands in that area which was between villages in the Royal Bafokeng community. With a grant from the Belgian Government I was able to house the clinic in prefab buildings, and in the following four years during which we operated that clinic 24 hours a day we touched the suffering and dying of the growing HIV affected community in the area. I sensed what the consequences of all this would be, and consulted key stakeholders in the health sector. This was early in 1993 – but this “sign of the time” was not yet being reflected upon in terms of policy formulation, still less of action.

I decided then that I needed to focus on the only resources I had – the people in the affected communities, and the business sector which could possibly finance a community-centered response to the HIV pandemic in partnership with us as Church. But, the time was not right yet to put anything in place. In fact it took me four more years to start what remained a hunch and a dream, but with very little content.

Circumstances dictated a move to Freedom Park, a huge informal settlement between two mine shafts of Impala Platinum in the midst of the Bafokeng villages. Perhaps Rustenburg diocese is rather unique in

2. "The Bophuthatswana Territorial Authority was created in 1961, and in June 1972 Bophuthatswana was declared a self-governing state. On 6 December 1977 this 'homeland' was granted independence by the South African government". Source: South African History online http://www.sahistory.org.za/places/bophuthatswana, accessed April 2013.
3. The Catholic Mission was outside the fragmented territory of Bophuthatswana and thus formally part of South Africa.
this respect as a predominantly rural diocese. Firstly, you find the Royal Bafokeng area with its 29 rural villages in a large area north-west of Rustenburg town in which Impala Platinum and Anglo Platinum operate several shafts (the platinum reef runs from there eastwards all the way to Brits near Pretoria where X-Strata and Lonmin operate platinum mines in the midst of other traditional villages). What is characteristic of this whole terrain is kilometre after kilometre of illegal informal settlements adjacent to the mines, and in between villages, i.e. shack settlements which house hundreds of thousands of destitute people, most of whom are migrants from the Eastern Cape and other rural areas of South Africa, and from many countries to the north of South Africa. And these impoverished migrants, many of them single women and single mothers who come here in a search of a way out of poverty….these are the most vulnerable to HIV infection because of a range of factors – especially socio-economic and cultural, and because of the presence of a predominantly migrant labour force of men from Lesotho and Mozambique in particular, but also from the Eastern Cape, who leave their families to work on the mines. Many of the miners have chosen to live in the same shack settlements thus saving their housing allowance as extra cash for their families at home. Therefore, there are sexual liaisons between men with money - and women with nothing.

Because Freedom Park was/is an illegal informal settlement, Government provided no services whatsoever to the 25,000 plus people. After a faction fight resulted in the deaths of 37 men there in mid-1996, we spent a long time reflecting first with the community members on their needs and priorities, developing trust, and then the possibility of a partnership between the community and the Church. They identified their first and major priority as a clinic, and Sister Georgina was uniquely gifted to provide this service. We were forbidden to build any kind of permanent structure by the authorities, so we began in a small shipping container which we added to as we obtained more funding. Then, we began discussions with the doctor in charge of the Impala Hospital, a very committed and far-sighted man, who saw the potential for a partnership between Impala and the Church – Impala taking care of the HIV positive mine workers in their hospital, and then Impala financially supporting our Tapologo programme in terms of caring for sick and dying people in the affected communities around the mines. "Tapologo" means a place of rest and peace in Setswana (a name suggested to me by
And so we began *Tapologo* HIV programme in 1997, and immediately touched and held the hand of the appalling misery in the informal settlements and traditional villages around the mines. At Freedom Park, Sister Georgina Boswell discovered that 49.4% of pregnant women tested HIV positive at her clinic (a figure which has stayed between 49% and 52% since then). Many other very poor people began to come from other shack settlements and traditional villages because she provided a one-stop service: they received a diagnosis, and were then able to get all their medication from our clinic pharmacy which was supervised by a private doctor who came into the programme in 1997 and has been with us ever since.

It was clear that many of the babies and tiny kids were gravely sick also. Our rule of thumb in those years was that if a little child lived beyond 3 years, he/she was probably not HIV positive – because an HIV positive child would have been dead before reaching the age of 3 in those shocking conditions. Sister Georgina immediately realised she could not cope with the sheer volume of sickness and suffering in the big settlement, plus all the additional patients from villages and other nearby settlements, and so in 1997 we developed our first Tapologo home-care nursing programme which became the model for the 11 teams we now have in affected villages and shack settlements.

She invited women from the community to come forward to work with her. She trained them in how to nurse and care for the sick in their shacks and we invited Lifeline to give these women courses in basic counselling skills – and they receive upgrading courses from time to time. They divided the whole settlement into sections, and then two of them took responsibility for each section. But those early years were very difficult because of stigma. Informal settlements can be very dangerous and violent places most of the time because there is only one thing driving everyone – how to survive. The home-carers began to be identified with that little understood but frightening sickness people called AIDS, and because of ignorance the men in the settlement began to target homes being visited by the home-carers. It got so difficult that at one point Sister Georgina began to receive death threats, and we had to close the clinic for six months. But eventually, the people recognised their loss, took ownership and invited us to open up again. In a rural setting such as I have described, an HIV programme is very dependent on
the local community taking ownership and working in partnership with a Church-sponsored programme, with the support of the tribal councils. But even then, problems can arise because of political interference by ward councillors with political agendas, and political party opportunists.

Here is one example of this. Four men, who said they were the ANC in the Freedom Park settlement, and who had been causing us problems with threats and intimidation, saw an opportunity in the developing centre where we had opened a skills training programme in additional prefab buildings especially for disadvantaged women, under the care of Brother Joseph Kiely, a De La Salle Brother. These four men came in one day during a class, threw everyone out, changed the locks on the doors of the prefab buildings and opened their ANC office. I immediately laid a charge at Phokeng police station, the four were arrested, and I appeared at the court to testify and to show documentation that those buildings belonged to me. They were found guilty of trespassing on my property and let off with a warning that they would go to prison if they did this again. For my sins, the Rustenburg ANC branch called me to a meeting to be dressed down for what I had done. The chairman happened to be a man I had helped when he was arrested by the Bophuthatswana regime, and he looked rather uncomfortable addressing me at the meeting. A young man from the ANC Youth League accused me of hiding behind the Bible with a gun. When I saw they were not open to a reasonable discussion about the actual issues, I laid into them and told them that if they ever tried anything like this in the future to deprive the poorest in the society of real service and care, I would nail them again – and keep on doing so, so they had better think about it. I then wrote to the Premier, Popo Molefe, and requested that he intervene with the Rustenburg ANC because, I told him, they were becoming the new oppressors of our people.

In passing, we were again very negatively affected by the strikes in the platinum sector last year. For example, I had to close down the whole Freedom Park operation for 3 weeks, with severe suffering to our patients and orphans, as well as another clinic for over a week.

From that first programme in Freedom Park, I found the necessary leadership and we expanded the home-care programme to other rural villages following the same model and training programme, but with an added component to ensure a high standard of care and ethos. We brought in retired nurses to head up each team of home-carers. These gogo’s nurses
immediately felt at home with the ethos I was at pains to develop in the whole team, i.e. holistic personal care for every person in their entire context, including the spiritual dimension, based on the values of deep reverence, non-judgmental love, and undying commitment in a very personal way to the child or the adult, and those affected by their sickness. In other words, holistic care, including the spiritual dimension, was the cornerstone of our particular approach in communities. This required motivating great sensitivity in our staff because each person, their religion, their faith, and their socio-economic background were unique. Those years from 1997 – 2004 were hope-filled years as we built up a team of some 130 carers and 11 professional nurses in 11 centres, managed by senior professional nurses, and we managed to find the funding through partnerships including the SACBC AIDS Office. We also involved the local communities by establishing a Community HIV/AIDS Forum around each of our centres.

But all the time I was experiencing the tragedy of appalling deaths as our carers found their patients in the morning dead on the floor of the shacks or homes. In 2002, I found another company in the area and convinced the CEO to enter into a partnership with me, and in 2004 I was able to open a hospice in-patient unit with 20 beds using a rather unique environmental design. Again, the staff was trained in counselling, non-judgmental listening, personal care, praying with the patient, so that the person could approach their death in peace and with a sense of dignity – and that included 14 children who have died in the hospice up till now. In the early years, we had to care for as many as 40 patients sometimes. Its function took on an additional dimension with the advent of ARV drugs and our partnership with the SACBC AIDS Office, which I will come to now.

So, in 2004, with the advent of PEPFAR, Sister Alison Munro and her team secured funding and initiated 22 sites in our dioceses. Tapologo was one of them. We simply founded our ARV system on the existing home-care programme. We now used the home-care centres also as ARV clinics, and then our ARV nursing team took out the drugs, opportunistic infection medication, files and so forth to the clinics which enabled the sick to come

5. ARV is an acronym for Antiretroviral, the current medical treatment for HIV and AIDS.
6. PEPFAR is an acronym for President's Emergency Plan for AIDS Relief, a US Government funded AIDS programme, originally in fifteen countries.
to a clinic in their home area, and they could then be followed up in their homes by the home-carers. Again the programme was holistic. It began with prayer and singing, then ongoing instruction to the sick about all aspects of the disease, prevention, and the ARV treatment, then a process where each went to a professional nurse for examination, a visit to a social worker assistant to look at their social environment and needs, and finally a visit to our AIDS clinician for the most problematic patients. Then, all the files were returned to our Tapologo centre to be captured on computer programmes by our admin staff. Blood samples were tested at a Toga laboratory housed in a fully equipped shipping container at the same administration centre. Now the hospice in-patient unit could be used to stabilise very sick patients prior to beginning ARV treatment, and not only for those who were dying and could not be saved.

And finally, also in 2004, we began our OVC programme which, for me, is always going to be the most challenging aspect of the holistic response which should characterise our Church HIV programmes. We took our home-care model and adapted it. Again people from the communities were trained by an NGO and became qualified child-carers, and they were supervised by social worker assistants, who in turn were managed by a qualified social worker. Because of the magnitude of the problem in the villages and informal settlements, we developed the concept of an emergency centre to which children could be brought after the death of a parent or guardian (but sadly, the ANC ward councillor blocked its recognition year after year). Our trained child-carers tried to identify foster homes, the social worker accessed social grants, and an after-care centre was set up. We obtained funding to enable the children to attend local schools, and after school they come to the centre for a cooked meal each day, help with homework, additional personality development activities, and the child-carers visit the foster homes several times a week to check on the situation. In addition, for the past three years we have implemented a partnership with the Royal Bafokeng in which finance is provided to us by the Impala Bafokeng Trust to set up such after-care centres in their villages, and Tapologo trains the child-carers from the village communities and runs the OVC programmes for the Bafokeng – not without difficulties.

Because all four Tapologo programmes are stressful and take their toll on our carers, a holistic caring for the carers programme is at the heart of

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7. OVC is an acronym for orphans and vulnerable children.
all we do – including a little all-purpose chapel I have for individual or
group counselling sessions by a sister, prayer times, singing and
solidarity, as well as more formal caring programmes.

The Tapologo Programme I started in 1997 developed into a
significant community-centered and community-run programme, and
there is no doubt that this particular response has been replicated or
developed in different ways in all our rural dioceses. I recognised that
after touching the hands of so many sick and dying children and adults, a
response by the Church could only be predicated on the one resource we
have – the people in our communities who can be empowered and kept
motivated by a leadership team which exercises their responsibility by
basing it on a spirituality and vision which enables us to find the strength
that can only come from God, and from solidarity and communion with
each other. This can promote a real sense of being called by God to be a
caring community, and to continue day after day to respond to these
precious “little ones” of our society with real self-sacrifice. In other rural
parishes of the diocese, I have also tried to encourage our parishioners to
develop home-care and OVC programmes – but this is very uneven and
depends on priests in particular motivating and supporting the
programmes in the parishes and, of course, finance.

**SUSTAINABILITY - FINANCE**

Quite clearly, the other major challenge is how to sustain such
programmes financially. And for us in Tapologo this is becoming
increasingly problematic in the present NGO funding climate in a rural
area. The past 3 years have been very difficult indeed, and we are just
about surviving as funding partners cut back on support, and in three
cases ended the partnership entirely. Unless we can find some significant
new funding this year we face the prospect of staff cuts and programme
cuts. In addition we have had a difficult time trying to secure a
partnership with the Department of Health to provide our ARV clinics
with ARV drugs so that we can partner Government in caring for the huge
numbers needing ARVs in this area.
**ARV PROGRAMME**

Because we were running several ARV clinics for 1850 patients, with the end of the PEPFAR support on the horizon, it meant that there were 2 options for us – transfer all 1850 patients to Government clinics, or enter into a partnership with the Department through which we hoped it would supply us just with the drugs, and we would try to find the extra funding to pay the nurses and cover the support programmes. We chose the latter, precisely because we knew the local clinics could not cope with that number of patients – they did not have nearly enough staff, and there was not enough finance to recruit more professional nurses. We worked very hard to secure an agreement but, for whatever reason, an imminent agreement was cancelled by a higher official in the Department. We had to begin transferring patients out, and what we feared has actually happened. Just one example. A woman who was doing very well after being nearly 5 years on ARVs at one of our clinics was transferred out. She did not get regular appointments, drugs were not there when she ran out of her supply, and recently she arrived at our hospice in-patient unit emaciated and very sick. The test showed she had a CD4 count of 1. She said to us: “I cannot take it anymore at the Government clinic. I have come here to die because I know Tapologo will care for me.” And she died in the hospice. We have resurrected discussions with the Department and a Memorandum of Understanding is now with the Provincial Government in Mahikeng. We can only hope and pray.

**PROFESSIONAL NURSES**

Another challenge concerns securing committed professional nurses, especially in rural areas. What has been particularly painful for me after working for so many years with wonderful retired nurses, who have had such an amazing caring ethos and spirituality, is the dearth of such a spirit and commitment in many of the young nurses who enter the field now.

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8. Mahikeng is the Provincial Capital of the North West Province of South Africa. It was formerly called Mafeking.
In terms of the Church's response in the present context of HIV and its challenges, I believe one “sign of the time” which will continue for many years, is the very unique challenge of orphan and vulnerable children, and child-headed households, in the current situation of the pandemic, especially but not only in rural areas. The sheer number of infected and affected children is only part of the problem or challenge – great as it is. Every child is a unique individual with special needs who comes from very particular social context, and our response must be tailored to that unique reality if that child is to have any hope of developing into a wholesome human being. I do not think we have nearly seen the full extent of the horrifying effects of this pandemic on the lives of these children, several many of them HIV positive, who are growing into teenagers and adults with significant and even very serious personality deficiencies, none of which can be laid at their door. We can but try to imagine what is happening inside a young girl who has dropped out of school to care for three siblings on her own…….

This is a systemic justice issue in the society, and we have only just begun the journey to seriously address this issue holistically as a nation. And I believe, in terms of Jesus, the Gospel, and Catholic Social Teaching principles, perhaps God is calling us to particularly focus as a Church community on this very challenging “sign of the time” in the present pandemic, among the other needs and programmes. As we face many challenges to sustain existing programmes and to respond to changing circumstances and needs, as a Church community we are invited by Jesus to share what is always possible for us, viz. the gift of presence to the “little ones” of our society. This echoes the inspirational challenge of Vatican IIs Gaudium et Spes: “The joy and hope, the grief and anguish, especially of those who are poor or afflicted in any way, are the joy and hope, the grief and anguish of the followers of Christ as well” (Gaudium et Spes, 1).

I close with the second half of that quote which I used at the beginning from Dr. Muliyil: “How can I understand a figure or a statistic unless I have held the hand that it represents? The people we are talking about are the same as us. By the way we treat them, we know just how much like Jesus we have become”.

72  CATHOLIC RESPONSES TO AIDS IN SOUTHERN AFRICA
REFERENCE

Catholic formal health institutions declined as the State took over health services. Women's Religious Institutes then established small primary health care programmes in needy communities and provided basic health services in small clinics and in the patients' homes. From the first days of the HIV epidemic, these small programmes cared for people affected by HIV. The work of the Church in these poor, out-of-the-way communities was in many ways invisible to the general public as well as to international funders. The Church's antiretroviral drug treatment programme changed all that. In 2003, when US Government funds became available through Catholic Relief Services to the SACBC AIDS Office, twenty church service programmes that had long offered home-based palliative care to people living with HIV could now give their patients life-saving antiretroviral treatment (ART). Over the ten years of the programme, Catholic HIV programmes became recognized as models of quality health care. Relationships developed with universities, government services, and research institutions and through these partnerships, Catholic health programmes spread their influence to other social sectors and institutions. Today the work of the Church in filling the gaps in health care for the needy is well known and respected locally and internationally.

A TRUE STORY: 2008 WINTERVELDT

The young doctor climbs into the old white van with the care workers. He works for the US agency that funds HIV Care and Treatment projects and has come to see how this Catholic health programme utilizes these resources. Earlier in the morning Sister Christine had walked him through the clinics, the community gardens, and the buildings that house the many other services the Sisters provide in this impoverished area—adult education, skills training, and orphan care. Now he wants to see first hand how the sick and dying are cared for in their homes.

The old white van sputters its way through the arid, inhospitable terrain of the Winterveldt, a semi-rural area north of Pretoria. This community is home to about 600,000 people, many of whom are
immigrants and refugees who were dumped there by the apartheid government since they did not fit into one of the other ethnic “home lands.” The inhabitants have long endured inadequate public services, including lack of healthcare, water supply, electricity, transport, and telephone lines, and its residents suffer from high rates of HIV and TB.

The van rolls up alongside a shack and the doctor follows the two caregivers down the steps onto the dry rocky ground and into the windowless one-room dwelling where he is greeted with the strong smell of urine. On the floor lies the patient, a withered looking woman almost hidden under a bundle of soiled blankets. He stands in the corner and watches one of the care workers kneel down and cradle the woman's head in her arms. In a low raspy voice, the woman explains that she is hungry and thirsty, but that it hurts to swallow. She doesn't know where her husband has gone or when he will return and there is nothing in the house that is soft enough for her to eat. Even if there was, she would be too weak to prepare it.

The doctor is overwhelmed. Despite his medical training, despite his big job, he feels helpless. But the care workers, women with little formal education, get right to work and make a plan. One will stay to bathe the woman, air the blankets and clean the house. The other one will go back to the clinic with the doctor to collect medicine and food that they can feed her.

As the doctor stands outside the shack waiting to leave, he shakes his head thoughtfully and says, “I wouldn't have known what to do, how to help that poor woman.” And just as he reflects on this, he sees another member of the community run up to the van and report to the caregivers, “There's a woman alone in that shack across the field who is so sick she can't get out of bed. We don't know what to do for her. Can you come and help?” The care givers agree to assist.

Now the young doctor knows how the aid funds are being spent. Now he knows what to write in his official report to the US Government: the resources are well spent. The Catholic Church is bringing life-saving health services to the needy in the forgotten corners of South African society.
A TRUE STORY, BUT NOT A NEW STORY

What the young doctor experienced in 2008 when he visited the Winterveldt is a window on the health services that the Catholic Church has provided in poor areas of South Africa for many years, long before the HIV epidemic and long before the infusion of international donor funds. This healing ministry began in the mid-1800s when Catholic religious orders began to arrive in South Africa. Most orders initially focused on teaching, but the health needs in the poor rural communities were so compelling that many of the religious began to provide nursing care as well. These Sisters opened emergency hospitals and developed permanent health services. By 1914 Church workers provided healthcare in many of the “black areas” where there existed no government hospitals or clinics. Beginning in 1935 the South African government began to subsidize mission hospitals and clinics in outlying areas. Many of these health facilities developed into educational institutions that provided training programs for large numbers of health workers. In 1951 alone, 500 nurses were trained at 22 recognized mission nursing schools (CATHCA 2011: 50).

But in 1973 the Government's Comprehensive Health Service scheme for government-aided hospitals and clinics came into force, and the South African Government took over nearly all Catholic hospitals. This was a devastating blow to Catholic healthcare. The only rural mission hospital that survived the purge was St. Mary's Hospital in Mariannhill.

To meet the many unmet needs of the impoverished communities they served, nursing Sisters established primary health care programmes and provided basic health services in small clinics and in the patients' homes. Thus, in the 1990's, from the very first days of the HIV epidemic, the Catholic health network already in place immediately began to provide palliative and supportive care for the people affected by that scourge (Parry 2005: 43, 45). In addition, individual parishes began to respond to the needs of the sick and dying and to care for the orphans they left behind.
A COORDINATED RESPONSE

Toward the end of the 1990s, as the HIV epidemic gained momentum, the Southern African Catholic Bishops' Conference (SACBC) decided there was a need for a coordinated response to the HIV epidemic that was causing such suffering in the country and established the SACBC AIDS Office to provide training in best practices to the many HIV Church service programmes and to pursue funding resources. In 2000, the Director of the AIDS Office, Sister Alison Munro, applied for and was awarded a large grant from Catholic Relief Services (CRS) to support many of the small Catholic HIV projects scattered throughout the country. She was also successful in raising funds from numerous other sources, including Catholic Medical Mission Board (CMMB), Cordaid, the Catholic Dutch development organization, and its British counterpart, the Catholic Agency for Overseas Development (CAFOD).

TREATMENT BECOMES AVAILABLE

The Church service programmes gave care and comfort, but they could not save the lives of the people they served; that would require the provision of costly antiretroviral drugs, completely beyond the budget of the HIV projects. But Sister Alison and her team in the AIDS Office wanted to do more than provide palliative care; they wanted to keep people alive so they could return to work and raise their children. Against all odds, they wrote a grant proposal that in 2004 was incorporated into a nine country *AIDSRelief* grant that CRS was awarded from the President's Emergency Plan for AIDS Relief (PEPFAR), the fund supported by US President Bush to provide antiretroviral treatment in fifteen countries, including South Africa.

In 2009 the AIDS Office was given leadership of the grant, with the CRS role limited to the provision of monitoring and evaluation technical support. This transition from CRS to the SACBC was the first transition of PEPFAR funds from an international organization to the local partner and has become the much publicized model for future US development aid (Catholic Relief Services 2010: 5).

Over the next decade in the PEPFAR programme alone over 45,000 people were placed on antiretroviral treatment, over 78,000 received
HIV and TB care, and 29,000 orphans and vulnerable children received vital services (Vosloo 2013). Many lives were saved. But something else happened as well. Like the young doctor who visited the Winterveldt, many people learned about the historic role of the Church in providing services to poor communities.

MINISTRY VERSUS PROJECT

South Africa, as the country with the most people living with HIV and an adult HIV prevalence rate of 17.9% (Republic of South Africa: National Department of Health 2010: 2011), received the greatest amount of international donor funds to combat the epidemic. And while the SACBC/CRS AIDSRelief grant was one of the largest awarded in South Africa, it was only one of around a hundred recipients of PEPFAR funds. Since many of those infected but unable to afford treatment lived in poor townships and in far flung rural communities, many grant recipients established HIV treatment projects in these areas. But most of the aid workers had neither lived in nor visited these disadvantaged communities, and they found it an uphill battle to adjust to the new environment, to develop activities acceptable and appropriate to the culture, and to earn the trust of the people. This process was made more challenging by the historic separation of communities under apartheid, the stigma attached to HIV, and the fear of antiretroviral treatment—a fear fed by government denial of the problem and resistance to antiretroviral treatment programmes. As a result, the implementation of drug therapy in some projects was delayed due to the need for government accreditation and until “community assessments” were conducted and “community mobilization” completed. The Catholic Church programmes, on the other hand, didn't have these challenges. The Church was already present in the community and already providing care to people living with HIV. The antiretroviral treatment programme was not a project; it was just another arm of its healing ministry.

One of the first Church service programmes to provide drug treatment was the St Joseph Community Care Centre in Sizanani Village, situated in Bronkhorstspruit, a periurban area, fifty kilometres from Pretoria. St Joseph's had long provided service to the community, including health care, income generating activities, child care, and a hospice. On the first
morning, St Joseph's scheduled a treatment clinic, the staff feared that the stigma associated with AIDS would keep most people away. There was no way that patients could slip in and out of St Joseph's unseen. But the staff need not have worried. On Day One when they opened the doors, they found a crowd of patients on the lawn outside, holding up the results of their HIV tests, anxious to receive treatment.

**MYTHS AND MISCONCEPTIONS**

In the early years of the antiretroviral treatment programme, the US Government sponsored many conferences for the treatment partners funded by PEPFAR. There were many objectives for these conferences—to present clinical updates; to explain the reporting methods and formats; to discuss grant requirements; and to promote an exchange of best practices among the partners. Generally each of the large treatment partners, including the SACBC AIDS Office, would give a presentation on their activities. A question and answer period followed. In these sessions, the CRS/SACBC presenter would typically be asked two questions. The first would be some variation of “What about condoms?” The second would be, “Do you treat only Catholics?”

The question on condoms I expected, even though probably everyone in the room knew the Church's position on the subject. The answer would be something like, “As you know, the Catholic Church does not promote condoms as the answer to the epidemic...” followed by a description of what the Church does do—give patients correct information, provide services in the home, care for orphans, provide treatment, etc. After the first year, people seemed to lose interest in this issue and stopped asking about it. The occasional statement that the Catholic Church was “killing people” by not distributing condoms was no longer heard. Perhaps this was because in South Africa there were condoms under every rock; yet the epidemic raged on.

It was the second question that always came as a surprise. Less than 7% of the South African population is Catholic (CIA 2008: online); most people who receive services in Church service programmes are not Catholic. I had never thought to explain this during my presentations. I didn't realize that so many people had the mistaken belief that the Church serves only its members. Other presenters from the SACBC/CRS...
programmes had the same reaction. The question, “Do you only treat Catholics?” literally jolted one religious Sister back from the podium where she had been speaking. Shocked, she answered, “No, of course not. We treat everyone who comes to us. I don't know their religion. I've never asked.” After the first year, this question too faded away. The antiretroviral treatment programme had exposed many people to the ministry of the Catholic Church and had dispelled a number of misconceptions.

GETTING THE SCIENCE RIGHT

In taking on a complex medical treatment programme, the SACBC and CRS intended to do good and to do it well. In this endeavor the Church was blessed with the participation of highly respected academics from four South African universities: University of the Free State; University of Pretoria; University of the Witwatersrand; and the University of Cape Town. Through their contact with the treatment programme, social science and medical professors conducted research that informed programmatic development; provided lectures at training sessions; evaluated the services the programme provided; and gave access to a number of resources at their respective institutions. Almost all these professors served without compensation, their reward being the opportunity to be part of a dedicated team committed to provide quality care to the poor, despite the limited resources and challenging conditions.

Three of the medical professors are world renowned HIV experts, held leadership positions with the Southern African HIVClinicians Society, served on international advisory boards, and were widely published in respected medical journals. One of the professors, Professor Robin Wood from the Desmond Tutu HIV Research Center at the University of Cape Town, donated his expertise and resources to evaluate the clinical outcome of tens of thousands of patients in the treatment programme and presented the results in journal articles and international conferences, concluding that this network of Catholic Church programmes, some of which operated out of shacks, freight containers, and from the back of an old car, provide effective and efficient antiretroviral services in a wide variety of poorly serviced areas in South Africa and made a significant contribution to health care in South Africa.
Professor Wood and Professor Van Rensburg from the University of the Free State also offered guidance to the SACBC/CRS Monitoring and Evaluation Manager, Dr Marisa Wilke, in her PhD study, “Models of Care for Antiretroviral Treatment Delivery: A Faith-based Organization's Response.” In her study of the different models of care at four Church treatment sites, some of the key findings were as follows:

- On average 73% of the patients who received care were not Catholic. These Church service programmes treated all community members who were in need, regardless of their religious affiliation.

- Community-based programmes provide access to the poorest members of society.

- Good care can be provided under the most basic conditions, whether in park homes, in freight containers, in old church buildings, from the back of a car, or under a tree.

- Where human resources for health are limited, many treatment tasks can successfully be shifted to lower level health workers, provided they receive proper training.

- Over 90% of the patients received adherence support and disclosed their HIV+ status to one or more persons, greatly increasing their adherence to the treatment regimen.

### Table: Indicator Results

<table>
<thead>
<tr>
<th>Indicator</th>
<th>St. Apollinaris</th>
<th>Hope For Life</th>
<th>Tapologo</th>
<th>Bela-Bela</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>26.85% (n=87)</td>
<td>32.38% (n=68)</td>
<td>27.87% (n=80)</td>
<td>32.97% (n=61)</td>
<td>29.42% (n=296)</td>
</tr>
<tr>
<td>Female</td>
<td>73.15% (n=237)</td>
<td>67.62% (n=142)</td>
<td>72.13% (n=207)</td>
<td>67.03% (n=124)</td>
<td>70.58% (n=710)</td>
</tr>
<tr>
<td>Minimum</td>
<td>18.05</td>
<td>19.07</td>
<td>19.94</td>
<td>21.13</td>
<td>18.05</td>
</tr>
<tr>
<td>Median</td>
<td>35.30</td>
<td>38.10</td>
<td>39.56</td>
<td>39.10</td>
<td>37.49</td>
</tr>
<tr>
<td>Maximum</td>
<td>66.58</td>
<td>77.44</td>
<td>65.77</td>
<td>75.17</td>
<td>77.44</td>
</tr>
<tr>
<td>Catholic</td>
<td>39.51% (n=128)</td>
<td>8.10% (n=17)</td>
<td>35.89% (n=103)</td>
<td>13.51% (n=25)</td>
<td>27.14% (n=273)</td>
</tr>
<tr>
<td>Non-Catholic</td>
<td>60.49% (n=196)</td>
<td>91.90% (n=193)</td>
<td>64.11% (n=184)</td>
<td>86.49% (n=160)</td>
<td>72.86% (n=733)</td>
</tr>
</tbody>
</table>
After receiving 2-3 months of ART at these sites, the patients were virally suppressed (virus suppressed to the point where it cannot be detected in blood tests), indicating that their treatment was initially successful.

Mo = months on ART. The 48+ month data are omitted due to the small sample. Table reflects median VL of the respondents with the lower and upper quartile in parenthesis. St. Apollinaris uses a different laboratory services and the undetectable viral load is indicated as <25, while it is <50 at the NGO sites.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>St. Apollinaris</th>
<th>Hope For Life</th>
<th>Tapologo</th>
<th>Bela-Bela</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.3 mo</td>
<td>&lt;25 [&lt;25;66,000]</td>
<td>&lt;50 [&lt;50;&lt;50]</td>
<td>&lt;50 [&lt;50;114]</td>
<td>&lt;50 [&lt;50;74]</td>
</tr>
<tr>
<td>12 mo</td>
<td>&lt;25 [&lt;25;72]</td>
<td>&lt;50 [&lt;50;&lt;50]</td>
<td>&lt;50 [&lt;50;&lt;50]</td>
<td>&lt;50 [&lt;50;&lt;50]</td>
</tr>
<tr>
<td>24 mo</td>
<td>&lt;25 [&lt;25;70]</td>
<td>&lt;50 [&lt;50;&lt;50]</td>
<td>&lt;50 [&lt;50;&lt;50]</td>
<td>&lt;50 [&lt;50;&lt;50]</td>
</tr>
</tbody>
</table>

A FLAGSHIP PROGRAMME

The SACBC/CRS antiretroviral programme has been the subject of professional papers in the *South African Medical Journal* (2010, 2012) and *PLoS One* (2012) and has been presented at numerous national and international conferences, including the International AIDS Society conferences (2010, 2012), the American Public Health Association Conference (2006), and the prestigious CROI (Conference on Retroviruses and Opportunistic Infections) Conference (2010). In addition, numerous papers have been presented at PEPFAR conferences, at South African professional conferences, and at Church-related meetings. All these presentations and journal articles can be found on the SACBC AIDS Office website: www.aidsoffice.sacbc.org.za. Most are referenced at the end of this paper.

As a result, the SACBC/CRS programme attracted many international visitors who were anxious to see how such quality medical care could be delivered in such poor communities. Visitors included the...
Director of the United States Centers for Disease Control and Prevention, international and local officials from the United States Agency for International Development; and US Health Resources and Services Administration; and numerous local and international academics and clinicians. It is worthy of note that when the Secretary of Health in US President Bush's Cabinet, Mike Leavitt, came to South Africa in August 2007, the one treatment site that the US Embassy in Pretoria arranged for him to visit was the SACBC/CRS Winterveldt Mercy antiretroviral treatment clinic. In addition, the US Deputy Secretary of State for Management and Resources, Thomas Nides, visited the Nazareth House treatment site in 2011.

These high level visits to SACBC/CRS treatment sites, many of which had operated on a shoestring for decades, not only served to keep the funds flowing, but also served as a witness to the quality health care the Church has provided, without fanfare, over many decades to those most in need.

MORE THAN DRUGS

The visitors at the Catholic treatment sites have been impressed with the excellent clinical services provided. They have also been impressed with the kindness shown to the patients and the willingness of the staff to go the extra mile to support their patients. Nurses and caregivers often work beyond clinic hours to follow-up patients in their homes, some walking long distances over rough terrain. Staff pray with patients and give them comfort and counseling. SACBC sites helped their patients secure identity documents and apply for social grants. Many of the SACBC sites distributed food parcels to the needy and established community gardens and nutrition education. Some sponsored skills training, income generating activities, and helped patients advocate for improved community service delivery. Most provided programmes to support the needy children in the patients' families. The staff at SACBC treatment sites understand that healing involves much more than drug treatment; healing involves social, emotional, and spiritual care as well. This holistic approach is what makes the Church's approach to HIV care and treatment unique.
TRAINING FOR AFRICA

One of the greatest challenges of providing health services in poor rural communities and townships is the limited availability of properly trained personnel. Health workers with good qualifications generally prefer to work in well resourced communities that offer better living and working conditions. This challenge was compounded by the fact that AIDS treatment was new and was not widely available in the public sector when the SACBC/CRS first began the AIDSRelief programme. Most health workers, including medical doctors, lacked the necessary education and clinical experience to provide appropriate HIV care and treatment. Further, the reporting requirements to the funder were stringent and required detailed records of the patients, their treatment regime, their compliance, and their clinical outcomes. This type of patient monitoring was new to most health workers and, as patient numbers increased, required electronic patient data systems. But many of the health workers had never even turned on a computer. This lack of computer skills also made it difficult for the treatment sites to meet the strict requirements for accounting for the funds they received, to keep track of drug supplies, and to fulfill the administrative requirements. For these reasons, training was urgently required.

SACBC/CRS embarked on a massive training programme. Experts from the Southern African HIV Clinicians Society were enlisted to train and mentor the doctors and nurses in the classroom as well as in the field. A hotline was made available for rural clinicians who needed to consult with an expert on one of their patients. Health workers were sponsored to attend clinical conferences. Many of the medical personnel worked part time at the SACBC/CRS treatment sites and part time in government hospitals. The skills they gained through this training benefitted patients in the public sector as well as those at Church treatment sites. Training was also provided for lay counselors, community care workers, site administrators, finance officers, and for staff responsible for record-keeping and data entry.

It has been necessary to offer training to site staff on a continuous basis. As staff at the treatment sites become better qualified and more experienced, some look for opportunities that offer better pay, more comfortable living and working conditions. And as HIV care and treatment becomes more widely available in the public sector, some staff
from the SACBC/CRS treatment sites are recruited into government facilities. There is a constant need to train the new staff that are hired to replace them. But there is a positive side to this picture: the staff trained through the SACBC/CRS antiretroviral treatment programme can be found in government institutions in many parts of the country and spread the reach of the Church's healing ministry. And when there is a need to partner with the local government, they can also serve as ambassadors for the SACBC/CRS treatment sites.

**PARTNERING FOR SUSTAINABILITY**

PEPFAR, the US president's emergency fund for AIDS Relief, was just that—an emergency fund. In 2003 when the fund was established, the HIV epidemic was out of control and treatment was essentially unavailable to the vast majority of the victims. The massive infusion of US government resources that funded antiretroviral treatment projects, including the SACBC/CRS programme, was intended to save lives in the short term, to prevent new infections, and to support governments to develop their own national response to the epidemic.

Since 2009 the South African government has stepped up its response to HIV and AIDS. Today HIV care and treatment is increasingly available in the public sector, and PEPFAR funding is winding down. Although HIV and the orphans left in its wake still present a huge challenge to the country, stand-alone emergency treatment programmes are no longer considered the most appropriate response. Today the goal of the government health services is to mainstream HIV care and treatment into the primary health care services and to strengthen all aspects of the health care delivery in the public sector. To that end, PEPFAR funding is increasingly being directed to the government health services and will no longer fund HIV treatment provided by nongovernment institutions, such as the SACBC.

The PEPFAR grant to the SACBC AIDS Office ends on 31 May 2013. And while there are some carry over funds remaining, the grant will not be renewed in 2014. The goal now is to ensure that the patients in Church programmes are sustained on treatment. Because these Catholic programmes have become well known and because the services they offer are highly respected, the AIDS Office is having success in
negotiating arrangements between the individual treatment sites and the relevant government entities for the continued care of the patients. These arrangements vary depending on the needs and resources of the Church treatment sites and of respective districts and provinces but can generally be described in terms of two broad categories:

- Where a public health facility in the catchment area is capable of absorbing the patients, those needing antiretroviral drugs are transferred to the government entity. In these cases, stand-alone Church antiretroviral treatment sites may close. Those Church sites that offer other services, such as hospice care, may continue to operate in this more limited role.

- Where the government health services does not have the capacity to absorb all the patients, either because it has no appropriate treatment facility in the area or because government facilities are overloaded, a public-private partnership is formed where government subsidizes the costs of the Church treatment centre, through the provision of drugs and laboratory services and in some cases contributes to operational costs (like Siyathokoza ART clinic in Botshabelo). Depending on the need, the Church site might serve as the district health facility for a certain catchment area (like Rosary clinic outside Newcastle). The Church site could also serve as a down-referral site, caring for stable patients or as a treatment initiation site that subsequently refers the patients on for long term care at a government facility (like the Sinosizo clinic near Groutville).

THE LEGACY OF HEALING

When the SACBC programme started in 2004, almost no government facilities offered the life-saving antiretroviral treatment. As an emergency response, the SACBC AIDS Office developed stand-alone antiretroviral treatment programmes. These were never intended to continue indefinitely; rather, the goal was to fill the gap in treatment for poor communities until the Department of Health had the commitment and the will to provide life-saving antiretroviral drugs as part of the
package of services offered in government health facilities. In a different setting, we might have planned for the integration of HIV treatment into the government health services from the beginning.

Today, a decade later, the circumstances are different. According to the UNAIDS 2012 Progress Report, South Africa now has the largest antiretroviral treatment programme starting an average of 30,000 people per month on antiretroviral therapy in its facilities throughout the country (Republic of South Africa 2013: 64). Since antiretroviral treatment is most effectively delivered as part of a comprehensive package of primary health care services, we would not embark on a stand alone treatment program again and we would not recommend other NGOs to do so. Rather, our recommendation would be that NGOs embarking on such programmes plan and coordinate their activities with the Department of Health and other government entities.

During the transition of the SACBC treatment to the public facilities, many government officials and health professionals visit the Church sites and see the care and respect with which patients are treated. The opportunity to experience a caring environment where the patients are put first will send a message more powerful than any recommendation we could offer.

Going forward, the SACBC AIDS Office continues to focus on the provision of home based care for the sick and disabled, whatever the cause. Patients will be counseled on HIV prevention and on the need for HIV testing; screened for TB; and assisted to get the necessary treatment at the appropriate health facilities. The care of orphans and vulnerable children will continue to be a priority.

The antiretroviral treatment programme implemented by the SACBC and its treatment sites opened the eyes of many government officials, medical experts and academics to the work that the Catholic Church has quietly undertaken year after year in the neglected and forgotten corners of society, sometimes with adequate funding but often without. This increased visibility, though neither sought nor expected, has been a witness to God's love and care for the poor and to the joy of those who work in God's service.
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SPIRITUAL DIRECTORS AND HIV AND AIDS

Susan Rakoczy IHM

This paper focuses on the findings of research conducted with spiritual directors in Gauteng and KwaZulu-Natal. The research seeks to learn when and how spiritual directors encounter the subject of HIV and AIDS in the spiritual direction conversation and how they respond. Personal interviews were conducted, a focus group discussion was held and several directors completed a written questionnaire. It was learned that in some cases directors become aware that HIV and AIDS is part of the directee's (seeker's) experience and so the director is challenged to engage with the person at very profound levels of empathy and interpathy. The director's experience with HIV/AIDS in other contexts helps her/him to be more sensitive when this topic enters into the direction conversation. The research also showed that HIV/AIDS needs to be addressed more explicitly in spiritual direction formation programmes.

In South Africa, we frequently hear it said in reference to HIV and AIDS that “everyone is infected or affected”. As she reflected on the pandemic, Gertrude, one of the spiritual directors interviewed about her experience with HIV and AIDS, stated very forcefully: “I believe that HIV is the single most significant opportunity for redemption that our society has seen including the apartheid struggle.”

The experience of HIV and AIDS is pervasive in South African society. In thirty years we have moved from the very first cases of AIDS in the early 1980s to an ever-increasing infection rate, through the years of denialism under President Thabo Mbeki, to the present time when anti-retrovirals are now finally widely available at government hospitals and clinics. The infection rate has begun to decline, although it remains extraordinarily high for women, especially those 15-24. No one is exempt since the pandemic has influenced every aspect of life in this country from government policies (or lack of them), to education, medical care and family dynamics. Thus it is to be expected that the various dimensions of HIV and AIDS also enter into the spiritual direction relationship and the direction conversations.

This research project was undertaken in order to learn how spiritual

1. The names of all participants in the research are pseudonyms.
directors experience the presence of HIV and AIDS in the direction relationship. Perhaps the seeker\textsuperscript{2} is HIV positive, or has family members or friends who are positive, suffering from AIDS-related illnesses or have died. The director may be HIV positive or also have relatives or friends who are positive.

**SPIRITUAL DIRECTION**

Spiritual direction is a ministry of pastoral care with a long history in the Christian tradition.\textsuperscript{3} In their now classic study, *The Practice of Spiritual Direction*, William Barry and William Connolly offer a comprehensive description:

> We define Christian spiritual direction, then, as help given by one believer to another that enables the latter to pay attention to God's personal communications to him or her, to respond to this personally communicating God, to grow in intimacy with this God, and to live out the consequences of this relationship (Barry and Connolly 2009:8).

Spiritual direction is a relationship of co-discernment, in which both director and seeker seek to find the presence of God in the seeker's experience. Ignatius of Loyola stressed that believers are to seek and find God in all things, which today includes HIV and AIDS. A director must be a person of faith, with the ability to listen deeply to all that is said and not said, to feelings and non-verbal expressions. She or he must pray regularly and deeply and be a constant seeker of the Divine in her or his own experience. Directors are not infallible and so they too learn from the experiences of the seekers they accompany, which is especially crucial when HIV and AIDS is present.

\textsuperscript{2} I prefer the term “seeker” to that of the classic “directee”, which to me connotes passivity.

THE INTERFACE OF SPIRITUAL DIRECTION AND HIV AND AIDS: A BRIEF LITERATURE SURVEY

While the literature on HIV and AIDS is huge and studies of spiritual direction are many, there are few published articles which bring the two together. There is an increasing number of studies about the effect of spirituality in the life of someone who is HIV+. The Bibliography on the website of CHART—the Collaborative for HIV and AIDS, Religion and Theology—of the School of Religion, Philosophy and Classics of the University of KwaZulu-Natal lists 52 resources under “spirituality” but none of the titles include spiritual direction, spiritual accompaniment or spiritual guidance.

Presence, the journal of Spiritual Directors International, has not yet published an article which directly addresses this area. An article published in Presence in 2012, “Spiritual direction with the person with a life threatening illness” does not mention HIV and AIDS although it does offer helpful approaches to a context which could include AIDS.

In my research I discovered three sources which directly address the interface of spiritual direction and HIV and AIDS. Walter J Smith discusses the spiritual care of persons living with HIV and AIDS which he describes as a “path not travelled before” (Smith 1995:448). On this journey with a person living with HIV and AIDS the director “has to remain close to life as it presents itself day by day” (:451). Because for the great majority of directors HIV is probably a new terrain, he or she is a learner and a listener from the experience of the seeker. The director is “a fellow sojourner, an advocate, an intercessor” (:455). A variety of issues may emerge in the spiritual direction conversations including sexuality, alienation from religion and religious institutions, questions about God, illness and feelings about death and relationships with family and friends. Smith describes the emotional sensitivity demanded by this relationship: “They (seekers) become like a sponge: if a relationship is

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5. See www.chart.ukzn.ac.za: “Resources”.

nurturing, they absorb the energy and feel more whole; if the encounter is detached and impersonal, they may feel they are losing energy and becoming less whole.” (:455). A director, or any spiritual care professional, is a person “who is able to approach HIV and AIDS as an intimate, as a person willing to enter its world, as a member of the human family that is affected by the disease in its various manifestations.” (:460).

