07

RESEARCH RESULTS

Klaus Fleischer et al.

Responses of the Catholic Church to HIV and AIDS in Africa: Lessons learned

An international field study by African and German theologians and health workers

Summary

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1. Introduction

Since the early years of the HIV pandemic, Catholic institutions in sub-Saharan Africa have responded by providing information, treatment, care and support to those infected and affected. Between 2010 and 2013, three interdisciplinary teams carried out field research to document and analyse the responses of the Catholic Church to the HIV pandemic in three African countries: Ethiopia, Malawi and Zambia. They focused in particular on how programmes initiated and run by the Catholic Church have assisted people living with HIV (PLWH), their families and groups in all sections of society in these three countries.

1.1 Study Background

The engagement of German Catholic institutions in efforts to respond to the challenges of HIV and AIDS in Africa stems back more than twenty years. Misereor and the Medical Mission Institute in Würzburg recognized the possible magnitude of the new pandemic and sought ways to assist local churches in Africa. Ecumenical discussion inspired this engagement through, for example, the "pharma dialog" of the Joint Church and Development Conference (GKKE) with the pharmaceutical industry active in the production of antiretroviral drugs (ARVs).

In 2006, the Commission for International Church Affairs of the German Episcopal Conference undertook a journey to South Africa. The purpose of the visit was to meet, face-to-face, with women and men living with HIV. The visit also aimed to learn how clergy and lay people in the local Church reacted to the plight of these people, their families and the various groups in society. Based on reports from a broad spectrum of affected persons, as well as Caritas and diocesan groups from all over South Africa, the group explored ways to define the responsibility of the Church and to develop appropriate forms of assistance from the countries of the global North. Six German bishops, accompanied by theological and health experts, under the leadership of Archbishop Dr Ludwig Schick, took part in the journey. Out of this profound experience, the Commission for International Church Affairs decided to set up a research

project entitled ”Lessons learned from the responses by the Catholic Church to HIV and AIDS in Africa”. The Commission had a very wide remit, covering theological, ethical and pastoral questions, as well as curative and preventive health issues – all from an African perspective. African theology and health researchers, therefore, were to be invited to develop questions, assisted by a team from Germany.

The study was inaugurated on 15 March 2010, with a budget of €198,000. It was led by the theologians Professor Dr Albert-Peter Rethmann from the Institute for Global Church and Mission (IGCM), Sankt Georgen, Frankfurt am Main, and his co-worker, Dr Gregor Buß, along with Dr Marco Moerschbacher from missio Aachen. Public health input was provided by Professor Dr Klaus Fleischer, Dr Klemens Ochel, and Dr Piet Reijer from the Medical Mission Institute in Würzburg (MI).

The MI set up a literature database and developed the research procedures, while the IGCM in Frankfurt am Main took care of the financial management of the project.

A selection of research sites had to be made, taking into account the research capacity, and the time and funds available. The following criteria were used in this selection process: high number of people living with HIV; long-standing efforts in HIV prevention, medical and pastoral care; involvement in international dialogue on social affairs with church-related agencies in Germany; and readiness to participate in the research. Four Catholic dioceses and three seminaries were selected for the study, as follows:

- Ethiopia: the Dioceses of Emdibir and Adigrat as focal points, and the major seminaries in Addis Ababa and Adigrat
- Zambia: the Diocese of Chipata as focal point,
- Malawi: the Archdiocese of Lilongwe as focal point, including the major seminary.

The study followed approved scientific criteria, with detailed documentation of the enormous variety of answers in the semi-structured interviews of individuals and groups, their answers in case studies, and back-

ground interviews with bishops and rectors of major seminaries and other religious institutions. The strength of the study is that the voices of individuals living with HIV, and those engaged in providing them with care and support, were clearly heard. The mandate for the study came from African Church leaders, but was taken up enthusiastically by the German bishops.

1.2 Church Response to HIV and AIDS in Africa

On a global level the African continent is the most affected by the spread of the Human Immunodeficiency Virus (HIV). More than six out of ten people infected with HIV live in sub-Saharan countries, amounting to a total number of 23.5 million.[1] For adults in Africa the infection is mostly transmitted heterosexually. Women are much more affected than men. Children are infected mainly during pregnancy and delivery, and through breastfeeding. In Africa 3 million children are currently living with HIV.[2] For the 17 million African children below the age of 17 who have lost one or both parents the future looks bleak. The issue of exactly why the HIV pandemic has assumed such immense magnitude in Africa cannot yet be answered.

In the late 1980s, church-related health and social services in Uganda were already responding to the ravages of "Slim" disease. The Irish Sisters of the Medical Missionaries of Mary, who headed the Kitovu Catholic Hospital in Masaka, in southwest Uganda, reported how AIDS had already killed large parts of the adult population in this region. There was very little effective medication available to the Sisters and their medical and nursing personnel to treat the symptoms, to ease suffering and to allow people to die with dignity.

Due to the vast numbers of infected and affected people, home-based care programmes staffed mainly by lay volunteers were established. One of the largest programmes in Africa was developed by the Catholic Dio-

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1 UNAIDS (2011), *Global Fact Sheet*, www.unaids.org.

2 Ibid.

cese of Ndola in the Copperbelt Province of Zambia. Soon it became clear that not only AIDS patients were in need of care and support. The entire family was vulnerable. The couple had to be counselled on the importance of testing for HIV infection and protecting the uninfected partner from infection. Children and adolescents needed information, education, care and support. They had to find ways of becoming an "AIDS-free" generation. Priests and Religious were –and still are – called to offer pastoral and spiritual support to infected and affected persons and their families.

1.3 Hypothesis

The main hypothesis of this study is that, in the Catholic Church, the huge body of practical experience of responding to the HIV pandemic over the past 30 years has not yet been sufficiently included in the formation and training of priests, Religious and the laity. In many fields and areas of training and skills building, ethical, moral and pastoral concerns in relation to HIV and AIDS need to be widened and deepened. Just as in the fields of health and social development, where the HIV pandemic has led to great advances in knowledge and practice, so in the fields of theology and ethics new ground must be broken to respond effectively to the challenges of the HIV pandemic. A proper theological and ethical reflection on HIV and AIDS will focus on structural issues, cultural factors and individual ethical issues. The HIV pandemic needs to be viewed, not in isolation, but as a challenge to the Church, particularly in relation to the pastoral, theological and ecclesiological aspects of the pandemic.

1.4 Methodology

This study describes the development of Church-based responses to HIV and AIDS in three countries – Ethiopia, Malawi and Zambia. It does so through the medium of case studies. The phases and methods of the project were as follows:

- Study and analysis of national and international scientific and theological reports and studies (as of March 2010)

- Development of a frame of reference (including a questionnaire) for the field study, to commence in September 2010; initial field trips for team building and distribution of tasks, development of study tools, formation of the research teams:
  - Team Ethiopia: Birkinesh Banbeta and Berhane Kidane (Ethiopia), Gregor Buß and Klemens Ochel (Germany)
  - Team Zambia-Malawi: Leonard Chiti SJ and Aaron Yambani (Zambia), Jos Kuppens MA und Jacqueline Mpanyula (Malawi), Marco Moerschbacher and Piet Reijer (Germany).
- Field study: interviews in the form of semi-structured individual interviews and focus group discussions, study and discussions on ethical case studies.
- Evaluation meetings in the dioceses in early 2011.
- Study week with all participating researchers at the Institute for Global Church and Mission, Frankfurt am Main, Germany, July 2011.
- Introduction and discussion of initial results during a three-day conference with Church leaders from study dioceses and representatives of the German Bishops' Conference, in June 2012, in Addis Ababa, Ethiopia.
- Documentation of the most significant parts of the study in a comprehensive report.
- Report presentation to the Research Group of the German Bishops' Conference on the Universal Tasks of the Church, December 2013.
- Report presentation to the Commission for International Church Affairs of the German Bishops' Conference (May 2014)
- Presentation of the study in the Diocese of Chipata and the Archdiocese of Lilongwe (May 2014)

1.5 HIV in Ethiopia, Malawi and Zambia[3]

HIV prevalence in Malawi and Zambia are above 10% in the adult population aged 15 to 49 years, while in Ethiopia the prevalence is just over 1% (2012). The prevalence of HIV infection has been over 15% in Zambia and Malawi (between 1995 and 2000) and close to 4% in Ethiopia (1997 – 2000). In all three countries, the annual number of new infections has dropped significantly in the last 10 – 15 years. In Ethiopia the number of new infections dropped from over 160,000 in 1996 to 24,000 in 2012, and from approximately 125,000 to 41,000 in Malawi and from 110,000 to 59,000 in Zambia in 1995 and 2012 respectively.

