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ISSN 1026-2946

Africa Journal of Evangelical Theology

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Subscription Information: Subscription rates and ordering procedures are published on the inside back cover. Information can be downloaded from our website: www.scott.ac.ke. Or email Ben Gichuhi: ajetjournal@scott.ac.ke

Purpose: *AJET* is published twice a year by Scott Christian University, a chartered private university in Kenya, in order to provide theological educators and students with evangelical articles and book reviews related to Christian ministry in Africa.

Publisher: Scott Christian University, the publisher of *AJET*, has been accredited by ACTEA since 1979 and was chartered as a private university by the Commission for Higher Education (CHE) Kenya in November 1997. Scott offers university level theological education with concentrations in Pastoral Studies, Christian Education and Missiology.

AJET is indexed in *Christian Periodical Index*; *New Testament Abstracts* (Cambridge MA); *Religion Index One: Periodicals*, published by the American Theological Library Association, Chicago; *Theology in Context* (Institute of Missiology, Germany); and in *DIALOG Abstracts* (Cambridge MA). *AJET* is indexed in the ATLA Religion Database, published by the American Theological Library Association, 300 S. Wacker Dr., Suite 2100, Chicago, IL 60606, E-mail: atla@atla.com, Website: <http://www.atla.com/>. *AJET* articles and information can be found on the web by searching “evangelical theology”.

An Introduction to the AIDS and Theology Issue

AJET normally does not produce issues that focus on a single theme. But when Dr. John Chaplin, HIV/AIDS Consultant for Africa Inland Mission International, invited my wife and I to the *Theological Perspective on HIV and AIDS Conference* and I saw the speakers listed, it seemed a natural theme for *AJET*. Africa Inland Mission, in partnership with the Centre for World Christianity at Africa International University (AIU), sponsored this conference in order to bring together people involved in theological education with those involved in AIDS ministries of various kinds. The intent was to answer two key questions: (1) How can theological institutions prepare new pastors and church leaders to respond effectively to this major crisis? (2) How can those involved in AIDS work ensure that their response to AIDS is based on careful Biblical reflection on the issues brought up by AIDS? The conference was inspired by part of the *Cape Town Call to Action* issued at the *Third Lausanne Congress*, “We believe that the teachings and example of Jesus, as well as the transforming power of His cross and resurrection, are central to the holistic gospel response to HIV-AIDS that our world so urgently needs. ... We commit ourselves to such urgent and prophetic action as part of the integral mission of the Church.”¹

The conference participants met together at AIU from Monday 28th May to Friday 1st June 2012, but were not confined to listening to the lectures and PowerPoint presentations offered by the speakers. Monday afternoon Diane Stinton introduced the Pastoral Circle as part of her presentation on *Contextual Research Methods for Theology and HIV and AIDS in Africa* and this became the model we used in small groups to discuss and reflect theologically on topics such as: 1) Stigma, Shame and “Outcasts” (people living with AIDS, men who have sex with men, commercial sex workers, drug addicts), 2) Judgment, 3) Poverty and Suffering, 4) Faithfulness, Marriage and Parenting, 5) Youth and Sexuality and Initiation Rites, 6) Changing Beliefs and Values, 7) Orphans and Vulnerable Children, 8) Gender Issues.

Most of us in the small group discussions had not come across the Pastoral Circle approach, so we were largely learning by doing. This yielded a full range of discussion as Africans and non-Africans from a number of different countries and cultures learned from one another about AIDS ministry, theological applications to AIDS ministry, and how different personalities interact. While each small group likely would have benefited from someone walking us through the Pastoral Circle on a specific issue in order to model it for us, we did end up with a great deal of practice in actually applying theological truths to AIDS ministry.

¹ <http://www.lausanne.org/en/documents/ctcommitment.html#p2-2>. For an example of how wide the range of secular and religious interest is in HIV and AIDS, see the following: <http://hivaidsclearinghouse.unesco.org/search/resources/FBOAnnoBib.pdf>

Wednesday was a different day altogether with a field trip to visit the AIC Kijabe Hospital AIDS programme, a community AIDS support group, and the Moffat Bible College AIDS Education Programme where students visit area primary schools to teach an AIDS Behaviour Change Programme based on Adventure Unlimited. Moffat's programme is currently headed by Dr. Bob Carter and his wife Hope who took over from my wife Janet when we moved to Scott in 2011. The opportunity to see what these ministries are doing afforded conference participants with experience, not simply information and theory.

During the Conference there was no lack of information about some of the many different aspects of AIDS ministry as the articles in this issue of AJET demonstrate. In fact the virtual storm of statistics, data, acronyms, PowerPoint presentations and passionate activism displayed by the speakers is impossible to reproduce in an academic journal but a few notes are helpful. Firstly, even in the statistics in these articles it is clear that the numbers about how many people are infected and affected, for example, are not consistent from one quoted source to the next. As with all statistics, how they are collected and when they are collected can easily change the totals. But it is clear that HIV and AIDS remains a huge medical, theological, and pastoral challenge to African countries, churches and communities as well as those individuals directly affected. Secondly, the information available on HIV and AIDS in Africa, and the secular, Christian, and non-Christian responses to it are seemingly endless, especially as one searches through the Internet. There is a surprising amount of theological reflection from many Christian traditions on the crisis as well. Third, what is offered in this issue of AJET barely scratches the surface of the evangelical theological response, and unavoidably leaves many critical issues begging for greater reflection, even argument.

For example, how many ways are there for Christians to deal with the connected and controversial issues of abstinence and condoms? Did your blood pressure just go up? It is clear that for those who favour the widespread use of condoms and who insist that information about condoms must be given to all age groups, including children, have the laudable goal of saving lives. It is their highest value and that value is assumed to be unchallengeable by many. Should a Christian theologian be allowed to ask, "Should that value, that goal, be unchallengeable, and are there any Christian values that are higher than a longer life in this life?" Or, "Does the use of a condom within a marriage of a discordant couple have the same moral value as the use of a condom by two teenagers experimenting with sex outside of marriage?" This conference did not set out to settle all theological questions regarding HIV and AIDS but it does highlight the necessity for theological thought about the crisis.

In this issue of AJET I have kept the basic chronology of the presentations at the conference, but due to space limitations I have included only one of the morning devotionals, that by Samuel Ngewa who examines the parable of the Good Samaritan in Luke 10:30-37 and applies it to the HIV and AIDS crisis.

Diane Stinton's lecture and PowerPoint presentation, "*Into Africa*" explores the contextual research methods we can use to make theology relevant to the issue of HIV and AIDS in Africa. After briefly introducing contextual theology in Africa and then qualitative research methods in general, she focuses on the four steps of the Pastoral Circle or Cycle: Insertion (examining what is happening); Social Analysis (why is it happening?); Theological Reflection (how do we evaluate what is happening?); and Pastoral Planning (how do we respond to what is happening?). This approach can be a powerful tool to help us understand and respond to theologically important issues, including AIDS.

Priscilla Adoyo's forthright lecture on the sexual issues involved in the HIV and AIDS pandemic and the role of the Church in dealing with it was challenging as well as informative. James Nkansah-Obrempong straddled the divide between theology and HIV and AIDS by introducing us to a brief history of the disease and then spoke at length about how theologians should respond to its challenges, first using the relationship between HIV/AIDS and sin as well as Biblical teaching about sickness and death, then showing how theology helps us deal with this crisis, before finally pointing the way forward.

Mary Getui, the chair of the Kenya National AIDS Control Council, spoke about gender issues in relation to HIV and AIDS, generously emphasizing Eunice Odongi's assistance in preparing the lecture. Prof. Getui highlighted the effect of HIV and AIDS on both men and women and raised a number of issues theologians and the Church should be dealing with in regard to gender. Peter Okaalet's PowerPoint presentation ranged widely over the AIDS crisis giving us the larger context on the way to describing how the Church should be involved. John Chaplin ably translated that PowerPoint into an article, allowing me the possibility of editing it for *AJET*. Dr. Okaalet's detailed presentation and Dr. Chaplin's re-presentation was a collaboration only two accomplished Christian medical doctors could have pulled off. John Chaplin's own article on some of the newer perspectives and advances on HIV and AIDS prevention and treatment was not only informative and accessible for the non-medical people at the conference, but also demonstrates how the landscape is changing and changing quickly. Keeping up is challenging.

Keith Ferdinando's major paper, *Evil and AIDS – An African Perspective*, is an example of much a theologian can contribute to the medical ministry by digging into the elements of the African worldview that undergird people's actions in response to HIV and AIDS. The medical and the spiritual levels of this pandemic are intertwined. Rich Harrell led the committee that produced the Summary Statements at the end of the conference. Instead of Book Reviews, this issue ends with a few resources for further reading. Some were gleaned from two conference lists while others came from elsewhere. Not all the books are written from an evangelical tradition, but will prove of some value because so many Christians from all traditions have worked in HIV & AIDS ministry, often together and often with secular groups.

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Who is the Neighbour?

An Application of Luke 10:30-37 to the HIV and AIDS Crisis

A Morning Devotional by Samuel M. Ngewa, Africa International University

The story we have in Luke 10:30-37 was told by Jesus in a literary genre we call “parable” (*parabolē*). A parable is a story told alongside a point one would like to communicate to those who are listening to the story. It may be based on facts or real happenings or just possible happenings within a particular context. During Jesus’ time, mention of a Priest, Levite, and Samaritan would trigger something in the minds of the hearers. The hearers related to the parable because these were characters familiar to them. If it was being told for the first time today, Jesus would probably have used such terms as “a Bishop”, “a Reverend”, “a Pastor” or similar terms in place of the Priest and the Levite. In the place of the Samaritan he could have used a prostitute, an outcast or such other categories of persons in our societies.

The point Jesus was telling the story against is a question asked by a lawyer (Luke 9:25) and the question was, “*And who is my neighbour?*” (Luke 10:29). Luke tells us that this lawyer asked this question “*to justify himself*” (9:29). The question seems very sincere and so one wonders why Luke would make this statement of judgment that the lawyer was not asking in sincerity but in order to justify himself. The act of “justifying self” has the idea of, “I am OK”, or “I have done well”. The lawyer thought he was doing very well.

Before we examine our passage more closely however, let me tell you a true story; and I would like to underline the word true. It actually happened in our times.

A certain old African lady in a God-fearing church was asked to pray during the Sunday morning worship service. She was asked to do so because she had always prayed good prayers – relevantly mentioning the needs of the people around her. This particular Sunday, however, she added in her prayer, the following words: “Lord, we also pray for those with *ukimwi* [she did not know such terms as HIV/AIDs], touch them Lord, and heal them.” After the service, the well trained pastor rebuked her for her prayer of that day. She was caught unaware by this because she had prayed many times before with very good response. The well trained pastor pointed out that her sin of that day was that she asked God to heal the persons with *ukimwi*. He then went on to say, “To pray for such is to compromise the holiness of God because those with *ukimwi* belong to the class of adulterers and fornicators.” The poor woman went home feeling bad that she had made her holy pastor unhappy (without intending to do so) and the holy pastor went home feeling well satisfied with his excellent ministry of the day – even rebuking an old lady who in her prayer wanted to bring those with *ukimwi* near God for His touch.

This is a true story telling us the attitude of a pastor in the 21st century. Let us go back to our passage from Luke 10 and examine the characters in the parable carefully.

Character One: A Certain Man

This man can be any of us - our brother or our sister. He certainly had a name (or could be given one), but that did not matter. He could be Kariuki, Odhiambo, Kimutai, Mutiso, Elizabeth, etc, but that does not matter. What matters is what he represents. He is a human being in need.

He was on his journey from Jerusalem to Jericho for some unknown reason. What we know for sure is that this was a dangerous road, and perhaps Jesus picked it specifically for that reason. Some of those who apply allegory to the parable say that he was travelling from the holy city of Jerusalem to the unholy city of Jericho. This could well be, but it is not necessary for understanding the story. Simply, he was on a journey. Relating this to us today, he was going about his daily business in life. As he went on his way:

1. *He fell among robbers* (10:30). Those who have had the experience of being at the mercy of robbers can identify with this. Robbers want to take everything good you have, and do not mind taking your life if you stand in their way. The virus (HIV/AIDS) we are talking about this week has no other goal in the body of the victim but to rob him or her of the good God-given things in the body. It wants to destroy them so that the victim is left with nothing to resist diseases, whether simple or major. It wants to rob and leave the door open for whatever germs want to get in to do so with ease. I do not want to interrupt our thoughts, but there were some robbers who after taking away everything their victim had, threw back some little money to him and said, "Get that for your fare". I remember when I was told this, my first words were: "Those were good thieves". By this, I meant that they were thieves whose consciences were still active to some degree. The HIV/AIDS virus does not have that kind of mercy.

2. *The robbers "stripped him" and "beat him"* (10:30) – leaving him with wounds (10:34). The only thing between him and death was "half life". Jesus used the phrase, "*went off leaving him half dead*". We can imagine how helpless this man was, and also how he had become a "no touch" human being to some people.

Character Two: A Certain Priest

This priest was given an opportunity to see this "robbed and beaten up" man. He happened to be going that way. There may have been other victims elsewhere this priest did not see but this particular one, "he saw". It was an opportunity for action. His response: "*he passed by on the other side*". It was not his business.

Who is the priest? He is the one who brings the voice of God to the people and takes the needs of the people to God. He was the one who represented

the people's religious affairs at the highest levels. What was his response? It is not my business, at least that is the way he acted. Why? I have heard some preachers suggest he may have been in a hurry to go and offer sacrifice, or he may have thought the person was dead and did not want to pollute himself by touching a dead body. These are all possibilities. The key point for Jesus' however, was "he lacked love for the victim". He did not act as a neighbour to the man in need. For whatever reason, that was his attitude. He lacked compassion. Let us for a moment reflect on the possibilities of how this attitude might be found in us.

Firstly, it is very likely that we have been in a hurry to do some ministry somewhere. Ministry to whom? Our ministry is to the people in need. This does not mean we will allow ourselves to be sidetracked by every little thing that comes our way. However, a man left half-dead and with no one else around is not a little thing. What things keep us so busy that we act towards people affected by HIV and AIDS in the same way as the Priest did?

Secondly, being afraid of touching a dead body and being polluted by that touch is frighteningly similar to the fear of touching a person affected by HIV or AIDS. This is being so holy that we cannot fit into Jesus' team, for he allowed a sinful woman to wash his feet (Luke 7:36-38), and he was not afraid to touch lepers (Luke 5:13).

Character Three: A Levite

He followed the *nyayo* (Kiswahili for "footsteps") of the priest. In our day, a Levite would be like the elders/deacons, and the priest could be likened to the pastor. These are the *mheshimiwas* (Kiswahili for "honourable persons") in the local churches. Just like the priest, the Levite "saw" and then "passed by on the other side". His attitude too was, "It is not my business".

Character Four: A Certain Samaritan

Let us consider certain facts about this Samaritan.

1. He was a despised Samaritan. He was not a person of high religious class as the Priest and the Levite were.
2. He was on a journey (10:33). In other words, he had business to attend to. He was not less busy than the Priest and the Levite.
3. He saw the man and had compassion. Compassion is "being moved by mercy". I believe that the greatest sin committed by the Priest and the Levite was their lack of compassion.
4. He came to the robbery victim, bandaged his wounds, poured oil and wine on them, put him on his own beast, brought him to an inn and took care of him. From this we note:
 - a) He got himself involved. He did not stay aloof.
 - b) He attended to the wounds of the beaten up person. What considerations do we make when we are saving persons who are bleeding to death? If we have no gloves that we need to protect us against possible

HIV transmission, do we stay uninvolved or do we have compassion and see a life that must be saved?

c) He spent his own resources for first aid. What about a church budget that includes provision for anti-viral drugs for those who can't afford them?

d) He sacrificed his comfort for the sake of the victim.

e) He looked for a place he could get further help for the victim – and met the expense, in full. This is like taking someone to Nairobi hospital and signing the documents guaranteeing payment for the patient's treatment.

Jesus' question to the lawyer was, "Which of these three: the Priest, the Levite, or the Samaritan (that is, **the pastor, the deacon** or the **outcast**) received the verdict of 'well-done' from God?"

The lawyer could not bring himself to saying, "the Samaritan", instead he said, "*the one who showed mercy toward him*" but from the context, he was certainly referring to the Samaritan. What if the despised classes of people are more compassionate than us, even if we do not want to call them by their names? Those who have no high social class but who do have compassion for people affected by HIV and AIDS have surpassed the "reverends" and the "pastors" who do nothing. *It is not the title but the act that matters before God.*

Through this parable the lawyer came to know from Jesus that, "*His neighbour is the human being, whoever he may be, with whom God brings him into contact, and who has need for his help*".¹ With this understanding, Jesus told him, "*Go and do like wise*" – that is, act as the Samaritan did. I like the way the Greek puts it: "Go and *σὺ ποιεῖς* (you yourself do) likewise". There is emphasis here, "you yourself". Ministry to people affected by HIV and AIDS is something we cannot leave with the Non-Governmental Organizations (NGOs), the government, or someone else. We must be personally involved in it, if we are obedient to Jesus' words.

Please, allow me to submit that at the Second Coming many will say to Jesus, "Don't you remember, I was reverend so and so, etc" and Jesus' reply will be, "That is good, but what did you do with the needy: the widows, the orphans, the people affected by HIV and AIDS?"

I want to be one of those to whom Jesus will say, "You acted like the Samaritan and I am pleased with you". What are some practical ways to act like a modern day Good Samaritan?

1. *Make no judgment.* None of us knows how anyone got to have HIV status. Even if we can guess in the case of some, we did not see the virus as it entered into their bodies.

¹ F. Godet, *A Commentary on the Gospel of St. Luke*, 2 vols., Edinburgh: T&T Clark, 1888-1889, p. 41 of Vol. 2.

2. *Make our first response “compassion” and not condemnation.* Deliberately explore ways of supporting those who are victims. Prayer is something we all can afford. Helping financially would be an excellent act.

3. *Educate our members to be like Jesus, and his approved character – the Samaritan.* That is, encourage and train persons who will respond to the needs of others with no strings attached.

4. *Preach a life of holiness for we know that some of the infections have been spread through sexual acts outside marriage.* Purity of life cannot be compromised even as we are moved with compassion. Our promotion of purity, however, must go alongside the love of Christ. He loved us when we were unlovable. Who are we to deny anyone such love?

In conclusion, Jesus told the lawyer, “Go, and you yourself do likewise”. May the Lord increase those of us who heed these words!

keeping up with contemporary Africa . . .

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"Into Africa": Contextual Research Methods for Theology and HIV and AIDS in Africa

by Diane B. Stinton

A true story is told about a missionary who went to a remote area in northern Tanzania to proclaim the Gospel among the Maasai, a famous warrior people:

One day he was explaining to a group of adults the saving activity of Jesus Christ, the Son of God. He told how Jesus is the Saviour and Redeemer of all humankind. When he finished, a Maasai elder slowly stood up and said to the missionary, "You have spoken well, but I want to learn more about this great person Jesus Christ. I have three questions about him: First, did he ever kill a lion? Second, how many cows did he have? Third, how many wives and children did he have?"¹

This story illustrates the critical need to proclaim the gospel here in Africa in light of the questions that *Africans* are asking. Whether we are ministering among Maasai elders in the village, or single moms living with HIV and AIDS in Kibera, or sheng-speaking youth in the city estates, our challenge is to invite Africans to discover Jesus in ways that are meaningful and relevant to their own worldview and experience.

The question is *how*? How do we gain those listening skills so that we truly hear the questions and issues that Africans are discussing? How do we discern the signs and symbols of authentic gospel witness in our midst? And how do we reflect, theologically, on the ministry in which we are involved? Given the central emphasis on *contextual* theologies in the Majority World today, that is, theologies that derive from and are addressed to a particular context, a key question for researching African theology is: how do we get *into* the context? How do we get "*into Africa*"?

The purpose of this article is to identify and encourage the use of selected research methods or strategies that can enhance theological research here in Africa. Within the present scope, attention is limited to two main aspects: first, a rationale for integrating qualitative research methods in theological studies; and second, an introduction to one recent methodological approach in the "pastoral circle" or "pastoral cycle," which holds great potential for conducting relevant research in the area of theology and HIV and AIDS.

The Use of Qualitative Research Methods in Theology

In 1981, mission scholar Harold Turner set forth a fundamental premise concerning methodology: "the nature of the field of study must provide the

¹ Joseph G. Healey, *African Stories for Preachers and Teachers* (Nairobi: Paulines Publications, 2005), 33.

major control over the methods employed.”² Turner asserted this priority in the context of seeking methodological advances in the study of African primal religions, yet the principle applies likewise to the study of Christianity in Africa. Since religion is a human activity that affects all aspects of life, Turner argues that the study of religion must be polymethodical, drawing upon all the human sciences. Various models employed in studying religion - cultural, anthropological, psychological, sociological and political - are valuable in elucidating aspects of any given religion in its milieu. However, Turner underlines that religion cannot be reduced to any of these particular categories, and therefore calls for “‘interpretative depth’ in the religious dimensions.” He concludes, “We need therefore a religious model for the study of the ‘religion’ of African religions... .”³

If our field of study is African Christian theology, then two key questions emerge from Turner’s observations: what *is* the nature of this field of study? And how can we strive for “interpretative depth” in analyzing African theology? While the field of African theology is very broad, a few key priorities have emerged over the past half-century that provide a summary description.

African Theologies are Contextual

As indicated above, a fundamental distinguishing mark of African, as well as other Majority World theologies, is that they are contextual. A landmark document in this regard is the “Final Communiqué” of the 1977 Pan-African Conference of Third World Theologians, held in Accra, Ghana. The concluding section entitled “Perspectives for the Future” sounds a clear call for how theology is to be done: “The African situation requires a new theological methodology that is different from the approaches of the dominant theologies of the West. ... Our task as theologians is to create a theology that arises from and is accountable to African people.”⁴ This new way is termed “*contextual*” theology, or “accountable to the context people live in.”⁵

Therefore, a widespread methodological presupposition is that genuine theological reflection cannot be separated from Africa’s socio-political, religio-cultural and economic contexts. Indeed, these contexts shape the real and concrete everyday experiences within which theology must proceed.⁶ The

² Harold W. Turner, “The Way Forward in the Religious Study of African Primal Religions,” *Journal of Religion in Africa* 12, no. 1 (1981): 1.

³ Turner, “The Way Forward in the Religious Study of African Primal Religions”, 13.

⁴ Pan-African Conference of Third World Theologians, December 17-23, 1977, Accra, Ghana, “Final Communiqué,” in *African Theology en Route*, ed. Kofi Appiah-Kubi and Sergio Torres (Maryknoll, N.Y.: Orbis Books, 1979), 192.

⁵ “Final Communiqué,” in *African Theology en Route*, 193.

⁶ Akintunde E. Akinade, “‘Who Do You Say That I Am?’ - An Assessment of Some Christological Constructs in Africa,” *Asia Journal of Theology* 9, no. 1 (April 1995): 184.

priority of contextual theology is likewise well established among other Majority World theologies.⁷

African Theologies are Communal

With daily, concrete experience a vital component of African theology, the concept of community, so central to African experience, is integral to theological formulation. John Pobee and Samuel Amirtham put it succinctly: "People need theology and, more particularly, theology needs people. Theology needs the reflection of people committed to Christian practice to preserve its vitality and wholeness."⁸

One prime example of theologising in community is found in Jean-Marc Ela. Ela's theological reflections are clearly rooted in his experience as a parish priest in rural northern Cameroon. He describes the role of the theologian graphically as follows:

A theologian must stay within earshot of what is happening within the community so that community life can become the subject of meditation and prayer. In the end, a theologian is perhaps simply a witness and a travelling companion, alert for signs of God and willing to get dirty in the precarious conditions of village life. Reflection crystallises only if it is confined to specific questions.⁹

Although theology entails reflecting upon specific issues of faith in a particular community, Ela notes that it must also be related to what is happening elsewhere. J.N.K. Mugambi concurs, stressing the historical dimension of theological discourse unfolding as theologians respond to ideas from previous and contemporary generations and in turn influence future generations of theologians.¹⁰ Thus the "community of faith" extends beyond that of one particular context to encompass other times and places of theological expression. For this reason, Kwame Bediako underlines the following methodological presupposition:

The study of Christianity in Africa should not be isolated from the study of Christian presence elsewhere in history. In other words, one must guard against making the African field (or any non-Western field of reference) so unique in the features it presents that it ceases to have any relation to what happens to Christianity elsewhere. Rather the African phenomenon must be

⁷ For example, see R.S. Sugirtharajah, "Prologue and Perspective," in *Asian Faces of Jesus*, ed. R.S. Sugirtharajah (London: SCM Press, 1993), ix; C.R. Padilla, "Toward a Contextual Christology from Latin America," in *Conflict and Context: Hermeneutics in the Americas*, ed. M.L. Branson and C.R. Padilla (Grand Rapids: Eerdmans, 1986), 81.

