Into the Sunshine

Integrating HIV/AIDS into Ethics Cuirriculum

Edited by

Charles Klagba

C. B. Peter

Integrating HIV/AIDS into Ethics Curriculum

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Integrating HIV/AIDS into Ethics Curriculum

Proceedings of the EHAIA-WCC "HIV/AIDS and Ethics" Workshop Held at Porto Novo, Benin, October 4-8, 2004

Edited by
Charles Klagba
C. B. Peter

Zapf Chancery
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PREFACE

Introduction to the Workshop Series and the Porto Novo Workshop

Background

For two years now there has been a series of workshops taking place at theological training institutions across Africa. These workshops aim at training the trainers on the issues of HIV/AIDS in order to integrate the HIV/AIDS issues in the theological programme. Skills are provided for these institutions to mainstream HIV/AIDS in their curriculum. As a result, Churches have begun to free themselves from their uneasiness to talk about this tragedy that is endangering the future of our continent.

The small but significant initiative of holding these workshops could be compared to the "sowing of the mustard seed". Now we needed to "water" the seed and make it "grow" in the places that benefited from this training, and to continue to sow more seeds in other places.

Consolidation of the Gains

For the period from September to December 2004, my aim was to start consolidating the gains from the previous workshops. I suggested three fields of work with the theological institutions at the continental level.

- Ethics and HIV/AIDS
- Pastoral Care and HIV/AIDS

- Christian Education and HIV/AIDS

The Ethics Workshop at Porto Novo

The main objective of the workshop was the exploration of viable strategies for a Christian ethics in the era of HIV/AIDS in the African context.

A. Implementation:
The main objective was achieved by gathering lecturers and scholars in Ethics from across the continent in a workshop of four or five days with the challenge to see how in a concrete way the Churches could tackle the issue of HIV/AIDS from ethical perspectives in a manner that would go beyond the approach of condemnation and stigmatisation.

B. Objectives:
The main objective of the workshop was paraphrased as follows for the ease of tackling it:
To produce tools of reflections as references on how to speak and to deal with the challenge of HIV/AIDS in the areas of:

- Prevention
- Pastoral care
- Treatment

These tools must be practical and easily usable not only in theological institutions but also in church communities by pastors, lay trainers (women's leaders, youth and Sunday schools).

C. Participants
Twenty to twenty-five professors in Ethics (women and men) from theological institutions across the continent were invited to the workshop

- Southern Africa: 5
- Central Africa: 5
- Western Africa: 5

- Eastern Africa: 5

D. The Workshop

The workshop had three main articulations:

First articulation: **The harvest of ideas**

1. One medical doctor specialist on HIV/AIDS gave factual information on the pandemic with its social consequences

2. One person gave a paper on the ethical issues from philosophical perspectives taking into account the African context.

3. One participant from each region gave a paper on the topic taking into account the cultural dimension (traditional values, gender issues) biblical and theological dimensions. The papers suggested concrete possible ways of dealing with HIV/AIDS in Theological trainings as well as in church community levels.

Each presentation lasted 90 minutes maximum followed by one-hour debates.

NB: We thought that It would be appreciable to have at least one paper presented by a catholic theologian.

Each presentation was in a written form and possibly publishable.

Second articulation: **Confrontation**

Participants first, in regional groups, and then in mixed groups, confronted ideas and approaches shared in the different presentations.

Third articulation: **Elaboration of tools**

Participants at this last stage designed tools that could be used as signposts in dealing with HIV/AIDS.

E. Date: 04-08 October 2004

F. Venue: Institut Protestant de Théologie de Porto-Novo (BENIN)

G. Publication: First Term 2005

H. Translation:
The workshop was bilingual: English and French. Translation services were provided.

So here is the book embodying the proceedings of the Porto Novo Workshop. I gratefully acknowledge the generous sponsorship of the Ecumenical HIV/AIDS Initiatives in Africa (EHAIA) and the World Council of Churches (WCC) to publish this book. I am further grateful to M/S Zapf Chancery Research Consultants and Publishers, PO Box 4988, Eldoret, Kenya and especially Rev. C. B. Peter, Senior Publishing Consultant, Zapf Chancery, for undertaking to edit the book and providing the publishing consultancy to produce the workshop proceedings in book form.

I hope that theological institutions and individuals involved in HIV/AIDS education across Africa, will find this book helpful in the Training of Trainers (ToT) and also in in the integration of HIV/AIDS into the ethics curricula.

Rev. Charles Klagba,
Theology Consultant,
Ecumenical HIV/AIDS Initiatives in Africa (EHAIA),
World Council of Churches.

Easter 2005

Introductory Address

(Translated from French)

By Rev. Charles KLAGBA

EHAIA Theology Consultant

Dear brothers and sisters in Christ, I would like to start this introductory address with a series of thanks.

If this seminar is taking place today it is due to the action of three persons namely the Dean, the Directors of Academic and Financial affaires of the Protestant University of West Africa. In spite of all communicational difficulties we encountered, you were so wonderful in the organisation of this seminar. Though you were occupied at launching the new academic year of your university, you really got commit yourselves to the effective realisation of this seminar. For all this engagement and for many other things, thank you very much.

My special thanks are all channelled towards you, participants, who honour us by your presence, as well as all contributors who will enlighten and highlight out reflections. I'm very much delighted by the president of the Protestant Methodist Church of Benin at this opening ceremony and this is a testimony that the struggle against HIV/AIDS depends on the degree of commitment of African church leaders.

I want to thank all of you present today.

In a context of global crisis, the Church, bearer of an extraordinary message, a message qualified as Good News; the Church that proclaims to all the fullness of life and life in abundance in Jesus, is challenged.

The Ecumenical Initiative for the struggle against HIV/AIDS in Africa was launched by the Ecumenical world to empower churches at becoming more competent in the issue and stimulate them at creating a welcoming atmosphere for those living with HIV/AIDS, as well as fighting against the spread of the virus in communities and society.

For two years now there has been series of workshops taking place with theological training Institutions in Africa. These workshops aim at training the trainers on the issues of HIV/AIDS in order to integrate the HIV/AIDS issues in the Theological programme.
The "sowing of the mustard seed" happened. Skills are provided for these Institutions to mainstream HIV/AIDS in their curriculum. Churches begin to free themselves from their uneasiness to talk about this tragedy that is endangering the future of our continent.
Now we need to "water" the seed and make it "grow" in the places that benefited from these trainings and to continue to sow more seeds in other places.

The present seminar is aimed at reflecting in one of the fields that greatly concern the church: the Ethical perspective.

What paradigms for a Christian ethics in the era of HIV/AIDS and in the African context?

I mean by Ethics the " theory" of action that a human being must undertake to handle life and reach happiness.

As African Churches, what is our message to foster the struggle against HIV/IADS? What are the ethical orientations and principles that should inspire and guide our actions?

What should do or should not do to overcome HIV/AIDS? I know however, that many churches have clear ideas about this issue, even if these ideas are not efficient on the ground in the struggle against the pandemic.

I can affirm – without risk of contradiction – that the HIV/AIDS pandemic has set all humanity in danger, and the African continent is most exposed.

These questions are very simple in their formulation but answers are not really easy to articulate.

Just as in philosophical field, there are many ethical approaches in theological discourses seeking as well a common object: Happiness as the target of the ethical reflection.

Ethics is a very explosive theme in our churches today; and however explosive it might be, we have no right to elude this issue.

I am convinced that it exists convergence areas for African Churches. Founded on this conviction, you, lecturers or scholars in Ethics from the continent are gathered in this workshop with the challenge to see how in a concrete way can Churches tackle the issue of HIV/AIDS from ethical perspectives in a manner that goes beyond the approach of condemnation and stigmatisation.

Dear participants, we are here in a laboratory to carry out applied research. For theology to become efficient, it should not de reduced to an intellectual exercise amongst ourselves, it has to be translated into the realities of ecclesial life and in the existential realities of our societies.

The objective this workshop is to produce tools of reflections as references on how to speak and to deal with the challenge of HIV/AIDS in the areas of:

-Prevention

-Pastoral care

-Treatment

These tools must be practical and easily usable not only in Theological Institutions but also in church communities by pastors, lay trainers (women's leaders, youth and Sunday schools).

The research work in our laboratory will have three main articulations:

First articulation: The harvest of ideas

1-One medical doctor specialist on HIV/AIDS gives factual information on the pandemic with its social consequences

2-One person gives a paper on the ethical issues from philosophical perspectives taking into account the African context.

3-One participant from each region gives a paper on the topic taking into account the cultural dimension (traditional values, gender issue) biblical and theological dimensions. The paper must suggest concrete possible ways of dealing with HIV/AIDS in Theological trainings as well as in church community levels

Second articulation: Confrontation

Participants first, in regional groups and then in mixed groups will confront ideas and approaches shared in the different presentations.

Third articulation: elaboration of tools

Participants at this last stage will design tools that can be used as signposts in dealing with HIV/AIDS.

Dear participants, the challenge is now in front of us: to better equip our Churches in the struggle against HIV/AIDS.

This mission is a response to our call as Christians and it is carried out in partnership God, this God who is capable of fulfilling all what we do not hope for or anticipate.

Thank you!

Contents

Part One
Presentations

PREFACE.....5
INTRODUCTORY ADDRESS by Rev. Charles Klagba.....9
KEYNOTE ADDRESS.....19
by the Commissioner Rev. Canon Gideon Byamuhisha
CHAPTER ONE: The Epidemic of HIV/AIDS: A Medical Apprisal.....35
by Dr. Bertin Affedjou
CHAPTER TWO: Ethics and HIV/AIDS: A Philosophical Perspective.....49
by Prof. Christophe Kwami Dikenou
CHAPTER THREE: Ethics of Prevention 57
by Rev. C. B. Peter
CHAPTER FOUR: Pastoral Care and HIV/AIDS: An Ethical Imperative.....69
by Fr. Dr. Vincent Nyoyoko
CHAPTER FIVE: Ethics of Breaking the Stigma: African, Biblical and Theological Perspectives.....91
by Dr. Joseph B. R. Gaie
CHAPTER SIX: Can We? Or Can't We?: A Christian Reflection on Ethical Dialectics in the Context of PLWHA.....113
by Rev. C. B. Peter
CHAPTER SEVEN: Gender and Ethics in the Fight Afainst HIV/AIDS.....131
by Dr. Prscille Djomhoue

Part Two
Curriculum Development: Suggested Modules on Christian Ethics and HIV/AIDS

1. Ethics of Prevention.....147
(French Speaking Group)
2. Ethics of Prevention.....149
(English Speaking Group)
3. Ethics of Prevention-2.....153
(English Speaking Group)
4. Ethics of Quality Care 155
(French Speaking Group)
5. Ethics of Quality Care 159
(English Speaking Group)
6. Ethics of Quality Care-2 163
(English Speaking Group)
7. Ethics of Breaking the Stigma.....165
(French Speaking Group)
8. Ethics of Breaking the Stigma 167
(English Speaking Group)
9. Ethics of Breaking the Stigma-2 171
(English Speaking Group)
10. Ethics of PLWHA Involvement.....173
(French Speaking Group)
11. Ethics of PLWHA Involvement.....177
(English Speaking Group)
12. Ethics of PLWHA Involvement-2 181
(English Speaking Group)
13. Gender, Power, and Ethics in the Struggle Against HIV/AIDS.....183
(French Speaking Group)
14. Gender, Power, and Ethics in the Struggle Against HIV/AIDS.....185
(English Speaking Group)

15. Gender, Power, and Ethics in the Struggle Against HIV/AIDS-2.....189
(English Speaking Group)

Appendixes

1. The Rector's Speech of Welcome.....193
2. The SAVED Model to Combat HIV/AIDS.....197
3. Summary of Keynote Address.....199
4. Additional Indicators.....201
5. A Song Taught by Canon Gideon Byamugisha.....203
6. Certificate of Participation.....205
8. The Workshop Programme.....207
9. Guidelines for Group Work.....209
7. List of Participants.....215
11. List of Contributors.....219

Part One
Presentations

KEYNOTE ADDRESS

Ethics, Religion, and HIV/AIDS

What Propels Us as Christians & Churches to Involve Ourselves in HIV Prevention, AIDS Care, and Advocacy & Partnership Building?

Commissioner Rev. Canon Gideon Byamugisha
Church/FBO Partnerships Advisor
HIV/AIDS Hope Initiative
World Vision International

Introduction

We now know many basic facts about HIV and AIDS although we know also that we have much more to learn as research continues, and personal experiences from a variety of people are shared. The pandemic of HIV/AIDS seems to have raised more questions than answers. Many of these questions need deep soul-searching and critical reflection than straitjacket answers and quick fix solutions.

In this keynote address I have chosen to present to you some of these burning questions rather than lecturing you on what should, or should not be done. I believe that when a group eminent ethicists, theologians, and church leaders, such as are present at this workshop, reflects on these questions, something worthwhile will emerge as

we grapple with the ethical dilemmas caused by HIV/AIDS and seek ethical responses to the dilemma.

My cardinal question is whether what we know about HIV/AIDS is being religiously and accurately shared for purposes of preventing new HIV infections and for promoting Care and Support of those who are living with or personally affected by HIV and AIDS?

Are we honestly, courageously, and realistically grappling with the questions and dilemmas this new reality of HIV and AIDS poses?

What more can we say? What more can we be? And, What more can we do both as people of faith and as institutions of higher learning?

The First Dilemma

For many of us, the fact that HIV/AIDS is **our** disease as individuals, families, local communities (places of worship, work, education, entertainment, residence and business), nations, religions and as the global family, may still be difficult to accept fully.

Because the disease was reported to have spread first among homosexuals, injecting drug users, prostitutes and other people we label as "sexually promiscuous," many of us still see HIV/AIDS as **other people's** disease. It may not take long for an attentive hearer among our audiences to hear elements of prejudice, judgment and intolerance in some of our speeches, sermons and reactions, which unfortunately reflect and betray the misconceptions, prejudices and inaccuracies that still surround this epidemic.

Beliefs about the Gravity of the Situation

Many of us have yet to come to terms with the extent of human suffering that this pandemic has brought and continues to bring. Some of us sincerely believe that the suffering will be short-lived and limited to a few of our people who refuse to listen to our sermons about changing behaviour— the drug addicts, the prostitutes, the adulterers and the fornicators.

Once these miscreants have served their punishment to the full (as some of us believe) and have been blotted out of our families and local communities, the battle will be over.

Unfortunately, there is the constantly growing number of infected people—far beyond the predicted estimates. Many faithful people are infected throughout unprotected sex with their unfaithful partners, while many innocent ones are infected through infected blood transfusion, skin piercing, ceremonial mutilation, and cultural practices like widow inheritance, and wife-sharing, etc. Then there are hundreds of thousands if unfortunate babies who get infected either prenatally, or through feeding on their infected mother's milk. All this does not seem to lend credence to the belief that HIV/AIDS is God's punishment to the sinners.

We must also recognize that there could be a statistically significant difference between people '**refusing**' and those '**failing**' to change from risky to non-risky behaviour in their sexual, social, cultural, economic and health care settings. Thousands of people might still be ignoring the new information, skills, attitudes, services and other support systems and mechanisms available at their disposal (at all levels of our society) to enable them make and take informed decisions, actions and choices.

Researchers stress that we have not yet seen the full impact of HIV/AIDS, which is still spreading with astounding rapidity and arrogance amidst our simplistic, individualistic, and confused responses to it.

If one individual's suffering is extreme, *(like my own experience of living with the disease has shown)* the cost to the total human society could be far immense.

In many of our countries, a generation of young adults is dying before its time, leaving many children orphaned at a time they need their parents most and leaving whole communities/ countries without both experienced and new leaders in business, politics, education, agriculture and security.

In many of our communities and countries, our health care system (already strained by poverty, civil war, malnutrition,

tuberculosis, malaria, measles, and other preventable diseases) cannot cope any more with the ever growing menace of HIV/ AIDS due to the excessive demands on its financial, technical and medical resources as the number of people in need of health and treatment continues to double, triple and quadruple.

Only with a sober, courageous and critical understanding of the basic facts and grim realities surrounding this disease of HIV/ AIDS, can we begin to design task-focused, inclusive, participatory and sustainable responses that are multisectoral, multilevel and multidimensional in nature, and impactful in results.

No Quick Fixes, No Room for Complacency

The HIV/AIDS disease raises many medical, social, spiritual and political questions at individual, family, local community, institutional, national and global level, all of them with profound implications to our religion beliefs, practices and morality.

Sex and Marriage

The first cluster of these moral and ethical questions focuses on sex and marriage.

- In a situation where millions of people are already HIV positive (most of us unknowingly and unshowingly); should our friends, daughters and sons, uncles and aunts marry or initiate sex without undergoing proper counselling and testing for HIV? What happens if in the whole local community, village, county or district; there is nowhere one can access this type of service?

- Should the re-election of our local community and national leaders be tied to their ability to provide such services for voluntary HIV Counselling and Testing? What happens if, despite the availability of these services, our sons and daughters, uncles, aunts, and ourselves choose not to utilize them?

- What should we say to or do for a potential couple that goes for the HIV Test and one or both of them test HIV positive?

Sex before or outside of Marriage

- Given the reality and high degree of HIV infection and transmission through unsafe sex (i.e. sex where one, or both, of the partners is already positive), what do we say and do for those people in our churches, mosques, temples or in our places of work, education, entertainment orbusiness who for one reason or the other and against our teaching on sexual sanctity in marriage and celibacy out of it either fail or refuse to refrain from their sexual exploits with our daughters, or sons, uncles, aunties, wives and husbands?

- Is mere talking enough, or should we advocate for some legislation against those having 'unlawful' and 'unsafe sex', that may lead to transmitting the HIV Infection?

- But even among legally married spouses (or cohabiting partners) should the choice of practicing or not practicing safe sex (i.e.HIV testing, remaining monogamous with mutual knowledge of HIV negative status of both spouses; using undamaged, unexpired condoms correctly and consistently for all sexual acts that involve penetration, guarding against other routes of infection and transmission) be left to the personal discretion of individual partners or should this be enforced?

HIV Infections at Birth

- Should HIV positive mothers become pregnant or should they postpone until they are able to access prevention of Mother-to-Child Transmission services and information?

- Should some of our faith leaders who are against scientific contraception with condoms or other means allow it to prevent a possible HIV infection among those who are HIV sero-status blind?

- Given the significant HIV transmission risk in breastfeeding; should an HIV positive mother who happens to give birth to an HIV negative baby breastfeed? What should be done in those cases where the family cannot afford alternative breast-feeding or fears to be seen not breast-feeding?

- When children are born with HIV, what is their proper treatment? What happens when a family cannot afford such treatment? What about cases where a family can afford such treatment but chooses not to because there are other pressing needs the family has to attend to?

- Should individuals, families, local community, national, regional and global leaders be held legally responsible for deaths that could have been prevented through introducing cost-effective HIV prevention policies and programs?

- To what extent are family members, local community leaders, national and global leaders legally bound to provide quality care, treatment and support to all those infected and affected by the HIV/AIDS because of their parents' HIV Infection?

HIV Positive Persons

- What are the moral obligations and responsibilities of HIV positive persons concerning their sexual and other behaviour that could put others at risk of infection?

- What should we say to, or do for, those HIV Positive people who refuse or fail to;

a) Know or acknowledge their HIV status,
b) Stop having sex,
c) Adopt safer sexual, social and health care related practices that could minimize transmitting the virus to others?

If one finds out his or her HIV status to be positive, should they be encouraged or compelled to inform a previous or current sexual partner(s)?

- What about friends, employers, personal doctors, barbers and parents? Should they be informed? And when they know; do they have a right or a responsibility to share this knowledge with others who could be put at risk by the unsafe behaviour of the HIV positive person?

Preventable, Postponable & Inevitable Deaths

- What is our individual and collective responsibility—as families, local communities, institutions, international bodies and as global leaders—for deaths that could have been prevented or postponed but have happened due to our silence, stigmatisation of the disease (and the people living with it) and our insufficient action?

- How much pain must be allowed or endured before a single death happens finally? Is there a ceiling or a limit to the use of resources in prolonging lives of sick persons beyond which individuals, families, local communities, institutions, nations and global leaders can be exonerated from further expense?

- What do we say or do to healthcare professionals, including physicians, medical students and nurses who refuse or are very reluctant to treat AIDS patients partly because they fear for their own health, or because they feel that treating them would be a waste of resources & energy for someone who is going to die anyway or because they wrongly feel treatment would interfere with the course of God's punishment?

HIV Testing

- Given that millions of people are already HIV positive and do not know it; does the common good of society demand that all of us test for the HIV virus?

- How would we fund and manage the practicalities of such a policy?

- If a religious, local community, national leader or educator has not yet tested for HIV/AIDS; does he or she have any moral authority to speak against those who may be spreading the virus, given that the leader may unknowingly be both infected and spreading the virus himself or herself through sexual intercourse with the spouse, breastfeeding or donating unscreened blood?

- How do we apportion blame to individuals for particular HIV infections or transmissions given the fact that even the most personal decisions or certain courses of action have to be viewed in their socio-economic, religious, cultural and political contexts?

Human Structures, Relationships and Organization

- What do we say and do about our social, economic, cultural, religious, political and business structures, relationships and organizations at local, (community, institutional), national and global level, which facilitate and contribute to the continued spread of HIV/AIDS?

- What do we do to get resources when there is not enough money or people to treat every disease or to do everything for every person, family, local community or nation?

- What do we say and do about the glaring disparities concerning resources, incomes, services and information between and within communities, countries and continents?

- What do we say and do to people who passionately, affectionately and most sincerely espouse and defend ideas, views and convictions that are at best misleading and at worst dangerous as far as HIV Prevention, AIDS Care, Impact Mitigation and Advocacy are concerned?

- In all these questions, who decides what action to take and by what values, norms and authority do they decide?

Widely Held but Misleading Messages and Views

The ABC message is the most common and frequently heard message on HIV/AIDS prevention. While this is so; it is a markedly superficial and inadequate message in responding to the immense challenges of controlling the epidemic.

Its failure to identify, point out and address the socio-cultural, economic and political factors underlying the spread of the epidemic should be a concern to all of religious leaders and people of faith.

The message has led to an overwhelming concentration on sexual behaviours and certain assumptions about them—with an almost exclusive focus on the individual for modifying these, without concomitant concern for influencing their structural determinants at family, local community, institutional, national and global level.

- Does what is 'lawful' necessarily translate into what is 'safe'?

- Should we talk about High-risk behaviours only or about High-risk environments too?

- To what extent are we prepared as people of faith to see the current epidemic in Africa not just as a result of some sinner refusing to change his or her behaviour (never mind that

many try to change and fail) but as a disease inextricably linked to socio-economic, cultural, and political factors, both current and historical, on the continent?

- To what extent are we willing to interpret the "**you**" in the scripture's "**if you obey**" to mean individuals, families, local communities, institutions, nations and the global human family?

- To what extent are we prepared to address the other HIV/AIDS transmissions that happen through other modes other than sex but which in the end multiply themselves through sex?

- Have we as people of faith studied the impact of economic recession, the debt crisis and the internal and external measures introduced to avert these crises on the transmission, spread and control of HIV/AIDS in Africa?

Prevention Measures, Religious & Public Attitudes

Discussion of education about and supply of condoms among sexually active populations and programs for the distribution of free needles for IV drug users have continued to evoke heated emotions, debates and controversy.

- What is our response to the commonly held beliefs that promotion of condoms and safe needles will increase promiscuity and drug abuse?

- What about the not common debate that condoms will not make unsafe sex safe but only less risky?

- What do we say about the irrational denial of vulnerability to HIV/AIDS that is so common among people who consider themselves '**too religious,'** "**too old**", "**too young**", "**too faithful**" or "**too respectable**" to catch or transmit HIV/AIDS?

- How do we reconcile the divergent views held by people of faith in reference to discordant couples living with HIV/AIDS? These views are represenred by the following statements:

"The mutual surrender and indefinite postponement of sexual union can nourish and strengthen a marriage symbolically, psychologically and spiritually."

"The consolation and intimacy of protected sex may be crucial to their psychological, emotional, social and spiritual functioning when one or both of the spouses is/are infected with HIV/AIDS?

- Could love, compassion and personal example be better recipes for virtue than moral interdicts full of "**Dos**" and "**Don'ts**?" when it comes to issues of sexual morality and conduct?

- Could there be differences between exhortations for sexual purity and those for increasing public health & safety or are they the same?

- Is there a difference between **"lawful"** and "**safe**" practices or is what is lawfully done necessarily and automatically safe?

Some one once said "*I think religion and religious believers are having a really hard part in HIV/AIDS*."

- What did she mean?
- To what extent was she right or wrong?

By virtue of the incarnation, is it possible that the image of God is in each person regardless of who they are and what they did or didn't do to become infected?

Could preventing HIV/AIDS infections by utilizing all the information, skills and resources available be counted among the list

of "*whatever you did to the least of my brethren, you did it to me?"*

Treatment

As religious believers and people of faith, we need to raise and answer the following questions:

- Do patients have an obligation to seek early treatment to protect sexual contacts and reduce the social and economic costs of treating Advanced AIDS?

- Families, local communities, institutions and nations have a similar obligation to provide such treatment-opportunities and services as are necessary to reduce the impact of HIV/AIDS in the individual and his/her society? What are their ethical and legal responsibilities if they do not?

- Is The potential good from treatment is of such importance that routine and universal HIV Testing becomes imperative for individuals, hospitals and nations among whom HIV/AIDS is highly prevalent?

- Who should pay for the AIDS treatments since most of the people living with HIV/AIDS are unable to pay for their monthly doses for the rest of their lives?

- Do drug manufacturers have a moral responsibility and obligation to reduce or forego profits in the interests of the needs of AIDS patients?

- Should we adopt a strictly utilitarian approach of "**the most care for the most people**" and allocate our resources to other purposes or should AIDS drugs be made available at public expense to all without discrimination?

- What is the ethical obligation of society and patients to health professionals?

- How do we provide for the psychological "**burn out**" among health workers, counsellors and homecare providers?

- Do physicians and other health care professionals have a moral claim for mandatory testing of patients so as to evaluate the amount of potential risk with a particular patient in case of an accidental needle prick?

- How do we balance the patient's strong moral claim to confidentiality and autonomy against the welfare of health care providers?

- Given the fatal nature of AIDS and the suffering of people living with it; is less vigorous testing criteria for experimental drugs ethically justifiable for deaths to be prevented *or delayed?*

- How do we deal with the fact that over 2/3 of all the people infected with HIV/AIDS live in Africa but less than 13% of the global resources spent on the disease are spent in Africa?

