



**BIBLE ENGAGEMENT IN THE CONTEXT OF HIV & AIDS IN AFRICA:
A STRATEGIC CONSULTATION FOR THE FORUM OF BIBLE AGENCIES**

BACKGROUND PAPER NO 1

**HIV/AIDS IN AFRICA:
HARMONIZING DEVELOPMENTAL AND
THEOLOGICAL RESPONSES**

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Introduction

The HIV/AIDS pandemic in sub-Saharan Africa defies attempts to describe it accurately. Despite the sheer volume of literature on the subject, it seems that words alone are inadequate to encompass the size and scope of the problem. On a continent that has already faced so much – war, famine, the Atlantic slave trade, colonization, exploitation of natural resources – a crisis has emerged that threatens to dwarf all those that preceded it. More than a disease, it is now a fact of life, having already virtually wiped out a generation, and leaving orphans and the elderly to cope in its aftermath.

Awash in “first world” affluence and insulated by the comfortable prosperity of academia, we in the West struggle to comprehend a problem of such breadth and complexity that seems so far removed from our reality. How can we understand both the size and scale of the epidemic without becoming overwhelmed? How can we both grasp the ‘big picture’ as well as how individual families and communities have been affected? Most importantly, how can we be compelled to act, in solidarity with fellow human beings, while at the same time respecting their agency, and attempting to not reinforce already existing colonial attitudes?

Faith communities represent both the best and worst in responses to the HIV/AIDS crisis. In the past they have been partially to blame for perpetuating stigmas and hindering public education efforts by an unwillingness to openly discuss issues of sexuality. However, today many faith communities are responding admirably in the face of incredible odds.

This paper provides a comprehensive overview of the state of the HIV/AIDS crisis in sub-Saharan Africa, its size, scope and the complexity of issues that contribute to the spread and deadly effects of the disease. It also examines some best practices in

addressing the crisis, both from within religious communities as well as traditional relief and development organizations. Additionally it looks at the theological community and surveys the landscape of indigenous African theologians to see how they are addressing this crisis of faith. Finally, a holistic view is taken to explain how Biblical theology, specifically, can speak to the crisis in such a way as to maximize the work that is already being done and to harmonize the approaches of the development and theological communities in such a way as to heal people emotionally and spiritually, as well as physically.

Methodology

The central argument of the paper is that traditional development approaches to the HIV/AIDS crisis in sub-Saharan Africa can be harmonized with theological responses from faith communities in such a way as to holistically address people's emotional, spiritual, and physical needs. .

In first assessing the overall picture, I am building on the insights of Paul Farmer (see *Pathologies of Power*, 2005 paperback edition) who appropriates tools from liberation theology to outline his perspective as a physician on human rights. Specifically, Farmer cites the work of Leonardo and Clodovis Boff and their strategy for affecting social change: observe, judge, act. "The 'observation' part of the formula is key, for it involves careful review of a large body of literature that seeks to explain the distribution of the disease within populations, to explore its clinical characteristics, and to evaluate...treatment regimens. This sort of review is standard in all responsible health planning, but liberation theology would push analysis in two directions: first, to seek the

root causes of the problem; second to elicit the experiences and views of poor people and to incorporate these views into all observations, judgments, and actions.”¹

This premise can be built upon to blend the tools and perspective offered by liberation theology with the close attention to Biblical principles characteristic of other Christian theologies. First, we seek to understand the big picture.

Overview of the Crisis

The Joint United Nations Program on HIV/AIDS (UNAIDS) states its mission as: “bring[ing] together the efforts and resources of ten UN system organizations to the global AIDS response.”² UNAIDS publishes an annual report on the state of the epidemic around the world. The majority of my statistics will be taken from this report, as it is arguably the most widely used and widely quoted source of information in the field of AIDS literature.³ Published in conjunction with the World Health Organization (or WHO, also an arm of the UN), the estimates in the yearly report are “based on all available data, including surveys of pregnant women, population-based surveys, and other surveillance information.”⁴

According to this data, in 2006 almost two thirds (63%) of all persons infected with HIV lived in sub-Saharan Africa – that’s 24.7 million people. An estimated 2.8 people in the region, both adults and children, became infected with HIV in 2006, more than all other regions of the world combined. 72% of the world’s AIDS deaths (2.1 million) were in sub-Saharan Africa.⁵

The WHO reports that almost all of the countries in its African region have generalized epidemics. A generalized epidemic is defined as one in which at least 1% of

¹ Farmer, p.146

² UNAIDS website: <http://www.unaids.org/en/AboutUNAIDS/default.asp> Accessed 3/19/07.