The widespread introduction of Antiretroviral Therapy in all three countries has reduced the annual number of deaths due to AIDS, i.e. from 120,000 in Ethiopia, 90,000 in Malawi and 89,000 in Zambia in the years 2003 to 2005, to 45,000, 54,000 and 29,000 respectively.

Church programmes in each of these countries have made uniquely valuable contributions to national responses to the HIV pandemic. These include, for example, the provision of medical treatment and nursing care, home-based care and social support, pastoral and spiritual care, voluntary counselling and testing, education and prevention initiatives, support for orphans and vulnerable children, and campaigns to reduce HIV-related stigma and discrimination.

These services have been provided to people of all faiths, with a high level of dedication and technical competence. Particularly prominent in the provision of these services have been congregations of women Religious in collaboration with volunteers (including many non-Catholics) mobilised, trained and supported by the Church. These services have played an important role in recent successes in the field of HIV control, including reductions in new HIV infections and HIV-related deaths in all three countries. In many places, especially in rural areas, the Church is

[3] All information in this chapter comes from AIDS Info, UNAIDS (http://www.unaids.org/en/dataanalysis/datatools/aidsinfo/)

the only institution providing HIV-related health services and social support to the local population.

The research teams that conducted in-country research for the report also looked into the question of how the Church sees itself in relation to the HIV pandemic. They concluded that, although the Church provides numerous HIV-related services, it often perceives itself as an external agency untouched by HIV, rather than as an organisation which is itself affected by the HIV pandemic. Even discussion of HIV infection among priests and Religious is often considered taboo. In the course of the research for this book, not a single priest or Religious woman or man living with HIV in the three countries could be interviewed, although several people acknowledged that they knew one or more.

2. Challenges to the church and theology

2.1 Church life and the African reality

The German theologian, Karl Rahner, highlighted the fact that there is friction between "theoretical" and "real" morality[4]. He explains this as "the difference – and the inequality – between lived morality and proclaimed pastoral morality".[5] Rahner considers this chasm to be a fundamental moral as well as pastoral challenge.

When looking at the problem of HIV and AIDS, the chasm between "taught" and "lived-out" morality becomes apparent. During discussions in Malawi, this problem was often exposed. One pertinent example is the phenomenon of discordant couples. In sub-Saharan Africa, the main route of HIV transmission is within a discordant relationship. If these partners are not abstaining from penetrative sex, the question of how to prevent HIV transmission within such a relationship has to be addressed.

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4 Rahner, K. (1995) "Theoretische und reale Moral in ihrer Differenz" in: *Selbstvollzug der Kirche. Ekklesiologische Grundlegung praktischer Theologie*, Freiburg: Herder, pp. 233-242.

5 Ibid, page 233.

The issue of condom use, as one of the most important means of HIV prevention, will have to be considered.

This research study repeatedly touched on these dilemmas. When addressing the topic of discordant couples, one interviewee in Malawi said: "I follow my conscience, which is influenced by my faith and my work. I do not follow the rules of the Church or my employer". A woman from a self-help group in Ethiopia stated: "I am aware of the Church doctrine, but I am unable to live it. I know that I have to follow my conscience in the end, but it still bothers me that I am unable to follow the Church doctrine."

The issue of discordant couples is therefore a prime example of the difference between theoretical and practical morality. The importance of overcoming the gap between "taught" and "practical" morality does not mean that the Church has to adjust to each and every social role model. The Church is challenged to be more sensitive in her teachings. Some African Bishops' Conferences have taken this to heart. They have advised discordant couples to protect each other from infection in such cases.[6]

The interviews of this study revealed that many African Catholics hardly listen to the Church any longer regarding issues of sexuality and marriage – a phenomenon that has long been familiar to people in Europe. In many cases this is linked to the fact that their reality can no longer be brought into line with the Church's teachings on morality.

2.2 Church life and HIV

The Catholic Church is one of the main stakeholders that cares most for people who are directly or indirectly affected by the HIV pandemic. In some regions, and especially in remote areas of Africa, the Church is often the only institution providing basic health care. Pope Benedict XVI

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[6] Catholic Bishops of South Africa, Botswana and Swaziland (2001) *A Message of Hope.* Cf. also Episcopal Conference of Chad (2002) *Bishops of Chad's Statement on AIDS: N'Djamena: Catholic Bishops of Chad.*

has especially emphasized the significance of the Catholic Church in the fight against HIV and AIDS:

"The Church does more than anyone else, because she does not speak from the tribunal of the newspapers, but helps her brothers and sisters where they are actually suffering."[7]

The interviews carried out in this study have clearly shown that the Church takes care of those infected with HIV, supports orphans and vulnerable children, and carries out HIV prevention activities. The Church, however, perceives this commitment as an external charitable service of the Church, but not touching directly upon the inner self of the Church. Those infected with HIV are frequently regarded as – to use a biblical term – a stranger: "The stranger who sojourns with you shall be to you as the native among you, and you shall love him as yourself;" (Leviticus 19:34) Although the stranger may be certain to receive active help from the Church, he still remains a stranger; he does not really belong.

Regarding church life and HIV, discussion of HIV infection among members of the Church, especially priests and Religious, is often considered taboo. It has frequently been reported that cases of HIV-positive priests or Religious are completely unknown, and exist only as rumours, not in reality. During the course of this study we did not find a priest or a religious ready to disclose his or her positive status.

Being HIV-positive is still a valid reason for excluding someone from entry to a seminary or a religious community. This suggests that Church leaders still find it unthinkable for a Catholic priest or a Religious to be HIV-positive. The usual argument in such cases is that such a person is not resilient enough to do service in a parish or a religious community.

The church-going faithful and the general public increasingly disagree with the taboo status of HIV and AIDS. A vast number does not perceive HIV infection as a barrier for clergy and Religious to play an active role

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7 Benedikt XVI. (2010) *Licht der Welt. Der Papst, die Kirche und die Zeichen der Zeit. Ein Gespräch mit Peter Seewald*. Freiburg: Herder, p. 145.

in Church life. HIV-positive persons are able to render service in the cause of the Gospel. Due to the availability of ART, an HIV-positive priests and Religious can work well under physical stress, and would surely be an asset in the field of pastoral care. They are well placed to bear an authentic witness to the Gospel.

Perceiving and accepting HIV as a reality within the Church would mean refraining from the utopian vision of an invulnerable and perfect Church. The perception of a vulnerable and stricken Church was described by Fr Teum Berhe, from Adigrat:

”There is no place in the Holy Bible where it says the church is perfect and holy. The Church is sinful, but still forgives the sinner. The Church is wounded, yet heals the wounded. Through the sacraments and prayers, we are striving towards holiness every day. Jesus makes it clear when he says: ’I came not to call the virtuous but to call the sinners’. (…) The problem is, I think, that some people still see priestly celibacy as a shield against HIV, because its main means of transmission is sexual. Priests are not born as priests, but after a long period of formation they become priests. Why are doctors getting HIV infections? Certainly not because of lack of awareness and knowledge. (…) Unless HIV-positive religious leaders disclose their status to the media and to the faithful, we cannot expect ordinary people to take a positive attitude. We need a courageous leader saying ’Here I am, just like you.’ We need new inspiration that closes the door on stigma and discrimination. The only answer is a renewed and much stronger sense of mission. We need a new sense of mission; we need suitable missionaries and seminarians.”

