

**THE HIV/AIDS POLICY OF THE ANGLICAN CHURCH OF NIGERIA:  
A CRITICAL ANALYSIS**

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**A thesis submitted in partial fulfillment of the requirements for the degree of  
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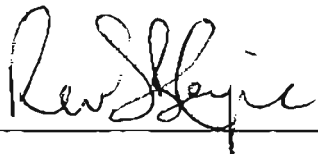
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## ABSTRACT

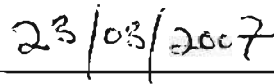
This thesis seeks to outline the HIV epidemic in Nigeria and understand the response of the Church of Nigeria (Anglican Communion) to the epidemic. In evaluating the Church of Nigeria's policy document, it also seeks to understand how the response needs to be strengthened. The thesis looks at the history of HIV and AIDS in Nigeria and the impact of the epidemic on the Nigerian society. It further identifies some of the factors that contribute to the spread of HIV in Nigeria and the government's response to the epidemic. For the Church to respond appropriately to the epidemic there is a great need to start by theologizing the epidemic in a more helpful way. It is based on this that this thesis further attempts to theologize the epidemic by discussing sexuality, the notion of *imago dei* and *shalom* as well-being. The thesis examines the six thematic areas of the policy document and presents a critical analysis in which it discovers that though there are good things in the policy document, it however, needed a more solid theological foundation and employment of an educative tool that is more inclusive. Central to the argument of the thesis is that no one factor drives the epidemic, but rather a complex interaction between several factors. Therefore, to strengthen the policy document the thesis suggests a number of things to do which include a more solid theological foundation and employing of the 'SAVE' approach as an educative tool in response to the epidemic.

## DECLARATION

This thesis unless otherwise stated, represents the writer's own original work. It has not been submitted for any degree at any other University.



Benjamin Chinedu C. Chinemelu



Date

## **DEDICATION**

This thesis is in loving memory of the soldiers of Christ that died as a result of AIDS-related illnesses and the soldiers still fighting the battle to overcome it. There is hope for victory over HIV infection.

## ACKNOWLEDGEMENT

To God be all praise and glory for God's uncountable mercies and blessings that kept me through the duration of this study. I lack words to express my appreciation to God's wonderful love and provision.

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It is a thing of joy for me to specifically mention the following lecturers for their input to my study: Rev. Dr Simanga Kumalo, Rev. Dr Elelwani Farisani, Dr Edwina Ward, Rev. Prof. Steve De Gruchy and Rev. Dr Beverley Haddad. God will enlarge your territories. Dr Haddad, I lack words to express my appreciation to you for your wonderful supervisory skills and contributions that made this research a valuable piece of work. My mother-god as I use to call you, thank you a million times.

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## ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANERELA+	African Network of Religious Leaders Living with or Personally Affected by HIV and AIDS
ARSRC	African Regional Sexuality Resource Centre
ARVs	Antiretroviral Drugs
CACA	Church Action Committee on HIV and AIDS
CBOs	Community-Based Organizations
CMS	Church Missionary Society
DACA	Diocesan Action Committee on HIV and AIDS
EPACA	Ecclesiastical Provincial Action Committee on HIV and AIDS
FGN	Federal Government of Nigeria
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
HBC	Home-based Care
HEAP	HIV and AIDS Emergency Action Plan
HIV	Human Immunodeficiency Virus
LACA	Local Government Action Committee on AIDS
LUTH	Lagos University Teaching Hospital
MAMSER	Mass Mobilization for Social and Economic Resources
MDGs	Millennium Development Goals
MTCT	Mother-To-Child Transmission
NACA	National Action Committee on AIDS
NASCP	National AIDS and STDs Control Programme
NEPAD	New Partnership for Africa's Development
NGOs	Non-Governmental Organizations
NIV	New International Version
NMDGs	National Millennium Development Goals
NRSV	New Revised Standard Version
PABA	People affected by AIDS
PACA	Provincial Action Committee on HIV and AIDS
PCA	Presidential Committee on AIDS
PLWH	People living with HIV
PMTCT	Prevention of Mother-To-Child Transmission
SACA	State Government Action Committee on AIDS
SAVE	Safer Availability Voluntary Empowerment
SFI	Society for Family Health
STDs	Sexually Transmitted Diseases
STI	Sexually Transmitted Infection
UKZN	University of KwaZulu-Natal
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	The United Nations Children's Fund
VCCT	Voluntary Confidential Counselling and Testing
VCT	Voluntary Counselling and Testing