Juan Reed uses the images of margin and centre in his discussion of spiritual direction and HIV and AIDS. Persons on the “margin” include the poor, the physically disabled, women, gay, lesbian and transgendered persons, people of colour, prisoners, persons who are chemically addicted, homeless people—and those infected or affected by HIV and AIDS which usually includes stigmatisation. Persons who have these experiences seek out a spiritual director because they are “outsiders-within”. This means “they possess the credentials of belonging such as baptism, education, ordination, religious profession, socioeconomic status, and so on, but who because of other aspects of their identity such as race, gender, sexual orientation, or disability, are excluded” (Reed 2000: 94).

Reed calls attention to two temptations to directors who accompany marginalized persons. Once the difference is acknowledged, they “are seen as so foreign that they come to be seen as less than full human beings” or they are “idealized and romanticized and seen, not as unique human beings, but only as representative of groups” (:94). In both cases, the director is not in conversation with a real person who is HIV positive or is affected by AIDS, but with an abstract type.

Reed emphasises that the director must be aware of her or his own social location. In terms of HIV and AIDS this demands that the director reflect on his or her experience with the pandemic. She may have lingering fears about HIV and AIDS while he may be coming to awareness of his judgemental attitudes. Accompanying someone infected or affected by HIV and AIDS will demand that the director shift their psychological and spiritual location as the relationship grows and deepens.

Directing at “the margin” involves pain and suffering but Reed also stresses that “it is also home, a place of joy and love. Marginal space, however, is always a site of struggle” (:101). As a director becomes more aware of the feelings and perspectives she or he brings to a spiritual
direction relationship in which HIV and AIDS is present, “...reflection reveals the margin as a place of rich possibility. Marginal space is no longer seen as a place where God is absent but a place full of divine revelation.”(102).

Writing from an African perspective, Benjamin Kiriswa of Kenya discusses HIV and AIDS within the broader area of pastoral counselling, which is a cousin to spiritual direction. His insights apply also to spiritual direction as he states “HIV/AIDS counselling can be described as an interpersonal relationship to help persons living with AIDS to experience God's presence in their suffering and to find spiritual healing” (Kiriswa 2004: 88). Dimensions of this relationship include dealing with self-acceptance, self-rejection, purpose of life and trust in God, relating pain and suffering to the redemptive work of Christ, fostering a sense of prayer and inner peace, and integrating death and dying into life” (:89).

SPIRITUAL DIRECTION AND “DIFFERENCE”

Contemporary spiritual direction formation and practice is paying a great deal of attention to factors of “difference”, especially that of culture, between director and seeker. These include gender, age, race, class, religion, and sexual orientation. Direct experience of HIV and AIDS is another crucial factor.

How can the director be deeply present to a seeker who is sharing the depths of their religious experience when they are different in significant ways? David Augsburger developed the triad of sympathy, empathy and interpathy which describes the ever deeper intellectual and affective presence of the director to the seeker in situations of difference.

“Sympathy is a spontaneous affective reaction to another's feelings experienced on the basis of perceived similarity between” (Augsburger 1986:31) director and seeker. For example, at a funeral a person may say to the person whose father has died, “I know just how you feel.” But of

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course he or she does not know. The process of “feeling with” the other is focused on one's own self-conscious awareness of having experienced a similar event. I use my own feelings as my barometer. Sympathy is thus a type of projection of one's own inner feelings upon another.

A second type of experience is empathy which is an intentional affective response to another's feelings, an experience of compassionate active imagination in which I choose to feel your experience with you but I do not own it. I share it. My experience is the frame, yours is the picture. The director is closer to the seeker in the experiences of difference, eg a black director and a white seeker, but has not entered affectively and imaginatively into what it means to be a white person of privilege in South Africa.

Thirdly and the goal of direction, is interpathy, a word coined by Augsburger. This is “an intentional cognitive and affective envisioning of another's thoughts and feelings” (:29) from another culture, worldview, religion, etc. The director temporarily believes what the other believes, sees what the other sees, values what the other values. The seeker's experience becomes both frame and picture. Interpathy is always partial but it can grow as a specific direction relationship grows and deepens and extends over time.

Spiritual directors who encounter HIV and AIDS in the direction relationship are challenged to move from a surface sympathy to affective empathy to moments of true interpathy with seekers who are either infected or affected.

THE RESEARCH PROJECT

The purpose of the research which was conducted in September and October 2012 in Aliwal North, Johannesburg and KwaZulu-Natal was to learn how HIV and AIDS impacts the spiritual direction experience. The focus was the director: what did he/she experience when persons disclosed that they were HIV positive? What other experiences of HIV and AIDS have entered into the spiritual direction conversation? In what other contexts has HIV and AIDS become part of their lives? Directors were asked to use the Ignatian categories of consolation and desolation to interpret their experiences of HIV and AIDS. In his Rules for Discernment in the Spiritual Exercises (#313–#336) Ignatius of Loyola
describes the effects of these affective experiences as either an increase or decrease of faith, hope and love. The research also queried how HIV and AIDS awareness is part of spiritual direction training programmes and asked for suggestions on how to incorporate it more fully.

The research was conducted through personal interviews, a focus group and an emailed questionnaire. Thirteen persons participated in one or more of these methods. Two experienced male directors declined to participate in the research.

THE PARTICIPANTS

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BACKGROUND IN SPIRITUAL DIRECTION

The formal training and experience of the participants varied from a few years of direction ministry to many years with a wide variety of persons. Three persons are staff members of the Jesuit Institute in Johannesburg and are engaged in training directors.
Formation as spiritual directors included the following:

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Some participants minister as directors as a full-time ministry and for others direction is one ministry amongst others. One participant who is a medical doctor uses spiritual direction skills in her medical practice. Participants are also involved in pastoral counselling, parish ministry, and formation ministry. Some have considerable retreat ministry experience.

**GENERAL AWARENESS OF HIV AND AIDS IN SPIRITUAL DIRECTION**

The participants shared a range of experiences when they reflected on how and in ways HIV and AIDS has entered into their spiritual direction ministry.

- “Of course the HIV/AIDS pandemic is always there; but for me it tends to be part of our social fabric rather than something that people have brought up directly in direction very much. Very aware in other roles pastoral counselling and general conversation around theology today.” *John*

- “I haven't had any of my formal directees coming to me speaking to speak about HIV, and the ways that they have been affected. but mostly I give spiritual direction to religious sisters, one priest, one businessman. Not at the coalface of HIV.” *Luke*

- “In spiritual direction, awareness is low; the questionnaire was the first, perhaps with married couples, pastoral counselling as a psychologist, haven't dealt with this much either; certain

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8. Quotation are taken verbatim from the taped interviews and focus group conversations.
contexts would be more aware but not much awareness.”

*Matthew*

- The doctor stated, “I see my work very clearly as spiritual and am amazed at the way spiritual direction is interwoven in my listening to patients and our ensuing conversations”.

*Gertrude*

- “I have come across persons who are HIV+ and in some cases being HIV+ has been a way for them to find new meaning and a new spirituality—God is also HIV positive!”

*Charlotte*

- “I am aware now more than ever before even though in practice I haven't had a lot of experience in directing people who live with HIV and AIDS. Probably one of the reasons is the fact that most of the people I accompanied were Religious.”

*Busisiwe*

*Elizabeth* had a very powerful experience which she described as a “clarion call” to enter into HIV and AIDS ministry which would lead to retreat ministry with carers.

First World AIDS Day 2000. I will never forget it. The woman who worked next door came with a paper from the clinic...that she was HIV positive. A lovely young person...She wasn't a Catholic. I said, “Let's go back to the clinic and find out what has to happen.” Boy friend disowned her. No relatives in the country. Choose what to do. Clarion call on the 1st of December. I didn't know what to do, Knew it was important, part of our lives, had quite a bit of contact before in social context. That's probably why I am here today. Since then I have been involved with retreats for caregivers, main contact, refuge for women, as a kind of spiritual direction... It was a clarion call. I wanted to be involved and asked God and this happened.
EXPERIENCES OF DISCLOSURE

Of the thirteen directors who participated in the research, eight had had persons disclose their HIV positive status while five had not. Two directors shared family experiences of HIV and AIDS which help them in spiritual direction and two directors shared other experiences of HIV and AIDS which have enriched their ministry.

- **“HIV/AIDS is one of the complex issues in spirituality because people most of the time they don't disclose easily. You work with the person and you could see that something is not revealed. And the time the person opens up and share with you and that is where you found you can take it as a cultural issue, is culturally rooted and you have to handle it in a gentle way according to the culture because the person will not immediately see that as HIV, will relate it to the culture, say 'somebody did this to me', 'the family didn't do this ritual', 'that's is why I am like this'. There is that avoidance of accepting that this is a disease.” Nontando**

- **“But somewhere, somehow, you hear that someone is struggling. But because it is not directed to me I always want to respect their space. But always give respect and give space. Only if a person comes directly to me.” Thembi**

- **“I have worked with students who have revealed that they are positive...The experience is always that somewhere there is the presence of God in this disclosure. If we can talk about it and pray about it there is a sense of relief at knowing his status...Once the disclosure is spoken of and they tell their story, we can together support one another, listen deeply to their story and offer some counsel as to a way forward in telling family or others concerned. Support is the operative word here.” Diane**

Busisiwe described her experience of accompanying a seminarian:

- **“At the beginning of the second year journeying with this person I was aware of restlessness in him and that restlessness had neither to do with his priestly calling nor this studies. He has given leadership in the community such as liturgy coordinator**
for the whole community. All the responsibilities that were given him became a focus for his sharing; as a result he shifted from his own personal and spiritual search for growth. That shift of focus was truly a sign for me that there was something more than meets the eye here! After listening, praying and waiting I knew him well enough to ask him straight out: what was bothering him? The whole truth came out. It was a moment of rejoicing, joy and freedom, a celebration that truth truly makes one free! With that the dynamics of sharing took a different focus.”

Some directors shared their feelings when a seeker disclosed their status:

- “Firstly I can say that you need to be strong because most of the time when a person reveals his status, it comes with emotions. And you need to be able to hold the person, hold all his emotions, to try to stabilize the person, that is the important thing, and bring the person to an understanding that the step you made to reveal it's a step to life, it's a step to life. That will bring the hope, the desire to see that the future is still there. And the person will feel comfort, will feel supported. So what I did then from there is that the person needs more support during those periods. Because for me it is like breaking in half, like a cup like this, and the cup is holding your tea, and you must make sure that the tea must not spill on the table. That is how the person is at the moment. So that gentleness, that support, especially the support that will make sense to the person. Making sure this person even though this HIV might be a way of discouraging, I am here to bring hope, that life still continues for the person.” Nontando

- “I struggled in the early years because one didn't want to abuse as a medical professional to initiate conversations on the spiritual. The thing that struck me when the HIV epidemic began to hit and I saw HIV + patients and their spiritual journey was very high on their agenda. And so they would come for treatment but there was this deep longing for hope. And so there was just open conversations time and time again. It was a paradigm shift in my life.” Gertrude
“My experience is one of feeling trusted, being confidential enough for them to speak and a feeling of integrity as a person reveals this deep trauma in their life.”  *Charlotte*

*Thabo* and *Thandi* shared their family experiences of HIV and AIDS. Thabo's sister died of AIDS and Thandi's brother-in-law died of AIDS-related illnesses.

“*My sister from what I gathered I believe she finally had AIDS but never disclosed it. Later on she passed on and having passed on she left a daughter. Sometimes her daughter would blame us to say we killed her mother because they are fighting for the house and you see....there is avoidance and people don't want to learn, misconceptions and misunderstandings. My sister also got very sick and would not say herself what is going on and indicated that there was a situation. She was very, very weak and then she passed on also. ...and I am quite worried because apparently these lessons are not... People make the same mistakes.”  *Thabo*

“*My brother-in-law died of AIDS related illness in March 1991. In 1986 he was diagnosed and at that time not only HIV and AIDS was hushed about a lot, people just didn't know a lot; people did not speak about and did not know about it... Two years prior to his death this time the doctor gave him two years. Five years seemed a long time. Two years seemed a very little time. I remember saying to my sister, 'If you want the family to support you have to tell the others.'... My father and brother were angry—wanted to kill him on the spot. My other sister went into a shell. Whole family under a cloud. Each one had to make a journey and it was not easy.”

“By the time we got to his last days, he actually died on Good Friday, and his Requiem was on Easter Tuesday. The thing is, dying on Good Friday—Lord, what are you saying?”

“How did I share with my community? I had to share with my community. I remember one day I was standing in the kitchen, there were only two other sisters in the community and they were novices; I was stirring the pot. I said to her, 'I want to share something but it is very difficult to get it out of me.' As I was
stirring and stirring the pot, it wouldn't come out. Eventually I said, 'My brother in law is dying of AIDS. Has AIDS and is dying.' Once out, such a load off my shoulders.”  

Thandi

**INTERPRETING DIRECTION EXPERIENCES:**  
**CONSOLATION AND DESOLATION**

The directors were asked to reflect on their experiences with HIV and AIDS and to use the Ignatian categories of consolation and desolation to interpret them.

In the *Spiritual Exercises* Ignatius of Loyola describes consolation as a deep affective experience:

> I call it consolation when the soul is aroused by an interior movement which causes it to be inflamed with love for its Creator and Lord…It is likewise consolation when one sheds tears, moved by love for God, whether it be because of sorrow for sins, or because of the sufferings of Christ our Lord, or for any other reason immediately directed to the service and praise of God. Finally I call consolation every increase of faith, hope and love, and all interior joy which calls and attracts the soul to that which is of God and to salvation by filling it with tranquillity and peace in its Creator and Lord (*SpEx* 316).

The directors identified various aspects of consolation in accompanying persons for whom HIV and AIDS was a living reality.

- “I feel great compassion and deep care for the person who is struggling with a so-called 'terminal' illness. My task is to offer them hope in a loving and merciful God.”  
  Charlotte

- “Consolation lies in finding that God is Present. The Sacrament

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9. References from the Spiritual Exercises are from The Spiritual Exercises of St. Ignatius Loyola. Translated by Elisabeth Meier Tetlow (Lanham, Maryland: University Press of America, 1987).
of the Present Moment, where a person is able to share his story and his fears.”  

Diane

➢ “Consolation—seeing people accepting the situation as it is and praying about.”  

Thembi

➢ “Seeing people get onto meds and deal with the illness and get better!!!!!!”  

Gertrude

➢ “Even though I could see that she was in her last time, you will go she would smile to you. I would feel very happy that at least the work I did with her at least is the reason she is feeling comforted; she's feeling that when time comes she will sleep peacefully. She knows that somebody is praying. This would give me strength to visit to pray, even to forgive her for what she was doing, the smoking, those kinds of things.”  

Nontando

➢ Speaking of her brother-in-law, Thandi said, “...a shock—around Corpus Christi—May, I remember praying in preparation for the feast—the line that stood out for me—'as I draw life from Father, so he who eats me will draw life from me.' This just stayed with me for so long. It was a long conversion process. At the end I could actually say as I draw life from Jesus may (my brother) draw life from me. It was a major breakthrough. From then onwards I was in a different space.”

Desolation was the opposite and painful experience. Ignatius describes it in powerful, affective language:

I call desolation that which is entirely opposite of what was described in the third rule, such as darkness of soul, confusion of spirit, attraction to what is base and worldly, restlessness caused by many disturbances and temptations which lead to lack of faith, hope or love. (SpEx 317)

The directors related moving experiences of desolation.

➢ “This subject is all about desolation. Just going week after week to Avalon Cemetery and seeing how many new graves every
single week, seeing how the fence is moved for more
land...Desolation experiences even if you don't know
individuals.” *John*

- “I think consolation is truth, veritas, coming to know reality.
  Desolation, turning back on God, has to do with denial, stigma,
  veil of secrecy and not wanting to talk about it. For me that's the
  work of the bad spirit however we want to talk about it. Stigma.”
  *Luke*

- “So sad for the millions, in the family, and the young people just
dying. And Zimbabwe in the 80s, whole villages destroyed,
forgot what percentage of staff in a hospital. Not understandable, part of the darkness and evil of our time,
darkness and pain suffering we need to find a way through... See
people suffering, feeling absolutely worthless and useless. Not
sure if desolation but it's pain, pain.” *Elizabeth*

- “But desolation was when we are not able to show the love and
share the love as brother and sister. Sometimes to survive we
look the other way; we don't want to see this because it is painful.
But finally God got me back and we could talk and then she died,
really in peace with one another.” *Thabo*

- “I was shocked a while back, week of guided prayer, most of the
retreatants were African, one girl a lovely young girl, she was in
her 20s, seemed to think that there was something wrong with
her because she was still a virgin. Of course I tried to keep it a
retreat but a lot of counselling. At the end she was convinced she
should no longer be a virgin. I can remember the moment she
said this; it was a moment of great desolation. I wonder how
many women think that way? She was educated, was a lovely
girl.” *Patricia*

- “I have felt desolated when a directee feels depressed and
together we are struggling to find meaning and purpose in life.”
*Charlotte*
WHAT DIRECTORS ARE LEARNING

The participants offered many astute insights from their experience of HIV and AIDS within the spiritual direction relationship.

- “AIDS is not a sin. Every person needs to be understood, listened to with love and understanding. No one is unaffected by the HI Virus.” Charlotte

- “Need to offer non-judgemental support, to guide in decision making, to offer forgiveness to those who are hurt, to suggest reconciliation and the Sacraments to some, to express that HIV is only a virus! You are alive and have a purpose in life.” Diane

- “Simply to receive people as they come, help them to hear themselves speak and gradually accept their reality. My learning is simply to be present to them and listen.” Busisiwe

- “This questionnaire has really been an eye opener, opened my eyes to the awareness to the possibility that HIV and AIDS might be there, could be affected, strong possibility being affected re a person's context.” Matthew

- “From the direction experience I learn that HIV is a disease like other diseases. That people who are infected need to be supported not only spiritually but socially, economically, that will give them the strength the willing to live more.” Nontando

- “I think one of the things that I have learned is similar to what has been said, that people becoming aware of the love that they have for their siblings, relatives. One example that I have is someone, one I am directing, a sibling who came to tell her first, very important that she knew first, before the wife would know.” Thembi

- “For me one of the important things is patience; be with the person where he or she is until they are able to reveal anything and then what gets me nearly all of our sisters from South Africa have somebody in the family that they themselves are ashamed
of. They tell me and not tell anyone else. Feel sorry that they are a big stigma to the family. Taking people where they are and moving from there, always important in direction. Always important in the AIDS situation.” Elizabeth

HIV AND AIDS AS A THEME IN SPIRITUAL DIRECTION FORMATION PROGRAMMES

Those who were part of the research had participated in a variety of spiritual direction formation programmes in Africa and other parts of the world. What was common in their sharing is that HIV and AIDS was not part of the programme in a focused way. They gave a number of helpful suggestions of how to incorporate this theme into these programmes.

- “HIV was not early in the training. It was just in one sub-title where we learn about cultures, sexuality, things like that. So I would suggest in the manual to prepare for spiritual direction this topic must take a quite big time so people can understand, people can learn, and people can also be familiar with HIV because outside here people will discriminate.” Nontando

- But in one of the courses it needs to be there and but later in the course, not in the beginning, but later when people have confidence and speak of self-esteem and also trust. I think. Trust is very important. When people trust me, this course would be easy to give. But I haven't done it.” Thembi

- “Realise what I don't know and find out. Very helpful for these programmes to have experience with care givers groups and so something ...something like Clinical Pastoral Education...all that is ideal, story-telling group that is part of the training. I don't disagree giving some knowledge especially about salvation where image of God comes in. Be part of the experience of AIDS carers groups.” Elizabeth

- “First let students respond to questions and their knowledge of HIV and AIDS. So many feel they KNOW it all, but on asking...”
questions we discover they have very superficial knowledge. Students need to acknowledge their own prejudice and discriminatory practices to those who are positive. Deep knowledge of Scripture, OT and NT. Many are lacking in OT passages of hope and God's care.” Charlotte

> “Training programmes demand that more LISTENING SKILLS are practiced and taught. That elementary Pastoral Counseling skills are taught and practiced, that all knowledge is not 'book' knowledge, but praxis. That the art of spiritual direction is one of reflection-action as a model. Provide knowledge of Scripture. Offer greater selection of suggested literature and reading from books and journals. There needs to be a greater element of ethical and moral development in the trainee spiritual direction. Not every priest or person is called to spiritual direction.” Diane

THE IGNATIAN SPIRITUALITY CENTRE PROGRAMME

The Ignatian Spirituality Centre is part of the Jesuit Institute in Johannesburg. The advanced training programme for directors addresses the questions of theodicy and suffering which are so pertinent to HIV and AIDS. Those infected and affected ask “Why” questions: Why does God allow HIV and AIDS? Why am I suffering?

Luke of the Centre's staff offered some important comments.

“Other things I would like to do apart from theodicy is also look at the question of salvation, what do we actually mean when Jesus is saving us, what does salvation mean. When I do soteriology I like to get across to people salvation is not only when you die and go to heaven, salvation is anti-retrovirals, give real practical, down to earth, getting life back.”

“Can't emphasise enough empathy, compassion, being nonjudgemental, good view of ourselves, opening a space for our directees to be free to talk about anything. These are attitudes and skills that we are trying to
empower during spiritual direction training.”

“I think it is important for trainees to recognise the stages of grieving, five stages, Kubler-Ross, people dealing with HIV frequently dealing with grieving and stages of grieving. Look at denial as one of the stages of grieving. It is almost a life skill that everyone needs, not just those doing spiritual direction”.

**SOME CONCLUSIONS FROM THE RESEARCH**

Some important conclusions emerge from this research project. Eight of the thirteen directors had experienced a seeker disclosing their HIV positive status or that of a relative or friend. However, each director had had this experience infrequently. Even very experienced directors have had very few disclosure experiences. So we can say that HIV and AIDS is present in the spiritual direction relationship more as a part of the pervasive South African atmosphere than as a subject of conversation.

The experience of HIV and AIDS in the director's family or in other situations sensitises the director to the issue and heightens their ability to listen deeply to a seeker for whom HIV and AIDS is part of their personal experience. They grow in empathy and interpathy and seem to have a “sixth sense” to the presence of HIV, although it may take a seeker a long time to share about HIV and AIDS.

Both consolation and desolation in relation to HIV and AIDS were described in powerful language. Consolation has been experienced by directors in various ways, including observing the increasing health of persons who begin to take ARVs, finding God in the sacrament of the Present Moment, having information about HIV and AIDS, and seeing HIV+ persons accept their situation and begin to deal with it.

Desolation is denial, stigma, isolation, the frustration of seeing young people not take care of themselves to prevent HIV, watching a seeker engage in self-destructive behaviour, not able to show love and care to a person who is HIV+.

Spiritual direction formation programmes need to include HIV and AIDS awareness in reference to a theology of suffering focused on the love of God. The participants recommended that those training to be directors should receive assistance on ways to reflect on their own
feelings and ideas about HIV and AIDS so that they do not project any of their possible negative approaches on to seekers.

CONCLUSION

This was an admittedly small research project, involving only thirteen spiritual directors in South Africa, the centre of the world-wide pandemic. It is striking that they have had so few disclosure experiences. But these disclosures have challenged the directors in many ways, which was apparent in their descriptions of consolation and desolation. Each experience of HIV and AIDS, whether in direction or with family or friends, deepens the director's ability to cross into the other's experience with interpathy, feeling and thinking what it means to be HIV positive, to be profoundly affected by another person's experience of HIV and AIDS.
REFERENCES


HIV/AIDS IN CATHOLIC THEOLOGICAL EDUCATION: THE CASE OF SJTI

Raymond Mwangala OMI

Theological institutions need to play a leading role in developing a theology of AIDS which is both credible and relevant. The paper describes how HIV and AIDS has become part of the education processes taking place at a Catholic theological institution, namely St. Joseph's Theological Institute (SJTI). It argues for the mainstreaming of HIV and AIDS in theological education including offering programmes and specific courses that are devoted to examining various aspects related to the HIV pandemic, integrating HIV and AIDS in already existing courses and programmes, encouraging students to write essays, projects and dissertations and theses on aspects of the pandemic and organizing conferences and workshops on HIV and AIDS that encourage research and publication on related themes.

INTRODUCTION

In less than 30 years AIDS spread across the globe becoming a major health and social pandemic. Like many communities in sub-Saharan Africa, staff and students at St. Joseph's Theological Institute (SJTI) have not been spared the devastating effects of the disease. Many have had to deal with AIDS-related deaths among family, friends and colleagues; some have encountered the disease in pastoral situations where they have been called upon to offer words of consolation. For many, the disease evokes fear - the fear of what would happen to them if it was discovered that they are HIV positive. AIDS is real and has become part and parcel of the reality at SJTI.

As a Catholic theological institution, SJTI has been responding to HIV and AIDS in a variety of ways: some members of the institute have engaged in pastoral ministry to those infected and to their families; others have been involved at the academic level, at conferences and meetings which have reflected on the meaning and impact of the pandemic. The institute, as a corporate body, has also responded in a variety of ways such as through the AIDS Action outreach programme and the participation in conferences on the pandemic.

This essay seeks to describe how HIV/AIDS has become part of the context, both immediate and remote, in which theological education is
taking place at St. Joseph's Theological Institute (SJTI) and what this means for the men and women preparing for ministry in this context. It describes the extent to which the pandemic has been integrated into the various modules taught, how it has been dealt with in the publications coming out of the institute. It also describes the presence of HIV/AIDS in the extra curricula activities in which students and staff have been engaged as a response to the pandemic. An underlying concern is whether HIV/AIDS has become mainstream in the theological education taking place at the institute. Although HIV/AIDS is not the only contextual issue which poses a serious challenge to the credibility of theological education on the African continent, this essay argues for the mainstreaming of HIV/AIDS because of the devastating effects of the disease. AIDS in Africa is closely related and connected to poverty, political instability, poor education, gender inequalities and several other social evils such that any approach to the disease must be multi-pronged. Mainstreaming HIV/AIDS in theological education does not mean ignoring these other factors; it simply argues for including the disease as a crucial player or hermeneutical key in the education process.

A BRIEF HISTORY OF HIV AND AIDS IN SOUTH AFRICA

A huge amount of material on the origins and spread of AIDS now exists. Debate about the actual causes of the disease, however, continues in some circles. Thabo Mbeki's questioning of the science around HIV and AIDS is one such case (see Ndinga-Muvumba & Mottiar 2007; Kunda & Tomaselli 2012). Literature linking HIV/AIDS to religion and theology in Africa, including on South Africa, is also abundant. However, a comprehensive and systematic theology of AIDS is in its infancy. The social, political and religious factors contributing to the pandemic are well documented (Knox 2008; Feldman 2008; Hunter 2010; Ige & Quinlan 2012).

Since it was first discovered in America, in 1981, HIV/AIDS has spread rapidly around the globe with the situation in sub-Saharan Africa reaching pandemic levels. According to the UNAIDS 2011 World AIDS Day Report, at the end of 2010 an estimated 34 million people were living with HIV worldwide. This was a 17% rise from 2001. Already by 2007, it was estimated that 68% of all people living with AIDS were...
located in Africa and that 76% of all deaths from the disease occurred there too. In sub-Saharan Africa, AIDS accounts for 20% of all deaths (Kerr 2012; Knox 2008). However, death rates have reduced while the total number of people living with the virus has increased, due to many governments making greater access to anti-retroviral treatment (ARVs) possible for their citizens and the investment of more resources to combat the disease worldwide. South Africa is still recognized as having the highest number of HIV positive people in the world, with the KwaZulu-Natal province having the highest HIV rates in the country (Hunter 2010:28). For an institution located in the KwaZulu-Natal province, as is the case of SJTI, this fact should be sufficient reason to make responding to HIV/AIDS a priority.

After 30 years, the pandemic has entered a new phase. It is no longer the crisis it was a decade ago. Significant gains have been made in treatment and care of the infected, but the battle is not yet won. A more systematic and coordinated approach is required now more than ever if the positive gains made over the last 30 years are not to be lost.

Beyond the obvious medical dilemma, AIDS presents theological and pastoral challenges: how to think and speak about God, how to speak the Word of God as good news in such a context of profound suffering and death and what all this is saying about the human experience of God. No doubt, the disease gives rise to heated debates about the appropriate response. These reveal various levels of anxiety about the disease itself. Often pastoral agents are asked to discuss the relationship between the disease and the Christian faith; unfortunately under pressure to say something meaningful some make quick and easy theological judgments (Louw 1990:38), which may have devastating consequences such as intensifying stigma and encouraging the discrimination of those infected and affected.

The nature and impact of the pandemic in Africa calls for the mainstreaming of HIV/AIDS in most sectors of life including and especially in theological education. The disease affects individuals as well as whole communities, people of faith and as well as those of none. 'Only a Church with AIDS can speak effectively and provide hope in a world of AIDS' (Smith & McDonagh 2003: 147). AIDS is everyone's problem and so it must also become everyone's concern. Unfortunately, as records show, responses to the pandemic in South Africa have been characterised by denialism, polemics, moralisation and unfounded
science with dire consequences (Ige & Quinlan 2012). Only recently have some positive gains begun to be recorded, with new infections in South Africa reported to have dropped by about 25% in 2010.

THE ROLE OF CHURCHES AND FAITH-BASED INSTITUTIONS

The response of churches and faith-based institutions in the first quarter century of the pandemic has been examined and has been found wanting (Maluleke 2003; Chitando 2008a). Apart from the slow and often confused response of some faith-based institutions, generally, there was silence and indifference, especially among academic theological institutions. A few exceptions can be found, but these only serve to prove the general trend.

Philippe Denis (2009:72-73) notes that attempts to develop a 'theology of AIDS' were made as early as 1990 with Daniel Louw's article on 'ministering and counselling the person with AIDS' which was published in the Journal of Theology for Southern Africa. Also, the Catholic Church organised three theological conferences on AIDS in 1998, 1999 and 2003, the third leading to the publication of the book, Responsibility in a time of AIDS. From a theological point of view, this is probably the most important Catholic initiative in the fight against AIDS in the first quarter century of its existence. Stuart Bate, editor of the book, had previously taught at SJTI. A resource book for those involved in pastoral ministry was also published as a result of this conference.

At SJTI, the first mention of AIDS in the theological journal, Grace & Truth, I could find was in the editorial note by Bernard F Connor and Mark Hay, in volume 15, number 1 of 1998. The volume focused on social reconciliation; AIDS is mentioned as part of the context in which the Truth and Reconciliation Commission (TRC) operated.

Further afield, since 2002, the Ecumenical HIV and AIDS Initiative in Africa (EHAIA), a project of the World Council of Churches (WCC), has played a leading role in the transformation of theological thinking on HIV and AIDS (Chitando 2008:6). This initiative has sought to mobilize churches, theological institutions and religious leaders to be actively involved in the response to HIV (6). The WCC initiative focused on churches and institutions affiliated with the council. As the pandemic
reaches its thirtieth year it is necessary to do a critical assessment of the various initiatives and approaches taken thus far if we are to face the future with courage, hope and renewed commitment.

**ST JOSEPH'S THEOLOGICAL INSTITUTE**

St Joseph's Scholasticate was 'founded in 1943 by the Missionary Oblates of Mary Immaculate (OMI) to prepare their candidates for ministry in the Roman Catholic priesthood' (*2012 General Prospectus*: 18). In 1990, the scholasticate was re-structured into two components: the scholasticate as the formation institution for OMI students and St. Joseph's Theological Institute (SJTI), the academic institution, with its own Board of Directors and Administration (Rakoczy 2005:88). Today, the theological institute is one of the leading pan-African, ecumenical, academic, spiritual and pastoral institutions on the African continent, with male and female students drawn from a variety of religious, cultural and national backgrounds.

During the 2012 academic year SJTI had an enrollment of 263 students, from 25 different countries, representing 14 male religious congregations, 10 female congregations, 4 Catholic dioceses, 1 Anglican diocese and 14 lay students. These were registered in three academic programmes, namely Philosophy, Theology and Development Studies. The institute also offers post-graduate qualifications in the areas of Catholic Theology, Christian Spirituality and Missiology. These are granted by the University of KwaZulu-Natal.

As a participating member of the Pietermaritzburg Cluster of Theological Institutions made up of the School of Religion, Classics and Philosophy of the University of KwaZulu-Natal, the Lutheran Theological Seminary and Seth Moketimi Methodist Seminary, St. Joseph's has the unique opportunity to collaborate and share resources with an ecumenical body of staff and students. SJTI is also a member of the Association of Oblate Higher Education Institutions (AOHEI), comprising St Eugene de Mazenod Theologate in the Democratic Republic of Congo (DRC), the Oblate School of Theology at San Antonio, Texas, USA, St Paul's University, Ottawa, Canada, Oblate Scholasticate, Obra, Poland, and Notre Dame University, Philippines. The institute also has a collaborative partnership with Tilburg University.
in the Netherlands. Through such a rich network of partnerships the institute has the unique potential to make a significant contribution in the area of Catholic thinking and ministry in the context of HIV and AIDS.

**Grace & Truth**

*Grace & Truth*, SJTI's theological journal was founded in 1980 by the Federation of Dominicans in Southern Africa (FEDOSA). Bernard F. Connor was the founding editor and served in this capacity until the journal was handed over to the theological institute in 1995. Paul B. Decock took over as managing editor. In his first note as editor, Decock announced the beginning of a 'new age in South Africa, and in Southern Africa as a whole'. Two changes to the journal announced by Decock were as follows: '[e]ach issue will focus on a particular theme and will have its own editor'.

Since its foundation the journal has been produced consistently, except for one year (1994) when the transition took place from the Dominicans to SJTI. Thus, the journal has been a ready vehicle for the spreading of the fruits of Catholic theological scholarship from the region and beyond.

As noted above, the first mention of AIDS in the journal was in the 1998 editorial note. In 2001 two issues focused on HIV/AIDS: volume 18, no 2 (August 2001), HIV/AIDS in Africa, and volume 18, no 3 (November 2001), Bioethical Issues: Genetics, Care, Research, HIV/AIDS. The first of these issues includes a wide variety of articles covering various aspects of the pandemic, including the Church's response to AIDS. The second contains only three articles dealing specifically with the subject of HIV/AIDS. It is significant that in its 30 year history only two issues have focused explicitly on the subject of HIV/AIDS. A closer study of the journal, however, reveals that the subject has been mentioned in several other issues such as Archbishop Denis Hurley's article on reading the signs of the times, Professor Susan Rakoczy's article, 'No Longer Invisible: Women in Church and Society' and Professor Philippe Denis' 'AIDS and the Crisis of Marriage in Southern Africa', which appeared in volume 21, no 1 of 2004. Based on numbers alone, however, HIV and AIDS cannot be said to have played a significant role in the journal nor can the journal be said to have made any significant contribution to the development of a theology of AIDS.
General Prospectus

The General Prospectus is published annually by the Academic Council of the institute. It gives official information on the institute, including the vision of SJTI, descriptions of qualifications offered by the institute and module descriptions. It has been published since 2006 after the institute was registered with the Department of Education (DoE) as a private higher education institution in 2004. One would therefore expect to find in this publication specific references to the pandemic and the institute's option to respond.

However, only the 2012 edition of this publication lists a module specifically directed to the study of HIV/AIDS: DDS135 HIV/AIDS and Development. Nothing specific is stated in the vision statement concerning HIV/AIDS. According to the description of DDS135 given, 'The module examines the relationship between HIV/AIDS and development, human and social, especially in the African context. It examines how individual and social development is affected by factors related to HIV/AIDS. It also examines how HIV/AIDS has become a profitable business for some'. This module is offered as part of the newly introduced (2012) Advanced Certificate in Human and Social Development qualification. Since the module is yet to be taught, an evaluation of its impact is not possible at this stage.

Other modules such as Bioethics (offered both in the Bachelor of Arts in Theology and the Bachelor of Theology degree programmes), African Ethics and, Challenges to Development (offered in the Higher Certificate in Human and Social Development programme) include a listing of HIV/AIDS in their module descriptions.

The impression one gets from reading the Prospectus is that HIV/AIDS plays no major role in the education taking place at St. Joseph's. To conclude thus, however, would not be justified as other activities at the institute indicate that this is not the case.

Havoc/Imbizo

Imbizo, formerly Havoc, is an annual publication of the Students' Forum. It contains a collection of reflective articles, news and information about activities and events related to the institute. Vol 6, No 2, of 1996 includes an article on the international AIDS conference held in Canada, in July.
1996, which one of the students from the institute attended. In this article the author describes some of the challenges around treatment as these were discussed at the conference. The article concludes with a call for action to fight the disease. Other articles published in the journal include narrative accounts of workshops organized by the AIDS Action group.

**Networking Cedara**

This is a weekly pamphlet of the institute for the purpose of internal communication of information on various aspects of the institute's academic and social life. Both staff and students contribute to the publication. Many articles on HIV/AIDS, reflecting either the opinion of authors or reporting on some HIV/AIDS-related events and activities have been published in the pamphlet. These show a general awareness of the pandemic by those associated with the institute. However, owing to the nature and purpose of this publication, it is unrealistic to expect that it would contain in-depth reflections on the subject.

**Student Papers**

Student papers at the institute are of two kinds: those done for specific modules and the exit level research papers in the Bachelor of Theology degree and the Bachelor of Arts in Philosophy degree qualifications. Students, in consultation with lecturers concerned, may write on a variety of topics. Copies of the exit level research papers are kept by the institute. One wishing to establish the kind of topics that have been written on would have to examine past papers. Some lecturers have indicated to me that they encourage students to write on contemporary issues, which include HIV and AIDS and that some students have written on the subject. The three departments are encouraged to collect the best student papers and to publish them. So far, only the Philosophy Department has taken on the challenge. Thus far, no student papers dealing with HIV/AIDS have been published.

**AIDS Action Youth for Life**

The AIDS Action Youth for Life group is a students' voluntary organization supported by the institute which runs workshops for young
people in schools and parishes in the Pietermaritzburg area. Founded in 2002 with the support of some academic staff, the group has continued to be the institute's most visible response to the HIV/AIDS pandemic. New members of the group are offered training at the beginning of each year which equips them with basic knowledge on HIV and AIDS and provides them with skills for running workshops for young people. These training workshops have been run with assistance of facilitators from the Archdiocese of Durban AIDS Care Commission. The group has received funding from the Southern African Catholic Bishops' Conference (SACBC) AIDS Office and from other donors both local and international.

On average, the group has been conducting between 15 and 20 workshops a year, with the number of participants ranging between 50 and 70 per workshop. According to the Chairperson's report of 2008, 14 workshops were conducted in 2006, with a total of 580 participants, while in 2007, 16 were conducted, with a total of 669 participants. Participants in the workshops come from a wide range of social, cultural and religious backgrounds. Topics covered during the workshops include basic information about HIV/AIDS, psycho-social factors related to AIDS, life orientation skills, etc. The group's motto is 'No one deserves to have AIDS'. Recently (2012), the group adopted the *Youth for Life Training Manual* as its guiding document for workshops. The manual covers topics which include the following: understanding who I am, understanding relationships, dealing with my emotions, dealing with my sexuality and dealing with myself. The manual comes with a workbook for workshop participants.

Members of staff have served as moderators and advisors to the group. Their input though has been minimal, leaving the group to organise itself. The AIDS Action group remains the most visible and consistent response of the institute to HIV and AIDS. There is, however, no clear and deliberate policy at the level of the institute to ensure that all staff and students participate in the initiatives and programmes of the group. In other words, the institutional framework is missing.

**OBSERVATIONS AND CONCLUSIONS**

From the above description it is clear that both staff and students at SJTI are aware of the reality of HIV/AIDS and have attempted to respond to
the pandemic both at the personal and at the institutional level. However, a deliberate and systematic attempt to introduce HIV/AIDS into the teaching and learning processes at the institute seems to be missing; a option to make HIV/AIDS mainstream has not be made.

## MAINSTREAMING

The concept of 'mainstreaming' HIV and AIDS in theological education has been widely used by institutions associated with the World Council of Churches. It has its background in the pedagogical debates of the 1960s relating to the need to end the isolation of children with disabilities by bringing them into regular classroom contexts, hence 'mainstreaming'. In contemporary usage, it is more nuanced. Basically, it refers to the attempt to ensure that the HIV pandemic occupies centre stage in an organization or institution. In the particular case of theological education, mainstreaming implies that institutions or departments of theology and religious studies deliberately focus on the HIV pandemic in their teaching, research and extra-curricula activities. Tokenism and making passing references to HIV and AIDS do not constitute mainstreaming! In short, **mainstreaming is the deliberate, focused and systematic placing of HIV at the core of an institution's academic programmes**' (Chitando 2008a:9) (emphasis in original).

As noted already mainstreaming HIV/AIDS in theological education implies that an institution recognizes the seriousness of the pandemic and addresses it in teaching and research. Central to the concept of mainstreaming is the attempt to help students learn how to make effective interventions in the struggle against the pandemic (2008a:10). Theological education should aim at helping students embody the person of Jesus Christ so as to be able to think and act as Jesus would. The basic question therefore should be how would Jesus think and act in the context of HIV/AIDS?

From previous research done by the WCC (Chitando 2008), a number of possibilities has emerged regarding mainstreaming HIV and AIDS in theological programmes. Some of these could easily be adopted and applied to the situation at SJTI:

1. offering programmes and specific courses that are devoted to examining various aspects related to the HIV pandemic such as the
recently introduced module referred to above;

2. integrating HIV and AIDS in already existing courses and programmes. This is a popular option as it does not require departments and institutions to go through the often challenging process of introducing new courses. An official policy to this effect would have to be made to ensure that this takes place;

3. encouraging students to write essays, projects and dissertations and theses on aspects of the pandemic. This too would require a deliberate policy;

4. organizing conferences and workshops on HIV and AIDS that encourage research and publication on related themes.

Theological education in Africa today takes place against the backdrop of the pain, suffering and death caused by AIDS. The experience of individuals and communities most affected by the pandemic must serve as the starting point for theological reflection. This will ensure that theological statements made are credible. There is also need for creativity to ensure that teachers and students develop relevant theologies that meet the needs of the time (Chitando 2008a:8). St. Joseph's can learn from other institutions that have made significant progress in introducing HIV and AIDS into theological education such as their Cluster partner, the School of Religion, Classics and Philosophy at the University of KwaZulu-Natal, which has been offering a 16-credit course on Church and AIDS since 1999.

CONCLUSION

To integrate HIV/AIDS in theological education calls for political will and requires commitment from all concerned, especially at the institutional level. There is no doubt that individuals at St. Joseph's, both staff and students, have been involved in HIV/AIDS research and other programmes. However, what is called for here is a collective and deliberate effort to make HIV/AIDS a non-optional part of the teaching and learning process at St. Joseph's. Serious efforts must be made to integrate HIV/AIDS in all courses and to network with others working in the field of HIV/AIDS. One way of insuring that HIV/AIDS remains on the agenda of the institute will be to introduce a compulsory module that
everybody attending the institute would be required to take. Another way is to establish a committee whose main responsibility would be to develop programmes and educational activities around HIV and AIDS. Already existing structures and committees of the institute such as the Programme Review Committee (PRC), the Research Committee, the Planning and Strategy Committee and the Programme Development Committee (PDC) could be given the task of integrating HIV/AIDS in the various programmes and activities of the institute.

A deliberate move should be made to make HIV/AIDS the pedagogical key for the education process at the institute. This will ensure that all modules include an aspect of the pandemic. Funds must be made available for new staff and to improve the library collection so that cutting-edge research results are readily available for staff and students. The results of research undertaken by members of the institute must also be made available to the general public. This will serve two purposes: ensure that theory is tested by praxis and also provide feedback which is necessary for the learning process.

The involvement of people living with AIDS (PLWA) must be a non-negotiable element of mainstreaming. This should aim at enabling them to speak for themselves and also to assist in breaking stigma and silence by bringing staff and students face-to-face with people living with the virus.

Among the curriculum goals should be included: reduce and eradicate the spread and impact of HIV/AIDS in Africa; strengthen the church’s role and capacity to respond to the HIV/AIDS pandemic; increase the capacity of students in developing, implementing and monitoring of HIV/AIDS prevention, care and support intervention programmes in their communities.

Finally, the objectives of mainstreaming should include among others: to institutionalize HIV/AIDS prevention, care and support in theological and pastoral education. Topics covered may include human sexuality, biblical studies, contextual theologies, pastoral issues such as counseling, etc. The point is not to repeat what is covered by other disciplines, but to use data from other disciplines in developing a theology of AIDS. If such an ambitious programme were achieved, HIV/AIDS would not only become mainstream, it would also contribute to rendering the theological education credible and relevant.
REFERENCES


HIV TESTING OF CANDIDATES FOR THE PRIESTHOOD AND RELIGIOUS LIFE

Alison Munro OP

An informal survey was made among religious congregations and among bishops about how leaders view HIV and AIDS, and whether or not there are policies in place regarding the admission of HIV+ candidates to seminaries and houses of formation. There is wide interpretation among the respondents of what is understood by an HIV policy. For some it is a formal written document, for others it is part of the health policy of the group; for others it is included in the constitutions or internal documents of the congregation. Not having an HIV testing policy at all appears to be problematic, especially if it implies that being HIV+ means being excluded from admission. This paper also examines the arguments for and against testing, and the position of canon law.