³ To read the report in its entirety, go to http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp

⁴ UNAIDS website

⁵ UNAIDS Update, p.10

women attending antenatal clinics in the urban areas are HIV infected. “HIV prevalence among pregnant women is a good indicator of the spread of the epidemic in the general population, as the level of HIV infection among pregnant women is close to the prevalence in the general population of men and women 15-49 years.”⁶ Therefore, WHO surveillance systems in most countries rely on monitoring HIV prevalence among women attending antenatal clinics. Additional sources of data on the course of the epidemic are prevalence surveys in specific risk populations (such as sex workers or mobile populations), routine screening of blood donors, patients with sexually transmitted diseases, and tuberculosis patients.⁷ Once a country is categorized as having a generalized epidemic (as opposed to a low epidemic or a concentrated epidemic, i.e. one confined to sub-populations) it means that HIV is firmly established in the general population. “Although sub-populations at high risk may continue to contribute disproportionately to the spread of HIV, sexual networking in the general population is sufficient to sustain an epidemic independent of sub-populations at higher risk of infection.”⁸

In addition to being accurate scientific indicators of the presence of the disease, women are also among its most vulnerable victims. Throughout the region, women bear a disproportionate share of the AIDS burden – they are more likely than men to be infected with HIV, and in many countries they are more likely to be the caretakers of those who are infected.⁹ Women in sub-Saharan Africa are infected more often and earlier in their lives than men. Young women aged 15–24 are between two and six times as likely to be HIV-positive than men of a similar age.¹⁰

⁶ UNAIDS and WHO, A History of the HIV/AIDS Epidemic with Emphasis on Africa. From: Workshop on HIV/AIDS and Adult Mortality in Developing Countries. New York, 8-13 September 2003, p.6
Accessed online 3/19/07:

http://www.un.org/esa/population/publications/adultmort/UNAIDS_WHOPaper2.pdf

⁷ Ibid, p.6

⁸ Ibid, p.3

⁹ UNAIDS Update, p.10

¹⁰ UNAIDS Report, p.88

Implications

No matter where one looks in sub-Saharan Africa today, it is possible to see the ripple effects of the virus. “HIV/AIDS today is a glaring reality in our lives. We have all seen and felt its effects on the human family. If not infected, we are affected in one way or the other. When one mentions, HIV/AIDS, the idea of threat to life, the perilous misfortune, affliction of human beings with suffering, unavoidable danger, disaster, and death come to mind.”¹¹

Life expectancy has been reduced drastically in many of the countries of sub-Saharan Africa, reversing years of progress made by development programs and other initiatives. Some estimates put life expectancy in the region at 47 years, compared to a projected average of 62 year without AIDS.¹² The people who die are teachers, health care workers, parents, government and other public sector employees, factory workers, or other types of workers. The vast majority of people living with HIV/AIDS in Africa are between the ages of 15 and 49 - in the prime of their working lives.¹³ Employers are forced to train other staff to replace those at the workplace who become too ill to work. “Through its impacts on the labor force, households and enterprises, HIV/AIDS can act as a significant brake on economic growth and development. HIV/AIDS is already having a major affect on Africa's economic development, and in turn, this affects Africa's ability to cope with the epidemic.”¹⁴ These deaths also mean that while governments are losing out in terms of their tax base and human capital productivity, there are increasing

¹¹ Nwaigbo, p.3

¹² AVERT website: <http://www.avert.org/africa.htm> Accessed 3/19/07

¹³ Ibid

¹⁴ Ibid

demands on public sector services such as health care, public education, and other social services.¹⁵

When a person dies from AIDS, their family not only loses that person's presence in their lives, but also their income. Some income earners are forced to stay home and take care for relatives who suffer from the disease. Children lose parents, and are forced to either look after themselves or move in with relatives or some other caretaker, putting an additional strain on those households that are already likely affected. "In sub-Saharan Africa, approximately 9% of children under the age of 15 have lost at least one parent to AIDS, and one in six households with children is caring for at least one orphan."¹⁶