⁸ S. Amirtham and J.S. Pobee, "Introduction," in *Theology By the People: Reflections on Doing Theology in Community*, ed. S. Amirtham and J.S. Pobee (Geneva: WCC Publications, 1986), ix.

⁹ Jean-Marc Ela, *My Faith as an African*, trans. J.P. Brown, S. Perry (Maryknoll: Orbis, 1988), 11. See also Ela's discussion on "Ending the Tyranny of the Clergy," 56 ff.

¹⁰ J.N.K. Mugambi, *The Biblical Basis for Evangelization: Theological Reflections Based on An African Experience* (Nairobi: Oxford University Press, 1989), 36.

seen within the wider setting of the general history of the transformations of Christianity.¹¹

African Theologies Include Women's Perspectives

Further with respect to theology and community, it is common knowledge that women form a very significant sector within African Christianity. Not only do they make up the strong majority of many Christian communities, they also carry out a great deal of the pastoral work in their respective churches. Despite this reality, women's perspectives have not featured prominently in African theology until recent times. Two leading African women theologians, Mercy Oduyoye and Musimbi Kanyoro, express the dilemma as follows:

African women theologians have come to realize that as long as men and foreign researchers remain the authorities on culture, rituals, and religion, African women will continue to be spoken of as if they were dead. ... Until women's views are listened to and their participation allowed and ensured, the truth will remain hidden, and the call to live the values of the Reign of God will be unheeded.¹²

Given this longstanding gap within theological publications, it is crucial to integrate women's perspectives in the study of African Christianity.

African Theologies have Formal and Informal Expressions

Christians in Africa have always theologized, if not formally, at least informally, in singing, praying and preaching. As Kwesi Dickson emphasizes, This is a point which cannot be made forcefully enough, for with the blossoming of theological exposition in recent years, particularly in the so-called Third World, there is the possibility - yea, a real danger - that Christians in Africa, and elsewhere, might come to associate theology solely with a systematic articulation of Christian belief.¹³

Pobee likewise emphasizes that the propositional style of expression is only one cultural mode of theological formulation, and on the basis of his in-depth study of martyrdom in the New Testament, he concludes that "[theology] may sometimes have to be gleaned from the being and doing of people."¹⁴ For example, Henry Okullu observes,

[W]hen we are looking for African theology we should go first to the fields, to the village church, to Christian homes to listen to those spontaneously uttered

¹¹ Kwame Bediako, "The Significance of Modern African Christianity - A Manifesto," *Studies in World Christianity* 1, Part 1 (1995): 59.

¹² Mercy Oduyoye and Musimbi R. A. Kanyoro, "Introduction," in *The Will to Arise: Women, Tradition, and the Church in Africa*, ed. Mercy Amba Oduyoye and Musimbi R. A. Kanyoro, (Maryknoll, NY: Orbis Books, 1992), 1.

¹³ Kwesi A. Dickson, *Theology in Africa* (London: Darton, Longman and Todd, 1984), 109. See also Bénézet Bujo, "African Theology: Which Direction to Take and What Methodology to Use?" *African Christian Studies Occasional Paper No. 3 and 4* (Nov./Dec. 1985): 9.

¹⁴ John S. Pobee, "In Search of Christology in Africa: Some Considerations for Today," in *Exploring Afro-Christology*, ed. John S. Pobee (Frankfurt: Peter Lang, 1992), 11.

prayers before people go to bed. ... We must listen to the throbbing drumbeats and the clapping of hands accompanying the impromptu singing in the independent churches. We must look at the way in which Christianity is being planted in Africa through music, drama, songs, dances, art, paintings. We must listen to the preaching of a sophisticated pastor as well as to that of the simple village vicar. ... Can it be that all this is an empty show? It is impossible. This then is African theology.¹⁵

The search for African theologies thus extends beyond formal written expressions to include informal expressions, for example in worship, prayer, preaching, artwork, drama, gestures and symbols.¹⁶ In view of these two dimensions of African theology, the formal and the informal, or the written and the oral, Kwame Bediako makes an important call for African Christianity itself to be distinguished from the scholarly literature on it. He proceeds on John Mbiti's distinction between oral theology that already exists in "the living experience of Christians," and the academic theology that can only arise afterwards in an attempt to "examine the features retrospectively in order to understand them."¹⁷ Looking to the origins of theology in the New Testament, Bediako argues that "an authentic tradition of literary Christian scholarship" cannot exist apart from the "spontaneous or implicit theology" located in "a *substratum* of vital Christian experience and consciousness."¹⁸ While the two elements of theology are not to be confused, Bediako underlines, the informal theology must be granted due significance.

Consequently, in order to seek interpretative depth in the scholarly penetration of African Christianity – the second challenge noted above from Harold Turner – serious attention must be given to "the observation and study of the actual life of African Christian communities."¹⁹ Bediako explains that the intention is not to set the study of the "lived" theology off against the written theology, since both are obviously important. Rather, it is because the informal expressions of theology cannot be fully circumscribed within the formal expressions that the former warrant particular attention. He thus asserts the following crucial directive for African Christian scholarship:

If it retains and maintains a vital link with the Christian presence in Africa, and with the spontaneous and often *oral* articulation of Christian faith and experience that goes on, it will be in a position to contribute significantly to understanding, as well as shaping Christian thought generally for the coming century.²⁰

¹⁵ Henry Okullu, *Church and Politics in East Africa* (Nairobi: Uzima Press, 1974), 54.

¹⁶ See Mercy Amba Oduyoye, *Hearing and Knowing: Theological Reflections on Christianity in Africa* (Maryknoll: Orbis, 1986), 45-50; Ela, *My Faith as an African*, 5.

¹⁷ John S. Mbiti, *Bible and Theology in African Christianity* (Nairobi: Oxford University Press, 1986), 229; quoted in Bediako, "Significance of Modern African Christianity," 52.

¹⁸ Bediako, "Significance of Modern African Christianity", 53.

¹⁹ Bediako, "Significance of Modern African Christianity", 58.

²⁰ Bediako, "Significance of Modern African Christianity", 58.

With this broad-stroke portrait of the *nature* of the field of study – that African theologies are contextual, the community of faith is crucial in their formulation with particular reference to the need for women’s perspectives, and their dual dimensions of formal and informal expressions – and with this directive for scholarship to maintain a vital link with “the actual life of Christian communities,” we return to the question of *how*? What are the implications for research methodology? Again, the second question that emerges from Turner’s assertion about religious methodology is: How can we strive for “interpretative depth” in the study of African Christianity?

Interpretative Depth Through Qualitative Research

While there is no simple, or single answer, in view of many valid approaches to constructive research, this section argues that qualitative methods can make an important contribution. Since qualitative research is not commonly associated with theological studies, a brief introduction and rationale is in order. While “qualitative research” is used as an umbrella term for a variety of research strategies, such as interviews, focus groups, participant observation, and other ethnographic methods, certain characteristics are shared which make this approach very conducive for exploring African theology.²¹

In brief, Robert Bogdan and Sari Biklen outline these characteristics as follows.²² First, qualitative research is especially concerned with context, so that the researcher enters the natural setting of the subjects to collect data and he or she is the key instrument for data collection. Second, it is descriptive, with more emphasis on words than numbers, both in recording the data and disseminating the findings. That is, more attention goes to capturing the respondents’ experiences and interpretations than to measuring the statistical frequency of responses. Third, qualitative research is concerned with process over products or outcomes. In other words, it allows room for probing the underlying perceptions and reasons rather than simply the stated conclusions. Fourth, analysis of data proceeds inductively, which is summarised as follows: “[Qualitative researchers] do not search out data or evidence to prove or disprove hypotheses they hold before entering the study; rather, the abstractions are built as the particulars that have been gathered are grouped together.”²³ Finally, qualitative research is fundamentally concerned with “meaning,” or the way in which people make sense out of their lives. Hence the researcher is interested in “*participant perspectives*,” and seeks to

²¹ For an example of the use of qualitative methods in theological research, see Diane B. Stinton, *Jesus of Africa: Voices of Contemporary African Christology* (Maryknoll, NY: Orbis Books, 2004; Nairobi: Paulines Publications, 2004).

²² Robert C. Bogdan and Sari Knopp Biklen, *Qualitative Research for Education: An Introduction to Theory and Methods* (Boston: Allyn and Bacon, Inc., 1982), 27-30.

²³ Bogdan and Biklen, *Qualitative Research for Education*, 29.

discover "what *they* are experiencing, how *they* interpret their experiences, and how *they* themselves structure the social world in which they live."²⁴

These characteristics of qualitative research together contribute to its chief strength, namely, the depth of understanding it allows.²⁵ In addition, one of the three most common and useful purposes of qualitative methods is exploration. Catherine Marshall and Gretchen Rossman advocate this approach when there is need "to investigate little-understood phenomena, to identify/discover important variables, to generate hypotheses for further research."²⁶ They give an example of a research question as follows: "What are the salient themes, patterns, categories in participants' meaning structures?"²⁷ Earl Babbie concurs that such an approach is typical "when the subject of study is itself relatively new and unstudied," and he concludes that, "exploratory studies ... are essential whenever a researcher is breaking new ground, and they can almost always yield new insights into a topic for research."²⁸

Given the unprecedented growth of African Christianity over the past decades, there are many new issues in need of serious investigation and qualitative methods can contribute significantly to this research process. If indeed, Africa is a "living laboratory" for 21st century Christianity, as Andrew Walls contends, then it is imperative that theological studies in Africa move beyond textual methods of research alone to credibly investigate the actual life of Christian communities. Walls underlines,

The laboratory space for theology is not in the study or the library; the major theological laboratory – workshop might be a more appropriate term – lies in the life situations of believers or of the Church. Theological activity arises out of Christian mission and Christian living, from the need for Christians to make Christian choices, and to think in a Christian way.²⁹

Elsewhere, Walls charges African theologians with a special responsibility for constructing new theologies in response to the social, political and economic issues arising across the continent. He explains,

One reason is simply that the situations which theology must address are starker and more convulsive in Africa than elsewhere. ... African Christianity has daily experience of famine, drought, war, displacement of populations; of a scourge like AIDS, not as a problem of marginal people but as a pandemic

²⁴ Bogdan and Biklen, *Qualitative Research for Education*, 30, quoting G. Psathas, *Phenomenological Sociology* (New York: Wiley, 1973); emphasis original.

²⁵ Earl Babbie, *The Practice of Social Research*, 5th ed. (Belmont, CA: Wadsworth Publishing Co., 1989), 285.

²⁶ Catherine Marshall and Gretchen B. Rossman, *Designing Qualitative Research* (London: Sage Publications, 1989), 78.

²⁷ Marshall and Rossman, *Designing Qualitative Research*, 78.

²⁸ Babbie, *The Practice of Social Research*, 81.

²⁹ Andrew Walls, "The Rise of Global Theologies," in *Global Theology in Evangelical Perspective: Exploring the Contextual Nature of Theology and Mission*, ed. Jeffrey P. Greenman and Gene L. Green (Downers Grove, IL: IVP Academic, 2012), 19.

affecting populations; and because African Christianity experiences these, African Christian theology needs to confront them.³⁰

In view of Walls' clarion call for serious scholarship on the actual life situations of contemporary African Christianity, this first section has developed the rationale for one means of doing so, namely, integrating qualitative methods into theological research. The remainder of the article introduces one particular approach for investigating and responding to particular issues in African Christianity which theology must confront. While it is little known among evangelical circles, the pastoral circle or pastoral cycle offers a viable and valuable resource for getting "into Africa" to research contextual issues. For example, among the many issues that warrant urgent attention, the HIV and AIDS pandemic, as noted by Walls above, affects entire populations of people. Aylward Shorter points out,

As the HIV/AIDS pandemic spreads, it is clear that it is both an infection and an affliction. The disease infects individuals, but it also affects them and their families spiritually, emotionally, socially and materially. ... AIDS ... does it in a particularly devastating and far-reaching way ... because it is incurable and because it is transmitted through the very processes of human life-giving, the sexual relations of men and women, and the procreation of children. AIDS therefore strikes at the very fabric of human society and at its basic institutions of marriage and family.³¹

Since the pandemic affects virtually every dimension of life, it calls for comprehensive, multi-disciplinary research including theological perspectives and responses. Therefore the holistic approach of the pastoral circle is especially conducive for researching theology and HIV and AIDS.

The Pastoral Circle / Cycle

By way of brief introduction, the pastoral circle is a recent methodological approach in use around the globe by those working in parishes, in justice and peace ministries, in development, and in the academy. Essentially it provides a flexible framework that can be used for pastoral planning, community action, or academic theology.³² Its origins are usually traced to Monsignor Cardijn, the founder of the Young Christian Workers in Belgium, who proposed

³⁰ Andrew Walls, "Africa in Christian History: Retrospect and Prospect," *Journal of African Christian Thought* 1, no. 1 (June 1998): 13.

³¹ Aylward Shorter and Edwin Onyancha, *The Church and AIDS in Africa – A Case Study: Nairobi City* (Nairobi: Paulines Publications, 1998), 46.

³² For an insightful examination of the Pastoral Circle in relation to European theological epistemology and methodology, see Frans Wijsen, "The Practical-Theological Spiral: Bridging Theology in the West and the Rest of the World," in *The Pastoral Circle Revisited: A Critical Quest for Truth and Transformation*, 129-147 (Nairobi: Paulines Publications, 2006). While it has a longer history of use in Catholic universities and seminaries (e.g., the Catholic University of East Africa), it has recently been introduced as one viable approach for academic research at Daystar University, Nairobi, and at the Africa International University, Karen, Kenya.

the simple method of *See, Judge and Act* as an attempt to integrate action with reflection.³³ In 1980 this basic approach was developed further by the Center of Concern, a Catholic social justice think tank in Washington DC, which sought to devise a methodological tool for enhancing analysis of critical social issues. The new approach was coined "the pastoral circle" and elaborated in a seminal work by Joe Holland and Peter Henriot, *Social Analysis: Linking Faith and Justice*.³⁴

The rationale for this new methodological approach is in line with the growing discontent over the past half century with those traditional theological methods that did not adequately integrate theology with life, or theological reflection with praxis, a legacy of Latin American liberation theology. For example, Rodrigo Mejía points out that Anselm's classic definition of theology of "faith seeking understanding" certainly sets forth a central purpose of theology in cultivating a deeper understanding of the Christian faith. However, the risk inherent in this definition is that of pursuing theology as a purely theoretical science that seeks to enhance human comprehension without necessarily inspiring faithfulness to the gospel in our daily living. He explains,

It is possible, indeed, to have a correct understanding of the Bible and not to be aware of the link between the truth of the Bible and the historical and social situation in which one is living. Theology as a science has to be theoretical, but as a whole project it has to be a service for the people of God in order to improve not only their understanding but also the practice of their faith in their concrete historical situation.³⁵

Hence Holland and Henriot proposed the pastoral circle essentially as a means of analyzing reality in the light of God's Word, on the fundamental assumption that one is *affected* by reality through appropriate processes. Jon Sobrino elaborates further, outlining three dimensions to this human activity, with obvious relevance to our consideration of the AIDS pandemic:

The first is "getting a grip on reality," which requires us *to be truly and actively involved* in reality, affected by things as they are [i.e., not simply intellectually aware] The second is "taking on the burden of reality," that is, taking charge of reality in order to transform it [i.e. the *praxic dimension*] The third is "taking responsibility for reality," that is, accepting the demands of reality and bearing its hardships [i.e. the *ethical dimension*].³⁶

³³ Rodrigo Mejía, "Pastoral Theology and the Pastoral Circle: The Methodology and Dynamics of the Pastoral Circle," in *New Strategies for a New Evangelization in Africa*, ed. Patrick Ryan (Nairobi: Paulines Publications, 2002), 125.

³⁴ Joe Holland and Peter Henriot, *Social Analysis: Linking Faith and Justice* (Maryknoll: Orbis Books, 1983). This work has been reprinted in multiple editions, translated into numerous languages, and disseminated to faith-based communities around the world.

³⁵ Mejía, "Pastoral Theology and the Pastoral Circle," 122.

³⁶ Jon Sobrino, "Foreword: Faith, Justice, and Injustice," in *The Pastoral Circle Revisited: A Critical Quest for Truth and Transformation*, ed. Frans Wijsen, Peter Henriot, and Rodrigo Mejía (Nairobi: Paulines Publications, 2006), 9; emphasis original.

This affectedness is prior to methodology, according to Sobrino: "Reality speaks, and the analyst listens."³⁷ Rooted in Ignatian spirituality, with its emphasis on attending to the world around us and seeking to discern God's loving presence and involvement in the details of everyday life, the pastoral circle helps us to "read" the signs of the times. Henriot explains,

But this "reading" is not simply *cognitive*, an intellectual exercise leading to understanding. It is also *affective* and *effective*: *Affective* in the sense of touching the deepest of our values and strongly motivating our responses. *Effective* in the sense of organizing our responses with planning, execution, and evaluation.³⁸

Significantly, therefore, human experience forms the heart of the process as a fundamental condition and the central core around which the pastoral circle operates. Also termed "the hermeneutical circle," "the circle of praxis," or "the pastoral cycle," it advocates four key moments or dimensions: insertion, social analysis, theological reflection, and pastoral planning.

Insertion: What is happening?

First, *Insertion* (also Contact, Encounter, Experience, or Immersion) seeks to establish "what is happening here?"³⁹ Through personal immersion in a particular human situation, the researcher gathers data, descriptions, or stories of what is going on in the situation, paying particular attention to the lived experience of the people affected. More specifically, stemming from the "preferential option for the poor" advocated by Latin American liberation theologians, priority is given to "the experiences, views, needs, feelings, and stance of the poor and most vulnerable in a community."⁴⁰

Various methodological approaches can be employed in this initial step, whether quantitative, a range of qualitative methods, or a mixed method approach, whatever is considered most feasible and conducive within the selected context. Since the aim is to "come to grips with" the reality, there is need to collect both objective data and subjective feelings. A distinction is made between the "empirical," the highly rational collection of information and statistics, and the "experiential," or the personal, subjective feelings gained through, for example, story-telling, drama, poetry, or artistic creations. For instance, one method of insertion is a "listening survey" which helps to discover the "burning issues" affecting local communities:

³⁷ Sobrino, "Foreword: Faith, Justice, and Injustice", 10.

³⁸ Peter Henriot, "Social Discernment and the Pastoral Circle," in *The Pastoral Circle Revisited: A Critical Quest for Truth and Transformation*, ed. Frans Wijzen, Peter Henriot, and Rodrigo Mejia (Nairobi: Paulines Publications Africa, 2006), 38.

³⁹ F. Wijzen, P. Henriot, and Rodrigo Mejia, eds., "Appendix I: Steps in the Pastoral Circle," in *The Pastoral Circle Revisited*, 251.

⁴⁰ Henriot, "Social Discernment and the Pastoral Circle," 44.

It involves not simply the collecting of objective statistical data (e.g., the number of people in a village, the health and education profiles), but also identifying the strongly felt needs, fears, expectations, etc.

The team conducting this kind of listening survey contacts these feelings by listening to what people talk about in local gatherings at markets, beer halls, funerals, churches, transport facilities, etc. What is frequently repeated, what is spoken of with emotion, what is voiced by influential persons: this can vividly tell us what is happening in people's lives.⁴¹

Finally, the sensitive nature of investigating HIV and AIDS calls for added discernment and attention to research ethics. For example, Christine Bodewes provides a detailed account of employing the pastoral circle to develop a pastoral plan in Christ the King Catholic Church, Kibera, Nairobi.⁴² In the context of meeting with sub-parish groups to discuss socio-economic problems, Bodewes records that her research team

observed early on that the mere mention of HIV/AIDS "shut down" the group and ended the discussion. People simply refused to discuss this topic. HIV/AIDS is still highly stigmatized because it is associated with sexual promiscuity. The stigma is so great that many people are embarrassed and ashamed to even say the word aloud. And yet, it is the most serious problem facing the parish. Thus, the team insisted that AIDS be included as a possible priority issue.⁴³

In sum, this first step of the pastoral circle demonstrates the incarnational approach to research and ministry which requires us to enter into life within a particular local context in attempt to spiritually discern what is happening.

Social Analysis: Why is it happening?

Second, *Social Analysis* addresses the crucial question, "why is it happening?"⁴⁴ The aim is to move beyond the anecdotal to in-depth analysis, probing the root causes, connections and consequences of what is taking place. Critical analysis considers key factors such as history, including both a "scientific" history of the past (e.g., main stages of development, key turning points, significant persons and movements) and an "intuitive" history of the

⁴¹ Jesuit Communications, "The Pastoral Circle and the Role of Social Analysis," http://www.jescom.co.zw/index.php?option=com_content&task=view&id=175&Itemid=53 (accessed June 9, 2011).

⁴² Christine Bodewes, "Can the Pastoral Circle Transform a Parish?," in *The Pastoral Circle Revisited: A Critical Quest for Truth and Transformation*, 77-93 (Nairobi: Paulines Publications, 2006). She introduces the context of this parish by noting that "Kibera has the notorious distinction of being the largest and most densely populated slum in all of sub-Saharan Africa, with over 700,000 people squeezed onto less than 550 acres," p. 77. For a full-length account of this pastoral project, see Christine Bodewes, *Parish Transformation in Urban Slums: Voices of Kibera, Kenya* (Nairobi: Paulines Publications, 2005).

⁴³ Bodewes, "Can the Pastoral Circle Transform a Parish?," 84-85.

⁴⁴ Wijsen, Henriot, and Mejía, eds., "Appendix I: Steps in the Pastoral Circle," 251.

future (e.g., projections, trends, extrapolations: “what will things be like ten years from now if nothing in the current situation changes?”).⁴⁵

Another crucial aspect of social analysis is a critical examination of any structures that contribute to the existing situation, for example:

- a. Economic Structures (production, labor, access to capital, marketing, technology, corporations, tax structures, interest rates, consumption, distribution, Environmental and economic policies etc.)
- b. Political Structures (Decision makers and their processes, public transparency and accountability, Constitutional laws, courts, political parties, lobbying and finance, etc.)
- c. Cultural Structures (Religion and religious institutions, family, neighborhood, education, symbols, media, communications, music, lifestyle, art, local traditions and values, etc.)⁴⁶

Other socio-cultural structures worth highlighting include gender relations and ecological factors. In addition, social analysis examines the values and cultural norms that influence the situation, either positively (e.g., sharing, community bonding) or negatively (e.g., dominance, selfishness).⁴⁷

Lastly, social analysis considers the key interrelationships between the history, structures and values before drawing conclusions regarding the most important influences in creating and sustaining the situation. Henriot notes, “The question of why such conditions exist will be guided by those whose *rights* are being violated and whose *responsibilities* are called upon to change the situation.”⁴⁸ He acknowledges that the language of “rights and responsibilities” is rooted in “the human dignity of each person in community.” Thus he makes explicit his own framework of values in undertaking social analysis, and rightly concludes:

No analysis is value free – we are prompted to ask certain questions, to look for answers in certain places, and to be open to consequences of these answers by the value framework within which we do our analysis. Yes, we must be objective in pursuing answers, but we must not be so naïve as to imagine that social research is totally value free.⁴⁹

Theological Reflection: How do we evaluate what is happening?

The first two steps or “moments” in the pastoral circle have been elaborated at greater length, since they are less familiar in conventional theological methods. However, both steps are decisive in fostering deeper understanding of the issue in context, before moving to the third step:

⁴⁵ Jesuit Communications, “The Pastoral Circle and the Role of Social Analysis.”