- What is the duty and obligation of employers towards the treatment of their workers' HIV infection and in ensuring that their rights of confidentiality, employment, and non-discrimination are protected?

Vaccines Research

- Supposing there was a vaccine that turned out to be effective, how would the manufacturers deal with the issue of its cost for the world's poor?

- When we talk of a vaccine that protects people; what do we actually mean? Preventing people from infection? Or from the disease?

- How should researchers measure the success or failure of a vaccine research given that waiting to use progression to AIDS as a measure of failure would keep trials running for many years due to the slow course of the disease?

- How do we ensure that the vaccines meet internationally agreed safety standards and that countries conducting trials have policies for AIDS research and a system of health care that provides advice, counselling and medical treatment as well the testing the vaccine?

Chronic Depression and Risk of Suicide among PLWHA
Although social discrimination and self-stigma seems to be waning; persons living with HIV/AIDS are frequently depressed and, in some cases, develop suicidal ideas and murderous tendencies. How do we eliminate the social discrimination and self-stigma that increases the risks of chronic depression among PLWHA?

Women & HIV/AIDS

HIV/AIDS tends to present critical fertility, reproductive, social economic and gender issues for women.

- How do we deal with those in a task-focused and results-oriented manner?

- Do HIV positive women have a right to be pregnant?

- Should women intending to be pregnant be subjected to mandatory testing as a measure to safeguard the baby?

- With most illnesses, it is the mother who assumes the caregiver role in the family; what happens when it is the mother herself who is sick and in need of care?

- How do we ensure that HIV positive women have the same support systems and sense of community and belonging to as the HIV positive men usually get?

- How do we deal with mothers with infected babies who may suffer from a tremendous sense of guilt and grief about infecting their children?

- How do we help HIV positive women, who don't have children, to deal positively with the loss of their childbearing potential in places where PTMCT Programs are not yet in existence?

- How do we handle the public attitudes that look at women more as "**infectors**" than as "**infectees**"?

- How do we deal with the largely popular "ABC" HIV Prevention messages that seem to be more stigmatising than helpful to the majority of women?

Conclusion

It is indicated from the above range of questions and unresolved issues that the HIV/AIDS epidemic confronts all people of faith with many difficult questions.

In answering these questions raised by HIV/AIDS we should be motivated by four urgent Religious imperatives:

- To show God's love for neighbours
- To save lives by preventing disease, managing illnesses and preventing (or where possible) postponing deaths.
- Working for reconciliation among people at all levels of our society.
- To see that justice is done at all levels of our society/global family.

All this would requires that we

- Gather the latest and most accurate information on the disease,
- Wrestle with deeply sensitive issues weighing differing and sometimes conflicting views and interests.
- Harness the power of discernment, under-girded by religious study, prayer and theological/pastoral reflection.
- Apply the distinctive character of eeligious ethical reflection, which treats every person as of infinite value irrespective of age, social status, sex, race, gender, etc.

Since ethics is a systematic study of moral reasoning in theory and practice, since it seeks to clarify questions about "**wrong**" and "**right**" while at the same time demonstrating their complexity; the reasoning and the convincing must of necessity be task-focused and informed.

For people of faith in general and for the universities in particular, entry into the ethical dialogue on issues raised by HIV/AIDS requires a comprehensive knowledge of basic ethical principles, a grasp of the personal, social, economic and political dimensions of the problem and clear scientific and technical information.

Societies and people affected by HIV/AIDS have burning questions and are faced with moral dilemmas and the people of faith in higher institutions of learning are being looked to for moral guidance in these questions and dilemmas.

Shall we, the people of faith, take the opportunity, rise to the occasion and contribute to seeking badly needed answers and

CHAPTER ONE

The Epidemic of HIV/AIDS: A Medical Apprisal

Bertin Affedjou

I intend to make this presentation according to the following plan:

- First Part: Spatial and Temporal Distribution of the HIV Infection
- Second Part: Ways of Transmission, Clinical Observations and Prevention
- Third Part: Conclusion

First Part: Epidemiology of HIV: Spatial and Temporal Distribution

Definition of Concepts

- HIV: Human Immunodeficiency Virus
- AIDS: *Acquired Immune Deficiency Syndrome*: The ultimate state of the infection comes around after ten years of the evolution of the sickness and it encompasses a certain number of pathological conditions known as opportunistic infections.

- Characteristics: Pandemic

HIV/AIDS: A worldwide major problem of Public Health

- Beginning of the Epidemic/pandemic: in the 70s/80s
- First targets affected:
  - Homosexuals and bisexuals of America, Australia and Western Europe.
  - Men and women with multiple sexual partners of the Caribbean, and the Central and Eastern Africa
- Further targets: Users of intravenous drugs and their sexual partners
- 1990: Explosion of the Epidemic
- Nowadays: Spread in all countries with tragic social and economic consequences, with disastrous effects on health systems.

SITUATION IN THE WORLD AND IN AFRICA – 1

UNAIDS / WHO 2003 ESTIMATES are as follows:

- 40 million people living with HIV worldwide out of which 26.6 million live in sub-Saharan Africa (approximately 70% of the worldwide total).
- 5 million people have been infected with the virus during 2003 out of which 3.2 million live in sub-Saharan Africa.

Situation of HIV in the world

- In USA, in Australia and in Western Europe, the situation of the pandemic has stabilized with decreased incidence of the sickness.

§ In Eastern Europe and Central and Eastern Asia, the pandemic is on rapid rise (1/5 of PLWHA are found in Asia).
§ Sub-Saharan Africa is by far the most affected continent and it contains the 2/3 of PLWHA (1 adult out of 12 is PLWHA in Africa).

Situation of HIV in Africa

§ Starting Point: East and Central Africa (Kenya, Malawi, Rwanda, Zambia and Zimbabwe).
§ Today the prevalence in the above countries is estimated at more than 10% and sometimes 40% with pregnant women in urban areas.
§ Prevalence consultants IST or TS estimated at 50%.
§ Principal mode of Infection: By the heterosexual route
§ Profile of the most affected people: 15 – 24 years with higher prevalence among women

SITUATION IN THE WORLD AND IN AFRICA – 2

§ The epidemic has killed more than 3 million people, with 2.3 million in sub-Saharan Africa.
§ Prevalence of HIV varies considerably throughout the African continent: Less than 1% in Mauritius to around 40% in Botswana and Swaziland

EPIDEMIOLOGIC SITUATION IN BENIN – 1

1985: 1st case

- Network sentry: rapid progression from 1992 to 1998
- Situation stabilized since 1998-99

- 2002: big national investigation to validate data; sero-surveillance by sentry network
- This has been achieved in the 12 departments

HIV in Benin

§ Putting in place the SSE of HIV/AIDS: 1990
§ Sero-surveillance on sentry sites
§ Notification of cases of AIDS
§ Selective investigation
§ SSE: essential data of selective sites (targets: CPN and consultants IST)
§ 11 sites from 1990 to 2001 (7 maternity and 4 centres of PEC of IST)
§ 45 sites in 2003 (39 maternity and 6 centres of PEC IST)
§ Prostitutes monitored by the AIDS project 3

EPIDEMIOLOGIC SITUATION IN BENIN – 2

§ 3 divisions randomly selected in each of the 12 department: Total 36 divisions
§ 242 urban and rural areas investigated
§ 17,628 subjects thus far tested of HIV

Results of the investigation

- National average of Prevalence: 1.9%
- With regional differences

EPIDEMIOLOGIC SITUATION IN BENIN – 3

§ 0.8% to 3% depending on departments
§ Less than from 1% to 6.4% depending on divisions

§ The prevalence of HIV is higher in urban areas than in rural areas;

Serological profile
- HIV1 99%
- HIV2 0.6%
- HIV1+2 0.3%

EPIDEMIOLOGIC SITUATION IN BENIN – 4

§ 2003: Surveillance with extension of sentry network
§ HIV CPN: 2.2%
§ HIV IST: 6.5%
§ HIV donors of blood: 2.1%
§ With tuberculosis: 18%
§ Syphilis: 1.3%

Estimates 2003:
- Annual births of seropositives: 1800
- Number PLWHA: 71,950
- Number of orphans: 32,810

EPIDEMIOLOGIC SITUATION IN BENIN – 5

Prevalence of HIV/AIDS cases in Benin in 2003

- Number of AIDS cases noted: 100
- Number of cumulative AIDS cases noted between 1985 and 2003: 6,203
- Age brackets most affected: 15 to 49 years (80%)
- Estimated number of new AIDS cases in 2003: 6,590

Some other statistics of prevalence in Benin:

- With Tuberculosis	2003:	18%
- Routine investigation	2001:	4.1%
- PS	1999:	55%
- Non-educated young	1996:	4%
- Workers in business	1996:	2.6%

AIDS cases noted in 2002 with great group of age
Normal evolution of the diagram of HIV prevalence
Evolution of the average HIV prevalence in the sentry sites in the pre-natal consultations in Benin from 1990 to 2001
Evolution of the average HIV prevalence in the sentry sites in the IST consultants in Benin from 1990 to 2001
HIV in Benin

Necessity of validation of data sero-prevalence by sentry network
HIV in Benin: Investigation of surveillance of behaviour at risk of infection with HIV/AIDS/IST in Benin 2001 (PNLS; USAID; FHI and CEFORP)

- Educated population: Educated, non educated, truck drives/ road haulers
- Size of the sample: 10,321 sites:
- Main/principal cities and other regions of the country
- Criteria for choice: routes, importance of the urban areas, tertiary activities, informal sector, bordering zones, proximity to the sentry sites

HIV in Benin: Investigation of surveillance of behaviour at risk of infection with HIV/AIDS/IST in Benin 2001 (PNLS; USAID; FHI and CEFORP)

HIV in Benin: Other selected investigations underway in 2004 and those planned ahead for the year 2005

§ Two major studies underway:
§ EDG: Starts in September 2004 (PNLS, PPLS, BHAPP, AIDS3, French Cooperation, CEFORP)
§ Investigation in prison area in Benin: underway (PNLS, French Cooperation, NGO JAAD)
§ Investigation to be conducted in 2005
§ Investigation in school area
§ Study of the infection with HIV among the health staff

HIV in Benin: Projection for the year 2010 (Logistic Spectrum and EPP from the data of the surveillance by sentry network)

Second Part: Modes of Transmission, Clinical Observations and Prevention

Modes of transmission

§ Blood and its derivatives or by-products
§ Genital secretions: sperm and vaginal secretions
§ Other biological liquids: saliva, urines, tears, breast-milk
§ Organ: ganglions, etc.
§ From infected mother to the child
§ 90% HIV infants (Mother to Child Transmission)
§ 30% – 40% of babies born of infected mothers are infected
§ Blood route (groups at risk: transfusion, users of drugs injection)
§ Blood by-products which are infected (transfusions);
§ Traditional practices: sacrifices, circumcisions at home, excision;
§ Use of infected sharp or pointed objects
§ Manicure, pedicure;
§ AES (professionnel contaminations)

Conditions of transmission

- Way of entry of the virus (genital or rectal routes, mucous routes, parental route, materno-fetal route).
- Quantity of virus (viral charge) is significant in transmission
- Sexual route (Group at risk: TS)
- Frequency: 75 – 85%
- Factors at risk: unprotected Sexual relations

Time/period of transmission of HIV

- During pregnancy
- During delivery/giving birth
- During breast-feeding
- Number of intercourse necessary for transmission: 1 is enough

Transmission by the Sexual route

AIDS sickness essentially sexually transmitted.
Majority of infections with HIV transmitted through unprotected sexual intercourses with a person already infected.

Transmission by non-sexual routes

1. Blood route

HIV Transmission can equally occur through the intermediary of blood and blood products which are infected (e.g. transfusions) or by use of contaminated syringes or by other sharp or pointed objects which are contaminated, traditional practices at home, excision, etc.

2. Group users of drugs injection

3. From infected mother to child

An infected mother to her baby/child can also transmit the virus:

- During pregnancy
- During delivery, or
- During breast-feeding.

CLINICAL OBSERVATION – 1

HIV progressively drains the capacity of immune system of the body (to protect and defend itself), thus rendering it vulnerable to various infections and all kinds of sickness and infection.

At the stage of AIDS, the sick person can no longer resist any attack.
There come many infections known as opportunists: pulmonary (tuberculosis), digestive, neurological, coetaneous (of skin), ocular, cancers, etc., testifying a major immuno-depression.

CLINICAL OBSERVATION – 2

AIDS patient can show all signs but the most frequent clinical manifestations are:

- § Significant loss of weight
- § Chronic diarrhea
- § Prolonged fever
- § Cough
- § Fatigue
- § Dermatoses with itches
- § Generalized adenopathies (ganglia)

PREVENTIVE METHODS – 1

At the moment, there is neither vaccine against HIV, nor medicine to cure AIDS. There is no radical solution. Thus the best available strategy is to concentrate on: prevention.

PREVENTIVE METHODS – 2

Struggle against HIV/AIDS is especially centered: around:

- ***Advocacy*** for the mobilization of resources
- ***Social mobilization*** (NGO, Associations and other structured organizations of aid for the fight)
- ***Communication for change of behaviour*** in relation to the three ways of transmission:

PREVENTIVE METHODS – 3

Prevention transmission by sexual route

A = Abstinence
B = Faithfulness between partners
C = Adequate use of condom (Preventive)
D = screening/testing: VCT / CIC

PREVENTIVE METHODS – 4

- Prevention of transmission by blood route: screening and monitoring of blood transfusion, sterilization, or, at least, single usage of material, prevention in treatments, etc.
- Prevention of the transmission from the infected mother to the child: PRETRAME – PNLS Benin

TAKING DELIVERY TO PLWHA

- *Medical Treatment*

- Treatment by the ARV drugs: prolonged life, physical capacity, etc.
  In Benin: IBAARV from February 2002
  Sites of TTT: Cotonou, Porto-Novo, Lokossa, Aplahoue, Abomey, Parakou, and Natitingou
  Extension in progress
- Prevention and treatment of opportunist infections

§ *Socio-psychological care*

Factors at risk of transmission

§ Economic factors
  - Poverty
  - Migration from rural to urban areas
  - Socio-economic status of the woman
  - Domestic and international migrations
  - Domestic and mobile prostitution in the sub-region
  - Proliferation of pornographic video clubs
  - Phenomenon of the liberated culture among the youth
  -

§ Factors linked to health
  - Non utilization of mechanical methods of prevention
  - Viral load of the infected patient
  - IST not well or not treated
  - High prevalence of IST
  - Insufficiency of the PEC of the PLWHA

Factors at risk of transmission

§ Socio-cultural factors
§ Reluctance in observing social and moral values
§ Multiplicity of sexual partners
§ Wrong perception of the risk and denial of the reality

- Socio-cultural practices: Levirate, sorority, forced marriage
- Premature sexual activities of young girls with adult partners
- Domestic and mobile prostitution
- High level of illiteracy and small percentage of utilization
- Sexual abuse of the children in vulnerable situations
- Stigmatization and discrimination of the PLWHA

Socio-economic impacts

- In the homes
  - Decreasing/reduction and loss of employment:
    - Reduction of the revenue
    - Readjustment of the budget of the homes (cost of medicine)
    - Decrease of savings and investments,
  - Loss of employment
  - Increase of dependence

- At the Enterprises level
  - Reduction of the productive forces/manpower
  - Reduction of the productivity
  - Increase in the costs of productivity
  - Reduction of demand
  - Reduction of investments
  - Increase of social expenses (medicine/health)

- At the government level
  - Reduction of taxes
  - Reduction of revenues and global budget of the country, of PIB.
  - Increase of social expenses (health/medicine, education)
  - Decrease of investments,

- Reduction of the stocks of foreign currency

Pyramid of HIV/AIDS

Many people are infected by HIV, but do not develop yet AIDS.

HIV/AIDS does damage in more areas than we think.

Third Part: Conclusion

CONCLUSION – 1

The AIDS pandemic has become a serious threat

Prevalence has rapidly increased in Africa and in our country

We must act very fast

AIDS is public health problem

AIDS is sickness, which originates from behaviours

AIDS is a development problem

Fight against AIDS is everyone's responsibility, because it is a question of national development.

CONCLUSION – 2

- AIDS is a reality; it is a virtually development problem.
- It represents an incomparable threat whose effects will be felt during later generations
- It influences an important modification of hope for life
- It compromises efforts deployed to reduce poverty by reducing the level of economic growth
- It reduces possibilities of access to education. This aggravates the suffering of woman.
- There is therefore the absolute necessity of synergy of action.

CONCLUSION – 3

- Experience has shown that efforts in the fight against AIDS can be crowned with success.
- This is the case in Senegal and in Uganda, just to mention these two examples.
- Considering mode of transmission and impacts HIV, the efficient fight goes beyond the mere medical field.
- The fight must integrate social and cultural contexts.

Categories of leaders to intervene:

- Journalists/communicators
- Parliamentarians
- Leaders of Institutions
- Executive power: Ministers
- Leaders of the communities and NGOs
- Religious and traditional leaders
- Leaders at the localities level
- Associations of people living with HIV/AIDS (PLWHA)
- Leaders of private sectors, etc.

CONCLUSION – 4

At multi-sectoral level, there is need of creation of alliances between:

- Journalists/communicators
- Leaders
- Religious people
- Public health sector
- Other sectors (education, productive sectors)

In the above-mentioned ways the efforts in fighting against HIV/AIDS can take the form of a synergistic and efficient counter-attack.

CHAPTER TWO

Ethics and HIV/AIDS: A Philosophical Perspective

Christophe Kwami Dikenou

Introduction

The main question of this forum can be summarized in the following words: "How can we tackle ethically the problem of HIV/AIDS in its three dimensions of prevention, care, and treatment within an African and Christian context?"

Before this Areopagus (learned assembly) of eminent lecturers of Ethics, my presentation aims at offering possible methodological orientations and reflection which, as we are all certain, will bring hope to our continent.

The AIDS pandemic constitutes a major challenge and a new social question considering its ominous social consequences.[1] It touches nowadays, on Philosophy, the bioethics. The latter constitutes a branch of a new discipline of Applied Ethics. From then, methods of bioethics can contribute to formulate an Ethics of HIV/AIDS. Consequently, our method will consist of presenting the two principal approaches which constitute the actual reflections of bioethics and also to draw lessons form there for ethical reflection on the problem of HIV/AIDS.

From a Bioethical Reflection to an Ethics of HIV/AIDS

The role of Theologians and the Philosophers

In the bioethical reflection, theologians and philosophers have played a significant role. In fact, the first bioethical reflections, in particular in USA, were the work of theologians and philosophers. They wanted aspired to formulate and make known their conviction vis-à-vis their Christian responsibility before new social questions. These early formulations of theologians and philosphers constitute the corpus of bioethics. We can mention here such Protestant theologians as Joseph Fletcher, J.F. Childress and Paul Ramsey.

Among the Catholics, we can mention the theologians like Richard McCornick, SJ, Warren Reich, and also the philosophers like Hans Jonas and Dan Callahan.

In France, the precursor of the bioethical reflection is the Centre Laennec of Paris is managed by Jesuit Priests.

The concern of theologians at the beginning of bioethical reflection explains the actual concern expressed by a certain number of philosophers to affirm a secular approach. Those philosophers conduct their reflections with different philosophical and ethical trends, such as deontologism, utilitarianism, intuitionism, etc. Some of them are, just to mention a few, H.T. Engelhardt, E. Pellegrino and Gilbert Hottois.

Diversity of Approaches of Bioethical Reflection

In the expansion of bioethical reflections, we can mark two main extreme approaches: the prescriptive and the descriptive. Bioethical thoughts move between these two approaches.

The prescriptive approach

This uses a deductive reasoning. It also insists on the discernment of "action guides" from a system of principles. Thus a moral agent (individual of group) can deduce rights and obligations. We have to note that in the establishment of the system of principles, there may

be an integration of traditional ethics and different theories such as deontologism, utilitarianism, intuitionism, etc. The most representative example of thos approach is principlism whereby deontologism (promoting respect, autonomy and the responsibility of the person, and human dignity) meets utilitarianism (promoting kindness, righteousness and justice). The principlism championed by the philosopher T.L. Beauchamp and the theologian J.F. Childress in their book entitled *Principles of Biomedical Ethics* (1st Edition, 1979, 4th Edition, 1994) reiterates the four principles as laid down in the Report of Belmont (1979) and proposes them as guidelines of biomedical activities. These four principles are: autonomy of the patient (*autonomy*), righteousness (*non-maleficence*), kindness (*beneficence*), and *justice*.

We have to note that without wasting time in the controversial philosophical questions of the compatibility of theories and of conflicts of values, the principlists are more preoccupied, as it is always the case in Applied Ethics, to face concrete biomedical problems and to propose operational guidelines for action.

In summary, the prescriptive approach aims at identifying general values and formulating the norms and principles which are sufficiently universal so that we can deduce from them guidelines for action.

The descriptive approach

This approach uses the inductive reasoning and contextualization. The bioethicians who adopt this approach, begin with a critique of the prescriptive approach. They accuse it of not payng sufficient attention to concrete situations, for example that of the sick person (his/her history, his/her family) and to economic and political stakes which influence the medical system. Epidemiologically, they reject it because of its deductive reasoning. Analytically, for the inaccuracy of its architectonic principles. The typical example of this approach is Bioethics known as narrative.

The advantage of this approach, is that it reduces itself to a concrete casuistic which discovers for each particular case the better

principles of action taking into consideration all parameters of the singular context considered. Descriptive ethicists thus work on a case-to-case basis in a pragmatic manner. Similar decisions in the past cases are recalled while making current decisions. In this manner they aim at establishing universal principles by consensus in terms of an open and communicative interaction.

At the individual level, the descriptive approach allows the moral agent to make his own decision especially in relation to his intensions, his attitudes, his proper norms of morality, his social "faithfulness", and his religious convictions. In such a case, the decision is always conditioned by the moral development of the agent.

At the international level, the descriptive approach is very useful in international instances such as UNESCO and HIO (Health International Organization) whereby we strive to establish universal principles of Ethics and Bioethics by consensus and with the common willingness to accord them a significance.

Finally, can we definitely consider these two contrasted approaches as mutually exclusive? Not precisely. These two seemingly diverse approaches actually converge towards an absolute value of "human dignity," which is the ultimate basis of the mission of Ethics and of Bioethics. That value is supposed to guide the action in all circumstances and will never suffer any limitation.

Therefore, what is instructive for our present forum, is that whatever moral values and principles, which everybody will bring in tackling the problem of HIV/AIDS, the ethical vigilance requires to make sure that these do not contradict the values and principles of human rights, universally recognized, among which the respect for human dignity constitutes the prime imperative, which no approach should go against.

For example, in the prevention against HIV/AIDS, the principles of human dignity are imposed universally such as autonomy (affirmed in the principlism and deontologism) and the responsibility of the person (affirmed by deontologism). In the access to the treatment, we can mention as an example, the principles of justice (affirmed in utilitarism) and of solidarity. This carries a strong significance in the

face of the problem of access to the treatment, particularly in poor countries where the majority of affected people (the sick and their relatives) are without a solution and where the medical/health system is deficient. Injustices in the access to treatment show a great lack of commitment to moral responsibilities of humanity vis-à-vis every sick person.

Otherwise, in this present forum, the use of descriptive approach, in its inductive specificity, can enable us to realise the diversity and difference of manners in which, individuals, religions (in our case Christianity) and particular societies, such as African societies, choose to adopt these or those other principles and conceptualize them in relation to the problem of HIV/AIDS. This state of ethical pluralism must be considered as a manifestation of human liberty rather than as an obstacle. Therefore, it must not enter into conflict with the rights of current people and those to come, the pluralism of values, principles and rules of Ethics of HIV/AIDS ought not only to be permitted but also accepted.

Because if we want to establish the values, principles and universal rules, those already in the cultural religious contexts of various human communities can be enriched and made the subject of consensus. in this way we can contribute to the formation of a universal ethics as the basis of education and sensitization in relation to HIV/AIDS pandemic.

More precisely, descriptive approach can allow us in this forum and thereafter, to conceive and to produce the modules for training taking into consideration African and Christian context and the context of the modern society.

Conclusion

In conclusion, if the problem of HIV/AIDS constitute a major challenge for all communities, it is more challenging particularly for the ethicists. Therefore I would like to conclude this presentation by echoing the words of the former French minister for health Claude Evin:

> The fight against HIV/AIDS, I understand, is to identify certain values: solidarity, refusal of exclusion, responsibilisation. This is not angelism (other-worldliness). Theaffirmation of those values has enabled a civic and social mobilization which could not have been achieved otherwise. There are values which give to the sick person hope necessary for the battle, and to our fellow citizens the willingness to react against the sickness.[2]

Our vow, as teachers of Ethics in Africa, is that our continent participates more actively in dialogue or "inter-comprehension," in the word of Jurgen Habermas, the philosopher. A significant example of this inter-comprehension is the World Council of Churches. In this way we can contribute towards the elaboration and application of a universal Ethics of HIV/AIDS. Human community is, and always will remain, a community of shared values.

I thank you. May God bless you!

Notes

[1]According to the UN Statistics Department, HIV/AIDS is the first cause of death in Sub-Saharan Africa and the fourth worldwide. The UNAIDS, UNICEF and USAID, in their report of 7th July 2002 on AIDS orphans, revealed overwhelming figures: 13.4 million of children of less than 15 years of age have lost their parents to the disease; from now to 2010, they will be 25 million.

[2]Claude Evin, Présentation du Plan de 2 ans de l
'Agence Française de la lutte contre le Sida, 29 Janvier 1990.

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CHAPTER THREE

Ethics of Prevention

C. B. Peter

Introduction

Recently an HIV positive friend of mine, who lost his dear wife to HIV/AIDS five years ago, invited me to his second wedding. He told me that he is marrying a wonderful woman, a widow, who herself is livingly postively. I asked him whether the bride-to-be was aware of his positive status. He proudly informed me that she was and loved him enough to decide to marry him despite his status (or rather because of it) so that she could take care of him. I felt deeply moved to hear of such a person. It also brought to my mind the fact that times are truly changing now. Our fight against stigma seems at last to begin bearing fruits.

Looking at the above true story brings to the fore the need of prevention of HIV/AIDS with a certain urgency. Here is a man and a woman—both positively living—planning to marry one another. Their entire life, indeed their entire survival, would be defined by a single word—prevention.

In this presentation I intend to look at the issue of prevention in a broad ethical spectrum. My plea is that the span of prevention should go beyond merely preventing the first infection of HIV, and embrace other factors like subsequent infections, stigma stereotypes

and despair.battle against HIV/AIDS. My approach in this presentation is reflective and the nature of my data mainly anecdotal.