WCC	World Council of Churches
WHO	World Health Organization

## CHAPTER ONE

### INTRODUCTION

#### 1.1 Background to research

The AIDS epidemic update for the 2006 provides new estimates that show the increasing number of people living with the HIV especially in Sub-Saharan Africa.<sup>1</sup> It is estimated that as at March 2006, 38.6 million to 46 million people are living with HIV world-wide, while an estimated number of between 4.1 million to 6.2 million people became newly infected within the space of one year.<sup>2</sup> The United Nations Development Programme (UNDP) on Nigeria's Human Development reports:

With an official prevalence rate of 3.5 million people living with HIV and AIDS, 1.5 million AIDS orphans, and 300,000 deaths annually, HIV and AIDS has become a 'generalized epidemic' in Nigeria, and current evidence suggests that the epidemic is yet emerging. The epidemic is still far from maturing.<sup>3</sup>

Nigeria, with the largest population in Africa, has made human, economic, social and political contributions to the continent. The HIV epidemic is a serious concern for the government and the people of Nigeria as "they recognize and acknowledge that the epidemic in Nigeria is on the threshold of an exponential increase in the country."<sup>4</sup> If nothing is done urgently, the nation will experience a great loss both in human and material resources. It therefore, calls for a response from all quarters in order to avert the looming threat this epidemic may cause to the Nigerian society.

The Church of Nigeria (Anglican Communion) is an integral part of the Nigerian society. As the epidemic is affecting the larger society, the Church is not spared. Many people

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<sup>1</sup> UNAIDS, *2006 Report on the global AIDS epidemic: A UNAIDS 10<sup>th</sup> anniversary special edition*, Switzerland: UNAIDS, 2006, p.8.

<sup>2</sup> UNAIDS, *2006 Report on the global AIDS epidemic: Executive summary*, Switzerland: UNAIDS, 2006, p.6.

<sup>3</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p. ix.

<sup>4</sup> FGN, *National Policy on HIV/AIDS*, 2003, p.1.

infected by HIV are Church members. "Indeed, some are pastors and ministers."<sup>5</sup> HIV is stealthily but steadily on the increase. Parents are dying, being outlived by an increasing number of orphans. The Church can no longer afford to be passive about the epidemic. Realising this, the Church of Nigeria (Anglican Communion) formulated a national policy on HIV and AIDS in its efforts to respond to the epidemic in 2004.

This study proposes to investigate the relevance of the Anglican Church of Nigeria's policy document to the Church's response to the HIV/AIDS epidemic in Nigeria. The hypothesis of this study is that this policy document, while having some strengths needs a more solid theological foundation and an educative tool that is holistic for a more pragmatic approach to the Church's response to the epidemic.

## **1.2 Research problem and objective**

Human dignity and identity should not be the preserve of only social elites and the privileged. Neither should it be the preserve of the physically healthy rather than unhealthy people. Religious values require equal treatment and regard for all manner and strata of people. The concern of God for justice is rooted in God's intrinsic nature and character,<sup>6</sup> for which the purpose, as revealed in Jesus Christ, is for the common good of all, and the ultimate well-being of all who are created by God. The Church's role in the epidemic raises ethical and moral issues particularly in the light of HIV and AIDS stigma and discrimination. The Church needs to mobilize available resources in order to ensure a holistic response to meet the challenges of the epidemic.