⁴⁶ John Gonzalez, “The Pastoral Circle,” <http://www.passionistjpic.org/wp-content/uploads/2009/08/The-Pastoral-Circle.pdf> (accessed June 9, 2011).

⁴⁷ Jesuit Communications, “The Pastoral Circle and the Role of Social Analysis.”

⁴⁸ Henriot, “Social Discernment and the Pastoral Circle,” 45.

⁴⁹ Henriot, “Social Discernment and the Pastoral Circle,” 45.

Theological Reflection, which questions, "How do we evaluate it?"⁵⁰ Scripture is fundamental to the process, as Holland and Henriot urge prayerful reflection upon the issue, particularly in light of the social analysis, followed by the identification and explication of scriptural passages of relevance to the issue. The aim is not superficial proof-texting, but rather in-depth consideration of appropriate biblical passages and overarching biblical and theological reflections. Not only Scripture, but also the wealth of Christian tradition can be mined for insight into the present situation. For example, Gerry Whelan recommends Christological reflection on the issue by selecting a passage from the New Testament in which the teaching of Jesus is brought to bear on the issue. In addition, drawing upon Bernard Lonergan's theology, he advocates Ecclesiastical reflection as follows:

[T]he three functions of the Church are, first, to assist religious conversion in individuals and communities (the priestly function). Next it is the mission of the Church to promote ideas, values and symbols that promote the common good (the prophetic function). Finally, the Church should involve itself directly in works of mercy, including running institutions such as schools and hospitals as a model for social structures in society over which it has no control (the kingly function).⁵¹

On this basis, he urges critical reflection on the extent to which the Church within the selected context is upholding its priestly, prophetic and kingly functions, and whether appropriate balance exists among the three functions or whether there is relative neglect in any of these dimensions. He then concludes, "This ecclesiological reflection is key to theological reflection in the pastoral circle. It is scientific and rigorous."⁵²

Pastoral Planning: How do we respond to what is happening?

The fourth dimension of the pastoral circle is *Pastoral Planning*, which asks, "How do we respond?"⁵³ It considers the role of individuals, parishes, agencies, institutions, and the wider church in planning action and evaluation in order to effect the desired change in the situation. Specific, viable strategies are sought, with attention to setting short-term and long-term goals. Consequently, as Wijsen points out, the pastoral circle is a form of action research which he explains as follows:

Action research as a research strategy developed on the margins of academic studies; it became a hallmark of much third-world or liberation theology, where theologizing serves as a means of empowering the people – especially the

⁵⁰ Wijsen, Henriot, and Mejía, eds., "Appendix I: Steps in the Pastoral Circle," 251.

⁵¹ Gerry Whelan, "Theological Reflection and the Slums of Nairobi," in *The Slums: A Challenge to Evangelization*, ed. Francesco Pierli and Yago Abeledo (Nairobi: Paulines Publications Africa, 2002), 90.

⁵² Whelan, "Theological Reflection and the Slums of Nairobi", 91. Whelan then provides a helpful account of his application of the pastoral circle in his ministry at St. Joseph the Worker Parish, Kangemi, Nairobi.

⁵³ Wijsen, Henriot, and Mejía, eds., "Appendix I: Steps in the Pastoral Circle," 251.

most marginalized – through adult education and community development. Here the methodological principles of learning by doing and doing before knowing are applied in their purest form. The presupposition is that the best knowledge comes from below and from within.⁵⁴

Finally, despite the pastoral cycle being outlined in separate steps, it must be stressed that this is not an orderly sequence of stages but rather a process in which various dimensions occur simultaneously or in fluid motion among the elements of the circle. Holland and Henriot explain, “None of these parts can be totally isolated; theology is not restricted to that moment explicitly called ‘theological reflection.’ In a wider sense, all the moments of the circle are part of an expanded definition of theology. All are linked and overlap.”⁵⁵ Furthermore, the circle is better conceived as a ‘spiral,’ akin to the hermeneutical spiral, because the process never returns to the same starting point. Rather, after evaluating the planned pastoral action, a new process begins, starting from the insertion in a new human situation.

Conclusion

This article has sought to “expand the borders of our tent” in theological research in Africa, particularly in relation to urgent contextual issues such as HIV and AIDS. Without diminishing the need or the value of traditional evangelical biblical and theological research methods, the argument is for enhancing these approaches by integrating new research methods that enable rigorous investigation into particular African contexts. More specifically, two approaches have been advocated: the wide range of qualitative methods developed over the past few decades, that now flourish in the academy and in industry, and the pastoral circle or cycle. As we diligently employ these and other methods to get “into Africa,” for the sake of serious contextual research in theology, we will contribute more effectively to the growing scholarship on African Christianity. In the process, significance will emerge not only for the Church in Africa, but also for this present “second age of world Christianity, ... indeed an age of global Christianity,” in which there is “possibility not just of contact but of communion, fellowship in the body of Christ, between Christians of different cultural and linguistic backgrounds” from every continent. For as Walls rightly concludes and appeals concerning this new multi-centric context of world Christianity, “theological interaction becomes possible on a scale previously inconceivable.”⁵⁶ May we truly heed this call for the sake of God’s kingdom in Africa and across the world.

⁵⁴ Wijsen, “The Practical-Theological Spiral,” 141-142.

⁵⁵ Holland and Henriot, *Social Analysis*, 13.

⁵⁶ Walls, “The Rise of Global Theologies,” 33.

Sexual Issues, HIV/AIDS, and the Role of the Church

by Priscilla Adoyo

Introduction

The issue of sex is a matter that has always been shrouded in mystery. One of my earliest memories in this regard is receiving a very hard slap from my mother one day for making a certain noise in my mouth using my lower lip and tongue. She did not bother to explain why I deserved such wrath from her and I was left totally baffled by her action. My mother was not the kind of person you asked questions of when she was angry. I have never, to this day, tried to make the same sound again. It was not until many years later (and I mean many!), that I came to understand that this is the sound produced by two people (or should I say a man and woman) having sex.

Talking about sex is not something that comes easily to most people. I always blamed parents for not educating their children on sexual matters until I took on my sister's two grandchildren to raise after they lost their father at the ages of five and seven. When the older one was eight years old, she came home from school after a lesson on the Christmas story and asked me, "What is a virgin?" I promptly said, "A virgin is ..." and I could not continue. I suddenly realized that I had never discussed issues of sex with her and the lesson would need more time than a simple answer. The house help, who was listening, burst into laughter. I told my granddaughter that I would explain later and never really got back to her. So, how different was I from my mother?

In considering this topic for this paper, I have tried to put the issues into different categories in order to help us think more clearly about the part we can play as individuals and as the church of Christ. What issues related to sex do we need to look at as we fight the scourge of HIV/AIDS? What factors have hindered our success in reducing the spread of the disease? Due to the many factors involved, I will only briefly touch on the following topics: vulnerable groups, the cultural factors contributing to the spread of the disease, violence against women, social and economic factors, and the role of the church.

The main purpose of this is to help generate some discussion since we all are aware of these issues - we just would rather not talk about them!

Vulnerable Groups

1. Adolescents

The largest group of individuals at risk of contracting HIV/AIDS is adolescents and young adults. In one survey done in Kenya in 1990, 26% of young women aged 15-24 had sex by their fifteenth birthday, and 64% of those who were 18 or older said they had sex by their eighteenth birthday. Fewer boys than girls stayed virgins through their teens, with 39% of young men reporting having lost their virginity by the time they turned 15, and almost three-fourths (73%) were no longer virgins when they turned 18.

In a 2003 study 1,751 secondary school girls aged 12 to 19 years were consulted by means of a self-administered questionnaire. Of these young women, 416 (23.8%) reported that they were sexually experienced at the time of the study. 4.1% of the sexually experienced girls had started sex below the age of 10 years, and some of those had been raped. The low and middle class private schools in the city centre had a higher incidence of sexually experienced girls. The same was observed in those girls staying away from their parents. The majority of the sexually experienced girls had started coitus within one to two years of starting their period or having a boyfriend. Some of these girls may have been forced to indulge in sex by men or boys or by circumstances. Lack of factual knowledge and parental guidance, and lust for material gains are some of the factors the girls felt may be responsible for the upsurge in adolescent sexual behaviour.¹

According to Michael Kelly, young girls often provide sex to pay for clothing and other personal needs. Others do it just as an experiment. Kelly identifies school related circumstances that aggravate the risk to students becoming infected as follows:²

- The early sexual activity of a substantial proportion of those attending school
- Schools serving children of widely divergent ages
- Sexual harassment on the way to and from school
- Sexual harassment and pressure by fellow students and teachers
- Unsupervised boarding or other school accommodation arrangements
- Pressure to conform to the perceived expectations and practices of peers and colleagues
- Failure of adult society to set appropriate standards and expectations
- Double societal standards for the sexual behaviour of males and females
- Transactional sex, whereby sex is traded for material, financial, or academic favours from individuals who control valued resources
- School or college as the locus for coerced sex
- Reluctance of adults to acknowledge these factors and to provide guidance and support for the children.

Young men have their own set of challenges. Peers dictate to them what it means to be a man. "To be a real man, one must drink, one must experiment with sex, one must have many sexual partners, one must take risks no matter what the consequences, one must be able to show a list of conquests and the longer the list, the more masculine and macho the person is supposed to be. There is the terribly wrong belief that a boy or young man who is a virgin,

¹ V.M. Lema, "Determinants of sexuality among adolescent school girls in Kenya", *East Africa Medical Journal* (1990) Vol. 67, Issue 3, pp. 191-200. See www.ncbi.nlm.nih.gov

² Michael J. Kelly, "The Response of the Educational System to the Needs of Orphans and Children Affected by HIV/AIDS" in *A Generation at Risk: The Global Impact of HIV/AIDS on Orphans and Vulnerable Children*, John Williamson, Geoff Foster, Carol Levine, eds. New York: Cambridge University Press, 2005. p. 68 ff.

never having had sexual intercourse, must be weak and sissy.”³ Ironically, when looking for a wife, these same young men expect to find one who has never had sexual intercourse.

2. Married Men and Women

Much in the African culture contributes greatly to the spread of HIV/AIDS in marriage situations. Culture expects and tolerates a man's unfaithfulness. Women are counseled before marriage to expect it and never to talk about it in public or never to talk about any form of domestic violence in public. When the woman cannot satisfy her husband's needs, he is entitled to find a younger one with 'hot' blood. This was not just the situation in the days of our grandparents. It is still happening today in the 21st Century. Studies have shown the spread of HIV/AIDS to be more prominent in married couples between the ages of 40 and 50 and above, when sexual dissatisfaction for men and menopause for women sets in.

Then there is the well-known cleansing ceremony for widows practiced among the Luo in Kenya. Here the woman whose husband has died is unclean and cannot remarry until after she has been cleansed through sexual intercourse with her brother-in-law or her late husband's close relative. Woe unto the parties involved if the husband died of HIV/AIDS.

3. Commercial Sex Workers

The risk of sexual transmission of HIV is increased by the presence of other sexually transmitted infections (STI). Since commercial sex workers are likely to have some form of STI, the chances that they will easily become infected with HIV are higher. And many sex workers in Kenya today are married people which makes matters even more complicated.

4. Homosexuals

Homosexuals are a well-known vulnerable group so nothing more needs to be said here for the purpose of this paper.

Cultural Factors Contributing to the Spread of HIV and AIDS

Cultural norms are often a good guide in many societies, but culture is also very ambivalent. Many Christians in Africa today still hold their traditional beliefs alongside their Christian doctrine. Even the majority of those who abandon traditional religious practices are still influenced by their cultural, family and community values.

Culture has played a major role in making sure that one knows what is acceptable and what is not. Generally, there have been good indications that many African peoples have been proud of their traditional moral behaviour. Many African cultures ensured that young girls kept their virginity until

³ Michael J. Kelly, *Education: For an Africa Without AIDS*, Nairobi: Paulines Publications Africa, 2008, p. 211.

marriage. Growing up, I was made aware of the fact that if a lady got married and she was not a virgin, all the relatives would get to know about it and this would bring shame to her family. In the Luhya culture, teenage girls of the same age group had one sleeping place where an elderly woman gave lessons on modes of behaviour and specifically sexual behaviour.

Men likewise were taught how to prepare for adult life during initiation and how to relate to the opposite sex. Although we can argue today that some of what was taught was not beneficial to the female of the species, there was in general a moral fibre running through the society. However, until initiation, much of what was taught in these initiation schools for both boys and girls was shrouded in mystery. Issues of sex were not talked about in public. This culture of silence is still largely the same today, minus the structures to give instruction to young people. Some of the social structures to train young adults went away with the coming of Christianity and modernity and no effective replacement has been developed in African societies as a whole. Often, the young people are left to glean what they can through the television and other social media, but this has very little, if any, Christian moral emphasis. Schools in Kenya have improved greatly in focusing on a curriculum that provides sex education, but this does not seem to have substantially curbed the spread of HIV/AIDS. A number of churches too have developed programmes to provide initiation rites to young people and this is to be commended.

According to Agrippa Khathide,

"The challenge to break the silence about human sexuality needs to be faced if we are to succeed in talking about HIV/AIDS. Perhaps the best place to break that silence is in the home. Parents must feel free to talk openly about sex to their children and allow them to ask questions. Most parents have abdicated their responsibility to give sex education to their children in the hope that school teachers and the mass media will fill the void. Nothing on earth can substitute for parental guidance."⁴

There is a lot of truth in this and yet my personal observation as a single woman has been that married couples have a more difficult time talking about sexual issues than the unmarried (especially in the presence of the unmarried) for reasons that might have some cultural undertones. At the same time, when singles are too vocal on the subject they are looked at with a lot of suspicion. This is made even more difficult in Christian circles. "How does she know all this? Why does she want to know about sexual matters?" I appreciate having been asked to participate in this conference but I also have a feeling that whoever put forward my name for this topic was not aware that I was a single woman. And I must say I had my own reservations about presenting the subject. This is a simple reality that we cannot run away from. If we do not

⁴Agrippa G. Khathide, "Teaching and Talking about Sexuality: A Means of Combating HIV/AIDS" in *HIV/AIDS and the Curriculum: Methods of Integrating HIV/AIDS in Theological Programmes*. Musa W. Dube, ed. WCC Publications, Geneva 2003, p. 3.

begin to set an example as the church, whom will we have to blame when things get out of hand, as they already have? The need for the church to break the silence around human sexuality is long overdue. The church has a responsibility to liberate her people from the fear and shame of talking about sex. And maybe that should start with our theological institutions with the training of our pastors and Christian leaders.

Violence Against Women and HIV and AIDS

In 2001, two million girls between the ages of 5 and 15 were victims of sexual trafficking. Violence against women has been identified as one of the strongest cofactors in HIV infection. Moreover, HIV positive women face greater discrimination than men infected with the virus, often resulting in isolation, violence and rejection. Inequitable gender relations in many cultures often limit women's ability to negotiate safer sex with their partners, including the use of condoms. "If more women and girls had the 'right to abstain' - that is, to decide when and with whom they have sex, to negotiate condom use, to live free from violence, and to earn incomes adequate to feed their families - they would have a real chance of being able to protect themselves from HIV infection."⁵

Social and Economic Factors and HIV and AIDS

Social, cultural and economic factors can exacerbate the pandemic and create barriers to HIV prevention. These factors include:

- Taboos surrounding sexuality - for example, women and girls in some cultural settings are not supposed to discuss issues associated with sexuality
- Lack of knowledge about sexuality, pregnancy and prevention of sexually transmitted diseases in adolescents
- General denial of the society at large that adolescents are sexually active before marriage
- In some cases, poverty drives women to have sex for money. Sex in this sense is not bound up with ideas of romanticism but is viewed more objectively.

Due to these factors, all of which play a part in contributing to the patterns of sexual behaviour, it becomes rather difficult to approach the problem based only on abstinence.

The Role of the Church in an AGE of HIV and AIDS

The initial outbreak of HIV/AIDS in 1981 in the homosexual community in the United States made it a story about sexuality and religion because the majority of American Christians at that time believed that the Bible forbade homosexuality. By 1983, an emergent medical/moral frame for the disease

⁵ UNFPA, *Engaging Faith Based Organizations in HIV Prevention: A Training Manual for Program Managers*. p. 8. <http://www.unfpa.org/public/global/pid/398>

made religion, and particularly Christianity, an integral part of the story in three main areas: AIDS as a punishment for immorality, as a pastoral challenge for denominations, and as a spiritual trial for the afflicted. As time went on, the church was accused of not showing the love of Christ to HIV/AIDS victims. The argument put forward was that since sexual activity was not the only source of transmission, all infected persons should not be treated with the suspicion that they had indulged in sinful behaviour. This in some ways was easier for the church to handle because now, pastors could talk about HIV/AIDS without having to mention the sexual part of it. While there is some truth to this, studies have categorized percentages of HIV infections by transmission route as follows:⁶

- Blood transfusion: 3–5%
- Parent-to-child transmission: 5–10%
- Sexual intercourse: 70–80%
- Injecting drug use: 5–10%
- Health care (injuries): <0.01%

Unfortunately, the church does not seem to be able to tackle the issue of sexuality effectively because as Khathide has observed, most people are confused and inconsistent when it comes to sex. Khathide goes on to say, “Perhaps the reason the church finds it difficult to handle sex and sexuality-related issues is because we have considered sex as belonging to a domain outside the sovereignty of God. Though we may find it hard to admit, it is true that human beings, including the church, regard sex as belonging to the Devil - something that is associated with darkness, evil and wickedness. The church seems to be comfortable with the fact that sex education is the responsibility of governments, schools and NGO’s. Thus, sex remains a taboo for the church. Even our African cultures have contributed to the present state of affairs.”⁷

Khathide calls this the “demonizing of sex” and argues that with this kind of mentality it is very difficult to fight against HIV/AIDS since no one wants to be associated with evil and wickedness. He calls for a theologically sensitive anthropology that does not stigmatize abstinence and faithfulness. The church also has to reaffirm sexual equality in a culture where a man is not said to be committing adultery when he is extra-maritally involved, giving him the freedom to move around and hurt others. Khathide concludes that talking about sex need not lead to sexual corruption, rather, “it should be viewed as a mechanism for airing thoughts and feelings in the hope of creating an environment in which people can express their sexual feelings without experiencing guilt.”⁸

⁶ UNFPA, *Engaging Faith Based Organizations in HIV Prevention*, p. 7.

⁷ Khathide, “Teaching and Talking about Sexuality”, p. 5.

⁸ Khathide, “Teaching and Talking about Sexuality”, p. 8.

Patricia Bruce observes that apart from the Roman Catholic Church's consistent call for abstinence, there have been attempts by other Christian groups to promote abstinence such as the recent campaign called "True Love Waits". A group of youths from the Catholic Diocese of Nakuru, Kenya have also formed a group known as the "Virgins Only Club" supported by the UN Fund For Population Activities. There are obviously some negatives to this kind of exclusive club because it does not help those who are already infected, but it is a step forward in the prevention campaign.

Various AIDS awareness campaigns have generally emphasized safe sex while only mentioning abstinence. There has been an underlying assumption that promoting virginity or abstinence would simply be too unpopular and doomed to failure. However, Bruce points out that in places like Uganda where HIV prevalence dropped from 21% in 1991 to 6% in 2001, what made the difference had been real behaviour change and social support for abstinence and faithfulness.⁹

Is there something that the church is not doing? Have we sufficiently grappled with the issue of sexuality and HIV/AIDS to bring about significant change? These questions remain for the Church in Africa to contemplate.

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⁹ Patricia Frances Bruce. "'The Mother's Cow': A Study of Old Testament References to Virginity in the Context of HIV/AIDS in South Africa" in *African Women, HIV/AIDS and Faith Communities*, Isabel Apawo Phiri, Beverley Haddad Madipoane Masenya, Ngwana Mphahlele, eds. Pietermaritzburg: Cluster Publications 2003.

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Theology and HIV and AIDS

by James Nkansah-Obrempong

Introduction

The first cases of HIV (human immunodeficiency virus) and AIDS (acquired immunodeficiency syndrome) came to public notice in the early 1980's. Since then the number of cases has greatly increased and HIV/AIDS has become one of the most deadly diseases to affect humanity in the last 100 years. The HIV/AIDS pandemic has taken the lives of many Africans and the disease continues to afflict the continent. Many people around the world and in Africa have been affected by this pandemic in many ways. Families, churches, and governments are trying to deal with this pandemic. Their approaches have focused on psychological, medical, and preventive methods. While these dimensions of fighting the pandemic are important, the HIV/AIDS epidemic needs an even wider multifaceted approach to deal effectively with the disease. HIV/AIDS is not only a medical problem; it has theological, ethical, social, and economic dimensions to it. If we would eradicate this pandemic from the world, it will require a multifaceted approach to do so. My thesis for this paper is that theology provides this multifaceted framework to address the scourge. My goal is to provide a theological framework for engaging and reflecting theologically and biblically on HIV/AIDS.

History and Facts About HIV/AIDS

HIV/AIDS was first discovered in the early 1980s among some North American homosexual communities, commercial sex workers and intravenous drug users. HIV/AIDS is no respecter of persons. It infects the poor and the rich, male and female, Christian and non-Christian. It can infect anyone regardless of faith, marital status, sexual orientation or social status.

Current statistics show that HIV has spread to every country in the world. Presently, world wide, there are 40 million people infected with HIV, 25 million people have already died from the disease, and Sub-Saharan Africa has suffered the most from the disease. Globally, 85% of HIV infections are through heterosexual intercourse. Infection in women is high and it stands worldwide at 42%. There are many factors for these high infections in women. Some are related to culture, economics, and a feeling of powerlessness.¹

Closer to home, Kenya has 2.2 million people infected with HIV - 7% of the population. 1.5 million people have died of HIV/AIDS since the epidemic was identified in Kenya. It is estimated that 700 infected people die daily in Kenya while there are 800 new infections every day.² These figures show the war on HIV is not over. Many more people are going to be infected and

¹ http://www.emedicinehealth.com/hiv aids/article_em.htm. Accessed May 18, 2012.

² <http://www.kenyaspace.com/hiv aids.htm>. Accessed, May 18, 2012.

affected if we do not keep on fighting this epidemic. It is imperative that we reflect theologically on the HIV/AIDS scourge.

Theology and the HIV/AIDS Challenge

Theology must seek to address the challenges HIV/AIDS poses for the human race, for the Church, and for society. The disease raises the issue of cultural practices that are at odds with the Christian faith, and issues of sexuality, protection, morality, medical care, stigmatization, powerlessness, and marginalization. Our responses to HIV/AIDS have largely focused on these issues. But for a comprehensive response to the issues HIV/AIDS pose for humanity, we also need to address them, especially issues of sexuality, culture, morality and poverty, from a theological perspective. What we have not done very well is develop a solid theological framework to shape our responses so we can address all the issues this disease has raised. For me then, HIV/AIDS issues are primarily theological issues. HIV/AIDS poses a challenge and raises questions about the meaning of life, the place of suffering in human experience, death, stigmatization, and the nature and character of God. Maluleke is right to observe, "AIDS raises deep challenges about the meaning of life, our concept of God, our understanding of Church, human independence, human frailty, human failure, human sinfulness and human community."³ These issues are theological in nature.

In addition to some of the issues pointed out by Maluleke, I add issues of human sexuality, our assumptions about sickness, gender, injustice, and poverty. All of these issues raise important questions that only theology can answer. God is concerned about these issues and the Bible can address them. Consequently, serious theological reflection is needed if the answers we give are to be informed by God's view of these issues. Theology, therefore, provides our foundation. It gives meaning to these many issues that confront humanity. It shows how God is involved, deals with, and relates to humanity on these issues. Theology helps us understand God's purposes and will for his creation. It challenges the ideological and cultural assumptions that underline our belief systems. It helps to give us balanced perspectives on these issues.