INTRODUCTION

South Africa remains the country with the world's highest number of HIV infections, estimated at 5,7 million with approximately 1,9 million people on treatment. Despite some evidence that globally the pandemic is beginning to plateau, we are not yet in a position to say that we are out of the woods. In our country possibly only half of those who need to be on treatment are receiving it, there are still new infections every day, people not receiving treatment are dying, and children are being orphaned. This despite the enormous strides that have been made to ensure more equitable, even universal, access to care and treatment. The new National Strategic Plan to address HIV, AIDS, Tuberculosis (TB) and sexually transmitted infections over the next five years was launched on 1 December 2011, and the Government has committed finance to deliver the related services. The news that anti-retroviral drugs will be manufactured in South Africa is welcomed, though it will be a few years before the pharmaceutical plant is up and running.

1. An earlier version of this paper was first presented to the AGM of the Leadership Conference of Consecrated Life of Southern Africa, April 2012.
Religious life and the priesthood have not been exempt from the scourge of HIV and AIDS, and we have, it would seem to me, a record as a Church of not always dealing with it in a positive way. (Munro 2004). Because HIV is most often sexually transmitted in our Sub-Saharan context we sometimes feel helpless when we are confronted with HIV among those vowed to celibacy. Not unlike society as a whole it would appear, some of us have fallen prey to stigma and discrimination towards those within our own ranks who are HIV-infected. Sometimes the care and compassion we extend to those with whom we work in AIDS ministry exceeds that which we practise when one of our own members is infected. (Munro 2004).

Over several years there has however been a greater acceptance of our own members who have needed to go on to antiretroviral (ARV) treatment which sadly was not available before 2004 in the public sector. This meant previously that clergy and religious suffering from AIDS-related causes died before treatment was as available as it is today. Because AIDS is now a chronic condition, incurable but manageable, the questions we need to pose in the context of the priesthood and religious life have, I think, different answers than they would have had fifteen years ago when treatment was not an option. We also know today that HIV and Tuberculosis co-infection is very common, and that TB is more easily transmitted than HIV in ordinary living and social contexts. TB is curable, but is not always easily diagnosed. Those on treatment need to adhere to strict treatment regimens over an extended period of time. In the case of HIV and TB co-infection, TB treatment and anti-retroviral treatment may be administered concurrently.\textsuperscript{4}

INFORMAL SURVEY

I conducted an informal survey among religious congregations and among bishops to help clarify a sense of how professional religious view HIV and AIDS, and whether or not there are policies in place regarding the admission of HIV+ candidates to seminaries and houses of formation. The questionnaire was answered by twenty nine people, a very small sample it is noted, 21 of them women religious, two brothers, and six bishops. Eleven major superiors or their delegates, and ten sisters working in AIDS ministry made up the group of women religious; six of these respondents are from diocesan congregations, fourteen from pontifical congregations, and the congregation of one is unknown. The diocesan congregations are all South African. Some of the pontifical congregations have very few members in South Africa. The late Bishop Michael Coleman was the first bishop to respond to the questionnaire, by return of email, and Sr Jacqueline Dormehl, HF, the last person from whom I received a response, not too long before she died.

It would not be just or accurate to generalise the findings to all religious congregations and all dioceses. Nonetheless there are some points of common concern facing religious congregations and dioceses around the admission of candidates which could possibly be more widely explored.

FINDINGS

Policy issues

There is wide interpretation among the respondents of what is understood by an HIV policy. In some instances it is a formal written document; in others it is assumed as part of the health policy of the given

5. The questionnaire asked for anonymous information on whether the respondents were male or female, whether (in the case of religious) the congregations were pontifical or religious, whether (in the case of bishops) priests in the diocese were mainly religious or mainly diocesan. Further questions related to policies concerning candidates seeking admission, HIV status among professed/ordained members, how ARV drugs are paid for, experience of stigma, and what involvement there is in the congregation/diocese related to AIDS ministry.

6. Health policies of congregations are contained within eg constitutions or formation policies, or stand on their own.
congregation; in others it is seen as included in the constitutions/internal
documents or other particular law of the congregation. Sometimes it
appears not to be something written. One respondent noted that “Our
constitutions state that we do not take candidates who have sickness that
would impair their ministry”.

Thirteen of the twenty nine respondents acknowledged not having a
policy, and almost none was able to provide one in writing. Some were
not sure whether a policy exists:
“ I don't think we have a policy, but am not part of
formation team.”
“ I don't think we have a policy yet, but it is something
we need to look into.”
“ There is no policy at present.”

Nine respondents indicated some form of a policy. Several
respondents made comments such as:
“ We don't admit people who are HIV+.”
“ We require a clean bill of health from all candidates,
not just for AIDS.”
“ We admit those who do not have serious health
problems.”
“ The diocese does not admit young men who are
known to be HIV+ or have AIDS.”

No written policies were provided by the respondents. One 'policy
statement' was received.

Two respondents knew of applicants who were not accepted because
of their HIV+ status. In the congregations surveyed there are no members
in initial formation who are HIV+ according to the respondents.

One respondent suspects that a member of the congregation who was
sick is now on treatment. This respondent also mentioned that a number
of years ago some finally professed religious who left a community
subsequently died of AIDS-related causes.

**Arguments for and against a policy**

Some respondents expressed their views concerning the acceptance of
candidates. Even where there is no policy in place there is an implicit

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7. Internal documents include constitutions, directives, formation policies.
recognition that congregations or dioceses need to be clear whether or not they accept candidates who are HIV+.

One respondent noted that “there is a new generation of young adults born with HIV ... If some feel called to religious life and are deemed suitable, we cannot have a policy that would further stigmatise and refuse admission simply on these grounds. We also cannot look at HIV as a reason for refusal. The lifestyle, values, openness, sincerity and motives of the candidates must be carefully explored and discussed with them.”

One respondent believes that “HIV is not a major issue in the countries where we have traditionally worked, in Europe, in the USA. We also minister in a country in South America where HIV and AIDS is rapidly becoming a major problem. We have worked in South Africa for only three years. If and when new candidates from these countries request admission to the Congregation, it will be necessary to have an HIV and AIDS policy.”

“In the process of initiation of a young woman into life as an xxx, the person would have to be in good health as our life involves many demanding apostolates and travel to other countries because of the missionary character of our congregation. I would see any serious or life threatening illness as a serious impediment to life and work as an xxx.”

“We do not have a formal policy as we assess each applicant according to her motives and reasons for entering religious life. But we do require HIV and TB testing as part of a thorough medical exam. This is not with a view to refusal, but to ensure the applicant is fit and healthy, and if necessary receiving any medication that is indicated.”

**HIV and AIDS among professed members**

One of the questions asked in the survey was: *Does your Congregation/Institute/Diocese have finally professed members/clergy who are known to be HIV+ or who have AIDS?*

Four respondents from religious congregations reported having finally professed members who are either HIV+ or who are on treatment because of AIDS. One bishop was aware of a religious priest in his diocese who is on treatment.

Four respondents mentioned knowing of members on treatment in countries outside South Africa, as well as in South Africa. For some of the respondents from international congregations their experience of
relational with HIV and AIDS is not in South Africa.

Six congregations with members on treatment are paying for the ARV drugs. In other instances the members are receiving drugs in the public sector.  

Twenty four respondents state that they don't know or are unsure whether some of the members of their congregations are HIV+.

Other points noted in the survey:

Most congregations responding are highly involved in AIDS ministry, as are all the dioceses. This ministry includes health-related services (twenty of twenty nine responses), orphan and vulnerable children services (twenty four of twenty nine responses), and pastoral and spiritual services (twenty two of twenty nine responses). The biggest involvement is in service to orphans and vulnerable children.

Stigma has been an issue, possibly more so in the past than it is at present. One respondent noted “At the very beginning when there was generally such fear and ignorance (late 1980s and early 1990s) some sisters felt we should not get involved.” Another respondent however suspected there is still “secret” stigma. Those who are infected are stigmatised by some.

Another noted that “at the moment stigma is not an issue. It may become one when members are discovered infected.” One bishop noted that “Some years back there was an issue around stigma among the clergy about testing prospective seminarians for AIDS. Some were in favour, some against.” A respondent noted that it would be very costly to admit people who are HIV and AIDS infected. The congregations have no money to see to the health complications of the infected.

Others noted that there are no members who are HIV +, and stigma is not a problem.

8. It is noted that this figure of 6 respondents does not correlate with the figure of 4 noted in the previous statement.
HIV TESTING OF CANDIDATES: SOME INSIGHTS FROM THE USA

In the late 1990s and early 2000s a number of people summarised an understanding of the widely varied HIV and AIDS policies and practices at the time in the USA, looking at current public policy, arguments in favour of testing, objections to testing, interpretations and opinions of canon law and recommendations that they believed needed to be followed. Some dioceses and religious congregations had put policies in place, others had not. Some tested candidates, others did not. (Fuller 1994, Fuller and Vitillo 2000; Fuller 2006: 20-21).

Testing and admissions policies

In drawing up and implementing policies it is imperative to address the issues of stigma and confidentiality. Dioceses and religious congregations have the right according to canon law to lay down conditions and criteria for selection of candidates; if HIV testing is to be used in the selection process it is important to use it for all concerned rather than just for some candidates. (Kelly 1998; Fuller 1994; Fuller and Vitillo 2000).

Various canons are noted as stressing the need for candidates to be physically and psychologically healthy, and noting the obligations on bishops and major superiors concerned regarding the admission of candidates. Bishops and superiors are reminded to ensure that the purpose of testing is clear, that they recognise the window of vulnerability they could be exposing, the psychological consequences of a possible HIV+ result and the need for candidates to provide informed consent for testing and counselling to be done. (Fuller 1994; Fuller and Vitillo 2000).

One of the concerns noted in favour of testing is the issue of possible exorbitant and ongoing medical costs. Linked to this are concerns about financial stewardship of scarce resources as expensive lifelong treatment started becoming available (Fuller 2006: 22). But also noted are points against testing, including the invasion of someone's privacy protected by Canon 220, the fact that someone could have a number of years of healthy living still available to him/her, and that medical advances could
change the picture. (Fuller 1994; Kelly 1998; Fuller and Vitillo 2000; Fuller 2006: 22-23).

The backdrop then in the USA is clearly also the homosexual HIV epidemic, and the time before treatment was as readily available as it is today in the developed world. There are arguments concerning the counter witness to the values of society that religious congregations and dioceses need to model in accepting new members infected by the virus. (Fuller 2006: 23, 25). And inevitably there are challenges with attempting to accommodate the human struggles of those infected and presumed to have been unfaithful to celibacy.

The response of dioceses and orders to HIV+ members (Fuller 1994; Fuller and Vitillo 2000) in the USA also varied, with some providing support, and other expecting their members to withdraw from active ministry. Developing policies regarding HIV testing followed one of three positions: i) excluding all HIV+ applicants, ii) using HIV status as one item of information about applicants, iii) not testing for or taking HIV status into account when considering an applicant. (Fuller 2006: 20). Public policy was followed, in the recognition that HIV testing could not be used to discriminate against students and employees.

One position taken by some dioceses and orders argues that testing is appropriate as long as confidentiality is maintained and results shared only with appropriate people; from another perspective the potential impact of testing and maintaining confidentiality in difficult circumstances argues against screening for HIV (Fuller 2006: 26). A test result could be considered as a significant part of a candidate's overall profile without necessarily precluding consideration for entrance. If HIV positivity is grounds for exclusion, HIV testing should be done early in the application process. If an order or diocese requires HIV testing it is responsible for maintaining confidentiality of all results reported to it. (Fuller 1994; Fuller and Vitillo 2000).

O'Connor (1992) points out that the four central concerns to be addressed by a policy are:

i) confidentiality; ii) informed consent; iii) strategies of care for persons who discover a positive HIV status because of a test requirement; iv) effect of a person's HIV status on a diocese's/congregation's decision regarding his/her acceptance as a candidate.

The authors cited in this section have extensively covered reasons for having an HIV testing policy in place rather than reacting to individual
situations of HIV infection. None says categorically that HIV testing should not take place, or that candidates should or should not be accepted into formation and seminary programmes. Having and following a clear admissions policy (which may or may not include HIV testing), is both necessary and important if candidates are to be treated justly.

**Canonical Implications of an admissions policy**

Canon law notes that health issues, the consent of the individuals concerned and the right to privacy are to be considered when determining the suitability of candidates for admission to formation and seminary programmes. Admission is neither a right nor an obligation. (Lagges 2011).

**Health of candidates a legitimate concern for bishops and major superiors**

Canon 241§1: The health of candidates seeking admission to the seminary is a legitimate concern. The diocesan bishop is directed to judge whether candidates are “capable of dedicating themselves permanently to the sacred ministries in the light of their physical and psychological health.” (Canon 241§1.) (Woestman 2002: 64-67; Feathergill 2010; Hite 1985: 117-119; Calvo 1991: 47-50).

Canons 641 and 642: The right to admit candidates who have required health, character, maturity, belongs to major superiors. (Calvo1991: 47-50).

**Consent of individuals**

Candidates for the seminary and religious life have long been required to undergo a physical examination and to submit a medical report to superiors. This has always been done with the consent of the individual. It is the right of the individual to refuse. It is also the right and obligation of competent superiors to refuse a candidate who is not judged by positive indications or evidence to possess the necessary qualities, including physical health (Woestman 2002: 64-67).
Right to privacy

Canons 1029 and 1051:1: The bishop, major superior and seminary rector have the responsibility of assessing the physical and psychological suitability of candidates to the diaconate and the priesthood (using standard medical examinations and psychological testing). Mandatory medical examinations and psychological testing are invasive of privacy and qualify the exercise of the right to privacy protected in Canon 220 (Fuller 2006:23; Gibbons 1995: 5-52). While mandatory testing does not necessarily violate a person's right to protect his privacy, the applicant still has a right to protect his privacy from any adverse effects resulting from testing. The fewer the number of persons authorised to receive this information the greater is the guarantee of confidentiality which extends beyond the congregation, seminary and the diocese. The right to privacy is not absolute and must be balanced with the common good of the church and the rights and duties of others (Canon 223:1. See Woestman 2002: 64-67).

Right to know purpose of testing

The applicant has the right to know the purpose of the testing and its consequences. Unless positive test results will be used as only one factor in assessing general physical suitability, a policy should state that an applicant will be excluded from admission if he/she is tested positive. The reasons for this exclusion should be given and based on current medical information (Fuller 2006).

Canon law provides a framework, as does a religious congregation's own law, for the criteria used in determining a candidate's suitability for admission to a formation programme. These criteria, including the position taken by the diocese/congregation on HIV, need to be known by the candidate ahead of his/her application for admission.

Consequences of testing HIV+

An applicant should be informed of the psychological consequences of testing HIV+. A positive test can enable an individual to seek available treatment and plan for the future. In mandating HIV testing for admission
the congregation, seminary or diocese assumes the obligation in justice to provide counselling. The policy should make provision for pre-test and post test counselling. Vocational alternatives should be suggested for those not accepted. (Fuller 2006).

Canon law protects the rights both of dioceses and congregations admitting candidates, and candidates seeking admission. Candidates seeking admission to religious life or the priesthood have a right to know what is expected of them re admission (including HIV policy information). Congregations/dioceses in turn need to be clear what their own policies are in line with the canons governing religious life and the priesthood.

EXAMPLES OF A POLICY STATEMENT

In the US literature I noted one example of a policy statement from the Diocese of Oakland in California.

The Diocese in consultation with the applicant for admission to the formation program and his physician, has the responsibility to determine the applicant's ability to complete training requirements and/or discharge the responsibilities of ordained ministry. HIV antibody testing should not be required by the Diocese of Oakland as a mandatory, routine screening mechanism for applicants for formation program admission. HIV antibody testing is strongly recommended under two circumstances: (1) as part of an applicant's own personal discernment regarding ordained ministry, if that applicant's past might have occasioned viral exposure; (2) if suggested by the physician in the course of the physical examination required of all applicants. (Schexnayder 1994: 83-86).

Only one policy statement from South Africa was received during the informal survey.

Every applicant who wishes to become a seminarian is informed that he will be required to go for an HIV/AIDS test. Up to now everyone has freely agreed to do this. The doctor is also informed and an additional paragraph has been added to the Medical
Exam Form for the seminary, which the doctor has to complete. Should a seminarian be HIV + he will be given any counselling needed and is included in the same medical benefits he would receive as an HIV-applicant. Naturally, he will also have to comply with all other requirements for the seminary applications, including passing his psychological examination, in our case done by the XXX University.⁹

**SOM**E **CO**NCLUDING **REMARKS**

People may not be denied employment, other than in particular labour situations, because of HIV+ status. We know that neither the priesthood nor religious life can be compared with societal labour situations. Dioceses and religious congregations need to guard against infringement of civil law and human rights in addressing HIV testing issues, and to note the provisions legislated for in Canon Law, protecting rights of dioceses and congregations, as well as rights of individual applicants around possible admission.

Not having an HIV testing policy at all appears to be problematic, especially if it is implied as it was in some responses to the survey that a policy may be put in place when and if there are HIV+ candidates. This would appear to be a reactive situation, and could be messy. Mandatory testing without informed consent is not recommended either, especially if being HIV+ means being excluded from admission.

Policy development is not an easy task, and one size does not fit all. But having a policy in place makes provision for decisions around exclusion or inclusion available to all concerned, applicants, superiors and bishops, current membership.

Clergy and religious do have a particular place in the Church as spiritual leaders and role models. There is a human courage that is needed for those among our members who are HIV+ and have AIDS to declare their status. Healing and love come in part from our willingness to share our pain.

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⁹. A South African diocese.
REFERENCES


CONTRIBUTION OF RELIGIOUS SISTERS TO HEALTH CARE IN SOUTH AFRICA

Melanie O’ Connor HF

Catholic nursing religious of different congregations have left a legacy that other organisations can hardly surpass. They established hospitals, clinics, training colleges and home-based care as cities mushroomed and towns and rural areas expanded. For many years, the Catholic hospitals and clinics provided the only medical care available to people especially in many remote rural areas. The 1970s onwards saw the decline in numbers of religious nursing sisters and a gradual closing or handing over of Catholic hospitals to local government. At the same time HIV and AIDS was beginning to show itself and Sisters responded as maternity wards were turned into hospices for the dying and caregivers were trained to nurse the dying in their homes. Today many of our nursing sisters have reverted to travelling around nursing the sick in their homes and providing basic health care as the original missionaries did. They do this along with their home-based caregivers, caring for the sick and dying in their homes and supporting the many child headed households left orphaned and vulnerable.

INTRODUCTION

There is a stream flowing out of the temple....and on each bank of the stream all kinds of trees will grow to provide food. Their leaves will never wither, and they will never stop bearing fruit. They will have fresh fruit every month, because they are watered by the stream that flows from the Temple. The trees will provide food, and their leaves will be used for healing people (Ezekiel 47:1,12).

The wealth of the church (stream) is its people bearing all kinds of fruit. When it comes to health care in South Africa, Catholic nursing religious of different congregations have left a legacy that none can surpass here. They not only go deep into the history of the country but deep into the memories of those whose lives they touched with caring hearts and hands over the last 125 years or more. They indeed have helped water, nourish and grow the country in many ways. They established hospitals, clinics and training colleges in answer to the needs of the people as cities
mushroomed and towns and rural areas expanded. In recent years they have turned more of their attention to primary health care, nutrition, orphans, vulnerable children and those suffering from HIV/AIDS.

BEGINNINGS

Apostolic Congregations of Sisters began to sprout in Europe in the aftermath of the French Revolution of 1789, many of them answering the need for health care and schooling. As people left Europe in search of greener pastures, so too, missionaries of different denominations followed on their heels - so much so that the 19th century became known as the great missionary era. The discovery of mineral wealth in South Africa brought a rush of prospectors to the country. In 1844 Natal and Orange Free State were incorporated into the British Cape Colony, subsequently Port Natal (Durban) was becoming one of the most important seaports of the British Empire. In the 19th and 20th centuries health care and schools were a great need and missionaries of different denominations, from Europe especially, responded to that great need.

Within the Catholic Church in South Africa formal nursing care began in the Natal Vicariate. This Vicariate was the third Catholic Vicariate to be established in Southern Africa and confided to the French Oblates of Mary Immaculate in 1850. The Cape of Good Hope and the Eastern Province Vicariates were established in 1838 and 1847 respectively (Denis 1998:99, 186). Although centred on Natal with a concentration of roughly seven hundred Catholics, mainly Irish, French, and Mauritian, the Natal Vicariate included Basutoland (Lesotho), Swaziland, Orange Free State Republic, Transvaal and more. (Brown 1960:301; Brain, 1997: 195 – 210). The first hospital established in Johannesburg was run by the Holy Family Sisters brought out from France especially for this purpose in 1887 when the city was barely one year old. At first the Sisters nursed sick miners in tents, then in a temporary hospital for awhile. A few years later Augustinian Sisters arrived from France in response to Bishop Jolivet's request for Sisters to care for settler Catholics in the Durban area. Within the space of a few

years the Augustinian Sisters were operating four health care centres: Escourt in 1891; Durban in 1892 from a humble homestead which emerged as the future renowned St Augustine's Hospital; Ladysmith's Sanatorium in 1897; then St Anne's in Pietermaritzburg in 1898 at the request of doctors in private practice and who were not allowed to attend to their patients at Grey's Hospital. Speaking of the Sisters at St Anne's one reporter remarked how the Roman Catholic nuns at first did not charge; they were “nurses, cooks, laundry maids and dairy maids who looked after the cows that were kept on the property.”

In the meantime the beginnings of the King Dominican Sisters' hospital work go back to the pioneering days of Rhodesia (Zimbabwe) under Cecil Rhodes. Sisters joined the expedition into the interior and nursed the sick and wounded. This was in response to a request by the Jesuit Superior, Father Alphonse Daignault to Mother Mauritia in December 1889. The first attempt in Rhodesia by the Jesuits at missionary evangelisation some years earlier had failed for a variety of reasons. The proposed expedition of the Pioneer Column of Cecil Rhodes seemed to offer a new opportunity for evangelisation in the region:

Fr A. Daignault asks Mother Mauritia for Sisters to join the expedition in support of the new missionary enterprise: initially, by nursing the sick and the wounded, and eventually, by engaging in teaching and other missionary tasks in the mission field. Mother Mauritia, after consulting with Bishop Ricards, discerns God's call to a new mission; hence she faces the risks involved and allows Sisters who volunteer to go.

Although the volunteers were trained teachers, they willingly took up nursing under Doctor Jameson's tutoring.

In 1888 Sisters of Nazareth arrived in Kimberley and began caring for children, the elderly and the destitute and by 1894 they had begun similar work in Yeoville, Johannesburg. They helped the Holy Family Sisters to nurse injured troops during the Anglo-Boer War.

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Apart from official hospital work in those early days a lot of informal nursing took place, district and otherwise. The Assumption Sisters, the first Sisters to arrive in South Africa in 1849, took care of the sick in their homes initially because many sick at the time were being sent to the prison to be taken care of. There was an attempt to build a hospital in Grahamstown but Bishop Devereaux died so their plan did not materialise. Holy Family Sister Bernadin in Durban was well appreciated for her herbal medicines. During the Anglo-Zulu War in 1879 Holy Family Sisters for three months helped with the nursing of the wounded soldiers brought to Pietermaritzburg until nurses arrived. When the Trappist monks arrived in Natal in 1882, they nursed the sick in three huts they set aside for the purpose. In Bloemfontein there was a disease outbreak in June 1889 which lasted for three months, the ravages were seen particularly among Catholics. In extreme cases some of the Catholics wanted to send their sick to St George's Hospice under the direction of the Anglican Sisters. To avoid that one Holy Family Sister was sent to look after the sick Catholics for the duration of the epidemic.  

During the Anglo-Boer War Convent boarding establishments had to be evacuated and were turned into hospitals for wounded soldiers whom the Sisters nursed. Then in 1916 there was an outbreak of 'Spanish' influenza which raged for five weeks. Sisters again took care of the sick in their homes. A half million died in South Africa during that period. Sisters themselves endured many hardships because of inadequate sanitary facilities which led to the ravages of dysentery, typhoid, smallpox and plagues – a number died young.

**EXPANSION YEARS**

The 1900s saw the proliferation of hospitals and clinics by Sisters of different Religious Congregations. In 1904 there was the arrival of two Little Company of Mary Sisters from Australia in Port Elizabeth to specifically nurse and care for the sick. In 1905 the first Catholic hospital was established in Johannesburg by the Holy Family Sisters - the Kensington Sanatorium as it was called. In 1915 the Holy Family Sisters ceased their association with the Johannesburg General Hospital and

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established the first Catholic hospital in Cape Town that same year. In 1927 St Mary's Hospital, Mariannhill, came into being and was staffed by the Precious Blood Sisters from Germany. It became the referral hospital for some 19 Government Community Clinics. The Belgian Sisters of Charity arrived in Polokwane (Pietersburg) in January 1928 and started working at the Mission of Doornspruit. The Sisters opened up a school and a small dispensary, which eventually grew into St Joseph's Hospital and Maternity Home. The King Dominican Sisters started Umlamli hospital in the Eastern Cape in 1933. The Benedictine Sisters established their first hospital at Nkandla in 1939. A number of hospitals in the rural areas started out as clinics before they grew into hospitals. In 1943 the Montebello Dominicans opened a small clinic which eventually grew into a hospital. The Loreto Sisters who arrived in Glen Cowie (Mpumalanga) in 1928 also opened a small clinic which over the years grew into St Rita's Hospital.

In 1943 the Holy Cross Sisters established St Konrad's Hospital in Taung, Northern Cape. This hospital served all groups over a vast area. Subsequently they began St Gerard's Mission in Garsfontein, near Pretoria, where the hospital had treated over 29 000 maternity patients before services were discontinued when Garsfontein was declared a whites only area. Another Maternity Hospital, the Marymount, built by the Oakford Dominican Sisters in 1949, soon became known for its excellent service. By 1950 there were 41 Catholic hospitals and 29 clinics in South Africa and the nurses and professionals were mainly Religious.

Health care facilities kept expanding. In 1954 the Oakford Dominican Sisters established the Marifont Maternity Hospital in Pretoria. At one time, a quarter of all the births in Pretoria had taken place there. In Pretoria, too, the Little Company of Mary Hospital opened in Groenbloed in 1957. In 1958, the Nardini Franciscan Sisters took over responsibility for St. Benedict's Hospital at Nkandla from the Benedictine Sisters. The mission there served 30,000 Zulus from the region. The Holy Rosary Sisters became noted for their assistance to the State in running sections of public hospitals.

For many years the Catholic hospitals and clinics provided the only medical care available to people in a number of areas. They were also the first to provide medical and nursing care in many remote rural areas. Their work highlighted the lack of provision of health care by the...
apartheid government. When the latter embarked on its relocation of people plan in the 1970s the Sisters reached out to the people in the resettlement areas and ran mobile clinics there each week and sometimes twice a week in places like “Compensation Farm” near Impendle in KwaZulu-Natal. A special characteristic of clinics in rural areas was and is their holistic approach to health care. The nursing Sisters were engaged in projects such as water conservation, trench gardening and the growing of vegetables among other things.

**HIGH STANDARDS**

Catholic Sisters are noted for the standards they set in health care. The Glen Grey Mission Hospital, Queenstown, opened in 1941, won two gold medals from the South African Nursing Council. The high standards set by the Sisters became the criteria by which any other medical services were judged. Christ the King Hospital in Ixopo (KZN), handed over to the provincial authorities in 1984, is now a key medical centre for the whole region.

**TRAINING OF NURSES**

With the expansion of clinics and hospitals also came the need to train nurses. The first application for such training at the Johannesburg Hospital was from a Miss Brink in 1896 but because of war etc training was interrupted. By 1912 St Augustine's Hospital in Durban had begun a training college.

Certification was important by then. Sister Henrietta Stockdale, an Anglican Sister, had already initiated the first professional nurses' training school for whites at Kimberley in 1877. She managed to get state registration of nurses and midwives instituted by 1900 - thus making South Africa the first country in the world with such legislation – then approval of nursing schools and provision of statutory curricula and examinations for nurses. Cecilia Makiwane, trained at the Lovedale

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Mission Hospital, holds the title of being the first black professional nurse to obtain state registration in Africa in January 1908. The standard had been set. When the Nardini Sisters arrived in South Africa in 1955 their nursing qualifications were not recognised by the local authorities, hence the Sisters had to start training at a local hospital run by the Missionary Benedictine Sisters of Tutzing.

In 1929 the Department of Native Affairs gave the mission hospitals money for the training of local women as nurses, the purpose being to take over the mission hospitals in the future. St Mary's Hospital, Mariannhill, along with other Catholic hospitals began training schools for nurses. They soon became noted for the quality of their training. Sister Pelegrima Zwane of the Montebello Dominican Sisters obtained a certificate in chemistry at Mahlabatini Hospital and started the clinic at Montebello in 1943. As early as 1940, two King Dominican Sisters were sent to the Witwatersrand University to train as medical doctors. More followed them; some qualified as Sister Tutors, among them Sr. Marietta Gouws who was the first Religious Sister to be appointed as State Examiner for nurses in South Africa. The white staff at Umlamli Mission Hospital in the Eastern Cape was gradually replaced by trained black Sisters of their Congregation.

The above has given us but a glimpse of some of the tremendous contribution of our nursing Religious Sisters to health care in South Africa over the years. Initially, in its implantation phase, the Catholic Church began by using a two pronged approach in its method of evangelisation, namely church and school. However, missionaries soon realised the great need for health care among Catholics, and in addition, care of the sick was also associated with the spread of the faith.

A THEOLOGY THAT SPURRED THE MISSIONARY ZEAL OF THE SISTERS

The intensity of missionary zeal in the 19th and a good part of the 20th century was, no doubt, influenced by ideas about the Church and the suppositions ingrained in its theology. One great task of missionaries was to save souls from eternal damnation. This was no less the aim of

8. For more information on Sr Mariette Gouws see CATHCA. 2011: 95 – 99.
other Christian missionaries. The controversial dictum “outside the church, no salvation” was taken very seriously and in a very literal sense by our early missionary nursing Sisters. Of course the Sisters did not want non-Catholics to be damned so they secretly baptised the dying and hid scapulars and medals under the pillows of patients and hoped for conversion. They adhered to a theology that looked heavenward.

In many ways their spirituality balanced their theology. The early missionaries preached a gospel of love by their lives. Perhaps the greatest contribution the nursing Religious Sisters gave in growing the country through their health care services is the bringing of the love of God to people. People were never turned away because they were not Catholic. When there was considerable concern in the medical field over the laying of white hands on black bodies, Johannesburg Hospital had no problem at all in that area. The Sisters were very devoted to their black patients. They worked for God Alone and went wherever their presence was required – as we saw with the King Dominicans, the “dauntless darlings,” as they were named by Rhodes' pioneering contingent.9

The spirituality of Sisters in the health care of people is probably best described in what we read from the Johannesburg Diggers' News of 6 November, 1890:

> Luckily for those who have had the privilege of being restored to health under its sheltering walls, an efficient staff of nurses were secured in the very earliest days of its existence. Ladies who had given up their lives to charity and good works were found who preferred, although of cloistered faith, to live apart from the world, yet of it, and to bestow their kindness and patience, and knowledge of nursing without stint, and with no hope of reward other than their own clear conscience in well doing. To these ladies a tribute of thankfulness is due, and although their work may be in the background, and not brought forward for special pronouncement, their kindness will live in the grateful remembrance of those who, making their acquaintance in sickness, have left it with the blessings of restored health.

As the Sisters opened their doors to others the theology of no

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9. Ibid, 19 – 27

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salvation outside the Catholic Church became less tenable. Convent schools and hospitals actually became a means of breaking down prejudices, fostering tolerance and a family spirit. In this they countered many of the ideologies of the day.

**DECLINE OF CATHOLIC HOSPITALS**

The 1970s onwards saw the decline in numbers of religious nursing sisters and the gradual closing of a number of Catholic hospitals or their take over by the local government. In 1973, with the formation of independent homelands, the government made the decision to take over mission hospitals. When this happened initially Sisters chose to remain working in the institutions as part of the staff. In places it was the black Sisters and nurses who took over the running of a hospital. St Mary's, Mariannhill, remained a private hospital and survives to this day along with its training school. Montebello Hospital, taken over by the government in 1981, has two Montebello Sisters still working in the hospital. In the 1980s one by one the Catholic private hospitals began to close.

**SISTERS RESPONDING TO THE SIGNS OF THE TIMES**

In the middle 1980s HIV/AIDS was beginning to show itself in South Africa. By 1985 it was reported that 500 people had died of AIDS in South Africa. By 1990 the situation was becoming worse and health organisations were beginning to mobilise but government was slow to respond. Congregations of Sisters began to develop a ministry to AIDS patients. A bold move was made in 1990 to rent a two-storey house in Kensington, Johannesburg, to use as a hospice for AIDS patients. It was the first of its kind in Johannesburg and was named Sacred Heart House. Sr Cecelia Newell of the Assumption Sisters started work there in 1991. The Salvation Army donated beds and lockers and many other organisations gave help in kind. Religious Congregations began sending some of their nursing Sisters as well as their novices to help.

Where rural clinics had no access to the drug nevirapine, suddenly maternity wards were turned into wards for the dying as mothers...
expressed the wish not to die in front of their children. Adults, young and not so young, who returned home to die found households depleted and no one to care for them. Sisters in rural areas, in order to cope, had caregivers trained to nurse the dying in their homes. Here CATHCA (Catholic Health Care Association),\(^\text{10}\) which was founded in 1988 as an umbrella body for Catholic health services, offered tremendous support in both funding and training, and providing nutritional food. Later came the role out of ARVs which made care easier.

Religious Sisters had found new ways to uphold the dignity of people. The founding missionaries had begun by travelling around nursing the sick in their homes and providing basic health care. Today our nursing Religious Sisters have reverted to doing the same especially in our rural areas. They do this along with their home-based caregivers, not only caring for the sick and dying in their homes but also supporting the many child headed households left orphaned and vulnerable.

In 2000, St Joseph's Hospital, Polokwane, became a community care centre and in 2002 a project was set up for the care of HIV/AIDS patients before the remaining Sisters left for Belgium and were replaced by a group of Congolese Sisters of St Vincent de Paul. The clinic in Badplaas, started in 1978 by the Holy Rosary Sisters is now run by the Congolese Sisters of St Vincent de Paul.

The Reverend Denis Bailey, who has worked with NGOs all over Africa, said recently in a conversation that when it comes to delivery of services for HIV/AIDS and also behavioural change it is the faith based organisations, which include many Religious Sisters, which are far more efficient than NGOs and they do it for a fraction of the costs. He also said that USAID has, after two decades, discovered this and is now working with faith based organisations.

**CONCLUSION**

This paper has sought to give a brief insight into an extraordinary legacy – a legacy perhaps somewhat overlooked by those of us who have not been in the nursing field. As we saw, the Sisters started in small ways, gradually expanding their service of healing throughout the country and

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further afield. They administered to rich and poor alike and often under
primitive conditions. Their lives and dedication no doubt spoke to the
people in a way that was aptly summed up in the *Diggers News*. They
took the responsibility for training others in the nursing profession,
ensuring high standards and quality of service. This actually stood in
good stead for the future takeover of their institutions when the Sisters
themselves were waning in numbers and finding it difficult to keep big
institutions.

Religious women today albeit fewer in number continue their healing
ministry in clinics and through district nursing - called for especially in
rural areas where HIV/AIDS is rampant. Along with the protection of
lives and promotion of a simple subsistence economy, a valuable
contribution the Sisters continue to give to society is in the enlisting of
the help of caregivers in districts, many of whom are youth or
unemployed adults. In this they have helped youth empower themselves
in service to others in the community.

To our nursing Religious we owe a big thanks – may your leaves
never wither but keep budding anew and may you never stop bearing
fruit.
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PART 2
Theological Reflections on AIDS in Southern Africa and Beyond
Thirty years after the discovery of HIV, how has the Catholic Church throughout the world responded? As Pope Benedict XVI has said on several occasions, the Catholic Church is “second to none” in effective action to prevent the further transmission of HIV, mitigate the impact of the present epidemic, and provide a person-centered and holistic approach to those living with or affected by HIV and AIDS. Thus it seems right and just that our reflection on the thirty-year history of the HIV pandemic and its impact should feature the Catholic Church's response to this crisis. Distinguishing characteristics of this ecclesial response can be found in the Church's witness to truth; her effective pastoral action; her competent educational, medical and social services within a holistic approach and promoting integral human development; the countless acts of solidarity offered and received. At the same time, there have been and are tensions with other social actors which would criticize, undermine or marginalize the Church's response. It is important that the Church maintain, even strengthen, her commitment “until AIDS is no more.”

THANKSGIVING

Thirty years after the discovery of HIV, how has the Catholic Church throughout the world responded? What has been most important in these 30 years filled with Church responses to HIV/AIDS is all that our Lord Jesus Christ has been accomplishing in the Holy Spirit to the glory of God the Father. Our first approach must therefore be deep gratitude. While one cannot give thanks for HIV/AIDS itself, one can and should gratefully recount examples, from around the world, of the responses that began very early and have increased tremendously in number, quality, scope and spirit.

MY FORMATION

My first encounter with AIDS was in 1988, at L’Arche in France. One

1. I am very grateful to my brother Mr. Robert Czerny of Agora Management Associates (http://www.agora-management.ca) for help in the writing, translation and editing involved in preparing this paper for delivery and publication.
day Catherine, an Assistant, told the founder, Jean Vanier, that her brother Serge had just died of AIDS. Serge was in his early 30s; he was homosexual, and most of his friends were viscerally anti-Catholic. But Noël, Serge’s partner, reported that he had asked for a funeral Mass. It fell to Catherine to arrange it. Her father, step-mother and two sisters were triply crushed – by the homosexuality, by the AIDS, by the early death of their only son and brother.

Catherine went to the parish close to the Père Lachaise Cemetery in Paris but the priest remained distant and showed no compassion – if Serge and his friends were not practising Catholics, why bother with a funeral Mass? Catherine sensed that the man was afraid; he certainly had no sense that these people needed to hear words of hope spoken “inside the Church.”

So Catherine asked Vanier, who told her to ask me – I happened to be on sabbatical at L’Arche during Lent of ’88. Later, she said that our first conversation reassured her. Both she and her late brother were being heard.

As the story unfolds, we notice that it is the Church as the people of God who are the first subjects of our response. In answering our question about the 30 years, it is important to get the subject right, the subject of the verb “to respond.”

I met the whole family just after Easter, on the evening before the funeral. Catherine wasn't sure they would come to the funeral; her father and one of the sisters had never gone to see Serge while he was ill and dying.

A quarter-century later, remembering that evening and the Mass and the cremation the following day, Catherine refers over and over to an attitude. She says that I acted as a friend who listens; as a humble, calm and upright presence, as a little light in the midst of their sad and complicated family. This motley group of troubled family and friends found a gentle but firm guide. They even allowed me to lead them in prayer. Catherine recalls: “You did all this in an accommodating and respectful way... As for me, I saw that my brother had received the honour due to him for what he was deep down, a child of God. And this is what was most important.”

I recount this incident because preparing to talk about the Church and AIDS over 30 years has brought me back to my own path, which you see began, in 1988, amidst death and resurrection in France.
Catherine says I helped her and some of the others then. Now, I realize that I was helped to begin my own formation long before doing AIDS ministry in Africa. I learned that, for the Church, AIDS is so much more about the living than about death, more about healing than about sin – though we're not afraid to call sin and death by their names. So the attitude is all-important: to listen, encourage, console, befriend, support, soothe, touch and pray, pray, pray.

What Serge, Catherine, the family and friends gave me was a starting point – this attitude, because Jesus is the friend of every child of God especially in time of need. And so our prayers should always recall the Jesus “gentle and humble of heart” who is close to those who suffer, as we read in Matthew 11:29, as well as the Easter Jesus who “descended into hell and, the third day, rose again from the dead” as we profess in the Apostles' Creed.

The same year in which Serge brought AIDS into my life and priesthood, Victor brought it into the Society of Jesus. He was HIV-positive and entered the English Canadian Province in 1988 – that was before testing became widely available. Two years later he took vows and continued his Jesuit formation. But then AIDS set in, for that was before anti-retroviral medication had been developed. Subject to the usual opportunistic infections, he knew his days were numbered; yet he forged ahead upright in life. Before his decline and during it, he saw life as pure gift, he loved people and learning and humour. He found God in all things and brought calm and perspective into his community. Victor died in 1994, at age 35, with his Jesuit brothers around him, having taught us that AIDS is a fact of life, no matter what your state of life.

My third teacher is Rosanna.

Rosanna, a single mother in her late twenties, lay abandoned because she was HIV-positive. Totally alone in a Nairobi slum and near death, till fellow-parishioners knocked on her door and rescued her. Now 8 years later, she thanks God for them. By way of sad contrast, “My family has not accepted me, not my mother or sisters or ex-husband. I've lost jobs because I'm HIV-positive.” Rosanna's infant daughter died of AIDS. But her 12-year-old son Jomo, who was conceived before Rosanna got infected, is HIV-free. He is a bright, healthy boy who loves drawing and playing soccer. For him she tries to keep healthy: “I want to see my son grow up.”

This attractive woman need not lack for boyfriends. But once, after...
sleeping with someone without telling him her status, she felt so badly that she went after him to apologize and encouraged him to get tested. She thanks God for his negative test. After that she effectively vowed abstinence. She tells young people her story, without rancour and with gratitude, and urges them to live well and to avoid the mistakes that lead to infection.

Rosanna fortified my faith in both the truth and the teachability of the Church’s teaching about sexuality – in the beautiful expression from the rite of ordination: teach what you believe, practise what you teach. None of this ought to change, even – especially – in the time of AIDS.

I wish everyone were like Rosanna but, of course, individuals are free to say “no thanks” and many do. We should not expect Catholic morality to reach and convince everyone and shape his or her behaviour. This marks the Church’s difference from public authorities. The State has to reflect the mores of the population and make everyone behave lawfully. The Church’s moral position arises from a different starting point: not 'what people generally think nowadays' and 'what present-day secular laws say,' but faith in Jesus Christ, His Gospel and other Biblical sources, and the development of Catholic teaching over the ages. When you teach and promote Catholic morality, you can be made to feel unpopular, as Jesus was, but we pursue what we know to be right and loving and respectful of human dignity – and therefore healthy in its most profound and holistic sense.

**GOD’S PEOPLE RESPOND**

The frightening new disease was first observed in 1981. It was named AIDS in 1982, and now we are marking 30 years since the discovery of HIV in 1983.

Elected in 1978, Pope John Paul II was the tireless Pastor: “The battle against AIDS ought to be everyone's battle... I urgently ask the world's scientists and political leaders, moved by the love and respect due to every human person, to use every means available in order to put an end to this scourge.” (John Paul II 1995:§116).

Pope Benedict XVI has been the master Teacher: “The God of Jesus Christ must be known, believed in and loved, and hearts must be converted if ... AIDS is to be combated by realistically facing its deeper
causes, and if the sick are to be given the loving care they need. Social
issues and the Gospel are inseparable. When we bring people only
knowledge, ability, technical competence and tools, we bring them too
little.” (Benedict XVI 2006).

What strikes me about our new Pope Francis is that he is a Teaching
Pastor. For the Liturgy of Holy Thursday in 2001, the then-Archbishop of
Buenos Aires, Cardinal Jorge Mario Bergoglio, visited the AIDS ward of
the Hospital Muñiz and washed and kissed the feet of twelve of the
patients. At that time, antiretroviral treatment was hardly available yet
and the stigma targeting those with HIV was everywhere very strong. We
can imagine the joy of the patients, who had certainly known stigma, to
receive the Cardinal's healing and holy touch in explicit imitation of
Christ himself (Cornejo 2001).

A study of Papal gestures, messages and statements on AIDS would
yield an illuminating answer to our question. But the doing of the
Catholic AIDS response takes place mostly at the grassroots level. All the
following anecdotes are based on personal experience; references are
supplied in order to indicate where the reader might find more
information.

In the early years of AIDS, what could a Catholic parish do whose area
housed many people succumbing to the disease? In 1990, Our Lady of
Lourdes Parish in downtown Toronto began offering a monthly healing
service for the infected, their relatives and care-givers. The so-called
“AIDS Mass” drew upwards of 100 people, enhancing the parish's
reputation in a community that, at first, was very alienated. More
recently, with readily available anti-retroviral medication, the HIV-infected
population has changed. The Mass continues, attracting some with HIV and others with other ailments who also come to receive
anointing. It is called “a Mass for those living with HIV and AIDS, their
caregivers and friends.”