This study seeks to outline the HIV epidemic in Nigeria and understand the response of the church of Nigeria to the epidemic. In evaluating the Church of Nigeria's policy document, it also seeks to understand how the response needs to be strengthened. It is also the objective of this study to show that a more solid theological foundation and

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<sup>5</sup> The Joint Christian Association on HIV and AIDS, *Guide on HIV/AIDS for Clergy*, Enugu: CIDJAP Press, 2005, p.10.

<sup>6</sup> Ajulu, Deborah, *Holism in Development: An African perspective on empowering communities*, California: Marc Books, 2001, p.59.

employing the 'SAVE' approach as an educative tool are important to the Church's response to the epidemic.

This study is significant in that it can offer a model of accelerated participation and engagement of the church in response to the epidemic. It will compel the review of unhelpful perceptions towards those living with HIV. The research deals with notions of human dignity and identity as the philosophical basis of the study and argues for the validity of applying these values to the epidemic. Because HIV and AIDS stigma and discrimination is so rife in our society, the Church, which stresses human dignity and identity, needs to make a contribution towards new theological thinking. This in turn will lead to appropriate action to mitigate the epidemic.

### **1.3 Theological framework**

This study employs the discussions on sexuality, *imago dei* and *shalom* as its theological framework. The spread of the HIV has been attributed to a human sexuality issue as the virus spreads mainly through unprotected sex. This has resulted in the idea previously held by religious bodies that HIV is a punishment from God for immoral behaviour. While sex and sexuality in Africa is not discussed openly, however, it is the very essence of human existence. Therefore, its importance in response to the epidemic cannot be over-emphasised.

In the same vein, the notion of *imago dei* implies that the virus cannot distort or diminish the image of God in the persons infected and affected by the virus since every person irrespective of HIV status is created in the image of God. This requires that dignity and respect should be accorded to people living with HIV as denial of that is a disregard of God. The understanding of this notion will compel humanity to respond to this epidemic in a more humane way.

In addition, the study also employs the notion of '*Shalom*.'<sup>7</sup> According to Yoder, "*shalom*, biblical peace is squarely against injustice and oppression. *Shalom* acts against oppressors for the sake of victims. It demands a transformation of unjust social and economic orders. In the Bible, *shalom* is a vision of what ought to be and a call to transform society."<sup>8</sup> *Shalom* from the Hebrew text and *eirene* from the Greek text stands for "material well-being and prosperity, justice, and straightforwardness."<sup>9</sup> This implies that *shalom* in the Hebrew Bible is marked by the presence of physical well-being and by the absence of physical threats such as war, disease (*HIV and AIDS*) and famine. *Shalom* and *eirene* are also linked to social relationships. "*Shalom* depended on the relations among people within a society. Oppression meant no *shalom*, but rather judgment, while justice led to *shalom*."<sup>10</sup> In addition to this, in the realm of morality, *shalom* refers to the "absence of fault, guilt, or blame."<sup>11</sup> In the context of HIV and AIDS today, stigma and discrimination, and the denial of access to ARVs and other helpful medication to people living with HIV can be seen as oppression and injustice.

*Shalom* therefore, means dwelling at peace in all our relationships; with God, with creation, with other people, and with ourselves. It implies the availability of ARVs and other medication needed by people living with HIV. Jesus proclaimed *shalom* as central to his mission on earth (Luke 4:18-19). God is involved in the well-being of the world he has created. Jesus goes to the lost and the outcast, the marginalised and the excluded (like people living with HIV). His death and resurrection is a profound proclamation of *shalom*. God has a particular concern for those who suffer. So it is the responsibility of the Church to continue with this message of *shalom* as his representative on earth, so that the hindrances towards an effective ministry to people living with HIV will be broken.

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<sup>7</sup> Yoder, Perry, *Shalom*, London: Hodder and Stoughton, 1989.