2.3 Formation of priests and reality in the communities

In many African countries priests are still seen as authorities on moral issues. The formation of priests with regard to issues related to HIV and AIDS is therefore extremely important. This study has shown that the sensitization of the new generation of priests on HIV and AIDS has improved considerably in recent years. For instance, the major seminary in

Adigrat makes use of a handbook covering medical and pastoral aspects of HIV and AIDS during the formation of future priests.

The integration of the HIV and AIDS topic into the curriculum of the Seminary gives hope that the priests of this diocese will be better prepared when confronted with issues related to HIV and AIDS. The study interviews revealed, however, that an alarming amount of work still remains to be done. More and more Church faithful refrain from addressing their parish priests on issues such as HIV and AIDS and on the issues of sexuality and marriage. There can be many reasons for this, but one is certainly that they do not consider the clergy to be competent partners in such a dialogue. They would rather consult a physician.

Yet HIV and AIDS cannot be reduced to medical issues alone. For many people, moral and spiritual issues are just as important. The gap which has opened up between the members of the parish and the parish priest must be closed. Perhaps the hesitant way in which HIV and AIDS has been addressed is an indication that issues of sexual morality are not discussed with sufficient openness within the Church. One of the interviewees from Malawi made a wish in this respect, namely, to have an "HIV-sensitive Church", which allows its members to address sexual matters in an open way.

The chasm between priests and parishes also has another dimension. Despite the fundamental importance which priests have in parish leadership, it would be short-sighted to leave the overall responsibility to them. The everyday tasks that priests have to deal with are quite numerous and complex. If they were expected to deal with all these issues on their own, they would quickly become over-burdened. The laity is also challenged when dealing with HIV and AIDS and has taken the initiative and founded self-help groups, home-based care programmes and campaigns to reduce stigma. Ignoring the potential of the laity in the fight against HIV and AIDS would be short-sighted in the extreme. An interviewee in Malawi underlined this by stating that Africa simply did not have enough priests for an effective response to this challenge: the laity should be involved much more in the Church's response to the HIV pandemic.

2.4 Church and cooperation

One main challenge for the commitment of the Church is dependency on funds, equipment, medical supplies and staff from abroad. This problem was highlighted by almost all interviewees. This is certainly a considerable challenge. It is intensified even more when church-related organizations regard themselves as individual players that cannot be – or do not wish to be – integrated into larger networks. Cooperation with other initiatives or organizations could still be expanded in Church circles.

It is quite astonishing that the Church often still perceives herself as an individual actor. Surprisingly enough, this applies not only in relation to government institutions or to secular NGOs, but also within the Church herself. For example, in Adigrat, several HIV programmes were founded by the diocese and others religious orders, but with minimal contact amongst these different initiatives. Interviewees from Malawi complained on ”a lack of coordination of activities and efforts of HIV and AIDS among different players”.

3. Considerations from a pastoral perspective

3.1 Structure and organization

All dioceses and episcopal conferences in the three countries have pastoral departments or a pastoral coordinator, as well as health offices. From the medical and the pastoral perspective, the HIV pandemic is seen as a challenge to be taken up by the Church. However, the relationship between the medical and the pastoral responses often leaves much to be desired. There is often a lack of coordination and the efforts being made do not always translate into holistic pastoral care which meets the needs of the beneficiaries.

In all the dioceses looked at, ways and means of addressing the issue of HIV through pastoral agents have been developed. In Chipata Diocese

every pastoral gathering at parish level includes a special session on HIV and AIDS, including the Church's teaching on abstinence and faithfulness, as well as medical issues.

An important response by the Church is formed by the home-based care groups which are working in most parishes of the dioceses visited. According to the report by the Zambia research group, this home-based care approach is "one of the main successes of the Catholic Church engaged with the HIV and AIDS pandemic". Yet, links between parish priests and the home-based care groups in their parishes are not structurally anchored. Moreover, Chipata diocese has no health policy, and the diocesan health office lacks the personnel and funds needed to implement a general pastoral agenda that takes account of HIV and AIDS. As the Zambian research report observes:

"There is no compelling policy for parish leadership to be involved in the fight against HIV and AIDS; the destiny of the fight is left to the jurisdiction of the parish leadership."

The report concludes that the pastoral aspect lags behind, "as most of the respondents had no deliberate programmes to access pastoral services. For example, the diocesan health office communicates directly to the parish home-based care without passing through the parish priest's office." The main activity of the home-based care groups is no longer care for bed-ridden patients, as ARV treatment has greatly reduced that number. On the agenda are rather pre-test and post-test counselling, information and sensitization, material help for the most vulnerable groups, and the information and support needed for people living long-term on anti-retroviral treatment. Support groups of people living with HIV constitute another important element of the Church's response to the challenge of HIV and AIDS. They enable PLHIV to come out into the open, to meet regularly, and to help one other to live positively with the virus. As one interviewee from the Archdiocese of Addis Ababa put it: "HIV and AIDS was believed to be a curse". [...] It was of great help when the affected people came out to tell others their story. An organization of such people was established to appeal to the public to accept the reality.

Earlier it was difficult to expose them because of stigma. This was a radical change in the way of thinking."

Livelihood support is another important pillar of the pastoral response, as it contributes towards reducing the socially detrimental effects of stigma. In Emdibir, Attat Hospital runs a very effective women's support programme with 3,292. The report explains:

"These women have a revolving fund where they can borrow and engage in small income generating schemes. There are animators from the public health office who meet with them every 2-3 weeks. Health education is a major component of their meeting. This has helped women to overcome their shyness and avoid dependence on men, which has a lot to do with prevention of HIV transmission. They help in the mobile VCT unit which the hospital sends to different villages. In some villages, the women have initiated their own feeding programme for the under-five children, taking turns in cooking the food which they themselves provide. Some have been trained to provide home-based care by professionals who themselves received special training, and provide basic care to bedridden patients in their villages and also teach others to do so. Stigma is becoming history now in the villages where these women are actively involved because they themselves used to fear HIV as a 'wild animal'."

The cooperation between pastoral facilities, health institutions and health desks does not always function smoothly, often due to problems with finance. The pastoral office of Chipata Diocese does not have an external donor. The major costs are linked to transport. The pastoral office tries to negotiate with other departments for the sharing of transport as a cost-saving measure. However, as the Pastoral Department relies mainly on external funding from Caritas, the organogram of the diocese, where Caritas comes under the Pastoral Department, does not seem to be operational.

3.2 Culture sensitive Church and theology

One major challenge in the response of the Catholic Church to the HIV pandemic is the cultural background of the people involved. The African

approach to disease in general – and to HIV in particular – is often different from the “Western” or medical approach. Disease often has to do with disturbed social relations and cannot be cured without addressing – and overcoming – these disturbances. So the Church, in her response to the HIV pandemic, has always to deal with complex cultural questions.

In Lilongwe, local Christian communities introduced the so-called *alangizi* to provide pastoral care for couples and youth. The *alangizi* are Christians assigned by the community to accompany young couples in preparation for marriage, to instruct the youth during puberty, and to provide counselling for couples in general. Pastoral practice is sensitive to traditional culture and uses one of its institutions, re-framed in the setting of a Christian community.

As in Ethiopia the elders are highly respected and the people listen to them, the Church’s health institutions also rely on elders for support on HIV-related issues. In the Diocese of Emdibir, the elders in Gurage area reached a consensus that, without HIV test results, engagements or marriage ceremonies would not take place. Some relevant norms of traditional Ethiopian culture (no sex before marriage, no polygamy) are in line with the Church’s teachings, but urbanization – and especially migration – tends to undermine these norms.

All three research reports on Ethiopia highlight migration as a major pastoral challenge. Because of endemic poverty and the loss of social cohesion, migration contributes to the spread of HIV, especially amongst the migrating youth.