Prevention Defined

Logically, prevention seems to mean "to stop something *from* happening." In other words, prevention is supposed to work like an Early Warning System. While such a definition has certain advantages, a more advantageous definition of prevention—especially in the context of HIV/AIDS— would need to embrace a more comprehensive span of situations. By this I mean that the strategy of prevention should target not only the HIV negative population, but also even PLWHA. It would aim at not only stopping stigma and stereotypes, but even addressing itself to those situations, which are already marked by stigma and stereotypes to see whether these can be eliminated, or at least minimized.

Preventing What?

As I said just now, our strategy of prevention need to be broad-based, especially as we are fighting against HIV/AIDS. We need to transcend that straitjacket definition of prevention, which is limited only to the prevention of HIV infection among the HIV negative population. While that is an important aspect of the strategy, there are other very important aspects that I wish to highlight below, beginning, of course, with the prevention of the first infection.

First Infection

Since the majority of people is still HIV negative, preventing the first infection among this population remains perhaps the strongest component of the strategy of prevention. The underlying premise here seems to be that if we can prevent the HIV negative population from the first HIV infection and maintain the negative population in an overwhelming majority, we will only have a small minority of the positive population to care for. Furthermore, one might assume that the lesser the number of vectors, the slower the speed of infection.

In their battle against HIV infection, the strategists of prevention have come up with the famous ABC formula—**A**bstain (from sex before marriage), **B**e faithful to one partner (after marriage), and if you cannot manage A and B, then at least **C**ondomize. The three components of the formula are mutually related in an interesting way. Whereas A and B go together, C is seen as an alternative to A and B. Also the ABC formula seems to divide the human population into two camps—the "cans" and the "cannots." It assumes that there are some people who are gifted with the ability to abstain from pre-marital sex and being faithful to one partner throughout their lives. These I call "the cans." On the other hand there are people who cannot practice abstinence and fidelity to one partner. These I call "the cannots." So A and B are for the "cans," whereas C is for the "cannots."

The ABC formula has certain significant characteristics. *One*, it is obviously geared towards the sexual route of HIV transmission, not taking cognizance to the non-sexual routes, e.g. blood transfusion, body mutilation as part of cultural practices, and mother-to-child-transmission (MTCT). Because of this sexual orientation, the ABC formula has strong ethical implications. *Two,* the formula appears to assume the neat division between A, B, and C. It is based on the logic of "A and B or C." It does not say "A or C and B or C." In this manner condomizing is restricted to the "cannots" — those who are failures at abstinence and being faithful. *Three,* the formula appears to address, almost exclusively, the HIV negative population. It does not seem to take into account the situations where one partner is positive. Indeed, in such a scenario the formula would collapse because then condomizing would embrace even serious and faithful partners one of whom is HIV positive as in the case of my positive friend planning to marry a negative woman, in what I narrated in my Introduction above. *Four,* the formula seems to address individuals not necessarily in the context of a relationship. Ignoring the important aspect of relationships in our battle against HIV/AIDS would entail serious ethical risks. The ABC formula does not address to the issue of relationships. Its perceived target is the individual

and its perceived motivation seems to be the survival of the individual. This is evident from some people's addition of a fourth element "D" (death or die) to the formula. So the expanded version of the formula would be ABCD (**A**bstain and **Be** faithful, or **C**ondomize, or **D**ie). Some extremists would like to take the C completely of the formula and propagate an ABD version (**A**bstain, and **Be** faithful, or **D**ie).

Perhaps because of the above characteristics of the ABC formula, strategists like Canon Gideon Byamugisha have critiqued it and offered (elsewhere in this book) their own alternative in terms of the SAVED model. The five letters of the catchword SAVED mean:

Safe sex, cultural and medical practices,
Abstinence and Access to prevention and treatment services,
Voluntary Counselling and Testing,
Empowerment, equipment and engagement, and
Disease prevention, management and control.

Byamugisha has defended this model by the following five arguments:

The SAVED model is comprehensive as it takes into account the non-sexual routes of HIV infection.

The SAVED model transcends individualism and takes into account the context of relationships.

The SAVED model is non-stigmatizing as it takes into account situations where faithful partners can also get infected by a previously infected (although now faithful) partner.

The SAVED model moves away from the "divisive condoms" leaving each community to interpret "safe sex" in its own culturally acceptable way.

Finally, the SAVED model is inclusive as it integrates the role of individuals, communities, governments, and churches in the battle against HIV/AIDS.

While I find all of Byamugisha's above arguments logically valid and vastly preferable as over against the prevailing models, his fourth argument on "leaving each community to interpret 'safe sex' in its

own culturally acceptable way" presents a practical problem. How are communities to interpret safe sex? I sincerely wish there were a culturally and ethically acceptable alternative to condoms to interpret safe sex. But I have not found any. So we are back to Square One of condomizing. Indeed the Canon himself in a lighthearted aside, during the Porto Novo Colloque, gave his rule of condom: "If it is not on, it is not in!"

Subsequent Infections

Prevention of subsequent infections in the HIV positive population is the next strong pillar of the strategy of prevention. Unfortunately, by many HIV/AIDS is seen as a one way traffic. If someone is declared HIV positive, then that is the end of it! He is already on the way to death. There is no cure, no hope, and no help. Such a person might become totally desperate and even nihilist. He or she might refuse to see any value in anything. He or she might even dispense with all notions of spirituality and morality and find life absolutely devoid of any meaning-giving system.

Such a scenario is contributed by the moralists and preachers of doom. This fatalistic approach does more harm than good. This is where the concept of "positive living" comes in. We begin to realize that testing HIV positive is NOT the end of the road. HIV is NOT irreversible, in that it does NOT HAVE TO lead to AIDS and death. An HIV positive person needs to be invested with all hope and good values of life. He or she needs to be seen as one LIVING with HIV, NOT DYING from it. He or she needs to lead a responsible life. This responsibility is highly ethical as it entails the aspect of doing good and right as over against bad and wrong. And the ethically good and right thing is as much to prevent subsequent infections to the already positive person as it is to prevent infections to other people. We begin to take cognizance of the medical fact that it is not merely someone testing HIV positive that matters. What matters really is the CD4 cell count and the viral load, which can be seriously and adversely affected by subsequent infections. Thus we encourage the HIV positive population to assume a positive

attitude towards life and avoid subsequent infections. This way an HIV positive person lives on to contribute meaningfully to his or her own life, as well as the community at large. Instead of becoming death-focussed, he or she becomes life-focussed. Indeed the Christian Gospel itself is life-focussed. It teaches that not only HIV/AIDS but this entire life span of ours here on earth leads us to death, and death leads us to life again. This blessed dialectic of life and death is the essence of the Christian Gospel as illustrated by the life and death of Jesus Christ himself.

Stigma and Discrimination

The next pillar in the strategy of prevention is the prevention of stigma and discrimination. Because of its overwhelming association with human sexuality, HIV/AIDS is perhaps the only medical condition of our times that has been subjected to severe moral judgement. The extent of this moral judgement has far exceeded even the medical response to the problem. As a result of the moral judgement, HIV/AIDS bears a damning and irreversible social stigma. If the ethical absolutists hoped that this stigma would help in any way to curb further infection, they have been proved dead wrong. If anything, the stigma has only helped in escalating the rate of infection and thus worsening the situation. Below is a true case study that I learnt from my friend Dr. S. C. Njenga, a medical practioner in Kitale, Kenya, who is also my student for an MA degree in Pastoral Care and HIV/AIDS:

> A few years ago a young woman went to consult Dr. Njenga for some ailments. The doctor, on the basis of his profession suspicion, gave her an HIV test and she duly tested positive. Dr. Njenga then counselled the woman about her condition and gave her a free supply of ARV. The woman refused to take these life-saving drugs fearing that if her parents learnt about these drugs, they would come to know her HIV positive status and throw her out of the home. Meanwhile she went on leading an active and unprotected sex life becoming pregnant three times and giving birth to three children by three different men. This year (when I came to

> know about this case study) the 28-year old woman developed AIDS Related Complex (ARC) and was hospitalized. Among her visitors were three very nervous gentlemen, the fathers of her three children. They wanted to know the truth about her condition but the hospital refused to reveal the same to them. By God's miraculous grace, the woman survived. She is now on ARV and an intensive counselling programme.

Since the fact of stigma and discrimination associated with HIV/AIDS is widespread and self-evident, the above true story cannot be dismissed as an isolated case. Indeed, it could be the tip of the iceberg! If only we had prevented HIV-related stigma and discrimination, the rate of HIV infection, at least in the case of this unfortunate woman could also be restricted.

Stereotypes

Next, there are stereotypes that need to be prevented in our battle against HIV/AIDS. By "stereotypes" I mean such notions and concepts that may be true in some cases, but not true in other cases, but which are accepted as though they are true in all cases. There are cultural stereotypes as well as stereotypes in theology, philosophy and ethics.

A very common philosophical stereotype is fatalism or predeterminism. Many people believe that life and death are solely in God's hands and therefore no matter what we do, or do not do, what has fate ordained for us is bound to happen. So why should we take precautions against HIV/AIDS? If it is our fate, we shall catch the infection against all precautions, and if it is not our fate, we shall remain protected from this lethal infection even if we threw all precaution to the winds. While such an argument might be logical, it is not comprehensive enough for it overlooks the cardinal fact of human freedom and moral responsibility. Were it not so, we would not forbid our children from playing near a fire. We do so because we realize that the child can make a wrong judgement and burn himself.

Then, there are cultural stereotypes. In the African context, for example, there are gender stereotypes sanctioned by various African cultures. The most common case in point is the perceived superiority of male over female, or men over women. Men hold unto themselves the power to decide. Women are expected to merely tow the line without questioning men's decisions. Indeed women are there FOR men and not the other way round. While this gender stereotype might have worked (and probably worked well), in the days of our ancestors, in the current era of HIV/AIDS it only helps to escalate the rate of infection, for women cannot negotiate for safe sex with their male partners, let alone demanding fidelity from them.

Another common cultural stereotype relates to human sexuality. Sex is deemed more like a duty than an experience of communicative enjoyment between a man and a woman. Men and women are not expected to talk during sex, but run through it on a fast track leading to orgasm (more often man's orgasm than woman's). This silent-sex stereotype is certainly not compatible with the current strategy to combat HIV/AIDS that calls for breaking the silence, talking it out.

Fear and Despair

Finally, there is the element of fear and despair. Because of the stigma and terminality mistakenly associated with HIV infection, in many cases persons discovering that they are HIV positive suddenly find themselves face to face with the damning reality that they are already on the gruesome path of slow and sure death. And, in any case, in the course of their remaining short life there will be social disgrace. Their best friends will now desert them. Their spouses will denounce them. Their employers will hound them out of making a living. Even the Church will have nothing more than pity for them. Such horrific apprehension fills the persons, newly aware of their HIV positive status, with total fear and despair. In many cases the HIV positive person may even feel intense anger against his or her perceived infector. And since the perceived infector is not likely to come round and own up, the anger of the victim is directed at the

society at large. “Why should I care for a society that rejects me? Why should I allow the society to live while I have been condemned to die?” These are the kind of questions the HIV positive person asks himself or herself.

In the Month of April 2005, Kenyans were stunned to read a very sad story in a major Daily newspaper. According to this story, an unknown person, alleging to be a woman student, published a notice on the notice-board of Moi University, Eldoret, Kenya, claiming that she had been infected with HIV by an uncaring boyfriend who had since died of HIV/AIDS. And since she herself was going to die anyway, she had decided to infect as many men as possible. She claimed that so far she had had sex with 124 students, only 6 of whom had used condoms. Therefore she believed that she had likely infected the remaining 118 with HIV. This was in addition to her allegedly having had sex with a number of lecturers. Following this notice she circulated a handwritten communiqué among lecturers. The following is an excerpt from that communiqué:

> Now since whoever infected me did not mind about my life, I will also infect as many as possible … So guys, anyone of you out there who may have crossed my “path” should count himself unlucky and should quickly place an order for ARV supply before it is too late.
>
> I decided to spread the virus indiscriminately in campus (and have no apologies), because it is here I got it [the virus] and intend to leave it here.
>
> So far I have had 124 students, yes one hundred and twenty four. Out of them only 6, yes only six, used a condom.
>
> I still reiterate the fact that I owe nobody an apology and am still on a spreading spree.
>
> Otherwise I wish you success in your end of semester exams as you wait for your slow and sure death.

While dealing with the data of the above nature, it would only be fair to apply an appropriate caveat, that we cannot assume the truth or falsity of anonymous communiqués. The above story could well be a hoax, a silly practical joke played by some demented campus prankster. Or it could be a serious attempt by some moral crusader

to warn the campus residents of the dangers of having indiscriminate and unprotected sex. But on the other hand, the story could also be true in its every gruesome detail. We cannot prove anything either way. Therefore, the truth or falsity of the story notwithstanding, whoever wrote that notice, has already made the point clear enough that an HIV positive person struck with total despair CAN turn into a nihilist and wreak havoc among his or her fellow human beings.

The Politics of HIV/AIDS

And finally, we may ask: Given the glorious human achievements in science and technology in the past 50 years, must we really remain so helpless before the challenge of HIV/AIDS? Is the task of developing an effective vaccine against HIV/AIDS REALLY more difficult than developing the weapons of mass destruction? Is cracking the genetic construction of the AIDS virus REALLY more difficult than cracking the human gene code? Is developing effective drugs against HIV/AIDS REALLY more difficult than sending a man to the moon and planning to build housing-estates on the Mars? Is defeating HIV/AIDS in its entirety REALLY more difficult than developing super-computers? I cannot venture to answer the above questions, but they do raise a genuine concern, a sincerely puzzlement to any right-thinking woman or man: Could it not be true that we have not been able to defeat HIV/AIDS because we have not set our priorities right? Could not be true that we have HIV/AIDS because we NEED it since it provides us with a billion-dollar relief industry?

Where was Ethics?

Looking at the chilling details in the preceding section, we may pose a question: Where were all the ethicists in the world while HIV/AIDS continued to ravage humanity? The HIV/AIDS pandemic has claimed millions of lives despite the fact that all ethical operators were fully at work at all times. There was plenty of ethical advice being pedaled around entirely free of charge. There were thousands of sermons loaded with the moral ought. Even the human conscience,

which according to a moral school, provides the bedrock for ethical decisions, was still there, advising human beings on what should and should not be done. The fear of hell was there all along. And the fear of an untimely "slow and sure death" (if I may borrow the horrific imagery of the hapless lady mentioned above) was right before our eyes. And yet, despite all these seemingly effective deterrents, the menace of HIV/AIDS continued its death-dance.

The above questions indeed, deserve a very attentive ear, esapecially in the area of Applied Ethics. It might be that ethicists, theologians and philosphers may have "reflected" for long enough. It is now time for some real action.

Conclusion

In this presentation I have sought to look at the aspect of prevention in a broad ethical perspective. My plea was that the arena of prevention should be comprehensive and more inclusive than popularly understood. I have also pleaded for the need of introducing a certain degree of activism in the area of Ethics so that it can help us in the concrete situations of life, especially in the context of the prevention of the HIV/AIDS pandemic.

CHAPTER FOUR

Pastoral Care and HIV/AIDS: An Ethical Imperative

Vincent G. Nyoyoko

Introduction

Man is born to suffer. This short sentence has ever remained one of the most inescapable aspects of human life. Looking around, we may even say that the world is more of suffering than one can understand. At no time can we find it easy to accept or understand suffering. Just about when the world governments were busy congratulating themselves of a blessed future of "health for all by the year 2000", HIV/AIDS emerged in human society. This situation is similar to St. Teresa's experience when she said that she "always found that it was when she had began to congratulate herself that things were going well that things really started to go wrong." (Quoted in Patricia Corr 1972:57). What is implied here is that we suffer at all levels of our being— physical, psychological, moral and ethical. Suffering seems to belong to that mystery, which is generally referred to as the "divine secret."

When we come face to face with suffering resulting from a pandemic such as HIV/AIDS that does not seem to succumb to any now known solution, we find that the immensity of the

phenomenon takes us beyond the range of our comprehension. It assumes the immensity of a mystery that is as it were the meeting place of all the mysteries of our being. This situation is powerfully and inspirationally expressed in the Book of Job.

Suffering resulting from the experiences of HIV/AIDS appears at first sight to be humanity's greatest enemy. What is important, however, is how one approaches it. If we refuse suffering we are in a way refusing to accept the human condition in relation to ourselves. If we accept it, it makes us strong, gentle and charitable, and gives beauty and dignity to the whole human personality.

Whatever way we want to look at it, the fact remains that there is much cruel and unnecessary suffering in the world, like the one resulting from the experiences of HIV/AIDS. Whether it is from the situations of those living with HIV/AIDS, or their friends, children, relatives and those who care for them, the story is the same. Indeed, we cannot in any way wish away this suffering. We can only enlarge and deepen our own perspective about its horizons, but we cannot not lay down the limits of suffering. For the Christian, the mystery of suffering, like that resulting from HIV/AIDS, is immeasurably enlarged in the mystery of Christ's suffering and ministry.

Suffering and illness, which HIV/AIDS brings about, must be seen without any equivocation as the greatest problem that has troubled the human spirit since the late twentieth century. As it is, there is very little that has been successfully done to check the menace of HOV/AIDS. Even prayer does not appear to have humanly helped the situation. Christians feel and experience pain and sufferings as do all other people as a result of living with or being affected by the HIV/AIDS pandemic. Where do we go from here? Must we give up and allow fate to determine the continuity or extermination of the human race?

I think here that a proper understanding of the plan of God for humanity must be sought out. We must remember that a major part of the plan laid out by God's providence is that humanity should fight strenuously against all sickness, including now HIV/AIDS, and

any other infirmity that will arise in future, and carefully seek the blessings of good health, so that we may fulfil our role in the society and in the Church. Additionally, those living with and those affected by HIV/AIDS, should emulate the suffering of Christ for the salvation of humanity as we all look forward to creation being set free in the glory of the children of God (cf. Col. 1:24; Rom. 8:19-21). In this situation, the role of those living with HIV/AIDS in the Church is to be a reminder to others of the essential or higher things, namely that our mortal life is to be redeemed through the mystery of Christ's death and resurrection. Those living with HIV/AIDS are not here left alone, all members of Christ's Body, the Church, are affected and so must utilize all means at their disposal, physically and spiritually to offer comfort and solace to others. It is here that the ethics of pastoral care in its contemporary understanding comes in.

Pastoral Care

To articulate our presentation properly, we need to understand what "Pastoral Care" is all about. Generally speaking, pastoral care designates the broad range of activities undertaken by ordained and non ordained ministers of the Church in response to people's needs. These activities can be in the form of sacramental and social ministries. As such, pastoral care of people living with and affected by HIV/AIDS is one of the ministries of the Church. These ministries can be as informal as conversational encounters and as formal as highly structured ritual events, including spiritual healing.

Pastoral Care functions significantly within the context of the Church— which in essence is the Body of Christ. Realistically, it is "the practical outworking of the Church's concern for the everyday and ultimate needs of its members and the wider community." (Atkinson & Field 1995:78). It should be observed that the pastoral concern of the Church has as its main thrust the love that God has for all and of course for the entire world.

Pastoral care has been undertaken from various angles. Some have attempted to place pastoral care in the overall calling of God to serve his people. An example of this trend is found in Jacob Firet's analysis of pasturing (1986), which comprises of the following: *kerygma, didache* and *paraklesis*. These terms have a New Testament Greek background. They all emphasise the activities of preaching, teaching and practical application. These terms will be seen to be very useful in dealing with people living with and those affected by HIV/AIDS. We may, for example, say here that it is in the paracletic ministry (where the term *paraklesis* includes encouragement, exhortation and consolation) that we experience and appreciate the focus of pastoral care that deals effectively with cases of HIV/AIDS. *Paraklesis* that deals effectively with cases of HIV/AIDS can also be looked at from the points of view of the prophetic proclamation (Jn. 4:15-42), pastoral or shepherding care (Lk. 15:4-7; Jn. 10:16), priestly service (2 Cor. 5:18-21), and physical healing (Mk. 2: 1-12). In all, there must be present a clearly manifest Christian caring imbued with missionary commitment in both its individual and corporate aspects. Generally speaking, the goal of pastoral care in situations of HIV/AIDS is to promote the full well being of those living with and affected by HIV/AIDS, and to assist them in the ongoing conversion that is part of Christian life. To contextualize our analysis we shall briefly look at each of the aforementioned perspectives in the situation of HIV/AIDS pandemic in our communities.

Prophetic Care and HIV/AIDS

The prophetic care that meets the situation of HIV/AIDS must be looked at from the twin nature of prophetic call. The first thrust of prophetic ministry has to do with warning (personal, communal and national) regarding impending judgement on the erring group; and the second has to do with the promise of restoration and renewal for the repentant (Jer. 13: 19; 23: 7-8; 30:3; Deut. 18:18-19). These two tendencies were fulfilled in the life and teaching of Jesus (Lk. 7:16; 24: 19; Acts 7: 37). It

was the same tendencies that energised the activities of the Early Church and more especially in the Pauline communities in the context of Christian fellowship (Rom. 15: 14; Col. 3:16; 1 Thess. 5:12). The Church in the face of HIV/AIDS and its varied challenges must— if it has to respond effectively to this pandemic— put on the prophetic mantle. An effective prophetic approach will make the Church credible before the world.

Shepherdly Care and HIV/AIDS

An important attribute of God in the Old Testament is that of a shepherd (Gen. 48:15; Pss. 23:1; 80:1; Is. 40:11). This imagery of practical caring was conferred on military and political leaders who were required to act as "under-shepherds" (2 Sam. 7:7; Jer. 23:1-4). In situations of faithlessness, there was even a promise of a Messiah in the form of a "Shepherd" (Ezek. 14:23-24; 37: 24; Zechariah 11:7-11; 13:7). In the New Testament the imagery was fulfilled in Jesus who came to gather together the "lost sheep of Israel" (Matt. 9:36; 10:6; 15:24). In John 10:11-18, Jesus proclaims himself as the good shepherd, thus fulfilling what was foretold in Ezek. 34:11-16. Additionally, in John 10, the shepherding metaphor carries with it the element of very close and intimate relationship with his followers. This intimate relationship is manifested in being trustworthy, self-sacrificing, guiding, protecting and nurturing (Jn. 21:15-17; Heb. 13:20; 1 Peter 2:25; 5: 1-4). The Early Christians faithfully imbibed this pastoral commitment in their acts of consoling, comforting and encouraging those who found themselves in one difficulty or the other, as is made clear by certain uses of parakaleo *(2 Cor. 1:3-7; 7:4-7; 2 Thess. 2:16-17; Heb. 6:18). These are further corroborated in the guidance offered in the Pastoral Epistles and in the tender remonstrations of the Johanine letters. In all the instances we have here highlighted, there is the mutuality of the summons to encourage, care for and shoulder burdens within the community of the People of God (Gal. 6:2; Heb. 10: 24-25). Following in the steps of the*

Early Christians and the standards set by the instances of God's actions in both the Old and the New Testaments, contemporary Church must seek to encourage, care for, and even shoulder the burdens of widows and orphans who are directly affected by the horrors and pains caused by HIV/AIDS. The Church must also note that widows and orphans receive God's attention both in the Old and the New Testaments. The Bible must, therefore, serve as the guide as to how contemporary Church should witness to the love and care that God extends to widows and orphans, in situations of HIV/AIDS.

Priestly Care and HIV/AIDS

Priestly care in the context of pastoral care received its form in the Levitical practices of the Old Testament. Priests acted as the go-between in matters relating to God and man. Later, Christ's sacrificing love became the priestly care par excellence *"in the order of Melchizedek" (Heb. 7:1-28), In this context, Christ assumes the role of the representative of the people before God, displaying, as fully human, his solidarity with the needy and, as Son of God, his divine calling (Atkinson & Field 1995:79). Of special note in Christ's priestly role are his identifying, mediating, forgiving and reconciling ministries. Without undermining the uniqueness and efficacy of Christ's death and resurrection, our contemporary Christians (or do we say the Church?) in situations of those living with and those affected by HIV/AIDS, are also required to live lives of sacrifice and service as the "priesthood of all believers" (Ex. 19:6; Is. 61:6; Rom. 15:16; 1 Pet. 2:9; Rev. 1:6; 5:10). In this perspective, all of us will be motivated by the love of Christ, and thus remain committed to the principle of reconciliation within our new community (2 Cor. 5:17-21; Eph. 5:1-2; 1 Pet. 1:18-23; 1 Jn. 4:13-19) now battling with the experiences of HIV/AIDS with the attendant stigmatisation, estrangement, and loneliness. In this context also, the Church will be in a position to review and redress her inaction for failing to be the leaven in society in the*

manner of Christ in this situation, which is similar to that of biblical leprosy.

Physicianly Care and HIV/AIDS

In the context of physicianly care, God is seen as the supreme healer, beyond which there is none other (Ex. 15:26; Deut 32:39; Job 5:18; Hoses 6:1). God's concern for the sufferings of humanity (including those arising from HIV/AIDS today) is lived out in the compassionate acts of the mercy of Jesus Christ. The comprehensive nature of Jesus' ministry to the needy is clearly manifest in the Messianic pronouncement of Luke 4:18-19 (cf. also Is. 61:1-2). In these instances we find a level of care, which is relieving, liberating and restoring. This physicianly care seeks to bring wholeness, typically through miracles of healing. (cf. Mk.11:5), to every aspect of personal and corporate life, including such that resemble those of present day HIV/AIDS. Just like other strands of pastoral care, God's physicianly activity is experienced intimately in the healing work of his followers (1 Kgs. 17:17-24; 2 Kgs. 20:1-11; Acts 5:12-16; 14:8-10; Rom. 15: 18-19; 1 Cor. 12:9), which continually remains as the guiding principle for contemporary Christians in the face of HIV/AIDS. It is consoling to observe that in the situation of HIV/AIDS pandemic, this pyhsicianly care is still being experienced in a number of ways within the Church. Some of these ways are: co-operation with medical practice, the use of means such as the laying on of hands and anointing with holy oil, the setting apart of individual healers, and the release of God's power to heal the soul, mind and body through his people gathered in prayer.

Mainstreaming HIV/AIDS in the Church's Pastoral Ministry

Despite advances in Health Sciences, the HIV/AIDS scourge has continued to ravage human life. In the process of battling with HIV/AIDS, human conduct, purpose and personality are disoriented and twisted. Life ceases to have meaning. The worst hit has been human

sexuality, procreation and productivity. The social, economic and environmental priorities are also affected. The society remains broken by the denial of fundamental Human Rights, grave inequalities, deep deprivation, marginalisation and stigmatisation.