A Relationship Between HIV/AIDS and Sin: Biblical Teaching on Sickness and Death

The notion that human beings suffer because of moral failure or sin has long been held by many people in the church. The HIV/AIDS epidemic has been seen as God's judgment on the human race for choosing to go its own way. As the statistics show, the primary means for HIV infection has to do with sexual behavior. Consequently, in its early development, HIV/AIDS was

³ Tinyiko Sam Maluleke, "Towards an HIV/AIDS-Sensitive Curriculum" in *HIV/AIDS and the Curriculum: Methods of Integrating HIV/AIDS in Theological Programmes*. Ed., Musa W. Dube. Geneva: WCC Publications, 2003, p.66

associated with people who had promiscuous sexual behavior. It was linked to immorality. This understanding of the pandemic made most Christians form the opinion that only people who are promiscuous contract HIV/AIDS. The Church interpreted this theologically, leading to the position held by some that HIV/AIDS is a punishment from God. People are infected because of the sinful lifestyles they choose. This belief was based on the premise that God is holy and righteous, and that he punishes sin. God punishes those who rebel and choose to ignore and violate his laws.

Consequently, infected people feared being looked at as sinful, so they did not disclose their HIV status. This contributed to new infections. Most infected people were stigmatized and discriminated against by those who were not infected. This is because everyone infected with the virus was viewed as sinful and therefore facing God's judgment, *which they deserved*. This reasoning is human and not divine. God does not have such attitudes towards sinners. God loves them and he wills to redeem and save them in spite of their sins, even if those sins led to HIV infection. The Bible affirms that "while we were yet sinners Christ died for our sins."

1. The Biblical Relationship Between Sin and Sickness

The relationship between sin and sickness is not new. In both African and biblical worldviews, sin always results in punishment if it is not purged. In Jewish and African cultures, sickness and death are attributed to many causes. Some of the major causes of sickness and death in African thought include sin, curses, witches, demonic forces and as punishment from God or gods as well as the ancestors. The Bible affirms some of these understandings of sickness and death so we will examine some of the biblical teachings on sickness and death.

The Bible teaches that sickness and death are the result of Adam and Eve's sin against God. Sin evokes punishment from God. Both the Old and New Testaments teach that Adam and Eve's sin against God resulted in sickness and death (Gen 3:15, 19). God told Adam, "The day you eat the fruit of the tree of the knowledge of good and evil, you will surely die". Of course, we know Adam and Eve did not die immediately after their disobedience, but they entered or triggered a dying state or process, which eventually led to their physical death. They became mortal and subject to death. In Ezekiel 18:20, God said the person who sins would die. Sin is a cause of death.

The belief in the cause and effect principle in African thought has made many Africans associate sickness and death with people offending God or the ancestors. When people continue to disobey God and live wicked lives, God may bring sickness and even death upon them to punish them. For example, an evil spirit tormented King Saul so that it made him depressed and filled with fear (1 Sam. 16:14). God struck King Uzziah with leprosy for entering the Temple to offer incense as if he were a priest (2 Kings 15:1-5, c.f. 2 Chron. 26:16-21). Pharaoh's sin and disobedience caused God to inflict diseases

such as boils on both animals and people in Egypt (Ex. 9:1-12). In Deuteronomy 28:21-22, 58-61; 29:22, God inflicted diseases on the people because of their sins. God also uses sickness to get the attention of people who do not have time for Him. Through their suffering, these people come to experience his love and care and they surrender their lives to Him.

The New Testament also sometimes links sickness and death with sin and as punishment from God. Worms ate King Herod's insides because he sinned by taking God's glory (Acts 12:23). The paralytic in Luke 5:18-20 was healed after Jesus pronounced that his sins were forgiven. After Jesus healed the man by the pool of Bethesda, he warned him to stop sinning or something worse might happen to him (John 5:14). The implication of this warning is that either his sickness was the result of sin or sinning would bring sickness upon him. Either way, sin can have the effect of causing sickness and death. In Romans 6:23 Paul says, "The wages of sin is death" and so links death to humanity's sin. In Romans 5:12-21 and 1 Corinthians 15:21-22, and 56, Paul argues Adam's sin not only introduced sin into the world, it also brought death to the human race. Sin and death entered the world through Adam.

However, sickness and death is not always the result of sin. In John 9:1-3, Jesus' disciples revealed their misunderstanding of sickness and sin when they asked Jesus if it was the parents of the man born blind who sinned or the blind man himself. Jesus' answer is insightful. He points out two important things we must know about sickness. First, He pointed out that in this case, no one had sinned. By saying this he challenged the cultural understanding that attributed all sickness or death to sin. Jesus dismissed the philosophical and ethical arguments for their position on the issue of the relationship between sin and sickness. Not all sicknesses are caused by sin. Second, Jesus reveals that sicknesses may have a particular purpose in God's plan and agenda. This particular sickness had a purpose - to bring glory to God Almighty. In the Old Testament we have Job's story; his sickness was not the result of sin but served a divine purpose for God to prove Job's love, loyalty and faithfulness to Him. Paul's teaching on how we should approach the Lord's Table affirms this understanding of sickness as well (1 Cor. 11:27-32). There some sicknesses came upon the Corinthian Christians not because of a particular sin they committed, but because of not properly "discerning the Lord's body".

A proper theology of sin helps us hold a balanced view on the matter. Furthermore, an adequate theology of sin moves us to see and appreciate what God did about Adam's sin, and by extension, what God did about sin on behalf of the entire human race.

HIV/AIDS should be seen in light of this broad biblical and theological explanation of sickness and death. Sickness is part of our fallen human condition. This is not to pass judgment or encourage stigmatization of people infected by HIV/AIDS. Rather, sexual immorality is due to our sinful human nature, and that plays a vital role in this pandemic. This affirmation is very

important as we look to address the challenges HIV/AIDS presents to us. We cannot down play human sinfulness and wickedness as critical in the spread of the disease.

2. What Has God Done to Deal with Sickness and Death?

Is God concerned about human suffering? Specifically, is God concerned about those infected and affected by the HIV/AIDS scourge? If he is, what has he done? In what ways has God dealt with these issues of sickness, pain and suffering, discrimination, stigmatization, marginalization, poverty, death, and all the other issues HIV/AIDS raise for humanity? I believe theology provides solid and concrete answers to these questions and shows how God has acted and dealt with the problems humanity faces today. The good news is that God, through the death of Christ on the cross and his resurrection, dealt with human sins and human sickness including HIV/AIDS.

If sin is the ultimate cause of sickness and death, as we established from the biblical texts we examined, then Christ's death on the cross is the critical antidote to sickness and death because it provided the ultimate answer to human sin and sickness. The atonement or the death of Christ on the cross resulted in two important benefits for humanity. Firstly, the atonement was God's answer to sickness. Through Christ's death, humanity received healing for every sickness that they would experience. Isaiah the prophet predicted that through Jesus' stripes we are healed (Isaiah 53:3-5). Healing is in the atonement. Peter affirmed the Old Testament teaching on the atonement when he says in 1 Peter 3:18 that by the stripes of Christ we are healed. On the cross Jesus carried and bore our sicknesses and brought healing to our sick bodies (Mt. 8:17).

Secondly, the atonement is God's answer to death. Adam's sin brought death to humanity but through Christ's death, humanity received life. Through the cross of Christ, death's power over humanity is broken. Both sin and death have no power over human beings any more.

Theology as a Proper Response to the HIV/AIDS Pandemic

We previously asserted that the challenge HIV and AIDS pose for us is not simply sexual, moral, medical, social, psychological and economic but also profoundly theological. The theological challenges HIV/AIDS pose for us are fundamental and important issues. If our response to the HIV/AIDS pandemic would be holistic and effective then, we all must take the theological dimension to the problem seriously, as we engage and fight the pandemic.

If the issues I have raised are theological in nature, then, theology should be critical in providing the framework for addressing and responding to the fundamental issues of human suffering, sin, stigmatization, discrimination, sexuality, morality, medical care, pastoral care and counseling. These matters are central concerns for HIV/AIDS. In addition, some questions are not just philosophical in nature, but primarily theological: 1) Why God has allowed so

much suffering in today's world through the HIV/AIDS scourge? 2) Where is God in HIV/AIDS and if he is there, how has God revealed his nature and character through this epidemic? 3) What does this disease tell us about God and his creation? The answers to these questions can be found in theology. Theology tells us about a loving and compassionate God who has provided solutions for his creation.

The HIV/AIDS scourge has provided the opportunity for us to discern the character and nature of God in the mist of this pandemic. God as the God of life, compassion, mercy and justice, has acted through the cross to redeem humanity from sin and sickness and has restored humanity to newness of life and given humanity hope. He requires us to show that same attitude and care for the sick, afflicted, and powerless so they can experience his shalom.

Over the years, our responses to the HIV/AIDS pandemic have focused on medical care, psychological counseling, pastoral care, social and economic empowerment, and other forms of assistance. Although these approaches have been helpful, they have not addressed the menace holistically. I suggest that we give theology a central place as we seek to respond to the HIV/AIDS epidemic. We cannot brush under the carpet or push aside the critical theological issues that the pandemic raises for us as Christians, including issues surrounding sexuality, morality and the place of God in human suffering. Theology provides the critical framework for reflecting on and engaging with these issues. It helps us respond more adequately to the people who have been infected and affected by the HIV/AIDS epidemic.

In addition to theology providing the framework for our response to HIV/AIDS, Christian virtues such as hope, love, compassion, mercy are important theological ideas that are foundational for our response to HIV/AIDS and help us to address the challenges this sickness has brought to the human race. Christian theology provides hope for the hopeless and helps them to look beyond their condition and situation to a God who is compassionate, faithful, merciful and loving and is concerned about their lives. "A theology of hope and love must be accompanied by practical care, which not only aims to improve people's quality of life within their community, but also demands action in the wider world."⁴

We must develop a proper theology of sexuality, one that is not based simply on cultural grounds, but one that is rooted in the character and nature of God as loving, caring, and faithful to his covenant. Such a theology would help us to understand God's intention and purposes for human sexuality and the sanctity of marriage. The Bible affirms the sacredness of marriage. Jesus approved proper sexual relations between a married couple as well as "faithfulness within a committed, monogamous heterosexual relationship as

⁴ Paula Clifford, *Theology and HIV/AIDS Epidemic*, Christian Aid, 2004, p. 1. See http://www.christianaid.org.uk/images/hiv_theologyfinal.pdf

‘good.’⁵ God provided sex within marriage for humanity to enjoy. Human sexuality is therefore a gift from God for pleasure and for procreation. For a long time, the African Church and African Christians have handled the subject of sex with shame and uneasiness. As the Micah Network paper points out, “This lack of frank discussion has escalated the AIDS crisis by failing to offer opportunity for dialogue, clear guidelines, provide role models or accountability for those (particularly the young) exploring their sexuality.”⁶

Furthermore, theology provides the materials to reflect on matters to do with the promotion of life, the dignity of the human person, justice, social responsibility, morality, death, just economic systems, pastoral care, empowerment, gender issues and religious beliefs that are essential for humanity to experience God’s shalom in their lives. Specifically, the nature and character of God, how God deals with diseases and sickness in his world form the bases for engaging and dealing with the HIV/AIDS menace in our societies. Theology not only shows how God has dwelt with sickness and diseases in the world, but it can provide the framework that shapes our response to HIV/AIDS. Particularly, theology deals with the issue of stigmatization of HIV/AIDS infected and affected people; it helps restore the dignity of the infected people as men and women created in the image of a God who desires respect and honor; it helps promote and protect life; and it addresses the wider issues of injustice and poverty that God takes very seriously.

Cavalcanti holds that theology provides a framework for pastoral care and counseling within which the church can guide its relationship with those infected and affected by HIV and AIDS. Theology helps the church model its actions in the struggle against discrimination and oppression wherever these are still experienced by HIV positive people. It can take the lead in espousing moral values that promote holy living. It also offers hope of abundant life and encouragement in the fight for proper medical provision for people who live in our world’s less affluent regions. “A theology of life is a more adequate model of theological thinking and practice for those who are confronted daily with issues of suffering, death and stigmatization. This is a theology that will express in a better way the Good News of the Gospel as well as respond to the context where the enemies of life arise.”⁷

Theology helps us to understand human sin, frailty, and fallenness. Theology teaches that all humanity (and all creation) is under the curse of the

⁵ Kristen Jack, “Towards a Christ-Centered Theology of HIV/AIDS – Discussion Paper” September 2005, p. 5, accessed from www.servantsasia.org/index.../8.../216-alias-of-news-with-id216.html, May 18, 2012. The paper is connected with the Micah Network.

⁶ Jack, “Towards a Christ-Centered Theology,” p. 5.

⁷ Rev. Joabe G. Cavalcanti, “Towards a Theology of Life within the Context of HIV and AIDS,” African Health Policy Network. Accessed from www.ahpn.org/Upload/page/36_Theology_and_HIV_151.pdf p.1., May 18, 2012.

fall, and suffering, disease and poverty are the direct result of humanity's original sin as we have pointed out earlier. However, theology also gives us the answer to the problems of sin, disease, suffering and poverty. The cross of Christ has brought victory over sin, disease, death and poverty to humanity.

Theology can help us to address the problem of ostracism and isolation from the community. It can allow us to move beyond the stigma and fear of this disease with a loving touch and a compassionate prayer, in order to bring holistic healing to those infected and affected by HIV/AIDS - physical, social and spiritual healing. God consistently acts with mercy towards those in society who are already judged and excluded.

A Theology of Embrace, Affirmation, Life, Hope and HIV/AIDS

Within this seemingly hopeless situation of the HIV/AIDS epidemic, the church has a message of love to share with a broken and hurting world. Christians have a message of God's love to preach to the world persuading the world to be reconciled to God. On the cross, God extended his open arms to the world and he embraced the world. We are no longer enemies of God, but have become children of God if we respond to God's love for his creation. God in his mercy and grace has forgiven us our sins through the death of Jesus Christ on the Cross reconciling us to Himself.

Regardless of how people acquired HIV, God expects us to show compassion and mercy to those who are suffering as he has shown us mercy and compassion and has forgiven us our sins and embraced us. We are no longer strangers and enemies of God but sons and daughters of God. He has affirmed us as His children.

Christ, through his death and resurrection from the dead, has ushered us into new life. Humanity has been made new and each one of us can be made new by the power of the indwelling Spirit. All who embrace God's love in Christ have become a new humanity. Humanity is once again recreated in the image of God and therefore deserves to be treated with honor and dignity. God has embraced humanity and has showered his mercy and favor on her. What humanity lost to sin is regained by the new life Christ gives to all who come to him in repentance thus giving us hope after this life. Also through the power of the Spirit, humanity is empowered by God to live holy and pure lives, lives that bring honor and praise to His holy name.

This message of hope, of life, and of affirmation and of embrace, will have to play a major role in a theology of HIV/AIDS if we want it to be relevant for those most in need of the church's involvement in this pandemic. The mission of the Church is to bring wholeness to a broken and hurting world. As Christians, we must value life as God values it, cares for it, preserves it, and nourishes it. Like God, we must promote life, protect life, and ensure the quality of life of those affected and infected by AIDS so they may enjoy life again. We should not delight in destroying life by denying people with AIDS

the quality of life they deserve.⁸ Now we are ready for a theological framework that can shape and guide our response to the HIV/AIDS epidemic.

God's Acts as Model and Basis for our Responses to HIV/AIDS

Volf points out, "God's reception of hostile humanity into divine communion is a model for how human beings should relate to the other."⁹ The Bible affirms this position. God calls us to be holy because he is holy (1 Peter 1:16). Theology demands we reflect the nature and character of the triune God's attitude to suffering and disease. Jesus' response to sickness and disease was consistently one of compassionate acts to alleviate suffering. Rather than enter into speculation on the theological cause of how someone became sick, he instead saw his own response as an opportunity to glorify God (John 9:1-3).

His attitude and response to the marginalized and despised was one of compassion rather than judgment. His interactions with Samaritans (John 4:7), Gentiles (Luke 7:9), tax collectors (Luke 19:2), drunkards (Matthew 11:19), and women of ill repute (Luke 7:37), were all marked by responses of compassion, love, and life. For example, Jesus went out of his way to receive and fellowship with the afflicted, the sinners, and the rejected. Rather than pronounce God's judgment on them, he instead taught that these ones were actually closer to God's Kingdom than those the world considers rich, powerful or successful (e.g. Matthew 5:3-12; Luke 6:20-26). Jesus announced that he had come not to judge, but to save (John 3:17; 12:47). Indeed, Jesus reserved his harshest criticism for the most successful and exalted citizens of his day (Luke 6:24-26), while consistently acting with mercy towards those that society had already judged and excluded. He shared God's love and compassion with these people and they changed their hearts and attitudes towards God and they embraced Him and followed the ways of God.

Jesus' encounters with lepers are but one example of his response to the marginalized of his day. Particularly striking was Jesus laying on of hands to heal leprosy (Mark 1:40-45), a dreaded skin disease that in Old Testament terms was a curse marking the sufferer as being outside of God's blessing (e.g. Leviticus 13:45-46). Yet, Jesus has a place for such people in his life and ministry. No one was an outcast for Jesus. He embraced all and respected all as men and women created in the image of God.

Jesus Christ called his followers to emulate his concern for and ministry to those who are suffering - the poor, diseased and the marginalized (Matthew 10:5-10; 25:31-46; Luke 10:25-37). He called his followers to acts of compassion rather than words of judgment. Indeed, Jesus specifically warned

⁸ Isabel Apawo Phiri, *HIV/AIDS: An African Theological Response in Mission*, theologyinafrica.com/blog/?page_id=98

⁹ Miroslav Volf, *Exclusion and Embrace: A Theological Exploration of Identity, Otherness, and Reconciliation*. Nashville, Abingdon Press, 1996, 100.

against judging people before the proper time (Luke 6:37; John 12:47; c.f. with Paul in 1 Corinthians 4:5), and especially against associating suffering with God's judgment (e.g. Luke 13:1-5). Jesus taught that we are all "sinners", and we are all in need of repentance and conversion. We must demonstrate a humble spirit as we deal with people and help them.

Conclusion

Theology modeled on God's deeds ensures God-glorifying, compassionate responses to the HIV/AIDS pandemic rather than attributing blame to those infected and affected by the disease. This is particularly true of the Triune God's attitude and response to sickness, suffering, pain experienced by the most marginalized members of society who were excluded and regarded as "sinners" or as being "unclean". God's love, mercy and compassion embrace all such people and he offers them hope and life. We must respond in a similar fashion. God's response becomes a model for our own response to the HIV/AIDS epidemic. We must extend love, grace, mercy and compassion to all who have been infected and affected by the sickness. The Gospel offers them life and hope in Jesus Christ who gave his life to redeem them from all their sins, pain and suffering.

As we reflect upon what we have heard and start our own formulation on a theology of HIV/AIDS, let us be humble enough to admit that we do not have all the answers to the problem of HIV/AIDS. However, the Gospel demands we share the message of love and hope with individuals, families, communities and entire countries facing inevitable death. We must assure them of God's presence and identification with them in their pain and suffering for he promised never to leave us or abandon us.

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Gender Issues in Relation to HIV and AIDS

By Mary Getui and Eunice Odongi

Introduction

This article discusses some of the religious beliefs, convictions and practices that reinforce pertinent gender inequalities and how they influence HIV vulnerabilities and risks. The discourse particularly provides a platform for religious teachers and leaders to conceptualize and interrogate gender perspectives and their impact on the advancement of their religious objectives and goals in this era of HIV and AIDS.

Gender here refers to the socially constructed and learnt roles and responsibilities for males and female. The concepts of 'sex' and 'Gender' are often interchanged, but, strictly speaking, "gender" is the human construct that establishes the moral and social implications of sexual differentiation. Gender roles vary depending on the place, time, and socio-economic, political and cultural context, but they are almost always present, and ultimately have a significant impact on vulnerability to HIV and AIDS.

Gender Dimensions of HIV and AIDS

Scholars have long recognized that gender inequalities drive HIV and entrench its impacts in every community in the world irrespective of social, cultural, political and religious affiliation. Gender inequalities are more inclined against women and girls. The inequalities between men and women that are created and reinforced by gender roles typically leave women especially vulnerable to HIV infection and its impacts, but it is also important to recognize that gender roles affect men's vulnerability as well. As a result of their societal roles and responsibilities, women and girls face a number of unique challenges that disproportionately affect their ability to protect themselves from HIV and its overwhelming effects. This is evidenced by the greater impact of the epidemic on women, especially in Sub-Saharan Africa and certain Caribbean countries, where the "feminization" of AIDS is most visible. Women carry the burden of care giving, and bear the greatest burden of HIV in terms of prevalence rates especially girls and women aged 15–24 years. One half of people living with HIV globally are women and 76% of all HIV-positive women live in sub-Saharan Africa. In this region, women are more likely to become infected with HIV than are men - 13 women become infected for every 10 men infected. Female-to-male ratios of new HIV infections range from 1.22:1 in West and East Africa to 1.33:1 in southern Africa. For every HIV-positive young man (15-24 years) there are three HIV positive young women.

Differentiated gender roles create unequal power relationships between men and women that influence their access to HIV information and related services, and their attitudes and practices affect their levels of vulnerability and risk to HIV infection and impacts. Attitudes, perceptions, beliefs and

behaviours portrayed towards men or women infected and/or affected by HIV are greatly influenced by the roles and responsibilities society has assigned to them. Gender roles dictate how each of the factors below differ between men and women:

- Masculinity and femininity
- Roles, status, norms and values
- Responsibilities and expectations
- Sexuality
- The division of labour, power and responsibilities
- The distribution of resources and rewards

Women's Greater Vulnerability to HIV

The consequences of gender inequalities in terms of low socioeconomic and political status, unequal access to education, and fear of violence, add to the greater biological vulnerability of women and girls being infected with HIV. This is evidenced by the "feminization" of AIDS mentioned above. There are several reasons for the feminization of AIDS.

1. Harmful Social Norms

Social norms about female sexuality and expected sexual passivity in women make it very difficult for women and girls to negotiate safer sex practices and access sexual health information and services because of a misguided fear that it will encourage sexual activity. Moreover, due to household obligations, limited mobility, and insufficient funds, women often face greater challenges to accessing health care services, including sexual and reproductive health services that could help protect from HIV. The same challenges exist for girls and women in accessing basic education which can empower girls to steer free from harmful social norms.

2. Economic Dependency

The power imbalance between men and women also translates into economic dependency for women on men as family heads in which most men have greater control and access to productive resources. For this reason women may feel pressured to stay in risky or abusive relationships with men; or feel forced to transact sexual favors for money or gifts; engage in sexual activities earlier than boys (early sexual debut), and often this sexual activity is with older men. More women than men live below the poverty line and this has similar effects.

3. Violations of Rights

Girls too often face greater violations of their rights (sexual violence, abuse and exploitation, discrimination, stigma). Women still bear the enormous stigma attached to being widowed by AIDS, and are often left to battle the discrimination alone. Forced and early marriages predispose young girls to STIs since their immature genitalia can easily lacerate or suffer lesions to facilitate viruses and disease organisms.

4. Sexual Violence

Sexual violence against women and girls can enhance vulnerability to HIV directly, as well as indirectly by limiting women's autonomy and access to prevention information and services through fear and intimidation.

5. Burden of Care Giving

Women and girls contribute to household chores or income generation and provide home-based care, take in orphaned children, tend to the family's fields. These responsibilities can limit their own opportunities for advancement.

Practices and Attitudes that Increase Men's Risks of HIV Infection

Masculinity emphasizes sexual domination over women as a defining characteristic of male-hood and shapes boys and men into self-reliant, high-risk takers. They are conditioned not to show their emotions and not to seek assistance in times of need or stress (WHO 1999). This expectation of invulnerability encourages the denial of risk, poor health-seeking behaviors and low risk perceptions.

Traditional roles and societal values related to masculinity encourage boys and men to adopt risky behaviours, including excessive alcohol use, multiple and concurrent sexual relationships, sexual favors and cross generational sex, and drug abuse, all of which increase their risk of acquiring and transmitting HIV. Societal expectations and social norms about masculinity often assume that men are knowledgeable and experienced when it comes to sexual issues. This can have the negative effect of preventing men from seeking sexual health information or admitting their lack of knowledge about HIV risk reduction.