The research report on the Diocese of Adigrat highlights that people with different religious beliefs are united through their traditional culture. Concerning the harmony between different religions and denominations, a spokesperson from a local NGO, OMCA (Orthodox, Muslim and Catholic Unity to Safe Life), responded:

“It is the long tradition we have inherited from our great grandparents. As history tells us, Ethiopia was the first country to welcome the Muslim religion and give refuge when the disciples of Mohamed were persecuted, and since then we live in harmony and participate in different social

affairs like festivals, funerals and different occasions. Our difference is only our religious practice in our respective worshiping places. Otherwise we have the same culture and socio-economic practices."

On the other hand, traditional culture can also play a negative role. The research reports from Zambia and Malawi highlight certain traditional practices which discriminate against women, degrade human dignity and contribute to the spread of HIV. For example, in Chewa culture, the traditional practice of *fisi* requires a young girl, after her initiation ceremony, to have her first sexual intercourse with a village elder. In a similar practice, known as "blanket for the chief", a chief visiting another area is given a local girl to sleep with.[8]

The persistence of these cultural practices, even in Christian circles, could be interpreted as a general lack of an in-depth evangelization. Has the Church sufficiently challenged African cultural practices that are against human dignity, in a spirit that is inspired by the Gospel? A certain dualism – or a gap – between theory and practice seems to persist between Christian teaching on abstinence and faithfulness and these traditional practices that contribute to the spread of HIV.[9] Further investigations are needed to learn more about the actual impact of these cultural practices. The research report from Zambia furthermore suggests that most people would not follow the Church's teaching and advice to abstain from sex before marriage.

Another challenge with regard to culture is the notion of witchcraft, which is often linked to disease and death, and thus especially to cases of AIDS. An informant in Chipata diocese said:

"Many people, especially in rural areas, believe that a person cannot just die from a natural disease; death is usually a result of witchcraft. This

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8 These and other practices were reported by the interview partners to happen. There is no empirical data, however, to prove that these practices are in actual use or how widespread they are.

9 Cf. Chiti, L. (2011) "The Church, culture and HIV/AIDS", *JCTR Bulletin* no. 89, pp. 25-26.

opinion is sometimes held, even with full knowledge that the deceased was HIV-positive. Witchcraft would always come into the picture."

There is a lasting tension between traditional and modern understandings of HIV, and awareness programmes have to take this into account. In addressing HIV, the "technical" explanation of how it is transmitted is insufficient. From the traditional African perspective, the important question is: who is responsible for it? This is a delicate issue, difficult to address but never to be bypassed. It also translates into competition between traditional healers and modern medical treatment. Especially in rural settings, a solution to a health problem would first be searched for from a traditional healer, and only if these attempts fail, would Western medicine be addressed for help. In the case of HIV infection, however, early detection and treatment are of capital importance.

When asked if one of his patients wanted to quit ART and go instead to a traditional healer, a social worker in the Diocese of Emdibir replied:

"I would tell a patient who wants to quit ART the problems that will arise if ART is stopped. I would tell him/her that he/she can take the ART with traditional treatment as long as what he/she takes is something that doesn't contain strong drugs. Most of the time people want to go for Holy water and that doesn't cause any problem if taken with ART."

A holistic pastoral approach by the Church has to take into account the different concepts of sickness, and has to address the healing of the whole person in his or her social environment as the pastoral coordinator of Chipata Diocese put it: "Our mission is to instil hope."

3.3 Pastoral agents

There is a growing awareness in all the dioceses that pastoral agents who are constantly confronted with issues on HIV and AIDS need to have a solid training in both the medical and the psychological field. Courses on HIV and AIDS are integrated into seminary formation, and special retreats, as well as events like World AIDS Day, are used to create awareness and sensitivity on questions related to HIV and AIDS.

Training and awareness creation on HIV and related issues are of paramount importance in Ethiopia, where priests play a key role in society. Their authority is respected and their word is listened to, in a similar way to the word of elders. But efforts to incorporate components of HIV and AIDS into the formation of priests at major seminaries have encountered difficulties, as the Rector of a seminary in the Diocese of Adigrat points out:

“The Ethiopian Catholic Secretariat produced a huge module of HIV components to be used as one part of the curriculum, but we find it very difficult to use since we already have a lot of demands from the university to which we are affiliated.”

Although pointing in the right direction, these efforts are, however, not sufficient. They indicate a lack of knowledge and insufficient sensitivity by the pastoral agents.

The officer in charge of the Ethiopian Catholic Secretariat’s AIDS Desk believes that priests and Religious are not sufficiently sensitive on matters related to HIV. During and after their formation, insufficient time is devoted to this issue. This is also the reason why, he believes, unlike Protestant and Orthodox clergy, Catholic priests and Religious in Ethiopia do not disclose their HIV-positive status and “do not share their experiences”.

The pastoral coordinator of Chipata Diocese identifies a “lack of trained chaplains” as the root of the problem. He advocates for greater HIV sensitivity as part of the priestly vocation, and also in the training of priests. This is also reflected in the answers given by parish priests in the case of an HIV-positive woman whose husband refuses to use condoms. Priests who were asked for advice on condom use by discordant couples tended to refer people to doctors or other medical personnel for advice. Parish priests interviewed in Lilongwe indicated that the Church does not speak much about HIV and AIDS, and that very little is being done for the clergy. They felt that this was a major gap in the Church’s response to this important issue. One Religious sister put it bluntly: “I do not feel equipped with the necessary tools to deal with HIV and AIDS.”

The question of including issues related to HIV and AIDS in the formation of pastoral agents remains one of the main challenges in the response of the Church.

3.4 Stigma within the Church

Another crucial point is the issue of stigma within the church. Concerning HIV-positive priests and Religious, a lot of silence and denial seem to persist. In the Malawian research report, one parish stated: “It is a delicate issue which affects us psychologically, especially seeing fellow priests getting sick.”

The research report from Addis Ababa could not address this issue, as people were not available for interview or refused to answer sensitive questions. The programme coordinator of the orphanage, “Missionaries of Charity – Gift of love”, confirmed: “There are no reports of HIV-infected priests, religious or catechists.” Various attempts in the Diocese of Chipata and beyond in Zambia to interview an HIV-positive priest or religious person failed. Their notion of an HIV-sensitive church would be of great interest for further pastoral planning.

The interviews with rectors and seminarians from the major seminaries in Ethiopia about the non-admission of an HIV-positive candidate also highlighted inner church stigma. The main reason for his non-admission was given as “physical fitness”. Yet a conclusive reason could not be given as to why a candidate infected with, say, Hepatitis B would be treated differently from the HIV-positive candidate. One seminarian put it as a rhetorical question: “Does the actual health status of the candidates allow to us assume that they are not able to fulfil the tasks of a priest?”

Nowhere during the research was it clearly expressed that an HIV-positive priest or a Religious person can give great encouragement to the HIV-positive faithful and that the Church welcomes them.

The fact that the bishop of Chipata encouraged his priests to go for HIV testing and to talk about the issue with one another has helped them to tackle stigma around the issue of HIV-positive priests and religious persons. All over Zambia, recent seminars on HIV and AIDS, sponsored by

Catholic Relief Services (CRS), were held at religious formation houses and have contributed to increased awareness of HIV-related stigma and discrimination.

The reluctance to admit HIV-positive seminarians and aspirants to religious life is also mirrored in the general acceptance of mandatory testing before admittance. There was only one mention, in the Malawi research report, of the mandatory HIV test before admission as being discriminatory. Admission of HIV-positive candidates has been discussed, for instance, by the Zambian Association of Sisterhood (ZAS) since 2009, but without reaching a conclusion. Every congregation decides autonomously.

The national Episcopal Conferences in the three countries have recommended workplace HIV and AIDS policies, but there are no such policies being implemented in the dioceses. Health institutions of Lilongwe Archdiocese made a challenging assertion, namely, that HIV-positive Religious and clergy are not ready to come into the open and that this leads to unnecessary deaths. In response to the question of what to do if a member of a religious order, or a fellow priest, is HIV-positive, the response was: "We tolerate one another, but in a segregating way."