The AIDS crisis in sub-Saharan Africa is expected to continue reverberating, even after infection, prevalence, and death rates begin to fall, as they have in some countries where prevention and treatment programs have been effective. With such a tremendous loss of human capital and reversal of decades of progress in economic development, the damage has been done. AIDS is also having a notable impact on other areas of public health, as it is considered the primary force behind the global resurgence of tuberculosis.¹⁷ Testing and prevention are still important battlegrounds in the fight against AIDS, as an estimated two million South Africans living with HIV do not even know that they are infected and believe they face no danger of becoming infected—and therefore are unaware that they can transmit the virus to others.¹⁸

Developmental Approaches

With the resulting loss of human capital, damage to the family structure, and strain on the bonds of community, development agencies are faced with complex

¹⁵ UNAIDS Report, p.93

¹⁶ Ibid, p.92

¹⁷ Ibid, p.90

¹⁸ UNAIDS Update, p.13

challenges as they attempt to perform their traditional roles of enhancing economic development and sustainability. The primary ways in which they address the crisis include: preventing the spread of the disease, medical treatment for those who are infected and caring for those in the community who are adversely affected by their own infection or that of family and community members.

Many NGOs and particularly faith-based organizations (FBOs) choose to focus their efforts on behavior modification for prevention. The “Faith in Action” report, conducted by the Global Health Council in 2005, undertook a comprehensive effort to evaluate the role of FBOs in addressing the AIDS crisis. In so doing, they noted that the World Health Organization finds that one in five organizations currently involved in HIV/AIDS programming is faith-based.¹⁹

However, the conservative social messages of some religious organizations are the frequent targets of criticism, particularly from the West. “By opposing sex education, discouraging condom use and explaining AIDS as God’s judgment on sins of sexual immorality, Christianity and Islam have both been portrayed as a liability for combating AIDS. This sentiment pervades a great deal of the AIDS literature from the social sciences, from governmental and non-governmental organizations, and from popular media.”²⁰ Liebowitz (2002) finds that research on the impact of FBOs on HIV/AIDS does not constitute a large portion of the overall extensive body of research that exists on the crisis. His research suggests that biomedical literature dominates this field and that due to the difficulty in quantitatively assessing the impact of religion on society, it is often overlooked as a factor. “Other reasons for the relatively limited exploration of religion in such studies may include its complex nature, the controversial issues

¹⁹ “Faith In Action” 2005 Global Health Council, p.14 cf World Health Organization World Health Report 2004: Changing History. Geneva: WHO, 2004.

²⁰ Trinitapoli, Jenny. “Religious responses to AIDS in sub-Saharan Africa: an examination of religious congregations in rural Malawi.” *Review of Religious Research*, 47 no 3 Mar 2006, p.256.

surrounding the separation of church and state, and the relatively modest impact of religious leaders in much of the developed world where many of the researchers are based.”²¹

Furthermore, the “Faith in Action” report mentioned above chose a survey of stakeholder opinion as its methodology, because a survey of literature in the field revealed a lack of empirically based information on the efficacy of FBOs in combating the AIDS crisis. Any overview of faith-based interventions in this area will by necessity include a combination of qualitative, anecdotal, and perhaps even speculative information.

“Faith in Action” attempted to explore FBO impact in five different areas: mitigating the impact of the disease, changing behavior, empowering vulnerable groups, accountability, and public policy. With regard to impact mitigation, the study found that in most countries surveyed, especially Kenya and Uganda, FBOs are thought to successfully utilize their existing networks of hospitals and clinics to serve the health care needs of people living with HIV/AIDS. In areas where FBO infrastructure is strong, interviewees also cite examples of FBO involvement in expanding access to antiretroviral drugs. Behavior change was found to be the most controversial aspect of FBO involvement, with many focused exclusively on abstinence and faithfulness (behaviors which are sometimes out of individuals’ control). The FBOs were found to have made some progress on empowering vulnerable groups, overseeing efforts to improve livelihoods and increase access to social and health care services for women. Accountability was perhaps the weakest point, as many FBOs were perceived to be weak in terms of documentation and evaluation. And lastly, informants provided a number of

²¹ Liebowitz, Jeremy. 2002. “The Impact of Faith-Based Organizations on HIV/AIDS Prevention and Mitigation in Africa.” Health Economics and HIV/AIDS Research Division (HEARD): University of Natal, p.4.

examples wherein FBOs had exemplified leadership in influencing public policy within the respective countries.²²