The archetypal image of the strong, virile, aggressive male also contributes to widespread homophobia, leaving men who have sex with men to struggle with fear and stigma. This can often compel men who have sex with men to keep their sexual behaviour secret and avoid accessing services or seeking information that can help them adopt behaviours to protect themselves and their sexual partners (whether male or female) from HIV transmission. This is extremely dangerous in societies like Kenya where studies show that over 60% of MSMs are bisexuals.

Intersection Between Gender, HIV and Religious Teachings

The governance of the church, its procedures and approaches and sometimes its messages mirrors the gendered attitudes, practices and perceptions of the socio-cultural background of its membership. Many women gain a substantive proportion of their informal education and information from religious gatherings.

The control and subjugation of women by men is too often permitted when it is based on religious principles of morality. The Christian is not encouraged to assert any rights over his/her body because Christian teaching insists that

s/he has no autonomy over his/her body; it belongs to her partner. Therefore use of condoms particularly by women in cases their spouses have multiple sexual partners is out of the question.

A Christian woman is not expected to negotiate for safer sex even in instances when she knows her spouse has been unfaithful. While it is admirable for one to demonstrate faith by praying for divine intervention so that one does not contract HIV from an unfaithful partner, as emphasized in religious dogma, how many Christian women get infected as a result?

Based as much on patriarchal thinking in African culture as doctrine, do Christian leaders who emphasize submission and meekness make women an easier and more willing victim of sexual abuse, vulnerable to STIs and other forms of injustice? Women are not encouraged to actively take responsibility for protecting themselves from contracting HIV nor are they expected to demonstrate any inclination towards understanding and exercising their sexual reproductive rights. In many instances, sermons fail to address the specific needs, fears and concerns of congregants, of which women form the majority.

In some instances, women who are married to dishonest religious leaders are often worse off than other congregants because they feel they have to keep up appearances and they often find no support system within the church. The general assumption is that church leaders are beyond reproach.

For married women the church prescribes fidelity and yet married women often have non-believing husbands who do not subscribe to the teachings of the church regarding fidelity and moral uprightness. The scenarios above are quite deadly, given the percentages of discordance (a state where one partner is HIV positive and the other partner is HIV negative).

For most women, being cheated on is humiliating but for Christian women, the experience also casts aspersions on them as believers because people question where their God was when her husband was practicing infidelity. As has been observed amongst Zimbabwean women, Christianity is not just a religion - it is also an escape route. Attending church, following the routine and keeping religious observances have become a form of escapism for many women in the age of HIV as they try to apply Biblical teachings to their marriages, relationships and lives at a time when hypocrisy has become a prevalent trend in most churches.

Misapplying the proverb, 'a foolish woman destroys her house with her own hands' may cause a wife to feel that she must ensure that her house stands. Such a woman believes she must take the blame for her husband's infidelities – "giving the Devil a foothold". Therefore she resorts to fasting and prayer, failing to realize that she is the victim and not the villain. The "reasonable" response for the average Christian woman is a spiritual one, that is, prayer and fasting to counter the spirit of adultery in her spouse. When a spouse confesses and acknowledges infidelity, the expected response is

forgiveness and business goes on as usual. No one takes the initiative to know HIV status of the other before engaging sexually. And if they do get tested for HIV, couples prefer to test and receive results individually and not as part of “couple counseling and testing”. The very real threat posed by HIV is not addressed in all this spiritual abstractness. The problem is further compounded by the fact that Christians often blame the devil for all the wrongs and fail to take responsibility for their own actions.

Addressing delegates at a SAFAIDS workshop held to commemorate 16 Days of Activism Against Gender Violence in 2009, an exasperated Edinah Masiyiwa, the Executive Director of the Women’s Action Group (WAG), stated that some Christian doctrines were harming efforts to combat gender violence and curb the spread of HIV.

“We run all these awareness campaigns and yet it appears that things get worse instead of better. You talk of condomising and then to your surprise you find grown women uttering silly statements like “ini handishandise condom nemurume wangu ndinongonamata kuti Mwari ngaave condom rangu” (I don’t need to wear a condom because I just pray for God’s protection),” charged Masiyiwa.

So while women “in the world” may perceive themselves as being at risk of contracting HIV and take measures to protect themselves, the women in the church are exhorted to pray, fast and “confess the blood of Jesus” over themselves.

Conclusion: Observations and Recommendations

Christians must investigate their attitudes towards women in positions of leadership. Are they controlled by cultural settings or by biblical teachings? These attitudes influence the valuing of women and treatment of them. Religious leaders, venues and gatherings are suitable for communicating HIV messages because of the esteem and unswerving loyalty congregants accord religious leaders, the numbers that attend religious gatherings, and the frequency of the gatherings. Needless to say, religious leaders are best placed to address issues of discordance and related STIs and HIV vulnerabilities alongside the emphasis they place on fidelity and submission. Christianity may offer uniquely effective structures and mechanisms for mitigating the social impact of the epidemic on society, and especially on its most vulnerable segment - poor women.

We must be bold to challenge cultural traditions practiced in churches that predispose both female and male congregants to the vulnerabilities and risks of HIV infection and its effects. We must provide concrete suggestions for

change in the teaching and practice of the church. Missionaries must make attempts to understand local attitudes and come up with friendly and relevant approaches of responding to HIV and AIDS. Religious teachers need to come out clearly on the way forward regarding the following issues:

1. Teachings on submission and sex with regard to STI/HIV.
2. HIV sero-discordant couples, the desire for childbearing, and the dilemma of risking STI/HIV infection.
3. In-vitro fertilization as an alternative means of conception for discordant couples.
4. Male participation at household and family levels in view of the increased burden of care for women and changing roles.

There are several ways that churches can help their members and communities deal effectively with HIV and AIDS.

1. Promote Prevention of Mother to Child Transmission (PMTCT).
2. Because men commonly have more sexual partners and more control over decisions regarding sex than women do, prevention efforts targeting fiancé, suitors, husbands and bridegrooms by religious leaders are crucial, not only to promote their own health, but also the health of women and girls.
3. To turn the epidemic around, men will need to take responsibility for their actions, and change begins with the ways that boys are raised. This means addressing certain cultural attitudes and beliefs that have traditionally encouraged risk-taking and discrimination against women. This reeducation is most effective when carried out in schools and religious institutions.
4. Encourage church-based clubs for positive women and men through which psychosocial support can be channeled.
5. Focus more on topics such as sexual gratification in marriage with a view to preventing potentially errant spouses from going astray.
6. Promote church-based Voluntary Medical Male Circumcision (VMMC) programmes and anti-Female Genital Mutilation (FGM) campaigns.
7. Integrate 'Gender, Sexuality and HIV' in pastoral counseling training.
8. Provide on regular basis skills training on sexual communication to churched couples.

The Church and AIDS in Africa: Towards a Spiritual Answer¹

by Peter Okaalet (as re-presented by John Chaplin)

Introduction

Psalm 11:3 encourages to me to stay the course with HIV and AIDS work, “What should the righteous do when the foundations are shaken?” (NKJV). This is a direct call for a Christian response to HIV and AIDS. I do not know the whole answer hence the title, “*towards* a spiritual answer.”

When I was working as a doctor in Uganda in the 80s, a 24 year old man dying of AIDS asked me, “Are you sure there is life after death?” I quoted from John 11 about Lazarus’ resurrection and 1 Thessalonians 4 about being resurrected at the trumpet call of God but he said, “Anyone can quote Scripture. You need to go to school and study theology. I want to hold onto that other life but I need to hear from someone who is trained to say there is that life.” That went like an arrow in my heart and so I went to study theology, to add the spiritual dimension to my medical training so I could deal with people holistically – physically, spiritually and psychologically.

I have heard theology described in five lines:

- God formed man,
- Sin deformed him,
- Education informs him,
- Religion may reform him,
- Only Jesus Christ can transform him!

Information is not enough. We may remember some things but forget others. Teaching and training are good but it is better to go through a process of transformation. “*Jesus answered and said unto him, 'I tell you the truth, except a man be born again, he cannot see the kingdom of God'*” (John 3:13). Once I was blind but now I see since I met with Jesus (John 9). We are what we are because of Jesus. He said, “without me you can do nothing” – hence our need of Jesus.

An Exceptional Threat Requires Exceptional Responses

In a 2005 speech, Dr. Peter Piot, the Executive Director of UNAIDS, explained why he thought HIV and AIDS was exceptional as a current crisis and as a long-term threat to humanity.² His reasons may be summarized as follows. Firstly, there is no plateau in sight. He said,

¹ This summary of Dr. Peter Okaalet’s lecture on 31st May 2012 was prepared by Dr. John Chaplin from the original PowerPoint lecture. A DVD of this PP lecture is available from Okaalet and Associates Ltd. See also www.okaalet.org.

² Peter Piot. “Why AIDS is Exceptional”. Speech at London School of Economics, Feb. 8, 2005. See data.unaids.org/media/speeches02/sp_piot_lse_08feb05_en.pdf

“an ‘epidemic equilibrium’ or plateau is nowhere in sight – not globally, not at the level of epidemics in most countries, and not over the long term. The pandemic has broken with the general pattern of diseases and natural disasters, which usually create their own brutal equilibrium, eventually enabling societies to cope. AIDS, so far, appears to be doing the opposite.”³

Secondly, the impact on society caused by AIDS is far reaching. He noted, “in sub-Saharan Africa’s worst-affected nations AIDS is steadily wiping out the labour force. How can governments function, public services operate, agriculture and industry thrive, and law enforcement and militaries maintain security, when they are being stripped of able-bodied and skilled women and men?”⁴

Thirdly, the AIDS crisis creates special challenges to effective public action. He declared:

There is no escaping the fact that the sensitive issues that are at the heart of the pandemic - sex, gender inequality, commercial sex, homosexuality, drug use - have proved to be an enormous barrier to prompt and effective public action, that is action by government and civil society. If HIV were not mainly transmitted through sex and needles used to inject drugs - but through some innocuous means - we would probably not be experiencing the pandemic of today.⁵

Piot insisted that there are three elements, each one essential and insufficient without the others, to ending HIV and AIDS. The first element is exceptional activism and responsible leadership that “must come from across the board, from politics, from civil society, from business, from churches, from the media - from every section of society” and on larger scale and with greater intensity.⁶

The second essential element to ending AIDS is adequate financing that “allows exceptional action on the ‘crisis’ front - such as swiftly expanding access to antiretroviral treatment and support for orphans - as well as exceptional action on longer-term solutions, such as strengthened HIV prevention and the development of vaccines and microbicides”.⁷

The third element is exceptional implementation so that actual on-the-ground action takes place. “Money raised and political will garnered has to be translated into bringing proven, successful services to the people who need them, whether it be treatment, HIV prevention, or impact alleviation.”⁸

³ Piot, “Why AIDS is Exceptional”, p. 3.

⁴ Piot, “Why AIDS is Exceptional”, p. 3.

⁵ Piot, “Why AIDS is Exceptional”, p. 4.

⁶ Piot, “Why AIDS is Exceptional”, p. 6.

⁷ Piot, “Why AIDS is Exceptional”, p. 7.

⁸ Piot, “Why AIDS is Exceptional”, p. 8.

So we must meet this exceptional threat with exceptional responses. The challenge of AIDS calls for a forthright and faithful response from Christians and the Church.

HIV and AIDS: Africa's Burden

Africa is carrying the biggest burden of HIV in the world. Swaziland has the highest prevalence where nearly 1 in 3 people are infected. This is mainly younger people who will carry it with them for life. What does this mean for that country?

Why does Africa have the highest prevalence of HIV? One of the reasons is the slow response by some countries. In Uganda there was a response in the 1980s but in Kenya it was not until 1999 that AIDS was declared a national disaster. It is not easy to find accurate data on North Africa, but AIDS is there.

Life expectancy has fallen in many African countries because of AIDS. For example, in Angola average life expectancy fell from 41.3 years before AIDS to 35 years in 2010. In Botswana life expectancy was 74.4 before AIDS but fell all the way to 26.7 in 2010. Life expectancy in Lesotho fell from 67.2 years to 36.5 years; in Malawi from 69.4 to 36.9; and in Mozambique from 42.5 to 27.1.

In Kenya the national prevalence is between 6-7% but it is 7.9% at the coast, 9% in Nairobi and 15.3% in Nyanza next to Lake Victoria. The high prevalence around Lake Victoria tells us something about the lifestyle. Around the lake there is fishing and exchange of sex for money and fish and trade. There are also cultural issues like wife inheritance where a widow is inherited by a close relative. If the death of the man was due to AIDS and the widow is infected, then inheritance encourages the spread of HIV into another family group. This high prevalence is telling people to change their lifestyle and risky cultural practices. Kenya has yet to reach its peak of those infected with HIV which is predicted to be over 1,500,000 in 2015. Kenya's vision 2030 may not be realised due to AIDS. New infections through Kenya's mode of transmission study showed that the highest new infections were in stable relationships.⁹

❖ Heterosexual sex within marriage/regular partnerships	44.1%
• Casual heterosexual sex	20.3%
• MSM and prison populations	15.2%
• Sex Workers and their clients	14.1%
• Intravenous Drug Users	3.8%
• Health facility related	2.5%

Church leaders must pay attention to these studies. We marry young people; we must ensure good pre-marital counselling that includes discussion about AIDS and prevention and the need for pre marital testing. If both are

⁹ Kenya HIV Prevention Response and Modes of Transmission Analysis, p. iv. See <http://siteresources.worldbank.org/INT/HIVAIDS/Resources/375798-1103037153392/KenyaMOT22March09Final.pdf>

negative, to bring HIV into the marriage one of the partners must be going outside the relationship, usually the man. We need to address this before marriage as well as once people are married.

Dealing Responsibly with the Impact of the HIV and AIDS Epidemic

What is the impact of AIDS? As a result of HIV and AIDS African countries and communities experience deepened poverty, slowed economic growth, reduced life expectancy, and increased infectious diseases. Women and children are the worst hit: 60% of those infected in Africa are women, and increasing numbers of children become vulnerable to these impacts.

There are diverse approaches to tackling AIDS. A strong human rights-based approach is one that uses human rights to identify desirable outcomes such as non-discrimination, privacy, education, information, health, and social security. This approach also seeks to identify permissible and desirable processes to reach such outcomes, processes that are participatory, inclusive, and non-discriminatory.

In addition, a rights-based approach to the epidemic seeks to strengthen the capacity of individuals (known as *rights-holders*) to claim their rights in the epidemic, and both state and non-state agencies (known as *duty-bearers*) to fulfill their obligations regarding such rights in the response to the epidemic.

The first time the UN met to discuss HIV at a global level was in 2001 when governments adopted the Declaration of Commitment on HIV/AIDS, including the agreement to take action on AIDS and human rights. Over 92 countries signed the Declaration which included this sentence: "Realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS. Respect for the rights of people living with HIV/AIDS drives an effective response."¹⁰

The UN has formulated eight Millennium Development Goals (MDG)¹¹ and numbers 4 to 6 are health related:

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. **Reduce child mortality**
5. **Improve maternal health**
6. **Combat HIV/AIDS, TB, malaria and other diseases**
7. Ensure environmental sustainability
8. Develop a Global Partnership for Development

¹⁰ Declaration of Commitment, UN General Assembly Special Session on HIV/AIDS, June 2001 on

http://www.unaids.org/en/media/unaids/contentassets/dataimport/publications/irc-pub03/aidsdeclaration_en.pdf

¹¹ These are listed on <http://www.un.org/millenniumgoals/reports.shtml> with much more information on each as well as many progress reports.

In relation to number six and in conjunction with the MDGs, the UNAIDS global goal is “mobilizing all” to work towards achieving three very difficult aims by 2015: zero new infections; zero discrimination; and zero AIDS-related deaths.¹² The UNAIDS call is for all people and organizations to work together to achieve these goals. The first may be possible; the second may be a bit more challenging; and the third is very challenging. We need to talk about these things in the Church. As people of faith we need to be relevant, speaking the language the rest of the world is talking about. Let us contribute to what is going on.

The Church and the Human Rights-Based Approach

A strong human rights-based approach is important and useful but should that be the Church’s approach? What is the Church’s perspective on human rights? Churches have had an historic and long-standing involvement in human rights. However, fully integrating human rights in the churches’ witness for justice has in some contexts proved difficult, including in relation to the HIV challenge and response. Different perspectives on human rights have themselves sometimes presented significant obstacles in ecumenical relations and cooperation. The relationship between Christian faith values and the rule of law must itself be interrogated in this context, in the light of historical and contemporary initiatives to embody faith principles in legal precepts. We need to negotiate and find ways to talk about human rights and what the Bible says.

Why are the marginalised running away from the Church when they would have run to Jesus when He was on earth? What is the missing link? Where are we falling short? Are we following the New Testament Jesus? Why is it that sometimes more love and compassion is shown to those with AIDS by nonChristians? If we really applied the love of Christ as He did, we would do more! For example, men who have sex with men (MSM) have their human rights, but the Church knows that the choices we make have consequences, both physical and moral consequences. When these men come to us, the love of Christ should constrain us to reach out to them.

Even dealing with less emotive examples is still very difficult for us. Reverend Canon Gideon Byamugisha, an Anglican priest, was the first major religious leader in Africa to reveal that he was HIV positive. He almost died of AIDS but has regained his strength and remained healthy because of ARVs (antiretroviral drugs). His first wife died and he married a second wife who was HIV positive so he would not infect another person. They have prevented re-infecting themselves by using condoms. But they wanted children and, by the results of scientific research and with God’s help, they have been able to have

¹² UNAIDS, 2011 - 2015 Strategy: Getting to Zero, p. 7. See the following pdf on the UNAIDS site. [http://www.unaids.org/en/aboutunaids/unaidstrategygoalsby2015/\(jc2034_unaids_strategy_en.pdf\)](http://www.unaids.org/en/aboutunaids/unaidstrategygoalsby2015/(jc2034_unaids_strategy_en.pdf))

2 HIV negative children.¹³ People talk about the ABC of AIDS prevention - Abstinence, Be faithful and Condoms. In Christian circles we say C stands for Character but there is a need to talk about condoms and where it is appropriate, to use them.¹⁴ Byamugisha uses a different acronym - **SAVE**.

S safer practices. This includes abstinence, faithfulness, condoms, PMTCT etc.

A availability of ARVs. If taken consistently they can reduce transmission by 96%. They can also be used in "treatment as prevention", though this is an expensive strategy.

Voluntary Counselling and Testing. Though now Provider Initiated Counselling and Testing (PITC) where clinics do not wait for people to volunteer for HIV testing. Provider initiated testing and counseling represents an aggressive effort to do HIV testing on all persons who come to medical facilities for any reason. Some facilities take blood from everyone and then counsel people, encouraging them to know their status. Once a person knows their status (if they are HIV positive or not) then the clinic can plan treatment, management of the disease and give advice on lifestyle.

Empowerment. This is focused on women, children and the marginalised.

Some denominations have hospitals that are geared up to deal with HIV and AIDS with a broad-based response: counselling, laboratory testing, medical treatment and care, support for the family, etc. These Christian-owned hospitals have the opportunity to bring spirituality into the response to AIDS.

UNAIDS recognises that the role of Faith Based Communities (FBOs) is more than service provision and includes spiritual encouragement, providing knowledge about HIV and AIDS, values, compassionate care, moral information, respectful relationships as well as curative interventions and material support.¹⁵ Faith based groups might be coming late to the crisis but may well be needed to take the response to AIDS farther than anyone else can. Christians are playing a key role.

The Challenge: Drivers of the Pandemic

There are different drivers of the pandemic. Some are related to biology such as an immature genital tract, co-existing sexually transmitted infections, pregnancy, stage of HIV in the sex partner, malnutrition, MTCT (Mother To Child Transmission), HIV subtype. For instance MTCT used to account for about 30% of new infections but this has now been reduced to almost zero in some countries so that Kenya is saying by 2015 there will be no MTCT. HIV 1, found in East/Southern Africa is more virulent than HIV 2 found in West Africa hence HIV is more of a problem in East/Southern Africa.

¹³ See Stephanie Nolen, *28 Stories of AIDS in Africa*, Toronto: Vintage Canada, 2008, pp. 275-286. Byamugisha also uses SSDDIM - Reduce Stigma, Shame, Denial, Discrimination, Inaction and Misaction as a plan for the church's response.

¹⁴ For an expert explanation of ABC, see Edward C. Green and Allison Herling's paper at <http://www.ccih.org/ccih-publications/164-the-abc-approach-to-preventing-the-sexual-transmission-of-hiv.html>

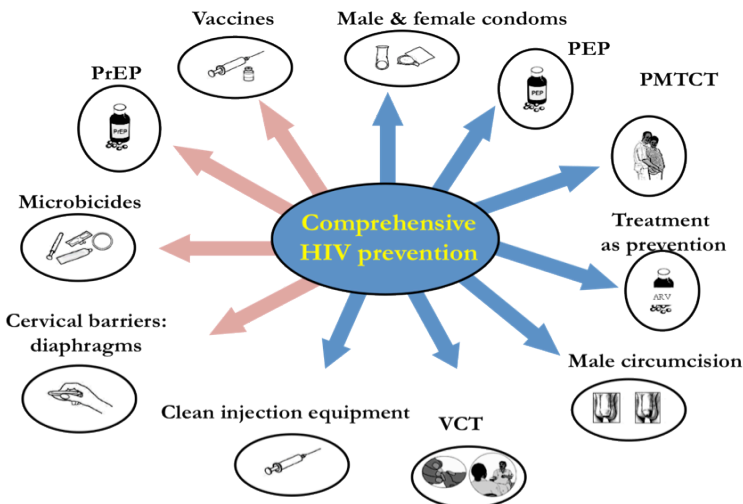
¹⁵ See the UNAIDS report on *Partnership with Faith-based Organizations UNAIDS Strategic Framework* at http://data.unaids.org/pub/Report/2010/jc1786_fbo_en.pdf.

Another driver is behaviour such as unprotected sex, multiple partners, early onset of sexual debut, intravenous drug use, and alcohol abuse. If people change the way they behave the chances of them contracting the virus can be reduced. Some people will not change but we as Christians should not give up. Maybe some of these will come to us by night and ask, "What can we do?" We need to have knowledge – current, accurate, scientific information. ("My people perish through lack of knowledge" Hosea 4:6)

A third set of drivers is cultural practices such as wife inheritance, inter-generational sex, cleansing ceremonies, dry sex and other risky practices, female genital mutilation, submissive sex - the use of money and gifts to entice young girls to have sex with older men.

AIDS: Same Problem, Different Answers

There are a wide variety of prevention strategies but there is a need for comprehensive prevention - using multiple means of prevention depending on the epidemic in that area. These include treatment as prevention, male circumcision, voluntary counselling and testing (VCT), clean injection equipment, cervical barriers (diaphragms), male and female condoms, microbicides, pre-exposure and post-exposure prophylaxis (PrEP/PEP), vaccines, PMTCT (Prevention of Mother To Child Transmission) as well as behaviour change such as abstinence (delay in sexual debut) and faithfulness (reduction in sexual partners).



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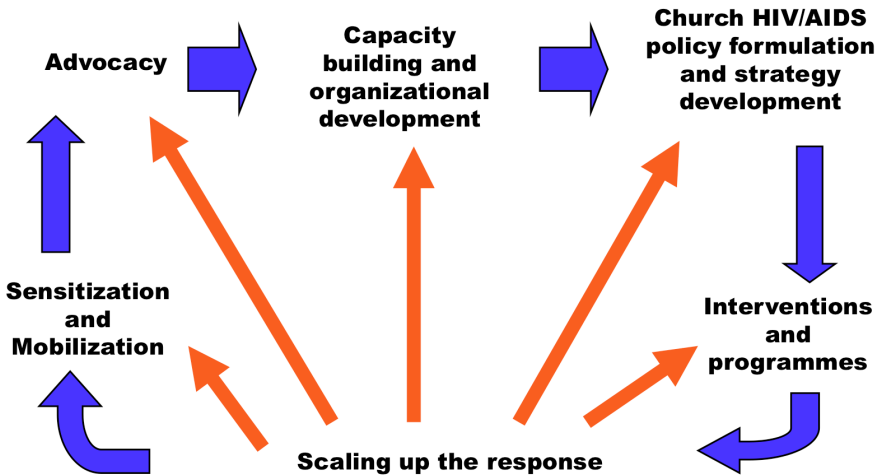
There is no one single bullet that will get rid of AIDS. We need to think of all of them in the context of where we are working and select those that are relevant. What should be the Church's response? A journey of a 1000 miles starts with one step. It is a process. Start small with what you can do.