Allowed to spread unchecked, HIV/AIDS weakens the human capacity to sustain life and reproduce graciously. In this manner it threatens to decimate entire communities of people. The cycle is dynamic and vicious. Typically, it is the poor who are driven further towards the peripheries and social exclusion as revealed by cases of stigmatisation of those living with the HIV/AIDS. These negative developments and HIV/AIDS lock into a dynamic relationship, whereby one feeds on the other. Life, sex and human sexuality become trapped in this cycle. The final effects of a rampaging epidemic on life, sex, human sexuality and relationship are grave and long lasting. Just how long lasting, no one knows, until a comprehensive strategy is adopted to stem the tide.

It has been asserted that HIV/AIDS pandemic can be prevented, checked, subdued or curtailed. The challenges posed by HIV/AIDS require a multi-disciplinary approach. How can we develop the will, attitude, value and resources to prevent the spread of HIV/AIDS without the concerted efforts of all areas of the Churches' ministry? A multi-dimensional and inter-related approach is called for. Effective means of prevention include the upholding of the sanctity of life, sexual abstinence and responsible sexual practices, mutual fidelity, economic and material empowerment, the dismantling of marginalisation and stigmatisation, condemnation of commercial sex industry, and women trafficking. What is implied here is that fundamental Human Rights of every individual, of those living with HIV/AIDS and those not affected, should be respected.

From the above, we see that HIV/AIDS raises serious ethical issues that must be pastorally tackled. Thus, the response to the challenge of HIV/AIDS comes from deep ethical and pastoral convictions about the nature of life, human conduct, and human sexuality. In this perspective, we affirm the potential for the goodness and sanctity of life, the nobility of sex and human sexuality. Therefore,

in responding to the challenge of HIV/AIDS we shall be motivated by urgent pastoral imperatives, to passionately discuss issues relating to the sanctity of life, sex, and human sexuality, and therefore endeavour to proffer pastoral means for combating HIV/AIDS. This pastoral approach requires a serious process of discernment, which must take into consideration the gathering of pertinent information, wrestling with very sensitive issues and weighing the sometimes differing and conflicting views and interests. This endeavour will be under-girded by sincere Christian pastoral principles. I have deliberately not discussed in detail Human Rights and related issues in this paper not because they have nothing to do with the devastating scourge but because they merit a full-scale discussion in their own right. This is because Human Rights and related issues form the very background in the upholding of the sanctity of life. Be that as it may, the whole issue of pastoral care can only function effectively alongside Human Rights.

The Sanctity of Life in the context of the Church's Pastoral Ministry

The Christian understanding of Sanctity of life raises very serious ethical issues that have pastoral dimensions. HIV/AIDS has been known to attack and tend to destroy the real meaning of life. Life seems to be its primary and principal target. Life is something to be admired and marvelled at. Our reverence for life is shown most strongly in our respect for human life, irrespective of how it is made or distorted by affliction like HIV/AIDS. The full content of our discussion of the Church's pastoral ministry directed towards an integral appreciation of the sanctity of life should be stated by placing emphasis on the integrity and sanctity of the human life, which imposes certain positive and urgent obligations on us as we wrestle with the problem of HIV/AIDS pandemic.

Integrity of life is achieved when life is complete; when it is enjoyed in all its dimensions, and can perform its due functions without hindrance. When we speak of human integrity, we mean its ontological, psychological, moral and functional integrity, within the

total human personality—all taken together and existing harmoniously. Human personality, when it is considered ontologically, consists in a union of a rational soul and body. This type of integrity gives birth to other types of personal integrity.

In addition to what we have just discussed, there is psychological integrity and functional integrity. It should be observed that even if all these are destroyed as could happen to those living with HIV/AIDS, there is no reduction at all of the ontological personality, which always remains inviolable. We should note this well in view of certain false medical conclusions that are propounded in the face of HIV/AIDS pandemic. Psychological integrity necessarily exists in the phenomenological order. Because of it man or woman, whether he or she is HIV/AIDS positive or negative, realises his or her proper identity. He or she is capable of realising himself or herself as a whole; independent, responsible and capable of deciding on his or her own acts. In this set-up, he or she realises the necessity of communicating with others, and also his or her responsibility to himself or herself, neighbour and God. This integrity helps men or women to live and perfect themselves in the functional and moral order irrespective of their HIV status. Therefore, men and women have a duty to look after their life not only to conserve their personality or ontological integrity, but also to ensure that it may be fully and existentially asserted and evolved through their functional and moral activities.

I should add here that ontological personality or integrity takes precedence over other types of integrity, just as life takes precedence over vital acts. This type of reasoning or understanding will help us steer clear of the fallacious thinking of some who feel that life itself, the ontological personality itself, should go when the functional activity is not perfect, as in the case when someone is infected with HIV/AIDS.

There is also what is called corporeal integrity, which refers to the totality of the whole human body. In this situation, the body members exist for the good of the whole and contribute to the benefit of the whole person. This principle of totality urges the various body

members to see it as a duty that life is conserved, irrespective of the state of that life.

It should be noted also that when we speak of the sanctity of life, we are speaking of it principally from the perspective of Christian teaching. We may not, however, forget that there is objective sanctity, which exists in all things. Sanctity in this sense is a supreme spiritual value, which belongs to the supernatural order, but surpasses the moral or ethical order. It is only in the context of pastoral care that this sanctity is emphasized and conferred its nobility. In this sense, sanctity of life remains a mysterious and intrinsic element of human personality (Rudolf Otto 1958; Mircea Eliade 1968). For this reason, it belongs to all to protect life, defend life and sustain life, even if it is hampered with HIV infection. This type of objective sanctity of life should be understood from the point of view of the present order of redeemed humanity. This objective sanctity of life can only be fully realised in relation to Christ the Redeemer. This rests on the understanding that every life is a reflection of the splendour of redemption, which sees the whole man fallen but redeemed in body and soul. With St. Thomas Aquinas, we can say that human life approaches somehow the material object of religion (S.T. 2. 2ae.q.81 art3).

If all that we have said above makes any sense, then we can boldly proclaim that to give reverence to human life, whether it is HIV/AIDS positive or negative, on account of its sanctity and dignity, is a virtue of religion. In this reverence to human life, the supreme majesty, honour and glory to God is acknowledged. For this reason, human life, whatever its status, should be conserved and evolved in a religious sense. We may not, therefore, be indifferent towards our body and bodily activities and conduct. From this attitude towards life, our position regarding modern physical culture and health vis-à-vis HIV/AIDS should be clear.

Bodily existence is an exalted good. Life is given to us in stewardship. It does not belong to us for keeps. Earthly life is a means towards another life. There lies the necessity to pastorally care for it. However, it should be added that health carries along

with it illness. The two have more to do with morality and holiness than we may realise.

Human health is the greatest possible harmony of human forces and energies with one another. It is the greatest possible spiritualization of the body and the greatest embodiment of the spiritual. Good health is the greatest possible gift that men and women can ever enjoy. However, an exuberant bodily vitality, which oppresses virtue, has more of the nature of human illness than does a feeble body infected with HIV/AIDS, which is crowned with virtue.

We must cherish health. It is a good entrusted to us to preserve. Physical integrity and flawless function of the bodily organs constitute fine values. But we may not extol health—least of all sheer biological or animal health—as a supreme and absolute value. We should be ready to accept health and illness to the degree in which they serve virtue and love. Concern for health should go along with readiness to accept illness, as may happen in cases where one goes out to assist those living with HIV/AIDS and from there gets infected. In this case, it should be realised that illness is a way of being human, since illness plays a very significant role in human society.

Illness is an attack on life. It points to some guilt that may be personal, or from society or government, in which case there is a denial of the spiritual and material pre-requisite for health. Illness could be a consequence of intemperance. Hence, responsible love and correct care of health is a pastoral imperative. Man or woman must be personally responsible for life. A true concept of health and sickness is a basis for Christian pastoral ministry. The pastoral care that has to do with the sanctity of life in the period of the HIV/AIDS pandemic must be constantly repeated and renewed, especially as there are noticed or reported attacks and wilful assaults on bodily life like knowingly transmitting HIV/AIDS to unsuspecting friends and neighbours.

A Pastoral Approach to the Ethics of Sex and Human Sexuality Education

It would seem incomplete if we ended our discussion on "Pastoral Care and HIV/AIDS: An Ethical Imperative" without doing some reflection on sex and human sexuality. Sex as used here refers only to the minimal expression of human sexuality in its genitality. Specifically, genitality is derived from sexuality and not vice versa. It is common knowledge that it is through sex and human sexuality that HIV/AIDS finds its fertile soil. It has been asserted that about 80% of those living with HIV/AIDS were infected through sexual relations. My reflection here will be brief. So much work has been done in this area that repeating might prove superfluous and unnecessary. This discussion will be directed towards highlighting the nobility of pastoral care that emphasises the morality of sex and human sexuality. This will show both the positive and negative implications of the sexual faculty.

Sex, like life, is a gift for which man or woman must be responsible. Sex is neither bad nor dirty nor unclean. Sex, as a faculty, in man or woman is very powerful. The powers of sex were created for a good purpose. It was not meant for the transmission of HIV/AIDS. Sex is with us to stay. We cannot erase it from our minds or eliminate it from our bodies. Sex must be viewed well. Man or woman is more than a sexual being; hence sex in man or woman may not be approached simply nor treated simply as something purely biological. Man or woman has received the natural gift of sex as a moral task. Sex in man or woman occupies a place in the total structure of the human person.

It is from sex that human sexuality is derived. Thus, pastoral ministry directed towards the morality of sex determines also pastoral ministry that is directed towards the morality of human sexuality. For many people, human sexuality is simply reduced to the physical and biological differences between men and women. Sexuality is thus, reduced to the sex faculty in us. In this sense, it is conceived as a source of amusement or a source of misery (as when unwanted pregnancy results from sexual intercourse, or when one is infected with HIV/AIDS whether in the married or unmarried state). Another

false notion of sexuality is when it is regarded as something, which has little to do with the serious business of living or with our daily task of behaving as men and women. The view of human sexuality is limited and distorted.

There is more to human sexuality than genital contact, which is merely biological and physical. There is also the appetitive side, which is rooted in the physical. It is this aspect of sexuality which explains the deviation and violence so often unhappily associated with it and which often results into the transmission of HIV/AIDS. This sex appetite does not automatically integrate itself into our total personality. Therein lies the problem.

The appetitive side of human sexuality must be integrated into our personality. This is where sex must be seen as a challenge to a person because the basic need, which we call here control, is not given with it. According to Fergal O'Conner (1972: 48), what we now call control "has to be acquired by constant discipline of thought, desire and action, if the appetitive side of sex is to be integrated into the personal." What is meant here is that the biological urges and tendencies will be personalised. When people behave in the matter of sex according to their moral beliefs and standards, then the personalisation of the sex appetite will be evident. They are no longer victims of their sexual desires and urges. Therefore, there is the reduced possibility of their being infected with HIV/AIDS and the like. This in no way prevents them from performing those patterns of sexual action, which their state in life demands of them. All said and done, we agree that sexuality creates specific problems for human beings as is noticed in the ravaging spread of HIV/AIDS. For that reason it is the concern of the particular virtue of chastity along with its companion abstinence which now remains as the most viable panacea for the stemming of the spread of HIV/AIDS.

Chastity is the virtue by which human sexuality is cultivated in the most appropriate manner. It is the virtue, which makes man or woman whole or integral. It is not a denial of our manhood or womanhood as is sometimes believed. A truly chaste person is very much human. It has nothing at all to do with coldness, aloofness and

indifference to others, especially of the opposite sex. On the contrary, the truly chaste person is warm and affectionate, capable of sharing life with others.

Chastity implies three things. These three things portend to be the most appropriate check of the spread of HIV/AIDS in our society. First, chastity implies knowledge of the human value or human life, which is at stake, and knowledge of those ways of acting by which the value is acquired. Secondly, it implies commitment to human goodness and to the performance of these actions through which the goodness is achieved. It is here that it shines out as a particular way of loving others. Thirdly, it implies some discipline, which is the capacity to act in a certain way and the emotional control, which aids us in performing the set out actions.

Chastity aids us in understanding ourselves as sexual beings, that is, that we are fully human. By it we understand the role of sex in life, the values implied in sexuality, and how the appetitive side of sexuality is to be integrated into life. By it we know how to cultivate ourselves sexually, without causing pain in the process. A follow up of what we have just said is commitment and control, which give birth to abstinence and fidelity in sexual relationship. By this means the spread of HIV/AIDS may be checked.

In all, chastity is the measure of our capacity to love holistically. It is the measure of how to treat others as human beings with life that must be protected. Negatively, it demands that we will never use others selfishly as in the cases of prostitution and women trafficking, which have been established as main channels for the spread of HIV/AIDS. The chaste person is one who is skilful in expressing love in a sexual way and within acceptable bounds and conditions. The chaste person is incapable of sexually abusing others as is noticed in various sexual deviations.

There are two ways of exercising chastity. These are marriage which should carry along with it fidelity and exclusiveness, and the unmarried state or single state which should carry along with it abstinence. Chastity plays a central part in married life. Married love and chastity go hand in hand. Growth in married love moves

side by side with chastity. Every valid use of sexuality in marriage is at once both an act of chastity and a check in the spread of HIV/AIDS.

Another way to sexual fulfilment is the unmarried state or single state. This state does not imply a denial of sexuality. It rather demands unselfish love. Here, the partners in love must learn and discover the values that are at stake for now: values like love, tenderness, care, concern, chastity, gentleness, refinement, indeed the whole barrage of values which might be summed up in two words, 'aesthetic' and 'abstinence'. These two words act as protector and fosterer of the value of chastity. In this way, the tide of HIV/AIDS is stemmed among the unmarried.

What we have said calls for an effective pastoral approach towards the ethics of sex and sexuality education. Such an approach would not be biased by gender or age. Through it the acquisition of factual information—be it about sexual relationships or HIV/AIDS—is properly inculcated in context. It also helps in the formation of positive attitudes, beliefs and values as well as development of morally sound family planning methods which are together important in the prevention of the spread of HIV/AIDS. Sexuality education, in the context of pastoral ministry, so planned emphasises the benefits of abstinence from sexual intercourse as well as promotes sexually healthy relationship that is devoid of coercion, abuse and unwanted sexual contacts. By the making of these informed choices people will in the process avoid situations of infections, including those of HIV/AIDS.

Pastoral Care and Bridge-Building in the Context of HIV/AIDS

The issue of bridge-building in pastoral care must remain as an important catalyst in dealing with those who are living with HIV/AIDS, their families and the entire community. This approach is meant to control the spread of HIV/AIDS by group behavioural change. The approach is supportive in orientation. Experience all

over the world has shown that to overcome those things that provide fertile conditions for the spread of HIV/AIDS, helping someone else to do so, is a powerful way to help oneself to overcome the problem and remain free of it. This is where the whole issue of community, behavioural change, the vulnerability factors interplay, care and prevention come in. We shall presently try to briefly explain the pastoral perspective to these ethical issues in relationship to the HIV/AIDS pandemic.

Africa is a land of great possibilities. Everything exists for the good of everything else. The great concern in African society is generally expressed from the point of view of harmony. Life, death, sickness, riches and poverty are seen communally, including even the supernatural of which the ancestors are an integral part. Thus, for the African, the community is the plane in which everything operates. In other words, the community is the plane of the interaction of possibilities. And since everything is religiously conceived in Africa, the community is conceived morally and therefore has some ethical orientations, which must be pastorally approached. This type of understanding is important in our analysis of issues surrounding those living with HIV/AIDS, their friends, relations and neighbours, including those who professionally care for them.

In a typical African society, everybody is his or her brother's or sister's keeper in the state of good health or ill health. This explains the moral understanding of the intricate relationships that exist in Africa, which inevitably prepares the ground for the Church's pastoral ministry in the face of calamities, and various pressures of life. It is the duty of the nearest kin relation to care for one who is sick; after all every affliction is seen as an affliction on the whole community. Therein lies the pastoral responsibility of the community to care for the sick. The understanding here is that the community is pastorally and morally responsible for doing everything possible to 'procure' healing for the sick. In this sense, the African community becomes a healing community. I want to believe that this understanding, if well articulated, can provide great succour for those

living with HIV/AIDS and thereby check the foreign influences of stigmatisation and marginalisation. The type of community understanding as we have mentioned above holistically becomes a healing community, a safe space of openness and acceptance; a healing space for sharing and telling life and death experiences. This community here becomes one of care, an environment of trust and commitment, in which risks can be taken for the other and where all, including even the ancestors acknowledge their mutual vulnerability in the presence of HIV/AIDS in their community.

This collective vulnerability implies that by the mere presence of a single person living with HIV/AIDS, everyone else can be hurt or wounded, or exposed to danger or attack by the same virus. It means that all are unprotected in the face of the presence of a single case of HIV/AIDS in the community or that all bear the signs of vulnerability. It may also mean that all are in danger of HIV infection, or for those living with HIVAIDS that they have little or no access to proper care and support. This is where the African community as a plane of intricate interactions towards life is challenged pastorally to recognise and address the conditions of inequality, injustice and alienation which promote the spread of HIV/AIDS, which in itself is an expression of a fragmented world—a concept that is alien to an African understanding of the society.

What follows from the community experience of HIV/AIDS is a change in attitude towards those living with HIV/AIDS. The collective or communal appreciation of the presence of HIV/AIDS in their midst creates a new awareness or a changed understanding where all now can come together in new and creative ways to address the health and social challenges of HIV/AIDS pandemic.

In this changed perspective, communities come together to pastorally address the problem of HIV/AIDS and human sexuality with the African understanding of openness, compassion, solidarity and hospitality. In these ways, negative, judgemental and condemnatory attitudes towards those living with HIV/AIDS are overcome, since all can now together examine and assess their own lives and actions as members of a moral society. This changed

mentality ably provides the environment for addressing issues like love, human relationship and sexuality in a new way and through it people together join forces to end all kinds of discrimination and the structural injustices which put people at risk for HIV/AIDS. This willingness to embrace this change creates a more loving and inclusive community where HIV/AIDS becomes everybody's enemy to be collectively tackled.

In the unfolding new community with a changed perspective, all are reminded that if one member suffers, all suffer with him or her. Therefore, in the context of HIV/AIDS the question of caring quality of the community is brought to the fore. This implies the provision of a holistic care and support for people living with HIV/AIDS. This care is to be also extended to the afflicted families, including widows and orphans. By these means, the impact of the pandemic on the afflicted and their families are ameliorated by the collective understanding that hope is not lost when a person is infected with HIV. It also helps all to come to terms with their own mortality. This communal caring becomes a very important instrument for the prevention of HIV/AIDS from spreading and also provides renewed hope for the families and communities.

Conclusion

There is no secret about the devastating effect of HIV/AIDS in our society. It has devastated the lives of individuals, families, and communities. It has caused great suffering and death. In today's society, there are only two groups of people, namely: those living with and those affected by HIV/AIDS.

As much as HIV/AIDS is a human sexuality related illness, it is a product of very many other factors including poverty, marginalisation, and mismanagement of resources, lack of proper education and many other social and economic deprivations. It is a multi-sectoral illness. Generally, it is a human illness and not punishment from God.

This paper, therefore, holds that dealing with the problem of HIV/AIDS requires a multi disciplinary approach, including "Pastoral Care," if its spread is to be halted or checked. It is my belief that the most devastating cause of HIV/AIDS infection is a crisis of the lack of life-centred pastoral ministry and errors in the understanding of life, human sexuality and management and provision of resources, including health and education resources. Governments and communities have the duty to make sure that citizens have adequate health and educational facilities. There must, in this situation, be enthroned principles for the promotion and upholding of Human Rights.

In matters of sex, I have opined in this presentation that in place of the condom mentality, there must be a healthy advocacy for inculcating through a well programmed pastoral ministry, a moral appreciation of human sexuality which demands premarital abstinence or continence and fidelity in marriage. This type of human sexuality resulting from a clearly conscientised pastoral ministry must be morally understood as a sexuality that should be expressed genitally only in an acceptable permanent marriage relationship. In this way, there is likely to be impressed upon peoples' lifestyle an appreciable guarantee for success in HIV/AIDS prevention. Pastoral ministry and care, where authentic values of life, love and the proper use of sexuality are emphasised, provide an enabling panacea for the prevention and spread of HIV/AIDS. This prevention must be based on the conscious choice of a morally healthy, free and responsible lifestyle. The development of pastoral care directed towards self-control and responsible self-discipline are also important in the period of HIV/AIDS pandemic.

I should like to sum up with the note that the articulation of issues of "Pastoral Care and HIV/AIDS: An Ethical Imperative" provides the most suitable platform for placing HIV/AIDS in the context of the Church's pastoral ministry. It provides accurate information and in the process challenges misinformation about HIV/AIDS. It motivates individuals to accept the responsibility for

personal choices and actions. It provides pastoral strategies for confronting discrimination and foster communal responsibilities and responses in the period of the HIV/AIDS pandemic. In all, this paper on "Pastoral Care and HIV/AIDS: An Ethical Imperative" does not provide abstract ethical reasoning, but rather promotes a sound pastoral strategy that is the only strategy to avoid, check and prevent HIV/AIDS from spreading beyond what it has done now.

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CHAPTER FIVE

Ethics of Breaking the Stigma: African, Biblical and Theological Perspectives

Joseph B.R. Gaie

Introduction

This paper presents a perspective on the ethics of breaking the stigma about HIV/AIDS, on African, biblical and theological grounds. I have argued that stigmatization is morally wrong from the different perspectives and therefore it ought to be eliminated altogether. Stigmatization is part of the process of dehumanization that is evident especially among the poor. De-stigmatization of HIV and AIDS is imperative as it is part of the re-humanization of the oppressed. I have further argued that from an African perspective it is morally wrong to stigmatize people on account of their illness. I have used the concept of *botho* in Setswana to buttress my argument. I have then argued that from biblical and theological perspectives there is need to do away with stigmatization, which can be seen as sin or failure to answer the call to love our neighbour.

I shall begin with a working definition of ethics and stigma giving the context of understanding what "to break" means. I will then present the three perspectives stated above.

Definition of Terms

Ethics

The first term that we should look at is "ethics." "Ethics, as a formal field of philosophical inquiry, is the philosophical study of morality" (Callahan, 1988:7). The study deals with issues of right and wrong. It asks what it means to say that something is right or wrong, morally good or bad, and whether there is any criterion of making such a determination. Reflections on these questions give rise to theories of ethics or theories of right and wrong such as utilitarianism and deontology (WCC, 1997:51). Ethics also helps its students to decide whether certain actions, states of affairs and situations are right or wrong. Moral philosophers have come up with what they call "moral principles." The most important of these are: beneficence, respect for persons, non-maleficence and justice (WCC, 1997:52; Gaie, 2002a: 17). It is not only just a code of prescriptions and proscriptions (Singer, 1993:1ff), but it is also about how human beings ought to be themselves. "Beyond deciding on what is right or wrong, ethical discussions are meant to help us understand ourselves and the sort of people we become as we make particular decisions and choices, even as these are a response to the crises, anxieties and tensions within our everyday life struggles" (Katongole, 2001:145). Ethics in other words is the discourse of attempting to have an understanding of the totality of human life in both an empathetic as well as an objective manner.

When we talk about the ethics of stigma then, we are considering the right and wrong in a morally significant manner, of how the response of human beings to the HIV and AIDS pandemic is consistent or not with the humanization or affirmation of humanhood of others and how the dehumanization, or refusal to recognize others' humanity, can be irrational and not acceptable from different perspectives.

Breaking the Stigma

The second term is "breaking the stigma", which I may call "de-stigmatization." Let us first look at what stigma means. Stigma means entails the assumption of some wrongdoing or moral culpability, which is seen as the basis of suffering or pain. It is "a sign of shame: feeling of being ashamed" (Procter, 1978:1095). In the context of HIV and AIDS those affected and infected sense a stigma not only associated with (Fenton, 2004:1187), but attached to the disease. People are ashamed of being diagnosed HIV positive; their relatives and friends are also ashamed. Other people think and believe that the HIV positive members of society should be ashamed of that fact. Being affected by the disease is a shame. The disease has a stigma attached to it. Society wants those affected to be ashamed since the disease is stigmatized.

"To break" means among other things, to separate into parts, to bring to an end or to pause (Procter, 1978:120). Sometimes "breaking' is a violent process. In the context of HIV and AIDS it simply means stopping the stigmatization, a process that can be called de-stigmatization. To bring the stigma to an end, or to begin or usher in de-stigmatization is a morally important process that ought to be done properly. Breaking the stigma attached to HIV and AIDS is morally wrong when it results into the stigmatization of some parts of the society. To break in this sense does not mean to temporarily suspect stigmatization but it means bringing it to a complete end. It also does not mean stoppage of one stigma and the start of another one.

In this chapter I have argued that de-stigmatization is a moral imperative. It would be morally wrong not to stop stigmatization.

What Stigmatization Does

It is important to realize the morally critical issues that surround the stigmatization of HIV and AIDS. It is taken for granted that stigmatization is prevalent in society (WCC, 1997:58; Phaladze and Tlou, 2001:199; Fenton, 2004:1187). The consequences of stigmatization are dire. Phaladze and Tlou (2001:199) have argued

that the stigmatization of HIV and AIDS has led to some women avoiding to openly seek for information relating to sexual and reproductive health in fear of being accused of sexual promiscuity. The result is a high risk of infection. The WCC (WCC, 1997:13, 58) has also noted that stigmatization of HIV and AIDS puts everybody in society at a greater risk of infection.

At another level it is very clear that just being infected and affected by HIV and AIDS is something that is painful. Suffering and pain are issues that necessitate action on moral grounds. When the affected and infected get stigmatized it is a further infliction of pain. The ethics of breaking the stigma actually calls for an understanding of what happens in the case of stigmatization so that appropriate action can be taken. As Fenton (2004) has pointed out, there are links between poverty and the risk of HIV infection. 95% of people living with HIV and AIDS are in poor countries where there are many factors militating against the poor. Even in more developed countries the poor are the ones most likely affected. The rich can afford medication and the correct information can easily reach them so that remedial action can be taken. The poor people and countries get poorer as more and more resources are diverted to the rich to fighting the disease.

From the above it is clear that poverty is not a morally acceptable thing. But what has to be emphasized is the fact that stigmatization of the poor countries and individuals will mean a further violence to the people, which is morally problematic. The ethics of breaking the stigma is therefore a process that conscientizes about the nature and implications of stigmatization. It shows how stigmatization is like adding salt to sore wounds.

The next issue then is to see how and why this is not morally acceptable from African cultural, biblical and theological perspectives. We shall begin with the African perspective.