Existing works of the Church opened their arms wider. Parishes and
Catholic hospitals, clinics, schools and orphanages included HIV/AIDS
ministries or services into their normal activities and, thereby, brought the
infected and the affected in to belong among their typical beneficiaries.

Cardinal Pham Minh Mân, Archbishop of Ho Chi Minh City, had
become very aware that many HIV+ women and children were totally
abandoned and rejected by their family members and effectively faced
“death sentences” on the streets. He asked Fr. John Toai, a physician's
assistant, the first Vietnamese vocation to the Camillians, not only to coordinate the Archdiocesan Office of HIV Pastoral Care but also to develop a residence for mothers and children living with HIV. Toai called it the Mai Tam Centre, or House of Hope, but an Australian volunteer described it as “love in action.” Many residents have no particular religious affiliation, but they happily notice that the priest, the sisters of the Order of St. Paul of Chartres, the volunteer caretakers and lay staff express no judgment about the past drug-taking or sexual behaviour that got them infected. Two battles successfully waged by Fr. John have been to help the mothers obtain gainful employment – he helped them form a sewing cooperative and a flower shop – and to convince reluctant local authorities to allow “his” children to go to school (Kelley 2010 and Toai 2012).

So besides expanding traditional works, the Church also reached out and started new ministries among those marginalised by AIDS, for example, those orphaned or widowed by AIDS, many households headed by children or grandparents, and those stigmatized and discriminated against.

Sr. Tarcisia, a German Holy Spirit Sister, knows the people and terrain of Papua New Guinea very well, having been a midwife there for decades. When AIDS appeared, she was coordinating the Catholic hospitals and clinics throughout the country. She quickly established a network of more than 80 HIV centres for education, prevention, counselling, testing and, more recently, anti-retroviral treatment (Hunhoff 2012).

Unlike many NGOs that go here and there to deliver AIDS services, the Church doesn't go – it is already here and there and everywhere. Locals can say: “The Church was with us before AIDS. The Church is generously with us now during AIDS and the Church will be with us after AIDS.” In that sense the Church is seen not so much as a sponsor of projects or as a service provider, but as the one whom everyone can call “Mother”: the mother who is here and has always been here and will be here as long as she is needed.

Knowing that many infections were spread through rape and violent sexual practices, Sr. Tarcisia wanted to increase male involvement in the response to HIV. So she set up special clinics and counselling centres and involved men in the prevention of mother-to-child transmission. Where the latter programme operates, no new paediatric infections have been
detected. This has been recognized by UNICEF as a model programme to eliminate new HIV infections among children.

Not only with boundless energy but also with bold creativity, Catholic HIV/AIDS ministries found new ways of confronting the pandemic. The essence, the core, the rule running through all the efforts, traditional and new, is the supreme dignity of every person in all three phases, as is said in much of Africa: be they already gone ahead and become ancestors, or living now, or still waiting to be born. And the essence of the response is like the Good Samaritan's: to reach out quietly to anyone – no matter the nature of the suffering – with compassion, with open-hearted care, and with an invitation to our table.

César, a transvestite who goes by the name “Lola”, works among the poorest in northern Mexico to alleviate the impact of AIDS. At a conference, he publicly thanked Bishop Gustavo Rodríguez, who heads the Social Ministries of the Mexican Episcopal Conference, for his interest and support. Highlighting the Bishop's humility, César said he felt accepted without judgment and, when invited to the Eucharist, truly accompanied by his Church (Czerny 2008).

Everyone is deserving, and everyone can serve. To use their own expression, many who serve declare themselves to be “risen from the dead” as we earlier saw Rosanna to be.

A Thai man named Nop has arms scarred with repeated injections of drugs. He contracted AIDS before anti-retrovirals became accessible. His toothless mouth gives evidence of the poverty and the poor state of health and nutrition, which certainly contributed to his development of AIDS-related illnesses. Nop says that that he was ready to die when Fr. Giovanni Contarin accepted him into his Camillian Social Centre for people living with AIDS. He credits the Centre for his “rebirth” to life. As he slowly-slowly regained physical strength, Nop began to work at the Centre in Rayong. His smile, his simple prayers, and his selfless acts of kindness eloquently proclaim his newly discovered conviction that God loves him without reserve. Now he wants to share this love with others who are like he used to be. As Nop goes to the hospital, Jesus Himself seems to walk in his footsteps in order to visit the sick (Contarin 2010).

The truth of the Church's response, manifest in people like Nop and Rosanna, Sr. Tarcisia and Fr. Toai, is summed up in the word spirituality which is faith become inner force to do for others as Christ has done for me. Spirituality pervades the Church's AIDS efforts and is what care-
givers of every kind most consistently say they require in order to keep going.

The world-wide response to AIDS shows the Church to be embracing, like the great statue of Christ overlooking Rio de Janeiro, with arms outstretched wide in welcome. Yes, there was a need to overcome initial fear and denial, or to rein in judgmental tendencies. At first those with AIDS might seem – and think of themselves as – outside the Church, yet bit-by-bit, Christians begin responding and, thereby, the boundaries get pushed back and what was “outside and foreign” now becomes us and ours. Theologically, spiritually, personally, we learned that the Body of Christ has AIDS and, evidently, we are the Body of Christ.

A Best Practice Report, published in 2008, tells how the Catholic Bishops of India exercised leadership. It catalogues the heroic and dedicated HIV-related service and teaching provided by Church-based organisations throughout the country. It also recounts the complex relationships that motivated, nourished, and sustained this constantly-evolving response, including those with government, other faith communities, non-governmental organisations, and, most especially, persons living with HIV and affected by AIDS (Vitillo 2008).

So the Church cooperates and networks, but it need not compromise. The Church does not have the same status as a Department of Public Health whose mandate is constitutional. The Church can serve where the State is absent. In some localities, forgotten by the State, the Church is effectively the agent of public health, public education and public welfare. In acute human situations, such as the agonizingly difficult one of discordant and doubly infected couples, the Church is there to accompany them. Pastoral solutions are needed and available; but these should remain confidential, and they are not to be generalized.

TO OUR QUESTION, ONE ANSWER

I return to the question: Since the discovery of HIV 30 years ago, how – from a global perspective – has the Catholic Church responded? Many good answers have already been suggested, in the description of experiences and the collection of reports; when sifted through, these can be generalized and trends perceived and conclusions tentatively drawn out. This would make for a good if modest beginning. For a more
complete answer, many solid reports, analyses and histories will have to be written.

On the way to the airport on Friday, I told the driver that I was going to South Africa to talk about the Church's worldwide response to AIDS. “Strange,” he said. “What's strange?” I asked a bit defensively. “To talk about that,” he declared earnestly, “the right person is Monsignor Vitillo!” In fact the driver was right, even more than he realized, and I had already prepared to recount the Vitillo story. This is how it begins:

Fr. Robert Vitillo (Paterson, New Jersey) was diocesan Secretary for Social Ministry and oversaw the work of five agencies with 500 staff. He had been reading about AIDS and, in 1985, he first encountered its reality. A staff member's brother was in the final stages of AIDS, and the family came for counselling. With his training in social work, this alerted Vitillo to what people would seek and expect from all Catholic ministries, and he arranged for HIV/AIDS training for all 500 staff.

Right from the start, Fr. Vitillo has been equipping others in the Church, many others, countless others, to respond to AIDS as Christ would want them to. But as I now continue my account, we will be drawing a truer and more radical conclusion than my driver's observation about the now Msgr. Vitillo's evidently outstanding competence to answer our question. He has done more than anyone to make sure that the Church responds to HIV/AIDS evangelically and effectively. Let me propose to you that the life ministry of Robert Vitillo also and very significantly is the answer, incarnates the answer, has facilitated and promoted the answers everywhere around the globe. As he is my dear brother in the priesthood and colleague in this ministry, I am glad to have this opportunity to testify to what God has done and is doing through him in the Church.

The story continues:

In 1986, Vitillo came to the Vatican to serve in the headquarters of Caritas Internationalis. Reports from Eastern Africa about the devastating impact of AIDS motivated Caritas to make it a priority and, in 1987, he was assigned to coordinate and promote the international response. In 1989 he spent an important time with the Sisters and patients of a rural AIDS programme in Masaka, Uganda. The impact on Vitillo was overwhelming. He became tireless in training Church leadership,
staff, clergy and those responsible for their formation, to be HIV/AIDS competent, catechetical and compassionate, non-judgmental and unafraid, truth-full and solidarity-full. He has inspired thousands – and with the multiplier effect, surely hundreds of thousands – with the motivation to be Christ for those afflicted in any way by the pandemic. With Sister Maura, he developed the famous Caritas Training Manual and ten years later, with some help from me, its companion Pastoral Training Manual (Vitillo 1996 and 2007).

Now a younger understudy of his comes into the story to illustrate the all-important organizational and indeed political dimensions of the Church’s response to HIV/AIDS. Fr. Hernán Quezada S.J., M.D., developed an AIDS hospice in Guadalajara, directed university research into AIDS and Migration, and helped to design an advertising campaign against AIDS stigma and discrimination. In advance of the International Conference on AIDS (IAC) in Mexico City in mid-2008, one could anticipate negative publicity that is typically targeted at the Catholic Church on such occasions. So Fathers Quezada and Vitillo put on a prior workshop for the whole Mexican Bishops’ Conference. Out of it came a Pastoral Statement on AIDS in which the Bishops declared the Church to be close to everyone with HIV or AIDS and urged Catholic institutions to welcome them. Released just before the 2008 IAC, the Pastoral Statement received positive media, deflected blanket criticisms, and stimulated additional Catholic engagement in response to HIV and AIDS (Comisión 2008).

Fr. Vitillo’s work with Fr. Quezada represents so many important efforts to help Church leadership to take a stand in public, to engage the media and government, pharmaceutical and other business interests at every level. Moreover, beginning in 2002, Vitillo worked hard to organize Catholic meetings and ecumenical pre-conferences ahead of each biannual IAC.

Msgr. Vitillo also encouraged networking amongst Catholic development, humanitarian, and pastoral agencies from Europe, North America, Australia, and New Zealand involved in offering HIV/AIDS services and supporting such programmes in poorer countries, in order to share their experiences and promote greater collaboration. Beginning in 1992, the AIDS Funding Network Group (AFNG) regularly reviewed trends in the pandemic to be aware of emerging needs for support by Catholic agencies in low- and middle-income countries; since 2006, it
has been meeting as the broader Catholic HIV/AIDS Network (CHAN).

Moreover, Msgr. Vitillo served as a tireless advocate, at the United Nations and in other international forums, for the recognition due to religious organizations and how they respond to AIDS, instead of allowing them to be discredited and sidelined. He opposes those who, at the policy level, refuse to accept the Church's focus on the dignity of the human person and its emphasis on responsible sexual behaviour as an acceptable strategy to combat the spread of HIV. For example, he helped to design, and continues to promote, the Caritas “HAART for Children” Campaign for early diagnosis and treatment for children with HIV.

Continuing to speak about the Church and AIDS in the public sphere and on the international stage, Msgr. Vitillo has been and is involved in an astonishing yet little-known achievement.

UNAIDS (the Joint United Nations Programme on HIV/AIDS, 1996) and Caritas Internationalis (1950) cross paths all over the world. Caritas organizations either sponsor or support HIV programming in some 116 countries. Since 1999, Caritas Internationalis and UNAIDS have been linked through an official Memorandum of Understanding (MoU).

Reviewed by the Holy See's Secretariat of State before signing, the MoU clearly states that Caritas will cooperate with UNAIDS in those areas and strategies where the two organizations share common values and strategies and that, in all questions, Caritas follows the teaching of the Catholic Church.

One of the HIV prevention strategies adopted by UNAIDS has been the vigorous promotion of condoms. Caritas has never agreed with nor cooperated in this prevention strategy. However, by actively participating in official meetings and Task Groups, Caritas has succeeded in encouraging UNAIDS to acknowledge other prevention strategies – such as fidelity in marriage, sexual abstinence outside marriage, and long-term and responsible behaviour change – in order to avoid all risks of sexual transmission of HIV (Cibambo 2012).

The MoU has helped the world AIDS effort to benefit from the deep knowledge gained by the Church's efforts. It has facilitated strategic dialogue between Catholic organizations and UN officials. Moreover, the MoU has made it possible for Caritas Internationalis to be included in many of the planning efforts by UNAIDS. For example, in 2006 Vitillo was appointed to the Universal Access Committee; and in 2011, to the Global Steering Group for implementing the *Global Plan Towards the Elimination of New HIV Infections among Children by 2015* and
Keeping their Mothers Alive.

The fact that UNAIDS signed and renewed the MoU means that this UN body reconciled two dimensions in their own minds. On the one hand, they recognize and respect the fact that Caritas follows the teachings of the Catholic Church in all matters, with some of which UNAIDS disagrees. On the other hand, they see the tremendous advantage of collaborating closely with our faith organization.

So in reply to our question, we have seen from the beginning the many, many members of God's people responding and learning to respond under the guidance of the Holy Spirit. And we also gratefully recognize the one-word incarnate answer of “Vitillo” with nearly 30 years of more than full-time involvement: helping everywhere to form and inform, to encourage and advocate, to network, organize and communicate. For both kinds of Grace at work amongst us, we say “Thanks be to God!”

CONCLUSION

To answer the question posed, Over the past 30 years since the discovery of HIV, how has the Catholic Church responded worldwide?, we began with thanksgiving for all the compassion and service offered, for all the lives transformed, and for all the life shared as the people of God responded to the Body of Christ with AIDS.

We appreciate the Church's typical ministries reaching out and expanding, and the launching and development of new ministries with energy and creativity. For this we credit Bishops and Superiors of Religious Congregations; we appreciate the initiative and guidance of Priests, Brothers and Sisters; we give special recognition to the countless Christians offering their services. We speak especially of those among the infected and affected who have been ministered to and who in their turn minister to others – those risen from the dead who share their new life with others.

A necessary accompaniment to pastoral or “hands-on” ministries are the essential enabling dimensions of organization, networking, cooperation and funding; research and reflection; theology and spirituality; communication and awareness-raising; formation and education.

All this has not gone unnoticed. In 2009 the Executive Director of
UNAIDS, Mr. Michel Sidibé, testified glowingly: “The Church's uncompromising position on the need for social justice – to do what is right – and on the inherent dignity of individuals, inspires us to champion for universal access to comprehensive HIV prevention, treatment, care and support as a moral imperative,” and he affirmed: “My friends, we in the AIDS movement look to the Church for leadership” (Sidibé 2009:3).

So, over the past 30 years since the discovery of HIV, how has the Catholic Church responded worldwide? The worldwide Catholic Family of God has shown herself to be Church Mother and Church Teacher and Church Learner.

Finally, the challenge for the coming decades: it will prove both essential and providential that the Catholic Church maintain, develop and strengthen her commitment, to persevere in all forms of this great ministry until AIDS is no more.
REFERENCES


CATHOLIC RESPONSES TO HIV/AIDS IN AFRICA: THE LONG WALK TO CONVERSION

Agbonkhianmeghe E. Orobator SJ

HIV/AIDS took the Christian community by surprise. Nothing prepared the Church for the devastation and intense suffering triggered by the pandemic. Like the rest of society, poor knowledge and exaggerated fear of the yet-unknown disease hindered Catholic responses and generated conflicting reactions and contradictory messages. Yet, as the Body of Christ, the Church in Africa could not be indifferent to the unfolding drama of HIV/AIDS. Nor could it circumvent the inconvenient truth that – as some courageous voices proclaimed – “the Body of Christ has AIDS.” The trajectory of Catholic responses stretches from denial and resistance to conversion and engagement via moments of stigmatization and marginalization, compassion and care for people living with AIDS. In Africa, the narrative of Catholic responses in the last 30 years would be incomplete without just acknowledgement of the pioneering initiatives and pastoral creativity of religious communities and individuals, especially women, who positioned themselves at the forefront of the fight against HIV/AIDS. They presented a credible, compassionate and redemptive face of the community called Church in Africa and beyond. Thirty years after the discovery of HIV, Catholic responses rest on a theological triptych composed of, first, a tradition of Catholic pastoral engagement in the context of HIV/AIDS; second, a systematically developed body of theological resources on HIV/AIDS; and, third, a contentious ethical education regarding neuralgic issues spawned by HIV/AIDS.

INTRODUCTION

In March 2009, en route to the West African country of Cameroon and in response to a journalist’s suggestion that “The position of the Catholic Church on the way to fight against it (HIV/AIDS) is often considered unrealistic and ineffective,” Pope Benedict XVI made the following remarks: “I think that the most efficient reality, the most present at the front of the struggle against AIDS, is precisely the Catholic Church, with her movements, with her various organizations.” He concluded by lauding the Church for its “very great and important contribution.” Expectedly, it was

1. http://www.zenit.org/article-25485?l=english. Three years earlier, on 5 August 2006, questioned by a journalist regarding the Church’s response to the urgent matter of AIDS, Benedict articulated the church’s response in the following terms: “We offer treatment, including treatment to AIDS victims, and we offer education, helping to establish good relationships with others. So I think we should correct the image that sees the Church as simply articulating a severe ‘No.’ We work a great deal in Africa to integrate the various dimensions of formation, so that it may become possible to overcome violence and epidemics, including malaria and tuberculosis.” Quoted in Bénézet Bujo and Michael Czerny, AIDS in Africa: Theological Reflections (Nairobi, Kenya: St Paul Communications/Daughters of St Paul, 2007), 16.
Benedict’s hint that the distribution of condoms could aggravate the problem of AIDS that set off a global media maelstrom of opposing views. The reduction of the pope’s statement to the condom debate is symptomatic of the perception of Catholic responses to HIV/AIDS in Africa and elsewhere. In the intense heat of sensationalized controversy over the (im)morality and (in)effectiveness of condom use, narratives of the Church’s “very great and important contribution” begin to wither and they evaporate. I agree with the pope’s position that the Catholic Church has played and continues to play a leading role in the prevention of HIV infection and care of people living with AIDS, albeit its responses are largely underreported or misreported. Yet, not infrequently, independent voices, such as the executive director of UNAIDS, Michel Sidibé, confirm the critical importance of the Church's responses to the AIDS pandemic:

My friends, we in the AIDS movement look to the Church for leadership. The Church’s uncompromising position on the need for social justice—to do what is right—and on the inherent dignity of individuals, inspires us to champion for universal access to comprehensive HIV prevention, treatment, care and support as a moral imperative (Vitillo 2012: 375).

However, it would be inaccurate to portray Catholic responses in Africa and elsewhere as homogenous. The responses have evolved over time and across varied contexts; and, they have not always been the most appropriate. Nor has the Church always been present at the forefront of the struggle against AIDS. As a Christian community, the Church's journey along the tortuous path of the AIDS pandemic has traversed uneven terrains and produced mixed results on several issues, such as prevention, care, education and ethics. In this essay, I have chosen to characterize my understanding of Catholic responses in the African context thirty years since the discovery of HIV as “the long road to conversion” – conversion to intense pastoral engagement, exhortation to moral rectitude and the development of theological resources on the challenges of HIV/AIDS for the community called Church.
THE ELEMENT OF SURPRISE

The advent of HIV/AIDS on the epidemiological landscape of Africa was as stealthy as its outcome was devastating. If complacency, reticence and silence marked the initial reactions, panic, confusion and denial characterized the subsequent responses to the menace of this global pandemic. The case of Masaka Diocese in southwestern Uganda is illustrative of the initial Catholic responses to the AIDS pandemic in Africa.

By all accounts, Masaka was in the eye of the HIV storm in the early 80s. Although the local ecclesial leadership had a premonition that something macabre and sinister was imminent – as the tell-tale signs of “slim”

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2. This was the first slang coined to describe the disease on account of the emaciated physical condition of people living with HIV/AIDS.

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longer a barrier between Masaka/Rakai and Kampala. People did not believe until they started burying people from Kampala. Later the bishops wrote a booklet which was circulated in 1982 or 1983. If the people had listened to us, there would have been very few cases... They were only interested in the use of condoms.\(^3\)

Simply put, HIV/AIDS took the Christian community by surprise. Nothing prepared the Church for the devastation and suffering triggered by the pandemic. Like in the rest of society, poor knowledge and exaggerated fear of the yet-unknown disease hindered Catholic responses and generated conflicting reactions and contradictory messages. Consequently, an initial response typical of the Christian community was a skewed theological hermeneutics of the AIDS pandemic.

When the epidemic first exploded, its message was clear for many people: they believed that God had finally visited a plague of biblical proportions upon God’s wayward people. Orthodox and fundamentalist ethics lined up the usual suspects, namely commercial sex workers, sexually promiscuous people, intravenous drug users and homosexuals, in the firing line of divine retribution (Orobator 2010:74-75).

I believe that a legacy of this prejudicial response to HIV/AIDS shows in the fact that “the debate about the transmission and prevention of HIV, and about the care of people living with AIDS, is strewn with dogmatic declarations of the righteousness of God and the moral liability of people living with AIDS” (Orobator 2010:75). One typical example of this reaction is Emeritus Archbishop of Kumasi (Ghana) Peter Sarpong’s categorical assertion that “the HIV/AIDS virus is the result of adultery or fornication” (Sarpong 2005:47). Happily the response of the Catholic Church in Africa has evolved beyond such blatant prejudice, harmful stigmatization and gratuitous imputation of blame to people living with HIV/AIDS.

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PASTORAL ENGAGEMENT

In discussing and assessing Catholic responses to HIV/AIDS in Africa, we need to expand the boundaries of our theological categories. In particular, we need to adopt a wider and more inclusive definition of “church.”

Often when the word 'Church' is mentioned in this context (of Catholic responses to HIV/AIDS) it is associated with official documents and pronouncements on morality which claim to exercise power and authority on behalf of God. But my decade of research into HIV and AIDS in East Africa has led me to discover and encounter a new kind of Church that does not embody inflexible notions of hierarchy and orthodoxy.

In East Africa, the face of the Church is not that of people who make condemnatory declamations. The face of the Church is primarily that of lay people and women religious (though also of priests), for whom people living with AIDS are more important than status, power and authority (Orobator 2010: 76).

In the African context, the responses of the Catholic Church since the discovery of HIV cover a wide spectrum of pastoral engagements and initiatives. In a different study, I have grouped them into four “overlapping categories of ’ecclesial activities’: 1. Individual initiatives, 2. Corporate/NGO actions, 3. Community-based programmes, and 4. Hierarchical/ecclesiastical approaches.” In this section, I present and discuss the first three categories of response. Across the continent, examples abound of particular instances when the Church adopted some or all of these approaches in response to the AIDS pandemic.

The evidence demonstrates that the responses broadly characterized as pastoral engagements were largely conceived, implemented and managed by lay Christians and religious congregations, particularly of women. Only rarely has published research appeared detailing the scale and scope of Catholic responses pioneered by these categories of people.

4. I have undertaken a comprehensive study of some of these initiatives in Eastern Africa. See From Crisis to Kairos, 90-121.
within the Church in Africa. Besides, true to the gospel virtue of humility and anonymity of charitable deeds, the Catholic Church in Africa would seem to have been loath or too busy to blow its own trumpet. There are exceptions. In a study on the commitment of religious communities to HIV/AIDS, some 446 respondents detailed the HIV/AIDS services being sponsored by their respective institutes:

- Information/education activities reached a total of 3,925,304 individuals, with a mean number of nearly 15,000 beneficiaries for each responding organisation.
- Care and support services reached 348,169 individuals. These services included nutrition, palliative care, home-, hospital-, and clinic-based care, and alternative medicine–based care.
- Antiretroviral treatment services were reported to have been delivered to 90,154 individuals during the twelve months prior to the survey (Vitillo 2012: 369; see also In Loving Service...2008).

Other concrete but limited samples would include the following. In 1987, a group of lay Catholic women and men founded Kamwokya Christian Caring Community and set up one of the first HIV/AIDS treatment facilities on the edge of Uganda's bustling capital city, Kampala. That same year, the women’s religious community of Medical Missionaries of Mary founded Kitovu Mobile Home-based Care programme in Masaka and Rakai, Uganda, both the epicenter of HIV/AIDS in East Africa. Later they would initiate a successful

5. A notable exception is Inventory of the Catholic Church's Response to HIV/AIDS in Kenya, which “documents the struggle of the Church to respond to the HIV/AIDS pandemic” in response to “the need for a comprehensive picture of the efforts undertaken by the Church in Kenya to combat the HIV/AIDS pandemic since the beginning….” See Msgr Michael Charo Ruwa, “Presentation of the Kenyan Catholic Church's Response,” in AIDS and the Church in Africa, ed. Michael Czerny (Nairobi, Kenya: St Paul Communications/Daughters of St Paul, 2005), 75-78. An updated inventory contains a country-wide directory of programmes initiated and/or coordinated by the Catholic Church in Kenya. The national and diocesan-based programmes and initiatives include 463 health facilities, 57 Prevention of Mother to Child Transmission programmes, 41 Anti-Retroviral Treatment centres, 573 prevention programmes, 15,916 community-based healthcare workers…. “The scope of the services includes the medical, the material and the psycho-spiritual needs of PLWHA (People Living with HIV or AIDS) and infected groups, together with prevention and advocacy”; Kenya Episcopal Conference, This we Teach and Do: Catholic Church and AIDS in Kenya Volume Two – Inventory (Nairobi, Kenya: Paulines Publications Africa, 2006), 22.
prevention programme called ‘Education for Life’. At the same time, the Franciscan Sisters initiated a similar programme at St. Francis Hospital Nsambya for people living with HIV/AIDS in the urban sprawl of Kampala. In 1992, a Catholic lay woman, Noelina Namukisa, founded a community-based organization called Meeting Point, with the aim of providing education, home-based care, counselling and support for HIV/AIDS orphans and single mothers. The founder of Meeting Point acted more out of her Christian conviction than as a representative of the official Church.

In several places on the continent, we can identify similar responses that would qualify as “catholic”, albeit not all would seek or bear the imprimatur of the hierarchy. Yet to all intent and purposes, these constituted the first credible, constructive and effective responses of the Church in Africa to the situation of HIV/AIDS. It is worth repeating that lay and religious women initiated and led these programmes. Sadly, the history of Catholic responses to HIV/AIDS in Africa has not justly and adequately recognized the pioneering role of women. Statistics show that women have borne the brunt of the AIDS pandemic, “Whether in the Church or in the sphere of public morality and policy, women's voices do not offer merely testimonies of victimhood but speak of a new ethics of compassion and solidarity in a time of crisis” (Orobator 2010: 77). Oftentimes, the media focus on contentious issues regarding the ethics and techniques of HIV prevention obscures the stories and achievements of these women. And where and when they are told, they are presented as heroic and exceptional efforts of individuals, which they justly are. Yet, considered from the perspective a broader definition of Church as the people of God, several African women have stood as the first ecclesial witnesses to the care and love of people living with HIV/AIDS at a time when religion was used by some people in the churches to warrant marginalization, stigmatization and discrimination against them. Thus firm evidence indicates that it is to the outstanding ministries of these women that we must look when we ask to know and appreciate Catholic responses to HIV/AIDS in Africa.
CALL AND RESPONSE: PASTORAL EXHORTATION TO MORAL RECTITUDE

I have hinted above that the response of the Catholic hierarchy in Africa was tardy and predictable. The array of responses of ecclesial leadership runs the gamut from queer to compassionate; timid to heroic. Perhaps one example that best illustrates the former was the now infamous August 1996 episode when the late archbishop of Nairobi (Kenya), Cardinal Maurice Otunga, joined cause with his Muslim counterpart, Sheikh Ali Shee, and publicly set off a huge bonfire stoked with boxes of latex condoms and safe sex education literature. It was a rare instance of inter-religious pact hitherto unseen in Kenya. More significantly, in a public, spectacular and dramatic manner, the event foregrounded an aspect of Catholic response rife among many ecclesial leaders, namely the uncompromising stance against condoms and what they deem objectionable sex education curricula as a means of HIV prevention, and for which the Church has gained notoriety.

Oftentimes, as mentioned above, what is designated as “the church's official response to the AIDS crisis has come in the form of pastoral letters” (Orobator 2005: 111), In Africa, the first pastoral letters from bishops and conferences of bishops made their appearance in the late 1980s, a few years after the outbreak of HIV/AIDS and the widespread sorrow and misery it sowed among urban and rural communities had become apparent. Understandably, it took the Church time to comprehend the theological implications and ethical challenges of the pandemic. The initial responses from the hierarchy showed evidence of misconception and misunderstanding of the true nature and effects of HIV/AIDS. It was not unusual for some church leaders to associate HIV/AIDS with sexual immorality and, therefore, explain its occurrence and prevalence via a warped theology of divine retribution and punishment. In a certain sense, it could be argued that such theological reading of HIV/AIDS also constituted a kind of response, albeit not exclusive to the Catholic Church.

The body of pastoral letters, statements and communiqués authored by individual Catholic bishops, conferences of bishops and regional and continental forums of ecclesial leaders contains varied and divergent responses to the AIDS pandemic in Africa. A collection published by
African Jesuit AIDS Network (AJAN) under the apt title of *Catholic Bishops of Africa and Madagascar Speak Out on HIV & AIDS* “includes eighty pastoral letters, messages, communiqués and statements that African Conferences and some individual Bishops have published about HIV/AIDS from the late 1980s until 2005” (Catholic Bishops of Africa and Madagascar 2006:9).

One statement stands out as an excellent example of the espistolary response of the Catholic Church in Africa, namely the Symposium of Episcopal Conferences of Africa and Madagascar (SECAM) document: “The Church in Africa in the Face of the HIV/AIDS Pandemic: Our Prayer is Always Full of Hope” (7 October 2003). In this statement, the cardinals, archbishops and bishops of Africa and Madagascar expressed solidarity “towards all who suffer”; they committed themselves “to making available our Church's resources be they our educational and healthcare institutions or social services” in the struggle against HIV/AIDS; they declared their readiness and openness to work in close partnerships with Christian and faith-based organizations and “others who are happy to put their resources to work in the struggle, and do so knowing well that we work according to our Gospel convictions”, specifically by initiating programmes that “educate appropriately and promote those changes in attitude and behaviour which value abstinence and self-control before marriage and fidelity within marriage”; finally, the ecclesial leaders affirmed the Church's responsibility to tackle socio-economic and political factors that aggravate and escalate the impact of the pandemic (Catholic Bishops of Africa and Madagascar 2006:108-178.

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6. Mgr Robert Vitillo, “A Witness to Truth and Solidarity,” reports that “Between 1987 and 2003, various episcopal conferences in Africa prepared some sixty letters, messages, communiqués, and statements about HIV and AIDS,” 366. To this we should add the Post-Synodal Apostolic Exhortation of Pope John Paul II, *Ecclesia in Africa* (1995). Although it focuses on wider concerns relating to the Church's mission of evangelization in Africa, several sections of the text deal with the Church's responses and responsibility in the situation of HIV/AIDS in Africa. See, for example, no. 114 and no. 116. Similarly, under the rubric of “The Protection of Life,” the Post-Synodal Apostolic Exhortation of Pope Benedict XVI, *Africæ Munus*, addresses “The problem of AIDS” and underlines the importance of “a global response from the Church ... based on a sex education that is itself grounded in an anthropology anchored in the natural law and enlightened by the word of God and the Church's teaching.” Furthermore, Benedict affirms and encourages church initiatives developed in response to the AIDS crisis and enjoins research institutions and pharmaceutical companies to redouble efforts towards discovering a cure and providing treatment. Lastly, he emphasizes the church's preference for person-centred education aimed at eliminating ignorance. *Africæ Munus*, nos. 72-73.
More importantly, SECAM appended a Plan of Action to its statement addressed “to the members of the clergy, brothers and sisters in religious life, to the faithful and all people of good will...” (Catholic Bishops of Africa and Madagascar 2006: 111-113). The Plan includes a whole slew of policies and initiatives, such as providing resources to address the situation of HIV/AIDS, advocating the protection and rights of women and girls; working with a cross section of partners, including practitioners of traditional medicine; advocating for increased access to care and treatment, as well as sacraments and sacramentals of the church for people living with HIV/AIDS; combating stigma; integrating HIV/AIDS into theological education and programmes of religious formation; developing theological resources to respond to the challenges of HIV/AIDS; etc. Perhaps more fundamentally, the Catholic leadership of Africa adopted as an action plan the duty to “Welcome people living with HIV and AIDS in a warm, non-judgemental and compassionate manner in our churches and ensure them a 'place at the table of the Lord'” (Catholic Bishops of Africa and Madagascar 2006:108-113).

To sum up the discussion of Catholic responses to HIV/AIDS in the form of pastoral letters and statements, it is essential to reiterate the salient point that

The Church's response to HIV goes far beyond the written and spoken word of hierarchical leaders; it is rooted in the daily ministry and services provided by countless members of the clergy, religious orders, professional staff, and faithful lay volunteers. This wide array of services includes education, health care, social care, emergency response, income-generating activities, and integral human development (Vitillo 2012: 368).

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7. One category of responses that should not be overlooked is in the area of media. There are countless audio and video mass media materials produced in response to the AIDS crisis. One in particular, “If you want to…” (produced by African Jesuit AIDS Network [AJAN], Nairobi, Kenya), “highlights what the Church is doing in response to the HIV/AIDS pandemic in Africa. Although the examples are mainly drawn from Eastern Africa, they reflect the Church's response to the scourge throughout the continent”; Michael Czerny, “‘If you want to…’ The Catholic Response to HIV/AIDS in Africa,” in AIDS and the Church in Africa, ed. Michael Czerny (Nairobi, Kenya: St Paul Communications/Daughters of St Paul, 2005), 74.
AIDS IN THE BODY OF CHRIST: THEOLOGICAL RESOURCES AND RESPONSES

The assortment of documentation generated by the Catholic Church in Africa deals with several aspects of the challenges and reality of HIV/AIDS, particularly the neuralgic issue of methods of prevention that advocate the use of condoms. Of the “eighty pastoral letters, messages, communiqués and statements” referred to above that have emanated from African bishops and conferences of bishops, there is hardly one that skirts this issue. Yet, while it is legitimate to discern in these responses “evidence of a solid and developing doctrine rooted in the Gospel of Jesus Christ and in Church tradition,” (Catholic Bishops of Africa and Madagascar 2006: 9), it would be far-fetched to speak of a clearly elaborated and formally proclaimed doctrine. Catholic responses on matters of the ethics of prevention and care have typically refrained from such proclamation, drawing instead on a body of Catholic social teaching and principles to argue and establish the priority and pre-eminence of the human person in designing and implementing prevention programmes. Notwithstanding rare but striking instances of dissension and disagreement, even at the highest levels of ecclesial leadership, the Catholic Church in Africa has been consistent in its opposition to the use of condoms. For many, this opposition sums up the entire anthology, even theological ethics, of Catholic responses to the situation of HIV/AIDS. I would argue that such sweeping generalization amounts to a regrettable trivialization of an otherwise robust inventory of pioneering, innovative and effective Catholic responses to HIV/AIDS in the context of the Church in Africa.

Besides the categories of pastoral engagements and exhortatory responses, one area that has been explored and appreciated to a rather less extent as a significant response of the Catholic Church in Africa is what I call “theological responses” that are not classified under the contentious category of the ethics of prevention and sexual morality. Beninois theologian Wilfrid Okambawa has made the claim that “If Africa has the highest HIV prevalence, it also has the greatest number of publications on what could be called the subject of HIV/AIDS theology.” He argues that

In the past twenty years a tremendous response to the issue of HIV/AIDS emerged in African theology to the
extent that today we may speak of the establishment of an HIV/AIDS theology. More than any other theological trend, this trend has had ramifications in most theological disciplines such as moral theology, pastoral theology, ecclesiology, biblical theology, and spirituality (Okambawa 2012: 335).

Ample evidence exists to validate this claim. We have multiple examples of literature that constitutes what Okambawa calls “HIV/AIDS theology.”

Here, as I have argued above, the matter under discussion, namely Catholic responses to HIV/AIDS, would need to be nuanced. Besides the official statements produced by ecclesial leaders, Catholic theologians in Africa have been active in elaborating systematic, innovative and research-based theological responses to the crisis of HIV/AIDS. While, typically, the body of theological materials have come from workshops, seminars, conferences and colloquiums, several individual theologians have undertaken critical studies of the challenge of HIV/AIDS for the community called church in Africa. Some of these studies have adopted the methodologies of the social sciences to observe, document and analyze the impact and implications of HIV/AIDS for the Church in Africa. The issues covered on the theological spectrum in response to HIV/AIDS include education, human rights, women's rights, theological anthropology, inculturation, scripture, etc. However, notwithstanding the

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8. Donald E. Messer argues the case of “a new AIDS theology”: “In response to this global emergency, Christians should instead move toward a new AIDS theology that emphasizes inclusion, not exclusion—compassion, not condemnation. More Christians leaders must make the effort to link biblical teachings with the imperative of caring for people with HIV/AIDS and to embrace a theological perspective that harmonizes with the radical love and action epitomized in Jesus, the Christ.” Breaking the Conspiracy of Silence: Christian Churches and the Global AIDS Crisis (Minneapolis, MN: Fortress Press, 2004), 19.


prolific theological engagement of African theologians in HIV/AIDS, it should be said that the Catholic Church does not hold a monopoly over theological responses to HIV/AIDS.11

CONCLUSION

In this essay, I have argued that thirty years after the discovery of HIV, Catholic responses to AIDS in the African context have followed a well-documented historical trajectory. Typically, they have evolved from silence, denial and resistance to pastoral and theological engagement and care of people living with AIDS. This historical pattern is akin to the process of conversion in the Christian sense of metanoia. Thus an appraisal of responses in the context of the Roman Catholic Church in Africa uncovers an uneven landscape of pastoral accompaniment, theological resources and ethical discourse, some part of which is unflattering. Retired Primate and Archbishop of the Anglican Church of Kenya Benjamin Nzimbi’s candid confession regarding the Church's responses to HIV/AIDS would seem apt in the context of the Catholic Church in Africa: “We want to apologize for not doing what we should have done and doing what we should not have done” (Bongmba 2007: 9; see Okwambawa 2012: 338).

At the onset of the AIDS pandemic, the church in Africa could not plead indifference to the unfolding drama of HIV/AIDS. The statistics painted a picture of imminent doom that rendered all but a few vulnerable. Nor could it circumvent the inconvenient truth that – as some courageous voices proclaimed – “the Body of Christ has AIDS.” Thirty years after the discovery of HIV, AIDS has become a permanent mark of the Church in Africa and elsewhere, calling for attentive listening to the plight of people living with HIV/AIDS, solidarity and justice (Orobator 2010: 79-80).

In Africa, the narrative of Catholic responses in the last thirty years would be incomplete without just acknowledgement of the pioneering initiatives, constructive engagement and pastoral creativity of religious communities and individuals, especially women, who positioned themselves courageously at the forefront of the fight against HIV/AIDS. As icons of ecclesial ministry in the time of AIDS, they embody and reflect the most credible, compassionate and redemptive face of the community called church in Africa and beyond.

In the words of Donald Messer, “the global AIDS emergency compels us to reclaim the essence of the church” (Messer 2004: 21). Thirty years after the discovery of HIV, the Roman Catholic Church in Africa has gradually rediscovered and embraced its essence and mission as a community of solidarity, compassion and care for the “least of these” members of the Body of Christ living with HIV/AIDS. Presently, Catholic responses in the context of the African church rest on a triptych composed of, first, a constructive pastoral engagement in the context of HIV/AIDS; second, pastoral exhortation and contentious ethical education regarding neuralgic issues spawned by HIV/AIDS; and, third a systematically developed body of theological resources on HIV/AIDS.
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INTRODUCTION

Discussion about the relationship between sin, HIV prevention and AIDS has often not sat well with academics and activists in the AIDS world. In the 1980s as the unknown pandemic spread and affected mainly homosexuals and drug addicts, some Christian leaders were quick to link the disease to immoral unchristian behaviour: sin. The remedy for HIV prevention was a Christian moral life promoting monogamous partnerships within marriage. But as the disease spread, it began to affect many other groups of people and it became clear that such a simplistic analysis was not only wrong but also deeply unjust. The impact on women including those living their marriage commitments and other victims of social injustice was particularly severe (Bate 2000:213; 216. Phiri 2004:423).

As the disease spread and became a pandemic, Christian writers increasingly focussed on the danger of stigmatising HIV positive people in the community. Stigma effectively cast them out from the community identifying them as "the other" in the common trap of prejudice: an "us
and them" mentality. The result: increasing their shame and humiliation when what they needed was support and care (Rosario 2000: 67. Waliggo 2000:48). At the same time Christian academic writing tended to avoid the category "sin" when dealing with HIV and AIDS (Flynn 2000: 148-155).

More recently it is anthropologists and even scientists who have made more use of the term. Smith (2004) has shown how rural to urban migrants in two cities in Nigeria who attend the rapidly growing urban Pentecostal churches use the moral teaching of the church and teaching about sin to construct sexual behaviour patterns:

On the one hand, relationships are legitimized as risk-free and decisions not to use condoms are rationalized, for example, 'both my partner and I are moral and Christian, therefore we are protected'. On the other hand, behaviour that flouts shared religious moralities is thought about as sin (rather than in terms of health risk) and dealt with through denial (Smith 2004:433).

An Orthodox Christian physician has examined the problematic relationship between sin and God's punishment in illness. Using examples from the medical profession and the scriptures he states the important truth that "sins have consequences, but disease is not sent as a punishment by God" (Jacob John 1995:379).

Some Christian academics are sometimes very critical of its usage. In a recent study of church leaders' HIV prevention messages to young people in KwaZulu-Natal, South Africa, one remarkable conclusion reached was: "an important barrier to Christian churches being fully engaged in HIV prevention is that premarital sex is associated with sin" (Erikson et al 2010: 104).

It is clear that theologians need to examine the theological category of "sin" as it impacts on HIV and AIDS. This is of particular importance within the context of a rapidly emerging urban African population on the continent. Understandings of sin are culturally dependent and so a study of sin and HIV and AIDS must reflect the urban African context. This is the purpose of this article.
Elsewhere I have noted that African urban culture is a patchwork of many cultural roots.

The majority of people in urban and peri-urban Africa have constructed a mix or a fusion of three principal cultural roots: The African traditional model; the Urban African model and the Western cultural model (Bate 2012:73).

The African traditional model sees humanity at the centre of the world. Humanity is being-in-community understood as relatedness between peoples: living, the living dead (ancestors) and the yet to be born. Living well (health and life) is a sign that the cosmic order of relatedness is in harmony. The Western cultural model has two major components. The first is an element of naturalism which sees the world as material and particular. It is observable, measurable, and controllable using the scientific method. The second component is enlightenment humanism manifest today as the human rights culture and secularism (Bate 2012:79).

The Urban African cultural model is becoming more important because Sub Saharan Africa is going through a process of rapid urbanisation. The Urban African model is influenced by modernity and Western culture and by traditional culture but also by the importation of Christianity during the colonial period. The most striking current manifestation of this is in the growth of Urban African Neopentecostalism. It is these aspects of urban African culture I would like highlight because of its impact upon sin, HIV and AIDS.

Academic studies of theology about issues such as HIV and AIDS require the use of systematic theoretical models in order to interpret analysed data and make theological judgements to provide solutions for

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1. This is found in urban African mega churches (Parsitau Mwaura 2010; Smith 2004). These churches also have an influence on main line churches (Bate 1999).
Christian action (Bate 2012:80).

For a theology of HIV and AIDS prevention, I propose the related theological categories of "sin", "salvation" and "life." These categories have the advantage that they are often defined in very different ways by people in urban African contexts and much of the contention about HIV prevention comes out of diverse views about these matters. To construct our theology I propose:

1. A Biblical Theology of sin, salvation and life
2. A Theological Anthropology of sin, salvation and life in urban Africa
3. An Ecclesiology based on a knowledge of and commitment to Church Teaching on HIV and AIDS prevention focusing on sin, salvation and life
4. A Pastoral Theology of HIV and AIDS from African Catholic Theologians focusing on sin, salvation and life

This article focuses on an examination of the theological category of "sin." It is the most controversial and so will benefit from a separate treatment. The categories of "salvation" and "life" will be treated in a subsequent article.

A BIBLICAL THEOLOGY OF SIN

In the Old Testament: rebellion against God and destruction of human relationships

Sin comprises a breaking of God's law, a breaking of human relationships, and a falsehood in front of God: “Almost every Hebrew word for sin is illustrated in the steps by which the man and woman rebel against the restraints of the will of Yahweh” (Fitzmyer 1990: 1402). In the Old Testament sin is part of the human condition “I was brought forth in iniquity; in sin my mother conceived me" (Ps 51; cfr. Jer. 16:12). It is contagious and universal (:1402).

In the Hebrew Scriptures, when it comes to what concerns sin, “a survey of four of the most important words shows the multiple OT approach to the idea” (McKenzie 1990:1305). Hattat, the most common, means “missing the mark” or a “failure.” “One who sins fails to meet what is required in relation to another person” (:1305). Awon, which is
often translated as “guilt” refers to a “twisted or distorted condition: one who sins is crooked or deformed, deviating from the standard” (:1305). The term *pesa* refers to “the violation of rights of others” or “infidelity to the covenants”; *ma'âl* refers to infidelity or “the breach of an obligation freely undertaken” (:1305).