The Curricula for HIV and AIDS – MAP International’s Experience

MAP International developed the following five-point response to AIDS which they then took to the Church.

1. Care and support for Orphans & Vulnerable Children (OVC) at the grassroots level.
2. Training of clergy in the areas of capacity and skills building.
3. Integration of ‘HIV Education’ into theological education: MAP-developed HIV/AIDS curricula are currently being implemented in over 24 theological Institutions in six countries in East and Southern Africa.
4. Policy and advocacy at national and international levels.
5. MAP-developed church-based HIV and AIDS materials.

MAP INTERNATIONAL’S FRAMEWORK FOR BUILDING CAPACITY OF CHURCHES TO RESPOND TO HIV AND AIDS



MAP International’s HIV/AIDS Curriculum for Theological Institutions: Choosing Hope

People who are sick need hope. AIDS is affecting every thing about them. They are being pushed away by family, church and society. They need hope. This “Choosing Hope” curriculum consists of ten modules:

1. Understanding HOPE: By knowing facts about HIV/AIDS
2. Discovering HOPE: Through our Biblical foundation
3. Spreading HOPE: By mobilizing the Church towards involvement in AIDS activities
4. Developing HOPE: By changing feelings and attitudes about AIDS
5. Sharing HOPE: Through pastoral care to families affected by HIV/AIDS
6. Offering HOPE: HIV/AIDS pastoral counseling
7. Giving HOPE: To parents and youth for AIDS-free living
8. Ministering HOPE: Home based care to People Living with HIV (PLHIV)
9. Establishing HOPE: Diagnosis of HIV through voluntary counseling & testing (VCT)
10. Supporting HOPE: Through antiretroviral treatment (ARV)

St. Paul's University, Limuru, Kenya offers a Master of Arts degree in Community Care and HIV/AIDS in association with MAP International (East Africa). One African who graduated from this course was a bishop of a Anglican diocese. He is passing on what he has learnt to his clergy and so to the diocese. A study is being considered to look at what impact this is having, using another diocese where such teaching is not happening as a control.¹⁶

The Church and HIV & AIDS: "Faith in Action"

The problems and solutions surrounding HIV and AIDS are too big for one person, one Church, one nation to deal with, but we can respond in our context, in our congregation. You may not have the answer to a situation but someone else might. Ask yourself what you can do in your own context. For example, start with KAP(B): Knowledge, Attitudes, Practices (Behaviour). New *knowledge* can result in *attitude change* which can lead to change in *practices or behavioural change*. There is power in knowledge if it causes change in attitude and change in practice. How can this happen in real life?

There are four common responses of the church to people living with HIV and AIDS: (1) being judgmental, (2) being anemic or 'weak', (3) being cautious or 'fearful', or (4) wholehearted or holistic. We need to move from judgmental to holistic. One lady who had done a MA in counselling came to MAP for a week-long seminar on counselling in HIV. She said, "What is the point? What will MAP add to what I have already done?" But she was judgmental towards those with HIV. This course moved her from judgmental to being holistic and she is now heading up an AIDS response where she is based.

One church in Uganda, faced with diminishing congregations, divided the area into zones and in each zone the church started to visit and care for those with AIDS. People started asking, "Why are you doing this?" The church members' answer, "The love of Christ constrains us to". People wanted to come to such a church and its numbers have increased four-fold.

Churches and faith-based organisations (FBOs) are in a unique position in sub-Saharan Africa to respond rapidly to HIV and AIDS. They attract large numbers of crowds; they meet regularly; and they have been active in the health and education sectors for years. But is the Church fully awake to the realities of HIV and AIDS in Africa? If I were to critique the response of your church to the HIV and AIDS crisis using the following thirteen criteria how would your church do?

These thirteen criteria are divided into three broad categories and can be used to evaluate a church's competency of its response to AIDS. The first category is **Foundational** and asks two questions about HIV and AIDS in Africa. First, does your church have a good knowledge of the facts and HIV

¹⁶ See also the chapter on "Curricula" in Peter Okaalet, *Bridge Builder: Uniting Faith and Science Towards an AIDS-free Generation*, Nairobi: WordAlive, 2009, pp. 121-131

and AIDS? Second, how is your church dealing with the issue of sexuality, an extremely important point because churches in Africa have difficulty talking about this topic. The second category measures how competent your church is with regard to the **Strategic Aspects** relating to HIV and AIDS, and has six aspects. What is your church doing in regards to 1) prevention, 2) addressing stigma, 3) advocacy, 4) empowerment, 5) leadership and 6) healing? The third category examines the **Ecclesiastical Aspects** of a church's response to the crisis and it has five aspects: 1) liturgy and sacraments, 2) counselling, 3) testing, 4) caring and 5) networking.

Strategies for Targeting Orphans and Vulnerable Children (OVC)

The church needs to particularly focus on orphans and vulnerable children with the following twelve strategies:

1. Focus on the most vulnerable children, not only those orphaned by HIV/AIDS.
2. Strengthen the capacity of families and communities to care for children.
3. Reduce stigma and discrimination.
4. Support HIV prevention and awareness, particularly among youth.
5. Strengthen the ability of caregivers and youth to earn livelihoods.
6. Provide material assistance to those who are too old or ill to work.
7. Ensure access to health care, life-saving medications, home-based care.
8. Provide daycare and other support services to ease the burden on caregivers.
9. Support schools and ensure access to education for girls as well as boys.
10. Support the psychosocial as well as the material needs of children.
11. Engage children and youth in the decisions that affect their lives.
12. Protect children from abuse, gender discrimination, and labor exploitation.

There is a move away from orphanages as sometimes it is hard getting people brought up in them back into mainstream life. It is better to support the children in the community and only have orphanages if there is no other way.

Healing and HIV and AIDS

Healing has been abused and misused. People have been prayed for and told to throw away their medication and this has resulted in their death. Can God heal? "Is anyone among you sick? He should call the elders of the church..." (James 5:14). God can deliver us from physical sickness and suffering but this is more the exception than the rule. Not everyone who asks for physical healing gets healed. It is estimated that about 10% of those prayed over get physically healed, but does this mean we abandon praying for sick people?

God does heal. When does He heal? It is His prerogative. Do we continue to pray? Yes, but as we continue to work with people, not instead of working with them. We don't measure our answers to prayer only by what we see, for there are other answers, unseen ones. The body and soul are inextricably linked together. That 24-year old man from the beginning of my lecture died a few days after I spoke with him, but he had become a Christian and had a

hope and a glow in his face. This was healing for him - the physical pain was too much.

Conclusion

What are some of the current challenges humanity faces in combating AIDS? Sustainability of AIDS programmes is a major challenge in the face of external donor fatigue and the global economic slow-down in recent years.

Surveys validate concerns about funding. A 2011 study conducted by the Catholic HIV/AIDS Network (CHAN) found that funding cuts and flat-lining by international donors had caused problems with drug adherence, supply chain, access and adequate nutritional support for Catholic organizations in developing countries.¹⁷

Other barriers that stand in the way of progress include: the costs of medication and laboratory testing; issues of ARV side effects and drug resistance; societal, cultural and religious beliefs that stand in the way of treatment; reliance on traditional healers¹⁸; very few children accessing treatment; and poverty and poor governance that give low priority to healthcare have impeded access to treatment.¹⁹

The Church is still a sleeping giant, only now beginning to wake up. But have we risen totally, completely? May the Lord challenge us to do a little more, otherwise, if help comes from other sources, in fifteen years we might be irrelevant and people may say to us, "When we were sick, where were you?" We might, as in Matthew 25 say, "When did we see you sick?" There are people all around us who need our help. We need to pool our resources. We need to respond with the compassion of the Lord Jesus Christ.

"If the Church of Jesus Christ rises to the challenge of HIV/AIDS it will be the greatest apologetic the world has ever seen." — Ravi Zacharias, writer and apologist.

¹⁷ *AJANews* 105, Feb. 2012 at <http://www.jesuitaids.net/htm/news/105ENG.pdf>, p. 3.

¹⁸ See for example, <http://www.nation.co.ke/Features/DN2/Faith-healer-or-prophet-of-doom/-/957860/1690928/-/1m3pwez/-/index.html>, and <http://www.shout-africa.com/news/tanzania-mixed-reactions-over-loliondo-hiv-aids-cure/>

¹⁹ *AJANews* 105 – Feb. 2012, pp. 3.

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Some New Perspectives and Advances on HIV and AIDS Prevention and Treatment

by Dr. John Chaplin, MB BS

Prevention

There is now a wide array of prevention strategies so it is important to look at the epidemic in your area, both geographical and ministry, and to select the strategies that will be most appropriate and effective. As with treatment it is likely that a combination of strategies will be most effective. However it is also important to look at our partners, especially the church, and select strategies that are acceptable to them and are in line with the Word of God.

Male circumcision has been shown to reduce the chances of being infected with HIV by over 50%.¹ It is less clear how effective it is in preventing women from being infected. One study suggested an increase in HIV infection in women. There have been concerns whether it would encourage men into more risky behaviour because they think they are protected. Some studies have refuted this as with good counselling the men circumcised were in fact, less likely to involve in risky behaviour.² This still leaves the question as to how good the counselling is when male circumcision is being rolled out widely. Certainly if men resume sex before full healing there will be an increase risk.

Voluntary Counselling and Testing (VCT) is not a prevention in itself but encourages people to know their status and with counselling can change people's lifestyle so that they are less likely to become infected. Those who are negative learn how to live so as to stay negative, and those who are positive, learn how to live positively, access treatment and avoid the spread of HIV. Providers (health facilities) are being encouraged to initiate and offer counselling and testing. Some people see good uptake with campaigns and with community health workers visiting and offering testing in people's homes.

Abstinence and delay in sexual debut is effective and studies have shown its impact in countries like Uganda.³ Some studies from the US in particular have failed to show benefits, though there are weaknesses in the studies. The

¹ *Voluntary Male Circumcision for HIV Prevention*. Fact Sheet July 2012 World Health Organisation http://www.who.int/hiv/topics/malecircumcision/fact_sheet/en/index.html

² K.E. Agot, J.N. Kiarie, H.Q. Nguyen, J.O. Odhiambo, T.M. Onyango, N.S. Weiss. "Male circumcision in Siaya and Bondo Districts, Kenya: prospective cohort study to assess behavioral disinhibition following circumcision." in *Journal of Acquired Immune Deficiency Syndrome*, 2007 Jan 1; Vol. 44 (1): 66-70. www.ncbi.nlm.nih.gov/pubmed/17019365

³ E.C. Green, A. Herling. *The ABC Approach to Preventing the Sexual Transmission of HIV: Common Questions and Answers*. McLean, VA: Christian Connections for International Health and Medical Service Corporation International, 2006. <http://www.ccih.org>

perception from the West is that young people do not want this message but there are examples of young people wanting it, embracing it and being effective in doing it in some African countries. There are challenges of transgenerational sex that need to be addressed and have been the topic of publicity and TV coverage.

Studies have shown the most effective strategy has been faithfulness and the reduction of sexual partners, the classic “zero grazing” advocated in Uganda.⁴ This seems to be contraindicated by recent studies that claim the highest number of new infections happens within marriage.⁵ However this shows that there is, or has been, unfaithfulness in marriage to allow HIV infection to come in. Good premarital counselling and testing is important.

When a person is first infected with HIV the amount of virus in the blood rises to very high levels - one study suggests 40% infections occur during this time. The body tries to fight the virus bringing it down to very low levels for years. However it never clears the virus and as it steadily destroys the body's defences the amount of the virus starts to go up in the blood until it is high again. It is at this time that the person develops AIDS. A high level of the virus in the blood (and therefore in the sexual fluids) means HIV can be spread a lot easier. So the times of highest risk of spreading HIV is when the person is first infected and later in the illness when the person becomes less well.

This means if a woman is first infected during pregnancy or breast-feeding there is a much higher risk of the baby being infected with the virus. Hence, it is now being recommended to re-test a pregnant woman a second time near to delivery. It also means if a person is in concurrent sexual relationships (has more than one partner at the same time) and becomes infected he is much more likely to spread it to his other partners as well.

Condoms are effective because of the low transmission rate through sexual intercourse – about 1% unless the person has just been infected and there is a high level of virus or there is a sexually transmitted disease that can increase the vulnerability to HIV infection by up to 10%. However condoms need to be used consistently. Even sex workers who use condoms often don't when with their regular partners. They have not been shown to be effective in a general epidemic but are effective in high-risk groups and in discordant couples where one partner is HIV positive and the other is negative for HIV. Female condoms have similar efficacy but are more expensive, less available and have not been embraced by many.

⁴ See Green and Herling, *The ABC Approach*

⁵ J.R. Glynn, M. Carael, A. Buve, R.M. Musonda, M. Kahindo, of the Study Group on the Heterogeneity of HIVeIAC. “HIV risk in relation to marriage in areas with high prevalence of HIV infection” in *Journal of Acquired Immune Deficiency Syndrome* 2003; Vol. 33: 526–35.

Treating sexually transmitted diseases to reduce the associated increased risk of spread HIV initially showed good results but further studies failed to show significant benefit in reducing overall HIV transmission though it still would be an important thing to do.

Treatment with ARVs (antiretroviral drugs) has been shown to significantly reduce the spread of HIV, maybe up to 96% in one study.⁶ Increasing the number of people on treatment would be an effective strategy of preventing HIV spread. But this is very expensive and presently beyond the capacity of many countries. Furthermore it is not an absolute guarantee of prevention as viral levels in sexual fluids can remain higher longer than in the blood, and another infection, such as malaria, can cause a temporary increase in viral level making the potential of transmission more likely. In the West a person is put on ARVs if in a discordant relationship or pregnant.

There was great excitement with the Tenovir vaginal gel showing up to nearly 50% prevention of HIV transmission if used consistently.⁷ However follow up studies using Tenovir as an oral agent had to be stopped early as it was failing to show any protection from HIV infection.⁸ There is a need for more studies to confirm if vaginal gel does indeed confer some protection as it is something a woman can use without a man's involvement.

One study suggests that Depo-Provera, the contraceptive injection that lasts for 12 weeks, may be associated with an increase in HIV.⁹ It is not clear why and this needs to be investigated, though at present the WHO is still recommending its use.¹⁰ Some progress is being made in researching HIV vaccines, but an effective vaccine still seems a long way off.¹¹

Much has been said about targeting high-risk groups such as Men who have Sex with Men (MSM), Intravenous Drug Users (IDU), and Commercial

⁶ M. Myron, M.S. Cohen et al. "Prevention of HIV-1 Infection with Early Antiretroviral Therapy" in *New England Journal of Medicine*, Aug. 11, 2011; 365 (6): 493-505.

⁷ Q.A. Karim et al, "Effectiveness and Safety of Tenofovir Gel, an Antiretroviral Microbicide, for the Prevention of HIV Infection in Women." *Science*. 2010 Sep 3; 329 (5996): 1168-1174. Published online 19 July 2010, [DOI:10.1126/science.1193748].

⁸ FEM-PrEP Project, "VOICE HIV Prevention Trial Discontinues Tenofovir Gel Arm for Futility (November 25, 2011)." http://fhi.org/en/AboutFHI/Media/Releases/VOICE_discontinues_tenofovir_gel112511.htm. FEM-PrEP Project, "VOICE HIV Prevention Trial Continues, but Researchers Suspend Oral Tenofovir Arm Because of Futility (Sept. 28, 2011)." http://fhi.org/en/AboutFHI/Media/Releases/res_VOICE.htm

⁹ R. Heffron, et al, "Use of hormonal contraceptives and risk of HIV-1 transmission: a prospective cohort study". *The Lancet Infectious Diseases*, Vol. 12.1, Jan. 2012, 19-26.

¹⁰ Department of Reproductive Health, World Health Organization, "Medical eligibility criteria for contraceptive use (2009 edition)". On 15 February 2012 WHO's Guidelines Review Committee upheld the recommendations. <http://www.who.int>

¹¹ Barton F. Haynes, et al, "Immune-Correlates Analysis of an HIV-1 Vaccine Efficacy Trial" in *New England Journal of Medicine*, April 5, 2012, 366: 1275-1286.

Sex Workers (CSW). The reasoning is, if these groups are focused on, then the most impact in HIV spread reduction can be made. However, the Church often is poor at reaching such groups. Is this something the Church should address? Jesus certainly reached out to outcasts: prostitutes, sinners, lepers.

Prevention of Mother to Child Transmission (PMCT)

This is a great opportunity for prevention. Nyeri in Kenya has been reported as reaching 100% coverage.¹² However usually women and their new born child can be lost to follow up at every stage – either they are not tested, or are not coming to get their result (though many are now having a rapid test and will get their result within a few minutes of being tested), not starting on treatment, not coming for delivery, not putting the baby on treatment, or the baby being lost to follow up.

It is best to get the couple tested so that there is support for the necessary treatment by the family, but there can be mixed experiences. Some women have found this helpful and effective, but others have been chased from their homes once they are found to be HIV positive.

There is a move away from using Nevirapine (an ARV) on its own for PMCT. It is 50% effective and there are more effective regimes. It has a long half-life and so stays in the body a long time even after a single dose. This means there is a stronger likelihood of the mother becoming resistant to it. This means in future the mother will not be able to use this or other drugs in this class of ARVs that form the basis for the common, cheap and readily available regimes of treatment of HIV. Fortunately this resistance seems to wane over the course of two years or so.

More commonly now, for PMCT, a combination of ARVs are used, starting during pregnancy and continuing through breast feeding to lower the risk of the virus being spread through breast milk. One effective way would be to put the women on HAART (a full treatment regime for HIV) and leave her on it. It is still recommended to do exclusive breast feeding – i.e. not using other food, cow's milk or formula milk – for four to six months.

The Church should encourage its female members to get tested, especially if pregnant, so as many as possible who are HIV positive can access treatment that can stop the child being infected.

Treatment

The use of ARVs (Antiretroviral drugs) has had a massive impact in Africa. AIDS deaths have decreased and people who were once ill have become well enough to return to work or look after their families, and work in their fields.

¹² Personal conversation with Chair of NACC Kenya, May 2012.

There is a film on U-tube under “Topsy ARVs” which shows a reverse time-lapse video shot over ninety days, “starting” with a lady who looks well, but progressively becoming thinner and frailer until day 1 when she needs support to sit up in bed and take her first dose of ARVs. Consistent use of ARVs can have such an impact in three months. However if treatment is left too late, when the person is too ill, there is a significant number who die even though they are started on ARVs. It is much better to be tested early, before the person becomes really sick, and to start treatment at an earlier stage when their body and immune system are still strong enough to fight off infections.

The WHO has recommended starting treatment at CD4 counts of 350 rather than 200 though many have CD4 counts much lower when first tested. The CD4 count is a measure of the body’s immunity with normal levels usually being between 600 and 1200. Someone who is HIV positive and with a CD4 count below 200 has AIDS by the WHO definition. The challenge, which the church can be involved in, is encouraging people to be tested early, before they are ill, so that treatment can be started at the best time.

AIDS seems to be at a watershed at the moment. Great strides have been made; impact is being seen; but it has been due to a lot of funding. Treatment is for life, so to maintain a person on ARVs costs money and to bring new people onto ARVs costs more. Probably less than a half of those who should be on ARVs are on them. Funding is basically being maintained – flat lining – but to reach more people with ARVs there is a need to increase funds.

Linked with this is the challenge of resistance. If there is too little funding, and not enough ARVs, people might start sharing their medication. Resistance to ARVs is a genuine and common problem if ARVs are not taken at full dose regularly. The worse situation is taking less than the optimal dosage as it allows the virus to replicate in the presence of low levels of ARVs which it gets used to and resistant to. If a person becomes resistant to their ARVs, the virus starts replicating again, their immune system starts deteriorating and they start becoming ill. Changing to different ARVs is then necessary but such second or third line regimes are much more expensive and less readily available. If someone has a virus that has become resistant to ARVs then the virus they infect others with will be the resistant strain. Resistance to ARVs spreads in the community, meaning first line treatment becomes less and less effective.

The church can play a big part in ensuring people take their medication regularly, go to the clinic for their next supply of ARVs, and go if they are unwell or have side effects. A “buddy” system where people befriend those on ARVs, forming a support group for people with HIV can be a means of walking through the illness with those who are infected. This opens up opportunities to share about God, to read His word, and to pray. There are many testimonies of people who have come to know the Lord when they become infected and the church reaches out with God’s love to help them.

Treatment can be a form of HIV prevention. This could mean starting people with HIV on ARVs even earlier, above CD4 counts of 350, but this is very expensive. It may be more appropriate to select certain groups such as discordant couples where one is HIV positive and the other is negative. Putting the positive partner on ARVs would be a way of protecting the negative partner. It is not absolute protection though and certainly with other infections, such as malaria, the HIV viral load will go up briefly and would potentially mean an increase risk of spreading HIV.

With HIV and TB co-infection it is best to start anti-TB treatment first but to start ARVs soon afterward as this seems to have better outcomes and fewer deaths. Stavudine (d4T) was a common part of early ARV regimes but has gone out of favour due to common side effects (nerve and pancreas damage especially) and so is not used in the West and increasingly less so elsewhere.

It is particularly important to start HIV positive children on ARVs because 50% of them will die within two years. CD4 counts are not as helpful in children so it is best to put all HIV positive children on ARVs. The difficulty is making the diagnosis as the normal blood test is an antibody test and the mother's antibodies cross the placenta into the baby's blood. This means a positive test in a baby only means the mother is positive. It can take up to a year for the mother's antibodies to clear from the baby's blood so it can mean waiting a year to see if the child is infected by which time the child can be very ill. The PCR test actually tests for the virus and so can identify HIV positive babies who are six weeks or older. It is much more expensive and less readily available but is particularly useful for this situation. We must carefully follow up children born to HIV positive mothers to check if they have HIV themselves and to start them on ARVs as soon as possible.

In the West AIDS is now being talked about as a chronic illness. Although there is no cure for it, ARVs are so effective that it allows people to live fairly normal lives for many years. It is now being recognised that HIV itself is a persistent inflammatory disease and, as is common with such diseases, it starts to affect multiple organs - heart, kidneys, bones, liver and brain. People with HIV for many years have a higher risk of cardiovascular disease for.¹³ This is making people wonder if starting ARVs even earlier will reduce this inflammation and so reduce such damage and risks in the long term.

There are many new developments in AIDS research. With them come increased opportunities for the church to make an impact in people's lives. The harvest is plenty but the labourers are few – pray to the Lord.

¹³ M. Desvarieux, et al. "Carotid atherosclerosis is related to HIV duration and anti-inflammatory profile and not to ARV exposure: the CHIC controlled study." Eighteenth Conference on Retroviruses and Opportunistic Infections, Boston, abstract 803, 2011. www.retroconference.org/2011/Abstracts/41184.htm

Evil and AIDS – An African Perspective

by Keith Ferdinando

Traditional Perceptions of Evil and AIDS

“He died of AIDS, obviously,” Moleboheng told her mother after the cousin left. She was far too polite and sensible to say this in front of the relative, for then the relative would report to others that her family were starting vicious rumours. Mama Khanyile conceded the possibility of AIDS, although that didn’t necessarily rule out isidliso. Her view was that the AIDS, if indeed it was AIDS, must have been sent by someone. Someone had wanted to see the young man dead and had used witchcraft to send this AIDS or isidliso to kill him. Moleboheng still insisted that was nonsense, as she does whenever her mother talks about witchcraft. In this, as in most things pertaining to witchcraft, the daughter and her family agree to disagree. She knows that within African society at large her way of looking at things is in a distinct minority.¹

The brief story told by Adam Ashforth underlines the equivocation surrounding the understanding of AIDS in the African context. It articulates a particular culturally acquired perception of its origin, and in so doing draws attention to the role of culture in human life and its near total impact on thought and behaviour. We are creatures of culture and respond to events in accordance with beliefs assimilated from our cultures. As human beings are bearers of God’s image, even though that image has been distorted as a result of the fall, there is much in culture that is good. However, sin profoundly affects human intelligence and understanding, which means that culture is also and in all cases deeply flawed by falsehood, which needs to be unmasked and replaced by truth. The Bible indicates that whole cultures can be penetrated by error, with inevitable consequences for all those who are shaped by them. And it is of course as true of Western cultures as it is of African. The problem is that people cling tenaciously to the most fundamental beliefs and attitudes that underlie a culture, such that substantial change is very difficult to bring about. We may indeed more easily identify the problems confronting people of another culture than those of our own.