The African Perspective

The following section deals with an African perspective. I am using the Setswana concept of *motho* (human being) and *botho* (personhood) to show that once we understand how a person is conceived of then we are able to understand why stigmatization is morally wrong because it is not botho.

The word *botho* is a noun of classes 1.2 (one two) and 14 (fourteen) in the Setswana language (Mogapi, 1984:12). It comes from the root *–tho* (Mogapi, 1984:20). The word means "a human being" as a metaphysical entity and "a person" at a moral level. These concepts will be examined below for us to understand the moral significance of this term for our research.

The Metaphysical Elements of Botho

At this level we are looking at being—that is, what makes *botho.* We want the essence of *botho* such that we would say that the absence of that thing in a being would disqualify it from being called a *motho.* In Setswana, *botho* is simply humanbeinghood or the essence of being a human person. It is that which separates people/ human beings from any other animal species. At a metaphysical level there is a thing that has the essence of *botho*/humanbeinghood. The question then is what a *motho* is. Kwasi Wiredu (1991:31) has provided something close to the answer. According to him a human person is that which is born of communication, a product of culture. It includes the mind, an ability or power to conceptualize and articulate. This power is usually realizable in an evolutionary process of cultural socialization. This means a motho is both physical/biological and immaterial—the mind. A motho, or

> being a human person implies having the capacity for reflective perception, abstraction, and inference. In their basic nature these mental capacities are the same for all humans irrespective of whether they inhabit Europe, Asia or Africa, just as in their basic nature theinstinctive reactions of, say, the frogs or Europe are the same as those of the frogs of Africa. … there is a common human identity" (Wiredu, 1991:32-33).

Lesiba et. al. agree as they argue that:

> although there are differences with reference to the constituting parts of a person, there is agreement that the person consists basically of a material aspect and a 'spiritual' aspect or aspects. We thus have a dualism with the resulting question of how these different aspects function together (1991:146).

In the case of Setswana a motho can be described materially and spiritually, morally and epistemologically. At a material/physical level Batswana refer to motho as "ke motho yo mo leele" (she/he is a tall person). They will also refer to a corpse as motho. Talking of the corpse, for example, they usually report back to those who remained at home when a member of the family was going to be buried and say, "re mmolokile" (we have buried him/her). This is a clear reference to the corpse a person. Another example is that the Batswana believe that when the corpse of a person is in the house or at home there should never be noise in order to respect the dead person. They will say that "o mo ntlong" (she/is in the house).

The spiritual nature or aspect of a person in the Setswana tradition is also reflected in the way Batswana talk about death. All living things are said to "swa" or die, including human beings. It is also very clear that the death of a person is referred to in a peculiar way. Batswana do no usually say motho o sule (dead) even though they can say that. They usually say "o tsamaile/ile" (she/he has gone); o re tlogetse (he/she has left us); o tlhokafetse (he/she is missing/cannot be found); ga a yo or ga a sa tlhole a le teng (she/he is not or no longer there).

We shall talk about the moral aspect of botho below so the next issue to talk about here is the epistemological aspect of motho. To say that a motho is epistemological in the Setswana tradition here we mean that knowledge is part of the definition of what a motho is. It is an aspect of the essence of a person. Batswana usually say that "motho ke phologolo e e botlhale go feta diphologolo tsotlhe" the most intelligent animal is a human being. The word botlhale means wisdom, intelligence, being clever and cunning. An

intelligent and wise being is that which is able to conceptualize reason assuming the many rules of thought such as contradiction, identity and excluded middle. When a child has done something demanding intelligence only befitting a human being Batswana say “ke motho tota” (she/he is a real human being). That means, being intelligent shows the child as a real human being.

The importance of the metaphysical concept of Botho

It is important to emphasise from the outset that the concept of *botho* is morality itself. Just like any kind of essence at a metaphysical level, the essence of *botho* is illusive in that it is difficult to define or pin down. There is nothing in particular that can easily be pointed out as the essence of *botho*. On the other hand, it is generally accepted that certain behaviour traits reflect the nature and essence of *botho*. This is not a big problem for the proponents of *botho* as a viable philosophical and moral position because morality itself has the same problem of pinning down what really makes something wrong. Sogolo (1993:126) has also made the same observation. In fact, some people have sought to solve the problem by suggesting that there is nothing which is wrong as such only emotional attitudes towards certain things cause people to think there is something wrong (Popkin &Stroll, 1986: 55; Gensler, 1998: 58). Yet others have suggested relativism as a solution—that the wrongness or rightness of actions vary from society to society, culture to culture or person to person (Billington, 1988:35ff).

Rantao (May 2002) defines *botho* as “good personality”. He also brings out the important idea that in Setswana a person who has no *botho* is viewed as not being a *motho*/person. When a person does things, which are viewed to be immoral or unbecoming they are simply described as the negation of personhood—*ga se motho*—he is not a person. This negation of personhood is both metaphysical and ethical in that the definition of a person is that of a human being who has loyalties to their kin, country and everybody else. Furthermore, according to Rantao, the Setswana tradition extols the virtue of love. It is this kind of metaphysical reality that gives

rise to the moral person—society expects certain behaviour from the individual. These behaviours will reflect the metaphysical reality called *motho* who has the moral concept of *botho.*

To expound on the above, in the English language people can speak of an old car as not being a car. What this means is that even though the car has the essential elements of a car, there are some aspects of those essential elements of the car that are missing. This suggests degrees of being. There is a sense in which the car is not a car. This is analogous to motho. A motho who is not a motho is one, for example, who is morally deficient. What this means is that whereas a motho is a being of a certain ontological status, there are statuses between botho and non-botho that we can talk about, which are important.

It is important to consider the metaphysical elements of botho because it will help in understanding the concept of botho/motho. A real or proper motho is a being with essential elements that include rationality and morality. This is important in that the essential elements of motho will enable us to understand what things the motho as motho should and should not do. Modern critics of the Setswana traditional outlook point out that in the modern day era of HIV and AIDS cultural beliefs fuel the spread of the disease. For example, goes the argument, because the Setswana tradition encourages young people especially girls to be subservient to elders, unscrupulous elderly relatives impose themselves on young girls and end up sexually abusing them, thus, exposing them to the dangers of HIV and AIDS. The youngsters do not resist because they are taught to obey the elders.

That could be what happens in practice, but then it would be indicative of either the abuse of the Setswana tradition or a misunderstanding of what really a motho is. Since rationality, morality and epistemology are essential elements of a motho, it seems untenable to propose a Setswana culture that promotes the violation of Batswana youth. Taking for granted that abusing young girls is immoral, it appears to follow that the Setswana tradition, which defines motho as a moral being, or botho as being moral, would not

tolerate the abuse of children by elders. As a matter of historical fact, child molesters were severely punished. Child molesters, those who committed incest, and homosexuals were among those people who were killed because it was believed that they were committing taboo acts—*botlhodi*.

So we can say that what a motho and botho are define what ought and ought not be done. This shows the relevance of metaphysics to a good understanding of botho and motho. This is not any different from the Western tradition. Because I am a human being I am not expected in the moral sense, to do certain things such as cruelty to animals and human beings. The Setswana tradition dictates that because you are a motho you cannot abuse children. Because you are a motho, you cannot allow yourself to be abused by an elderly person. As noted above, rationality is part of the defining characteristics of a motho. A clever child would know what to expect from the elders. For example, they cannot be cruel to the child and claim that it is dictated by culture. Of course, people can be quick to point out that Setswana traditionalists were very cruel, but that can hardly pass the test of truth because there were always limits to what a person could do to others. The fact that some people abused their status does not invalidate the view that the Setswana tradition defined motho as a being that should not do certain things including letting oneself to be abused and abusing others.

The traditional Setswana culture is very protective to children, because as suggested above, the acceptable activities of a being are defined by what it is. Botho defines that because people what are they are they have to behave in a certain way towards children, also because of what children are. For example, there is a saying in Setswana , *e re o ntima, o mphele ngwana.* This translates into a couple of senses. Firstly if a person has something against their neighbour or fellow citizen, it does not mean they should take it on their children. They should rather treat their fellow citizens' children as if they do not have anything against their parents. Secondly, treating fellow human beings' children unkindly because they have something against their parents is the most selfish thing to do. Lastly,

treating the children of one that people have something against well is equivalent to treating the people themselves well (Seboni, 1962:25). It is also critical here to note that for Batswana *ga go ke go twe o gola leng, go a twe o tsalwa leng* (literally this means: it is never said "when are you going to grow up?" It is said, "when are you born?"). The saying means that once one is born they are a motho/person (Seboni, 1962: 30). This is important because it means a child has the same metaphysical status as an elderly person. This is consistent with Kaphagawani who has argued that for the Chewa in Malawi

> it is indeed the case that elders tended to have an epistemological monopoly over the young. But to concede this point is not to assert an ontological distinction between the elders and the young; rather, it is merely to point out an epistemological difference; the young are not onotologically less human than the elders (Kaphagawani, 1991:173).

The Moral Elements of Botho[2]

Botho, as stated above, is simply, morality (Mmolai & Gaie, 2003; Gaie, 2002b). To say that a person has botho is the same as saying that they are morally good. To say they do not have botho is the same as saying they are immoral. This position is not clearly articulated as one complete argument but can be gleaned from various writings and utterances some of which will be looked at below. In this section it will become clear that botho is the most important moral term that is used in Setswana. I will also point out that it is related to the Zulu/Ndebele term "ubuntu". It is sometimes used loosely but mostly it is moral in content wherever and whenever it is used.

Understanding of Botho

The Mmegi news paper (30th March 2004, p.7) carried out an editorial entitle "we want PBRS with Botho". It explained that the performance based reward system would be welcome in Botswana if it would involve the civil service becoming service oriented and the service done efficiently, courteously and with all the kindness

and good human relations possible. The civil service would stop being a terrorising monster to the public which ordinary people needing service would try to avoid as much as possible and become a welcoming and humane one.

Botho as virtue

Batswana have shown that they have the concept of botho as virtue. This is shown in the case of taximen who returned over P4million that they found on the road to the bank (Mmegi Monitor, 2002ab:6, 8; Geoflux, 2002:13; Maleke, 2002:6). The action of the taximen was extolled as virtue. Monty Chiepe is quoted as having said:

This is the highest demonstration of honesty and botho. What is even more touching about this is the fact that taxi men demonstrate this very important Setswana attribute, a group of people not considered the most probable for these virtues (botho and honesty). What makes their deed even more outstanding is the fact that it happens at a time when everybody seems to be preoccupied with materialism at the expense of values that make us Batswana (Mmegi Monitor, 2002a: 6).

This view reflects Batswana as virtuous persons who ought to reward honesty. The view goes on to see botho as what makes them who they are. Virtue is being someone who radiates botho, someone capable of being trustworthy even when in a tempting situation. The action of the taximen is described as what "reflects the true spirit and nature of our being as Batswana or even further as Africans. Their actions touch right to the full definition of 'BOTHO'; '**Motho ke motho ka baba bangwe'"** (Geoflux, 2002:13). The statement translates into "a person is a person through and because of other persons". Geoflux, a company in Botswana led by Chiepe, Botswana Society, a community of prominent Batswana, and Mmegi Monitor, a local newspaper felt that it was botho—morally desirable to ensure that people who have behaved virtuously are not ridiculed like it was happening to the taximen (Maleke, 2002:6), but they were to be honoured and encouraged. Botswana as a country that believes in virtue ought to protect virtue

and encourage virtuous behaviour. On the other hand Botshelo complains about the fact that the said taximen have attracted a lot of attention simply because they returned money to the bank. He points out that he appreciates the fact that they have behaved virtuously. He also points out that the security company that was supposed to guard the money did something consistent with botho as it gave the gentlemen something. Botho, according to his understanding, means that virtuous people should be rewarded and what is of paramount importance is not the size of the reward but the meaning of the reward. He takes issue with the fact that the taximen were capturing the headlines because the issue they were involved with was money, which is not as important as human life. Botshelo points out the fact that the media did not harp on the discovery of foetuses in Selibe Phikwe and the incident will soon be forgotten in spite of the fact that it is an issue of great importance. Botshelo is worried that the person who reported the presence of those foetuses ought to be seen as a hero who personifies botho, but society does not seem to care very much about him. Botshelo agrees that botho is virtue. He points out "Mrs Phumaphi, using her position and authority, was able to convince the *Ditsela tsa Itshetso Society* to donate one of its houses initially earmarked for the homeless, to Boitumelo Morapedi to share with her child. This is *botho*" (Botshelo, 2002: 24). Another example of both as virtue is seen in the case where the Botswana national vision 2016 chairperson is quoted as having called upon the church to spice their sermons with teachings about botho as portrayed in the vision. The chairperson of the vision council, Dr. Gloria Somolekae, is said to have acknowledged the compliance between the teaching of the church and Botswana's national vision 2016. This is an apparent reference to the Christian teaching on virtue. Peter Hikhwa is quoted as having said that the church is able to build people morally (Matshediso, 2004:4).

Lack of virtue is lack of botho and virtue is having botho. Mosojane (2001:17) argues that in African traditions people do not criticise someone in mourning. They would rather wait for the

mourning period to pass before they can take issue with the bereaved if they think there is some issue to settle. He argues that in their village there is someone who is insensitive enough to criticise someone and falsely accuse them of misusing council property whilst the object of this attack is in mourning. This unwarranted attack is, in his view, lack of botho.

Mmegi, (2003:16) is concerned about the apparent "public indecency" evident during music festivals held purportedly to raise funds for HIV and AIDS reduction activities. The commentary lists a few examples of some activities that end up with people having sexual encounters in an unacceptable manner. This necessitates need for national soul-searching, an introspection to find out if the Botswana nation has become too permissive. The commentary suggests an apparent lack of virtue in the nation of Botswana, or an equivalent of lacking botho. Naledi (2003:2) has also taken botho as its commentary. According to this commentary, it is a happy occasion to have witnessed the President of Botswana, F. Mogae and some eminent persons in society launching the special fund to honour all members of the nation who have shown botho in a special way. It is a matter of concern that the spirit of botho has been waning in the nation of Botswana for some time. The hope is that it will be rekindled by the few acts of virtue that are encouraged by activities such as the said fund. The commentary goes on to congratulate a group of men belonging to a recreational football club for standing against the abuse of women and children. It then urged them to cooperate with the Society of Men Against Aids (SMAA) so that the two can have a good social impact. The existence of these groups shows botho as a national virtue. Mooketsi (2003:2) does quote Limit Nkala as having argued that rape is wrong because botho demands consent. Rape as lacking virtue is simply lack of botho.

Man (2003:16) has argued that botho is important for the realisation of a compassionate, loving and caring nation. The nation can attain botho if parents become role models of their children. In so doing they will respect their children, show compassion to them

and not use "vitriolic language". Parents are supposed to be upholding moral standards, but nowadays they are nothing but morally bankrupt by being rude, aggressive and callous. They are "deficient of proper mores"; they commit "horrendous atrocities" to their children; there are "unprecedented and unparalleled cultural and moral disintegration"; defilement is on the increase with both women and men being perpetrators and some men rape their daughters. "Such behaviour" he argues, "is totally disturbing and not inimical for the construction of a nation which values botho". He concludes: "a nation without high standards of morality faces a bleak future".

Another example of botho as virtue is reflected by Mmegi Monitor (2002a: 8) where the cultural traditions are seen as forming part of the virtuous status of the state. The commentary points out the fact that the way youth dress and speak nowadays gives some credence to fears that the nation is losing its soul. It also points out that people who accused virtuous members of society of being naïve and foolish when they returned millions of Pula they found on the road is a sign that botho is gone. But, the president should honour these gentlemen to show that theirs was "a noble act".

In another case of identifying botho with virtue, Mmegi (2004b) argues that botho demands good behaviour even when one feels betrayed. The comment was raised by the fact that the South African Football Association did not vote for Botswana's candidate in a CAF election in spite of the fact that the Batswana supported South Africa for a long time. The comment came just before the FIFA vote to determine the 2010 world cup host. People were divided as to whether the Botswana delegate to FIFA should vote against South Africa hosting the tournament since the South Africans had "betrayed" Batswana earlier on during the CAF elections presidency. The commentary points out that Batswana are related to South Africans in a very special way. Botho demands that the former should help the latter even if they have betrayed them before. Hence the South Africans can learn what botho is by being treated with botho.

Ubuntu

One concept that has been expressed in the literature is Ubuntu. This concept, in my view, expresses the essence of botho. It is the treatment of people as persons deserving special moral consideration. Ubuntu in other words is the morality of the African whereby the African sees themselves as being what they are because of people. Ubuntu is "true humaneness" (Prinsloo, 1991:42). Botho or Ubuntu is the way of life in which rationality and morality are seen as foundation for community life. It is a way of viewing the universe as an environment within which the self-realisation of an individual is possible only through and in others. This concept really means that there are certain things that cannot be done in this society given the importance of reason. For example, some people might think that traditional Setswana cultures gave room for child abuse. This is not possible given the fact that Setswana traditional culture is rational. From the culture it can never be botho for an elderly person to abuse a child. In fact, incest is viewed as botlhodi (taboo) which could result in the abuser being killed. The idea of respect for elders does not mean the elders can abuse children without the latter objecting. But this is not true as sayings such as *susu ilela suswana gore suswana a tle a go ilele* (the elders should respect the young so that the young can respect them) precisely mean that the elderly does not merit respect when he abuses children and therefore they cannot accord him the respect that is accorded elders. Ubuntu or botho is also simply virtue as expressed in the western tradition.

Botho and Stigmatization

From the above, it is not easy to imagine a situation whereby Batswana embrace the stigmatization of people who are affected by HIV and AIDS. Botho as virtue demands empathy with the affected. The stigmatization of this disease is seen from the Setswana point of view as a self-destructive move, which is contrary to botho. Botho is when a person is what people should be, that is, by definition, moral. This is consistent with the Akan (Gyekye, 1991: 324-325; Osei, 1999: 26). Botho is also when an individual "realizes his or her

full potential as an integral part of his or her community" (Phaladze & Tlou, 2001:201), which would be undermined by the stigmatization of some members of our society.

The Biblical and Theological Perspectives

Some Examples in John

The bible can clearly be seen as being not only against stigmatization but demanding destigmatization. A few examples from the gospel of John can help us understand how stigmatization is not consistent with the gospel. One can venture to say that generally the mission of Jesus on earth is the spread of love. It is the demand for people to change the way they see reality.

The Jesus-Nicodemus conversation (John 3:1ff) shows what people need to learn. The ignorance displayed by Nicodemus reflects what people can be. He did not know what being born again meant. Likewise, judging people affected by HIV and AIDS and stigmatizing them is a mark of ignorance. It is not knowing that Jesus came for the salvation of human beings, not their judgement. The realisation of this makes one perceive the heavenly things so that they cannot fail to see the divinity of HIV and AIDS sufferer. The believer is able to think beyond earthily birth spoken of by Nicodemus and perceive the salvific mission of Christ. The sufferer does not arouse feelings of pity, resentment and judgement but enables us to see beyond their physical condition to the greatness and mercy of God. The believer realises the love and power of God transcending the disease and what we ordinarily perceive as goodness.

The conversation between Jesus and the Samaritan woman also helps us understand his loving kindness (John 4:7ff). The woman had had many men in her life. Jesus did not condemn her. He rather promised her a drink in the well of everlasting love and mercy. Again the woman did not understand that the ordinary water she was drawing was nothing compared to what Jesus was offering. The lesson is that the condemning spirit in us blinds us to the living waters

that Jesus offers. We cannot see the good shepherd (John 10) for what he is.

In the case of the woman caught in adultery (John 8:3-11) Jesus showed us what being human involves. There is a lot of hypocrisy. People who accuse others are usually the ones who are at fault. Jesus warns us not to stigmatize others. In the case in point the Jewish community that time stigmatized women and claimed they were doing God's will. Jesus says that we cannot do that and be his disciples. We cannot condemn anyone even if they have sinned. Our greatest commandment is to love one another as he has loved us. We should do so to the point of dying for each other (John 1512-17). From these we are able to construe that whether or not somebody has sinned is not a question that is open for our discussion. The most important thing for us to do is to love those infected and affected by this disease and loving them does not and can never include stigmatizing them.

The Theology of Botho

Dumi Mmualefhe, has theologized the concept of Botho.[3] For him to talk about HIV/AIDS in the context of Botho is to engage in a serious spiritual introspection. It is about engaging ourselves in a reality check, it is indeed to place ourselves into "the big picture" in order to determine where we stand, who we are, for what purpose we live, and most importantly; what we are! To address this issue is to focus on **us** and not **them**, for in Botho there is no them. We can talk about them only in so far as our 'identifiability' and identity as Batho depends on the BE-ness of those we erroneously regard as "them, those, and others!" (Mmualefhe, 2004: 1).

He further shows the inseparability of the HIV positive from the rest of the world (Mmualefhe, 2004: 4-5). A HIV positive member of the society is not just an "isolated case" as some people can refer to individuals. The person is a microcosm of their society such that encountering them is encountering their family, their tribe, their country and in the case of Africa, their continent. We can as well say that an encounter with a single human being is encountering the

human race. From this perspective, I cannot point to my sister and brother without some of my fingers pointing to me. I can never stigmatize another person without stigmatizing myself in the process. This calls for a proper understanding of what we are. Without others we are nothing. We have to be aware of ourselves so that we can see our goodness in sharing ourselves; for it is a truism that "no thing shares of its own, for all creatures are nothing in themselves. Whatever they share, they have from another" (Eckhart, 1979:151). Once we understand that we are one with the infected and affected, that is to say, we are the affected and infected, then we will not stigmatize ourselves. We can only stigmatize ourselves if we are ignorant of what it means.

Conclusion and Recommendations

I have assumed that there is stigmatization of those infected and affected by HIV and AIDS. I have argued that stigmatization is the infliction of pain on the already afflicted, which is morally wrong. Botho calls for virtuous behaviour which includes treating everybody well. St. John calls us to love our neighbour and the theology of botho makes us to see ourselves in others so that we do not stigmatize them as we would stigmatize ourselves in the process.

I would like to recommend that we teach ourselves to theologize from our African cultural heritage so that we can be able to view ourselves differently. We should be able to be proud of our good cultural practices and beliefs. In this case our belief that we are because each of us is, can help us deal with stigma not as an individual's problem but as something concerning all of us as a community locally, regionally and the human community. This should also make us aware of the problem of stigma not just concerning some people but the whole of humanity.

We should try to see how stigma relates to us as localized people.

Notes

[1]The material in this section is common with a chapter in the proposed book that I am editing with Dr S. Mmolai entitled "Botho and HIV and AIDS".

[2]The questions of whether or not Africans and by extension, Batswana have a traditional philosophy and a morality that are comparable to other systems such as Europe are taken for granted. We hold the view that Setswana traditional thinking is universalizable to the same extent and with similar difficulties to European cultures. So we are not going to have that debate here. Godwin Sogolo (1993: 119ff) for example, has ably demonstrated this position.

[3]His Master of Theology thesis and a paper presented at Tlokweng in Botswana in August 2004 present an enlightening reflection on the theology of *botho.*

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CHAPTER SIX

Can We? Or Can't We?
A Christian Reflection on Ethical Dialectics in theContext of PLWHA*

C. B. Peter

Introduction

Early in the month of September 2004 a news item appearing in a Kenyan daily dashed the hopes of many. It was about the results of an AIDS vaccine trial on which specialists from the universities of Nairobi and Oxford had been working for the past six years. After six years of relentless labour, putting to risk the lives of 439 study volunteers, and an investment of over twelve million US dollars, it was announced that the vaccine-project had failed![1]

A month earlier, a Nairobi court (in an unrelated incident) had jailed Dr. Margaret Gachara, the former director of the National AIDS Control Council of Kenya for three years. Her crime? She had been convicted of defrauding the government into paying her a salary nearly ten times more than what she was entitled to. In her two years of office she had managed to cheat the government out of some three hundred thousand US dollars.[2]

The above two incidents might appear different and unrelated in their content, but there is a common theme running through them—the theme of human failure. In the first incident it is the failure of

human ability. In the second, it is the failure of human integrity. In the context of the first incident we ask: can we ever hope to get a vaccine to protect us against the ravage of HIV/AIDS? In the context of the second incident we ask: can we ever put our trust in the ability of a human being to remain honest especially in such a sensitive area as AIDS control? The money that Dr. Gachara stole, could have been enough to buy ARV treatment for one month to some 160,000 PLWHA in Kenya for whose care she was morally responsible (There are said to be some 200,000 PLWHA in Kenya at the moment who need ARV, out of which only about 10,000 are actually able to get it. That leaves us with about 190,000 PLWHA who need ARV, but cannot afford to get it).

Any reflection on human achievement and failure would implicitly belong to the area of ethics. The two true incidents that I have quoted above pertain to human ethical failure. They make us rather skeptic of human ability to do good. On the other hand, there are million of words of good advice coming from well-meaning teachers, preachers, leaders, and mentors. The apparent assumption of these good advisors is that human beings *have* the ability to do good; they only lack good advice. So here is the dialectic between two ethical assumptions—that human beings are capable of doing good, and that they are not. That dialectic is the subject of this paper.

My purpose in this paper is to offer a Christian reflection on this ethical dialectics in the context of PLWHA. My main thesis is that ethical reflection is not so much a matter of merely advising the DOs and DONTs, as it is examining certain assumptions underlying the advising. For the purpose of this paper those assumptions are as follows:

1. *Human beings **are** capable of being ethical and following good advice.*
2. *Human beings are **not** capable of being ethical and following good advice.*

In other words, ethical advising can make sense only against the backdrop of the struggle between freedom and determinism. I have attempted to offer my ethical reflections in this paper with the help of insights from philosophy, theology and biblical studies, especially in an African PLWHA context. In order to understand the ethical dialectics between freedom and determinism, I have used the Hegelian model of "Thesis-Antithesis-Synthesis" as follows:

1. *The Thesis: Yes, we can*
2. *The Antithesis: No, we can't*
3. *The Synthesis: But we will*

Why Dialectics?

I have used the dialectical approach in this paper for a number of reasons. My *first reason* is personal. When I was given the task of writing this paper, I wanted to say something fresh and original. I found, to my dismay, that the pandemic of HIV/AIDS is not only exterminating us physically, but it is also killing us intellectually. Now we seem to have become so much saturated with AIDS-talk, AIDS-research, and AIDS-study that almost nothing new remains to say. I found myself in a dilemma. Should I give you the AIDS statistics? But there are already thousands of pages of mind boggling statistical data. Should I talk of codes of conduct for PLWHA? But you have heard them before. Should I go into the area of transmission and prevention of HIV/AIDS? But you know it already. Should I present a biblical reflection on HIV/AIDS? But others have done it before, and perhaps better than I. So I felt like the proverbial disabled man lying by the poolside in John Chapter 5 whose problem was that others (philosophers, theologians, ethicists, biblical scholars, and medical researchers) had already jumped into the pool before him, leaving him nothing new to do except lie by the poolside for 38 years! So I decided to use the dialectical method, just for a change, to understand ethics.