Uganda is an often-cited and well-known case where involvement of faith groups is thought to have met with some success in reducing the rate of infection. In some urban surveillance sites, prevalence declined from 30% to 10% between 1993 and 1999.²³ The “ABC” message (Abstain, Be faithful, use Condoms) is widely credited with this drop in new cases of infection. Liebowitz notes that it was a multi-sector approach that emphasized behavior change, and demonstrated that government promotion of condom use can coexist with church efforts to emphasize abstinence and fidelity. Uganda also benefited from a high level of social capital and institutional involvement.²⁴ “Combined evidence suggests that religious organizations and other opinion leaders in Uganda (e.g., political leaders, school authorities, and traditional healers) who advocated abstinence and fidelity have had a significant effect on the overall decline in the HIV infection rate.”²⁵

Today, many FBOs have implemented programs to address the growing AIDS crisis. For example, in 2000 World Vision launched its “Hope Initiative” in high-prevalence, high-risk countries around the world. The initiative focuses on prevention, care, and advocacy and aims to integrate AIDS work into the larger existing World Vision programs on child health, micro-enterprise development, food security, education and peace building.²⁶ Food for the Hungry, another Christian NGO, lists its programs as: Biblical training on abstinence and faithfulness, medical support, outreach, and

²² “Faith in Action: Examining the Role of Faith-Based Organizations in Addressing HIV/AIDS. Global Health Council, 2005. http://www.globalhealth.org/images/pdf/faith_in_action/faith_in_action_final.pdf. Accessed 3/19/07.

²³ Liebowitz, p.19

²⁴ Ibid, p.20

²⁵ Green, E.C., *Faith-Based Organizations: Contributions to HIV Prevention*. Washington, D.C.: USAID/Washington and The Synergy Project, TvT Associates, Washington, D.C. (Sept. 2003), p.9

²⁶ http://www.worldvision.org/get_involved.nsf/child/hope_about. Accessed 4/10/07.

supporting orphans and HIV/AIDS victims.²⁷ World Relief, which is the international development organization affiliated with the (US-based) National Association of Evangelicals targets its efforts to work through local churches. A program called “Mobilizing for Life” “equips churches and trains local believers to reach out with compassion to their hurting neighbors.”²⁸

World Relief’s leveraging of local churches in the fight against AIDS is particularly interesting in light of Jenny Trinitapoli’s study of religious responses to AIDS in rural Malawi. She says she chose to look at individual congregations because most studies have focused on religious nonprofits and denominations, overlooking congregations which are often the first and most immediate level of religious organization. Her study finds that religious leaders in Malawi often discuss AIDS in their weekly services, that they refer to it both explicitly and implicitly, and that religious messages regarding the spread of HIV are focused on abstinence and fidelity.²⁹ The impact of these efforts remains difficult to assess. Nevertheless her findings are important because they challenge the common assertion that religious organizations are silent about AIDS, or that they stigmatize people living with HIV/AIDS.

Scholars and NGOs in the West may have a hard time distinguishing between conservative messages about sexual behavior and messages that are stigmatizing. Trinitapoli’s work maintains that while such conservative messages may make secular Westerners uncomfortable, they still need to be included and wherever possible, impartially assessed, within the broader field of scientific research. Such honest appraisal may reveal that clergy members, as key authority figures in many communities, could be

²⁷ http://www.fh.org/hiv_aids_work. Accessed 4/10/07.

²⁸ <http://www.wr.org/whatwedo/aids.asp>. Accessed 4/10/07

²⁹ Trinitapoli, p.267

an untapped resource for working to combat the spread of HIV.³⁰ “Part of the challenge now is for health workers to overcome their own biases against working with FBOs.”³¹

In 2005, *Time* Magazine highlighted the work of Peter Okaalet, director of the Africa chapter of MAP International, a Christian NGO. Okaalet, a physician, decided to go to seminary in the mid-1980s in order to bridge the gap between physicians and ministers in addressing the AIDS crisis. Now, he runs seminars and has helped establish master’s degree programs in pastoral care and HIV/AIDS at 14 Bible colleges and seminaries in East and Southern Africa. The *Time* profile posed the question, why focus so much energy on ministers and churches? “People forget that churches also have hospitals in Africa,” Okaalet responded. “Most of the mission-based hospitals are in the rural areas where governments cannot reach. Where the road for the four-wheel-drive stops, the pastor gets on his bicycle. Where the bike path stops, the pastor lays it aside and goes on foot.”³²

Green (2003) points out that the spiritual fortitude provided by the belief systems of these religious organizations uniquely equips them for dealing with a tragedy of this size and scope. He says that they “stress and support faith, idealism, and compassion, which are powerful and sustaining motivators for employees and volunteers who work with sick and dying individuals under extremely difficult conditions.”³³ This means that the work of FBOs is effective not only because their message resonates with those to whom they are ministering, but also with those performing the ministry.