The lack of coherence in dealing with the issue of HIV and AIDS within the Church, and in the Church's public statements, can also be felt in the following statement from Malawi on what an "HIV-sensitive Church" would look like: a Church "where they accept seminarians who are HIV-positive to go on with their formation and do not withdraw them from the seminary, where candidates to sisterhood should also be allowed to continue, where priests care for one another and do not discriminate against those infected, and where people accept that anyone can get the virus."

To some extent, the Church has learned how to address the issue of HIV and AIDS in her pastoral work and in her public statements, but seems to be slow in accepting and dealing openly with the fact that pastoral agents themselves are also affected and infected. As one health worker in

Malawi put it, “The fact that people are not able to say that they are HIV-positive shows that they are discriminated against.”

3.5 Donor dependency

Finances are one major problem of the local churches in Ethiopia, Malawi and Zambia, which depend heavily on foreign funding for their health and development work – not only for their HIV programmes. Self-sufficiency is far from being achieved, and endeavours towards it are hampered by the economic weakness of the surrounding societies. Money from donor organizations is linked to the donors’ policies, which can be subject to change and which sometimes lack continuity. The National Pastoral Secretary of Malawi stated: “There is a donor dependency, but we do not know how we can manage without donor aid.”

The General Secretary of Adigrat Diocesan Catholic Secretariat is critical of the way HIV projects have been funded, and suggests radical changes: “In some cases, the amounts of money the so-called partners announce and the amount that reaches us are incomparable. Not even half of it reaches the targeted beneficiaries. Some remains, in one way or another, with the partner organization in the donor country. Or they come with their own people, and a huge amount is consumed by these expatriates. The salary of just one expatriate could have covered the cost of more than ten experts here. So for me it is the system that creates this problem and unless the system is changed nothing can be done.”

The problem of financial discontinuity also applies to the home-based care programmes in parishes of both Chipata and Lilongwe. In 15 out of 24 parishes in Chipata, home-based care programmes used to be sponsored by CRS. This funding has stopped, and the home-based care programmes have had to continue on a smaller scale, mostly on a voluntary basis or supported by local resources. The Bishop of Chipata confirms that the local people take a very negative view of this kind of donor behaviour, namely, funding for a limited period of time and then leaving without ensuring sustainability.

In Lilongwe, all 35 parishes used to run home-based care programmes, sponsored by CAFOD and CRS. After the donor funds finished, only 8 parishes managed to continue their home-based care programmes with local resources. In the research report for Lilongwe, the situation is summed up as follows:

"Basically the organization has done well; previously ... home-based care was in all the parishes. We came into the situation with enthusiasm because there was funding, but now most of it has ceased. This has meant a marked decrease in activities. So one may say that the initial dependency on outside funding decreased creativity. Donors somehow did not help beneficiaries to start relying on their own resources."

High staff turnover is another problem. In Chipata, the Diocesan Health Office is not paid for by the diocese. The Office depends entirely on foreign funding. A few years ago, a new building was set up to provide offices for several health services. The funding stopped, and only a few rooms are now being used. In the Diocesan Health Office of Lilongwe, the salaries of most staff are paid for by international donors. Only a minimal staff is sustained by contributions from the diocesan-run hospitals.

Even on the national level of the Episcopal Conference of Malawi, the Health Secretary is not paid for by the bishops. This means that activities are not determined solely by the Health Secretariat or by the Episcopal Conference, but – at least in part – by foreign donor agencies.

The problem of donor dependency heavily affects networking between the various institutions involved, especially between the pastoral and the medical level. Moreover, a stable and appropriate monitoring and evaluation structure cannot be set up under these circumstances.

The problem of financing the structures of the local church is not addressed in a satisfactory manner by pastoral theology and ecclesiology. The former "mission churches" in Africa have been Africanised to some extent, yet the question of finances has not yet found an answer within local contexts as pointed out in the Lilongwe report: "Somehow, the church does not start looking for alternative funding as long as outside funding comes." The economic situation of most African countries ren-

ders the question even more acute. What does it mean to be “Church” in the context of widespread poverty and deprivation?

A Church working as an NGO in the area of HIV and AIDS has to meet expectations which might not be in accordance with her own self-perception. Health services in Malawi are, to a great extent, provided by the Church, while it is primarily the Government’s responsibility to provide for health institutions. What does it mean to be “Church” in a context where the State does not assume its tasks and responsibilities?

The problem of the sustainability of HIV-related programmes is a challenge for donor organisations and recipients:

“Donor money is earmarked for specific activities with a lot of do’s and don’ts. ... Donors think that if they help you today it ends the problem in a couple of years. But since this is mostly not the case, it is difficult to sustain our interventions.”

The General Secretary of Adigrat Diocesan Catholic Secretariat gives this advice: “If we still depend on parents, on benefactors and projects, I do not think we will go very far. So the question is how to prepare ourselves, how to capacitate ourselves with the money which might stop tomorrow. We need to work on this strategy very well. Whatever money we receive, whatever development we do and whatever work we do, it has to have a double edge: first, immediate support, no matter what sort of support we offer; and second, what we do should not be simply a relief or support for the moment but has to have a long term plan.”

The recommendation then, which is also that of the Malawian research report, is to include local income generating activities in every project “for helping HIV and AIDS-infected and affected, so that they may help themselves”.

3.6 „An HIV-sensitive Church“: Quotations

Some quotes of the interview partners about what an HIV-sensitive Church in their view looks like, or should look like:

"For me, to be a HIV-sensitive church is to give hope, to promote life and not to discourage people who are already discouraged, have lost hope and expect death." (Catholic Sister, Adigrat, Ethiopia)

"An HIV-sensitive Church is:

- one that cares, protects life and renders spiritual and material help
- one that cares for the sick, supports them physically and mentally
- one that is realistic about the practical situation
- one that is open to talk about HIV and AIDS among Christians and religious."

(Report from Zambia)

"An HIV-sensitive Church is a Church:

- that talks freely about issues of HIV and AIDS
- that wants HIV and AIDS to be incorporated in all the activities of the church
- where people can give testimonies
- where we mainstream issues of HIV and AIDS in all our programmes, not just waiting for annual World AIDS Day, and where we integrate HIV and AIDS issues in our homilies, workshops, wedding ceremonies and church programmes."

(Report from Malawi)

4. Ethical perspectives

4.1 Preliminary remarks

Before analysing some ethical aspects of HIV and AIDS, three preliminary remarks have to be made. First, Catholic moral teaching must acknowledge the ethical challenges that result from the HIV pandemic. These challenges affect the daily life of people affected by HIV and AIDS. The care of the sick, the poor and the vulnerable forms an essential nucleus of Christian faith. Jesus has been sent to proclaim the Good News to the poor (Lk 4:18-19), because "it is not the healthy who need a doctor,

but the sick“ (Mt 9:12). Thus, as Pope Benedict XVI wrote in his exhortation, *Africae Munus*:

”In the spirit of the Beatitudes, preferential attention is to be given to the poor, the hungry, the sick – for example, those with AIDS, tuberculosis or malaria – to the stranger, the disadvantaged, the prisoner, the immigrant who is looked down upon, the refugee or displaced person.“[10]

The second preliminary remark is a reminder that Catholic moral theology and social ethics relating to HIV and AIDS are under enormous pressure as a result of people's expectations. Here again, a passage from *Africae Munus*:

”The problem of AIDS (…) is an ethical problem. The change of behaviour that it requires (…) ultimately involves the question of integral development, which demands a global approach and a global response from the Church.“[11]

The third preliminary remark concerns the whole human being, who is at the centre of each and every attempted response as Agbonkhianmeghe E. Orobator has commented: "The discourse on the morality of HIV prevention should be conducted primarily as a discourse about people rather than a polemic over prophylactic devices".[12]

4.2 Examples of ethical focal points

4.2.1 HIV as punishment from God?

The responses to the question of whether HIV could be seen as a punishment from God were various. A vast number of interviewees replied that they would say no. At the same time, however, they also said that such beliefs are still widespread. In response to this question, many re-

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10 Benedict XVI (2011) *Africae Munus*, No. 27.