<sup>8</sup> Yoder, Perry, 1989, p.5.

<sup>9</sup> Yoder, Perry, 1989, p. 11-16.

<sup>10</sup> Yoder, Perry, 1989, p.15.

<sup>11</sup> Yoder, Perry, 1989, p.16.

#### 1.4 Outline of the study

In chapter two, the history of the HIV and AIDS epidemic in Nigeria is considered. It also outlines the impact of the epidemic to the Nigerian society and the factors that contribute to its spread. The responses of the Federal government of Nigeria to the epidemic are also highlighted.

Chapter three of the study attempts to theologize the HIV/AIDS epidemic. In order for the Church to respond in a more helpful way to the epidemic, it needs to operate from a solid theological foundation. Thus this chapter attempts to theologize the epidemic by discussing sexuality, the notion of *imago dei*, and *shalom* as well-being.

Chapter four focuses on the National HIV/AIDS Policy of the Church of Nigeria starting with the history of the Church. It discusses the process that led to the formulation of the policy and the policy itself in detail. A critical analysis of the policy document is given using the theological notion of *shalom*. Furthermore, the 'SAVE' approach is employed as an educative tool that is more inclusive in response to the epidemic. The chapter also shows the reception of the policy document within the Church.

Chapter five deals with the need to strengthen the HIV/AIDS policy document and makes suggestions as to a way forward for the Nigerian Anglican Church.

## CHAPTER TWO

### HIV AND AIDS IN NIGERIA

#### 2.1 Introduction

The HIV infection has cut across all the continents of the world. Africa seems to be the most infected and affected continent by HIV and AIDS. It is on record that “most severely affected is sub-Saharan Africa, where more than two-thirds (26.6 million) of all HIV-infected people live.”<sup>12</sup> The impact of the epidemic can be seen as the life expectancy of countries drop, the health systems became over-burdened, and there is considerable reduction in economic resources of both government and communities. In addition, the epidemic has impacted the social systems of communities. One of the reasons given by Vhumani Magezi and Daniel Louw as to why Africa is hard hit by the epidemic is that “the region has poor and limited health facilities and resources (human and financial).”<sup>13</sup> Quoting Smart, Magezi and Louw assert that “50% - 60% of people living with HIV-related diseases worldwide have no access to professional health care workers in order to address their medical needs.”<sup>14</sup> Furthermore, according to Magezi and Louw “poverty provides the social context within which the pandemic flourishes in Africa. Thus HIV and poverty are intricately linked and they interplay.”<sup>15</sup>

This chapter provides the history of HIV prevalence in Nigeria, its impact on Nigerian society and the factors that contribute to the spread of the epidemic. In addition, it will look at the response by the Federal Government of Nigeria to the epidemic as the epidemic causes enormous social challenge.

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<sup>12</sup> Weinreich, Sonja and Benn, Christoph, *AIDS: Meeting the challenge, Data, facts, background*, Geneva: WCC Publications, 2004, p.8.

<sup>13</sup> Magezi, Vhumani and Louw, Daniel, “Congregational home-based care: Merging the African family and church family systems for effective HIV ministry” In *Journal of Theology for Southern Africa* 125 (July), 2006, p.64.

<sup>14</sup> Magezi, Vhumani and Louw, Daniel, “Congregational home-based care: Merging the African family and church family systems for effective HIV ministry”, 2006, p.64.

<sup>15</sup> Magezi, Vhumani and Louw, Daniel, “Congregational home-based care: Merging the African family and church family systems for effective HIV ministry”, 2006, p.65.