It seems that the most promising area for religious involvement in the fight against AIDS in Africa, from a developmental standpoint, continues to be influencing behavior modification and prevention efforts. However, as Philippe Denis points out,

³⁰ Ibid, p.267

³¹ Green, p.4

³² Gorman, Christine. “Bridge Builder,” *Time* Magazine, October 31, 2005.

³³ Green, p.5

“good information does not always bring about a change of behavior.”³⁴ Denis also highlights the fact that understanding the cultural context is vital to understanding the crisis itself. Changes in socio-economic environment that disrupt family structure, types of sexual practice, and sexual violence are all important factors in the continued transmission of HIV. “HIV/AIDS calls on the churches to understand sexuality in all its dimensions: not only as an individual act, which can be right or wrong, but as a reality determined by social, economic and cultural factors. In Southern Africa one cannot understand the current patterns of sexual behaviour without reference to the migrant labour system, which has destabilized family life and gender relations for generations in large sectors of society.”³⁵

FBOs that wish to continue and improve upon their current work in the area of HIV/AIDS would benefit from further scholarship assessing effectiveness of their work. Wherever possible, efforts should be made by FBOs themselves to improve systems of monitoring and evaluation and provide quantitative assessments of their results. Such quantitative research is likely the best way to convey to the wider scientific and public health community the value of said work. Lastly, forward-thinking theologians who influence the belief systems that under gird the work of religious FBOs should attempt to understand behavior change not just as individual choices regarding sexuality, but as societal forces that influence those individual choices. By addressing larger questions of poverty, justice, and community, it may be possible to facilitate an environment in which those choices become easier.

³⁴ Denis, Philippe. “Sexuality and AIDS in South Africa.” *Journal of Theology for Southern Africa*, no 115, 2003, p. 64.

³⁵ *Ibid*, p.75

Theological Overview

Western theologians who are used to thinking about issues in the abstract, philosophical, academic sense are often at a loss when confronted with the ugly realities of an HIV-positive world. Much like development professionals, theologians in the West are in need of appropriate models of engaging with the global South, and with Africa in particular, that take into account the realities of cultural, religious, economic, and socio-political differences. This section looks at some theological approaches to HIV/AIDS, maintaining some modalities of classification familiar to Western readers, while at the same time continuously critiquing through the eyes of African theologians. We will first examine two traditional theological approaches to AIDS, then explore some areas of theology that could use further developing, and then examine ways in which churches are acting out their theology, aka lived theology or praxis.

Traditional Approaches

Generally speaking, there have traditionally been two ways of approaching AIDS theology from the western perspective. We in the West would recognize them as what we call the conservative and liberal approaches.

Briefly, the conservative approach focuses on individual behavior as the key to understanding and preventing the spread of the virus. While being strong on messages of abstinence and faithfulness that have proven effective in some settings (see previous section on Uganda), these churches and religious leaders run the risk of re-stigmatizing the infected. Some have even viewed AIDS as God's punishment for immoral behavior. Often paternalistic, those who espouse this view assume that individuals are free to make the choice to engage in high-risk behavior. "...too much emphasis on abstinence and fidelity strikes one as being simplistic and narrow-minded. These campaigns take no

account of the factors, which lead people to behaviour patterns putting themselves at risk, whether physiological, cultural, social or economic.”³⁶

While abstinence and faithfulness are in fact key from both a public health standpoint as preventative measures, and from a moral standpoint for the fabric of the religious community, too heavy a focus on them can ignore societal structures of injustice and oppression which also contribute to the situation of the infected/affected. “Prone to moralistic judgment over those who seemingly have led promiscuous lives, the church has sponsored little analysis of patriarchy and gender injustice within society.”³⁷