11 Ibid, No. 72.

12 Orobator, A. E. (2006) "Ethics of HIV/AIDS Prevention: Paradigms of a New Discourse from an African Perspective", in: Hogan, L. (Ed.) (2006), *Applied Ethics in a World Church*, Maryknoll, NY: Orbis Books, pp. 147-154.

spondents in Ethiopia mentioned the story about the man who had been born blind (John 9:1-3). When asked by his disciples what sin had caused this man to be blind, Jesus replied that the man's blindness was not due to any sin by him or his parents. The respondents interpreted this story to mean that, in our present context, a person with AIDS may not be regarded as having been punished by God.

4.2.2 Reasons for the spread of HIV

With regard to the reasons for the spread of the disease, the responses can be divided into two categories. The immediate causes of the pandemic were seen as the misbehaviour – or at least the risky behaviour – of individuals. Responses commonly referred to unprotected sexual intercourse, multiple sexual relations, or simply ignorance. On the other hand, the root causes of the pandemic were seen as unjust social and economic structures, such as lack of education, poverty, forced migration and the unfair treatment of women.

Moreover, the HIV pandemic is not simply a medical, a sexual, or an ethical problem. As important as these aspects may be, it would be very short-sighted to define the pandemic simply in these terms. An effective strategy against the further spread of the virus must also take into account issues of justice from a global as well as an individual perspective.

Darüber hinaus ist die HIV-Epidemie nicht nur ein medizinisches, sexuelles oder ethisches Problem. So wichtig diese Aspekte auch sein mögen, es wäre sehr kurzsichtig, die Krankheit nur anhand dieser Gesichtspunkte zu definieren. Eine wirksame Strategie gegen die Weiterverbreitung des Virus muss auch die Frage nach Gerechtigkeit aus einer globalen sowie einer individuellen Perspektive berücksichtigen.

4.2.3 Discordant couples

One of the most fiercely discussed issues was that of discordant couples. This is an issue that could not be answered so easily. Four types of responses can be identified:

- Sexual abstinence so the non-infected partner does not become infected

- Condom use
- Allowing married couples to decide according to their consciences what they consider to be the correct behaviour
- No advice; married couples are referred to a medical expert, such as a doctor.

Especially the two different functions of a condom – contraceptive on the one hand, protective on the other – lead to different points of view. As the fourth type of answers shows, some priests and other church members also tried to avoid giving answers. Others also missed a clear guidance by the church on the issue of discordant couples.

In October 2002, the Episcopal Conference of Chad stated:

"With regard to the condom, the Church wishes to recall here, through our Bishops, that its use is subjected to the normal moral rules as for the other human acts. The ultimate moral rule is our conscience. It is up to each and every one of us to train one's conscience and to assume one's responsibility according to the situation in which one finds oneself. Because «no one is bound to do the impossible», spouses cannot be asked to abstain from sexual intercourse; we therefore understand that a person, through love, may be led to use the condom to protect himself/herself or to protect his/her partner. But everybody must understand that the condom does not provide 100% protection and that it does not ultimately solve the real problems raised by AIDS."[13]

4.2.4 Vulnerability of women

Within the context of discordant couples, the role and position of women has to be addressed in more detail. The case studies demonstrate that women – especially young women – are at much greater risk of HIV infection than men. As women quite often get married very young or are economically largely dependent on their husbands, they are often not in a position to lead an autonomous life. Due to their precarious living con-

[13] Episcopal Conference of Chad (2002) *Bishops of Chad's Statement on AIDS*. N'Djamena: Catholic Bishops of Chad.

ditions, they can be forced to risky sexual behaviour. Apart from their personal rights to safety, respect and dignity, women have a particularly key role in protecting family life and also in promoting social cohesion.

5. The different levels of response

The challenges of HIV and AIDS encompass all dimensions of human life, from personal maturity and the formation of conscience, to the position of women in society and the fair distribution of goods. As the example of the discordant couple shows, there are moral conflict situations which are very difficult to resolve. Ethical responses do not happen in a vacuum or in pure theory, but are meant to lead ultimately to a decent way of living. The search for answers will take place on different ethical levels. We identify three different levels, namely the structural, the cultural and the individual level.

5.1 Structural level

On the structural level, the lack of distributive justice has contributed to the rapid spread of HIV. Unjust structures, as in the field of education, food supply, trade, health care, distribution of resources and patent rights mean that many people in sub-Saharan Africa are deprived of the opportunity to lead an independent life.

Caring for people living with or affected by HIV should therefore not be simply a charitable act, but is also a mission of justice. Church-related involvement in HIV-related work often lacks a structured and systematic orientation. The guiding principle for Church activities is mostly that of charity rather than justice. Bishop Kevin Dowling from South Africa points out:

“Faith-based responses must be technically correct and based on sound analysis and scientific research. This is a challenge for faith-based communities because it involves a move from random acts of kindness to

structural involvement in processes with the affected people which change the suffering and dehumanisation caused by HIV”.[14]

To achieve a more systematic approach to HIV prevention, there is need of increased professionalism in planning, implementation, monitoring and evaluation. Also the development of policies and strategic plans, and competent education and training of Church staff are indispensable.

Increased professionalism can be achieved if the Church makes more effort to network with other organizations. The Church needs to work more closely with *all* people of good will. Stronger ties should be established with governmental and non-governmental organizations. This will save financial and personnel resources. Other stakeholders in the field of health should not be regarded as competitors, but as operational partners.

However, the Church also has to introduce her special profile and mission into the public debate. Advocacy on all levels was still new territory for many of our interviewees. There were repeated complaints that the engagement of the Church in HIV-related work was not sufficiently acknowledged by the public or by government authorities. Yet, the Church agencies also need assistance in advocacy work. The call by SECAM has to be emphasised again:

”We are committed to ... advocate with government at all levels and with inter-governmental organizations to establish policy priorities that adequately support those affected by HIV and AIDS, that provide access to care and treatment and a life of dignity for people living with HIV and AIDS, and that implement the commitments made at various other inter-governmental meetings.”[15]

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14 Dowling, K. (2010) *Catholic Social Teaching and the Response of the Church to HIV/AIDS. National Catholic Reporter 8/7/* 2010

15 SECAM (2003) *The church in Africa in face of the HIV/AIDS Pandemic: Plan of Action*, Dakar: SECAM.

5.2 Cultural level

The research results revealed that certain cultural patterns and traditions may favour the spread of HIV. Sexual practices or conventions such as *Kusasa fumbi* (cleansing rites for widows) and *Fisi* (forms of sexual initiation of girls) may increase the risk of HIV infection. In most cases women – especially young women – are affected. On a cultural level there is a need to review, from an ethical perspective, which values, practices and conventions contribute to the spread of the HIV pandemic.

In sub-Saharan Africa, initial reflections may focus particularly on female vulnerability to HIV, since women and girls are especially affected by the HIV pandemic. But it is difficult to improve the situation of women, as there are behaviour and thought patterns that have been in operation for centuries. Even widely promoted HIV prevention strategies such as ABC are of questionable value for many women, as Gillian Paterson notes:

"We only need to take a look at the renowned prevention strategy, commonly known under the abbreviation 'ABC', **a**bstinence, **b**eing faithful, **c**ondom use. This strategy evolved from the (currently prevailing) biomedical debate and is a classic example for a mantra claiming general validity, yet in reality it is tailored to an autonomous, adult man from the western hemisphere. Abstinence? In many parts of the world abstinence is not an option for women. Marriage is a cultural necessity, and the same applies for children; early marriage is quite common and often highly welcome; women are economically dependent on their men; and the circumstances of sexual intercourse are usually not controlled by women. Faithfulness? Many women are faithful, but they get infected with HIV by their unfaithful or drug-addicted partners. Condom use? What woman or child has ever convinced a man, against his will, to use a condom?"[16]

Many strategies in the fight against HIV and AIDS take insufficient account of the special problems of women. Each of these strategies should

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[16] Patterson, G. (2007) "Der Gender-Falle entkommen. Die Aufdeckung patriarchalischer Strukturen in Zeiten von Aids", *Concilium* 43, (3), pp. 342-352.

respond to these two questions: What are the cultural factors favouring this worrying situation of women and girls? Will it be possible to identify beliefs and behaviours in the cultural traditions that could be useful to ensure the special protection of women?