My *second* reason is that the dialectical method may help to check the error of absolutism. It seems that when it comes to the

fields of ethics and theology, many people like to take the easy route of advising others what should or should not be done. In the context of African theology, for instance, John Mbiti has lamented:

> *Some of us are getting tired of seeing all sorts of articles and references under the big banner: AFRICAN THEOLOGY (or some similar wording). The substance of these articles often turns out to be advice on how African theology should be done, where it should be done, who should do it, what it should say, ad infinitum. Some of these self-made theological advisors, whether they be African or foreign, have little or nothing to produce beyond their generous advice…*[3]

What Mbiti has observed above about African theology might apply to many ethical discourses as well. The temptation to become advisors is almost too great to resist!

So there is a lot of ethical advising around. Some advise abstinence, others condoms, while still others ABC. The advising seems to be based on the assumptions that (a) the advice by itself is absolutely sound, and therefore bound to succeed, and (b) that human beings are capable of following all good advice. In such an approach we tend to neglect the need to be analytical and reflective enough to subject the entire phenomenon of ethical decision-making to critical analysis.

My *third* reason for using a dialectical approach is that it takes into account the ethical decision-making as a comprehensive process, going beyond absolutes. A dialectical approach fulfils at least one demand of natural justice—that there are always two sides of a story. We arrive at the truth not by judging one concept against the other, but by studying the tension between mutually opposing concepts. Perhaps for this reason, J. Philip Wogaman has discussed the biblical legacy of Christian ethics through the following six "tensions:"[4]

Tension One:	*Revelation versus Reason*
Tension Two:	*Materialism versus the Life of the Spirit*

Tension Three:	*Universalism versus group identity*
Tension Four:	*Grace versus Law*
Tension Five:	*Love versus Force*
Tension Six:	*Status versus Equality*

Another advantage of a dialectical approach is that it does not just stop at showing the struggle between "thesis" and "antithesis." It rather points to a way forward, a "synthesis," something to which we can look forward with hope. And when it comes to our war against the pandemic of HIV/AIDS, hope is our most potent weapon.

However, while making use of the Hegelian approach, I am duly aware of its critique, especially in the 20th century. The catastrophes of the 20th century (the onset of the HIV/AIDS pandemic being the last and the most devastating one) have proved Hegelian interpretation of history wrong in that history is no more moving towards a golden climax and final synthesis than Hegel would have us believe! My use of the dialectical method is not meant for the prediction of history in a Hegelian sense. It is merely meant as a tool of critical reflection.

The Complex Jungle of Ethics

Ethics presents us with a rather complex and sometimes impenetrable, jungle of theories, opinions, and approaches.

First, there are the overlapping areas of theological ethics, philosophical ethics, and religious ethics.

Second, there is the problem of defining ethics. Some would define ethics simply as "a code or set of principles by which men live."[5] Others would add two more elements to the above definition: (a) the general pattern or way of life itself, and (b) inquiry about the way of life and rules of conduct.[6] Still others would opt for a rather academic definition of ethics. Cletus N. Chukwu, for instance, has quoted Kenyan philosopher the late Prof. H. Odera Oruka's definition of ethics as "a philosophical inquiry into the moral language and principles about values."[7] On the other hand, John Wilkinson uses

the Semantical approach to defining ethics. According to him, the word *ethics* "is derived from the Greek adjective `çthikos` which comes from `çthos`, a noun which in the singular means *character*, and in the plural *manners* or *customs*, even customs which are prescribed by law."[8]

From the foregoing attempts at defining ethics, it would appear that ethics basically concerns relationships—not only intra-human relationships, but also relationships of human beings with the world of nature. Chukwu has aptly observed: "Who would imagine that trees, landscapes, animals, rocks, rivers, [the] dumping of industrial wastes, [and] pollution, would some day acquire moral values as they have done in our times."[9] This ethical focus on relationships is crucial to our understanding of ethics in the context of PLWHA

Third, there is a vast complex of ethical theories and the vexing question of how to classify them. One way of classifying ethical theories is to think in terms of "objective" versus "subjective" ethics. According to the former, ethical theories are valid by themselves, whereas according to the latter the validity of ethical theories depends on the prescriber.[10] Another way is to think in terms of "classical" versus "modern" ethics, the former being mainly descriptive, and the latter analytical.[11] Then, of course, one could use the three-pronged classification of ethical theories into (a) deontological (ethical precepts being good in themselves must be followed out of a sense of duty), (b) consequential (actions are justified by their consequences), and (c) situational (cutting across "a" and "b"). Most ethical theories could be covered by the above scheme of classification, except perhaps the triad of naturalism, non-naturalism, and emotivism. But then, one could argue that this triad contains not so much ethical theories, as ethical apologetics against the positivistic dismissal of the validity of ethical statements.[12]

Fourth, there is the question of ethical approaches. The three most common approaches are: the descriptive, the prescriptive, and the analytical. The first concerns elucidation of various ethical theories. The second concerns various "codes of conducts" in various professional ethics (e.g. medical ethics). The third concerns

logical analysis of ethical statements and moral judgments. My approach in this paper is a fourth one (reflective) whereby I am concerned with examining the assumptions behind ethical judgments.

While working out an ethical theory in the context of PLWHA, one will have to meander through this ethical jungle and identify such pathways as lead to a set of ethical theories relevant to the context of PLWHA.

The Existential Dilemma of PLWHA

Persons living with HIV/AIDS suffer not only from the tragic fate of the pandemic, but also from a devastating existential dilemma of which they may not always be aware. A philosophical analysis of that dilemma is important in our search for relevant ethics for PLWHA. In my opinion there are two aspects of the existential dilemma of PLWHA.

The *first* aspect of the dilemma is what I may term as "involuntary objectification." A person living with HIV/AIDS is reduced to a mere object. He or she becomes an object of other people's care, love, counselling, and even moral advice. He or she is no longer the subject of these things, but the mere object. As such a PLWHA loses his or her authentic existence. In fact he or she loses any existence at all, and is left with mere being. This is a very sad scenario where a human being, originally created in the same image of God as the rest of humankind, succumbs to his or her "limit situation" (if I may borrow the term from Heideggar rather out of context) and assumes a dependent existence. For the PLWHA all values, aspirations, meanings, and hopes are reduced into a single haunting word—survival, mere prolonging of days on earth, no more, no less. If someone carried out a social scientific research into the existential dilemma of PLHWA and asked them how they felt about their objectification by, and dependence on, others, I am inclined to think that many of them would cry out in the words of Jean-Paul Sartre—"Hell is other people."

The *second* aspect of the existential dilemma of PLWHA is their encounter with nihilism. By this I mean that a PLWHA may

fail to see any meaning or purpose in anything, whether good or bad. I have come across the tragic story of a man in Kenya who, when knowing that he was HIV positive, went about living a loose life to infect as many women as he could and recording their names. After his death, the list of his unfortunate victims was recovered from his bed. It contained the names of some 80 women! This is what happens when someone succumbs to nihilism. It is remarkable how the pandemic of HIV/AIDS has brought to reality almost the same kind of nihilism about which we read in the novels of Fyodor Dostoevsky and Albert Camus.[13]

The existential dilemma of PLWHA is caused by the attitude of stigma, discrimination, and even condescending that is applied to them by the society. As such, for us to think of PLWHA as a human sub-society and to think in terms of the "ethics of PLWHA" is itself highly unethical. We will need to redefine PLWHA as those who are merely aware of their status as against the rest of us who are not yet aware. Once while teaching an MA programme in Pastoral Care and HIV/AIDS, I asked my students as to how many of them had tested HIV negative. Some students raised their hands. I said, "The rest of us are guilty until proven innocent." And what about those that have tested negative? Unless they test every week, how can they be absolutely sure of their status? This means that we can no longer afford to think of PLWHA as a human sub-society. They are very much a part of us, and we are very much a part of them.

The Thesis: Yes, We Can

The thesis of the ethical dialectic is oriented to a positive view of humankind, which is enshrined in the Judeo-Christian anthropology. Man (in an inclusive sense) is the "crown of creation." Men and women are created in the image of God. The term "image" here seems to be difficult to interpret. What has the God of Judeo-Christianity to do with images? Perhaps in this light Ved Mehta finds the use of the word *image* blasphemous.[14] However the Bible *has* used the terms image (mlx) and likeness (twmd) (Genesis 1: 26-

28), and the burden of interpreting their meaning rests on our shoulders, as the readers of the Word of God.

John Wilkinson has summarized the various interpretations of the image of God into four broad categories: *substantial* (human ability to stand erect "heavenwards"), *constitutional* (human possession of divine attributes, e.g. reason and freedom), *relational* (human privilege to enjoy a special relationship with God), and *functional* (human privilege to perform Godlike functions, e.g. having dominion over the creation).[15]

Such an optimistic view of human beings raises our hopes and confidence in human ability to do the right thing. The advice for abstinence and faithfulness to prevent HIV/AIDS transmission is oriented to this positive anthropology. The assumption is that the human will is capable of choosing the right thing. This assumption reminds us of Plato who ascribed the existence of evil to the lack of *knowledge* of good, and not necessarily to the lack of man's ability to do good. According to Plato, if only man could *know* what is good, then he would automatically *do* what is good.[16] It would seem that dispensers of good advice have the same assumption—that people out there are desperately waiting for good advice, the knowledge of good. Give them that good advice, that knowledge of good, and *hey presto*, all their problems will be solved!

But will they? If the answer to the problems of the world were in good advice, then those problems would have been solved a long time ago, since already there is more good advice in the world than there are problems. This reminds me of Sigmund Freud's damning comment on religion in his classic *The Future of an Illusion*. Freud says that of all the institutions of human society (cultures, civilizations, polity, etc), religion is one institution that has stayed around for the longest period of time (5,000 years). We have protected it and sponsored it to the highest degree. It has enjoyed the fullest support of the largest number of members of the society, from every social

class. And yet religion has failed to solve our problems. If anything, it has only brought in serious problems of its own. And how shall we interpret the biblical narrative of the Fall? Was the knowledge of the good and the evil originally ordained by God or was it condemned? That narrative has a very significant bearing on the question: were man and woman created originally as ethical beings, or were they forced to become ethical as a result of the Fall?

Therefore, any valid consideration of *Imago Dei* will need to be juxtaposed against the reality of the Fall. Perhaps that is why Professor Musa Dube when she subscribes to a rather glorious anthropology, at the same time hastens to allude to the Fall:

> *My own theological framework is largely informed by the fact that I subscribe very much to the following beliefs; namely, that creation as a whole was created by God and it was created good, hence all life is sacred; that all people, regardless of their color, gender, class, race, religion, ethnicity, health status, age, or sexual orientation, were created in God's image and are loved by the same, and given human dignity and access to earthly resources; that the Divine hand created all things to be interconnected and in balance; that when some people are denied their human dignity, God's will is disregarded; that when balance, the goodness, the image of God is violated in creation, evil results; that human beings are made in God's image to become co-creators with God, given the task of ensuring that the goodness of the earth and its balance remains to and for all and to God; that the church is particularly positioned to be the guardian of God's will in the world; that God's revelation continues to be manifested to us through the Holy Spirit and the prophets that arise among us. Clearly, this framework does not subscribe to perspectives which, for whatever reason, hold that certain groups of people - on the basis of their ethnicity, health status, gender, race, age, class, or sexual orientation - should be subjugated, oppressed or denied their God-given human dignity. In this framework, salvation is liberation from spiritual, physical, economic, cultural and political oppression and from exploitative structures and institutions. In this framework, social structures and institutions that sanction oppression and exploitation do not*

represent God's will, and must be counteracted by those of us who accept the role of God's stewards in caring for the earth.[17]

The Antithesis: No, We Can't

The thesis of the ethical dialectic is countered by the antithesis (No, we cant). This is oriented to the negative anthropology of the ancient West Asian cultures that provided an immediate context for the biblical narratives. According to the ancient Mesopotamian creation epic, *Enuma Elish*, man was created as a by-product, as an afterthought. Men and women had no real purpose in creation except to care for the gods. John Barton in his book *Understanding Old Testament Ethics* has quoted German scholar Eckhart Otto as follows:

> In Mesopotamian tradition man was created from the blood of a god who represents chaos and guilt, and thus bears within himself elements of a life bound to failure. This negative anthropology is linked to a pessimistic idea of the aim of human life, whose purpose is to relieve gods who have become guilty of the burden of work. Work as the object of human life is seen as a punishment for the guilt of the gods.[18]

This negative anthropology might sound distasteful to some of us, but it has a significant presence in the biblical witness, especially in the so-called "Wisdom Literature" of the Old Testament. Take, for example, the book of Ecclesiastes. The writer of this book is engaged in an ardent search for good life—a dominant ethical theme with the ancient Greek philosophers, Socrates, Plato and Aristotle. He searches for the good life, the true *eudemonia* in wisdom (1:16-18), pleasure (2:1-10), and toil (2:18-23), but gets miserably disillusioned at the end of each and declares, "all was vanity and a striving after the wind, and there was nothing to be gained under the sun." (2:11)[19]

A similar thought resounds in the book of Job, especially in the speeches of Job's friends. Look, for example, at the following excerpt from the speech of Eliphaz:

Can a mortal be more righteous than God?
Can a man be more pure than his Maker?

If God places no trust in his servants,
If he charges his angels with error,
How much more those who live in houses of clay,
Whose foundations are in the dust.
Who are crushed more readily than a moth!
Between dawn and dusk they are broken to pieces.
Unnoticed they perish forever.
Are not the cords of their tent pulled up,
So that they die without wisdom?[20]

In the New Testament we recall the heart-rending lament of St. Paul when he describes his moral dilemma:

…but I am unspiritual, sold as a slave to sin.
I do not understand what I do.
For what I want to do I do not do,
But what I hate I do…
For I have the desire to do what is good,
But I cannot carry it out.
For what I do is not the good that I want to do.
No, the evil I do not want to do—this I keep on doing …
What a wretched man I am!
Who will rescue me from this body of death?[21]

This negative anthropology has significant bearing on our war against HIV/AIDS. On the one hand it makes us skeptic about the human ability to succeed even in a good cause, say, the battle against HIV/AIDS. I have already mentioned about the failure of the AIDS vaccine project in Kenya, at least for the time being. This reminds us of Wogaman's dismal assessment of the 20th century when he remarks, "Medical advances were mocked by the sudden emergence of AIDS, reminding us that the consequences of our ignorance can still be deadly."[22] A similar thought is reflected in Wilkinson when he compares AIDS with syphilis. Wilkinson notes that even though we have finally conquered syphilis, it has taken us some 400 years to mark that achievement.[23] So what about our war on AIDS? Will

it also take us nearly half a millennium to win it? Will AIDS disappear eventually by the year 2,400? These thoughts are quite threatening. But we cannot afford to ignore them. That would be bad strategy—underestimating the enemy's strength. In my language there is a saying, "If you are going out to hunt foxes, then carry some bullets for lions also."

On the other hand a negative anthropology also gives us a realistic strategy in our war on AIDS. The option to recommend condoms as a preventive strategy falls under this category. Recommendation of condoms is a humble confession of human weakness. The same applies to the issue of stigma and discrimination against PLWHA. Who, after all, sanctions stigma and discrimination against PLWHA? Is it not the followers of the glorious anthropology, the self-proclaimed perfectionists? If we give due recognition to the reality of human fallen-ness, then we shall certainly not judge others. Rather, we might judge our own attitudes.

The Synthesis: But We Will

Finally, what happens when the thesis is countered by the antithesis? Is there an un-ending struggle between the two? No. That is not dialectics. That would be dualism. In dialectics the struggle between the thesis and the antithesis evolves into a third option, the synthesis. So far, I have described the tension between two types of anthropology—positive and negative. But the matter does not end there. It continues from there until it evolves into a synthesis, a third type of anthropology, which I might call a "strategic anthropology." I call it "strategic" because this new anthropology helps us to plan new moves in our war on AIDS. Yes, it is true that we are created in the image of God. Yes, it is equally true that we are fallen beings. But on top of every other truth, there is the final truth that, after all, we are redeemed beings. Our redemption brings to us the final synthesis of the mutually opposing aspects of our being. Christ, our Peace, and our Passover provides the ultimate point for that glorious synthesis as Paul says:

God was reconciling the world to himself in Christ,
Not counting men's sins against them.
And he has committed to us the message of reconciliation.[24]

This synthesis gives us the ultimate guidance in our ethical struggle in the context of PLWHA. We shall neither unduly pamper ourselves because of our creation in God's image as that might make us pseudo-perfectionists whereby we might be tempted to stigmatize and discriminate against PLWHA. On the other hand we shall also not be bogged down by the human fallen-ness and failure as that might tempt us into defeatism and thereby surrender in the battle. If we want, but can't, we should not just rant! We should keep on moving towards the synthesis and say, "Yes, we *think* we can. Yes, we *admit* that we can't. But, by God's help, we *know* that WE WILL."

St. Paul describes this glorious synthesis beautifully as follows:

We are hard pressed on every side, but not crushed;
Perplexed, but not in despair;
Persecuted, but not abandoned;
Struck down, but not destroyed.[25]

Emboldened by such faith, we begin to share a new anthropology. In that new anthropology we no longer think in terms of ourselves as the thesis and the PLWHA as the antithesis. No. We rather begin to appreciate that PLWHA do not represent the terminality, but there is something beyond them, the real synthesis. This movement towards the synthesis necessitates the involvement of PLWHA into the fullest enjoyment of life. They become an integral part of the dialectical reality of life. Then we no longer think of the ethical responsibility of the NON-PLAWHA to the PLWHA, but the ethical responsibility of *both* the NON-PLWHA *and* the PLWHA to the rest of the world. Thus in this synthesis PLHWA no longer remain as mere objects, and we as the real subjects of agape. But they too become subjects along with us so that like Paul we might

proclaim: "In Christ there is no positive, and no negative, but all are reconciled into a new humanity!"

Conclusion

In the foregoing pages I have attempted to offer a Christian reflection on ethical dialectics in the context of PLWHA. My main submission was that instead of taking the easy route of dishing out ethical advice as to what we should do for PLWHA, or for that matter, what ethical responsibilities could be assigned to the PLWHA themselves, we first need to philosophically analyse their existential dilemma. I attempted that analysis and isolated two elements in the existential dilemma of PLWHA: involuntary objectification and nihilism. Furthermore, I have presented the ethical dialectics in its three facets: the thesis (positive anthropology), the antithesis (negative anthropology), and the synthesis (strategic anthropology). My main recommendation was that this last facet (the synthesis, or strategic anthropology) has the potential to solve the existential dilemma of PLWHA and thereby integrate them into our programme of ethics. The entire presentation drew from insights in theology, philosophy and biblical studies.

I should like to conclude this paper by reiterating that this is a military scenario. We are involved in a battle. HIV/AIDS is the enemy. It is attacking us on every side. It is outwitting us in our smartest maneuvers. This is a fateful battle. Our defeat or surrender to the enemy will mean our total annihilation from this planet. Can we be prepared to accept defeat and surrender? No! Never! This is one battle we cannot afford to lose. With our great synthesis in Christ, with our newfound strategic anthropology, with confidence in ourselves as the redeemed children of God, we shall fight on, because God is waiting for us with the sweet reward of victory. In the immortal words of Shakespeare:

> *The gods today stand friendly that we may,*
> *Lovers of peace, lead on our days to age.*
> *But since the affairs of men rest still incertain,*

128

Let's reason with worst that may befall.
If we do lose this battle, then is this
The very last time we shall speak together?
What are you then determined to do?[26]

Notes

[*]I am deeply grateful to the WCC, the EHAIA, and the UPAO for the kind invitation to participate and present this paper in the Conference on Ethics and HIV/AIDS.

[1]Arthur Okwemba, "Aids Vaccine Fails Crucial Test," *Daily Nation* (Nairobi), 2 September 2004, 23.

[2]*Daily Nation* (Nairobi), 28 August 2004.

[3]John S. Mbiti, "The Biblical Basis for Presents Trends in African Theology," in K. Appiah-Kubi and S. Torres, ed., *African Theology En Route* (Maryknoll, New York: Orbis Books, 1979).

[4]J. Philip Wogaman, *Christian Ethics: A Historical Introduction* (London: SPCK, 1993), 2-15.

[5]Richard H. Popkin and Avrum Stroll, *Philosophy Made Simple* (London: W. H. Allen, 1969), 1.

[6]J. Kahiga Kiruki, *Introduction to Critical Thinking* (Eldoret, Kenya: Zapf Chancery, 2004), 135.

[7]H. Odera Oruka, *Practical Philosophy* (Nairobi: Nairobi University Press, 1990), 2. Quoted in Cletus N. Chukwu, *Applied Ethics and HIV/AIDS in Africa* (Eldoret, Kenya: Zapf Chancery, 2003), 40.

[8]John Wilkinson, *Christian Ethics in Health Care* (Edinburgh: The Handsel Press Ltd., 1988), 3

[9]Chukwu, 39.

[10]Popkin and Stroll, 47-54.

[11]Ibid., 44.

[12]Naturalism holds that not only are moral judgments true or false, but they are also reducible to the concepts of some natural science (usually psychology). Non-Naturalism holds that whereas moral judgments are true or false they cannot be reduced to any natural science. On the other hand, emotivism holds that moral judgments are neither true nor false, but are merely expressive of the feelings of those who utter them, and evocative of the feelings of those who hear them. See Popkin and Stroll, 48.

[13]See, for example, *Crime and Punishment* by Doestoevsky and *The Myth of Sisyphus* and *The Outsider* by Camus.

[14]Ved Mehta, *The New Theologian*
(London: Weidenfeld and Nicolson, 1965), 3. Mehta was commenting on Bishop John A. T. Robinson's article "Our Image of God Must Go" which was published ahead of the bishop's famous book *Honest to God.*

[15]Wilkinson, 44-45.

[16]Popkin and Stroll, 2-3.

[17]Musa Dube, "HIV and Other Challenges to Theological Education in the New Millennium," in Grant LeMarquand and Joseph D. Galgalo, ed., *Theological Education in Contemporary Africa* (Eldoret, Kenya: Zapf Chancery, 2004), 109.

[18]E. Otto, *Theologische Ethik des Alten Testaments* (Stuttgart: Kohlhammer, 1994), 62. Quoted in John Barton,
Understanding Old Testament Ethics (Louisville and London: Westminster John Knox Press, 2003), 1.

[19]C. B. Peter, "In Defence of Existence: A Comparison Between Ecclesiastes and Albert Camus," in *Bangalore Theological Forum*, Vol. XII, No 1 (1980-1): 30.

[20]Job 4: 17-21 NIV.

[21]Romans 7:14-24 NIV. Compare this with the Latin poet Ovid in his *Metamorphoses*:*Video meliora proboque/Deteriora sequor.*
(I see the better and approve it, but I follow the worse). Quoted in Wilkinson, 48.

[22]Wogaman, 192.

[23]Wilkinson, 471.

[24]II Corinthians 5:19 NIV

[25]II Corinthians 4:8-9 NIV

[26]William Shakespeare, J*ulius Caesar.* Cassius to Brutus, Act V, Scene i. Quoted in Chukwu, 154.

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CHAPTER SEVEN

Gender and Ethics in the Fight Against HIV/ AIDS: A Case Study of Mark 5: 25-34 in an African Context

Priscille Djomhoue

Introduction

The Israelites, the Babylonians, the Persians and the Greeks explained a disease, or sickness, or illness, in two ways[1]: It was understood on the one hand as a punishment or consequence for an individual's or family's sin (Deut. 28:58-61; 2 Sam 24:15; 2 Kings 5:27; Ex 20:5; etc.). But then the Bible also stresses that Job was a person of integrity and uprightness, a man who feared God and shunned evil so that there was no one like him on earth (Job 1:8). In the New Testament we read about the man born blind. Jesus plaonly maintained that neither the sin of the man himself, nor that of his parents was the cause of his blindness. Thus the ancient idea was fought by Jesus who refused to attribute sin as an "a priori" cause to all sicknesses (John 9:2-3).

On the other hand, the ancient peoples that suffering came as a result of demonic presence. The offended demons would revenge by sending sicknesses, diseases, and mental illnesses. Also certain infirmities such as deafness and muteness (Mark 9:25) came as a result of demonic influence. The New Testament, apart from Luke 4:40, generally distinguishes between the sick and the demon-

possessed. For many years, HIV/AIDS has been associated with evil spirits because of its incurable character. Certain sick people would prefer to go and consult a traditional practitioner, when the modern medicine was unable to offer a solution. But research today demonstrates that HIV/AIDS is an infectious disease which one can contract just like any other. This enables us to say that the disease can infect anybody, whether upright or sinner.

The dictionary defines a disease as deterioration of health, in the functions of the living beings. The disease can affect a person at a certain place, just as it can rage constantly in a very extended geographical zone. This is why HIV/AIDS is known as a "pandemic."

Unlike others diseases, HIV/AIDS up to today remains incurable. This means that it affects many people whom it surely and progressively destroys. The Bible does not know HIV/AIDS, but it mentions some sicknesses like the pestilence that made great devastations, while the physicians of Egypt watched helplessly (Ex. 9:15; Lev 26:25; Deut. 28:21). We also know incurable diseases which some people have recovered from, for example the woman who was bleeding for 12 years. The sickness of that woman has similarities with HIV/AIDS because of its incurable character, also in relation to the damages it caused.

It is for this reason that we have chosen Mark 5:25-34 as a paradigm for our reflection. Our problem rotates around the following question: Considering the experience of the woman of Mark 5:25-34, can we have reasons for hope in the face of HIV/AIDS? How do we treat this pandemic? The reading of the text will allow us to highlight the damages caused by the loss of blood. And the woman's attitude (and also that of Jesus) which led to her healing will allow us to ask for a basis of healing of HIV/AIDS in Africa and in the world. We will articulate our reflection in three points: the description of the disease and its consequences, the healing of the anonymous woman, and the possible healing HIV/AIDS in Africa.

The Disease and Its Consequences

The account of the bleeding woman is known to the three evangelists as recorded in the three Gospels. They all insert it into the account of the healing of Jairus' daughter (Matthew talks of the daughter of a notable person: Mt. 9:18-26; Luke 8:40-56). The account begins at verse 21 with the story of Jairus' daughter. This story is interrupted in verse 25, picked up again in verse 36 and ends it verse 43. In reality, our account presents an intrigue set within this periscope. It presents a certain number of actors: the sick woman, the physicians, the society which we can compare to a certain extent with the crowd, Jesus and the disciples. The problem is that of the sickness of the woman of which she is healed and set free at the end of the account.