## 2.2 Brief history of HIV and AIDS in Nigeria

According to Barnett and Whiteside, “The HIV epidemic is not the first global epidemic, and it certainly won’t be the last: it is a disease that is changing human history. This epidemic shows up global inequalities. Its presence and impact are felt most profoundly in poor countries and communities.”<sup>16</sup>

Nigeria is the most populous nation in sub-Saharan Africa with a population of over 120 million in 2002.<sup>17</sup> The country recorded her first case of AIDS in 1986.<sup>18</sup> At that time the response was to deny the fact that it was a problem to the nation. Little or no effort was made by the government to see that the virus that causes AIDS did not spread. By the time the government realised that HIV is real, the nation had been greatly infected. One of the significant events that brought the message home to many Nigerian sceptics was “the announcement on 2<sup>nd</sup> August 1997 by Professor Olukoye Ransome Kuti that Fela Anikulapo-Kuti, his brother and one of the country’s most prominent musicians, had died of HIV-related illness.”<sup>19</sup> That announcement shocked the entire nation and awakened the nation to the need to respond to HIV.

According to surveys carried out by the Federal Ministry of Health, the first sentinel survey conducted in 1991 showed that 1.8% of the Nigerian population were already living with HIV.<sup>20</sup> Since then, the infection rate has rapidly grown from 3.8% in 1993 through 4.5% in 1995 and 5.4% in 1999 to 5.8% in 2001.<sup>21</sup> In 2004, the UNDP reported that, “With an official prevalence rate of 3.5 million people living with HIV and AIDS diagnosis, 1.5 million AIDS orphans, and 300,000 deaths annually, HIV prevalence has become a ‘generalized epidemic’ in Nigeria, and current evidence suggests that the

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<sup>16</sup> Barnett, Tony and Whiteside, Alan, *AIDS in the Twenty-First Century: Disease and Globalization*, New York: Palgrave Macmillan, 2002, p.24.

<sup>17</sup> FGN, *National Policy on HIV/AIDS*, 2003, p.xiii.

<sup>18</sup> NACA, *HIV/AIDS: National Strategic Framework for Action 2005-2009*, Nigeria: Society for Family Health, 2005, p.3.

<sup>19</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, Nigeria: UNDP, 2004, p.19.

<sup>20</sup> FGN, *National Policy on HIV/AIDS*, 2003, p.2. See also NACA, *HIV/AIDS: National Strategic Framework for Action 2005-2009*, Nigeria: Society for Family Health, 2005, p.3.

<sup>21</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, Nigeria: UNDP, 2004, p.19.



epidemic is yet emerging. The epidemic is still far from maturing.”<sup>22</sup> The result is, the magnitude is already alarming and has become a problem to the nation. This is because “this increase represented 10% of the total figure on the continent and 8% of the 42.1 million people who are currently thought to be living with HIV and AIDS diagnosis globally.”<sup>23</sup>

However, the most recent report suggests that the HIV prevalence dropped to 5% in 2005.<sup>24</sup> Nevertheless, it will be much better if the infection rate is brought totally under control and a mechanism for proper statistics be put in place. As the non-availability of treatment hinders people from going for an HIV testing, this may affect the statistics that are always given in regard to the reduction in the prevalence rate. One woman once said to me, “Why should I go for HIV testing? It is better for me not to know that I am living with the virus than to know that I am without drugs for treatment.”<sup>25</sup> This kind of attitude hinders an accurate assessment of HIV prevalence.

However, there is clearly no state or community in Nigeria that is free from the effects of the HIV epidemic. The prevalence rate of HIV-related disease and AIDS diagnosis in Nigeria differs from one zone to the other, one state to the other, and in terms of age and gender. The UNDP report on Nigeria has it that “the regions with the highest median prevalence rates include the North Central, North East and South South zones.”<sup>26</sup> The diagram below shows the HIV prevalence by geo-political zones in 2003 in Nigeria, which suggests that the rate of infection is already high and cuts across the country. The diagram signifies that HIV infection in Nigeria seems to have reached epidemic proportions.