The Church has the obligation to strongly promote women's rights and to fight against any form of suppression or discrimination. "So in Christ Jesus you are all children of God ... There is neither Jew nor Gentile, neither slave nor free, neither male nor female, for you are all one in Christ Jesus. " (Galatians 3, 26-28)

Furthermore, the effectiveness of cultural thought patterns and conventions shows that an ethical directive will remain unsuccessful if it does not display sensitivity towards these factors. This requires an enculturation of ethical guidelines and moral concepts that takes account of traditional African culture. Paul Chummar states with regard to the theological formation in the seminaries: "Even institutions specializing in developing an enculturated theology largely teach Western moral theology as if it were a universal theological ethics. This is a form of theological colonialism."[17]

In order to avoid this form of theological neo-colonialism, Chummar recommends the elaboration of enculturated theological ethics, following more strongly local traditions.

This will help to overcome the chasm between taught theory and common African practice. In many interviews during the research, there was a gap detected between the Church doctrine and the life of the faithful. Sermons and recommendations of the clergy are hardly observed any longer. Increased enculturated ethics could counteract what Karl Rahner calls this "difference between theoretical and practical morality".

[17] Ibid.

5.3 Individual level

The Church's insistence on abstinence and faithfulness is often dismissed by other organizations as unworldly. However, the Church has good reasons to stick to her ideals, not only regarding her own tradition, but also in the light of scientific investigations in connection with the spread of HIV. Michael Kelly thinks that the importance of the ideals of abstinence and faithfulness cannot be valued highly enough:

"Ideals can provide (...) tremendous motivating force in the moral sphere. Based on respect for the sacred value of life and the wonder of sexuality created by God, the ideals of abstinence and marital fidelity inspire, motivate and move towards appropriate action."[18]

However, everyday experience does not always correspond with these ideals. In many cases it cannot. We frequently encounter discordant partnerships that are based on faithfulness. The spouses want to be faithful and want to express their love to each other. However, they have to recognize that the HIV-negative partner is at risk if appropriate protective measures are not taken during sexual intercourse. One of moral issues that arise here is the question of condom use.

The interviews did not reveal a uniform picture in response to the dilemma of discordant couples. Most interviewees tended to trust the affected partners to reach a responsible decision according to their own conscience. The Bishops in South Africa, Botswana and Swaziland also came to a similar recommendation:

"There are couples where one of the parties is living with HIV and 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 and AIDS, they must listen to their consciences. They

[18] Kelly, M.J.: "Some AIDS-Relevant Teachings of Moral Theology in the Field of Sexuality", in: Moerschbacher, M; Kato, J.; Rutechura, P. (Eds.) (2008), *A Holistic Approach to HIV and AIDS in Africa*, Nairobi: Paulines, pp. 117-128.

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."[19]

The use of condoms is not the only issue for debates on sexual ethics. Catholic theology has to focus on a new perception of human sexuality as a whole. As the Irish moral theologian Enda McDonagh explains, sex is part of God's Divine Plan of Creation for humans to be sexual beings: "In one Genesis account (Genesis 1:27), when God created humanity, 'in the image of God he created them; male and female he created them'. For love and companionship, for life-giving and co-creating, this gift of sexual duality was given to humans as images of God. ... A Christian theological view of sexuality has no place for the 'sex is dirty'-syndrome."[20]

A more positive view of sexuality would certainly be a substantial step forward: "Sexuality therefore participates in our fulfilment as men and women. The Church looks positively on sexuality, which it views as a task to accomplish, a responsibility to assume".[21]

6. Lessons learned and visions upheld

6.1 Key issues

This three-country research project has identified the following issues as of key importance on the way to an HIV and AIDS-sensitive Church:

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19 Southern Africa Bishops Conference (2001) *A message of hope from the Catholic Bishops to the people of God in South Africa, Botswana and Swaziland*, Pretoria: St. Peter's Seminary. Available at: http://www.oikoumene.org/en/resources/documents/other-ecumenical-bodies/church-statements-on-hivaids/southern-africa-bishops [Accessed: 24 April 2014]

20 McDonagh, E. "Theology in a time of AIDS" in: Gill, R. (Ed.) (2007), *Reflecting Theologically on AIDS. A Global Challenge*. London: SCM Press, pp. 43-59.

21 Episcopal Conference of Chad (2002) *Bishops of Chad's Statement on AIDS*. N'Djamena: Catholic Bishops of Chad.

- Despite recent successes in global HIV control, HIV and AIDS are still of major concern in many parts of the world, especially in sub-Saharan Africa. However, responses to HIV need to strive for a truly holistic model.
- It is vitally important to break the silence about HIV and AIDS within the Church, including among Religious and clergy.
- The Church hierarchy should be empowered to address issues related to HIV and AIDS in the sense of *Africae Munus*, for example, by developing a realistic strategy for the Symposium of Episcopal Conferences of Africa and Madagascar (SECAM).
- There is a need for better appraisal of human sexuality.
- Structural and culturally based violence and practices, especially against women, must be urgently addressed.
- The Church at all levels requires a more systematic approach, especially:
  - Better networking with all partners
  - Better coordination and cooperation in pastoral, human development, charity and emergency ministries
  - Improved planning and implementation for greater sustainability of programmes, including applying for public funds.
- A more intense and continuous dialogue with the scientific community is needed, especially to:
  - Bridge the gap between theology and pastoral formation
  - Strengthen capacity building on all levels: diocesan, regional and international.
- Responsibilities should be shared with other faith communities, civil society and the general public in order to improve advocacy and develop common good practices.
- The Church in affluent countries should address issues of global justice, especially if unsustainable economic policies create vulnerable conditions in low income countries.

- The Church, as a community of believers committed to health and healing, can promote a community dimension of health, from a local up to a global scale.

6.2 Recommendations at the level of the Universal Church

Pope Francis has explained the role of the Pope as a vocation in terms of being a "protector", who understands power as service. Convinced that the Pope's role is also that of the Universal Church in the service of local churches worldwide, the authors of this study come to the following recommendations concerning the Universal Church:

- That theological reflection on ethical and other dimensions of HIV and AIDS is enhanced at every level of theological teaching and research. The issue of HIV and AIDS should be addressed as one of integrated development and global justice, as well as a holistic approach of moral theology towards understanding human sexuality as a gift of God.
- That the situation of discordant couples, also addressed by the Fathers of the Second Special Assembly of the Roman Bishops' Synod for Africa[22], as well as pastoral and ethical support for discordant couples, may be studied by an interdisciplinary and international body, in order to give clear guidance for the people concerned and in order to avoid conflicting messages.
- That the formation of pastoral agents of the Church, especially in major seminaries, may systematically include capacity building on

[22] Synod of the Bishops II Special Assembly for Africa (2009),"… this Synod proposes: … a pastoral support which helps couples living with an infected spouse to inform and form their consciences, so that they might choose what is right, with full responsibility for the greater good of each other, their union and their family." (Propositio 51). Available at: http://www.vatican.va/roman_curia/synod/documents/rc_synod_doc_20091023_elenco-prop-finali_en.html [Accessed 24 April 2014]

medical, ethical and pastoral knowledge and skills in the field of HIV and AIDS.