The Sickness

The description of the sickness of that woman is very short in verse 25. The text talks of blood. The text does not mention what type of haemorrhage that woman suffered from, but it is assumed that it was a case of uterine bleeding. Referring to Leviticus 15:19-30, we learn that such type of bleeding in a woman was viewed as making her impure together with anybody else who would come in contact with her.While the text is silent about details of the sickness, it does inforsm us about its manifestations and on its multidimensional consequences.

Social and Psychological Consequences

The verb "to afflict" is eloquent. It means to hit hard, to overwhelm with illness or misfortune. The woman is hit by an illness that has physical consequences on her person. She feels pain. We ask ourselves whether we should not take the number 12 here in its symbolic sense. If it translates "the totality," we can understand better that the the biblical author of this text wanted to put more emphasis on the fact that that woman has spent her life moaning and enduring her illness. It is clear that it is not an occasional illness, but a lasting situation, which becomes part and parcel of the daily

life of the sick person. But those physical pains are doubled by many other pains: the state of impurity brought by her illness preventing her from being with others, thus bringing about her isolation from others. That is, she is stigmatized and rejected by the society. This rejection makes her become a social outcast, that is, a person who does not exist in the eyes of the society. We think that the fact that this woman is anonymous, the fact that she is presented without any reference to a certain family as it is the case with the account of Jairus' daughter of that periscope corroborate well that this idea.

Another indicator in the text which shows the stigmatization of this woman is the use of adjectives "apprehensive" or "afraid" and "trembling" in verse 33. These adjectives present the psychological state of this woman. She is a frustrated person. The disciples have somehow reason to consider that their master asks a ridiculous question, because in the crowd, people inevitably touch each other without knowing. The woman feels guilty and panics for she has suffered social isolation for quite a long time, and also because she is aware that she has done what was not permitted. In summary, the anonymous woman is physically, socially and psychologically sick. And the list of these sicknesses is endless.

Financial Consequences

Verse 26 presents her economic and financial situation. That situation has evolved because her riches have gone over time. She was a rich woman, who was able to pay her physicians. We have to note that at that time it was luxury and a sign of being economically well off, to be treated and followed up by a Physician.[2] This mention of earlier riches of the woman shows well that the sickness is not linked with a particular class of people, it can affect anybody. The tone of the account is very significant: "she had suffered a great deal under the care of many doctors" (Verse 26). This sounds like a critique of the medical group, which is partly responsible for the financial suffering of the woman. Have they made her spend on medical treatment more than she ought to have spent? Are we not ourselves victims of a swindling situation whereby physicians without

ethics and laws could have been primarily preoccupied with filling their pockets without necessarily any concern of the health of the sick person? The text seems to confirm this hypothesis, for it affirms that after she had spent all that she had, she was not only without any improvement but also her situation worsened (5:26). It is also possible that this assertion is meant to stress the incompetence and ignorance of the doctors. But the tone of the text makes us incline towards the first hypothesis.

The unfortunate, woman ruined is forced to adopt an attitude taken by the poor of that time in case of illness, that which consisted of consulting the traditional healers. Mark, in this text, gives us a picture of the society in which the State does not take responsibility for the health of its people. Having heard therefore talking about Jesus as an exorcist who is particularly good, she goes to him (Verse 27). But she does not even dare to present her case to Jesus, but decides to introduce herself in a somewhat fraudulent manne. This is probably because either she is aware of the fact that she is not allowed to be mingled with the crowd thus feels shame, or because she is no longer able to pay the standard fee of an ordinary traditional healer.

She believes that she will be healed by a simple contact with Jesus' garments. The question Jesus asks is very interesting. The sick woman has conducted herself in a way in which she should not have done it. So Jesus asks, "Who touched me?"She unveils herself and, to everyone surprize, Jesus adopts the attitude which could not have been adopted by a true Jew of that time. At the Jesus' question asking who has touched him, she becomes greatly afraid because she has become used to being excluded and treated without care. She tells Jesus everything, Jesus, far from being irritated, treats her with sweetness and calls her affectionately, "my daughter,"[3] and pronounces that her healing is definite (verse 34).

The Healing of the Woman

We want to show in this chapter that the healing of the woman suffering from bleeding is not to be taken in a magical, or fetish,

sense. Her healing does not come from a power which can be obtained from objects, for example object used by Jesus (in this case his garments, which the woman touched at first. There are people who think that objects linked to Jesus like the Bible, used as talisman, can deliver them from evil powers. Here it is the power of God, (which is Jesus Christ himself), which brings about the healing of the woman. A number of conditions were met in order for this to happen, and Jesus is right when he declares: "Your faith has healed you." If we say that the healing is not to be taken into a mere magical sense, in reality it is because we want to highlight also the responsibility of others, both in the suffering and the healing. To give the God-given liberation a mere magical character would be to separate humankind from is responsibility of participation with God in the work of liberation of fellow human beings.

Therefore, in order for the sick woman to be liberated, it involved a commitment on her part, and also the commitment of others who are with Jesus. That is why men and women who follow Jesus are called to imitate him.

The Woman

The liberation of the woman comes first of all from her courage and her ability to dare, to dare violate laws, which might even provide for a death sentence for someone mingling fraudulently with the crowd. She dares break the taboo of impurity.

We have to realize that in each miracle of Jesus there are notmally two aspects: the acceptance of the sick and the work of the Saviour. In other words, Jesus is the one who plays the principal part in the process which leads to the liberation and healing: At Pool of Bethesda (John 5), Jesus, before healing the disabled man, wants to asctertain the sick man's willingness for healing. In the account of the resurrection of Lazarus John 11), everyone seems to have accepted the fact of Lazarus' death, and Jesus' work is seen in terms of a high level of initiative. Bur in our case here, Jesus seems to be passive and the woman some how snatches healing from him.[4]

Jesus

The courage and the willingness of the woman are supported by Jesus' action, which took the opposite direction of what we would have expected. With the woman's situation of impurity, instead of accusing her of hypocrisy, he treats her affectionately. The compassion of Jesus towards the woman is always the same which he has been manifesting all along towards the sick and the suffering people. It is in fact that attitude to which are invited those who live with the sick and people living with HIV/AIDS.

To Treat and Heal HIV/AIDS in Africa

The reading of Mark's Gospel should inspire us in the fight against HIV/AIDS in Africa. It is certain that there is a big gap in terms of time between the text and us. But we will be inspired by the text because despite that gap, there are certain similarities between the people of the period of the text and African societies in modern times.

The Society.

The society of the text present a stratified social structure. There are the rich minorities who can afford to hire a doctor; there are middle classes who can afford to pay the treatment of a traditional healer or nurse; and then there are the poor who follow Jesus, because this one does not ask anything for any service offered.

In Africa, there are people who can afford private hospitals for referral; there are those who only have means for public health facilities; there are those who can only go to traditional healers; and finally there are those who take refuge in the Church. But the Church sometimes seems overburdened and lost, not knowing how to react to the situation.

The medicine.

One of the underlying hypotheses in our text is that in the case of the suffering of the woman with hemorrhage, there is incompetence of the physicians in the face of an illness which they could not

master. In Africa, doctors, nurses, etc. are not always informed and updated about the most recent advancements in medicine. Poverty, corrupt intentions, and lack of interest of our governments do not always allow the continuous training and re-training of the medical personnel. Therefore, when cases of new sicknesses are reported, we only have to guess. If there is an elite medic who would want to apply modern techniques to old and new cases of sickness, there will always be something missing on the ground, either appropriate material, or enough physicians. We know the *leitmotif* in the laboratories of our hospitals, "There are no chemicals." We are not always capable of buying for ourselves modern materials, or state of the art medical equipments. Beside the modern medicine, there is traditional medicine which subsists with its rudimentary means.

3. The Culture

One of the aspects of the society (the context of the text) is characterized by the fact that the woman was considered more as a thing than a person: in the society. She occupied an entirely subordinate place. She is depicted as a being always dependant on others. Before marriage, her father would be her master (1 Sam 18:17), after the mariage the husband; and finally, at the death of the husband, she becomes dependent on the first born sons. The only consideration she gets is being the mother of sons she gave to the family.[5] Just like the woman, young peopel also have more obligations than rights. They do not have any word which counts, they have no power of decision making. In Africa, the situation is qrite a bit the same.[6]

To treat and heal HIV/AIDS in Africa and worldwide, needs a miracle, just as it was the case for the woman with haemorrhage. This miracle is possible if many forces can converge towards that end—the sick or the those that are positive, the State, the doctors, men and women who are not yet infeceted but affected all the same, and the church. The whole society must mobilize its efforts for the miracle to happen.

The Sick and the HIV Positive People

These must fight against any form of oppression and dehumanization. This implies a lot of courage on their part. They must care for themselves by developing a positive attitude, namely prevention from re-infection and avoid to infect other people, who are not yet positive. Those attitudes, somehow would stop the proliferation or the evolution of the disease.

They must also come out of their hiding places and go where other people are, go to the physicians and counselors in that field. Their testimony will inspire other people with a sense of courage and fortitude.

The Physicians

Contrary to the physicians of the account of the bleeding woman, doctors have the responsibility to put into practice the oath of Hippocrate which they take at the end of their studies, namely to be preoccupied first of all with the health of the patient. The invasion of HIV/AIDS has created in our societies the dire need for change. A popular adage says, "AIDS is a thick coin business." Whole medical team are mobilized with the support of donor money, and many complain when they are not made part of the team. But that complain does not reflect a care for the vocation, but the disappointment of not benefiting from huge budgets which international organizations put into the fight against the pandemic. Also, at a certain time, doctors had created parallel channels of sale of ARV drugs. If there were no such adjunct points of sale, it was only to corrupt the doctor and the pharmacist in order to buy the drugs. This is shocking beyond words. Many sick people and families were impoverished in such situations. Fortunately, prices of ARV drugs have now considerably dropped, but access to the drugs is not always certain for various reasons. However, this does not mean that there in no doctor who is devoted.

The State

The principal responsibility of the governments in the fight against HIV/AIDS will consist of creating and subsidizing the systems of Medical Insurance so that every citizen who is sick may have access to treatments and medicines.

One of the main reasons of the threatening predominance of HIV/AIDS is poverty. The fight against the pandemic would consist of creating jobs and organizing economic systems so that at least the daily bread may not remain elusive for most people.

The Family and the Environment

The resoponsibility of the family in sympathizing with others, to consider their ability, to accept infected people as human beings, is indispensable. But even those supposed to be not yet infected, stand in need of testing in order to prevent it.

Those not infected who take care of the sick must know the measures to take to protect themselves from infection.

The Church

We refer to the document of WCC[7] (World Council of Churches) which asks the churches to endeavour for better care of infected people:

- To give them particular attention, especially to children of all ages who are affected by the pandemic, and to create around them an environment which understands and supports them
- To help to safeguard the rights of infected people
- To define and to promote those rights via existing channels both at the national and international levels
- To promote and facilitate the exchange of correct information about HIV/AIDS, and to promote open discussions and fight against under-information and fear
- To plead that medical institutions and governments allocate more funds to the search for a lasting solution to

the medical and social problems which aggravate the pandemic

The church must help in the fight so that certain traditional aspects in our cultures, which promote the proliferation of the vice of HIV/AIDS, may be abolished.[8] There are in African cultures, elements which may favourably influenceour fight against HIV/AIDS. These are: for example, the encouragement of virginity and the discouragement of sex before marriage both for the girl and the boy. In our cultures, the virginity was mandatory for a young girl and not for the young man. Today, the challenges of HIV/AIDS call for a reconsideration of the gender. Male and female, at the same level, are all called to equal responsibility.

The challenge of the pandemic calls for a re-definition of roles, and to a reconsideration of male and female. It calls for the equal right of education, right of participation, and right of decisions-making for both women and men.

The Church must help men and women to remove from our culture certain risky practices, for example, Lévirat, sorority, polygamy, excision, and scarifications.

Africa must also break certain taboos, especially the taboo linked with sex. In many families, sex is not talked about in the presence or with children. The family is a place *par excellence* where to educate a child. If a child does not get from his or her parents certain information at that level, he or she will receive distorted information from the streets.

Notes

[1]Alexandre WESTPHAL, *Dictionnaire Encyclopédique de la Bible*, Tome II, Valence, Imprimeries réunies, 1935, p. 86.

[2]Cf. Etienne TROCME, *L'évangile selon Saint Marc*, Genève, Labor et Fides, 2000, p. 151.

[3]See also Etienne TROCME, op. cit. p. 152.

[4]Louis BONNET, *Le Nouveau Testament Explique 1: Matthieu, Marc, Luc*, édition revue et augmentée par Alfred SCHROEDER, St Légier, Emmaüs, 1985, p. 343.

[5]See H. MEHL-KOEHNLEIN, "Femme" in, J.J: Von Allmen,*Vocabulaire Biblique*, Neuchâtel, Delachaux et Niestlé, 1956, p. 103-104. However, the OT knows another era of appreciation of the woman. There are those who participated in public manifestations, namely to popular religious feasts (Deut 1:12; 2 Sam 6:19), to sacred festivals (1 Sam 1:4). They have the right to perform certain duties in the sanctuary (Ex 38:8). In the judiciary, girls have the right of paternal inheritance where there no boys (Numb 27:8). The OT also signals the important role played by certain influential women- judges or prophets (Mary sister to Moses, Ex 15:20, Deborah, Judges 4, 5; Hilda, 2 Chr 34:22f; Rehab, Jos 2:9, etc.).

[6] Cf. Patricia France Bruce, "The Mother's Cow: A Study of Old Testament References to Virginity in the Context of HIV/AIDS in South Africa" in, Isabel Apawo Phiri et. al., *African Women, HIV/AIDS and Faith Communities*, South Africa, Cluster Publication, 2003, p. 44-70; Beverley Haddad, "Choosing to Remain Silent: Link Between Gender Violence, HIV/AIDS and the South African Church" in, Isabel Apawo Phiri et. El., *African Women, HIV/AIDS and Faith Communities*, South Africa, Cluster Publication, 2003, p. 149-167.

[7] Face au SIDA : l'Action des Eglises, Document d'Etude du COE, WCC Publications, Geneva, 1998, p. 106.

[8] Cf. Musa DUBE, "Talitha Cum! Calling the Girl-Child and Women to life in the HIV/AIDS and Globalisation Era" in, Isabel Apawo Phiri et. El., *African Women, HIV/AIDS and Faith Communities*, South Africa, Pietermaritzburg, 2003, p. 71-93.

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Beverley Haddad, "Choosing to Remain Silent: Link Between Gender Violence, HIV/AIDS and the South African Church" in, Isabel Apawo Phiri et. El., *African Women, HIV/AIDS and Faith Communities*, South Africa, Cluster Publication, 2003, p. 149-167

Part Two

Curriculum Development: Suggested Modules on Christian Ethics and HIV/AIDS

1. ETHICS OF PREVENTION
(French Speaking Group)

Introduction

What do we understand by Prevention? In reality it is to take measures or rather a group of measures, which aim at warning an individual or the society about the imminent danger of contracting HIV.

Ethically, it is to think about all measures that can help a person or the society to adopt an attitude appropriate to the current context characterised by the threat of AIDS. This will include the relationship of men and women with one another. Prevention also calls for education and responsibility in order to limit the spread of the pandemic. Thus prevention is meant to protect those who are not yet infected on the one hand ,and challenge those living with HIV not to worsen their situation on the other.

However, prevention does not merely target those suffering from HIV/ AIDS. It targets the entire society.

Objective

The main objective is to protect , as long as we can, the life of people at all levels. In that perspective, we strive to meet the following objectives:

- Socially, our objective is to maintain and to develop the solidarity, the cohesion and communication in the society by urging the PLWHA in the society to share their experiences and to offer useful knowledge on the problems of this vice. Also, by Prevention we aim at breaking the taboos that reinforce the barrier

of silence encouraging reflection on the future and enthusiasm of the person and the society.

- § To bring the members of our societies to get rid of such elements of our traditions as levirat and sorority which,in the context of HIV/AIDS become, risky behaviours
- § To educate the public on the economic and political consequences of HIV/AIDS.

Main Themes to Be Tackled

- § The meaning of life
- § Personal and collective responsibility
- § Sexual, moral and spiritual education

Methodology

Training (familial, school, academic, cultural, spiritual), songs, sketches, narrations, proverbs, sculpture.

Duration

Permanent training until the final victory against HIV/AIDS.

Assessment

- § Permanent evaluation until the final victory against HIV/AIDS
- § Evaluation of the outcome

Bibliography

- § Reading of the Proverbs
- § Leviticus and Laws on sexuality

2. ETHICS OF PREVENTION
(ENGLISH SPEAKING GROUP)

Introduction

In spite of the fact that the modes and means of transmission are well known, HIV/AIDS cases continue to increase in many parts of African continent;

This module highlights the preventive strategies of HIV/AIDS in light of insights from Ethics and theology in the 21st Century.

Aim

This module aims at critiquing the philosophical and Ethical foundations of the current HIV/AIDS prevention strategies with the view to helping the learner to come up with more task focused, result oriented and effective strategies.

Learning Objectives

By the end of this module, students should be able to:

1. Define Ethics of prevention
2. Identify Ethical theories underlying preventive strategies
3. Highlight the strengths and weaknesses of Ethical theories underlying preventive strategies
4. Formulate life affirming and effective strategies for prevention of HIV/AIDS in the African context

Course Content

1. Definition of terms and key concepts

2. Current preventive strategies in relation to modes of transmission via:
    a) Sex
    b) Blood
    c) Mother to child
    d) Etc
3. Ethical theories underlying each preventive strategy
    a) Deontology
    b) Consequentialism
    c) Situationism
    d) Emotivism
    e) Determinism
4. A critique of Ethical Motivations
    a) Individual survival
    b) The context of relationship
    c) To please God

Methodology

1. Class room Lectures
2. Group Dynamics
    a) Brain storming
    b) Role Play
    c) Focussed group discussions
    d) Case studies from real life
    e) Exposures / Visits

Duration of Training

35-40 hours depending on time duration/time allotted

Assessment

1. Class test
2. Term Paper
3. Examination

Bibliography

Chukwu, Cletus N. *Applied Ethics and HIV/AIDS in Africa*. Eldoret, Kenya: Zapf Chancery, 2003.

Deutsch, Charles and Sharlene Swart. *Learning from One Another.* South African Theological Publications in India: 1995.

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3. ETHICS OF PREVENTION-2
(ENGLISH SPEAKING GROUP)

Introduction

1. Course on HIV/AIDS prevention
2. Explain HIV/AIDS
3. Brief history of HIV/AIDS
4. Ways of transmission

Aim

To understand moral and ethical issues surrounding prevention of HIV/ AIDS infection

Objectives

By the end of the course, the learner is expected to be able to:

1. Clarify what ethic of prevention is
2. Explain the need to prevent HIV/AIDS
3. Identify different roles necessary for prevention

Content

What ethics of prevention means/involves

1. The Biblical basis of prevention
2. Training/education
3. Methods of prevention
    a) Abstinence
    b) Being faithful
    c) Condom usage
4. Traditional moral values

a) Breaking the (silence) taboo
b) Sex education by parents and pastor

5. Role of the state
    a) Political will/commitment to action
    b) Designing policy
    c) Using resources
    d) Mobilizing local community
    e) Creating action group
    f) Using peer group
6. Mobilizing stake-holders
    a) PLWHA
    b) The affected
    c) Healthcare providers/traditional healers

Methodology

1. Classroom lectures
2. Assigned readings
3. Music, dance, drama
4. Participation of PLWHA

Duration

45 hours per semester for the award of certificates.

Assessment

1. These must be continuous assessment and tests
2. Written examinations must be conducted
3. Assessment of teachers

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4. ETHICS OF QUALITY CARE
(French Speaking Group)

Introduction

Quality care consists of providing adequate care to a person or a group of persons in a difficult situation.

In other words, it is one of the ways of fighting the HIV/AIDS pandemic, by taking care of infected and affected people.

In our work, it is our duty to examine, to organize and to reflect on the need of care and how best such care can be given. For quality care a bond of faith, hope and love is necessary between the caregiver and care receiver..

Goal and Objective

Our goal is to put in place measures which aim at easing the negative effects of the disease of the sick person, that is:

- To help him or her to manage his or her physical, moral and spiritual suffering
- To restore in him or her human dignity
- To integrate him or her in the society as a player and participant in economic, political and cultural life of the community
- Also we have as other objectives to census a certain number of qualities , namely: kindliness, availability and sincerity; all these qualities, produce psychological, effects which are favorable to a more responsible and abundant life.

Main Themes to Be Tackled

- Invitation to the promotion and respect of human rights
- Invitation to cultural concept of humankind in Africa
- Promotion of African values such as fraternity and solidarity in the daily lives of individuals and communities
- The meaning and sacredness of life
- Faithfulness to life and to God

Methodology

- Sensitization of the communities by spiritual leaders
- Preaching and working for an awareness of the sacredness of life
- Training the opinion leaders on measures to be taken to enhance a quality life among the suffering people
- Collecting funds for material and financial support of the sick people
- Exhortation of the care-receiving people to accept their situation and enjoy again the taste of life in order to become again full time players in the life of the community. It is here that we talk of the social reintegration of the sick person.

Duration

The duration of training as well as for supervision is indefinite, that is permanent and continuous.

Assessment

- Theoretical evaluation to see whether the caregiver has assimilated the methods of work
- Observation and testimonies of the infected and the affected

Bibliography

The whole literature and pastoral sources related to the care and the supervision of the sick people.

5. ETHICS OF QUALITY CARE

(English Speaking Group)

Introduction

HIV/AIDS continues to cause considerable pain and suffering for those infected and affected by it. Evidence indicates that much of this pain and suffering can be prevented or managed successfully by quality care.

This module seeks to expose underlying problems and existing care strategies with the view of identifying the right modals of quality care in the context of HIV/AIDS in Africa.

Aim

This module seeks to define key concepts underlying quality care, critique them in light of contemporary realities and improve upon them to develop desirable modals for quality care.

Learning Objectives

By the end of this module the student will be able to:

1. Define key concepts in quality care
2. Identify underlying problems that militate against quality care in the African context
3. Highlight those modals of quality care that are life affirming and enhancing
4. To critique Ethical theories related to quality care and identify suitable Ethical frame works/modals for quality care in the context of HIV/AIDS.

5. Formulate a comprehensive plan for quality care to be used by the community

Course content

1. Definition of terms and key concepts in quality care
2. Appraisal of the people infected and affected of HIV/AIDS in the community
3. The history/types of care – in reference to:
    a) The Bible
    b) Church history
    c) Nursing movement
    d) Red cross
4. Ethical foundations of care in relation to:
    a) Deontology
    b) Consequentialism
    c) Situationism
    d) Principle of beneficence
5. Quality care should take into account
    a) Nature of sickness
    b) Partnership of recipient and caregiver
    c) Its being Holistic
    d) Its being relationship based
    e) Its being a continuum

Methodology

1. Class room Lectures
2. Group Dynamics
    a) Brain storming
    b) Role Play
    c) Focussed group discussions
    d) Case studies from real life
    e) Exposures / Visits

Duration of Training

35-40 hours depending on time duration/time allotted

Assessment

1. Class test
2. Term Paper
3. Examination

Bibliography

Chukwu, Cletus N. *Applied Ethics and HIV/AIDS in Africa*. Eldoret, Kenya: Zapf Chancery, 2003.

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6. ETHICS OF QUALITY CARE-2

(English Speaking Group)

Introduction

1. Why is it important?
2. How it may be seen?
3. Important question asked ?
4. Issues arising
5. What the module seeks to do

Aim

To come up with a model of quality care that is Ethical/moral from a widely acceptable parading.

Objectives

By the end of the course learners should be able to:

1. Define quality life
2. Show the complexity of quality life
3. Assist PLWHA lead quality life
4. Assist the affected to face the existential situation
5. Assist the infected and affected at physical, social, psychological and spiritual levels.

Course Content

1. THE MEANING OF THE ETHICS OF QUALITY CARE

a) What/which Ethics?

b) Ethics of: Love, Respect, Human Dignity

c) Useful traditional models of care (E.g. traditional concept of family where children of my brother/ sister are mine)

2. *THE SANCTITY OF LIFE*
   a) Ubuntu/Botho e.g. traditional concept of adperson
   b) Creation (e.g. Genesis)
3. *COMMUNITY*
   a) Reclaiming sound aspects of African idea of community (doing away with individualism)
   b) Africanization of globalisation
   c) Ethics of participation (no victims but all are partners in working for Ethical quality life)

Methodology

Lectures, assigned readings, seminar/workshop, dance, drama, music, PLWHA participation, practical internship, dialogue, cell group training

Duration

45 hours on going.

Assessment

Internship/practically based. Interview of beneficiaries of internship

Bibliography

WCC literature and relevant material

7. ETHICS OF BREAKING THE STIGMA
(French Speaking Group)

Introduction

1. By stigmatization, we understand: the frustrations, despair, marginalization, abandonment and the discrimination against the PLWHA
2. It is the issue of showing love practically and to regenerate hope
3. To search for the manifestation of the results of ethics of quality care (see previous sub-theme).

Goals and Objectives

1. To combat against all forms of stigma and discrimination directed at the sick person and those around him or her (the adftected) tto seek to liberate the infected and the affected from the inferiority complex in relation to HIV/AIDS.
2. To ensure from the society a sincere acceptance of the sick person . Our fundamental objectives are:
    a) To rebuild and to reinstall social and communal equilibrium
    b) To inculcate in the community a group-dynamism which would promote a permanent fight for the preservation of everybody's life
    c) To exhort and urge the community to practice a true solidarity wit those infected or afftected by HIV/AIDS
    d) To enhance the economic, political and cultural profitability of the community

Thems to be Tackled

1. The understanding of Hospitality and Solidarity in Africa
2. The understanding of rights for life and human equality (*see, texts on human rights and what Jesus Christ says in the Gospel*)

Methodology

1. To create time for reflection and Forums for interdenominational exchange
2. To encourage testimonies of PLWHA

Bibliography

(see, above)

8. ETHICS OF BREAKING THE STIGMA
(English Speaking Group)

Introduction

Stigmatisation resulting from HIV/AIDS is morally wrong, since it is part of the process of dehumanisation of people infected and affected with HIV/ AIDS.

Therefore destigmatization of HIV/AIDS is imperative as part of the rehumanisation of the oppressed.