**In the New Testament: wrongdoing, violating God’s law, active evil and failure to believe**

Many of the Old Testament categories emerge in the New Testament. *Hamartia*, for example, also understands sin as “missing the mark” (Fitzmyer 1990: 1402). It is “the general term for sin as concrete wrongdoing, the violation of God's law (Jn. 8:46 Jas 1:15)” (Milne 1982: 1117). On the one hand Paul refers to sins as human acts of transgression (Gal 3,19), and trespasses (Gal 6:1). But he also personifies sin (*hamartia*) as “an active evil force that pervades human existence. It 'dwells' in humanity (Rom 7:17,23), deceives it and kills it (Rom 7: 11)” (Fitzmyer 1990: 1403). Sin is contagious (:1402).

In John, "sin consists essentially of failing to believe, of giving up” (Brodie 1993: 496; Cfr. Jn. 16:9). It is linked to a preoccupation with the things of this world and a tendency to become enslaved by them (: 329). It is also the experience of advancing blindness as the text of the man born blind illustrates. The blind man “not only received sight but then went through various stages of advancing insight" (:343). By contrast the Jewish interrogators become increasingly blind and they “end in abiding sin (v 41)” (:343).

This is why the role of the Holy Spirit is to convince people of this sin, since all sins can be forgiven in Christ (Mk 3:29). In this context we understand the meaning of the "Sin against the Holy Spirit": the failure to see the Holy Spirit's presence in Jesus' ministry (Harrington 1990: 604).

**A THEOLOGICAL ANTHROPOLOGY OF SIN IN URBAN AFRICA**

In the Catholic Tradition, theological anthropology is concerned with the relationship between humanity and God. It affirms the dogma that God created humanity in his image and that he continues to be related to us
through gifts and graces given to humans. It recognises that sin is a reality in human history (original sin), that sin is an offence against God which distorts the image in which we are created and that virtues and vices are habits that reinforce themselves. It affirms that salvation refers to the deliverance from sin and evil in this world and a continuation of human life after death expressed as life in the presence of God and in the resurrection of the body at the end of time. It teaches that God sent his only Son in human form as the way to salvation, as true God and true Human, as the one who proclaims good news for the poor, as the one who accepted suffering and death in order to destroy sin and evil and who achieved this through the paschal mystery. This is available to every human being through faith in Christ.

It is with this theological basis that we can examine the understanding of sin within the three cultural roots of urban Africa: African traditional culture, Western culture and African urban culture.

When we use these cultural roots to create a theological anthropology of sin within a context, we are creating a theology of *inculturation*. This means that, firstly, we look for good news in each of the cultural roots as an expression of compatibility with the gospel. This is the first criterion for inculturation in the Church (EA 62). Secondly we look at how these expressions reflect a theological unity with the Church and its tradition. This is the second criterion for inculturation (EA 62).

**Sin, in African Traditional Culture: Antilife forces resulting from human wrongdoing**

Kasomo 2009 has attempted the most recent "investigation of sin and evil in African cosmology" (145). He links sin with evil as wrongdoing and badness noting that "sin in African thought refers almost exclusively to the area of inter-human relations" (155). His work is quite dependent on Magesa who notes that "sin and evil in African cosmology are antilife forces" (1997: 161). Sins are always human acts:

- In African religion, sin is always attached to a wrongdoer and ultimately the wrongdoer is a human person. The sense here, then, is that sin and evil do not and cannot exist in human experience except as perceived in people.
- It is people who are evil or sinful, whether or not they are
Sin as wrongdoing “relates to the contravention of specific codes of community expectation including taboos” (Magesa 1997:166). It is the breaking of such codes which is considered wrongdoing or “sin.” This is so whether or not people are aware they are breaking such codes and thus the need for those who have a deeper knowledge of these codes such as elders. "These are the ethical experts of and for the people” (:67).

Sin is an affront to the moral teaching of the elders and ancestors. This also affirms the importance of transcendence since ancestors are concerned about and support those on earth yet chastise them for immoral pursuits. "The idea of acknowledging the fault and asking for pardon and forgiveness by the living from the ancestors is essential" (Ncube 2003:91).

These understandings can clearly be incorporated into theological anthropology provided that they are linked to the more fundamental reality of God the Creator and Saviour in the paschal mystery. This is the challenge for inculturation in this culture.

**Sin in the Urban African model: Evil spirits and God’s punishment for immorality**

A major difference between traditional and urban African culture not linked to secular Western culture is the presence of the monotheistic religions. One of the fastest growing phenomena in urban Africa today is Neopentecostalism which is my focus for the Urban African model.

Sin in urban African Pentecostalism is clearly influenced by traditional Christian notions. It is linked to immorality and a lack of lived human and Christian values in urban African society. This results from the level of social disorganisation and cultural deracination that migration to the African cities entails today. This situation is often explained in urban African Pentecostalism by the control that Satan has over the world: “the contemporary world is tightly in the grip of Satan who is spreading immorality, corruption and suffering” (Dilger 2007: 65). Urban African Pentecostalism often sees itself a protagonist in the spiritual fight against sin and evil: "The FGBFC's² main concern is consequently to take up the

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2. (FGBFC) Full Gospel Bible Fellowship Church, one of the biggest Neo-Pentecostal churches in Tanzania (Dilger 2007: 59).
fight against Satan and his diabolic henchmen and to save humanity not only on a local, but also on a global scale” (: 65). Consequently everyone is born into a situation of sin but can be saved

...by becoming aware of the ways Satan exerts control over a person's life...the awakening (uamsho) ...the prerequisite for entering the state of salvation and escaping the control of Satan is by dedicating one's life to God by accepting and spreading the teachings of the Bible (Dilger 2007: 65).

However Smith's study in Nigeria asserts that urban African Pentecostalism also promotes the view that AIDS is God's punishment for sin.

The dominant religious discourse about AIDS is that it is a scourge visited by God on a society that has turned its back on religion and morality. When asked at the end of the survey what they thought the ultimate origin of AIDS was, 35% of respondents in Kano and 26% in Aba said that it was 'God's punishment' or that 'only God knows'. Many other responses tied the origin of AIDS to immorality (Smith 2004:430).

To summarise we can say that "sin" in this culture is mostly understood in the way biblical theology presents it. However the anthropological studies cited add some nuances. The East African study notes a tendency to replace human agency for sin with evil spirits. It also suggests that sins and sicknesses are immediately attributed to evil spirits and demons which have possessed individuals, groups and societies corrupting and destroying them. This results in a lessening of personal accountability for wrongdoing. The West Africa study also suggests a spiritual etiology for sickness as God's punishment but in this case resulting from human immorality and thus accountability.

Sin in the Western Model: sickness, poverty and social deviance

In secular society sin as an offense against the deity is rejected as a concept. It is replaced mainly by two notions: sickness and social deviance. On the personal level it is replaced by psychological sickness. “Contemporary secular culture is bent on marginalizing, if not
displacing, sin-talk, so that religion and spirituality can be harmoniously integrated within the secular therapeutic project.” (Delkeskamp Hayes 2007: 108-109). On the social level it is replaced by law-breaking or criminal activity including legislated antisocial behaviour. These activities are also seen by secular culture to have sickness aetiologies which also link them to the secular therapeutic project. Some economists speak of economics as the new theology where sin is linked to economic deprivation: "Material scarcity and the resulting competition for limited resources have been widely seen as the fundamental cause of human misbehaviour - the real source of human sinfulness" (Nelson 1991:xxi).

SIN AND HIV AND AIDS AMONG AFRICAN CATHOLIC THEOLOGIANS

Knox and Orobator

A number of African Catholic Theologians have written extensively on HIV and AIDS. Of particular note are the works of Peter Knox (2008) and Agbonkhianmeghe Orobator (2005). Knox focuses on the contribution of local cultural beliefs in Christian ministry to the sick and in particular on the role of the ancestor cult in African religion as a theological category which "contributes strongly to a comprehension of salvation in the context of AIDS not just as an illness but as a pandemic affecting one way or another every family and the whole population" (2008:25). Orobator focuses on developing an ecclesiology for ministry in the context of HIV, AIDS, refugees and poverty in Africa. The few references to sin strongly link it to poverty (2005:37; 202). In particular, following Gutierrez, he focuses on the social structural component of sin (:180). In addition, following Nyamiti and Dulles, he recognises the importance of the transcendent nature of sin in relationship to God (:77-78).

Two edited works containing contributions from a variety of African Catholic theologians contain significant contributions on the relationship between sin, HIV and AIDS. These are Responsibility in a time of AIDS (Bate ed.2003) and AIDS in Africa (Bujo and Czerny eds. 2007).
Responsibility in a Time of AIDS

The focus of this book is Southern Africa. It results from a conference of theologians and Catholic AIDS activists in 2003. The relationship between sin and AIDS discussed by the various authors can be subsumed under the following headings:

Confusion amongst Christians when relating sin and AIDS
There appears to be some confusion in the way people understand the relationship between sin and HIV and AIDS. In the first place a simple correlation of sin and AIDS is unhelpful. The rush to the moral sexual question overlooks more important matters. Munro (2003:49) affirms that the stigma, exclusion and suffering of people with HIV and AIDS is exacerbated by a partial reading of scripture leading to a simplistic theology of sin.³

The confusion is compounded by the fact that AIDS has become something much wider that an issue of personal sinful behaviour. It affects many aspects of what it is to be human.

It is something that affects many different aspects of our human life…a matter of life and death, of sickness and health, of medicines and no medicines, of jobs and unemployment, of wealth and poverty, of politics and power, of spirits and witches, of sin and evil and of ethics and morality (Bate 2003a:147).

Sin should not be detached from HIV and AIDS
The confusion and the mitigating circumstance surrounding HIV and AIDS does not mean that the issue of sin should be avoided. Ncube rightly affirms this assertion of David Power:

The link between sin and illness is not something which keeps the ill away from God. Illness is a human condition in which God is glorified, for the sick become a symbol of Christ who gives his life for others. There is a reconciliation with God and with the Church because

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there is reconciliation with one's condition, a healing of the feeling of being a person divided, a spirit incapacitated by the weakness of the body (David Power cited in Ncube 2003:107).

Some of the confusion is easily removed by replacing the hyperbole of critics by correct teaching. It has been pointed out that serious sin in Church teaching "requires grave matter, full knowledge and full consent" (Ryan 2003:6). The nature of many relationships in a context of poverty and false stereotypes concerning the role of women in African society make full knowledge and full consent impossible in many sexual relationships, even within marriage, in the modern urban Africa context.

Full knowledge and full consent also contain a cultural component within them since culture provides the labels for the illness which allow her to identify the illness within her own identity as a human being. In this way the feeling can be identified as headache, cold, Umkhuhlane, possession by evil spirits, sin, being bewitched or “thakatha’d”, false consciousness or whatever other label the culture may prescribe" (Bate 2003a:151).

**Sin has a remedy**

Now “in Catholic cultures the remedy for sin is confession and absolution” (Bate 2003a:152). And this is very important because ignoring sin drives it underground, yet the remedy is always available and always effective. It is strange why such a simple cure is so often replaced by denial and defeat. The spiritual remedies:

recognise the importance of supernatural in both illness etiology and healing remedies. Illness etiologies may be ascribed to the activity of spirits, demons or other malevolent spiritual beings as well as to immoral human behaviour usually understood as sin. Healing therapies include the casting out of demons or evil spirits, the confession and forgiveness of sin, anointing with oil, laying on of hands and prayer for the sick person (Bate 2003a:160).

This means that a clear statement about sin in relationship to HIV, AIDS and other human issues is something not to be avoided but
something to be adequately addressed in a way that is saving and life giving for individuals and communities.

**AIDS in Africa: theological reflections**

The focus of this book is "to consider AIDS in Africa in some of its complexities" (Bujo & Czerny 2007:11). The authors are Catholic theologians mainly from east and central Africa who examine the question "what do God and his church help us to learn about AIDS" (:12). The relationship between sin and HIV and AIDS is discussed by a number of these authors. Here are the main insights.

*The reality of sin in African culture*

The African cultural sense of wrongdoing as rooted human agency and its communal consequence is seen as a value that African culture brings to the Christian category of "sin." The first African Synod indicated a number of such values which "include, among others, a profound religious sense, a sense of the sacred, of the existence of God and of a spiritual universe a sense of the reality of sin and of rites of purification and expiation" (Matadi 2007: 35).

Sin in African culture has consequences since "the errors or guilt of an individual reduce the life force of one’s fellow beings, while one person's good contributes to greater life for everyone” (Bujo 2007:69). These consequences can include illness and thus the relationship between sin and AIDS. "Accordingly to speak of sin in relation to AIDS in no way narrows the concept to the sixth commandment. Rather it invokes every type of behaviour that may lead to the destruction of harmonious living in the African sense mentioned above" (:69).

*Inappropriate correlations of sin and illness*

But there are also some incorrect ways in which sin is correlated with illness and communal wellbeing. One of these is the false correlation of sin and suffering which leads to false stigmatisation (Matadi 2007:39). Another false correlation is the "powerful cultural subterfuge" of the stigmatizing of the perceived sinner, which is fundamentally judging others based on our own perception (Czerny 2007: 51).

Stigma and discrimination result in harmful and destructive exclusion, setting apart the clean from the unclean, the normal from the abnormal and, always,
the us from the them. Once people have been separated from what we consider familiar and acceptable, we then give ourselves licence to treat them according to a different set of rules, which invariably means badly, cruelly, inhumanely. We say that they have brought it upon themselves, as all the while they really serve as screens onto which we project our own fears and unresolved hang-ups. We punish them for what we cannot abide in us, and scapegoating them brings us an illusory peace and security (Czerny 2007:51-2).

The inevitability of personal sin is a world of structural sin
The criteria for serious sin are seriously compromised in a social context of poverty, discrimination and violence. It is for this reason that the notion of personal sin cannot be abstracted from the social context within which it flourishes. "In the language of Catholic social teaching, structural sin — grinding poverty in its multiple ramifications provides the enabling environment in which individual sin can and does flourish" (Czerny 2007:60). However such a context does more than diminish the seriousness of personal sin, it also affects the nature of the mission to fight sin. "Offering compassion while overlooking the sinful structures, or preaching morality and prevention without fighting poverty, flies in the face of the Church's tradition and negates her mission to proclaim the Kingdom of God in which sin and death are defeated forever" (:60).

Six theological statements about sin and AIDS
These two books provide us with a series of six important theological statements about the relationship between sin and AIDS.

1. There is confusion when relating sin and AIDS.
There is no simple correlation. The rush to the sexual question often overlooks more serious matters such as sex education and HIV prevention. And the labelling of HIV positive persons as sinners excludes them through inappropriate stigmatisation and lack of compassion for their suffering. HIV affects many different aspects of our life as humans.
2. **Sin should not be detached from HIV and AIDS**
Sin is a reality in all human life including the world of HIV and AIDS. Serious sin in Church teaching requires grave matter, full knowledge and full consent, something which is rarely present in a context of poverty and suffering particularly in the life of women. Illness does not keep people away from God. Illness is a sign of Christ's passion and reconciliation which brings healing.

3. **Sin has a remedy**
In the Catholic Church the remedy for sin is confession and absolution. Ignoring sin drives it underground yet the remedy is always available and always effective. A clear statement about sin in relationship to HIV and AIDS needs to adequately address questions of human culpability and the grace of forgiveness in a way that is empowering and healing of individuals and communities.

4. **The reality of sin in African culture promotes localised Christian expressions of sin and forgiveness**
Sin and illness cannot just be dissociated. To speak of sin in relation to AIDS in no way narrows the concept to the sixth commandment. Rather it invokes every type of behaviour that may lead to the destruction of harmonious living in the African sense mentioned above.

5. **There are inappropriate correlations of sin and illness**
There are also some incorrect ways in which sin is correlated with illness. These include the false correlation of sin and suffering which leads to false stigmatisation. This is judging others based on our own perception and setting them apart from us as the unclean. We punish them for what we cannot abide in ourselves.

6. **The inevitability of personal sin in a world of structural sin**
In Catholic social teaching, structural sin provides the enabling environment in which individual sin can and does flourish, thus reducing its seriousness. This affects the nature of the mission to fight sin which becomes a struggle against the sinful structures of society.
AN ECCLESIOLOGY OF SIN

The importance of ecclesiology in ministry

Christianity is a community based religion. Membership of the Church confers rights upon Christians but it also implies duties, expressed in the teaching of the Church. These include orthodoxy regarding doctrine and discipline regarding ministry. For this reason it is incumbent upon Christians to follow the laws and teachings of their churches when involved in ministry. Ministry always has an ecclesiological foundation. Ecclesiological problems emerge when the ministry of the Church becomes subject to the preferences and proclivities of individuals which sometimes leads to confusion and controversy. When this happens Christian ministry can become part of the problem rather than part of the solution because of unreflective and confused approaches to people who are in need.

Sin in Catholic teaching

Catholic Moral Theology teaches that for a serious sin to be committed three conditions are required. The act itself must be an offense to God in terms of Catholic Teaching. The person committing the act must have full knowledge that this act is indeed an offense against God. The person committing the action must do so in full freedom without any constraint from another person or situation in which they find themselves. The Catechism of the Catholic Church expresses this as follows: "Mortal sin requires full knowledge and complete consent. It presupposes knowledge of the sinful character of the act, of its opposition to God's law. It also implies a consent sufficiently deliberate to be a personal choice" (CCC 1859; See also CCC 1754). Culpability regarding the sinful nature of actions acts is often reduced or diminished by social and personal conditions. "Imputability and responsibility for an action can be diminished or even nullified by ignorance, inadvertence, duress, fear, habit, inordinate attachments, and other psychological or social factors" (CCC1735).
African Magisterial Teaching on Sin and HIV prevention

African Magisterial Teaching on HIV prevention has been relatively consistent during the 30 years of Catholic responses to HIV and AIDS. The Bishops focus on the sacredness of life and fidelity to sexual activity within marriage only. There have been relatively few references to sin in relation to HIV and AIDS.

SECAM\(^4\) has issued two important documents on AIDS, neither of which mentions sin in relationship to AIDS, preferring to stick to a more positive message of salvation and morality. However there is a reference to evil: "personified in materialism and consumerism, which unfortunately dominates our society and therefore enhances the divide between developed and developing worlds, the have and the have-nots" (SECAM 2001). A subsequent document (SECAM 2003) has no reference either to sin or evil. It is rather a positive message of solidarity in the struggle against AIDS. The section on HIV prevention is based on education, particularly of youth, for lifestyle change based on abstinence and sex within marriage.

The SACBC\(^5\) Message of Hope (SACBC 2001) has one reference to sin in section 3 entitled Message to Married couples: "We proclaim Christ's message to you, the people of today, 'The Kingdom of God is near. Turn away from your sin and believe in the Good News' (Mark 1, 15). However, in addition, it lists a series of unacceptable attitudes and behaviour (i.e. sins) promoted by the use of condoms. These are:

"It is alright to sleep around as you like even if you are still young - as long as you do not contract HIV/AIDS"

"There is no need for training yourself in self-control"

"There is no need to prepare yourself to be faithful to a future spouse"

"It is alright to use another person for selfish pleasure"

(SACBC 2001).

In 2006 the Kenya Bishops’ Conference (KEC) published what seems to be the first African magisterial document in English which specifically deals with the question of sin in a context of HIV and AIDS.

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4. Symposium of Episcopal Conferences in Africa and Madagascar
5. Southern African Catholic Bishops’ Conference
Volume 1, on policies, contains 13 references to sin. I have subsumed these under a number of headings which are illustrated by texts from the document.

**The reality of sin in our lives**

If we speak with clarity about sin, it is not with a view to stigmatising people 'out there,' still less to finding a scapegoat for the dreadful situation confronting us. We know from our own bitter experience how collusion with sin wreaks havoc in personal and social life. But at a deeper level, this uncomfortable truth about ourselves, which God's grace makes available to us if only we can exercise the humility to receive it, is perhaps the greatest single gift we have to offer those suffering from HIV or AIDS. Confessing sin is, for one thing, a vital antidote to hypocrisy. "It would be wrong, theologically unsound, to think that this calamity is the work of an avenging God, punishing mankind for individual and collective sins" (Catholic Bishops of Kenya 1987; KEC 2006:15).

**Conversion from willful and ignorant fornication**

But the man or woman, teenager or youth, who more/less wilfully and more/less ignorantly is sinning by fornication or adultery and is putting health, happiness and life at great risk, does need to meet Jesus in the Church and feel His touch, discover the sin, repent and hear His words, "Go in peace and do not sin again!" (KEC 2006:17).

**The futility of advice on minimizing consequences of sin**

Much as Christians want to reach out tolerantly to someone intent on serious sin, we never want to condone, even implicitly, the abuse of a poor youth by an adult or an adulterous man's forceful sexual advance upon his faithful wife. Some would have the Church offer such people advice on how to minimise the destructive consequences of their behaviour, as if, having rejected
the central message of life-giving responsibility, they are likely to heed the call of commonsense decency and choose the lesser evil. In such situations, we find ourselves pushed to the very limits of our capacity as Catholic leaders in a world fractured by sin. But it is a delusion to imagine that 'compassion' can ever be invoked to tolerate death-dealing actions as being normal or acceptable (KEC 2006:18-19).

**The sin of presuming AIDS is God's punishment for sin**

To condemn someone, or speak about someone, or treat someone, as if God is punishing him/her with HIV for having sinned, is very wrong and probably itself sinful. It violates the teaching of Jesus and destroys family and community. To interpret AIDS as God's punishment for sin is wrong. It is theologically unsustainable, as powerfully demonstrated in the book of Job and in many healing narratives of the Gospels. All such judgmental expressions seriously undermine efforts at care, support and prevention (KEC 2006:20-21).

**Sinful social structures**

Evil is at work in the larger context of structural sin that provides the enabling environment in which individual sin can flourish. These sinful social structures – local and national, Africa-wide and international – constantly cause abuses of human dignity and fuel the spread of HIV, and all these the Church continues to denounce, prophetically, calling for a real change of heart in those who have the power to decide and for greater social justice at every level (KEC 2006:21).

**ARTICULATING THE THEOLOGICAL MODEL**

The mediations of sin, HIV and AIDS through the scriptures, theological anthropology, ecclesiology and reflections of African Catholic theologians cast a diversity of light on this complex matter. At the same
time they help us to avoid two pitfalls when discussing sin, HIV and AIDS. The first is to ignore the issue completely saying that the Church should not speak about sin in such a tragic situation. The second is oversimplification of the matter by choosing a view that suits us theologically and then looking for evidence to defend this position.

The complex analysis of sin allows us to construct a theology which can inform ministry. This theology is a local theology focussed on Africa and especially urban Africa. It provides us with a justification and foundation for the ministries we pursue. It demonstrates that the theological category of sin is critical to an understanding of a theology of HIV prevention.

**Contribution from Biblical Theology**

Sin in the Old Testament is the failure to live in faithfulness to the requirements of the community and God's covenant. It occurs usually through a distortion of a human situation into falsehood and lies leading to folly in the relationship of the people of Israel with God and in community amongst themselves. The essence of sin is located in an attitude of believers which is best described as rebellion against God and destruction of human relationships.

Sin in the New Testament is concrete personal wrongdoing and the violation of God's law. In Paul it is sometimes personified as an active evil force and the participation in this force. In John it is also expressed as failing to believe in God and giving up by becoming seduced by the things of the world leading to advancing blindness: a participation in active evil which is basically founded on a failure to believe.

**Contribution from Theological Anthropology**

Within the urban African context, sin is sometimes understood as human wrongdoing which has a consequence of destroying life forces within the whole community as taught by African traditional culture. Sin as taught by urban Christian Pentecostalism is often caused by the devil and evil spirits that possess people, consume them and cause them to create the immorality found in urban African contexts with a consequence that God is angered and punishes the community. The only remedy is conversion.
However, among the urban African elite sin is increasingly an irrelevant matter as a result of the influence of global Western culture which states that there is no God and what we call sin is basically about sickness, poverty and social deviance in crime. The remedy is human development and progress.

The African theologians surveyed remind of us of some simple yet fundamental truths that often get ignored in the crisis situations of contexts such as that of HIV and AIDS. Firstly, as Christians we must acknowledge the reality of sin in our lives as personal wrongdoing. Sin cannot just be washed away as sickness and communal dysfunction. Indeed the ability to be aware of the reality of sin is a positive value that African culture brings to the Church. It is fundamentally an aspect of our relationship with God.

However there is considerable confusion when relating sin, HIV and AIDS. This is part of the tendency to make inappropriate correlations of sin and all illness. Confused attitudes include interpreting illness as suffering caused by sin. Whilst this may be true in some cases, by and large this is a false causal nexus in Catholic theology. Even more problematic is the false stigmatising of those who are HIV positive or suffering from AIDS. Such stigmatising is clearly sinful itself, based on pride which divides the community into us (the good and the right) and them (the bad and the wrong). In fact all people are sinners as Jesus reminds us with his injunction to cast the first stone if you have no sin and to judge not lest you be judged.

On the other hand there is a clear relationship between personal sin and structural sin. Moral choices amongst those who have resources in society are often just that: choices. But for those who have limited or no resources there is often also no choice. Examples of this include the abuse of women, children and other vulnerable adults and the struggle of the poor just to survive with whatever is available. Comments about sin in a context of poverty must be made with extreme caution by those outside of it. Yet ministering within such contexts clearly contains a component of helping those caught within the traps of inhuman and immoral lifestyles to a better life of body, soul and community. This is also the reason why sin cannot just be detached from human life within the context of HIV and AIDS. There is no doubt that the transmission of HIV and AIDS even within such tragic contexts includes those linked to inappropriate and indeed exploitative, destructive and thus sinful
Finally the important truth that sin has a remedy should not be overlooked. Confession, repentance and re-conversion towards God and his Kingdom are healing acts that bring life and joy to the sinner and this therapy is always effective as God forgives repentant sinners.

**Contribution from Ecclesiology**

The General Catholic teaching on sin requires much more for imputability than is generally understood. An important consequence is that cultural and social factors often diminish the culpability of actors in a way that is poorly understood by secularists and naturalists and even many Catholics.

The teaching of the African Magisterium focuses on the sacredness of life and fidelity to sexual activity within marriage only. This places the reality of sin as an offense against these two injunctions. Most documents of the African Magisterium have very little on sin, HIV and AIDS. This lacuna may be deliberate, possibly because of the concern not to fall into the trap of stigmatising and judging but also because the message of living the Gospel faithfully is inspired by the goal of salvation and life.

Evil on the African continent is most clearly articulated by the Magisterium as being located in attitudes of materialism, consumerism, and global capitalism which divide societies into haves and have-nots. HIV and AIDS more readily flourish amongst deprived communities, the victims of sin more than they are the perpetrators.

Some bishops have also emphasised those who call AIDS God's punishment on sinners are themselves sinning (KEC 2007: 20). Such calls would seem to contravene at least the second commandment, to take the Lord's name in vain and the eighth, to bear false witness.

HIV prevention is articulated mainly as education, particularly of youth, for lifestyle change based on abstinence and sex within marriage only. The *Message of Hope* (SACBC 2001), in particular, but not exclusively, emphasises that sexual licentiousness and promiscuity is sinful behaviour. The use of condoms is sinful when it promotes such licentiousness. This view is echoed by the Kenyan Bishops' "collusion with sin wrecks havoc in personal and social life" (KEC 2006:17). The
remedy is the encounter with Jesus in the Church to recognise the sin and to repent.

Finally the Magisterium has pointed out the futility of some expectations that the Church would provide recommendations about minimizing the consequences of what it considers immoral behaviour. What humanist western culture calls the rights of people to sexual freedom and liberty is not acceptable to the Church. Secular modern society is incorrect to expect the Church to compromise its moral teaching on sexuality to accept the modern values of sexual libertarianism: "it is a delusion to imagine that 'compassion' can ever be invoked to tolerate death-dealing actions as being normal or acceptable" (KEC 2006:19). Pope Benedict in an interview on the way to Cameroun calls the focus of secular society on the condom in its ABC method: "a banalization of sexuality, which, after all, is precisely the dangerous source of the attitude of no longer seeing sexuality as the expression of love, but only a sort of drug that people administer to themselves" (Benedict & Seewald 2010:193).

But the situation is somewhat different when speaking about those forced into sexual activity as a result of poverty and abuse or when there is a danger of infection. Pope Benedict XVI made a telling comment in this regard when he says:

There may be a basis in the case of some individuals, as perhaps when a male prostitute uses a condom, where this can be a first step in the direction of a moralisation, a first assumption of responsibility, on the way toward recovering an awareness that not everything is allowed and that one cannot do whatever one wants. ...She [the church] of course does not regard it [the condom] as a real or moral solution, but, in this or that case, there can be nonetheless, in the intention of reducing the risk of infection, a first step in a movement toward a different way, a more human way, of living sexuality (Benedict and Seewald 2010: 193).
CONCLUSION: SIN IN PUBLIC DISCOURSE

A society without a sense of right and wrong grounded in the reality of the Divine will, is a society which has deluded itself, believing in the secular myths of progress and the possibility of human perfectibility. Several centuries of human life since the Enlightenment and the growth of secularisation have taught us that these mythical truths do not describe the reality of global wars, poverty, violence, discrimination and growing antisocial behaviour in the modern world. The category of sin has declined in public consciousness and this has been accompanied by the growth of a lack of moral accountability for the actions of individuals, groups, nations and global entities such as multinational corporations and criminal syndicates.

The age of enlightenment and the growth of scientific knowledge have brought benefits of wealth, resources and human power to improve human wellbeing. These, the Church acknowledges (Cfr GS 4). Nevertheless, this abundance has brought with it additional responsibility on human communities and leaders to ensure a similar growth in human values and morality. This has not happened. Often because people have become consumed with themselves forgetting both the rest of creation and in particular the Creator. Secularist views about religion in healing consider the notion of sin to be stressful and indeed pathogenic. Corrina Delkeskamp-Hayes has pointed to three ways in which the healing professions attempt to remove the notion of sin from Christianity in order to promote healing practices.

The first approach interprets religion as a human conceptual construction. It therefore concentrates on helping religious persons to re-construct their religion so as to promote medical healing...teaching believers how to keep their religion free from worries about sin. The second approach considers religion as a phenomenon embodied in (secular) caring and sharing interactions. It seeks to exclude anything that might undermine human solidarity. In particular it requires that any reference to sin be avoided, because (so it is assumed) this will lead to discrimination. The third approach separates traditional Christian rituals from their theological and metaphysical grounds, thus separating those rituals from
worrisome connections to sin. This approach endorses experimenting with the symbolic and psychological power of bodily movements, narratives and images (Delkeskamp-Hayes 2007: 112).

Sadly, a public society which believes in progress and the perfectibility of the human condition has little use for, and has turned away from the category of religious obedience to God and morality and accountability in human life. These have been identified in this study as the principal components of what we call sin. It is the discipline of theology which rightly investigates these areas since it provides a transcendent source, the divine, unavailable in the human philosophies of ethics. Theology must increase its presence in the public square by promoting the need for a sense of personal and public sin linked to repentance and conversion. This correction will respond to the overly positive message of secular humanism which has not sufficiently acknowledged the brokenness of the world.

A viable public theology must develop a sound doctrine of both the brokenness of the world and of sin if it is to make a realistic contribution to society…the acknowledgement of sin makes a more decent, moderate, wise and human society possible, a society in which people can trust one another, are more inclined to work together and achieve more than they can in a society that is built on a notion of human beings as autonomous entities capable of self-improvement, and, thereby, the improvement of life in general (Vroom 2007:472).

There is possibly nowhere more than the world of HIV and AIDS where the category of sin is often seen to be taboo. The category of sin and HIV is indeed dangerous ground because it can stray into the issues of stigma and discrimination raised here. But avoiding them does not mean abandoning a reflection of the link between sin, HIV infection and AIDS. This would be to deny one aspect of accountability. Pandemics like this are often metaphors for many others contexts of social and human suffering brought on by human activity. This article has shown that human wrongdoing and the presence of the divine collide in all such situations and the need for spiritual discernment and theological judgement are essential for a thoroughgoing response to the challenges of peoples' lives.
REFERENCES


The idea of working together for the common good of humanity has today become a founding principle for interreligious dialogue. One of the areas where cooperation between people of different religions is imperative is undoubtedly HIV/AIDS. Such collaboration is also relevant to the South African context and involves all religious traditions and Christian churches. For Catholics, interfaith dialogue is linked with praxis that unites the Church and the various religions in a common struggle against HIV/AIDS that has become an interfaith concern in the widest sense of the word. The epidemic touches and challenges every faith community in this country. The paper reveals that among many responses to the epidemic in South Africa, there is also a Catholic response that has provided not only practical medical care, but also created remarkable community-based palliative care and counseling for the sick and dying from HIV/AIDS. The question which the paper attempts to answer is whether and to what extent this Catholic response to the epidemic has included cooperation with other religions in the area of AIDS prevention and care for those living with and affected by the disease. The research shows that generally there is little formal dialogue on HIV/AIDS in South Africa between Catholics and other believers. There is however evidence of informal interfaith contacts and cooperation on HIV/AIDS, mainly through faith-based and nongovernmental organizations.
whether and to what extent this Catholic response to the epidemic has been inclusive of cooperation with other South African religions. Are there any signs of mutual relations between the Catholic Church and the religions in South Africa in the area of HIV prevention and care for PLWHA? Or have the various faith communities remained isolated in addressing the epidemic?

1. HIV/AIDS – A CHALLENGE FOR ALL RELIGIONS IN SOUTH AFRICA

The HIV epidemic is devastating the world, including the developing world, and especially the southern region of the African continent, including South Africa. Because of the enormous negative impact of HIV/AIDS on the South African society, the epidemic has become a real crisis not only for the government but also for all religions. This crisis is covered in the media almost every day. Faces of people dying from AIDS cry out from the TV screens and the pages of magazines. Special conferences are organized and resolutions made. We are “flooded” with endless statistics of people dying or becoming infected, yet the reality does not go away. The reality is that humanity is more than thirty years into the epidemic. Since 1981, the epidemic has spread rapidly to every corner of the globe, infecting more than 58 million people and killing nearly 30 million by the end of 2009 (South Africa HIV&AIDS Statistics 2010). Worldwide 34 million people are currently living with the disease and the overwhelming majority of HIV infections, around 95% of the global total, live in the developing world. Africa continues to be considered the epicentre of the epidemic. Out of the total 34 million worldwide, more than 22.9 million people have been infected with HIV in sub-Saharan Africa giving this region approximately 68% of the global total of HIV-positive cases (Worldwide HIV&AIDS Statistics 2010). The above number includes 5.6 million South Africans who lived with HIV in 2009 (around 10% of the total population), including 300,000 children under the age of 15 (UNAIDS Report 2010). This makes South Africa the single largest population with HIV/AIDS. Some

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1. The ASSA (Actuarial Society of South Africa) model of 2008 produces a similar estimate of 5.5 million people living with HIV in 2009, or around 11% of the total population (South Africa HIV&AIDS Statistics 2010).
positive news is that the number of people who died of AIDS in South Africa declined from an estimated 257,000 in 2005 to 194,000 in 2010. The figure for 2010 was significantly less than was predicted by the ASSA2003 model (388,000 AIDS deaths). This decline in estimated AIDS mortality is believed to be due to antiretroviral treatment becoming more widely available (South Africa HIV&AIDS Statistics 2010).

Perhaps the most tragic and long-term legacy of the HIV epidemic are orphans. Around 14.8 million AIDS orphans live in sub-Saharan Africa. This includes 1.9 million South African orphans due to AIDS death (Sub-Saharan Africa HIV&AIDS Statistics 2010). Undoubtedly caring for them is one of the greatest challenges facing society. Many orphans grow up as street children or form child-headed households to avoid being separated from siblings. Others are brought up by grandparents with limited capacity to take on parental responsibilities. All are traumatized by the illness and death of parents, and often by separation from siblings. Trauma is exacerbated by the stigma and secrecy around AIDS that still exposes children to discrimination in their community and even in their extended family. Orphans are also more prone to becoming HIV-infected through abuse, sex work or emotional instability leading to high-risk relationships. Women are another social group heavily affected by the epidemic in South Africa. They are at greater risk of infection due to physiological, anatomical and socio-economic reasons. The generally low status of women in society and within relationships is one of the predisposing factors that makes the epidemic even worse. Economic dependency and the threat of physical force in particular, make it difficult for women to protect themselves from infection (Lamond 1996:18; PACSA 1999:2).

The above statistics indicate that for religious leaders HIV/AIDS has become one of the biggest challenges they have faced in recent South African history. As HIV-prevalence rates continue to increase, religious leaders face the human consequences of the epidemic daily. Whether in the Muslim, Hindu, or Christian communities, or the many traditional African communities, the effects of HIV on communities are equally devastating. Responding to loss, the overwhelming grief in communities, and the sheer practical burden of arranging care for so

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2. Calculation made by ASSA2008 model.
many people are huge responsibilities that have been shouldered by religions and often by individual spiritual leaders at local level. One can even risk saying that, in a sense, HIV/AIDS is repeating what apartheid did in the past, that is, marginalizing a section of the population and tearing families apart. Fortunately, many religious leaders have realized their unique role in providing care for PLWHA, in preventing the disease, and in challenging the stigma and denial which surrounds it. They are also aware that the epidemic calls for a deeper look at closer and more constructive cooperation among religions, faith-based organizations (FBOs), and non-governmental organizations (NGOs) (Byamugisha, Steinitz, Williams and Zondi 2002).

2. IMPORTANCE OF DIALOGUE AMONG RELIGIONS IN SOUTH AFRICA IN THE CONTEXT OF THE HIV CRISIS

Before dealing with interreligious cooperation and the Catholic Church's response to the epidemic, a few clarifications are necessary with respect to the concept of dialogue and its importance in the context of the epidemic. Usually interreligious dialogue includes different types of activities, such as intellectual or academic debate, conferences and exchanges, joint practical work and the sharing of resources. It also includes daily contact among believers and sharing religious experience. All these activities are categorized under four types of interreligious dialogue: dialogue of doctrine, action, life and religious experience (Pontifical Council for Interreligious Dialogue 1999). People often understand interreligious dialogue as formal contacts among religious leaders. Some theologians, however, encourage a broader reading of the term and see interreligious dialogue and collaboration as anything that 'contributes to enhanced and peaceful life' (Amoah 1998). Therefore, effective IRDC can happen through means as simple as living and eating with people of other religious traditions. Thus in practice, dialogue is either formal or informal. The boundaries between formal and informal IRDC can often be moved by direct encounters, for example, when spiritual leaders and clerics meet PLWHA in person or see the impact of HIV on communities. Whatever form of dialogue religious leaders use, the aim is to understand the “other” and to inspire people to work towards a common goal (World Faiths Development Dialogue 1999).
Working across religions is one of the keys to any real response to the crisis that confronts humanity. When addressing specific problems such as HIV/AIDS, the goal of IRDC is to find a common theological approach as well as practical solutions. Constructive IRDC can have a meaningful and far-reaching impact in developing and encouraging work on HIV. Where religious leaders work with governments, NGOs and policy-makers, their potential influence within societies is considerable (World Faiths Development Dialogue 1999). When churches, mosques, temples and traditional healers work together, they can disseminate greater information about HIV to the broadest possible cross-section of the population and counteract negative stereotypes and discrimination by conservative religious groups. They can be time- and cost-effective, because they use social networks which are already well established and eliminate inconsistency between the religions in the messages about HIV. Interreligious collaboration can develop a critical mass of knowledge to influence various government decisions and policies. It can further empower women (often more regular worshippers than men) to raise HIV awareness, challenge gender stereotypes and improve their decision-making power in communities, by involving them in HIV education, prevention and care. Finally, religions and FBOs have the potential to cut across religious divides to encourage joint work and in a practical way involve PLWHA as faith-based leaders, which is a powerful method of challenging the stigma and promoting non-discrimination (World Health Organization 2007).

Religions, churches, and their FBOs can exercise their influence and cooperate at many different levels: grassroots, national, regional and international (World Faiths Development Dialogue 1999). The most recognized level is cooperation between senior members of the religious hierarchy, often working with government. A good example of such cooperation on the African continent is the African Forum of FBOs in Reproductive Health and HIV/AIDS which brought together representatives from the Muslim, Catholic, Anglican, Methodist, Buddhist, Hindu and African traditional religions. Similarly, the African Religious Leaders Assembly on Children and HIV/AIDS (a theological

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and advocacy group) united representatives of diverse religious traditions
to discuss social, cultural, religious and political norms that perpetuate HIV.\footnote{The leaders called for increased resources, involvement of PLWHA at all levels of society, non-discrimination, gender equity, curriculum development for theological schools, and increased IRDC to support children and adults affected by HIV. Available at http://www.wcrp.org <20 October 2012>}

In South Africa, in the fight against HIV, the various religious leaders have come together at the national level through the works of the Religious Leaders Forum (RLF) (Haron 2006:455) and most of all through the National Religious Association for Social Development (NRASD) and its Religious Sector HIV and AIDS Task Team.\footnote{NRASD – Advisory Forum. Available at http://www.nrasd.org.za/people-partnerships/advisory-forums/ <24 October 2012>} The latter includes all the directors of the largest religious HIV and AIDS programs in South Africa, namely, African Independent Churches, Anglican, Buddhist, Catholic, Hindu, Lutheran, Methodist, Moravian, Reformed, Muslim, and many others. Thus, the Religious Sector of NRASD has brought together representatives from all the religious groups on the AIDS issues. In fact, it is the only body that has provided training to a number of religious leaders from across the religious spectrum, in various interfaith groups.\footnote{In general the focus of the training was in the following areas: behavior change communication (centered on prevention); HIV Counseling and Testing (HCT); support for Orphans and Vulnerable Children (OVCs); Home and Community Based Care (HCBC), workplace programs and institutional capacity building. See NRASD – Focus Areas. Available at http://www.nrasd.org.za/focus-areas/ <2 May 2013>}

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The South African Chapter of the World Council of Religion and Peace (WCRP-SA) is also another important and involved organization. Founded in the 1980s, the WCRP-SA has brought together members of the various religions in South Africa. This interreligious organization has become important for a number of reasons. In the past, it created a space for the religions to express their disapproval of racial injustice and dehumanizing policies. During the time of transition (1990s), the WCRP-SA viewed itself as a potential instrument of reconciliation in situations of conflict and confrontation (Kritzinger 1991:v). At present, the WCRP SA gives to South Africans a sense of religious diversity as the main
characteristic of their society. The organization engages in the struggle for justice, peace, securing freedom and harmony – values fundamental to all religions in South Africa. Numerous activities of the WRCP-SA give a new vision of interreligious contacts and co-operation in the contemporary South African context including gender equality, the environment and HIV/AIDS. The Catholic Church in the Durban group of the WRCP-SA is represented by Cardinal Wilfred Napier, OFM.

The above examples of IRDC are formal. Less formal but extremely effective is the middle ground of practical interreligious service provision to communities. Those who are not spiritual leaders or ordained clergy also implement interfaith activities, bringing together people from different religions to work with, and on behalf of, communities of mixed religious background. This is the work of both secular and faith-based organizations. It is essential to mention here that such mutual interfaith cooperation and involvement in AIDS projects at grassroots level in no way seek converts to the represented and involved religions. It is a well-known principle that interreligious collaboration at project level does not concentrate on any missionary activity to gain converts. The AIDS projects are thus inclusive and are extended to the HIV infected across the religious spectrum. The best example are the Catholic AIDS projects, many of which have people of other religious affiliations on their staff to serve believers from all traditions. What is also particularly inspiring is that many HIV/AIDS activists and spiritual leaders see potential in dialogue on HIV— not only to address HIV, but also to generate interfaith cooperation in other social areas. Face-to-face encounters between Catholics and other believers at grassroots level can have as important a role as what happens at clerical levels. It seems that working across religions is a key to any constructive response to the HIV crisis confronting all South Africans.