- That the situation of HIV-positive priests and Religious men and women be taken seriously, so that a spirit of welcoming may be fostered by addressing the issue of HIV-related stigma within the Church; so that support groups for infected and affected pastoral agents may be encouraged; that on this issue a systematic networking of religious orders and congregations, including the "International Network of Religious Leaders living with or personally affected by HIV and AIDS" (INERELA), be put in place.
- That the Universal Magisterium of the Catholic Church serve the local churches and their magisteriums, so that in accordance with the principle of subsidiarity, specific problems that arise in the local context may be addressed and solved at the local level, and that the magisterium of the bishops in various cultural contexts be strengthened.

6.3 Responses of the Catholic Church in Africa

It would be a mistake to generalise findings and statements about Church responses to the HIV pandemic for the whole of Africa. Just as there are differences in the pandemic itself in terms of onset, vulnerable groups, response capacities and actual responses, so dioceses, regions and national units also differ with regard to culture, ethnicities, history, faith traditions and the enculturation of faith responses to the pandemic. Two realities have to be addressed in the response of the Catholic Church in Africa to the challenges of HIV and AIDS.

First, many people are forced by economic, social, cultural or political pressures into risk behaviour which they cannot avoid.

Second, many socio-pastoral workers, Religious and clergy are themselves living with HIV. They have not yet been allowed, however, to live openly with HIV in the service of the Church.

The Church's response to HIV and AIDS was part of the post-synodic Apostolic Exhortation, *Africae Munus,* published in November 2011. The

main focus of this document was the provision of care services, in particular health care:

“In the spirit of the Beatitudes, preferential attention is to be given to the poor, the hungry, the sick – for example, those with AIDS, tuberculosis or malaria – to the stranger, the disadvantaged, the prisoner, the immigrant who is looked down upon, the refugee or displaced person (see Matthew 25:31-46). The response to these people’s needs in justice and charity depends on everyone”.

6.4 The Catholic Church in Germany and HIV and AIDS

Since the start of the new millennium, the number of new HIV infections and of AIDS deaths worldwide has steadily diminished, year by year. However, the total number of people living with HIV is still increasing. It would therefore be disastrous if international, national and community responses to the challenges of the HIV pandemic were now to slacken. Constant and untiring commitment to HIV prevention, care and support remains of paramount importance.

The Catholic Church in Germany has a special responsibility, based on her numerous connections with African local churches, her long-term experience in the fight against HIV and AIDS, and her financial resources.

Poor people – and in particular poor women – are suffering from the direct and indirect consequences of the HIV pandemic. HIV and AIDS should be recognized as an indicator of structural injustice within the cooperation framework of the Universal Church. The Catholic Church in Germany must therefore ensure that the HIV pandemic does not continue to be a disease of poverty. Church-related relief organizations need to use their experience of holistic approaches to health and development.

In many African countries, the Church still remains an essential provider of health services to the poorest of the poor. Church health facilities constitute a uniquely valuable network – extending even into remote areas – of holistic health care. The withdrawal of support by the Catholic Church in Germany for HIV-related health care, especially in sub-

Saharan Africa, would be disastrous. The mission of Jesus ”to proclaim the Kingdom of God and to cure diseases“ (Luke 9:2) has always been – and remains – the core issue of Christian mission.

Often the Catholic Church – even in Germany – reacts to the issue of HIV and AIDS with a kind of speechlessness. Many believers and church-related activists find it difficult to react positively to the issue of HIV and AIDS. This is in stark contrast to the deep commitment and professional competence of Church-related health institutions. But when it comes to human sexuality, a strange silence can often be observed. This silence has to be overcome.

The Catholic Church is often regarded as a moralising and didactic institution with regard to issues of sexuality. The Church needs to take to heart the words of Pope Francis:

“A beautiful homily, a genuine sermon must begin with the first proclamation, with the proclamation of salvation. There is nothing more solid, deep and sure than this proclamation. Then you have to do catechesis. Then you can draw even a moral consequence. But the proclamation of the saving love of God comes before moral and religious imperatives. Today sometimes it seems that the opposite order is prevailing.” [23]

[23] “A Big Heart Open to God“. Pope Francis’ interview with Antonio Spandaro SJ, 19 September 2013. Available at: http://www.thinkingfaith.org/articles/20130919_1.htm [Accessed 24 April 2014])

Literature

Benedict XVI (2010) *Licht der Welt. Der Papst, die Kirche und die Zeichen der Zeit. Ein Gespräch mit Peter Seewald.* Freiburg: Herder.

Benedict XVI (2011), *Africae Munus*.

Chiti, L. (2011) The Church, culture and HIV/AIDS, *JCTR Bulletin* no. 89, pp. 25-26.

The Catholic Bishops to the people of God in South Africa, Botswana and Swaziland (2001) *A Message of Hope.*

Dowling, K. (2010) Catholic Social Teaching Finds Church Leadership Lacking, *National Catholic Reporter*, 8/7/2010.

Episcopal Conference of Chad (2002) *Bishops of Chad's Statement on AIDS*. N'Djamena: Catholic Bishops of Chad.

Kelly, M.J. (2008) "Some AIDS-Relevant Teachings of Moral Theology in the Field of Sexuality", in: Moerschbacher, M., Kato, J. and Rutechura, P. (eds.), *A Holistic Approach to HIV and AIDS in Africa*, Nairobi: Paulines Publications, pp.117-128.

McDonagh, E. (2007) "Theology in a time of AIDS", in: Gill, R. (ed.), *Reflecting Theologically on AIDS. A Global Challenge*, London: SCM Press. pp. 43-59.

Orobator, A.E. (2006) "Ethics of HIV/AIDS Prevention: Paradigms of a New Discourse from an African Perspective", in: Hogan, L. (ed.), *Applied Ethics in a World Church*, New York: Maryknoll, Orbis Books. pp. 147-154.

Patterson, G. (2007) "Escaping the Gender Trap: Unravelling Patriarchy in a Time of AIDS", *Concilium 43*. No. 3. pp. 342-352.

Rahner, K. (1995) "Theoretische und reale Moral in ihrer Differenz" (1995) in: *Selbstvollzug der Kirche. Ekklesiologische Grundlegung praktischer Theologie* Freiburg: Herder, pp. 233-242.

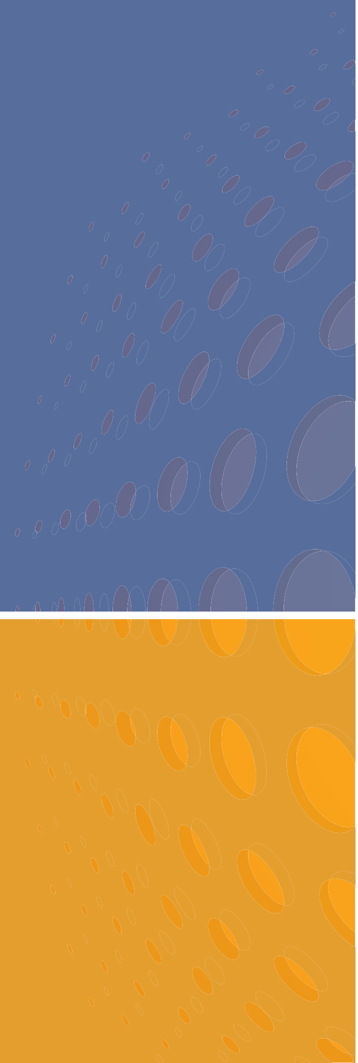
Symposium of Episcopal Conferences (SECAM) (2003) *The church in Africa in face of the HIV/AIDS Pandemic: Plan of Action.* Dakar: SECAM.

Websites

UNAIDS. (2014). *AIDS Info*. Available at: http://www.unaids.org/en/dataanalysis/datatools/aidsinfo/

UNAIDS (2011) *Global Fact Sheet*, Geneva, www.unaids.org

Synod of the Bishops II Special Assembly for Africa (2009) (Propositio 51). Available at: http://www.vatican.va/roman_curia/synod/documents/rc_synod_doc_20091023_elenco-prop-finali_en.html



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