On the contrary, a more liberal approach focuses on the larger society as the source of the problem and sees people as victims of their circumstances. “It might be argued that the most urgent ethical issue arising from the pandemic of HIV/AIDS is the lack of distributive justice. The poorest, most marginalized and oppressed members of society are also most vulnerable to the threat of HIV and the tragic consequences of AIDS. They are deprived of access to the preventative education, care, treatment and support which they urgently need.”³⁸

Instead of focusing on individual behavior as a means for changing the course of the pandemic, this attitude encourages the faithful to advocate at a higher level for large-scale change that would alter the conditions that allow the virus to take hold. It also focuses on lack of access to treatment as a key area where injustice is most visible. “It does not make sense that one part of humanity can have a quality life even after infection with HIV, while the other half dies quickly due to poverty and curable opportunist

³⁶ Denis, Philippe. “Denis, Sexuality and AIDS in South Africa” in *Journal of Theology for Southern Africa* 115 (March 2003), p. 74.

³⁷ Haddad, Beverley. “Reflections on the church and HIV/AIDS” in *Theology Today*, 62 no. 1 (April 2005), p.34.

³⁸ Czerny, Michael and Robert J. Vitillo. “The church’s role and approaches in HIV/AIDS advocacy” in *AFER* 47-48 no 4-1 (Dec 2005-Mar 2006), p. 285-286.

infections. This is where the message of Jesus in Luke 4:18-19³⁹ defines the mission of the church to deal with all forms of oppression that include social injustice, disease, and poverty, racial and sexual discrimination and to promote liberation, social justice, life and healing. Globalization has not promoted equal distribution of drugs to all the infected people of the world.”⁴⁰

Problems arise when this theology draws too heavily on Western liberal ideas toward conservative beliefs and cultures, making them irrelevant in the African context. It could also be argued that such focus on societal structures, to the exclusion of individual behavior, does not sufficiently empower people to make decisions that affect their future, seeing them only as victims.

It is clear that the Western divide between conservative and liberal approaches does a disservice both to African worldviews, which tend to see individuals as inseparable from their community, and to the realities on the ground on a continent wracked by disease and suffering.

Indigenous Theology

Isabel Apawo Phiri writes about sitting with a group of African women theologians and discussing the crisis confronting them in the HIV/AIDS pandemic. For these women, she said, the central issue was one we would call ‘theodicy’ – attempting to understand the coexistence of human suffering and a loving God. “If one believes strongly that HIV/AIDS is a punishment from God for the disobedient, then what kind of mission is directed to the infected? Is HIV/AIDS a punishment from God or is suffering

³⁹ Luke 4:18-19 marks Jesus’ first public address that inaugurates his ministry, where he says “The Spirit of the Lord is upon me, because he has anointed me to bring good news to the poor. He has sent me to proclaim release to the captives and recovery of sight to the blind, to let the oppressed go free, to proclaim the year of the Lord’s favor.” (translation: New Revised Standard Version)

⁴⁰ Phiri, Isabel Apawo. “HIV/AIDS: an African theological response in mission” in *Ecumenical Review* 56 no 4 (Oct 2004), p. 429.

necessarily a result of sin? Does God use HIV/AIDS and suffering to bring people to God-self? Why does God allow the faithful partners, who are committed to prayer, to get infected? Is there room for the justification of unjust systems that cause people to suffer unnecessarily? Why is there still stigma among the people of God towards people with HIV/AIDS? Can faithful married women protect themselves from the virus? Why do some people get infected and not others, yet they are all praying to God for protection? Is there hope for the infected and affected of HIV/AIDS?”⁴¹ Any theology that attempts to deal with the AIDS crisis must address these and other questions of theodicy if it hopes to be resonant with the infected/affected.

A relevant theology must also address the issues of gender and sexuality. This is especially tricky for those with Western liberal ideas about women’s roles in society when engaging with more traditional cultures and belief systems. Nevertheless, with women being more vulnerable to the virus, both physiologically and because of sexual violence and lack of choice to engage in risky behavior, these issues cannot be ignored. “For the church to become a place of redemption, hope, and healing, positive Christian teaching on sexuality must be introduced. Women, particularly, need to find in the church a safe space to unburden the load they carry as subordinate partners in marriage relationships. They need to know that their husbands’ unfaithfulness will not go unchallenged by the church, nor will those whom they take into their confidence dismiss their stories of abuse. The church must see its ministry in an HIV-positive world as a place where sexuality is celebrated in its goodness, and challenged where it brings death.”⁴²