7. The latter is especially addressed by the WCRP/HIVAN Forum creating a context for people and organizations (NGOs, FBOs, CBOs) to: build contacts outside of the usual networks; raise knowledge levels and provide relevant and timely exposure of issues around HIV and AIDS; and create dialogue among groups that do not normally come in contact with each other. See WCRP/HIVAN Forum. Available at http://www.wcrpsa.org.za/wcrp_hivan_forum.html, accessed, May 2013.
3. CHALLENGES TO DIALOGUE ON HIV/AIDS BETWEEN THE CATHOLIC CHURCH AND THE RELIGIONS

Despite the importance of IRDC on AIDS, there are certain attitudes, common to most religions, which constitute real barriers to the provision of effective interreligious care and prevention. Firstly, counseling people about HIV prevention cannot be done without addressing sex and without exploring people's attitudes and behavior in this area in a non-judgmental way. There has always been a greater temptation to accuse of sinful behavior those who suffer from HIV/AIDS. This is especially true because HIV is usually a sexually transmitted disease and most religions support sex only within marriage. The assumption is still that HIV equals sin, that the disease became an epidemic because of promiscuous behavior. Thus, PLWHA are vilified as sinners and the epidemic is seen as the direct result of their illicit behavior.\(^8\) This kind of thinking remains common in the rhetoric of many religious groups.\(^9\) Their general message remains that God warns us to stay away from sin, because sin (such as AIDS) kills. Moreover, despite a growing awareness, at least at a policy level, of the negative impact of condemnatory and moralizing messages, interfaith communities at grassroots level continue to spread them. A dichotomy therefore exists between the policy and the practice of some of the churches and religions (UNAIDS Report 2002). Stigma around HIV/AIDS is a real challenge which continues to discourage religious leaders from closer collaboration, especially at grassroots level. Fortunately, the majority of religious bodies have publicly distanced themselves from the claims that the epidemic is a curse from God.

Another issue that constitutes a real challenge to cooperation especially

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9. Many FBOs have used their influence to maintain the status quo rather than to challenge negative attitudes towards marginalized groups and PLWHA. During the international symposium “Religious health organizations break silence on HIV/AIDS” (organized by the African Regional Forum of Religious Health Organizations in July 2000) it was noted that religious doctrines have principally helped to create the perception that those infected have sinned and deserve their “punishment.” See Singh, B, “Breaking the silence on HIV/AIDS: religious health organizations and reproductive health” (Conscience, 2001). This has increased the stigma associated with HIV/AIDS. See Parker, R and Aggleton, P, HIV/AIDS-related Stigma and Discrimination: A Conceptual Framework and an Agenda for Action (New York: The Population Council, 2002).
between the Catholic Church and other religions is the use of condoms as one of the main means of HIV prevention. Yet some religious leaders (mainly Catholic but not only) remain focused on anti-condom messages, viewing abstinence and fidelity as the only viable option for HIV prevention and education. This creates an obstacle towards mutual engagement (programs and projects) between Catholics and others. On various occasions, the Catholic Church and its FBOs have been challenged for making abstinence and fidelity the cornerstones of their HIV campaigns (Aprodev 2000). Yet on the other hand, only a relatively small number of religious organizations outside the Catholic Church understand that the aims of the ABC (Abstinence, Be Faithful, Condom use) remain elusive ideals for poor women who are often economically dependent on men and culturally have little control over their bodies. The alternative – the ABCDE view – seems to be a more holistic and realistic approach. However, the difference between the ABC and ABCDE approaches is a real source of contention for FBOs and leaders across the religious spectrum.

Although considerable HIV/AIDS work has been carried out by all religions through practical engagement, much of such dialogue is still limited by a lack of information about, understanding of, contact with the issues and the people affected, or a lack of direct PLWHA involvement. There is also poor understanding among religions and FBOs of how social inequalities, including gender inequality, exacerbate the problems faced by the poor and of how these reduce the range of choices. All these challenges to interfaith cooperation and developing HIV-prevention are generally the same for all religions. Undoubtedly HIV poses fundamental questions to traditional notions of how people live, the social rules under which they operate, and what they understand as morality. Effective IRDC must therefore overcome ignorance, stigma, tensions within and between different religious traditions and differences in approaches to HIV/AIDS. Despite all these obstacles, there is considerable potential to develop IRDC on HIV that will be based on strong religious leadership and diverse interreligious initiatives.

10. The example here is from Nigeria where the Nigerian Interfaith Commission for HIV/AIDS decided to exclude condoms as part of an HIV-prevention strategy. Similarly, one meeting in Tanzania, between Muslim and Christian leaders, fell apart as Muslims accused Christians of "lax behaviour... by allowing girls to wear mini-skirts in school" (Christian Aid. “Nigeria trip report”, July 2003).

11. ABCDE stands for “advocacy for gender equality”, “attention to body and sexuality”, “work with community and in context”, “dialogue for development”, and “empowerment for sharing of power.”
4. THE CATHOLIC CHURCH'S RESPONSE TO THE HIV EPIDEMIC AND OPENNESS TO IRDC

The Catholic Church's involvement in the common struggle against the epidemic got off to a slow start (Bate 2003:197-210), influenced by socio-political realities, by ethical dilemmas and by an inability on the part of church and community leadership to recognize signs of impending tragedy. From the very start, also the church's approach to HIV prevention with its message of sexual abstinence, outside of marriage and faithfulness within, had been misunderstood and challenged by various religious leaders, the government, and even the public – as being unrealistic in an environment where research had shown that most adolescents were sexually active. Yet one of the ironies of AIDS in South Africa was that despite the Catholic Church's ban on condoms, the church became a major provider of AIDS care and services in the world, on the continent, and in South Africa. Already by the year 2000 approximately 12% of all AIDS care worldwide had been provided by the Catholic Church organizations, while 13% had been provided by Catholic NGOs, meaning that the Catholic Church and related organizations had provided 25% of the AIDS care worldwide. This made the Catholic Church the largest institution in the world providing direct AIDS care (DeYoung 2001).

Over the past 30 years, the SACBC AIDS Office has supported numerous programs and projects in South Africa and the neighboring countries, making them one of the largest anti-HIV/AIDS initiatives in Southern Africa. Since the early days of the epidemic, the Catholic Church has supported a real diversity of enterprises starting from 'awareness raising, education and prevention, home based care, and [including] care for orphaned and vulnerable children'. Over the years, 'home based care services have [become] the backbone of the Church's response to AIDS' (SACBC AIDS Office). The Church has remained at

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12. The major initiatives include establishing treatment sites (and satellite centers), training of clinical and support personnel, and initiating treatment for HIV/AIDS patients. This was possible because in 2004 a PEPFAR grant was awarded to Catholic Relief Services to support treatment of PLWHA in nine countries. The SACBC AIDS Office 'became the major partner and implementing arm of the program in South Africa'. In 2009, the grant mentioned shifted from CRS to the SACBC AIDS Office thus enabling the SACBC/CRS program to initiate more than 40 000 patients on ARV treatment. See SACBC AIDS Office http://www.sacbc.org.za/about-us/offices/aids-office/ <2 December 2012>

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the forefront in the care of the chronically ill and their families with established hospices for the dying, with home and family care within communities, and with spiritual counseling and support to the terminally ill, their families and their care givers. Prevention education, and training for youth, children and adults has been another area where the Church made a unique impact. The latter initiative included the “Education for Life” program which has been a strong component of the treatment policy (SACBC AIDS Office). Furthermore, the Church has provided well organized orphan care. The “Nazareth House”, faith-based organization located in Cape Town is the best example of this. It was the first Catholic orphan care institution in South Africa to provide pediatric antiretroviral therapy for the HIV-positive patients. Today, there are some highly successful day-care centers for OVC throughout the country.13

What is of special interest to this research is the Catholic Church's openness to IRDC in the area of HIV prevention and care for PLWHA. The SACBC AIDS Office's website encourages “collaboration at all levels with various inter-faith groups, NGOs, the private sector and government departments to facilitate the provision of services to those in need” (SACBC AIDS Office). This constitutes an important call, not easily found in other religions, for practical engagement on the AIDS issue between the church and other religious entities and nongovernmental organizations. This call also appears in another official church document on HIV “The Message of Hope” (2001). In this document, the SACBC called 'on all people of [Southern Africa] to break the silence around HIV/AIDS by naming AIDS - AIDS and by accepting people who are living with this disease'. The Catholic bishops emphasized the need for a theology of hope thus going beyond messages of a punitive God and popular associations of HIV with sin. In recent years, the theology of hope has become a response to fatalism in connection with HIV. Experiencing several problems such as poverty, abuse, unemployment or sickness can breed apathy and a fatalist attitude towards life. Even deeply religious people can become very fatalistic about the extent to which God is in control of their destiny. The Church

13. One needs to mention here that until the end of 2011, the 'PEPFAR support has also enabled the SACBC AIDS Office to support about forty sites providing a number of services to orphaned and vulnerable children. Over the life of the program more than forty thousand children have received educational, health care, paralegal, shelter, nutritional and other support' (SACBC AIDS Office http://www.sacbc.org.za/about-us/offices/aids-office/ <2 December 2012>.

INTERRELIGIOUS COLLABORATION
therefore encouraged hopeful attitudes, a vision for justice, equality and respect for human rights in its message.

The document discussed also encourages all “others” to volunteer their time and energy to visit and care for those afflicted. These “others” refer to the religions, churches, FBOs and NGOs in the fight against HIV. IRDC in the area of AIDS has been further reinforced by yet another document entitled “Fruitful Encounter” (2007) which repeats the same theological basis and principles for interreligious dialogue as the conciliar documents (LG, GS, AG, NA, DH) and the documents of the Pontifical Council for Interreligious Dialogue. What is new in “Fruitful Encounter”, and relates to the South African situation, is the section which speaks of dialogue with the religions (ATRs, Buddhism, Hinduism, Islam and Judaism) to face together the challenge of the 'threatening epidemic of HIV/AIDS and other related diseases' (FE 7). These guidelines are another valid basis for encounter with the various religious communities and a sign of the Catholic Church's openness and readiness to IRDC to eradicate the disease.

Through all these various initiatives of the SACBC AIDS Office and church official documents, the Catholic Church has expressed its belief that religions working together can have a far reaching effect when it comes to stopping the epidemic and that their work on HIV puts them at the heart of meeting the challenge. Yet there is always a difference between church official statements and documents calling for IRDC and their concrete implementation in life. The next section examines to what extent (formally and informally) the Catholic Church has engaged in mutual collaboration with South African religions in fighting the HIV epidemic.

5. EXISTING COLLABORATION ON HIV BETWEEN THE CATHOLIC CHURCH AND RELIGIONS

This research reveals that in South Africa new groups from different religions have emerged with the specific purpose of providing services to PLWHA and/or promoting HIV education and prevention. They are directly or indirectly interreligious and mainly work at grassroots or community level, thus being quite distinct from official, formal models of interreligious dialogue. Some of them may work under the patronage
of churches or interreligious organizations, but not necessarily through their structures. These groups provide unique models of interreligious cooperation on HIV and can be found everywhere in the Catholic, Christian churches and in other religions. The most relevant for this study include the “Damietta” Initiative, “Positive Muslims”, “Woza Moya” Project, “MaAfrica Tikkun”, and Sai Baba and Ramakrishna Medical Camps and Clinics. All these organizations establish in some way common ground for IRDC in the area of HIV prevention and care of PLWHA.

**Mutual cooperation with Islam**

The two largest religions in South Africa are Christianity and Islam. In the democratic South Africa, both Christians (Catholics) and Muslims live side by side without any major conflict. Can they, however, create in their respective traditions a space for a new type of co-existence based on official conversations and acceptance of their differences, and a mutual collaboration which includes cooperation on HIV/AIDS? An interview with Archbishop George Daniel of Pretoria in 2007, who was at the time responsible for interreligious dialogue on behalf of the SACBC, revealed that one cannot yet speak of any formal dialogue between the Catholic Church and Islam in the new South Africa. Such dialogue, in terms of organized meetings between religious leaders with a view of reaching a closer understanding on the essential tenets of our respective faiths, has not happened. Neither is there evidence of any formal groups on either side who meet to explain to one another their religious convictions.

Perhaps one of the reasons for the above is the lack of “representativeness” on the Muslim side concerning dialogue “at the top” which would have made contacts easier and the meetings official. Furthermore, despite the peaceful coexistence of the two religions in South Africa, mutual prejudices and misrepresentations continue to prevail (Interview with Abp Daniel). In this context one of the main obstacles is the socio-political factor which includes for instance majority-minority relations. Dialogue becomes difficult when partners in a minority or even a majority situation adopt a defensive or superior attitude (Fitzgerald 2003:181-193). The best example of this impediment is the existence of Muslims in colonial and apartheid South Africa and the present situation of Christian communities in some
Islamic countries. Another sensitive issue is the missionary character of Islam and Christianity. This explains the tendency which prevails on the Muslim side to think that Christians enter into dialogue or charitable activity with a hidden agenda to convert Muslims to Christianity. The opposite is also true, Christians are suspicious that Muslims enter into dialogue only to strengthen the position of Muslim minorities in Christian countries.

The above obstacles to formal dialogue between Muslims and Catholics continue to prevail in South Africa. Therefore, it would be overoptimistic to say that in South Africa at the present moment both Christians and Muslims debate religious questions or that there are official joint initiatives undertaken by the Catholic Church and the Muslim community which concentrate on addressing social issues such as HIV/AIDS. Such a dialogue continues to remain at an initial stage (Interview with Abp Daniel). Dialogue between Catholics and Muslims occurs rather in a common involvement in issues of human liberation and development, social justice and the reconstruction of society. It is only in this context that informal encounter between Catholics and Muslims happens. It then takes place at grassroots level which is precisely the place where one can discover what is already happening in practice between Catholics and Muslims, including the area of AIDS. An example of such practical dialogue has been the contacts with various Muslim communities established by the “Damietta” Initiative.

With respect to Muslim-Catholic involvement in addressing the HIV epidemic, the state of mutual contacts is rather complex. In the initial stage of the disease, and also later, Islam did not feature predominantly in the fight against HIV in South Africa or in international discussions of the work of FBOs. The main reason was a low prevalence of HIV among Muslims in the 1980s and 1990s. Muslims have always seen themselves as protected against the AIDS epidemic because of the social values system prescribed by their religion. Nevertheless, a rapid increase in rates of infection throughout the Muslim world suggested that Islamic values were not an adequate defense. Yet the connection of ethical and

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14. There is some evidence that attest to this fact. In terms of an overall lower HIV prevalence rate, a study conducted in 2005 of three Muslim residential areas in the Cape Town area, found that 2.56% of Muslims living there were HIV positive. This is significantly lower than the antenatal data estimate of 15.1% published by Health System Trust, 2007. See Kagee, A, Toefy, Y, Simbayi, L, Kalichman, S, “HIV prevalence in three predominantly Muslim residential areas in the Cape Town metropole” (*South African Medical Journal*, 95/7 July 2005), 512-516.
moral issues with HIV risk behavior made the social stigma associated with AIDS more pronounced in Muslim societies (Hasnain 2005:23). Islamic values system did not immunize Muslim communities from perceived social ills such as unprotected pre- and extra marital sex, as a study in the Muslim Community in Cape Town found. The above denial and misconception that Muslims were exempt from the spread of AIDS in their communities was one of the reasons that they were rather reluctant to engage in a common struggle against HIV/AIDS. To refute this distorted message about Islam and HIV prevalence among South African Muslims (mainly coming from the pulpit), a religious organization named “Positive Muslims” developed a theology of compassion – a unique way of reading the Qur'an and understanding the Prophetic precedent that focuses on God who cares deeply about all creation (Willson 2008).

The organization is an interesting example of the Muslim response to the epidemic in South Africa, building common bridges between Muslims and others, including Catholics in the Cape Town area. The organization offers education, counselling and support to Muslims living with HIV, conducts public awareness campaigns, engages in ongoing research on HIV/AIDS prevalence in the Muslim community, and explains the relationship between Islam, compassion and being non-judgmental. Its specific focus is on providing one-on-one communication and support to PLWHA through a buddy system through which they can have a personal friend with whom they share their feelings and emotions. The organization connects with the wider interreligious community through calling for building all the relevant structures (both in government and in civil society), for deeper awareness, and for greater non-judgemental support to PLWHA. Its interreligious dimension can be seen, for instance, in a number of

15. Muslim women were almost 4 times more likely to report infidelity as a reason for divorce than men. In the same study, more than half of the sample of 600 divorced couples got married to legitimize a pre-marital pregnancy. See Toefy, M Y, Divorce in the Muslim community of the Western Cape: A demographic study of 600 divorce records at the Muslim Judicial Council and the National Ulema Council between 1994 and 1999 (Cape Town: UCT, 2002).

16. The expectation is that the buddy is then able to give emotional support as well as help to monitor a HIV-positive member's health. This strategy is in contrast to 'traditional care programmes [which] often focus on treatment and counselling services, without taking into account emotional support in the form of friendship' (“Positive Muslims”, http://www.commit.com/en/hiv-aids-africa/node/129205) <21 November 2012>

workshops on AIDS, Islam and women organized for women from various socio-economic and religious backgrounds. These workshops resulted in the empowerment of hundreds of women becoming leaders themselves (Willson 2008).

The “Gift of the Givers” is another Muslim NGO that addresses HIV/AIDS epidemic in its own unique way. The foundation was initiated by Dr Imtiaz Sooliman in 1992 with the aim of giving humanitarian aid to people all over the world including South Africa. It has been supplemented by a host of secular and religious bodies and run by a group of Muslim professional development workers who have at their disposal a wealth of knowledge and expertise. Over time, the “Gift of the Givers” project became a widely recognized non-governmental, humanitarian, and disaster relief organization of African origin (Interview with Dr Imtiaz Sooliman). Among some of the project's diverse activities, which have benefited South Africans over the years, there is the support of various HIV/AIDS projects and programs. The main ones include help offered to the “Bhekuzulu” self sufficient project, run by the AIDS Foundation of South Africa (AFSA), the first established South African AIDS NGO in 1988 and the “1000 Hills Community Helpers” in KwaZulu Natal, whose aim is to improve the lives of children and adults infected and affected by chronic illnesses such as HIV.

The question of interest for this study is the foundation's contribution to interfaith relations in the area of AIDS. Does the “Gift of the Givers” project establish any form of dialogue with the religions in the course of its activity? There are no indications that the foundation engages in any direct collaboration with other religions in addressing the epidemic. It is neither structured on multi-religious participation nor does it directly cooperate with any church, including the Catholic Church, at official or grassroots levels. Any involvement of members of other religions supporting the foundation is certainly not at an institutional level. Rather

20. The Foundation helped to equip a computer room, library, children's school up to grade R, a toddlers’ creche and a separate baby creche. It contributed to a kitchen that is run efficiently where volunteers prepare and serve meals to approximately 400 - 1700 people per day, as well as a clinic with a nursing sister, enrolled nurse, pharmacy and dispensary. See “World Aids Day 01 December 2010 - Gift of the Givers”, available at http://www.giftofthegivers.org/world-aids-day-01-december-2010/index.php, accessed 15 October 2012.
representatives of other religions or churches cooperate with the foundation, or serve as experts and professionals in a particular field or area. They do it on humanitarian grounds. Such support is therefore neutral with respect to religious affiliation. The foundation creates a platform\textsuperscript{21} for them for participation which crosses cultural, political, ethnic, social and religious boundaries (Interview with Dr Sooliman). In this sense, the foundation is an example of the practical dimension of dialogue with diverse cultures and religions and indirectly contributes to interreligious cooperation on HIV.

A good example of work that directly crosses the boundaries between formal and informal dialogues is the “Damietta” Initiative run by the Franciscans/Capuchins in Pretoria.\textsuperscript{22} The project was officially endorsed by the Franciscan Family in Rome in 2005. The Initiative is international and focuses on direct dialogue with Muslim communities at grassroots level and on building peace and introducing non-violence across the entire African continent, including South Africa. At the formal level, “Damietta” works with the SACBC and the Muslim Judicial Council SA in addressing the root causes of conflicts. Drawing on national, international, religious, and secular resources, the project especially focuses on organizing Pan-African Conciliation Teams (PACTs) to monitor cultural tensions and promote interfaith understanding through courses on mediation and arbitration. Through the activities of PACTs, the Initiative reaches people of all faiths mainly through school and religious, youth and community-based organizations. Although the main focus of the project still remains peace-building, the PACTs also aim at cross-cutting issues such as HIV/AIDS and gender. In this regard the Initiative mainly addresses hostility and violence related to HIV/AIDS.\textsuperscript{23} Its interreligious dimension is also seen in HIV-education programs which continue to target people of different religions at grassroots level and encourage religious leaders, school and community groups towards non-discrimination, gender equality, religious and social tolerance and peace.

The “Damietta” Initiative constitutes an important example of

\begin{footnotesize}
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\item[21.] A good example of this “locus” is the contribution made by many medical doctors from across the religious spectrum. Medical personnel is one group, but not the only one, which is involved in the foundation’s works (interview with Dr Sooliman).
\item[22.] Available at http://www.damiettapeace.org.za <15 December 2012>
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dialogue of life and practical cooperation between Catholics and Muslims in South Africa which is the result of its response to challenges, including the HIV epidemic, which society has faced since 1994. The project also shows that a positive approach and collaboration among religions is possible and might be fruitful if the collaboration is focused not on what divides the religious groups but on their common goal. The “Damietta” project offers, therefore, a real chance for practical dialogue between Catholics and Muslim communities in South Africa in fighting the HIV/AIDS epidemic.

**Dialogue with Judaism**

As in the case of Islam, formal encounter between the Jewish community and representatives of other religions, including the Catholic Church, remains underdeveloped. The past system of segregation encouraged the South African Jews, as it did in the case of other cultures, to keep their distinct ethnic identity, separateness and Jewish nationality. Religiously, the South African Jews have been regarded as conservative with a strong attachment to tradition. These conservatives belong to Orthodox Judaism (85%). The others (10-15%) belong to progressive Jewish congregations. Within Judaism, therefore, there are various streams and diverse inter-group relations, with emphasis on interaction between orthodoxy and reform (Hellig 1995:155-176; 1984:95-116; 1986:233-242). This indicates a real proliferation of various religious tendencies among South African Jews.

The research revealed that the Jewish synagogues in particular play a vital role in addressing the AIDS crisis by undertaking education and prevention programs; providing welcome and support for people living with HIV/AIDS, their families and friends; and by working with AIDS service and advocacy organizations in South Africa. The South African Jewish community provides outreach programs mainly through “MaAfrika Tikkun”, a Jewish charity organization. The organization sponsors a food kitchen in the township of Delft, which serves 300-500 people daily.

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people every day, and is active in Mfuleni located on the outskirts of Cape Town. It runs a weekly project to support those living with HIV/AIDS in the areas mentioned. The “MaAfrica Tikkun” works mainly in partnership with government to develop neighbourhood community centres into functional hubs for learning, skills development and safe recreation. The goals and objectives of “MaAfrica Tikkun” are to make a difference by caring for the vulnerable children and youth, as well as caring for those who impact their lives. This is done through a set of core activities such as child and family services, early childhood development programs, school health, primary health care, and support services (feeding and nutrition, transport, reaction and distribution). The main intention behind the Western Cape programs is to build strong leadership for the future through informal education projects in schools and catalyze community development projects.

Concerning mutual collaboration on HIV/AIDS between the Jewish community and the Catholic Church, not much has happened so far at the practical level. “MaAfrica Tikkun” operates in cooperation with government without any interreligious outreach. Yet at the official level, for instance, in 2006 leading Catholic cardinals and Jewish rabbis addressed the plight of AIDS orphans and the role of religious leaders in fighting HIV/AIDS following a 4-day International Jewish Catholic Liaison Committee conference in Cape Town. Although the meeting differed with regard to prevention strategies, they called for unrestricted palliative care and appropriate attention for all those suffering, threatened or victimized by the AIDS epidemic. They also called for an end to HIV/AIDS stigma.

Engagement with Hinduism

There are no indications of formal IRDC between Hinduism and the Catholic Church in South Africa. This is because the Hindu community as a real minority was isolated during colonial and apartheid times, with no possibility for developing official interfaith relations. Further, South

African Hinduism has always been specific in its character and has not concentrated on formal interreligious contacts. The uniqueness and complexity of Hinduism in South Africa can be seen in its four streams: Sanathanism (traditional and ritualistic Hinduism), Arya Samaj (focused on formless Deity), neo-Vedanta (associated with the Ramakrishna Centre and the Divine Life society), and Hare Krishna (linked with International Society for Krishna Consciousness). The three last streams or movements came to South Africa only in the twentieth century and constitute reform Hinduism or neo-Hinduism (Maxwell, Diesel and Naidoo 1995:180-182,191-199).

Although dialogue of life, work, and spirit between Hindus and Catholics exists mainly through intermarriages and cohabitation in the same areas, it is still very limited due to the complexity of Hinduism. The most inclusive approach to other religions is represented by neo-Vedanta Hinduism associated with the Ramakrishna Centre of South Africa in Durban and its ashrams. The same inclusivist approach to religious matters and religions is shared by the Divine Life Society with its headquarters in Durban. If any formal dialogue were to be established with Hinduism in South Africa, it would be with the neo-Vedantic Hinduism (the Ramakrishna Centre and the Divine Life Society) on the grounds of their universalistic convictions and beliefs. It would also be possible to establish a common practical bridge between the two neo-Vedantic movements and the Catholic Church, especially since the Centre and the Society have already engaged in numerous charitable activities mainly among the disadvantaged such as school feeding schemes, distribution of clothing and self-help materials, or providing clinics for the poor and PLWHA (Maxwell, Diesel and Naidoo 1995:180-182,191-199).

There is no study at present that projects the potential impact of a Hindu response to HIV beyond that which one can guess from an understanding of its traditions and moral values, but there are at least three reasons one should be encouraged. Firstly, there is a historical precedent for a Hindu response to disease and suffering that can be seen in the many associations addressing the needs of people in Hindu

27 There are also other neo-Vedantic organizations besides the Ramakrishna Centre and the Divine Life Society in South Africa. The best known are: the Chinmaya Mission (Durban), the Vedanta Mission in Isipingo Hills (Durban), the Adai Shankara Ashram in Johannesburg, the Gita Mandir in Raisethorpe (Pietermaritzburg), and the Saiva Sthithantha Sungum. See Maxwell, P, Diesel, A, and Naidoo, T, “Hinduism in South Africa”, 196.
communities in South Africa. Secondly, today it is the norm, not the exception, for Hindu faith leaders to be engaged with leaders of other faith groups in discussions of the role of FBOs in responding to HIV. Thirdly, strong parallels exist between Hinduism and the Abrahamic religions (Judaism, Christianity, Islam) in how it describes its ideal way to God through love and compassion for others. Yet in the first decade of the disease, like Islam, Hinduism did not feature in national and international discussions of the work of FBOs concerning the fight against HIV. This was mainly due to a low prevalence of HIV/AIDS among South African Hindus during the 1980s and even later (0.3% by 2008) (South Africa HIV&AIDS Statistics 2010). However since the early 1990s the various Hindu groups in South Africa, together with other FBOs, have played a significant role in the response to AIDS and have mobilized strongly against AIDS in their communities (Report on the global AIDS epidemic 2008).

The study of various streams of Hinduism in South Africa indicates that although there is generally a lack of mutually organized events by Catholics and Hindus, which would encourage a more fruitful engagement between the two, this does not mean that there is no basis for dialogue and collaboration in the area of the AIDS. In fact, Neo-Hindus supplement health care in numerous poor areas of KwaZulu-Natal through the Sai Baba medical camps and the Ramakrishna clinics. Both organizations utilize provincial clinic facilities, bring in volunteer medical specialists and donate medication on weekends. The Ramakrishna clinics also run paediatric camps every 2 months for 500 children (The Ramakrishna Centre of South Africa). The Sai Baba and the Ramakrishna projects indicate that establishing a common practical bridge between neo-Hindus and Catholics can be possible and fruitful.

**Encounter with Buddhism**

The general impression about the Buddhist community in South Africa is that it is open to, and focused not only on dialogue with other believers but also with the diverse cultures present in this country. This openness can be seen in the spiritual activity of the main Buddhist meditation centers through which Buddhism reaches those who search for religious experiences.

experience. Concerning interfaith dialogue Louis van Loon makes a very important comment that Buddhism in South Africa is neither dogmatic nor focused on missionary activity to gain converts (van Loon 1995:213-215). Its inclusiveness can be seen in the diversity of participants who visit the centers or attend meditation retreats. They come from a wide spectrum of religions and cultural backgrounds.

With respect to the Buddhist response to HIV epidemic in South Africa, in 2000, the Buddhist Retreat Centre in Ixopo, Kwa-Zulu Natal, initiated the “Woza Moya” Project. This is an HIV/AIDS community care and support project which provides services in the areas of home based care, orphan intervention and food security. The main guide and supporter of the project is the Dharmagiri Trust. The gradual development of the “Woza Moya” project includes initiation of home-based care for the community of Ufafa in 2000, followed by the project's first outreach program in the surrounding areas. In 2001, the AIDS Foundation of South Africa (AFSA) became “Woza Moya's” biggest donor. At the beginning of 2002, the project became officially a non-profit organization. In September 2004, “Woza Moya” went into partnership with the Heifer Project to address poverty, unemployment and malnutrition in the Ufafa community. This resulted in the setting up of the Food Security Program which identified and helped the most vulnerable families in the region. A year later (2005), the project moved into the new community hub near Ixopo (2005). In 2006, director of the program, Susan Hedden a therapist from the Karuna Institute in the UK, joined the Religious Sector Forum in Johannesburg thus representing the Buddhist community. This year the project will celebrate 13 years of existence.

The “Woza Moya” project has been researched and identified as the most prominent response from the Buddhist community with regard to HIV and AIDS in sub-Saharan Africa. There is no indication of any official engagement of the project with the Catholic Church. The “Woza Moya” is rather supported by Catholics through their personal involvement as volunteers in the Ixopo area. If any form of dialogue exists among the Buddhists and Catholics in South Africa, it is rather on an individual basis through the work of the “Woza Moya” initiative and mainly through the meditation centers.

30. This becomes evident while studying the Project’s guiding principles and team reflections. See “Woza Moya” Project – “Team reflections for 2010-12” and “Organizational development: guiding principles”, available at www.wozamoya.org.za <10 December 2012>
African tradition's contribution

Concerning dialogue with African tradition, serious encounter with traditional religions (ATRs) is an essential condition for Christianity. This is the case especially if the church does not wish to remain outside of African culture as something foreign or alien. There has been no evidence of any formal dialogue between African traditional religions and the Catholic Church. Practical dialogue is a much more accessible approach. Undoubtedly the ATRs can make a significant contribution to the ongoing struggle against the epidemic. There are numerous ways in which the ATRs could contribute to this process and engage in cooperation with other religions. First, through the emphasis on the spirit of community and solidarity, the traditional religions can contribute to the renewal of communal solidarity among the South African people who are confronted with new kinds of family life in large industrial areas and with fragmenting, which is the result of isolationist interests of various groups including political bodies. Second, in the context where South Africa faces the HIV epidemic and where other related diseases are threatening the population, the traditional healers in particular have a significant role to play in this regard. The healers do not only treat the obvious physical symptoms of the disease but approach it in a more integral and holistic way. They seek to point out its underlying moral, psychological or spiritual causes thus empowering the sick in a new and effective way (Thorpe 1992:118-123).

There are more than 300,000 traditional healers in South Africa. HIV programs and STI testing and treatment programs should therefore develop stronger linkages with traditional healers providing treatment of STIs, secondary infections, pre- and post-counseling for the individual and the family (Rogerson 2002). In fact, there have already been attempts to combine the best of the traditional and the medical systems. A variety of projects looked at the usefulness of traditional herbal remedies for the treatment of HIV-related illnesses. Such collaboration started in the Western Cape in 2005 to encourage medical cooperation between doctors and traditional healers and cross-referrals between them in HIV/AIDS interventions. It was believed that such cooperation would help to avoid potential disruptions and interactions with ARV treatments through prescriptions by traditional healers and to persuade more male
clients to know their HIV status. Furthermore, studies have looked at traditional healers' perceptions of sexually transmitted infections as well as HIV infection. With this information, collaborative projects started training traditional healers as educators and counselors to disseminate information on HIV and sexually transmitted infections in their communities and to their peers. One such project involved the Inanda healers from the Valley of a Thousand Hills, Kwa-Zulu Natal. In 2000, community leaders called for help in strengthening their response to the AIDS epidemic. As a result, social scientists and medical doctors began working in partnership with local traditional healers on HIV prevention projects.

These are only a few examples of possible areas of contribution which African tradition and religion can bring to the common fight against HIV. These seem to be the areas where the Catholic and the Christian churches should begin their conversation with the traditional religions to establish dialogue of “praxis.” It is noteworthy that some of the elements, which would constitute a “practical bridge” between the Catholic Church and traditional religions and African culture, also appear in the previously mentioned Catholic guidelines for IRDC (FE 7).

6. EVALUATION AND THE WAY FORWARD IN IRDC ON HIV/AIDS

Despite their differences in beliefs, teachings, rites and rituals, South African traditionalists, Buddhists, Christians, Hindus, Jews, Muslims and others make human beings the centre of attention and try to guide their faithful to a meaningful, dignified and confident life. All these traditions are witnesses to how in the past religion contributed to hope in South Africa and how the entire nation still needs to be affirmed fully by

31. Nine traditional healers were recruited to work with five community health workers in five townships on the outskirts of Cape Town, and it has been fairly successful. See Werford, J, Involving traditional health practitioners in HIV/AIDS interventions: Lessons from the Western Cape Province (Cape Town: Center for Social Science Research, UCT, 2006).

religion. Nowhere is this truer than in the attempts of religions to deal with human sexuality. Nowhere has this become so obvious as in the responses of religious people, hierarchies and authorities to the HIV epidemic which has developed into a crisis in South Africa and become a truly interfaith concern in the widest sense of the word. The epidemic touches and challenges every faith community in South Africa. Through trying to find constructive ways of dealing with HIV, religions in South Africa have become a source of hope for those afflicted and a source of support for society.

It is regrettable that in the initial stage of HIV/AIDS in South Africa, religions did not always take a leadership role willingly or on their own initiative. Many leaders from established religious traditions have only later acknowledged their initial complicity in denial and silence regarding HIV. To a great extent this has changed and nowadays an increasing number of monks, priests, imams, nuns and pastors are receiving training on HIV-related issues, and are in turn raising awareness in their places of worship. They are increasingly conscious of their special role in HIV prevention and their responsibility in challenging discrimination, stigmatization and promoting acceptance. In this context IRDC on HIV can be seen as important and necessary. Through such dialogue religious and spiritual leaders can influence many sectors of society, including government. Their position on sexuality, sexual activity, and gender can impact the content and direction of HIV programs in South Africa. This is especially true in the context where religions have large established national networks, often with far greater urban and rural coverage than government or non-governmental organizations.

This research disclosed that in South Africa the Catholic Church has been involved with multiple aspects of AIDS response for the last 30 years with particular focus on awareness, education and care services for PLWHA. The church's activities which include various programs and projects have been well established at grassroots level and appear to be integrated into larger service-delivery frameworks, yet generally they have remained limited in interfaith collaboration and remained specifically Catholic. All the Catholic FBOs also appear to be well-resourced, closely committed to people and communities, yet less focused on formal interreligious cooperation. Nevertheless, this Catholic “separateness” is common to all Christian churches and
religions in South Africa. Various factors have been pointed out which explain why the religions and Christian churches run their HIV programs and projects on an individual basis.

This means that generally in South Africa there is little formal and concrete experience of interfaith work on HIV/AIDS regarding meetings of officials or common interfaith projects between Catholics and other believers. Therefore, the paper looked not only at “what is”, but also at “what might be” concerning formal and informal interfaith encounter. In South Africa there is rather evidence of informal interreligious contacts and cooperation on HIV/AIDS, mainly through FBOs and NGOs. Indeed, there exists a well established interfaith dialogue of life and praxis at the grassroots or community level. The “Damietta” Initiative, “Positive Muslims”, “Gift of the Givers”, “Woza Moya” and many others are the best examples of such practical engagement. The works of these organizations proved once more that interfaith relations in South Africa cannot be programmed at the table but happen at the level of “praxis” and in the day to day contacts.

Concerning the way forward, there is undoubtedly a need for increased IRDC on HIV prevention and care for PLWHA, which requires further exploration. The justification for increased interreligious dialogue and HIV work should be seen in the religions' gaining more by working together. They already have the reach, experience, capacity, spiritual mandate and sustainability to work on HIV more than other institutions. The greater the number of different religious organizations coming together to use these means, the greater the number of people of different religious persuasion will benefit from it. This potential will not be fully used unless it is given priority, support and resources by communities, religious leadership, government, and international donors. Both faith organizations and spiritual leaders should continue to champion the need to work together and must be given the resources and support they require. However, this is dependent on the decision of religious leaders.

There is another aspect to IRDC on HIV in South Africa that is imperative, such dialogue must be inclusive of minority religious groups. In many places in South Africa, poor people tend to belong to popular, indigenous or minority religious traditions, rather than the more established ones. Supporting dialogue or cooperation that includes only established religions might perpetuate the marginalization of vulnerable
groups. It is critical that interreligious cooperation continues to be supported at community level. Cooperation between the Catholic Church and the main religions is important but it also requires effective and practical engagement with indigenous minority groups. Finally, a unique benefit of mutual engagement of religions on AIDS in South Africa will be the reinforcement of religious diversity itself. Equally, a common response of the religions to the struggle against the epidemic will give the religions a sense of being adequate, responsible and necessary in the democratic South Africa.

CONCLUSION

The aim of this research was to examine the existing collaboration between the Catholic Church and the religions in South Africa in the struggle against HIV/AIDS. The paper described the HIV epidemic as a real crisis for all religions. It introduced the main religious contributors and stressed the importance of an interreligious collaboration in this epidemic. It also examined the state of relations between the Catholic Church and the various religions in the common struggle over the last 30 years. The study pointed to various cultural, economic, political and religious factors in South Africa, some of which can be viewed as contributory to IRDC and others as obstacles to such dialogue. This paper further discussed various examples of the Catholic and the religions' involvement in the fight against HIV and showed that the religions and the church offer an essential service to society by providing leadership to address issues of stigma and promote HIV prevention, education, and care.
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CONDOMS AND CONSCIENCE IN THE CONTEXT OF THE HIV AND AIDS PANDEMIC

Charles P. Ryan

Since incidence of HIV status in humans is primarily identified with sexual activity, a moral dimension has been discussed from the beginning. When medical and social agencies began to advocate the use of condoms as a means of containing the spread of the condition the Catholic Church in particular criticised them as being 'part of the problem' rather than a help towards a solution. Other religious groups, including other Christian denominations were frequently more tolerant and pragmatic, but the official position of the Catholic Church remained basically unchanged until 2010 when Pope Benedict XVI, in an interview with a German writer, appeared to adopt a more lenient attitude to the use of condoms. This paper will explore the reactions to the Pope's 2010 statement and see whether they constitute a change in the Church's position on condoms.

THE PROBLEM

The development of Antiretrovirals has made progress possible in the postponement of death and the control of opportunistic diseases in HIV positive patients. Many HIV positive people are now living reasonably healthy lives and have an acceptable life expectancy. However, the only reliable method of achieving protection from acquiring the disease or becoming HIV positive lies, as it did when AIDS was first diagnosed, in abstinence from sexual activity or fidelity to an HIV negative partner.¹

Even the scientific community is not unanimous about the efficacy of condoms in preventing infection. Nevertheless, I am confident that using a condom has some value in preventing transmission, even if they are not totally reliable in themselves, and are open to error in the manner of their use. Medical workers, Public Health Officials and politicians continue to promote the use of condoms in the hope of, at least, reducing the incidence of HIV status.² On the reliability of condoms one can make the following statements:

1. One is aware that there are other ways of becoming HIV positive than through sexual activity – mother to child transmission, use of contaminated surgical devices etc. – but sexual activity is by far the most prevalent way of becoming positive.
2. The scientific data is not relevant to this paper. Suffice to say that the reader can access large quantities of information and views by using the Google search engine requesting such topics as: “the efficacy of condoms in preventing AIDS”, “Condoms and AIDS”, “Reliability of Condoms” etc. The reader can then form his/her own opinion.

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1. A very high percentage of the human population believe condoms help prevent the transmission of the AIDS virus.
2. Condoms are aggressively advertised commercially as being reliable for that purpose.
3. Very many public health officials, politicians and medical practitioners believe they are reliable, or, at least, useful.

THE ISSUE

Assuming that condoms are useful in preventing transmission of the H.I. Virus, our interest in them is more in the moral implications. Almost from the initial identification of the H.I. Virus, and the suggestion that condoms could be of use in reducing the rate of infection, moralists and religious leaders have been condemning their use. Since the 1968 publication of the encyclical "Humanae Vitae" (Paul VI 1968) the use of all artificial contraceptives, including condoms, had been declared 'inherently evil'. Their condemnation as a protection against AIDS infection was quickly added to the anti-condom campaign. The position of the Catholic Church in general was that the use of condoms to combat HIV was immoral and would, in fact, make the problem worse. Some illustrative quotations are relevant:

Pope John Paul II's position was that sexual abstinence – not condoms – was the best way to prevent the spread of the disease while, as recently as March 17, 2009 Pope Benedict XVI, addressing the media before a pastoral visit to the Cameroun, repeated that AIDS was “… a tragedy that cannot be overcome by money alone, that cannot be overcome through the distribution of condoms, which even aggravates the problems” (Squires 2009).

In South Africa in particular the published view of the Southern African Catholic Bishops' Conference (SACBC) is unambiguous:

The bishops regard the widespread and indiscriminate promotion of condoms as an immoral and misguided weapon in our battle against HIV/AIDS for the following reasons:

1. The use of condoms goes against human dignity.
2. Condoms change the beautiful act of love into a selfish search for pleasure – while rejecting responsibility.

3. Condoms do not guarantee protection against HIV/AIDS.

4. Condoms may even be the main reason for the spread of the disease.

Apart from the possibility of condoms being faulty or wrongly used they contribute to the breaking down of self-control and mutual respect. The promotion and distribution of condoms as a means of having “safe sex” contributes to the breaking down of the moral fiber of our nations because it gives a wrong message to our people (SACBC 2001:2).

It is noted here that the bishops' statement draws conclusions about moral dimensions, but also makes judgements in the psychological/sociological domain by predicting how people will react to the wide availability of condoms, as well as the scientific domain when suggesting that the use of condoms would not help to reduce the rate of HIV infection.

Similar statements to that of the SACBC were made by virtually every bishops' conference in the world.

The worldwide condemnation of the use of condoms by the Catholic Church was such that many members of the secular media concluded that the Church was more interested in defending dogmas than in the welfare of people!

There were, however, voices within the Church that appeared to disagree with the Church's official view. The Medical Mission Institute in Wuerzburg, Germany has published a catalogue of many bishops and Church leaders who have spoken out against the wholesale condemnation of condoms (Kieffer 2001). Almost every country had one or two bishops that 'stepped out of line' in making statements that appeared to be at variance with the official Catholic position.

In South Africa, Bishop Kevin Dowling, the Bishop of Rustenburg, made his position clear in many statements and discussions, e.g.
If we simply proclaim a message that condoms cannot be used under any circumstance then I believe people will find it difficult to believe that we, as a Church, are committed to a compassionate and caring response to those who are suffering, often in appalling living conditions. For me, the condom issue is not simply a matter of chastity, but of justice (Byamugisha et al 2002:95).

And in 2011, in a radio interview in the US, Bishop Dowling said: “...We do not distribute condoms. We give people the information they need to make an informed decision in Conscience about what they are going to do with their lives.”

So from the beginning of the AIDS epidemic the Catholic Church had a clearly-articulated position against the use of condoms to prevent infection, but there continued to be a minority view within the Church leadership that expressed a contrary view. There is no indication that the Church made any effort to force the 'mavericks' to step in line with the majority view, and the result was that the members of the Church, as well as the interested secular media, were confused.

The confusion was further compounded when Pope Benedict made a statement shortly after his pastoral visit to the Cameroun which seemed to constitute a turnabout in the Church's position. In an interview with one Peter Seewald, reported in The Telegraph newspaper of London on November 20, 2010, and subsequently published in book form, Benedict said:

There may be a basis (for the use of condoms) in the case of some individuals, as perhaps when a male prostitute uses a condom, where this can be seen as the first step in the direction of a moralisation, a first assumption of responsibility (Benedict XVI and Seewald 2010:99).

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This and other excerpts from the interview were subsequently published by L'Osservatore Romano, but even though some Vatican commentators strove to suggest that the Pope had been misunderstood, the cat was out of the theological bag, and world opinion could be summarised by one reporter's comment: “No Pope has said something like this”! One can understand how the world was confused by this development, coming, as it did, only months after the March 2009 statement made while travelling to Cameroon.

Does this mean that the Church has changed its doctrine on the use of condoms? Many commentators will answer with a resounding YES, and it has been observed that other statements from Church leaders have become very rare. But the situation is not quite so simple!

THE REALITY

There is no necessary conflict between the 'rigid' approach to condoms and the 'tolerant' approach. Both are valid and authentically Christian. The anti-condom statements can be said to deal with Objective Morality while the tolerant position is dealing with the Subjective Morality (Conscience). Let me explain:

OBJECTIVE MORALITY

The mandate of the Church from Christ to “Go, teach…” (Matt.28, 19-20) remains. This teaching duty extends to moral matters as well as to dogmatic matters. The duty of the Church is to teach God's Law or the Moral Law. Assuming that there are precepts of divine origin which are binding on humanity at large, and assuming that those precepts are found in Scripture and Tradition and interpreted by the Church, then that is what has always been taught by the Church and will continue to be. Pope Benedict, for example, was referring to such when he recently made a statement on abortion: “Direct abortion, that is to say willed as an end and as a means, is gravely contrary to the moral law.”