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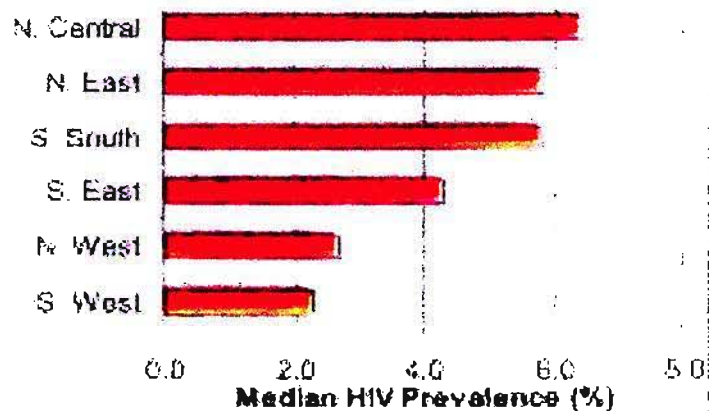
<sup>22</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.ix.

<sup>23</sup> Folayan, Morenike, “HIV/AIDS: The Nigerian Response” In Nana K. Poku and Alan Whiteside (eds.), *The political economy of AIDS in Africa*, England, USA: Ashgate Publishing, 2004, p.85.

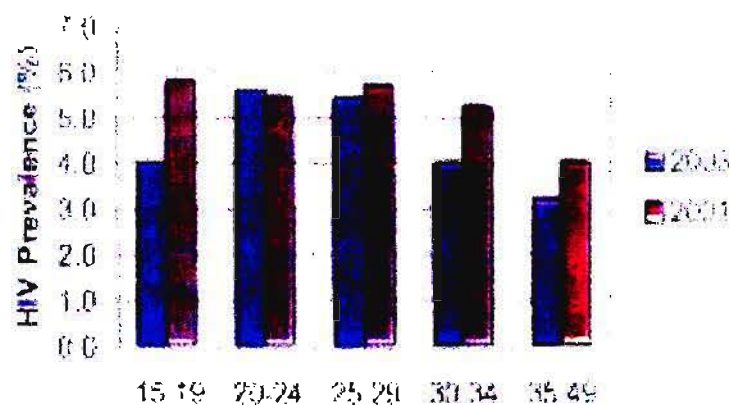
<sup>24</sup> NACA, *HIV/AIDS: National Strategic Framework for Action 2005-2009*, Nigeria: Society for Family Health, 2005, p.3.

<sup>25</sup> Personal conversation with a woman in Katsina, 7<sup>th</sup> September, 2003.

<sup>26</sup> NMDGs, *Millennium Development Goals Report 2004-Nigeria*, Nigeria: National MDGs, 2004, p.viii.



In Nigeria, as far as age and gender factors of the people living with HIV are concerned, young people and women are mostly infected. This view is supported by Folayan who asserts that “the most severely infected are adults in the sexually reproductive and economically active years, where twice as many women as men are infected.”<sup>27</sup> To put it more clearly, the prevalence rates are as follows: “20-24 years at 5.6%, 25-29 years at 5.4%, and 15-19 years at 4.0%. Of the total population infected in Nigeria, 60% are young people below 25 years, and 54% of all adult infections are women.”<sup>28</sup> The diagram below shows the HIV prevalence among age groups in 2001 and 2003. It is clear from the diagram that young people are highly infected.



<sup>27</sup> Folayan, Morenike, “HIV/AIDS: The Nigerian Response” In Nana K. Poku and Alan Whiteside (eds.), *The political economy of AIDS in Africa*, 2004, p.85.

<sup>28</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.22.