This module therefore seeks to appraise the various modes of stigmatisation towards getting an Ethically sound programme of destigmatization.

Aim

This module aims at equipping the participants /learners with the necessary knowledge of the causes and effects of stigmatisation and the skills to formulate an Ethically sound programme of destigmatization.

Learning Objectives

By the end of this module the students will be able to:

1. Understand what stigmatisation is and how it affects those living with and those affected by HIV/AIDS.
2. Identify the sources and causes of stigmatisation in a multidimensional context
3. Formulate a programme comprising various strategies of destigmatisation

Course Content

1. Definition/Clarification of terms and key concepts
2. Sources of stigmatisation
    a) Culture
    b) Religion
    c) Ethics
    d) Economy
    e) Politics
3. Effects of stigmatisation
    a) Alienation
    b) Continued infection (snowball effect)
    c) Etc.
4. The Task of Destigmatisation
    a) Biblical and Ethical bases for destigmatisation
    b) Education and training
    c) Strategic planning
    d) Church fellowship
    e) Use of ICT and mass media to deconstruct the past presentation regarding HIV/AIDS
    f) Resource mobilisation

Methodology

1. Classroom Lectures
2. Group Dynamics- Brain storming
    a) Role Play
    b) Focussed group discussions
    c) Case studies from real life
    d) Exposures / Visits

Duration of Training

35-40 hours depending on time duration/time allotted

Means of Assessment

1. Class Test
2. Term Paper
3. Examination

Bibliography

Chukwu, Cletus N. *Applied Ethics and HIV/AIDS in Africa*. Eldoret, Kenya: Zapf Chancery, 2003.

Deutsch, Charles and Sharlene Swart. *Learning from One Another.* South African Theological Publications in India: 1995.

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WCC. Study *Document and Statement on HIV/AIDS*. Geneva: WCC, 2002.

9. ETHICS OF BREAKING THE STIGMA-2
(English Speaking Group)

Introduction

Ethics of breaking the stigma deals with the affirmation of human life, which is what human beings ought to do. It tries to show how stigma is and how it ought to be broken. Whilst it assumes the reality of stigmatisation it seeks to identify reasons for stigmatisation.

Aim

To develop ethics of destigmatisation

Objectives

At the end of the course, learners should be able to

- Demonstrate and understanding of stigmatisation/ destigmatisation
- Identify instances of stigmatisation
- Identify sources of stigmatisation
- Identify ways of destigmatisation
- Destigmatize stigmatised situations

Content

- What stigma is: different kinds of stigma, reasons for stigma and what stigma does
- Ethics of destigmatisation: what/which ethics, traditional basis for destigmatisation, biblical perspectives
- Humanisation /impact (anticipated) of destigmatisation: enhancement of dignity, mutual understanding, togetherness, new level of moral life

Methodology

- § Lecture, seminars etc.
- § Drama, dance, music

Assessment

Visits, exams, CAT on sight assessment of learner

10. ETHICS OF PLWHA INVOLVEMENT
(French Speaking Group)

Introduction

Our main concern is to clearly know what the PLWHA involvement is. Knowing that we are in a context of fight against HIV/AIDS, the fight which would lead us to restore social stability shaken by this pandemic. Therefore our concern and our reflection on the subject leads us to count two main levels of PLWHA involvement:

- Involvement in the fight against HIV/AIDS
- Involvement in the life of the community

In addition, we must find valid arguments to enable us achieve this aim.

Goal s and Objectives

1. To search for and find arguments, ethical principles which can efficiently lead us towards our objectives.
2. To bring the PLWHA to consider and take the disease like any other disease (e.g. cancer, diabetes, Blood Pressure , etc.).
3. To enable the PLWHA recover their place in the community iso that all members op the comunity can pursue common o bjectives

The main objectives are:

1. To make the PLWHA fruitful person. and no longer a burden as they have the responsibility of rendering services and the right to enjoy of all that belongs to the society.
2. We have also found it necessary to call upon a number of mobilising values and stimulating such that we *promote* an

efficient participation of the PLWHA at the two levels mentioned above:

a. Concerning the participation of the PLWHA, to the actively fight against HIV/AIDS, we recommend: a sense of responsibility, and living with hope as one remains attached to life, preach and live the love as one abstains from spreading the disease but making edifying testimonies encouraging other sick people to be attached to life, to take all measures worthy for a human beingin the image of God so as to exalt human dignity.
b. Concerning the involvement of the PLWHA to the community life, the objective is to trust the PLWHA in the sense of equality of all human beings accoring to the Gospel. Thus, we exalt the following principles and we shall ensure that the participation of the PLWHA becomes effective and efficient:
    i. By justice: the task of the society is to facilitate the access to the treatment for the PLWHA; in addition, their context of living ought to have a clean and clear improvement (at this level, we challenge the State and public authorities).
    ii. By solidarity: churches and family members have the responsibility to protect and support the PLWHA in their efforts to contribute to the society.
    iii. By the right to education and equality to participate in public life.

Themes to Be Tackled

1. Reflection on special gifts of which each human being is a bearer
2. The power of God through sickness
3. The meaning of a testimony: the case of the PLWHA

Methodology

1. To facilitate the involvement of PLWHA in all sectors of activity

2. To teach the society through suitable and appropriate processes on the problem of AIDS and to accept the involvement of the PLWHA in the total life of the community
3. To organize the campaign of sensitizating the public and the government in order to bring a particular attention to the PLWHA
4. To utilize all means of communication (drama, music, sketch)

Assessment

1. Evaluation
2. Observation on the field (family, church, at the State level)

Bibliography

See above and other presentations

11. ETHICS OF PLWHA INVOLVEMENT
(English Speaking Group)

Introduction

Since the PLWHA have largely been marginalized, are regarded as a dependant sub society and are reduced to mere objects of other peoples care, the PLWHA
are denied the right to life in its fullness.

This module focuses on appropriate Ethical frame works to deconstruct the minds set of people and to reconstruct a society where PLWHA are fully integrated into the main stream of life.

Aim

This module aims at understanding the prevailing social constructions and mind set which have marginalized the PLWHA: To deconstruct the mindset and to reconstruct an Ethically society where the PLWHA are involved in the reconstruction of their own lives.

Learning Objectives

By the end of this module participants/learners will be able to:

1. Appraise the situation on the ground concerning the PLWHA.
2. Identify attitudes and structures that marginalize the PLWHA.
3. Understand the religious, Ethical, social, cultural and political roots to the attitudes about PLWHA
4. To develop Ethical and other frameworks that can help to reconstruct the mindset of people so that the PLWHA can be integrated fully into the society

Course Content

1. Definition of terms and key concepts.
2. Statistical analysis of PLWHA at international, National and local level.
3. Qualitative approach to understanding the PLWHA situation (case studies, true stories, personal interviews etc)
4. Attitudes and structures that marginalize PLWHA
    a) Culture
    b) Religion
    c) Ethics
    d) Economy
    e) Politics
5. Appraisal of Ethical issues involved in PLWHA integration
    a) Sanctity of life
    b) Freedom
    c) Basic human rights
    d) Self-acceptance
    e) Love and hope
6. Formulate a programme of reconstruction for the integration of PLWHA in the social main stream.
    a) Exploration of Ethical theories
    b) Reflection on Biblical texts
    c) Analysis of theological concepts
    d) Etc

Methodology

1. Classroom Lectures
2. Group Dynamics- Brain storming
    a) Role Play
    b) Focussed group discussions
    c) Case studies from real life
    d) Exposures / Visits

Duration of Training

35-40 hours depending on time duration/time allotted

Means of Assessment

1. Class Test
2. Term Paper
3. Examination

Bibliography

Chukwu, Cletus N. *Applied Ethics and HIV/AIDS in Africa*. Eldoret, Kenya: Zapf Chancery, 2003.

Deutsch, Charles and Sharlene Swart. *Learning from One Another.* South African Theological Publications in India: 1995.

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12. ETHICS OF PLWHA iNVOLVEMENT-2
(English Speaking Group)

Introduction

Because of the stigmas surrounding HIV/AIDS pandemic, PLWHA have to a great extent been isolated and little help and comfort denied. Many have been left to be on their own. This module, therefore, seeks to formulate the ethics of PLWHA involvement for institutions.

Aim

To formulate/design a module on ethics of PLWHA involvement for various institutions focussing on the jull ?? Involvement of PLWHA in life activities.

Objectives

By the end of the module, the learners will be able to:

- Emphasize the role of the church should play in involving PLWHA, managing and stigma and controlling the spread of HIV/AIDS ethically and otherwise
- Import skills in the formulation of ethics for PLWHA involvement
- Help the learner understand the contribution in perceptions of HIV/AIDS status

Content

- Breaking the HIV/AIDS stigma: the How's
- The general value of life: it begins and ends in God, Bible
- Ethical debates: how and how not to perceive PLWHA

Methodology

- Lectures

- § Role play
- § Invite PLWHA in activity and in teaching
- § Visits
- § Music, dance and dram

Duration

45 hours: 1 semester

Assessment

- § CATS (continuous assessment tests)
- § Test and exams at the end of the semester
- § Visits in homes/pastoral placement
- § Peer teaching

Bibliography

- § WCC literature and any other relevant literature
- § The Bible

13. GENDER, POWER, AND ETHICS IN THE FIGHT AGAINST HIV/AIDS
(French Speaking Group)

Introduction

According to statistics, women are more affected by the virus than men; but that must not make us lose the focus, the necessity to take into consideration the situation of all while putting the emphasis on gender, simply to focus on specific aspects of each gender. This in order to make efficient our struggle against the common enemy, one would here talk of a positive discrimination.

Goals and Objectives

To search through a positive discrimination, specific situations of each gender in order to make the fight more efficient.

In fact, the two genders having been created in God's image, there is a specific aim for every human being. In that perspective, both genders are precious and equal before God. Therefore, help which we must bring to them must target fullness of life, which would not be discriminatory.

We target to discover weak points of each gender and the failures, which would in themselves constitute abnormalities and disfunctionality of nature for the efficiency of our fight against HIV/AIDS.

1. Weaknesses of the female:
    - frustrations of women caused by discriminatory cultural practices
    - principal victims of polygamy

- the woman is relegated to the second level in the process of decision-making.

2. Weaknesses of the male:
   - excess of power of a man: irresponsibility and inhuman behaviour.
   - men victims of the polyandry are also in a situation similar to that of women.

It is therefore all those weaknesses that we must first of all fight before we embark on fight against HIV/AIDS or better we must engage into a simultaneous fight against both those weaknesses and HIV/AIDS.

14. GENDER, POWER, AND ETHICS IN THE FIGHT AGAINST HIV/AIDS
(English Speaking Group)

Introduction

Issues related to Gender, Power and Ethics have a significant bearing on the struggles against HIV/AIDS.

This module concerns a critical appraisal of issues related to Gender, POWER AND ethics and their interplay in the context of HIV/AIDS.

Aim

This module aims at enabling students to understand social constructions with regards to Gender, Power and Ethics. It further enables them to deconstruct these structures. Finally, it seeks to empower them to reconstruct issues surrounding Gender, Power and Ethics in the context of HIV/AIDS,

Learning Objectives

At the end of this module students will be able to

1. Understand the key concepts involved in the module i.e. Gender, Power, Ethics, HIV/AIDS and struggles.
2. Critically appraise the social construction with regard to Gender, Power and Ethics in relation to HIV/AIDS.
3. Formulate the appropriate modals of Ethics, Gender and Power for Social reconstruction

Course Content

1. Defining the terms and key concepts
2. The African traditional understanding of Gender, Power, and Ethics in relation to illness.
3. The Biblical understanding of Gender, Power, and Ethics in the context of illness.
4. Theological understanding of Gender, Power, and Ethics in relation to illness.
5. Modern understanding of social construction theories in relation to Gender, Power, and Ethics.
6. Gender, Power, and Ethics on the context of HIV/AIDS struggles.
7. Reconstruction Theories relating to:
    a) Human rights
    b) Sanctity of life
    c) Etc

Methodology

1. Classroom Lectures
2. Group Dynamics
    a) Brainstorming
    b) Role Play
    c) Focussed group discussions
    d) Case studies from real life
    e) Exposures / Visits

Duration of Training

35-40 hours depending on time duration/time allotted

Assessment

1. Class Test
2. Term Paper
3. Examination

Bibliography

Chukwu, Cletus N. *Applied Ethics and HIV/AIDS in Africa*. Eldoret, Kenya: Zapf Chancery, 2003.

Deutsch, Charles and Sharlene Swart. *Learning from One Another.* South African Theological Publications in India: 1995.

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15. GENDER, POWER, AND ETHICS IN THE FIGHT AGAINST HIV/AIDS-2
(English Speaking Group)

Introduction

This module examines the dynamics of gender, power, and ethics in the HIV/AIDS struggles. There is a debate as to whether gender goes beyond the traditional understanding of man and woman: roles and responsibilities and their inter relationship. The module seeks to understand the fundamental basis and use of power (by human beings in the gender) face of HIV/AIDS struggles.

Aims

To discuss the various ethical principles in the HIV/AIDS struggles focusing on gender and power

Objectives

By the end of the module, the learner will be able to:

- Identify the ethical issues and principles in the HIV/AIDS struggles
- Define the terms: power and gender in the context of HIV/AIDS
- Identify the moral/immoral ways of the use of power and gender in the HIV/AIDS struggles

Course Contents

- Power: definition, and of power, source of power
- Gender: definition, interpretation of gender, relevance of power and gender
- HIV/AIDS struggles – levels of power
- Gender and power in the biblical perspective/ Relevance of the Bible

Methodology

- § Lectures
- § Role plays
- § Music, dance and drama
- § Visits

Duration

One semester: 45 hours i.e. 3 hours by week for 15 weeks

Assessment

- § Continuous assessment tests
- § Research paper
- § Visits (placement)
- § Exam at the end of semester

Bibliography

WCC publications, Musa Dube and other relevant material

Appendixes

1. The Rector's Speech of Welcome

(Translated from French)

Mr. President of EPMB,
Ladies, gentlemen, politico-administrative authorities,
Mr. the Manager of EHAIA project of the Ecumenical Council of Churches (COE)
The Consultant of EHAIA project for theological institutions of Africa,
Distinguished guests,
Dear Colleague Professors,
Dear Participants to the symposium,

Once again a symposium on HIV/AIDS jointly organized by The Protestant University of West Africa and Ecumenical Initiative for the fight against HIV/AIDS in Africa. Today, we assemble, Professors of Ethics in the Faculties, Academic Institutes and Christian Universities of Africa in order to reflect on the theme: ***What paradigm for Christian Ethics at the era of HIV/AIDS in African context?***

HIV/AIDS poses in itself a big ethical problem. Is it necessary that, in addition to usual calamities which poor people of all continents and especially those of Africa face, a new catastrophe comes on our way? AIDS poses an ethical problem because it is

the poor people who are more exposed to it and among the poor, women and children are the privileged targets.

AIDS poses an ethical problem because it brings us, just like in biblical times, to condemn the 'Job' of today by driving them back to realize that it is for their sin that they suffer. Instead of uniting against it, we prefer to be too hard on those who are victims today.

AIDS poses an ethical problem when it imposes on all cultures, all religions and on all individuals the duty to re-evaluate their knowledge, their teachings, their practices, in other words, to revisit the millennium of existence during which this came into existence.

AIDS poses an ethical problem because it has captured us with fear of death. It poses an ethical problem when we see what obstruction it causes, what flux of money it drains. It is honest to say that today that there are people who don't have interest in defeating AIDS because it has become the bottom of their trade.

While choosing the theme for this symposium ***What paradigm for Christian Ethics at the era of HIV/AIDS in African context?***, the organizers had understood that, before the disorganization of our cultures and societies, we don't have any other choice apart from coming together in order to explore ways and means susceptible to give us new perspectives. It is necessary to find new models which would help us to pursue our search as human beings, and especially as Christian in the service of humanity that needs God so much.

Ladies and Gentlemen, participants to the symposium, you have come all the way from Botswana, Cameroon, Ivory Coast, Ghana, Kenya, Lesotho, Madagascar, Nigeria, Uganda, Zambia, France,

Switzerland and Benin in order to reflect on the paradigm which would be adequate for Christian Ethics at the era of HIV/AIDS. The Protestant University of West Africa welcome you all with joy. On behalf of its Professors, of its administrative personnel/staff and of its students, I welcome you at Porto-Novo campus. Benin is the land of welcome, a peaceful country. May the Lord who brought safely up to here protect you during your stay and help you in your works.

Ladies and gentlemen, politico-administrative authorities, distinguished guests, with your positive response to our invitation, you have demonstrated your great concern for AIDS, but especially your attachment to all reflections which would contribute to lessen the damages, while waiting for its eradication. Please accept our heartfelt gratitude.

In total, so long as there will be on earth, a man, a woman, a child who suffers from AIDS, we will never rest. Therefore, embark on your work and may God bless your reflections.

I thank you.

2. The “SAVED” Model to Fight HIV/AIDS

Safe sex cultural and medical practices.

Abstinence/Access to prevention and treatment services.

Voluntary Counselling and Testing.

Empowerment, Equipment, Engagement

Disease Prevention, Management and Control

Merits of the New “SAVED” Model over the A.B.C Model

1-Comprehensive: takes into account all routes of infection other than sex.

2-Communication: moves away from the individualistic approach (A B C) to a multi-sect oral, multi-level and multi-dimensional approach.

3-Non-Stigmatizing and more accurate: unlike the ABC which overlooks the facts that many faithful people still get infected from already infected partners and other routes of infection.

4-Moves away from the divisive "condoms" as each community will interpret "safe sex" culturally and practically acceptable and possible to them.

5-Inclusive: brings in the role of individuals, communities, governments, Institutions and the global community.

[Contributed by Canon Gideon Byamugisha]

3. Summary of the Keynote Address

By Canon Gideon BYAMUGISHA

PARADIDM SHIFTS FOR AN AIDS COMPETENT CHRISTIAN ETHICS FOR AFRICA

Biblical basis: Mathew 5: 17-44

SUGGESTED SHIFTS

I-ETHICS NEEDS TO SHIFT FROM BEING A "SINGLE-EDGED" SWORD TO BEING A DOUBLE-EDGED/ MULTI-EDGED ONE.

Rather than asking what is "right" or "wrong" it should ask "what is "right" and "safe", "wrong" and "unsafe".

II-SHIFT FROM "FREE-WILL" OR "CHOICE" ETHICS TO "CONDITIONED WILL AND CHOICE" ETHICS;

III-FROM "INDIVIDUALISTIC" ETHICS TO "COMMUTARIAN" ETHICS (multi-sectoral, multi-level and multi-dimensional).

IV-FROM EXCLUSIVE FOCUS ON "SEX" TO "PUBLIC HEALTH" INCLUDING SEXUAL HEALTH.

V-FROM "FATALISTIC" ETHICS TO "ACTIVE"/ "PATICIPATORY" ETHICS.

VI-FROM "PERMANENT ETHICS" (carved into stone) TO "TENTATIVE" AND "CONTEXRUAL" ETHICS.

VII-FROM "PHILOSOPHER/PRIEST" ETHICS TO "PEOPLE (popular) /PROPHETIC"

VIII-FROM DETACHED MORAL/ETHICAL REASONING TO "IMMERSED/INVOLVED" REASONING

4. Additional Indicators for Group Work

I. PROBLEM STATEMENT : background of what are the key issues

II. WHICH ETHICS?: given the competitive nature and variety of ethical models around which is the most appropriate for overcoming the above problems and getting in bringing about quality care.

III. WHAT METHODOLOGY?: how do we ensure that the preferred ethical model (s) gain(s) precedence in our churches so that people benefit from it (them).

IV. WHAT RESULTS?: what would show that we have succeeded in terms of the quality and quantity of life lived by people in Africa

V. WAY FORWARD: what should Pastors and Christians can say, do and be in light of all the above.

[By Canon Gideon Byamugisha]

5. A Song thought by Canon Gideon Byamugisha

UNITED AGAINST AIDS

UNITED AND BE SAFE

GET THE FACTS AND GET TO KNOW

WHAT AIDS IS ALL ABOUT

6. Certificate of Participation

CERTIFICATE OF PARTICIPATION

I, Revd. Charles KLAGBA, Theological Consultant of EHAIA (Ecumenical HIV/AIDS Initiative for Africa) certify that,

==========

attended the workshop on new paradigms for a christian Ethics in the era of HIV/AIDS in the african context, held at West African Protestant University Porto-Novo (Benin) from 4th to 8th October 2004.

Revd. Charles KLAGBA

Theology Consultant EHAIA

Signature of the Participant

7. The Workshop Programme

Sunday 3rd October
Arrivals
19.00 : Meals and introductory session

Monday 4th October
8.00-10.00 : Opening ceremony& Keynote address
10.00-10.30 : Break
10.30-11.30 : Facts about HIV/AIDS
11.30-12.30 : Paper on Ethics from philosophical perspective
15.00-17.00 : Sub-theme 1 :**Ethics of Prevention**
17.00-17.30 : Pause
17.30-19.30 : Group work

Tuesday 5th October
8.30-9.00 : Morning worship
9.00-10.30 : Sub-theme 2 : **Ethics of Quality Care**
10.30-11.00 : Break
11.00-12.30 : Sub-theme :3 **Ethics of Breaking the Stigma**
15.00-17.00 : Group work
17.00-17.30 : Break
17.30-19.30 Plenary 1

Wednesday 6th October
8.30-9.00 : Morning worship
9.00-10.30 : Sub-theme 4 : **Ethics of PLWHA involvement**
10.30-11.00 : Break
11.00-12.30 : Sub-theme 5: Gender, Power and Ethics in the HIV/ AIDS Struggles.
15.00-17.00 : Group work

17.00-17.30 : Break
17.30-19.30 Plenary 2

Thursday 7th October
8.30-9.00 : Morning worship
9.00-10.30 : Group work
10.30-11.00 : Break
11.00-12.30 : Group work.
15.00-17.00 : Group work
17.00-17.30 : Break
17.30-19.30 Plenary 3

Friday 8th October
8.30-9.00 : Morning worship
9.00-10.30 : Plenary 4
10.30-11.00 : Break
11.00-12.30 : Plenary 5
15.00-17.00 : Synthesis and conclusions
17.00-17.30 : Break
17.30-19.30 Synthesis and conclusions
Cultural evening

Saturday 9th October
Departures

8. Guidelines for Group Work, Plenary Sessions, and Regional Meetings

The Aim of the Workshop

To identify viable paradigms for a Christian ethics in the era of HIV/AIDS in the African context

The Objective

To produce modules as references on how to deal with the challenge of HIV/AIDS in the areas of:
-prevention
-pastoral care
-treatment

These modules must be practical and easily usable not only in Theological Institutions but also in church communities by pastors, lay trainers (women's leaders, youth and Sunday schools).

GROUP WORK

Group Work 1

Each group designs a Module on: **Ethics of Prevention**

This module must have
-an introduction
-the aims and the objectives of the module
-the content : the main themes or subjects
-the methodology
-the duration of the training

-means of assessment
-the bibliography

Group Work 2
Each group designs a Module on: **Ethics of Quality Care**

This module must have
-an introduction
-the aims and the objectives of the module
-the content : the main themes or subjects
-the methodology
-the duration of the training
-means of assessment
-the bibliography

Group Work 3
Each group designs a Module on: **Ethics of Breaking the Stigma**

This module must have
-an introduction
-the aims and the objectives of the module
-the content : the main themes or subjects
-the methodology
-the duration of the training
-means of assessment
-the bibliography

Group Work 4
Each group designs a Module on: Ethics of PLWHA involvement

This module must have
-an introduction
-the aims and the objectives of the module
-the content : the main themes or subjects
-the methodology
-the duration of the training

-means of assessment
-the bibliography

Group Work 5
Each group designs a Module on: **Gender, Power and Ethics in the HIV/AIDS Struggles**

This module must have
-an introduction
-the aims and the objectives of the module
-the content : the main themes or subjects
-the methodology
-the duration of the training
-means of assessment
-the bibliography

Group Work 6
This gtoup will be available, in case it is needed, to cover the topics that might emerge during the Workshop.

PLENARY SESSIONS

Plenary 1
Each group reports to the participants the designed modules on the sub-theme 1 : **Ethics of Prevention**
The participants contribute to the modules

Plenary 2
Each group reports to the participants the designed modules on the sub-theme 2: **Ethics of Quality Care**
The participants contribute to the modules

Plenary 3

Each group reports to the participants the designed modules on the sub-theme 3: **Ethics of Breaking the Stigma.**
The participants contribute to the modules

Plenary 4
Each group reports to the participants the designed modules on the sub-theme 4: Ethics of PLWHA involvement.
The participants contribute to the modules

Plenary 5
Each group reports to the participants the designed modules on the sub-theme 5 **Gender, Power and Ethics in the HIV/AIDS Struggles**
The participants contribute to the modules

REGIONAL MEETINGS

Each region suggests a plan of action for the follow-up of at regional levels in 2005

SYNTHESIS AND CONCLUSIONS

General Presentations
1-Keynote address by the Rev. Canon Gideon BYAMUGISHA
2-Factual information on HIV/AIDS by a medical Doctor (Benin)
3-Ethics from philosophical perspectives by a professor (Benin)

Sub-Themes

1 Ethics of Prevention

A African

B Christian

By Southern Africa

2 Ethics of Quality Care

A The sick

B The grieved widows, orphans etc

By Western Africa

3 Ethics of Breaking the Stigma

A African

B Biblical and theological

By Southern Africa

4 Ethics of PLWHA involvement (get a PLWHA to speak)

A African

B Biblical and theological

By East Africa

5. Gender, Power and Ethics in the HIV/AIDS Struggles

By Central and Eastern Africa

NB: The contributions must be written and publishable.

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Integrating HIV/AIDS into Ethics Curriculum

For the past few years the World Council of Churches, through its organ "Ecumenical HIV/AIDS Initiatives in Africa" (EHAIA), has been sponsoring workshops across the continent of Africa to integrate HIV/AIDS into theological curriculum. In October 2004 a Workshop was held at Porto Novo (Benin) dedicated to the theme of integrating HIV/AIDS into Ethics curriculum. About 25 ethicists, theologians, activists, and church leaders representing both the Francophonic as well as Anglophonic Africa gathered at Porto Novo.

One of the major highlights of the Workshop was the development of draft modules for teaching Ethics within the HIV/AIDS contexts.

This book contains not only the various scholarly presentations tackling the problem of Ethics vs. HIV/AIDS from medical, philosophical and theological perspectives, but also the modules that were developed there.

This book is aimed at educating and empowering everyone involved in humanity's grand battle against HIV/AIDS.

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