4. This was part of an address from the Pope to representatives of 179 countries that are accredited to the Holy See diplomatically. The address was presented in the Vatican on January 7, 2013 and subsequently reported in Zenit, the Vatican website. (www.Zenit.com)
that the Pope did not say Abortion is a sin because sin requires additional elements which we shall discuss later). The Moral Law is out there. It is to be observed by all. It is in the External Forum. Catholics and people of good will are obliged to inform themselves on the content of the moral law and live accordingly.

It is easy to imagine the Church taking a position when there is a question of unjust aggression, destruction of innocent lives, slavery, unjust laws etc. etc. In the matter of condoms the Church will surely say: “Sex is to be enjoyed by partners within marriage. Overt sexual activity outside of Marriage is against the moral law. Any government policy that facilitates or encourages sexual activity outside marriage is contrary to the moral law” It is not difficult to continue and say: “The government of South Africa has a policy that encourages promiscuous sexual activity among the unmarried. Therefore the policy of the government of South Africa is against the moral law (immoral).” There is an assumption in the latter statement, namely, that the free supply of condoms will, in fact, increase the promiscuity of unmarried people. It could well be replied that, in fact, youths in South Africa are already quite promiscuous and any increase in their sexual activity caused by government policy is offset by the decrease in HIV infection that will be achieved. In short, one opinion says “it is good to distribute condoms” while the other opinion says “to distribute condoms will increase immoral behaviour.”

**SUBJECTIVE MORALITY (CONSCIENCE)**

Actions are performed by people, and only people can incur guilt. Someone can only be guilty when he/she is aware of having transgressed the moral law. Traditionally, the Church has always taught that for an individual to be guilty three elements must be present in the action: “A mortal sin is the transgression of a divine law in a grievous matter with full knowledge and consent” (Jone and Adelman 1955:45).

The above quotation is from a moral theology manual which was published in English in 1955, but which had been originally published in German in 1929. It is one of the well-respected moral theology handbooks that were in use in Seminaries all over the world in the nineteenth and twentieth centuries, but which were replaced only after Vatican II by less systematic works.
It should be noted, again, that mortal sin requires:

1. Transgression of a divine law in a grievous manner
2. Full knowledge
3. Full consent.

An individual knows that a certain action is a transgression of a divine law by using his conscience. The particular action that is judged by conscience might or might not actually be a transgression of divine law, but the individual makes that discernment based on the information available to him/her. The information available may be true or defective when compared to the moral law taught by God and the Church. That is why a conscience may be, in fact, true (if in accordance with Objective Morality) or erroneous (if it is contrary to Objective Morality). However, it is crucial to be aware that, whether one's knowledge is true or erroneous, for an acting individual, the only knowledge that is relevant, is the knowledge that the individual actually possesses at the time of the action. This can be summarised by saying that Conscience must be followed whether it is true or false. The issue of erroneous conscience, as well as his teaching that erroneous conscience must be followed, is clearly and comprehensively discussed by Thomas Aquinas.⁵

The supremacy of Conscience was supported by Pope Benedict when he said:

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 the Church (Ratzinger 1968: 134).⁶

In talking about Conscience in this way he was merely repeating what is found in the Old Testament, in the New Testament, in the writings of Thomas Aquinas and other theologians, in Vatican II documents and, indeed, in logical and rational thought on the matter of human dignity, freedom and autonomy (Ryan 2003: 2-18).

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⁵ Thomas Aquinas, Summa Theologica, Ia IIae, Q. 19, Art. 5, et passim
⁶ This was written by Ratzinger before he became Pope, but since 1968 he has never made any attempt to change what he wrote.
JUDGING

On one occasion I was having difficulty persuading a class of seminarians that not all HIV positive youths who are sexually active outside of marriage are guilty. I mentioned the difficulty in conversation with a group of priests, only to be greeted with a silence that was eventually broken by someone saying: “But, are they not guilty?” It is a source of constant surprise to me to discover how many people, including leaders in the Church, are not aware of the distinction between the moral law and what an individual may conclude in Conscience.

Jesus made it very clear that we should not judge: “Do not judge and you will not be judged; because the judgement you will get, and the standards you use will be the standards used for you.” And “How dare you say to your brother, 'please, let me take the splinter out of your eye' when you have a log in your own eye? You Hypocrite!” Even when Jesus was dying at the hands of false accusers, he said to his Father “They do not know what they are doing.” So, we are obliged to teach but forbidden to judge. It is surely one of the greatest occupational hazards for religious leaders (and teachers of moral theology!) to follow on their teaching about morality with a desire to verify that our teaching is observed. The fact is that the only way we can know the state of conscience of another is when that person reveals it to us (as, for example, in the Sacrament of Penance).

This teaching is a wonderful liberation for us who are involved in pastoral work. We are freed from the tendency to assume that those we minister to are guilty of sin, especially if they are HIV positive outside of marriage. The only duty of Christian pastoral workers is to be compassionate to those who are suffering (“Be compassionate as your heavenly Father is compassionate”) and leave judgement to God.

But there will remain a niggling doubt: “Maybe they are guilty. After all, they are breaking God's Law. My duty is to offer them forgiveness.” Here we must look at the present-day circumstances.

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7. Read Matthew 7, 1 – 5.

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THE SIGNS OF THE TIMES

While we are explicitly forbidden to judge the conscience of others, as discussed above, it is possible to investigate the methods by which consciences are developed and formed, and the likelihood that, in a particular setting, they will correspond with the Objective Moral Order. Psychology: Jean Piaget (Piaget 1965) and Lawrence Kohlberg (Kohlberg 1972) were among the first empirical psychologists to conduct substantial studies of how the capacity of people to make moral judgements develops. What is of particular interest to us is the stage (level) of growth which Kohlberg referred to as the Conventional Level—a time of human growth ideally occurring between the age of 12 years and 16 or 17. A person at the Conventional Level accepts moral values from those on whom he or she is emotionally dependent. In practice, this means that the teenager (for that is what we are discussing) will accept the moral norms of their peers. The notion of 'peer pressure' is very familiar, but what is important in the work of psychologists is that they demonstrate that teenagers have no other way of knowing what is right other than from peers and others where there is emotional dependence. The only way for parents and moral teachers to effectively influence the moral norms of teenagers is for them to maintain a strong emotional relationship with them, and this is something which occurs very infrequently in modern urbanised society. The significant relationships are more likely to be with peers, musician idols, teachers, sports idols etc. and it is their behaviour that will determine the moral norms of the teenager.

Observing South African society one must conclude that government, teachers, peers, musicians etc. openly scorn the moral teachings of the Catholic Church. A Catholic youth growing up in such a society needs to be strongly influenced by Christian parents and religious leaders who are able to communicate with them at the emotional level, but in many cases this does not happen. The result is that the teenager may continue to follow Catholic observances – conform in the home, and attend Church services with family - but will take moral norms from people outside that environment. One can conclude that young people in South Africa (and


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much the same can be said of most of the rest of the world) grow up in a *morally toxic environment* and would need very special instruction and emotional and social support to withstand it.

**SEXUALITY AMONG THE YOUTH**

I am in possession of a sheaf of reports compiled by governmental agencies, NGOs, and academics that indicate that, by the age of eighteen about *eighty per cent* of young people in South Africa are unmarried but sexually active (not to mention a recent statistic that says that the first experience of sex by *thirty per cent* of young men in South Africa is rape!) (Smith 2012:7).

An interview conducted by a doctoral candidate in Kwa-Zulu Natal gives the following shocking example of attitudes:

“Question: How many girlfriends do you have?
Answer: I have six girlfriends in total.

Question: How do you spend your time with them?
Answer: I divide my time amongst them and I visit them at different times so that I can spend time with each of them. I tell them that I love them but the truth is that I really love one out of them all. I show my love to her by having sex with her without a condom. I trust her and I believe that I am her only boyfriend. When I have sex with the other ones I use a condom. If you have sex with someone using a condom it means you do not trust them and you do not love them. If you do not use a condom it means you love that person and you trust her” (Zwane 2003:63).

By complete accident and co-incidence it was subsequently discovered that the interviewee was President of the Youth Group in his Church Community and received the Eucharist regularly. Some will find this hard to believe, but it is quite possible that he was living his life in the community and in the Church in good faith!

Attending a workshop with medical professionals I once asked a doctor who worked full-time in helping HIV positive patients Whether...
she found that Catholics were less likely than others to be sexually active and HIV positive. She laughed and said: “You must be joking. There is no indication whatever that there is a difference!”

A research project published by North-West University, South Africa in 2011, and entitled: “Cohabitation and premarital sex amongst Christian youth in South Africa today: A missional reflection”, while weak on empirical data, nevertheless recognises that extra-marital sexual activity is a huge problem amongst Christian youth and constitutes a “great threat to the institution of marriage” and that a “culture of cohabitation” is very much the norm among Christian youth in South Africa (Mashau 2011). This is but a further confirmation of information available from diverse sources.

**SOME CONSEQUENCES**

We may draw certain conclusions from the above discussion:
1. An extremely high percentage of young people in South Africa are sexually active.
2. This is confirmed from empirical data sourced from Government, NGO's and academic research.
3. As Christians we are enjoined not to judge the guilt of those whose behaviour is in conflict with long-established Objective Christian Moral Teaching which says that overt sexual activity is for married couples only.
4. The findings of psychology and the experience of those who work with young people strongly suggests that sexually active young people are not conscious of sin, i.e. their conscience is clear about their behaviour.
5. If they do attend Church and hear what the Church has to say about the moral law and sexual activity, their reaction can be summarised by their saying: “They don't understand. If they knew and experienced what I know and live they would not be saying this!” So, the reaction is much more likely to be “They don't understand” than to be “I will not obey.”
6. In short, the assumption is that the vast majority of sexually active young people have no sense of guilt and are not guilty.
7. In order to communicate effectively with our youth and with the world we must speak in a language that they will hear with their hearts as well
as with their minds. We appear not yet to have developed such a language and we are losing the youth. They are not guilty but they are harming themselves and society in a disastrous way, not to mention the scourge of AIDS that will not go away.

8. What is said about the youths is almost equally true of adults. What Piaget and Kohlberg and others have proven is that a very high percentage of people at the Conventional Level of Moral Growth never mature further into autonomous adults who can think and act autonomously. They are just as likely as the youths to conform to the moral norms of the surrounding society, and just as unlikely to be guilty of sinning in doing so.

**WHAT HAS ALL THIS GOT TO DO WITH CONDOMS?**

We have discussed the fact that a high percentage of South Africans – youth and adults – are sexually active outside of marriage. This is against the Objective Moral Law. We have also seen, however, that because of the sexually toxic environment in which they live it is most unlikely that they are conscious of any guilt in so doing.

Considering that Pope Benedict XVI has said that for a male prostitute to wear a condom could be: “... a first step in the direction of moralisation, a first assumption of responsibility” can we not equally say that the innocent masses who are sexually active in South Africa would be acting responsibly in using a condom? How much more would this be true of women who are vulnerable to sexual violence and rape? How much more would it be true of mothers whose husbands are HIV positive while they are still negative? How much more would it be true of women who have to have recourse to prostitution to survive and support their children? The wearing of a condom may not be totally reliable, but it is something in a desperate world.

We will not recommend condoms, or even less would we insist on their use, but we can make the necessary information available to those who are vulnerable and, as Bishop Dowling said: “...let them make an informed decision about what they are going to do with their lives.” We are actually speaking about people who are not actually free. Some are physically deprived of their freedom; others are emotionally immature and therefore not autonomous – but both groups are, in fact, incapable of sinning by virtue of their lack of consent. Nothing will be achieved, however, by
insisting that 'condoms are part of the problem and will make things worse'!

**OBJECTIONS**

When morality is discussed in the above terms certain objections frequently surface:

1. Are people not obliged to form their consciences, and an informed Conscience will accord with the Moral Law? Answer: How does a conscience become informed? Is it not through education? Whose responsibility is it to provide that moral education to youths? Is it not generally parents and Church? When the family is dysfunctional – single parent, child led, abusive etc. - a situation which is too common in our society - and when the Church has lost effective contact with a large number of its members, then the possibility of having an 'informed' conscience is very low. Informed consciences are much less common that we might think.

2. Must the Church not always uphold certain standards? Answer: Yes, that is part of its teaching mission. But standards are in the external forum and even if someone does not conform externally we have no right to judge the internal Conscience. Likewise, we must be careful about how we impose standards lest, in the process, we present a moralising, judgemental image instead of the caring compassionate image Christ would wish us to have.

**CONCLUSION**

We must not continue to condemn condoms. Their use can be appropriate in many situations. If we are not comfortable speaking well of condoms, let us say nothing. In the meantime, let us actively confront the real issue, namely the tragic sex-promoting environment that exists in South Africa and in the world since the so-called Sexual Revolution that started in Europe and the US in the 1950's and is now hitting Africa like a lethal storm.
REFERENCES


Community-based work and volunteering plays an important role in HIV and AIDS-related healthcare and social services to communities in South Africa. The emergence of faith and/or religious vibrancy in this HIV and AIDS community work requires critical, social and theological scientific research. Therefore a critical question is: Should community-based volunteers understood as a Religious Health Asset due to their faith and/or religious solidarity and vibrancy be considered a new form of being church emerging in a time of HIV and AIDS? This is a qualitative research exploring the phenomenon of HIV and AIDS voluntary work in South Africa from a social science perspective, and then examining the concept of community-based volunteering from a Religious Health Asset perspective. Participant observation and open-ended interview data collection methods were used with 10 volunteers from different community-based projects and from various religious backgrounds in KwaZulu-Natal. This article concludes that faith practices in community-based volunteering can be understood as a religious health asset but not as a new form of being church emerging in time of HIV and AIDS. However, visible faith vibrancy can be attributed to a new form of missionary spirituality of the laity.
THIS STUDY: BACKGROUND

HIV and AIDS Community-based volunteerism, with the evolving of the epidemic, has grown from all angles: VCT (volunteer counselling and testing), medical care, homecare, orphan care, education and so on. For instance, in 2006, research findings show that in South Africa general “volunteer labour accounted for 49% of the non-profit workforce” (Perold, Carapinha, and Mohamed 2006:12). This is a clear evidence of the growth of local community-based volunteering which combines health, education and social development for which HIV and AIDS is the major issue (Thabethe 2006:40-42). Personal experience from the involvement with the organisation, the Sinomlando Centre for Oral History and Memory Work in Africa, working to capacitate other NGOs (non government organisations), CBOs (community based organisations and FBOs (faith based organisations) enhances the awareness about the prevalence of faith vibrancy in HIV and AIDS community-based volunteerism. Thus while providing health and social services to adults and children in households, community-based volunteers are one such a civic grouping that is using faith gestures. It is an observable and an unavoidable act. A substantial amount of work is done around defining the concept of volunteerism and the act of volunteering in general (Mutchler, Burr, and Caro 2003:1269; Williams 2001:1; and Perold, et al., 2006:11).

Clearly from the Theology and Development research studies, and through the African Religious Health Assets Programme (ARHAP) research perspectives on HIV and AIDS, one of the major church-based health initiatives and an indicator of religious health assets is the engagement of community-based volunteers. That is, as key servers in the multisectoral response and action faith initiatives and communities volunteers are also deployed by church clinics, hospices, hospitals and community church organisations and projects (De Jong 2003:10 and ARHAP Research Report 2006:21 and :118). Beyond institutional deployment, individual volunteers including professional people are making efforts to identify with the way Jesus responded to issues of health and well-being of his time. Looking at some of the arguments given about such faith responses to HIV and AIDS, there are observable faith-based outcomes (Schmid 2007:27) such as:

- People's faith impacts on their well-being;
- Faith acts such as prayer impact on recovery of patients;
• People of faith work in health services;
• Faith communities provide health services to their own membership or to a wider public and;
• CBOs with a faith base (FBOs) offer health services.

Researchers in religion and theological studies, agree that faith can be regarded important for the provision of health and well-being by many South Africans. However, a tangible gap is observed in 'the faith acts' fostered and nurtured by volunteers or laity – people with no professional title behind their names. With this consciousness, the value is in this paper contributing towards a critical and a theological sense about the faith gestures seen in HIV and AIDS community-based volunteering; hence, 'what does faith vibrancy in community-based volunteering mean for the institutional church?'

**Method**

This paper is based on a qualitative research method located and focusing on groups in KwaZulu-Natal (KZN). Narrative interpretive techniques are applied to examine:

1. a social science perspective on the concept of voluntary work in times of HIV and AIDS in South Africa;
2. a Religious Health Asset perspective on the faith identity and acts displayed in community-based volunteering in Southern Africa.

The field research and sampling helped in the data collection method among HIV and AIDS CBOs and projects located in KwaZulu-Natal, South Africa. Data was gathered from a sample size of 10 interview informants from different projects and from participatory observation informants at 4 CBO projects workshop meetings. The method of analysis used is found from the 'Social Theology' framework suggested for studies in Theology and Development. This framework is built on the foundational work of the liberation theologian, José Miguez Bonino (1983) in *Towards a Christian Political Ethics*, and it is adopted and critically outlined as a social theology methodology, (i) social analysis, (ii) theological reflection and, (iii) strategies for action. Objective theological theory for analytical argument draws from Leonardo Boff's (1986:155) Catholic concept of ecclesiogenesis, in particular, the author's base Ecclesial model.
PRESENTATION OF DATA AND RESULTS

Participant observation data

Four separate groups from FBOs and CBOs were observed and 2 of these groups are urban-based and 2 are rural-based. These are factually represented below:

**Gender distribution**

- Males: 15%
- Females: 85%

Figure 1: Gender

**Age range distribution**

- 20-25: 15%
- 25-30: 30%
- 30-35: 12%
- 35-40: 17%
- 40-45: 8%
- 45-50: 8%
- 50-55: 4%
- 55-60: 3%
- 60+: 3%

Figure 2: Age Range
Religious affiliation

![Figure 3: Religious affiliation](graph)

Organisational distribution

![Figure 4: Organisational Distribution](graph)
FACE-TO-FACE INTERVIEW DATA

10 informants were recruited to participate in the face-to-face interview process. Figures below show the interpretation of the responses.

**Gender distribution**

![Gender Distribution](image)

Figure 5: Gender Distribution

**Age range distribution**

![Age range distribution](image)

Figure 6: Age range distribution
Figure 7: Denominational affiliation

Denominational affiliation

- Apostic Faith Mission 10%
- CBO 40%
- NGO 50%
- FBO 10%
- AICs 60%
- Roman Catholic 20%
- Anglican 10%

Figure 8: Organizational affiliation

Organization type affiliation

- AICs 60%
- Roman Catholic 20%
- Anglican 10%
- Apostolic Faith Mission 10%
- CBO 40%
- NGO 50%
- FBO 10%
PRESENTATION OF RESEARCH RESULTS

Contextual faith view, activities, motivation for volunteering

Contextual faith views, activities, motivation for volunteering are articulated. Servers come from populous communities with high unemployment, poverty, a high prevalence of HIV and AIDS, and many children orphaned and made vulnerable by AIDS. Respondents are affected and are poor themselves. Churches and church pastors are understood as less involved in such contexts.

Religious affiliation

A religious affiliation is discovered. The dominance of Christian religion among respondents is noted, in particular the mainline churches, the Pentecostal churches and/or African Initiated churches. In line with this finding it is noted that those respondents have access to church facilities.
Facets of faith: Chorus and praying

The use of Chorus and praying is established. All respondents prefer to start any meeting or workshop with a chorus and a prayer as rituals to invite, acknowledge, thank and ask God to be present for consultation, protection, strength and guidance in this HIV and AIDS work that they do.

Use of the Bible

The use of the Bible is also established. All respondents believe that the Bible is a Holy Scripture. Some respondents even identify with at least one Biblical figure as their role model for the work they do in HIV and AIDS.

Being a volunteer and being a believer is inseparable

Interfacing volunteering and believing is dominant. Respondents view community volunteering in HIV and AIDS work and being a believer as one and the same thing.

Religious rituals and items

Religious rituals and items are noted. Some respondents use religious ritual symbols like the vaseline from the Prophet, and holy water and oils from their respective church traditions.

IsiZulu beliefs and customs

In particular, volunteers encourage and teach young people about Ukuhloluwa kwezintombi (virginity testing) and Ukuya emhlangeni (attending and participating at the reed dance). These are dominant with rural groups.

DISCUSSION

Contextual and social aspects

The depiction of gender and age in this research is contextual, dynamic connected to social aspects especially poverty, unemployment, illiteracy
and direct experience of HIV and AIDS. Between 59% and 70% of volunteers are in the age range 20 - 40 years. Between 80% and 85% are females, and males are a minority. This statistical presentation means that in South Africa specific social issues facing volunteers cannot go unnoticed. Other social science research works on home-based care ascertain that 'women are principal caregivers in CHBC (community and home based care)', and it is a clear suggestion and perception that women in Africa are understood mainly as nurturers (Thabethe 2006:104). In such contextual dynamics and social aspects local churches and church leadership are still found distant.

To explain further these dynamics and social aspects are the hurdles in community-based volunteering. There are misconceptions from both the beneficiaries and the servers' family members about volunteers. The expectation is that when one is working there should be some form of remuneration that they get in order to put food on the table. For example, one respondent says “volunteering is something good but it is not easy because these HIV positive people are difficult to work with … [and] at home where I stay it is difficult because they tend to say, 'You go out to work but we do not see anything; you just work but you do not get paid'.” That is, the volunteers are compromised assets in the provision of community health and social care services.

Therefore, in South Africa the evolution of HIV and AIDS in the last 30 years, as elsewhere in Africa, has seen:

- community-based volunteering remain and considered women's work because women are understood as nurturers by nature (Thabethe 2006:104);
- HIV and AIDS epidemic as a health and social crisis has remained a disease of the poor resulting in organic evolution of community-based volunteering with volunteers becoming a quick win in health and social care services (Thabethe 2006:103; Schneider, Hlophe, and van Rensburg 2008:1; Abbatt 2005:3; and Lehmann and Saunders 2007:1).

The reality of volunteers in HIV and AIDS work is contextual and its social aspects are changing the nature of volunteering from an activity offered free, with servers not expecting any form of payment, to 'an opportunity' for material remuneration and 'hope' for employment. A

1. Nkabi

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new form of challenge for the Church is embedded in volunteering disguised as 'working-freely-for-God' while there is a strong 'hope' for opportunities for remuneration.

**Religious health asset perspective**

The volunteers are aware that as members of their churches they are representing the Church's activities and contributions in addressing the HIV and AIDS pandemic. However, their concern is the aloofness of pastors as local church leaders in the community affected and infected by HIV and AIDS. For example one informant states that “they [pastors or church leaders] need to involve themselves because they are also part of this world which is plagued by this disease.” The 'involvement' can mean moving from confined, passive and 'one way' spaces like pulpits to more proactive roles and spaces like HIV voluntary counseling and testing campaigns and HIV education. Theology and development researchers confirm the challenge about 'involvement'. Haddad (2006:80) observes that “church leaders are quick to condemn, but are slow to respond with effective strategies that will stem the tide of the epidemic.”

The healing effect to 'stem the tide' of HIV and AIDS is marked by the quality of involvement, listening, the inclusive reading of the Bible, and singing of hymns and praying. Further, researchers highlight that HIV and AIDS have evolved to be a public health issue in which illness, death and social dependency have compromised and jeopardised hope, freedom, wellbeing and human dignity of the poor (Gennrich 2004; Oppenheimer and Bayer 2007; and Schmid 2007). Understandably, HIV and AIDS ravage a person's whole body and soul. For a Christian believer, who is a community-based volunteer, faith involvement may mitigate such a compromise by a healing effect. For example, another informant argues “the work that we do ... [of] taking care of orphans, taking care of sick people and distressed members of the community, you see!? I see that as love. I then call them so we can read the bible even when there [are] visitors and we just 'touch up' on the word of God. For me, that show[s] that I will not doubt myself about believing; but I have

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2. Mdlalo
3. Buthe

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As Christians, community-based volunteers understand their faith and their faith acts as informing their responses to the health and wellbeing of other people living with HIV and AIDS. Therefore, the belief is that faith acts attached to community-based volunteering do respond simultaneously to the ravaged body and soul.

Thus in the evolution of HIV and AIDS in the last 30 years in South Africa:

- The slowness and the condemning character of the local church leaders as a response to HIV and AIDS remain unavoidable and one informant argues “...a priest is a priest because of a congregation and if that congregation dries out who is going to be left for him to preach to? No one!” Thus the local church leaders do not participate and support the initiatives such as VCT and HIV education at the door step of their churches and communities (Haddad 2006:80) but rather continue judging people living with HIV and AIDS (i.e. both infected and affected) including community volunteers.

- Grassroots faith acts and community action are inseparable “it is interweaving of the intangible within the tangible which gives the tangible its specific 'religious' character, and it is the expression of the intangible in tangible ways which gives the intangible its legitimacy” (De Gruchy 2007:17). Thus ordinary Christian people working as volunteers in HIV and AIDS are indeed a religious health asset (ARHAP 2006:21).

ARGUMENT

Being a believer and a community worker

A strong sense that interfacing HIV and AIDS community-based volunteering with believing is growing. That is, being a community volunteer in HIV and AIDS work and being a believer are seen and believed as inseparable balancing of an ever existing tension between the “being Church” (Bosch 1991:9) and the “being institutional church” (:9) in unpremeditated ways. Scholars of missiology and ecclesiology show
that there is always a tension between being institutional church and being 'Church'. However, both 'being institutional church' and 'being Church' have a similar “commitment to the Christian faith” in the world, and that is, “the missio Dei” – God's mission (Bosch 1991:9 and :10). That is, 'being Church' is ecumenical, missionary and communion (:9), and then, 'being institutional church' seeks to manifest these qualities and drive the significance of Christian faith efforts in the world ensuring that 'being Church' is visible in the world (:10).

The evolution of HIV and AIDS has also seen increased ambiguities and tension around the question of 'being Church' and 'being institutional church' rising quite strongly from all directions. That is, churches and church leadership have been faced with a critical question about: how to be ecumenical, missionary and communion on the one hand, and then on the other hand, how to be visible drivers of significant Christian faith efforts among contesting views and voices on issues of prevention (condom use in particular), treatment, and care.

Thus the mere fact that grassroots members of the Christian communities serving voluntarily in the HIV and AIDS work are trained using secular models on the use of condoms as one of the scientifically proven methods of HIV infection prevention results in their thinking and feeling not supported by their local churches and church leadership in such an enterprise. Besides, church leaders are also not involved even in contemporary HIV initiatives like the antiretrovirals (ARVs), treatment campaigns and education and prevention education as conducted by volunteers. This therefore may suggest a salient continuity of the tension between a sense of 'being Church' and a sense of 'being institutional Church' in the time of HIV and AIDS. Thus the struggle is to understand the ways and means of maintaining the balance in the equation about driving the Christian faith efforts versus popular efforts backed by sciences in responding to HIV and AIDS. Therefore, the first argument to make is that the grassroots Christian efforts are visibly trying to interface 'being Church' and 'being institutional church' in their own unique ways. That is, in the light of Rom. 12, 'being an HIV and AIDS community-based volunteer' and 'being a believer' enables people living with HIV and AIDS to experience the day-to-day tangible and intangible presence of Jesus Christ in 'an act-out-of-action' spirituality of building a new community and society in times of HIV and AIDS.
Not ‘a new form of Church emerging’

Volunteers' faith acts and vibrancy is merely out of individual and optional baptismal calling, rather than from a universal and a particular church (i.e. doctrinal teaching). This argument is premised from Boff's (1985: 131-130) Catholic understanding of ecclesiogenesis as “a Church that is born of faith of the people” and church as an event which can happen under a tree, house, and church building as compared to happening in the institution and its goods and services and historical continuity (p.155). Thus the focus is on the base ecclesial communities' model, namely, Small Christian Communities (SCC).

That is, three elements characterise base ecclesial communities: 1) an oppressed yet believing people. This element means the gatherings of people are considered to be motivated by common events and plight, and are bound by community spirit to live a fraternal life and in relationship (Boff 1985:125). 2) The gospel is heard, shared, and believed in the community. With this element get-togethers are perceived to be a result of the callings of the gospels that is “an event… is continually reshaped whenever individuals meet to hear the Word of God, believe in it, and vow together to follow Jesus Christ (p.127). 3) Sign and instrument are the third element to consider. Here meetings are seen as open to the world and society and are encouraging formation of popular movements (p.128-129) centred on 'Grace and salvation' expressed in sacramental form (Boff 1986:21).

Now in consideration of the above explanation of each element as measures to argue for or against the religiosity found in HIV and AIDS community-based volunteering the following conclusions are drawn:

- the HIV and AIDS community-based volunteer gatherings are not showing that 'fraternal life and relationship' that is doctrinally bound, even though these people appear “an oppressed yet believing people” motivated by “the communitarian spirit” (Boff 1985:125).
- the groups of HIV and AIDS community-based volunteers are not a result of 'the callings of the gospel'. Quoting and using the Bible is not shared in common, and that cannot be equated to 'the reading, reflecting on and being shaped by the life and death mysteries of Jesus Christ' (p.127).
• the groups of HIV and AIDS community-based volunteers are not a 'sign and instrument of celebrating faith and life'. Thus the tangible acts like prayer, song, the Bible usage and bringing of some blessed oil and/or water to the sick and the dying to facilitate the intangible benefits like healing, trust and hope in God do not warrant the 'communion of saints'(128) and the sacramental form.

Therefore, the argument is that faith vibrancy and religiosity found in HIV and AIDS volunteering does not warrant base ecclesial communities considered as 'a new form of Church emerging' (Boff 1985). But then what is it and what may it mean theologically? Since this paper is conceived based on Boff's (1985) Catholic Ecclesial model, the field research which is approached from a general view of church dictates that other models, like the Calvinist Ecclesial model by Bosch (1991), cannot be ignored going forward.

**A new form of missionary spirituality**

In 30 years of HIV and AIDS existence and evolution, manifestations of faith vibrancy and religiosity found in volunteering may actually be one of the signs of the times for the Church in Southern Africa, and elsewhere in Africa, to consider being an organic community rather than remaining legalistic in its pastoral systems of care and support. Thus the institutional church may need to learn from:

1. Community-based volunteers' attitude of a "believing people" (Bosch 1985:125) motivated by "the communitarian spirit" (125) 'reclaiming' the sense of serving beyond the Sunday service and church walls. The Church may try to "rediscover its [pastoral] diaconal function" among its laity (Richardson 2006:47) by NOT getting stuck into the 'cleric diaconal function'.

2. The quoting and use of the biblical texts seems to say that the 'Bible is the Word of God and the Word of God is life' for a Christian and a volunteer. That is, the use of the biblical texts points the Church to 'the medicine of God's Word' (West and Zengele 2006) in the response to the epidemic. The ordinary Christians, men and women across denominational traditions, are re-grouping and organising to break the grounds of the
Church's spiritual and missionary terrain of responding to HIV and AIDS (:63).

3. The faith symbols such as some blessed oil and/or water allow the Church to see that the simple Christians are living off their spiritual motivation. Community-based volunteers bringing along faith healing symbols from their churches suggest that healing of body and soul is a reclaiming of 'being a sign and an instrument of God' in another way. That is, in the light of Ezekiel 34:16 and Matthew 25:35-40, these people are openly and freely adopting and re-adapting Jesus Christ's attitude of being “agency of justice, solidarity and wellbeing for the poor and the dying” (De Gruchy 2003:22).

Finally, the argument is that faith vibrancy and religiosity found in volunteering points the Church to the new form of HIV and AIDS missionary and pastoral spirituality forged by the laity. It may not be a scientifically proven “spirituality” characterised here, but in times of HIV and AIDS it is real.

CONCLUSION

In conclusion, this paper fulfills its purpose of establishing that the HIV and AIDS community-based volunteers and their faith acts can be regarded as a religious health asset. Another achievement is also to establish that the faith and/or religious solidarity and vibrancy among volunteers cannot be considered a new form of being church emerging in a time of HIV and AIDS. But then a conclusive argument reached is: As a theological interpretation of faith acts found in HIV and AIDS community-based volunteering in South Africa, this faith vibrancy in volunteering seems to indicate and call for a realisation that a new form of HIV and AIDS missionary and pastoral spirituality forged by the laity may be emerging.

This research was conducted on a small scale and open to general understanding of Church and religiosity. How can the same results compare when a similar research is conducted on a larger scale (across South Africa and Southern Africa) but narrowed down to the Roman Catholic Church's HIV and AIDS projects and their community-based volunteering initiatives?
REFERENCES


AN EMERGING FORM OF THE CHURCH?


It is now widely recognised, in public health institutions and in the academia, that religion, alongside other factors, has an impact on the course of the HIV and AIDS epidemic in sub-Saharan Africa. The response of religious institutions – and of the Catholic Church in particular – to HIV and AIDS in the field of care and treatment has been massive. They have initiated, complemented or supported western-based biomedical programmes throughout the continent. Religious institutions were among the first to run AIDS prevention campaigns in Africa. Yet on two issues, religious leaders clashed head on with governments and health authorities in matters of AIDS prevention: the use of condoms and sex education. Critics have pointed out that the link between sex, sin and immorality often made by Christian ministers and preachers and internalised by large sectors of the African community

added to stigma attached to HIV and AIDS (Campbell et al 2005: 810). Religious institutions shape the discourse on HIV and AIDS. They add meaning to the epidemic and mediate the prevention messaging. They influence not only what is said but what is not said on HIV and AIDS (Dozon 1999:692).

If the role of religious institutions in the evolution of the epidemic is undeniable, one should not underestimate the influence HIV and AIDS exerts on religion itself. The epidemic changes faith and religious practice in local communities. There is a relation of mutual influence between HIV and AIDS and religion.

This mutual influence has to be seen in a historical perspective. The thirty-year-old long HIV and AIDS epidemic is an evolving phenomenon. In Southern Africa, after a slow increase of the infection rate in the late 1980s and early 1990s, the number of AIDS-related deaths started to increase dramatically in the late 1990s to remain at an alarmingly high level until the South African government rolled out an ambitious and fairly effective Antiretroviral (ARV) programme. The infection rate, however, remains high. In the early days of the epidemic the response of religious institutions, including the Catholic Church, was occasional and geographically limited. After 2000 it became more effective thanks to mobilisation at grassroots level and funding from international organisations and public health agencies. The churches could see the impact of the epidemic on the lives of their members. They felt compelled to take action. In recent years the impact of faith-based interventions has been more limited due to reduced funding. Meanwhile HIV and AIDS has become part of the landscape for all sectors of society including the churches. This paper argues that since the outset of the epidemic new attitudes and behaviours have developed in South Africa not only with regard to sexuality, gender and public health but also spirituality, theology, morality and church life.

The main source of information for this paper is a set of oral history interviews conducted between July and December 2011 in the Pietermaritzburg area as part of the “Memories of AIDS Project”, a research programme of the Sinomlando Centre of the University of KwaZulu-Natal supported by the National Research Foundation of South Africa (NRF) and the South Africa Netherlands research Programme on Alternatives in Development (SANPAD). For this particular paper ten interviews, with an accumulated recording time of
twenty-two hours, were selected. All interviews were conducted by Ntokozo Zitha, a Zulu-speaking graduate of the University of KwaZulu-Natal. She made use of a topic guide designed by the research project steering committee. Like the other fieldworkers she was asked to engage the research participants on issues such as power, sexuality, gender, disease stigma, religion, faith and community support.

The two men and eight women who agreed to be interviewed belonged to Fountain of Life, a support group of people living with HIV established in Pietermaritzburg in 2003. All members of this informal body are HIV positive. They meet once a month, usually on a Sunday. They share stories and encourage each other to take their antiretroviral medication. Some go to clinics and hospitals to engage in HIV awareness. With the help of faith-based NGOs, the Pietermaritzburg Agency for Community Social Action (PACSA) for instance, they distribute food parcels and money for transport to their members. Fountain of Life is not supported by or affiliated to any particular church but the majority of its members, including Mary Khumalo, the founder, have strong Christian convictions.

All the research participants were confessed Christians but only eight were regular churchgoers. Three belonged to mainline churches (Methodist, Dutch Reformed and Seventh-Day Adventist), four to Pentecostal churches (the Oasis of Workshop Tabernacle, the Pietermaritzburg Christian Fellowship and an unspecified Pentecostal church) and the remaining four to African independent churches (St John's Apostolic Faith Mission, Christian Catholic Apostolic Holy Spirit Church in Zion and Twelve Apostles Church in Zion). Of those who worshipped in a Pentecostal church two were from a Catholic background. One moved from one Pentecostal church to another.

Previous studies showed that, when AIDS started to take its toll in Southern Africa, three competing worldviews – the bio-medical approach, the Christian message and African traditional religion – were

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3. During the first phase of the project (2008-2010) 41 interviews of pastoral agents and NGO workers involved in the fight against HIV and AIDS in the Umgungundlovu District, KwaZulu-Natal, were conducted. The target for the second phase of the project (2011-2013) is 60 interviews and 10 focus groups. On completion of the project all the interview transcripts and audiotapes will be accessible to researchers at the Alan Paton Centre, University of KwaZulu-Natal, Pietermaritzburg.

4. To respect the confidentiality of the informants, all names of persons as well as the name of the support group have been changed.
in competition, creating conditions for confusion, shame, silence and denial. The first defined AIDS as a deficiency of the immune system caused by a virus called HIV. The second, directly or indirectly, presented HIV and AIDS as the consequence of sin. The third explained the phenomenon of multiple deaths by a lack of harmony between the living and the dead due, among other reasons, to the transgression of cultural taboos (Delius and Glaser 2005; Posel et al. 2007). People living with HIV and AIDS, especially women, suffered from being blamed for bringing the disease to the community (Leclerc-Madlala 1999).

The interviews suggest that the situation is changing. Despite their pain and anger the dominant trait of the interviewees was their assertiveness. They understood better their condition and knew how to distinguish the biomedical causes of the disease, the language of the church and their own spiritual experience. They showed a surprising ability to counter the accusations thrown at them by spouses, relatives and community members. They knew that these allegations were unfounded and were able to express it. The interviews revealed the irritation or, more accurately, the anger that the attitude of men towards women in matters of sexuality and disease provoked in women.

One of the most interesting aspects of the Fountain of Life support group members' was their ability to articulate a religious discourse on their experience as people living with HIV. In contrast to the message often conveyed by religious institutions, especially in the early years of the epidemic, of HIV and AIDS as a punishment of God or, in its milder form, as the inevitable consequence of a moral transgression, the Fountain of Life members refused to take any blame, religious or not, for their HIV condition. Rather they emphasised, when speaking of their religious experience, positive aspects such as love, compassion, reconciliation and forgiveness. Crucially, they put more emphasis on the fact of being still alive – thanks to the ARV treatment whose power was attributed to God – than on being under the threat of death. Many interviewees were able to articulate spiritually and, one may say, theologically their views on God, Jesus, the church and Christian morality in a context profoundly transformed by the widespread availability of ARV treatment.

In response to a question on the effect of HIV on her relationship with God, Mary, the founder, described with a great richness of expression the journey which took her from anger to peace of mind. At first she rebelled
against God who had permitted her to be infected despite the fact that she “behaved herself” and avoided “sleeping around.”

My relationship with God has gone through a lot of changes. As I said, there was a time where I was a very angry with God. I felt angry at a number of levels. Why me?
I behaved myself. I was not sleeping around. Why did he allow this to happen to me? You know that kind of thing. And then I became reckless and don't care. Nothing good happens, you know.
So I went into relationship with my husband. We got the child, got married later on. He died through that short marriage. It was hell.
My anger definitely goes to the Creator. If you tell me: “I knew you and I chose you to be mine and I have created you. I have no plans to harm you.” Then I get harmed. Even if it is not you, why let the devil harm me?
So it was a journey of finding me and finding God and re-defining who God is to me from the stubborn woman, rebellious young woman, to learning to humble myself to his feet.
And I appreciate who he is and I am surrendering to his will. Once I did that, a lot of things started to flow. But he lets me re-sit, he lets me fight, he lets me throw tantrums. We had that relationship. I throw tantrums. I ask questions.
So what is the point if there is no relationship? Why should I believe his word? But I am learning because I have been on depression treatment three times.

It was, she summarised, “a journey of finding me and finding God and re-defining who God is to me from the stubborn woman, rebellious young woman to learning to humble myself at his feet.”

When asked how she managed to live positively with HIV and AIDS, Beatrice brought into the picture the traditional Christian teaching that life and death are in God's hands, but instead of seeing it as an invitation to passively accept HIV and AIDS as the will of God, she interpreted it as saying that people living with HIV were no more at risk of dying young than anybody else. God had the power to let them live as long anybody:
Because when I look at it, it does not mean that if I am HIV positive tomorrow I will die. Somebody can walk on the road at this very moment and get smashed and die. Nobody knows who will go away. Only God knows that Beatrice is going to close her eyes today. No doctor, nobody will tell me, “You are going to die tomorrow.” I said, “No. My God knows it. This is your day.”

Nontokozo, who had led a turbulent youth, described her journey of recovery as a return to God:

I prayed to God when I was sick, when I lost my husband. God knows where I come from. He knows I come from a rubbish bin that has got worms. I said, “Please give me a second chance so that I can be a living testimony. What I already do in my life, I want to transmit it to other people's lives.”

The ARVs feature prominently in this oral narrative. To Nontokozo they are the expression of God's benevolence:

I took Christ as my personal Saviour. I took him as my Saviour in these ARV tablets, before I put them in my mouth. When I come from the clinic, I say, “Lord, this is nothing you can do better than these tablets.”

Thandeka, who combined Christian faith and belief in the power of the ancestors, made the point that God should not be blamed for her HIV condition because, thanks to the pills, she was still alive:

I do not blame the ancestors because they are not God. Even God I do not blame him. Why did I have the disease? Why did he not protect me because I praise him? I cannot blame him. I do not blame anyone because I do not even know how I got HIV. I do not blame anybody because God has protected me until now when I am taking my pills. I do not blame the ancestors because they are not God. They do not see that I am taking the treatment. It is only God who knows that I take the treatment because I pray.

The most articulate of all the interviewees on religious matters was
Nontokozo. She made a long speech to explain that the ministers of religion who refused to promote condoms during church services were wrong because many born again Christians were infected. They did not trust the power of the Holy Spirit:

They say a child of God does not use condoms and then I say, “Please, can you show me in the Bible where it is written about condoms?” I use to say at this point that we put the Holy Spirit aside because we all have the Holy Spirit, the one of speaking in tongues, because we speak about the reality of life. [...] I feel sorry for my church because a lot of people have died of AIDS in my church.

Likewise she was adamant that the ARV treatment was wanted by God. If she had the power, she insisted, she would go to Parliament and ask the government to close the churches which speak against the treatment.

They say that if you are a child of God, you do not take the treatment and I will say: Can you please page for me in the Bible and show me where that is written. Jehovah is not against the treatment because if he was, we would not have the doctors, the scientists and all those who have a hand in discovering the treatment, and those who diagnose people who have diseases.

The reluctance of church people to face the reality of HIV and AIDS is another common theme in the interviews. Beatrice, the new coordinator of Fountain of Life, spoke about this at some length. Her pastor had allowed her to speak to the congregation, she explained, but the sentiment continued to prevail among the worshippers that people living with HIV were people who “sleep around”:

We have been trying to engage with churches because… in the churches… They don’t want to talk about HIV and AIDS. I am so thankful because my pastor is somebody with whom I have been able to sit down… I told him about my experience and he is very open about it since. Like now, we are trying to open a desk in the church. It is because a lot of people in the
church are dying. It is because they cannot talk. It is because when they find that somebody is HIV positive they say he has been sleeping around. It is not that this person has been sleeping around to be infected. There are many ways for a person to be infected by the virus.

The problem, according to her, was the people in the church “always judge”, especially if they are “born again”:

We always judge ourselves. This one is a born again. What happened? You see. This is what we try to break in the churches. And it is not only my church. I want to go to the other churches as well.

George, a white man who works in the media sector, had the same experience. In his church nobody said anything about HIV and AIDS because they were not able to face the reality of the disease:

Some people in the church when they get to hear that somebody is HIV positive, it is really as if he is about to die, you know. Maybe by sitting next to them they are going to get it, you know. They do not really understand that the church is more kinda like… You understand what I'm saying.

CONCLUSION

Despite the wider availability of antiretroviral drugs the battle against the HIV and AIDS epidemic is far from being won. Any reflection on the ministry of the Christian churches in this area should take into account the fact that, in South Africa as in other parts of Africa, the epidemic has moved to a new phase. Even though infection levels remain high, fewer people die. Now that the fear of an inevitable death has been removed, at least to some degree, HIV positive people start to look more positively at their experience. Their Christian faith helps them to see that their continuing good health is a gift of God. Some of them have beautiful words to describe the spiritual journey they have pursued since they discovered that they were HIV positive.