In this case the issue is that of African conceptions of misfortune. The experience of suffering is a universal one, with which every human being without exception is confronted. However, responses are culture-specific, and in consequence they are often very different. The approach common in African

¹ A. Ashforth, “AIDS, Witchcraft, and the Problem of Power in Post-Apartheid South Africa”, *African Studies* 61.1 (2002), 121. *Isidliso* “otherwise called ‘Black poison’”, is “an evil work of the people they call witches”.

tradition has been termed an “interpersonal causal ontology”,² the meaning of which is expressed more simply in a Zulu proverb, “There is always somebody”.³ This means that when suffering comes in almost any form, it may be attributed, for example, to the malice of a spirit, the punishment of an ancestor, or the aggression of a witch or sorcerer. This need not imply an ignorance of the empirical reason for the affliction. The empirical approach explains *how* an event happened; but the pursuit of a spirit or sorcerer responds to the deeper, more unsettling question of *why* it happened - why to this person and at this time? Traditional approaches are concerned with the pursuit of the meaning of an illness or an accident, and they locate it in primarily personal terms. Accordingly, they do not deny the fact that snake venom and lightning kill, or that germs and microbes make people sick. Rather, in the words of one informant, “it may be quite true that typhus is carried by lice, but who sent the infected louse? Why did it bite one man and not another?”⁴ In contrast, secular Western approaches focus exclusively on the empirical factors responsible for the suffering, and do not pursue the question “why?” at all. Not unreasonably African peoples are not satisfied with this, which would leave them, as it leaves westerners, in a meaningless and inexplicable cosmos.

In African contexts AIDS will therefore very frequently be understood in culturally defined terms as the result of personal causation. This situates it in the cultural universe of the sufferers, their families and of course the society in general. The approach is powerful because it provides an explanation that is familiar and that has deep roots in traditional thinking. It enables comprehension of the phenomenon, gives it meaning and, perhaps most important of all, offers a strategy for dealing with the problem, although one that is essentially ineffective in terms of its curative potential. Recent research therefore shows that, for example, in Cameroon AIDS deaths are likely to be blamed on witchcraft; in Botswana too people attribute AIDS to witchcraft, especially because of the length of the illness; in Chiawa, south of Lusaka in Zambia, a witch finder was hired in 1994-1995 due to the high number of deaths occurring due to AIDS and accidents, and 15 people then died as a result of the imposition of a poison ordeal to flush out the witches; and research conducted in two villages of the Abakwaya of Tanzania, a region where there is the highest incidence of AIDS, showed that 80% of the population visit diviners and traditional healers before seeking other treatment,

² See T. D. Stabell, “‘The Modernity of Witchcraft’ and the Gospel in Africa”, in *Missiology* 38.4 (October 2010), 461.

³ A.I. Berglund, *Zulu Thought-Patterns and Symbolism*, London: C. Hurst, 1989 [1976], 270.

⁴ Quoted in M. Gluckman, *Custom and Conflict in Africa*, Oxford: Basil Blackwell, 1955, 85.

occasioning a consequently high mortality rate.⁵ The belief that witchcraft is the cause of HIV-AIDS may also lead to carelessness about its spread, because emphasis is placed on the occult factors involved rather than the physical.

An Evangelical Theological Response to Evil and AIDS

Theology, and more specifically evangelical theology, is concerned with making the connections between the unchanging word of the living God, and the shifting worlds of human beings. It is about bringing truth to bear on ourselves, and on the reality we inhabit. In this case, therefore, a theological response must begin by addressing the culturally defined world of the sick, their families and their societies in the light of revealed truth. If the culture is offering responses to AIDS that do nothing of any substance in terms of real prevention and cure, then what is required is the pursuit of cultural transformation, which can only emerge from a profound renewal of belief structures. In the African context, as in many others, Christian teaching very often fails to address this level, resulting in a superficial, and indeed syncretistic, Christian discipleship. What is required is a biblical and counter-cultural response of some depth.

Before proceeding, it must be emphasised that a theological response to AIDS in the African context does not mean simply moving towards a Western, secularised view of reality. The problem of illness, including AIDS, needs to be understood in biblical and not in Western terms. A Western secular approach may be effective in purely clinical terms but, as we have noted, it leaves the sufferer in an empty and meaningless universe. African understandings of illness may be deficient in many respects, but their great positive value is a retention of the pursuit of meaning. There is a deep sense that suffering ought to make sense, that there must be a reason, that we do not inhabit a meaningless universe. A Western perspective which abandons the pursuit of meaning will not do, which is why even in modern African cities people continue to go to diviners and traditional healers, often before seeking other more empirical forms of treatment. Moreover, from a biblical perspective the pursuit of meaning is not invalid, but rather the contrary. When the disciples encountered “a man blind from birth” they asked Jesus, *Rabbi, who sinned, this man or his parents, that he was born blind?* (Jn 9:2). Jesus did not criticise their attempt to understand the reason for the man’s suffering, but he enlarged the range of possibilities which they should consider: *Neither this man nor his parents sinned, said Jesus, but this happened so that the work of God might be displayed in his life* (Jn 9:3). The pursuit of meaning, the elementary desire

⁵ The examples in this paragraph are all drawn from G. Ter Haar (ed.), *Imagining Evil: Witchcraft Beliefs and Accusations in Contemporary Africa*, Trenton, NJ and Asmara, Ethiopia: Africa World Press, 2007, 123, 221, 234, 262.

to understand, that is evident in African thought, is legitimate. AIDS does indeed take place in the context of a universe that has meaning, because a sovereign God made and rules it. The issue is that of ensuring that we look for meaning in the right places, which for Christians involves submitting our thinking to the evaluation of Scripture.

Therefore, the goal must be a reconstruction of the understanding of suffering in biblical terms. At root this means a deeper awareness of both creation and redemption, with all their rich and multiple implications, through which belief structures, and so lives, will be transformed (Rom 12:2). This is the challenge for Christian health workers in Africa, who are themselves products of their various cultures - Western or African - all of which distort truth to some degree and in one way or another. It is also, and especially, the task of the church, and a particular challenge to its approaches to catechesis and discipling, which can all too often be superficial or even non-existent, in striking contrast with the radical and life-changing approaches to the formation of new believers which characterised some of the earliest churches.⁶

Transforming Perspectives

The vital issue is that of the causation of disease. This leads in turn to the question of response, for necessarily the way in which men and women attribute cause will determine the range of therapies that they are prepared to consider. In biblical terms the identification of causation is not simple, and in any single event various causes may be operative at different levels of reality. Applied to the particular case of illness, four different levels may in principle be relevant at any one time.

1. Physical Causation

The Bible affirms the reality of physical causes, which corresponds to the empirical approach of modern medicine. Central to the biblical revelation is the doctrine of creation which has rich and multiple implications. Especially important for present purposes is the fact that the God who created is rational, consistent and faithful, one who speaks and reasons, and whose works reflect his own rational and consistent nature. Accordingly, the cosmos he has made and which he continues to uphold, is one of order and regularity, whose structures and rhythms may be observed, identified, understood and, to some degree, harnessed to human ends. The cosmos is not arbitrary and capricious, just as God is not arbitrary and capricious. It is not subject to the control of fickle and unpredictable spirits and spiritual forces, as it is in animistic thought and cultures, for which nature is "a supreme mystery,

⁶ See, for example, C. E. Arnold, "Early Church Catechesis and New Christians' Classes in Contemporary Evangelicalism", in *JETS* 47.1 (March 2004), 39.

inconsistent, unpredictable, and arbitrary”.⁷ There is indeed a strong demythologising polemic in the Old Testament, found especially, although not exclusively, in the early chapters of Genesis, which identifies the sun and other celestial bodies, the sea and the great fish as part of God’s good physical creation, and subject to his rule.⁸ They are not spiritual powers and forces, as they were for many of the peoples of the ancient Near East. Moreover, such an approach also sharply distinguishes the biblical understanding of nature from animistic perceptions.

At the same time, God made human beings in his own image. The exact meaning of the *imago Dei* is not explicitly developed in the Bible and remains a subject of discussion, but the flow of the text in Genesis 1 is suggestive. Both the initial divine deliberation, *Let us make man in our image, in our likeness* (Gen 1:26), and its fulfilment shortly afterwards, *So God created man in his own image* (Gen 1:27), are each followed by very similar statements of the role which humanity is to play on earth: *and let them rule over the fish of the sea and the birds of the air, over the livestock, over all the earth, and over all the creatures that move along the ground* (Gen 1:26), and again, *Be fruitful and increase in number; fill the earth and subdue it. Rule over the fish of the sea and the birds of the air and over every living creature that moves on the ground* (Gen 1:28). The implication is that at least one aspect of the divine image lies in the fact that men and women are endowed with reason, along with the ability to order and rule that which God has made. They are able to study the world: to observe, identify and understand the regularities of natural processes, and to do so to an ever-increasing degree. Human beings are knowing beings (*homo sapiens*). Moreover, not only are they *able* to do so, but it is their *calling*. They are mandated by the creator to pursue understanding of what he has made - to rethink his thoughts after him. This is expressed in the words attributed to the astronomer Johannes Kepler (1571-1630): “I was merely thinking God's thoughts after him. Since we astronomers are priests of the highest God in regard to the book of nature, it befits us to be thoughtful, not of the glory of our minds, but rather, above all else, of the glory of God.”⁹ Moreover, they are responsible beings, stewards of creation who are summoned to exercise rule over God’s world as his image bearers, and to use and adapt their growing knowledge both to care for the world and in the pursuit of beneficent human ends.

⁷ R. Stark, *The Victory of Reason: How Christianity Led to Freedom, Capitalism, and Western Success*, New York: Random House, 2006, 15.

⁸ G. J. Wenham, *Genesis 1-15*, Dallas: Word, 2002, 9.

⁹ These words, allegedly of Johannes Kepler, are much quoted but not so easy to locate. They are cited by H. M. Morris, *Men of science, men of God: great scientists who believed the Bible*, Green Forest, AR: Master Books, 1982, 11-12, and widely referred to on the web but without identification of their location in Kepler’s works.

All of this means that a seriously scientific comprehension of the physical realm becomes possible, precisely because the Bible recognises the reality, regularity and orderliness of natural, physical causes, and the consequent possibility of understanding them. It is largely for this reason that the rise of science took place almost exclusively in societies whose cultures were significantly permeated by a Christian view of reality: "Christian theology was essential for the rise of science in the West, just as surely as non-Christian theologies had stifled the scientific quest everywhere else."¹⁰ By contrast, given the animistic understanding of the world, the very notion of an animistic scientist is "an oxymoron, like a square circle".¹¹ In particular, the biblical perspective means that human beings are able to study and increasingly to understand themselves, and specifically the incarnate - physical and bodily - dimension of their nature as human beings, with immense potential for both preventive and curative medicine. The empirical pursuit of medical knowledge, including knowledge of the human body and its functioning, of health and disease and the factors that contribute to both, arises out of a specifically biblical conception of reality. To engage in medical research and to apply its findings to the pursuit of human well-being is a profoundly Christian calling, rooted in what the Bible has to say about the nature of God, of creation, and of the mandate addressed to Adam and Eve at the very outset of history.

Moreover, such an approach reflects the biblical notion of wisdom, whose central concern is that men and women live in conformity with the way God has designed the world he made, rather than in defiance of it. They should seek to understand the patterns of creation and life that the creator has established, and actively allow their thoughts and lives to be shaped by them. Accordingly, as God has made a world that is orderly, with natural causes and consequences, true biblical wisdom lies in identifying them, and then working with them to promote health and respond to disease. In contrast, folly means ignoring the discernible structures of physical reality and so, for example, accepting exclusively mystical explanations of illness and relying on correspondingly esoteric therapies. "Israel's sages believed that both nature and the world of human beings were determined by a fundamental order. To act in harmony with the universal order which sustained creation was their supreme goal: human behaviour either strengthened the existing order or contributed to the forces of chaos which threatened life."¹²

Accordingly, while the Bible may not have much to say about them, the few references that exist assume without debate the use of medicine and of

¹⁰ Stark, *The Victory of Reason*, 15.

¹¹ D. L. Miller, *Disciplining Nations: The Power of Truth to Transform Cultures*, Seattle, WA: YWAM Publishing, 2001, 111.

¹² E. J. Schnabel, 'Wisdom' in T. D. Alexander, & B. S. Rosner (eds.), *New Dictionary of Biblical Theology* (electronic ed.), Downers Grove: InterVarsity Press, 2001.

physicians, because their development and use are an inevitable consequence of the biblical understanding of the way the world and its human inhabitants have been made. For example, Hebrew dietary and hygienic rules were more developed than those of other Ancient Near Eastern nations, and soundly based on the observed facts of contagion and infection. Albright writes, "No part of the Hebrew Bible is more clearly empirico-logical in its background than the rules of purity", and he contrasts them with the taboos of other Ancient Near Eastern peoples in which the influence of sympathetic magic is evident.¹³ The book of Proverbs shows an awareness of the relationship between mental state and physical health (14:30; 17:22; 18:14). Jeremiah 8:22 assumes the existence of balm and physicians, although clearly the text has a primarily spiritual reference: *Is there no balm in Gilead? Is there no physician there? Why then is there no healing for the wound of my people?* Exodus 21:18-19 implies the use, and expense, of medical care: *If men quarrel and one hits the other with a stone or with his fist and he does not die but is confined to bed, the one who struck the blow will not be held responsible if the other gets up and walks around outside with his staff; however, he must pay the injured man for the loss of his time and see that he is completely healed.* Even Paul's encouragement to Timothy displays an awareness of the medicinal value of a little wine: *Stop drinking only water, and use a little wine because of your stomach and your frequent illnesses* (1 Tim 4:23). Meanwhile, the denunciation of Asa's use of physicians (2 Chron 16:12) need not imply condemnation of physicians as such but perhaps of Asa's dependence on them to the exclusion of God, or of his use of the contemporary medico-religious practices of neighbouring peoples.

Accordingly, the Bible does not suggest that illness is normally dealt with simply by prayer, although prayer is certainly a major part of the response, as we will see. There is a strong and consistent biblical emphasis on the use of *means* as human beings live out their daily lives and pursue the fulfilment of God's will. In terms of evangelism this quite foundational point is expressed in the title of William Carey's momentous work, *An Enquiry into the Obligations of Christians to Use Means for the Conversion of the Heathens* (1792). Similarly, just as the fact that God gives food and expects his children to ask him for their daily bread, does not remove the necessity of working for it, so also the fact that health is ultimately in his hands, does not remove human responsibility to be active in its promotion and restoration. This obviously includes abstinence from behaviour - very frequently sinful behaviour - that has a known link to illness, including forms of sexual activity associated with the spread of HIV-AIDS. And where illness occurs, it also includes the use of

¹³ W.F. Albright, *Yahweh and the Gods of Canaan*, London: The Athlone Press, University of London, 1968, 152-153. See also R. K. Harrison, 'Disease', in G. W. Bromiley (ed.), *ISBE*, vol. I, Grand Rapids: Eerdmans, 1979, 955.

medication whose efficacy has been established by those natural sciences whose origins are deeply embedded in the biblical worldview.

2. Moral Causation

The impact of human sin on the physical creation is obvious at various levels. Pollution and environmental degradation are frequently linked to human irresponsibility, greed and selfishness. However, at a more profound level the rebellion of men and women at the beginning of history has brought about a fundamental and pervasive dislocation and alienation in the cosmos as a whole. The Bible indicates that there is a profound relationship between the human race and its habitat which goes beyond purely empirical connections, such that when Adam and Eve rebelled, the world they inhabited experienced a “fall” with them. The verdict pronounced on Adam following his disobedience indicates that such a fall came about as the result of a divine word of judgement: *Because you listened to your wife and ate from the tree about which I commanded you, “You must not eat of it,” cursed is the ground because of you; through painful toil you will eat of it all the days of your life. It will produce thorns and thistles for you, and you will eat the plants of the field. By the sweat of your brow you will eat your food until you return to the ground, since from it you were taken; for dust you are and to dust you will return.* (Gen 3:17-19). The relationship between the spiritual state of human beings and the condition of the world they inhabit is again expressed when Paul looks back to the moment of the fall, the point at which the natural order was *subjected to frustration and bondage to decay*, and ahead to the final redemption of God’s people when it will be *liberated and brought into the glorious freedom of the children of God: The creation waits in eager expectation for the sons of God to be revealed. For the creation was subjected to frustration, not by its own choice, but by the will of the one who subjected it, in hope that the creation itself will be liberated from its bondage to decay and brought into the glorious freedom of the children of God. We know that the whole creation has been groaning as in the pains of childbirth right up to the present time* (Rom 8:19-22). And so the book of Revelation looks forward to a new creation from which all evil of every sort will be forever banished, *a new heaven and a new earth* (Rev 21:1), in which *there will be no more death or mourning or crying or pain, for the old order of things has passed away* (Rev 21:4). In brief, human rebellion has had devastating consequences for the whole cosmos, while the consummation of God’s work of salvation at the return of Christ will bring about a dramatic reversal.

In the light of this, all human suffering, including illness, should be understood as a consequence of the fall. Sin entails devastating physical as well as spiritual consequences for all human beings, of which the ultimate is death itself. Human pain is, therefore, in the words of D.A. Carson, “the

effluent of the fall, the result of a fallen world”.¹⁴ However, this does not mean that particular cases of suffering are necessarily due to particular individual sins. In the Old Testament a substantial body of literature and reflection, including Job 1-2, Psalms 37 and 73, and the prophecy of Habakkuk, wrestles with the ambiguities of human suffering. The *wicked* seem frequently to escape justice and judgement, while the righteous suffer, and often experience no apparent resolution of their trials. Meanwhile, the righteous may suffer innocently because of the sin of the wicked, as when Jonathan, son of king Saul, fell in battle on Mount Gilboa along with his father. Similarly, Jesus rejected the idea that the affliction of the man *blind from birth* was due to sin (Jn 9:1-3), or that those who died in an atrocity committed by Pilate at the Temple or from the collapse of *the tower in Siloam*, did so because they were greater sinners than everybody else (Lk 13:1-5).

Nevertheless, throughout the Old Testament there is also a persistent and unavoidable emphasis on the retribution that sin brings. It is seen on a national scale when the kingdoms of Israel and then Judah are destroyed by Assyria and Babylon respectively, or at a personal level when King Uzziah is struck down with leprosy due to his sacrilegious presumption in assuming the role of a priest (2 Chron 26:16-21), and examples could be multiplied. On occasion Jesus suggested that particular sin had caused specific sufferings. He counselled the man healed at the pool of Bethesda, *See, you are well again. Stop sinning or something worse may happen to you* (Jn 5:14). Paul and the author of Revelation attributed some particular cases of illness in local churches to specific preceding sin (1 Cor 11:30; Rev 2:21-23), while James exhorted his readers, *confess your sins to each other and pray for each other so that you may be healed* (Jas 5:16). And Luke, a physician, attributed the sudden death of Herod Agrippa to the fact that he *did not give praise to God* when the people of Tyre hailed him as a god (Acts 12:20-23). In brief, sickness is in the world because sin is in the world: in a general sense, all sickness without exception is the result of sin, and there are no *innocent* sufferers for none are without sin. Sometimes there is a direct and even obvious relationship between specific sin and consequent illness. However, one cannot simply, and naively, reason back from every individual case of illness and pain to a specifically identifiable sin that has brought it about.

3. Occult Causation

Human rebellion not only brought about massive disruption to the natural realm, but has also resulted in the subjection and oppression of human beings by Satan and the forces of darkness that he controls. Sin means that “man attempts to live independently of his Creator, treating himself as his own god, and thereby not only ceases to be truly himself but also loses control of what

¹⁴ D. A. Carson, *How Long, O Lord: Reflections on Suffering and Evil*, Leicester: Inter-Varsity Press, 1990, 48.

should have been under his dominion *and falls under the control of demonic powers* [my italics]”.¹⁵ The primary manifestation of this is spiritual and moral: Satan holds lost men and women captive in spiritual blindness and death, unable and disinclined to pursue their own redemption (Rom 8:6-8; 2 Cor 4:4; Eph 2:2; 1 Jn 5:19). He is a murderer and destroyer (Jn 8:44), and his purpose is to bring about the eternal alienation of human beings from the creator in whom alone life is found.

But it is also clear in the Bible that Satan has a role in physical suffering including illness. Insofar as it was his temptation of the first human couple that brought about the fall, from which all disease ultimately flows, he may indeed be seen as implicated in a general way in all human illness, suffering and death. This would explain Peter’s statement that Jesus *went around doing good and healing all who were under the power of the devil* (Acts 10:38). However, the Bible suggests that he may also on occasion be directly involved in particular cases of suffering. This is manifestly true of demonic *possession* (which the synoptic gospels refer to as being *demonised*, *having a demon* or being *in an evil spirit*¹⁶), but it may also be true of some who do not present the classic symptoms of *possession* but suffer simply physical afflictions. The woman whom Jesus cured of curvature of the spine (possibly *spondylitis ankylopoietica*¹⁷) had been *crippled by a spirit* and *kept bound* by Satan (Lk 13:10-17). Job’s trials, including his own physical illness which may have been a very acute form of dermatitis,¹⁸ were brought about by Satan, while Paul’s *thorn in the flesh*, probably an illness, was cased by a *messenger of Satan* which would almost certainly have been understood to be a demon (2 Cor 12:7). The Bible makes it clear, however, that the sufferings of both Job and Paul took place only in the context of God’s sovereign rule, as we shall see. Further, it would be very far from the truth to suppose that the biblical witness identifies Satan or demons as the invariable explanation of every particular, individual case of illness: “for the New Testament writers there was no simple equation between infirmity and the demonic”.¹⁹

Similarly, the biblical testimony repudiates any “simple equation” between infirmity and witchcraft. Belief in witchcraft has certainly been extremely widespread, if not universal, in human societies across the globe and

¹⁵ C. K. Barrett, 1962, *From First Adam to Last: A Study in Pauline Theology*, London: A. & C. Black, 1962, 92-3.

¹⁶ See K. Ferdinando, *The Triumph of Christ in African Perspective: a Study of Demonology and Redemption in the African Context*, Carlisle: Paternoster, 1999, 190-191.

¹⁷ The diagnosis proposed by J. Wilkinson, “The Case of the Bent Women in Luke 13:10-17”, *Evangelical Quarterly* 49 (1977), 196-200.

¹⁸ F. I. Andersen, *Job: An Introduction and Commentary*, Nottingham: IVP, 1976, 96.

¹⁹ J. C. Thomas, *The Devil, Disease and Deliverance: Origins of Illness in New Testament Thought*, Sheffield: Sheffield Academic Press, 1998, 302.

throughout history.²⁰ Although the precise content of witchcraft beliefs is highly culture specific, at its heart lies the belief that some human beings are able to harm and even kill others by non-physical, occult means. While it is an issue of some dispute, the Bible also refers to witchcraft as a potential factor in human suffering, but references are few and there is scarcely any explicit, sustained discussion of the matter. However, Balaam was clearly a pagan sorcerer with an established reputation for the power of his magic, which is why Balak, king of Moab, sent for him: *come and put a curse on these people, because they are too powerful for me. Perhaps then I will be able to defeat them and drive them out of the country. For I know that those you bless are blessed, and those you curse are cursed* (Num 22:6). What is striking in the story is that God intervened in such a way that Balaam was compelled to bless rather than curse his people. The projected occult aggression was smothered as God reversed the evil intention of Balak and Balaam. “The only force that shapes the destiny of Israel is God’s plan, and no magical practices can thwart that divine intention.”²¹ Sorcery may therefore exist but, like Satan and his demonic agents, it is subject to God’s sovereign will.