Third, meaningful Scripture engagement is essential for religious communities who want to remain relevant to the HIV-positive world. Phiri writes, “A mission-

⁴¹ Ibid, p. 423

⁴² Haddad, p. 35

oriented theology of HIV/AIDS acknowledges that the Bible is central in Africa and is used as authoritative within the church. Whenever the church is seeking direction, the Bible is consulted in all circumstances. Musa Dube has rightly stated that it is therefore not surprising that in this era of the HIV/AIDS pandemic the church has gone back to the Bible to search for knowledge concerning the disease, healing, stigma and isolation, guilt and fear, caring, death and dying. The major problem of African Christians is their uncritical reading of the Bible, which becomes dangerous in the era of HIV/AIDS as it leads to wrong interpretations.”⁴³

Too often the Bible has been used as a tool or a weapon to oppress those seen as immoral. And while at times in the Biblical narrative, God is presented as wrathful and vengeful, he is also compassionate and shown as standing alongside the poor, the oppressed, and the suffering. Exploring and emphasizing these themes with the infected/affected, rather than simply reiterating moralistic pronouncements, can lead to the Bible being a source of inspiration and encouragement in the most difficult of circumstances. “The Bible-study group where biblical texts are explored contextually becomes a place of solidarity – the kind of solidarity that should drive the church in an age of HIV/AIDS.”⁴⁴ Therefore, the discipline of theology should continue to probe the Bible for fresh new ways of understanding God’s will in the midst of the crisis, while also paying attention to questions of theodicy and issues of gender and sexuality.

Praxis

Churches and religious communities in Africa have been and will continue to be in the midst of working out their theological approaches while immersed in the crisis. The three main areas where they have put their theology to work are: caring for the

⁴³ Phiri, p.426-427

⁴⁴ Haddad, p.33

infected/affected, messages aimed at prevention, and advocacy. Caring for the sick is a fairly well-understood role for religious communities and so will not receive much attention here, other than to say that in hospitals as well as community centers and home visits, people of faith continue to live out their mission of comforting those broken in body and spirit.

Messages aimed at prevention are also fairly well-understood, as they were discussed in the previous section. The challenge will continue to be: how can lessons of abstinence and faithfulness be included in an overall prevention effort that does not re-stigmatize the infected, does not ignore other public health approaches, and does not overlook the larger societal sins that oppress the people and lead to the spread of the virus? “A moral judgment is as necessary as ever in these times of AIDS. But it needs to be well informed. Pronouncements, which envisage the sexual act in isolation from its social and cultural context are counterproductive.”⁴⁵

Advocacy is a newer and more uncertain terrain for religious communities, but one that holds great promise. “How do we summarize the Church’s role in HIV/AIDS advocacy? Perhaps it is best presented as promoting integral access for all – access to life and family, full participation in society, membership and inclusion in our faith communities, adequate nutrition, care and treatment, and support for those grieving the loss of loved ones as a result of HIV related illness.”⁴⁶ Just as religious leaders have the moral authority to potentially affect the behavior of individual congregants, so their words carry weight with the world around them. These leaders must continue to call attention not only to the personal behaviors that have led to the spread of the virus, but to the larger societal injustices, such as gender inequality, sexual violence, or lack of access to antiretroviral drugs, that keep people in bondage to poverty and disease.

⁴⁵ Denis, p.75

⁴⁶ Czerny, p.288

Conclusion

The AIDS crisis has already effectively wiped out a generation of Africans. To say it is a defining moment in history would be a vast understatement. However, it is also a defining moment for the church. Perhaps more than any other crisis, it is forcing a reevaluation and reshaping of theology to explain the unexplainable and console the inconsolable. “Yes, we live in critical and dangerous times; but our HIV-positive world challenges our traditions and cultures and forces us to seek new ways of living that are redemptive for both women and men. The church has been given a moment of grace and opportunity to rethink its mission and transform its structures in order to become a place of redemption, hope, and healing.”⁴⁷ It is crucial that the work of theologians continues to explore the intersection of conservative and liberal ideas, individual and societal sins, and academic and practical theology, if they hope to remain relevant to a continent full of the sick, the dying, the widowed and the orphaned. In so doing they can inform the work of development professionals, who, whether motivated by religious faith or by some other moral conviction, are co-laborers in the effort to manifest God’s presence in the midst of hopelessness.

⁴⁷ Haddad, p. 33

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