Stigma recedes but is still very strong. The stereotype of the “loose
woman” who causes men to be infected because of her bad behaviour remains prevalent. HIV and AIDS are and remain a gendered phenomenon. Fewer men than women disclose their HIV status and go to the clinic for treatment. HIV positive people still face stigma, gender oppression and various forms of discrimination.

This study suggests that new developments are taking place in South Africa. The Fountain of Life members interviewed for the project refused to be blamed for their condition. Some took responsibility for past failures but they did not believe they were infected because of their sins. They did not hesitate to criticise their church leaders when they felt that they contributed, passively or actively, to HIV and AIDS stigma. They expressed the desire to talk about their condition and to promote ARVs. Many wanted their churches to encourage the use of condoms because, in the current of state of gender relations in South Africa, even among church members, it was the only way to prevent the spread of HIV and AIDS.
REFERENCES


PART 3
Selected SACBC and SECAM Statements on AIDS
I. SACBC STATEMENT ON AIDS (5 May 1988)

The Administrative Board of the Southern African Catholic Bishops' Conference issued a brief statement reiterating the basic position of the Catholic Church on the AIDS epidemic.

The Bishops' Conference regards equally abhorrent both the scourge of AIDS, so destructive of human life, and the response of the South African government making provision for so-called safe sex, however indiscriminate, by the use of condoms.

Premarital chastity and marital fidelity are the best protection against AIDS.

II. PASTORAL STATEMENT OF THE SOUTHERN AFRICAN CATHOLIC BISHOPS' CONFERENCE ON AIDS (January 1990)

Introduction

The AIDS crisis, which has descended upon our world suddenly and unexpectedly, presents the Church of today with a major challenge. This disease, perhaps more than any previous disease in history, raises for Christians in our time problems of morality, sin and God's providence.

The crisis has served as a revelation of the inadequacy of the moral and theological assumptions of many Christians. For example, some Christians believe that AIDS is God's punishment for sexual sin, and those who contract the disease are treated as sinners who must be rejected.
and ostracised from the community. They are made to feel ashamed and even guilty. They are feared and even hated for having a disease that is perceived to be a threat to everyone.

Through the AIDS crisis more people face the reality of death; question the meaning of life and the after-life, and the theological question of why God allows people to suffer and die in this way. It also raises difficult questions about human relationships, medical care and social welfare.

Basic issues concerning sin and morality arise. In the minds of some people the worst sins and the most important moral issues concern sexual behaviour. The person who is perceived to be a sexual sinner may be treated in a loveless and unjust manner as if this way of treating people were not far more sinful in the eyes of God. Similarly because sin is related to punishment, it becomes easy to think of AIDS as a punishment for sin even though the person-with-AIDS (PWA) may not have contracted the disease as a result of any sin at all.

The tendency to find someone to blame for the things we fear is too easily indulged in without regard for the morality of love, justice and truth.

Is morality simply a matter of blind obedience to moral laws or is it a matter of how we human beings relate to one another and how we take responsibility for one another? The latter frequently calls for both self-giving and patient understanding of others that are more demanding than simply keeping the law. The AIDS crisis reveals not simply the existence of sexual sins but also, and much more significantly, the absence of love and care for people in their suffering.

We know AIDS is spread very often because of ignorance and negligence. In terms of morality, we must now face the sinfulness of not doing everything in our power to prevent the spread of AIDS.

Our moral awareness and attitudes have to grow and develop. We go through stages towards a greater moral maturity. Perhaps the AIDS crisis is God's way of challenging us to care for one another, to support the dying and to appreciate the gift of life. AIDS need not be a crisis, it could also be a God-given opportunity for moral and spiritual growth, a time to review our assumptions about sin and morality. The modern epidemic of AIDS calls for a pastoral response.

1. **Pastoral Response**
   Any Christian consideration of a pastoral response to persons with AIDS must begin by looking at the example of Jesus in the gospels. There we
see that Jesus, confronted with the sickness and suffering of people, and above all their rejection by society because they are considered to be “sinners', is always filled with deep compassion and a willingness to heal. The leper said to him: “Lord, if you want to, you can cure me.” Jesus' reply was: “Of course, I want to.” (Mk 1:40-41). In his ministry Jesus sought to overcome the prejudice, suspicion and fear that surrounds diseases such as leprosy which alienated people from society.

It is this attitude of Jesus, who mixes with outcasts and shares meals with them, that must inspire the corresponding attitude that Christians need to shape in the face of AIDS. One of the saddest examples of the AIDS crisis is the experience of rejection that persons with AIDS feel. The God Jesus reveals in the gospels is a compassionate and loving Father who forgives. Moreover, Jesus tries to impress upon people that all, including the Pharisees who supposedly “keep the law”, are in need of forgiveness. Human self-righteousness and judging others are sins that Jesus clearly condemned.

It is important to remember that a person can contract AIDS without performing any sinful activity. It can be contracted through legitimate sex, blood transfusions, unsterilized needles, infection of an open wound, and by an unborn baby in the womb of the mother. There may be other ways of contracting it as yet unknown to us. But even if AIDS has been contracted by dubious activity, we are not to stand in judgement over others. Judging and rejecting a person with AIDS may well be a greater sin than the act by which it was contracted. To brand a person with AIDS as a sinner is not only to forget one's own sinfulness but also to run the risk of committing the serious sin of rash judgement.

As Christians it is our duty to reach out to and accompany persons with AIDS, and their families, as they go through the inevitable stages of anger, depression and feeling alienated. We congratulate the many individuals and support groups who have done this already and who continue to search for more effective ways of responding in a loving and creative way to the reality. We believe, moreover, that persons with AIDS themselves can teach us much. There are many examples of the courage and determination, especially in the face of death, of persons with AIDS. Despite their own fears and pain they have learned to grow in a relationship of trust in God in a situation that may have appeared to them to be utterly meaningless, and some of them spend their last days in helping others manifesting “the works of God” (John 9:3).

One consideration we need to bear in mind in a pastoral approach to
AIDS is the extent to which the worldwide disease has tended to produce panic among people. While there may be positive aspects that have to do with a heightened awareness of danger, the negative side is that “panic” can break down human relationships. Here we do not simply mean relationships with persons who have contracted AIDS. On a general level an atmosphere of suspicion and fear has arisen (usually based on ignorance), which keeps people apart.

2. The duty to prevent the spread of the disease
The threat to the human race posed by AIDS is so serious that there is a grave duty on the part of organisations and individuals to prevent its spread. And here two areas are of particular importance: The first is the dissemination of information and the second is acting in a responsible way with regard to sexual activity.

Organisations, particularly the state, have an obligation to disseminate information about AIDS, the size of the problem and its prevention. Individuals, in their turn, have a duty to become well informed for wilful ignorance about so serious a matter is sinful. The facts can be obtained. As a service to people we have added an appendix of essential facts, as well as instructions as to where more detailed information can be found.¹

Certain medical authorities and governments advocate using the condom as a preventative measure against the spread of AIDS. However, condoms are not always reliable. If a person persists in sexual promiscuity, he or she will still be at great risk of contracting AIDS. Furthermore, if an attitude prevails that when using a condom sex is safe, then the condom message can increase rather than decrease the incidence of AIDS.

Any person who has contracted AIDS should take very seriously the responsibility of preventing further spread of the disease. This will call for great consideration of others, which will often have to be shown by taking great care and exercising restraint.

3. Sexual responsibility
It has been said in different ways that the fear of AIDS has put a drastic curb on sexual promiscuity and has slowed down the so-called sexual

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¹. Facts about HIV contraction, and contact details of service organisations are not included here, but are widely available.
revolution. It must be pointed out, however, that this is not yet virtue. Abstinence out of fear of this disease is not yet chastity. Chastity has to be seen as a quality of genuine relationship. This is a special message for youth who should try to see their companions as persons of immense dignity and beauty and not as sexual objects.

Human sexual relationship is an expression of commitment and faithfulness to one's marriage partner. For unmarried people, abstinence from sexual relations corresponds in truth to the fact that no such lasting and total commitment exists.

Faithful partnership is something that needs time to grow and to deepen. Trust has to be developed so that the two partners can give themselves in trust to each other, it is only within this experience of trust and as an expression of this trust that sexual unity can be successfully experienced. Sexual union is the expression of a loving human relationship, which has reached the stage of a mutual commitment to each other for life.

Christianity has always proclaimed not only the possibility but also the duty of imitating in marriage the total commitment of the Father and the Son to one another in the love of the Spirit. The sacrament of marriage is an expression of faith in the power of God's love at work in married couples and the hope that this love will conquer human weakness and infidelity.

It has already been noted by others that an important way to ensure one neither contracts nor spreads AIDS is for two sexual partners to remain faithful to one another. The risk of AIDS, therefore, places a further moral obligation on people to be sexually faithful to each other. For such unfaithfulness is not only a sexual sin against one's partner but also a sin of putting his or her life at risk. Mutual sexual fidelity eliminates a major source of AIDS transmission.

4. Social repercussions
As the spread of AIDS continues, increasing repercussions throughout society are likely; altering the way people relate to one another and in some areas even how society is organised. We ask that two extremes be avoided: ignoring the issue, treating it lightly, not preventing its spread and being indifferent to its consequences for those infected; or, at the other extreme, believing unfounded myths and rumours that provoke panic and inconsiderate reaction. Uninformed and selfish reactions may be morally
worse than the disease itself. For instance, to talk of “African AIDS”, or to dismiss it as a “white problem” or to label it a “gay disease”, is false. AIDS is a disease that might infect any human being. So while people must be educated about the disease, shock tactics which only produce fear and horror, or even worse cause aversion to people, are not helpful.

Certain socially undesirable features of South African society, make the spread of AIDS much easier. These are:

- The building and maintenance of single sex hostels for workers instead of family housing, which system encourages prostitution and even homosexual practice;
- Migrant labourers from neighbouring countries are also housed in single sex hostels away from their families. If they are found to have contracted the AIDS virus they are repatriated, which shows a lack of responsibility by their employers;
- An abnormally large prison population, which can create conditions for homosexual practice;
- Poverty and harsh conditions of life that make marriage and family life difficult, and which lead to short-term sexual intimacy and drug abuse;
- An overabundance of material goods for some members of society brings about a pointless life where people search for excitement in sexual promiscuity or through escape into drugs.

Even apart from AIDS, these issues must be addressed by all in South Africa – the general public, state authorities, businesses, and people's organisations. The incidence of AIDS underlines the importance of striving for a new, just and more caring society.

To prevent the spread of this disease, health authorities in particular and others responsible for the general welfare should:

- Combine care for the common good with respect for the dignity of each person, especially those infected with AIDS or considered to be in “high risk” categories;
- Take due care in clinics, hospitals and surgeries not to spread infection;
- Assure complete confidentiality and take every precaution against stigmatization of persons, whenever people are tested for the disease;
Avoid all exploitation of the incidence of AIDS, for instance, by refusing health insurance or asking special fees, or charging higher prices for the burial of AIDS victims.

It is impossible to foresee the full effects of AIDS on our society over the coming decades. Certainly, its repercussions will be with us for a long time. It is likely to cause economic losses as workers are laid low by it. Also special care will have to be taken of an increasing number of orphans, whose parents have died from AIDS. Furthermore, a larger share of the community's resources will have to be directed towards those suffering and dying from AIDS; either by providing support services for them at home or establishing hospices for those approaching death. This will require not only money, but even more importantly suitably trained and compassionate personnel.

Conclusion

The modern crisis of AIDS, is a challenge and an opportunity. It is not simply a tragic problem. It is not an occasion for imputing blame, but an opportunity to reflect more deeply on 'the works of God.” In the Gospel of John we read:

His disciples asked Him, “Rabbi, who sinned, this man or his parents, for him to have been born blind?”

“Neither he nor his parents sinned,” Jesus answered, “he was born blind so that the works of God might be displayed in him.” (John 9:2-3).

III.

A MESSAGE OF HOPE FROM THE CATHOLIC BISHOPS TO THE PEOPLE OF GOD IN SOUTH AFRICA, BOTSWANA AND SWAZILAND (30 July 2001)

We the people of Southern Africa find ourselves in the middle of a great crisis in our nations caused by HIV/AIDS. Many people despair when they are stricken with HIV/AIDS because they feel rejected and sometimes are rejected by their families and communities. Some even commit suicide. In
this desperate situation we, the Catholic Bishops of Southern Africa, bring a message of hope to all who are living with this killer disease:

*Do not despair - you are not abandoned by Christ nor by us. When you find yourself in a hopeless situation on account of AIDS, Jesus, your brother, remains right next to you and never abandons you. We encourage your families and communities to accept you with love and to stand by you. We urge them not to abandon you but to continue Christ's mission of mercy, compassion and love. The Church loves you, welcomes you and reaches out to you in many ways.*

We have a message for our nations, the youth and married couples.

1. **Message for our Nations**

Many people and especially Governments promote condoms for preventing AIDS. This is a matter of deep concern for us in the Church.

*The Bishops regard the widespread and indiscriminate promotion of condoms as an immoral and misguided weapon in our battle against HIV/AIDS for the following reasons.*

- The use of condoms goes against human dignity.
- Condoms change the beautiful act of love into a selfish search for pleasure - while rejecting responsibility.
- Condoms do not guarantee protection against HIV/AIDS.
- Condoms may even be one of the main reasons for the spread of HIV/AIDS. Apart from the possibility of condoms being faulty or wrongly used they contribute to the breaking down of self-control and mutual respect.

*The promotion and distribution of condoms as a means of having so-called "safe sex" contributes to the breaking down of the moral fibre of our nations because it gives a wrong message to people. What it really says is this:*

- "It is alright to sleep around as you like even if you are still young - as long as you do not contract HIV/AIDS."
- "There is no need for training yourself in self-control."
What undermines the morals of our countries?

- It is lack of self-control and lack of respect for others.
- It is unfaithfulness and irresponsible sexual behaviour.
- It is loose living, which destroys human dignity - UBUNTU - and self-respect.

This is our conviction as Catholic Bishops of Southern Africa. We proclaim our message loud and clear, a message which will strengthen again the moral fibre of our countries:

"Abstain and be faithful" is the human and Christian way of overcoming HIV/AIDS.

Abstain from sex before marriage and be faithful to your spouse in marriage - this is the answer, which Christ gives us. With his help we will overcome AIDS and build up a new, happy and healthy South Africa, Botswana and Swaziland.

2. Message to the Youth

Dear young people, we are well aware that you are searching for real love, happiness and meaning in your lives. God says, "I am offering you life or death, blessing or curse. Choose life, then, so that you and your descendants may live..." (Deuteronomy 30,19). Make sure you choose life by accepting God's way.

Do not allow yourselves to be misguided by people who show you the wrong way by offering you condoms. Abstain from sex before marriage and be faithful to your spouse in your future marriage - this is the way Christ shows us.

We often hear people saying, "Condoms save lives and therefore they should be promoted." Our answer is, "If we follow Christ's way, we shall save far more lives and encourage people to grow in self-control and responsibility for others."

Dear young people you should not say: "It is impossible to abstain".
You must prove to yourselves that abstinence is possible and that lust is not love. There are many groups of young people who help one another in their struggle to live chaste lives. There are groups such as "Youth Alive" which promote "Education for Life" through workshops and programmes inspired by the mottos "True Love Waits" and "Choose Life". Yes, it is difficult to abstain, but it is not impossible with God's help, which we obtain through prayer. Do not listen to people who say, "You will go mad if you do not have sex!" In fact you will be very healthy in mind and body.

To young people who are living with AIDS:

*We encourage you to speak up openly and help your companions to avoid the disease. In this way you will truly become promoters of life. You are continuing the mission of Christ who said, "I came so that they may have life and have it more abundantly" (John 10,10).*

We call on young men:

*Respect girls and young women and relate to them without making sexual demands of them.*

*St. Paul says, "God wills you all to be holy. He wants you to keep away from sexual immorality" (1 Thessalonians 4, 3).*

### 3. Message to Married Couples

We make a strong appeal to all married couples,

*Husbands and wives, remain faithful to each other as you promised on your wedding day. In this way you proclaim God's faithful love for us. In your difficulties, our God who is faithful will never abandon you. Keep in contact with God through prayer and listening to his word. We encourage you to support one another in your struggle of life.*

There are couples where one of the parties is living with HIV/AIDS. In these cases there is the real danger that the healthy partner may contract this killer disease. The Church accepts that everyone has the right to defend one's life against mortal danger. This would include using the appropriate means and course of action.

*Similarly where one spouse is infected with HIV/AIDS they must listen to their consciences. They are the only ones who can choose the appropriate means, in order to defend themselves against the infection. Decisions of such an intimate nature should be made by both husband and wife as equal and loving partners.*
Call to Conversion
We proclaim Christ's message to you, the people of today, "The Kingdom of God is near. Turn away from your sin and believe in the Good News" (Mark 1, 15).

So often we blame God or other people for what happens to us. Instead we have to take responsibility for our actions before God. This involves listening to God's word and to the teaching of the Church so that we can have informed and mature consciences.

The message of the gospel is very different from that which we receive from television, videos, internet, newspapers and magazines, which so often promote uncontrolled sex and infidelity.

Dear People of God. We have to solve our problems in this "Kingdom Way". Therefore let us heed the call of Christ to return to the way of self-control and fidelity. St Paul encourages us to shine among corrupt people like stars lighting up the sky as we offer them the message of life. (see Philippians 2, 15-16).

Call to Action
We call on all people of our nations to break the silence around HIV/AIDS by calling AIDS - AIDS and by accepting people who are living with this disease.

We express our deep appreciation to all who are working generously (and very often with little remuneration) for people living with AIDS and for AIDS orphans.

We also pay tribute to the Priests, Religious Sisters and Brothers and to men and women of the community who so often work quietly and generously to bring Christ's healing ministry to the most neglected and forgotten.

As Bishops we are proud of the enormous outreach in every diocese in AIDS prevention, caring for those living with AIDS and those affected by AIDS, especially children and orphans.

We call on small Christian communities, prayer-groups, sodalities, priests, religious and pastoral workers, to join hands with all people who are engaged in the struggle against AIDS.

We wish also to encourage others to volunteer their time to visit and care for those who are afflicted by this disease.

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 the
times challenging all people to inner transformation and to the following of Christ in his ministry of healing, mercy and love.

Call to Prayer
We invite all people to unite in prayer to Almighty God in this time of crisis in our nations. In the past in South Africa we approached God to help us in our struggle for freedom and human dignity and we experienced the great miracle of transition. Now we pray for another "miracle" to bring us that inner freedom which will enable our nations to choose the right way to uphold human dignity in our new struggle - the battle against HIV/AIDS. Jesus is with us still today on our way of the cross of HIV/AIDS.

Jesus invites us in his hour of agony to join him in deep prayer to the Father as the way to resurrection and life.

May the Lord guide us all, give us strength and touch us with his healing hand.

We greet you with affectionate love and bless you, in the name of the + Father, the +Son and the +Holy Spirit.


IV.
THEOLOGICAL AND PASTORAL RESPONSE TO HIV/AIDS IN AFRICA
(SECAM PRESS STATEMENT December 2001)

We the Secretaries General of Regional and National Episcopal Conferences on the continent of Africa, met under the umbrella of SECAM (Symposium of Episcopal Conferences of Africa and Madagascar) from 26th November to 1st December 2001 in Cape Town, South Africa. We shared insights, experiences and studied together the Church's theological and pastoral response to the HIV/AIDS pandemic in the whole world with particular emphasis in Africa.

We have noted with concern the deplorable effects of the virus, which has spread to every corner of the continent and beyond. The disease is
spreading at an alarming rate. According to the latest UN statistics, it is estimated that around 40 million people in the world have contracted the virus. This disease has robbed millions and millions of lives and it has reversed development, particularly in Africa. It also contributes to widening the gap between rich and poor. It is therefore undermining social and economic security and has resulted in unprecedented trauma to millions of people.

We came out with a very clear conviction that “the Body of Christ in Africa” is deeply inflected with the scourge of HIV/AIDS pandemic and it requires an urgent response from everyone to take courage and have hope!

We came up with the conclusion that the church must take a leadership role in fighting HIV/AIDS at all levels, so that she really plays her role of being the voice of the voiceless and hope for Africa.

The vision of the church was seriously examined as that of a continuation of Christ's mission on earth. She is therefore convinced and committed not only to represent Christ but also to render him present in order to continue his mission which includes among others:

1. To give life to the full (Jn.10:10)
2. To relieve people from human miseries, to heal them from infirmities and diseases (Mt.8:17)
3. To heal people from trauma, to comfort the sick, the desperate and to give them hope (Acts. 10:38).
4. To liberate the oppressed people from social economic evils (Lk.4:16-20).

Pursuant of the mission of the Church in the ecclesiology of the Fathers of the Synod of Africa, “The Church as Family of God”, the Conference identified the following pertinent values.

1. **Sacredness of Life**

We are aware that the HIV/AIDS pandemic has come at a time when life has become cheap and is at times treated like a commodity. The membership of the Church must promote the culture of the sacredness of life and love for life. Therefore a person living with HIV/AIDS has a right to life, integrity, support, treatment, and in particular, compassion.
2. Compassion

The Church is called to be disciples of Jesus who was found among the outcasts, and the most vulnerable in society.

The entire membership of the Church in Africa is called upon to make present God's compassionate presence among the most vulnerable members of society, the disadvantaged and suffering. This is a presence which gives hope. We as individuals, and as a Christian Community are called by gospel values to be caring agents of compassion.

3. Solidarity

Like Jesus Christ, whose solidarity with humankind was expressed in becoming one like us, the Church in Africa is therefore called to greater solidarity with all people who suffer from the HIV/AIDS epidemic. We are convinced that the response to the pandemic finds its best expression in simple, caring forms of solidarity by being with those who suffer and by sharing our resources of time, gentleness, food, money and whatever else we have.

Solidarity through teaching
We have noted in the Conference that the principle duty of the church is to teach the truth at all times. We believe that the Church membership must come out and firmly teach the authentic values of life, true love and sexuality as well as the sanctity of traditional virginity of boys and girls, and fidelity in marriage as the principle means to curb further infection of the HIV/AIDS pandemic.

We also noted the importance for Church leaders to use appropriate language and presentation of doctrine in order to avoid stigmatising the people affected with HIV/AIDS.

Furthermore we realize the need for the Church leadership to take a leading role in raising a loud and clear voice at every level of society to overcome evil. This evil is personified in materialism and consumerism, which unfortunately dominates our society and therefore enhances the divide between developed and developing worlds, the have and the have-nots. This results in underdevelopment, economic dependency, lack of education and displacement through war.

In a special way we have noted that the Church as a body needs to re-
address the place of women and children in society, particularly since they are the most affected by the pandemic. We feel that some men in Africa hide behind culture in their degradation of women. Men must be encouraged to respect women and to acknowledge their major role in society.

**Solidarity through church as family of God**
The church is a family and hence a community by its very nature. This is fundamental of traditional African life and culture. We noted with concern the escalating numbers of AIDS orphans becoming overwhelming everywhere. The numbers of street-children and child dropouts are increasing at an alarming rate; child-headed households are becoming all too common. There is also an increase in child labour, the family values are lost, etc. We commend the exemplary work done by church institutions in support structures for the suffering from the HIV/AIDS pandemic. We are all too aware that more ought to be done.

Ultimately, the local church communities and individual Christian families are called to open their hearts and doors and become more and more part of the family of the AIDS orphans and other vulnerable children.

**Recommendations**

We therefore, as we leave for our respective countries wish to recommend the following steps which we are convinced can contribute to reversing the trend of HIV/AIDS and restore the African traditional value of life.

1. That the Church doubles efforts in her leading role to fight against the HIV/AIDS pandemic at all levels, in all aspects.
2. That the Church as Family of God commits herself in concrete terms, to promote the Gospel values and attitudes and educates by example to uphold the gift of life according to gospel values. Further that the church leadership should come up with concrete programmes that focus on sexual health education, behaviour change, HIV/AIDS counselling in order to link prevention with care and support.
3. That the Church at the grassroots becomes a true family of God characterized by solidarity, empathy, and compassion.
4. That the Church leaders teach their followers by action, in order that they become the voice of the voiceless by advocating for the rights of those affected by this disease.
5. That the Church as the family of God welcomes the development of new ministries in order to offer effective and efficient services to those suffering from the HIV/AIDS pandemic.
6. That the church works in collaboration with other faith based organizations, governments and other bodies to fight against HIV/AIDS.
7. That all efforts be exerted to organise workshops at national, diocesan and other levels of church to increase the knowledge and sensitivity around the issue of HIV/AIDS.
8. That the SECAM Secretariat takes up the role of advocacy and networking with the international bodies on behalf of the Church on the African continent.
9. We ourselves with the HIV/AIDS regional and national coordinators endeavour to meet at least once a year to review the progress of the Church's participation in this important mission.

Fr Peter Lwaminda, SECAM Conference of the Secretaries General
Cape Town, 26 November – 1 December 2001

V.

SACBC AIDS OFFICE ENDORSEMENT OF CIVIL DISOBEDIENCE PROTEST (20 March 2003)

The AIDS Office of the Southern African Catholic Bishops' Conference endorses the Treatment Action Campaign on Civil Disobedience protests launched today, Thursday 20 March 2003, the eve of Human Rights Day in South Africa.

We note with dismay and frustration the way in which the Ministry of Health continues to deal with the HIV/AIDS pandemic. Too much time and effort is being wasted on ongoing debates around HIV/AIDS. South Africa with one of the highest AIDS prevalence rates in the world and situated in the corridor of the worst infected and affected region cannot
continue to watch thousands of people dying daily. We urge the
government to work speedily on implementing a treatment plan, an
investment in a better health care delivery for all.

This endorsement comes with a strong caution that the Catholic
Church does not condone any violent action committed by AIDS
activists and protesters.

We need the government to work together with all sectors in
endorsing the National Treatment Plan.

*The Catholic Church is committed to extensive programmes for the
care of people affected by HIV/AIDS.*

**VI. AIDS IN SOUTH AFRICA**

Archbishop Buti Tlhagale, February 2003

Never before has the value of ordinary life which we take for granted,
become so precious as it is in the face of the ubiquitous threat of
HIV/AIDS (Human Immunodeficiency Virus / Acquired Immune
Deficiency Syndrome). There is still a stubborn unwillingness, a refusal
to come to terms with the reality of the disease, a refusal to recognise that
AIDS is increasingly becoming a single cause of the disintegration of our

If we all firmly believed that AIDS is a destroyer of the gift of life we
would all lend a hand towards the prevention of the disease, especially in
view of the fact that a cure eludes the medical profession. AIDS is the
very antithesis of life, an absurdity on the negation of the beautiful. It
renders the gift of sexuality suspect, the very gift that makes life possible.
Christians are to disseminate the Good News, they are to be healers as
their Master. It is therefore consistent with Christian calling to be
courageous and generous in giving care to those PWA (People with
AIDS). Church is not just a place of worship but also a refuge of healing
and of friendship. We therefore strongly recommend that each Christian
community, each community of faith, each congregation, has a
responsibility of sharing the burden of those with AIDS by being
available, by accompaniment, and by giving care. The absence of such
gestures is in fact an indictment on Christian communities - about their
much vaunted claims of love of neighbour, of caring for the other.
We are our brothers' and sisters' keeper. AIDS is putting that claim to the test. Each congregation ought to account how it has responded in an ongoing manner to the AIDS pandemic. As Church leaders we ought to hold each other accountable. What do we and our respective communities do about caring for and ministering to PWA? What do we do about healing our brokenness with visible and tangible compassion?

Secondly, the Churches can go a long way towards helping to remove the stigma from PWA. The Jews asked Jesus about the man born blind: "Who has sinned? Was it he or his parents?" The Church's preoccupation with moral judgment, the temptation at passing judgement on PWA creates a serious problem. This is not to deny the fact that relationships are not morally neutral. Relationships entail a moral dimension. There are values of fidelity, of self-respect, of respect for the other. Values are foundational to any relationship. Rather than being judgemental about PWA it is imperative that Churches help to develop a solid sense of moral responsibility in relationships. While AIDS disease offers us an opportunity for moral awakening in our responsibility towards each other, it is equally important to change our judgmental attitudes if we are to be open and effective in talking and doing something about it.

Thirdly, consistent with the overall goal of 'Love Life' - Churches could also usefully aim at targeting the youth, especially young people who are not yet sexually active, by helping them to cultivate a positive attitude about themselves, their self-worth and by helping them to unlock the world of possibilities and dreams of who they possibly can become. We can help to release energies in them, on an incremental basis, that will entice and compel them to hold on to their dreams, dreams of a radically different life-style and different living conditions from those of their parents. Such a vision of life, life in abundance, is consistent with our being made in God's image. Children, pupils, students ought to stay in school until they gain a profession. The only door that truly leads to genuine freedom, is self-mastery, self-respect, education and a profession.

Let's talk about it and do something about it (i.e. AIDS). Let's impose a ban on 'spaza' teenage families in season and out of season, a refrain that needs to inset itself into the rhythm of youthful lives. We challenge the churches to adopt this positive goal of 'Love Life', avoiding teenage pregnancies, retaining pupils (students in schools) for the sake of their future. Teachers are to do more than teach but also form, develop human growth.
Fourthly, it is not inconceivable that all the organisations genuinely committed to the elimination and prevention of AIDS could collaborate in specific areas of common interest. 'Love Life' is a secular organisation, investing significant resources in the campaign against AIDS by encouraging the churches to identify those areas of possible collaboration with 'Love Life'. 'Love Life' has become the premier organisation that has publicly and significantly raised the level of involvement with young people throughout the country through its Youth Centres. There is need for collaboration. The bill boards help to drive the message home, at times in subtle ways, at times in a brutally frank manner, that annoys those who still want to beat about the bush about the radicality of AIDS. It is important too, to form on-going, committed and structured partnerships, which are clearly aware of ideological and theological moral differences, but are at the same time committed to a common goal of confronting HIV/AIDS headlong.

VII.

“THE PAIN AND TRAUMA OF AIDS CAN BE BEATEN BY INTERNATIONAL COMPASSION”
(Bishop Kevin Dowling, 11 November 2003)

“The toll exacted by sickness and death associated with AIDS could, if not dealt with comprehensively, cause the disintegration of the South African society,” warned Bishop Kevin Dowling of the Southern Catholic Bishops' Conference, at Sizanani Conference Centre in Bronkhorstspruit, east of Pretoria.

Bishop Kevin was addressing two hundred international delegates from thirteen African countries, who are gathered to find ways of caring for the orphans and vulnerable children in sub Saharan Africa.

He encouraged government and business to listen to “those who experience the plight of orphans and vulnerable – Church constituencies are constantly exposed to the cries of innocent and helpless children.”

Global structures are a hindrance to the life of the African child. International debt repayments, unfair trade barriers and huge agricultural subsidies continue to keep our continent perpetually impoverished and unable to fully realise the potential of our own human and natural resources.

Besides the growing and heart-rending culture of child-headed households, grandparents are being forced by circumstances to care for
orphans and vulnerable children.

Grannies are not a *solution* to the orphan crisis. They are tired by demands made on them. In their poverty they are denied opportunities to enjoy their deserved time of rest and old age. It is not easy to bury your own child and then take care of their children.

Thus it is important to respect the role of home-based carers. Home carers are compelled to incorporate orphan care as part of their calling.

We must also begin to train and support small children to care for their own terminally ill parents.

Positive government and business contribution can help to ease the escalation of orphans and vulnerable children. The provision of anti-retroviral programmes, including Prevention of Mother to Child therapy and child care supplemented by nutritional programmes, is a vitally important sustainable solution to the crisis facing us. This will enable the parents to live longer and to be able to care for the children.

How can billions be spent on a mythical war against Iraq while doors are closed to the survival of those of those infected and affected by AIDS? America and the West must realise that AIDS will destroy their economies in the long term. AIDS and poverty can only produce more terror attacks. Economic giants of the world will subsequently lose prospects for investment, trade and growth as Africa is crippled by AIDS.

It seems that only in the face of such considerations, well argued, will the world powers perhaps be moved to respond to this human tragedy. The policies or lack of policy of governments and the powerful ones of the world who debate in Five Star luxury and postpone urgent decisions until 'next year' condemns a few hundred thousand more to a painful, horrible death.

VIII.

THE CHURCH IN AFRICA IN FACE OF THE HIV/AIDS PANDEMIC: “OUR PRAYER IS ALWAYS FULL OF HOPE”
(MESSAGE ISSUED BY SECAM, DAKAR 7 October 2003)

Dear brothers and sisters in the faith,

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

“*Grace to you and peace from God our Father and the Lord Jesus Christ!*” (1 Cor. 1:3).
We, Cardinals, Archbishops and Bishops of Africa and Madagascar greet you in faith and with warm affection. Gathered in the 13th Plenary Assembly of our Bishops' Conferences of Africa and Madagascar (SECAM), we have taken up the AIDS pandemic and its horrible consequences. In doing so we have been very close to you, our dear brothers and sisters who are infected and affected by HIV/AIDS and also to you who have been moved to join in the fight against the scourge of AIDS.

1. We are in solidarity

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

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

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

2. Let's be true to ourselves

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

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

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

3. Let's change behaviour

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

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

4. Let's be responsible.

The solidarity that we spoke of earlier binds us to joint responsibility in

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1. Education for Life, Youth Alive, Action Familiale, Pro Vita
tackling the global and complex challenges facing us: interminable and recurrent wars, conflicts and violence in which rape is often used as a weapon, not just psychologically violent but physically destructive through HIV/AIDS!

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

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

**Plan of Action**

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

1. **In solidarity with you, we commit ourselves to:**
   1. Utilise and increase the human, material, and financial resources dedicated to address the situation of HIV and AIDS in our communities, and to identify focal points in parishes, dioceses, and national Episcopal conferences in order to assist with gathering information and development of programme strategies. In this same effort, we are committed to coordinating our efforts at the continental level in the struggle against the pandemic.
   2. Make sure that the health services of the Church, the social services and the educational institutions respond appropriately to the needs of those who are ill with AIDS.
   3. Focus on the particular vulnerability of girls and the heavy

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burden on women in the context of the HIV pandemic in Africa.

4. Advocate vigorously for access to treatment for those who are prevented from obtaining it through poverty and structural injustices.

5. Involve those who are knowledgeable about traditional medicines and other natural remedies in research into means of struggling against AIDS.

ii. Faithful to our Gospel convictions, with you we commit ourselves to:

1. Collaborate with other Christian confessions and with people of other faiths working in their respective communities to support those affected and infected by HIV/AIDS.

2. Promote closer partnerships with civil society, the business sector, governments, the United Nations, international and intergovernmental agencies, and particularly with organisations of people living with HIV and AIDS, in order to increase the capacity for care and support, without diluting our evangelical convictions.

iii. Facing the serious threat of AIDS, with you we are committed to:

1. Promote changes of mentality, attitude and behaviour necessary for confronting the challenge of the pandemic.

2. Work tirelessly to eradicate stigma and discrimination and to challenge any social, religious, cultural and political norms and practices which perpetuate such stigma and discrimination.

3. Play a major role in eradicating the damaging myths of stigma and discrimination by facilitating Voluntary Counselling and Testing (VCT) so that those who are infected might benefit from the care and support they need. This will also help better to control mother-to-child transmission.

4. Advocate with government at all levels and with intergovernmental organizations to establish policy priorities that adequately support those affected by HIV and AIDS, that provide access to care and treatment and a life of dignity for people living with HIV and AIDS, and that implement the commitments made at various inter-governmental meetings.
iv. **In shared responsibility with you, we commit ourselves to:**

1. Develop educational programmes which integrate the theme of HIV/AIDS in theology and religious formation. These programmes will also include moral principles and practical skills for promoting healthy relationships and a well-integrated sexuality.

2. Promote and deepen theological reflection on the virtues of compassion, love, healing, reconciliation, and hope, all of which are capable of confronting the judgement, shame, and fear that so often are associated with HIV and AIDS.

3. Organize workshops at the regional, national, diocesan and parish levels in order to increase accurate knowledge and sensitivity around all HIV and AIDS-related issues relevant to our Church.

4. Encourage people living with HIV/AIDS or affected by it to become actively involved, in our local communities, as resource persons in the struggle against the pandemic.

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

1. Train clergy, religious, and committed laity to accompany people living with and affected by HIV and AIDS with prayer and spiritual counselling.

2. Provide doctrinal, spiritual and social formation, and the best possible professional training, for those willing to become involved in caring for and accompanying those who are living with and affected by HIV/AIDS.

3. Welcome people living with HIV and AIDS in a warm, non-judgemental and compassionate manner in our churches and ensure them a “place at the table of the Lord.”

4. Provide the sacraments and sacramentals, as appropriate and requested, to Catholics living with the virus.

5. Put into action the challenge addressed by our Holy Father Pope John Paul II to the Church in our continent through his Apostolic Exhortation, *Ecclesia in Africa*:

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

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

IX.

SACBC CALLS FOR GREATER COOPERATION BETWEEN STATE AND CHURCH IN ASSISTING PEOPLE WITH HIV/AIDS (4 February 2004)

“The Catholic Church calls on the South African Government to step up its response to AIDS in the country by delivering on its proposed anti-retroviral roll out, and to overcome all bureaucratic hurdles which are hindering the realization of initiatives promoted by civil society in the health sector”, said the Bishops in a statement issued at the end of their plenary assembly in Pretoria today.

It would be tragic for our nation if the people stricken by the pandemic had to be deprived of basic assistance and medical care because of red tape and even more so by point scoring.

The Catholic Church has projects in place to provide treatment to HIV/AIDS patients in 24 sites throughout the country, reaching some of South Africa’s most marginalized communities. The first 5 sites will be starting to operate in the next week.

Second only to the State, the Catholic Church is the largest provider of home based care for the sick, of palliative care for the dying, and of care and support for AIDS orphans. Yet, many Church projects are struggling financially, while every year media reports highlight huge amounts of Government funding that goes unspent. Due to bureaucratic inefficiency and indifference many orphans who are entitled to maintenance grants

and sick people who have the right to disability grants, do not get them.

The Catholic Church urges the relevant government departments to streamline application processes to ensure speedy delivery. On her side, the Catholic Church has programs in place to assist people in obtaining necessary documentation to access grants and is ready to offer her services to collaborate with the appropriate state authorities.

A solid partnership and collaboration between State and Church in this area is the only way of ensuring that this funding reaches those who need it most.


The Southern African Catholic Bishops' Conference has announced a R2 064 000 grant to finance programs and initiatives fighting against HIV/AIDS in Botswana and South Africa. The announcement was made at Mariannhill Monastery near Durban, at the conclusion of the meeting of Bishops from South Africa, Botswana and Swaziland representing 5 million Catholics.

The amount has been added to R6 700 000 which was allocated to projects since the beginning of 2004. The money will be used to disseminate information, promote prevention programs and to treat and care for those who are infected, and support those who are affected by the disease and particularly the orphans- there are almost a million orphans in our region. The sponsored projects are fully operational and are constantly supervised by Church officials. In the last quarter of the year the AIDS office will contribute R8 000 000 more to approved projects.

Anti-retroviral Therapy
A greater amount of money has been allocated by the Catholic Church for the Anti-Retroviral therapy: 400 people are presently receiving ARV treatment at seven designated sites. These will be increased to ten in September 2004 when three more sites start functioning in Hlabisa (KZN), Winterveld (Tshwane/Pretoria) and Francistown (Botswana).
SOUTHERN AFRICAN CATHOLIC BISHOPS' CONFERENCE (SACBC)

Catholic Bishops announce the launch of their Anti-retroviral programmes in 22 sites in Southern Africa.

Thirty bishops, clergy and religious, and thousands of people were present when the SACBC announced the official launch of its Anti Retroviral (ARV) programme in Botswana, South Africa and Swaziland at a Mass celebrated at Regina Mundi Church in Soweto on Sunday 30 January.

This marked a further development in the HIV / AIDS programmes, which the Catholic Church has been running for several years, comprising home-based nursing and counselling, care for orphans and vulnerable children, hospice in-patient units, and education and prevention programmes.

Training of doctors and nurses for ARV programmes began towards the end of 2003. During 2004, the provision of ARVs began in 22 sites. Crucial to the implementation of this ARV programme is the careful accompaniment of patients on ARV treatment by the Church's home-care workers, many of whom are volunteers. A great debt of gratitude is owed to them.

Twenty sites, across seven of the provinces, are in South Africa, and are funded through the PEPFAR initiative of the United States Government. They are mostly in outlying areas not yet served by the South African Department of Health.

A Netherlands Catholic Agency, CORDAID, supports an outreach programme of Good Shepherd Hospital in Siteki, Swaziland, into remote rural areas. In Francistown, Botswana, CORDAID supports the treatment of foreign patients who are not citizens of Botswana.

The Ford Foundation from USA supports additional people on treatment at two sites in KwaZulu Natal: Madadeni (Newcastle) and Mtubatuba (Ingwavuma).

Fifteen hundred patients, including children, were on treatment at the end of December, with others beginning adherence training with the view to commencing treatment over the coming weeks.
Based on the results of a study commissioned by the Catholic Church, the SACBC applauds the breakdown of stigma where people are on treatment, giving them hope and new chances, while at the same time it recognizes the challenges in providing treatment to children.

The Southern African Catholic Bishops' Conference acknowledges and appreciates the cooperation offered by the South African Health Department and by the Provincial Hospitals, a collaboration that has facilitated the launching of the ARV programmes.

**XII.**

**CATHOLICS, JEWS PUT ASIDE DIFFERENCES IN AIDS FIGHT**

**Catholic and Jewish leaders meet in Cape Town**

*(7 November 2006)*

A high level meeting in South Africa, one of the world's countries hardest hit by the AIDS crisis, has united Vatican and world Jewish leaders in a call for international action against the pandemic.

The *International Herald Tribune* reports that world Catholic and Jewish leaders met in Cape Town on Tuesday to discuss Jewish and Catholic perspectives on health care with special reference to HIV/AIDS.

"No modern plague has afflicted as much death as HIV/AIDS. We wanted to look at ways Jewish and Catholic communities could be a source of blessing and healing," Rabbi David Rosen said following the first meeting in Africa of the International Jewish Catholic Liaison Committee, a key interfaith gathering.

The committee established by the Vatican through the Holy See's Commission for Religious Relations with Jewry is headed by the president of the commission, Cardinal Walter Kasper and Rabbi Rosen, president of the International Jewish Committee for Inter-religious Consultations, the representative body of world Jewry.

The meeting was attended by leading cardinals and rabbis, including Archbishop Lawrence Henry and Cardinal Wilfrid Napier from South Africa as well as the Chief Rabbi of Israel Yona Metzger and the Chief Rabbi of South Africa Warren Goldstein.
A joint declaration issued at the end of the meeting, addressed the plight of AIDS orphans and the role of religious leaders in addressing the pandemic, which is particularly prevalent in southern Africa.

"While recognising that our respective traditions may differ regarding possible preventative strategies with respect to HIV/AIDS and related afflictions, we unreservedly unite in calling for unrestricted palliative care and appropriate attention for all those suffering, threatened or victimized by this tragic pandemic.

"This call goes out especially to government and all who have the power, means and influence to implement it," the statement said.

The Church, which opposes the use of condoms as a contraception, is divided over calls for the church to permit condoms in the fight against AIDS, particularly when one partner in a marriage has the virus, the Herald Tribune says.

Rosen, said Jewish ethical teaching allowed for the use of condom if "marital relations were life-threatening", although it disapproves of them as a form of contraception.

"Where the Catholic Church has a strong emphasis on family, loyalty and chastity, we say these values are important but that there are people who are infected not because of a lack of loyalty or morality," he said.

The declaration released by the meeting said the "reality of millions of orphans, especially in sub-Saharan Africa, was seen as a pressing call for greater attention on the part of the international community aimed at enabling the economic and social development of the countries involved."

The meeting called for religious leaders to take a role in education, treatment, care for those affected by AIDS as well as the "need to eliminate" the stigma associated with the disease.

In another story, Kenyan Catholic bishops will release the Church's national policy on AIDS, All Africa reports.

The document "aims to encourage and fortify Kenyan Catholics, Christians and Muslims and believers from other faiths, to unite in the fight against HIV, the virus that causes AIDS," a statement from a task force that prepared the Church policy said.

The policy specifies the stand and role of the Church in dealing with HIV/AIDS and gives details of those involved within the Church in fighting the pandemic, the statement said.

The latest edition of Kenya Catholic Directory lists over 140 special
centres run by the Church countrywide to provide care for vulnerable groups, amongst them HIV/AIDS victims.

A national Catholic AIDS conference is proposed for 2007 to commemorate the 20th anniversary of the bishops' first message on AIDS in 1987.

Source: World Catholic and Jewish leaders meeting in South Africa unite against AIDS (International Herald Tribune, 8/11/06)
ABOUT THE EDITORS AND AUTHORS

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