Much later, in a quite enigmatic passage, Ezekiel seems to have had the activities of female sorcerers in view: *Woe to the women who sew magic charms on all their wrists and make veils of various lengths for their heads in order to ensnare people ... I am against your magic charms with which you ensnare people like birds and I will tear them from your arms; I will set free the people that you ensnare like birds* (Ezek 13:17-23). As the prophecy is addressed to the exiles their sorcery may well testify to the influence of Babylonian culture. The bands of cloth and veils were apparently part of the ritual that they followed, magic amulets perhaps *intended to bring about untimely deaths.*²²

References are equally few in the New Testament, but Paul identifies witchcraft as one of the acts of the sinful nature in Galatians (5:19-21). The Greek word he uses, *pharmakeia*, which is translated as *witchcraft*, is related to *pharmakon* which initially denoted a drug often used in erotic magic. “For the most part, however, the cognates of φάρμακον [*pharmakon*] refer more often to magical material used for purposes of hate rather than love.”²³ In the culture which the Galatians shared, therefore, one of the forms that sin took

²⁰ See M. Marwick (ed.), *Witchcraft and Sorcery*, Harmondsworth: Penguin Books, 1982 [1947], 14.

²¹ H.C. Kee, *Medicine, Miracle and Magic in New Testament Times*, Cambridge: Cambridge University Press, 1986, 18.

²² D.E. Aune, 'Magic', in G.W. Bromiley (ed.), *ISBE*, vol. III, Grand Rapids: Eerdmans, 1986, 215. See too R.H. Alexander, 'Ezekiel' in F.E. Gaebelin (ed.) *The Expositor's Bible Commentary*, vol 6, Grand Rapids: Zondervan, 1986.

²³ E. M. Yamauchi, 'Magic in the Biblical World' in *Tyndale Bulletin* 34 (1983), 181.

was sorcery, the attempt to use occult means to harm another person. Paul recognised the reality of the act and its hostile intent, although he does not discuss its exact nature nor comment on its efficacy.

Although Paul's letter to the Ephesians contains no explicit reference to witchcraft, the city of Ephesus was well known as a centre of magic, which was somewhat focused around the temple of Diana. An awareness of that background illuminates the meaning of parts of the apostle's argument as he addresses Christian believers concerned, perhaps, about their exposure to occult aggression, including witchcraft and demonic attack. Especially significant in this context is his emphasis on Christ's absolute superiority over every conceivable source of power in the invisible world of spirits and occult activity. Christ's is the name that is above every name, for God has *seated him at his right hand in the heavenly realms, far above all rule and authority, power and dominion, and every title that can be given* (Eph. 1:20-21). For Paul's readers the words *rule and authority, power and dominion* explicitly identified the spirits that stood behind pagan magic and of which they may have been afraid, but Paul insists that every such power, whether known by name or not (*every title that can be given*) was subject to Christ the Lord. Moreover, it is significant that he neither affirms nor denies the efficacy of witchcraft or sorcery, although he apparently assumes that if it exists the power behind it must be demonic and not merely human.²⁴ Nor does he discuss the details of the Ephesians' beliefs in witchcraft, whatever they may have been, and they were certainly varied and complex as is the case also in African tradition. In short, he does not mock or minimise their fears, but he does not confirm them either. What he does is to declare that, whatever hostile powers there might be, whatever they might do, whatever they might be called, however they may be conceived, Christ is infinitely greater and is able to guard his people who, as he goes on to say, are indeed already seated *with him in the heavenly realms* (2:6), and therefore also *far above all rule and authority, power and dominion*. His purpose is so to plant in their minds the truth of Christ raised and reigning, and of their own position in and with Christ, that their fears, whether well-founded or not, will be relieved.²⁵

What is striking is the relative lack of reference to witchcraft in both Old and New Testaments, even though it was well-known, and often much feared,

²⁴ H. Hill, "Witchcraft and the Gospel: Insights from Africa", *Missiology* 24.3 (July 1996), argues that witchcraft may come from the unconscious power of human beings. However, there are biblical grounds for supposing that the power behind all supernatural activity, other than that effected by the Holy Spirit or angels, is demonic. Accordingly, in Matthew 12:24-28, when Jesus and the Jerusalem rabbis debated the source of the power by which he expelled demons, both parties recognized only two possibilities – it was either Beelzebub (Satan) or the Holy Spirit.

²⁵ See the brief discussion in P.G. Hiebert, R.D. Shaw, T. Tiénou, *Understanding Folk Religion*, Grand Rapids: Baker, 1999, 173.

among neighbouring peoples. The Bible recognises that there are practitioners of the occult arts, and on quite rare occasions seems to confirm that they may indeed be instrumental in inflicting harm on their intended victims. However, it stops very far short of seeing witchcraft as a total explanation of pain or illness. Nowhere do the Scriptures suggest that witches and sorcerers are *major* or *pervasive* causes of human suffering, and the rarity with which the issue comes up is decisive evidence against such a conception. The emphasis falls on the moral dimension mentioned above, far more than on occult causation. Human beings are not primarily victims of occult forces that they cannot control; they are responsible sinners who, in their sufferings, live out the consequences of their own rebellion. “Rather than endorsing witch discourses featuring a world of normally virtuous people being attacked by others who represent evil incarnate, the Bible presents everyone as sinners, with terribly flawed understandings of the nature of evil.”²⁶ If one seeks a biblical *explanation* of suffering, it is not to be found in witchcraft.

4. The Sovereign God

In Scripture God is the sovereign Creator of all that exists, and an ever-present, living and dynamic reality, who is Lord of health, illness and death. His agency in bringing suffering and death on communities or individuals is evident throughout the Bible, and has already been discussed. However, he is also sovereign in the incidence of suffering in *every* case, for there is no corner of the cosmos in which he is not Lord. So it is he who allowed Job and Paul to suffer demonic affliction, while limiting both the extent and duration of their trials. The biblical text makes it clear that Satan could do nothing to harm Job without divine authorisation, and when he did act he could not go beyond the limits that God had set (Job 1-2). Paul uses the so-called “divine passive” to refer to his own affliction by a demon: *there was given me a thorn in my flesh, a messenger of Satan, to torment me*. Furthermore, he stresses the way in which the affliction, even though it came through demonic agency, served to accomplish God’s own good purposes: *to keep me from becoming conceited* (2 Cor 12:7-10). In Revelation even the beast that rises from the sea under Satan’s inspiration, and then goes on to attack and subdue the people of God, can do so only within limits imposed by God. This is again indicated by the repeated use of the passive voice: *‘the beast was given a mouth to utter proud words and blasphemies and to exercise his authority for forty-two months ... He was given power to make war against the saints and to conquer them. And he was given authority over every tribe, people, language and nation’* (Rev 13:5,7).

The use of magic was widespread among Israel’s neighbours: “There can be no doubt that both the Old Testament and the New Testament were born in

²⁶ R. J. Priest, ‘Witches and the Problem of Evil: Looking behind accusations of witchcraft’, in *Books and Culture: A Christian Review* 15.6 (2009), 30-32.

environments permeated with magical beliefs and practices.”²⁷ However, the relative neglect of the whole issue in Scripture is significant, and suggests that an overwhelming awareness of God’s sovereign and omnipresent power on the part of the authors of Scripture put the feeble performances of magic practitioners in the shade. We have already noted the way on which Balaam’s aggressive sorcery was turned into the blessing of God’s people. In dealing with Egyptian magic, whether at the time of Joseph or Moses, or of Babylonian divination in the book of Daniel, the Bible does not deny that the practitioners were able to produce supernatural effects, but it points to the weakness and inadequacy of their efforts in comparison with the acts of the living God.

Consequently, throughout Scripture godly sufferers turn to God for relief. This does not remove their responsibility to pursue health and healing through empirical means. This is indeed the normal way in which he brings healing, although on occasion he may act directly, or miraculously, to heal without the use of any means at all. However, whatever the mode of God’s operation, afflicted believers do not pursue witches or sorcerers, nor seek to appease or accommodate demons. Faced with suffering both Paul and Job prayed. Job indeed was not aware of the immediate, Satanic, cause of his suffering, but in a world where occult explanations were rife he relentlessly sought relief from God alone. The same is true of the many individual psalms of lament, in which the sufferer turns to God alone in his pain. And of course Paul prayed repeatedly for the removal of his affliction, until he became convinced that it was God’s will for him. If the varied purposes of God constitute the ultimate explanatory framework in which suffering takes place, then for the believer prayer must inevitably be vital to any response. *Is any one of you sick? He should call the elders of the church to pray over him and anoint him with oil in the name of the Lord* (James 5:14, and note also 5:16).

5. Multiple Levels

Finally, the Bible has a holistic vision in which the different levels of causation may be operative simultaneously. Perhaps the most obvious example is the crucifixion of the Lord Jesus Christ himself, which was caused by Judas’ betrayal, by the conspiracy of the Jewish religious leadership of the time, by the approval of the Roman authorities, by Satan himself, and ultimately *by God’s set purpose and foreknowledge* (Acts 2:23). Similarly Job’s sufferings involved physical factors, including hostile political activity and climatic events, as well as Satanic involvement and ultimate control by God of all that was taking place.

In the case of physical illness, the involvement of natural factors will invariably be assumed as it is consistent with the way the world has been created. However, in terms of explanation illness occurs in the context of a

²⁷ Yamauchi, “Magic in the Biblical World”, 169.

fallen physical creation. It is for that reason that harmful germs, bacteria, viruses and so on have become a part of the whole process of cause and effect. Moreover, there may be a particular moral element and, in exceptional cases, perhaps even some occult involvement, although the latter would be very difficult to identify. However, whatever the factors involved, God is always the one who remains Lord of health, illness and death.

Responding to HIV-AIDS

The final issue is that of considering how this brief analysis might apply to the understanding and treatment of HIV-AIDS in the African context.

1. Renewed Minds

The first and most critical issue is the way in which HIV-AIDS is understood and explained. Minds shape lives; we live out our beliefs. In the case of HIV-AIDS the total explanatory structure at the heart of many traditional African cultures is rooted in an essentially erroneous perception of the causes of suffering. Its consequence will invariably be the adoption of futile therapies, which in some cases lead to a worsening of the patient's condition, and possibly its transmission to other persons. It is also likely to contribute to a fatalism which perseveres in the sort of destructive sexual behaviour in which HIV-AIDS flourishes, believing that nothing at all can make any difference. The errors involved come ultimately from Satan, who is *a liar and the father of lies* and whose purpose is destruction (Jn 8:44). The answer to lies is truth, which liberates from error and its consequences. Accordingly, as Paul exhorts his readers: *Do not conform any longer to the pattern of this world, but be transformed by the renewing of your mind* (Rom 12:2). The lies that have been assimilated from the specifically African cultural *pattern of this world* must be effaced, as minds are renewed in the light of truth, thereby producing a transformation of life. The issue is at heart a profoundly spiritual one, concerned with the noetic, or intellectual, consequences of sin. The response lies in the ministry of God's Spirit, who alone can bring about the penetrating and transformative appropriation of biblical truth that is required. It challenges the church to a much deeper grasp of God's word, and a correspondingly earnest effort to communicate it in its richness.

2. Medicine, Witches and Community

The vital concern must therefore be to promote the replacement of an occult explanatory framework (the traditional African "interpersonal causal ontology") with one rooted in the uniquely biblical notion of a physical creation, imbued by its creator with order, regularity and comprehensible natural causes, but fallen as a result of human sin. This may seem to represent the promotion of Western cultural values as opposed to African ones, but the reality is more complex. Modern Western cultures have in fact strayed from the biblical approach, in which God constantly upholds and is sovereign over the operation of physical causes, which are therefore totally open to him, and has moved to a closed materialistic system that entirely excludes him. This

leads inevitably to purely secular medical approaches with no place for prayer, the confession of sin, or simple faith in God.

A faithfully biblical approach would entail a number of things. First, it would mean the pursuit and application of empirical medical responses to prevention and cure, rooted as they are in a biblical understanding of creation. Second, this necessarily implies a vigorous and biblical response to the traditional explanatory framework. On the one hand, this means an insistence that identifying the witch as the generalised source of human suffering is a false and unbiblical approach which actually multiplies human pain through the persecution of suspected witches, as well as the neglect of real causes and cures. On the other hand, it means constantly underlining two critical biblical truths: that the creator God is sovereign over all that he has made, including every occult power; and that the victory Christ has gained over Satan and all the powers of evil through his death and resurrection, has secured the liberation of his people from their grip. *For he has rescued us from the dominion of darkness and brought us into the kingdom of the Son he loves, in whom we have redemption, the forgiveness of sins* (Col 1:13-14). Third, it means stressing the absolutely primary role of human rebellion and sin in bringing disease and suffering into the world.

There is, however, another dimension to be considered, which goes beyond the teaching of truth and seeks to address the common life of God's people. Witchcraft accusations reflect tensions and relational breakdowns in human communities; they breed and multiply in the noxious atmosphere of interpersonal suspicion, animosity, resentment and hatred. For that reason anthropological approaches to witchcraft have often tended to see witchcraft accusation as a major way of articulating and dealing with human conflicts.²⁸ However, while there may be some validity in that argument, such accusations do nothing to heal divided communities but tend rather to make division permanent. They sustain a climate of suspicion, fear and hostility, and all too often lead to violence and even murder. Consequently, a major element of any Christian response to witchcraft belief and accusation must be the pursuit of harmony, forgiveness and reconciliation. "The church must develop methods to deal with the suppressed hostility that spawns and sustains witchcraft."²⁹ God's people need to live out the reality of the gospel, and so to be communities of reconciliation themselves that they are able to function without hypocrisy as light and salt in the wider society. The role of leadership within the church will therefore not only be that of more profoundly communicating

²⁸ M. Marwick, "The Social Context of Cewa Witch Beliefs", *Africa* 22 (1952), 120-35 and 215-33, is a major exponent of this approach. See also M. Marwick, *Sorcery in its Social Setting: a Study of the Northern Rhodesian Cewa*, Manchester: Manchester University Press, 1965.

²⁹ Hiebert et al, *Understanding Folk Religion*, 174.

truth, vital though that is, but also of so fostering a climate and practice of love, forbearance and reconciliation among the people of God that the discourse of witchcraft will simply become redundant.

3. HIV-AIDs and Sin

All illness is “the effluent of the fall, the result of a fallen world.”³⁰ In the case of HIV-AIDS there is often a direct and obvious causal link between moral failure and the onset of disease. This means that a major element of the Christian response lies in communicating how God intends that the good gift of human sexuality should be employed. It is surely true that if sexual promiscuity were eliminated, HIV-AIDS would progressively, and perhaps quite rapidly, disappear. Once again the biblical notion of wisdom is central, the pursuit of a style of life which moves with the flow of God’s creation, rather than behaving in self-destructive defiance of it.

However, HIV-AIDS still shares in the ambiguity that characterises human suffering in general. Thus, faithful spouses or newborn babies may suffer as the result of the wrongdoing of others, while unwitting transfer of the virus may take place through careless use of unsterile needles or the transfusion of infected blood, and so on. To always link HIV-AIDS to a particular preceding sin will in many cases be inappropriate, as well as pastorally disastrous.

In pastoral terms this means that sufferers and their families need care at both the medical and spiritual levels. Counsel is vital, including the sensitive probing of the circumstances which have brought the patient to his or her present condition. In all cases, pastoral support will include prayer, and encouragement that is rooted in the truth of the liberating gospel of hope. In some cases it may mean forgiveness on the part of those who have been terribly wronged by the faithlessness of a partner in the most intimate of human relationships; in other cases it will mean confession of sin and repentance. However, underlying it all there must be an explicit recognition, communication and understanding of the unlimited and transforming grace of God as it is displayed on the cross. The violation of God’s law will may often be the cause of “evil and AIDS”, but it is His grace in Christ that provides the ultimate and uniquely complete response, as it does for all human sin and pain. In this area as in all others the children of God need faithfully to reflect the heart of their Father ‘who did not spare his own Son, but gave him up for us all’ (Rom 8:32). It is the “reckless grace” of the prodigal God which alone offers true hope.³¹ *But while he was still a long way off, his father saw him and was filled with compassion for him; he ran to his son, threw his arms around him and kissed him* (Lk 15:20).

³⁰ Carson, *How Long, O Lord*, 48, quoted above.

³¹ T. Keller, *The Prodigal God: Recovering the Heart of the Christian Faith*, New York: Dutton, 2008, xv.

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Theological Perspective on HIV and AIDS: Summary Statements

Edited by Rich Harrell, Committee Chair

Held 28 May – 1 June 2012 at NEGST/AIU, Nairobi, Kenya

Introduction: We, the assembled believers in Jesus Christ, serving throughout sub-Saharan Africa as pastors, medical workers, community developers and theological educators, participants in the Theological Perspective on HIV and AIDS Conference, thank God for this opportunity to address this issue that has so deeply affected every area of life among the peoples of Africa. We have been challenged in our thinking and in our faith to find concrete ways of founding our actions in sound theology and practical expressions of God's love toward the individuals among whom we seek to serve to God's glory. Therefore, we wish to declare our observations and commitment at the end of our conference.

1) **Grace:** Grace and Peace from God our Father and the Lord Jesus Christ! Grace is a central theme in addressing HIV and AIDS biblically. Having understood the HIV and AIDS situation, the church's first reaction to HIV and AIDS should be of compassion and acceptance, not condemnation. Stigma and judgment are symptoms of a bigger problem – a deficiency of grace in the church's communal life. A lack of awareness of both our sinfulness and the immensity of God's saving grace contributes to this problem. The journey from judgment to grace needs to be made deliberately, one step at a time. Christ's people must extend the grace they have received to the infected and affected and to one another.

2) **Practical Theology/Pastoral Circle:** Practical Theology means presenting the Gospel in ways that are relevant to the life of the people with whom the church is in relationship. This is crucial. The Pastoral Circle is a tool used in this regard and involves identifying and analyzing practical problems/experiences encountered by the church, reflecting biblically upon them, and then responding wisely, holistically, and effectively. Practical theology should be contextual, communal, gender sensitive, and open to informal expressions (such as prayer, music, drama, and dancing) in addition to formal ones.

3) **Christology/God's Character:** Our attitude towards the sick and marginalized in society (such as those with HIV and AIDS) should be the same as Christ's, who was full of grace, compassion, mercy, and love. Jesus was most critical of the hypocrites and the judgmental but 'a friend to tax collectors and sinners' (Mt. 11:19). The parable of the Good Samaritan (Luke 10) illustrates His character. Teaching and endeavors in HIV and AIDS ministries must be grounded in a thoroughly biblical theology.

4) **Family priorities:** Biblical principles of marriage and parenting must be taught in the church and modeled in the lives of believers. Our God-given priority is to our spouse and children. Children need the love, teaching, and mentoring of their parents in order to be able to avoid many of the traps that lead to a life-style that is prone to HIV and AIDS.

5) **Behaviour change:** Changing sinful attitudes and behaviours necessitates courageous biblical teaching about taboo issues, such as sex, combined with godly role models. With behavior issues it is helpful to ask, "Why are you doing this?" or "What does it mean?" People need to understand what is at the root of their behavior and take ownership in changing it. We must all remember that Christ through the work of the Holy Spirit in the believer's life is the one who performs the internal transformation necessary to bring about behaviour change. Authentic transformation results in repentance, forgiveness and reconciliation.

6) **Gender issues:** Each gender has its own distinct and equally challenging issues when facing HIV and AIDS, so a unique and yet balanced approach is required for both sexes.

7) **Church's response:** A helpful progression in responding to HIV and AIDS involves sensitizing the congregation towards HIV and AIDS; mobilizing its people; advocating for those infected with and affected by HIV and AIDS; and building capacity, policies, and strategies that lead to intervention programs. The church, and in particular its leadership, need to receive training on HIV and AIDS and need to interact with those infected. Practical HIV and AIDS training should be integrated into theological education at Bible colleges and universities. The church has a biblical mandate to live out care and concern for widows, orphans and vulnerable children. The response of the church has been too often judgmental, anemic, or cautious, but it must change and become gracious, wholehearted and holistic.

8) **Opportunity:** HIV and AIDS should be seen as an opportunity rather than a burden for the church. God often uses adversity to draw us to Himself. The church should be a place of refuge where people want to come in their time of need. It provides a unique opportunity for the church to display Christ's love and to pursue increasing conformity to the image of Christ. "If the church of Jesus Christ rises to the challenge of HIV/AIDS it will be the greatest apologetic the world has ever seen!" (Theologian Ravi Zacharias)

Conclusion: Therefore, in light of our faith in Jesus Christ and our commitment to call people from among all the Gentiles to the obedience that comes from faith, we resolve to implement the recommendations in these summary statements and to encourage other believers to join us and instruct them in the implementation of these principles and practices by God's grace and through His power for the glory of name in this world and the next.

Resources and Books

Adventure Unlimited is produced by Family Impact, which has been in Kenya since 2002. It runs programs such as Adventure Unlimited; Choose Freedom; Radical Relationships; Enjoy Your Marriage; Positive Parenting and has a major emphasis in Prefect Leadership Training. These programs respond to the issue of HIV and AIDS by spreading the supremacy of God in family life and relationships.

Family Impact, PO Box 7552 – 30100, Eldoret, Kenya

<http://www.familyafrica.org>

info@familyafrica.org

Africa Resource: Visual Tools for Africa

The purpose of Africa Resources is to create low-cost videos that are useful for training church leaders and members in areas that would make them effective in responding to issues of African life that cry for the transformation of Christ. These films may be done in collaboration with other agencies, training institutions, and churches which are able to market and use the films at a grass-root level. Training guides will accompany the videos. www.africaresource.org

info@africaresource.org

Christian AIDS Bureau of Southern Africa (CABSA) is a caring Christian community ministering reconciliation and hope in a world with HIV that guides and supports Christian communities towards HIV competence through advocacy, information services, training, mobilising and networking. – www.cabsa.org

MAP International has many resources for dealing with various aspects of AIDS ministry including, "Choosing Hope: The Christian Response to the HIV/AIDS Epidemic: Curriculum Modules for Theological and Pastoral Training Institutions". This practical guide was created to facilitate the training of pastors in the use of God's Word to address HIV/AIDS.

MAP International, P.O. Box 21663-00505 Nairobi, Kenya. Ph: (254) 20 3864481

Strategies for Hope

Strategies for Hope is a series of booklets, videos and a training package on HIV/ AIDS prevention and care, mainly in sub-Saharan Africa. The video titles include: *The Orphan Generation*, *Under the Mupundu Tree*, *Open Secret*, *Stepping Stones Revisted*, and *What Can I Do?*

Strategies for Hope Trust, 93 Divinity Road, Oxford, Oxon OX4 1LN, UK

Tel: +44 (0) 1865 723078

www.stratshope.org/ sfh@stratshope.org

True Love Waits (Youth for Christ) challenges teenagers and college students to make a commitment to sexual abstinence until marriage. Created by LifeWay Christian Resources, *True Love Waits* encourages moral purity by adhering to biblical principles. This youth-based international campaign utilizes positive peer pressure by encouraging those who make a commitment to refrain from pre-marital sex to challenge their peers to do the same.

<http://www.lifeway.com/Article/true-love-waits>

truelovewaits@lifeway.com

Why Wait? - Youth for Truth Curriculum

This Bible based curriculum, edited by Dick Day, is for schools from primary 5 to the end of high school. It is produced by Sub-Saharan Africa Family Enrichment (SAFE), a local faith-based non-governmental organization (NGO) in Malawi and addresses the HIV/AIDS pandemic. At the request of the Malawi Ministry of Education, in 1994 it developed a life skills curriculum, *Why Wait?*, for government primary and secondary schools throughout the country. Schools using *Why Wait?* have greatly reduced dropout rates due to pregnancy and/or early marriage.

<http://www.whywaitafrica.com/index.html>

day-safe@chanco.unima.mw

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Africa Journal of Evangelical Theology

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***Africa Journal of Evangelical Theology* 31.1 2012**

Printed by Kijabe Printing Press
P.O. Box 40, Kijabe, Kenya