It is a well-known fact that the most common route of HIV transmission in Africa is through heterosexual intercourse.<sup>29</sup> According to the UNDP report on Nigeria, the country is “like most other African countries in sub-Saharan Africa, where transmission of HIV is mainly through heterosexual intercourse.”<sup>30</sup> This means that people are having unprotected sexual encounters without giving thought to what may be the outcome. When one engages in an unprotected sexual relationship without first knowing one’s HIV status and that of one’s partner, the risk of being infected is high especially when one’s partner is already infected. This is because no precaution is taken. The UNDP report further stated that more cases of transmission are reported in urban than in rural areas. One may therefore ask: why is it that fewer cases are reported from the rural areas? Does it mean that health facilities are not sufficient in rural areas? Or is it a sign that the people in rural areas do not care about their health? These questions may not be easy to answer. However, it is reported that, “in 2003 Federal Ministry of Health (FMOH) sentinel survey, there is evidence that the gap between the urban and rural areas may be narrowing.”<sup>31</sup> This indication shows how generalized and far spread the epidemic is in the country.

### 2.3 The socio-economic impact of the epidemic

There is an increasing number of orphans caused by the epidemic. The estimate for 26 African countries suggest “the number of children losing a father (paternal orphans) or mother (maternal orphans) from any cause will be more than double between 1990 and 2010.”<sup>32</sup> In 2001, the number of orphans as a result of AIDS-related illness in Nigeria was estimated to be above 900,000.<sup>33</sup> The number has increased to 1,800,000<sup>34</sup>, within five years which shows a double increase. Many of these children may end up not going

<sup>29</sup> Weinreich, Sonja and Benn, Christoph, *AIDS: Meeting the challenge, Data, facts, background*, 2004, p.4.

<sup>30</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.23.

<sup>31</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.23.

<sup>32</sup> Foster, Geoff and Germann, Stefan, “The Orphan Crisis”, In Max Essex et al (eds.), *AIDS in Africa*, 2<sup>nd</sup> edition, New York: Kluwer Academic, 2002, p.665.

<sup>33</sup> FGN, *National policy on HIV/AIDS*, Nigeria: FGN, 2003, p.4.

<sup>34</sup> Avert, “HIV and AIDS statistics for Africa”, accessed from <http://www.avert.org/subadults.htm> on 19<sup>th</sup> July 2006, p.2 of 3.

to school. They are therefore “at the risk of suffering from child abuse, prostitution and other social crimes, and might become HIV positive.”<sup>35</sup> In addition, as the adults in the family struggle with HIV, the children are left with the responsibility to care for their dying parents. In fact, this is a break down of family structure where it is the duty of parents to take care of their children. According to Janet Frohlich, “as the epidemic progresses, this nuclear ‘family’ unit is being drastically eroded – and the role of household head in particular is undergoing radical alteration.”<sup>36</sup>

The socio-economic impact of the epidemic on households, communities and society cannot be quantified. The case of Vandekiya local Government Area of Benue State which “grapples with increased poverty, loss of skilled labour, increased mortality and morbidity, a weakened social and leadership structure, and the risk of extinction is a good example of the socio-economic impact of the epidemic in Nigeria.”<sup>37</sup> Generations of families have been wiped out by the epidemic and their farmlands are now desolate.

Many studies have attempted to determine the economic impact of the epidemic. According to Guy CZ Mhone, “such studies attempt to investigate the impact of HIV and AIDS from a macroeconomic and a microeconomic perspective.”<sup>38</sup> However, as Mhone noted, “HIV infection will increase the morbidity of labour and thus reduce its productivity and increase the costs of employment. Subsequently, AIDS will reduce the size of the labour force and impact negatively on costs of production and increase the cost of retraining and hiring new employees.”<sup>39</sup> All these tend towards a shortage of labour as a result of sick leave or absenteeism. The UNDP report on Nigeria stated that, “absenteeism and dropout are rife among the infected, resulting in colossal loss of man-hours.”<sup>40</sup> When companies or industries start losing labour force as a result of the epidemic, it will at the same time affect income generation, which may eventually lead to

<sup>35</sup> FGN, *National policy on HIV/AIDS*, Nigeria: FGN, 2003, p.5.

<sup>36</sup> Frohlich, Janet, “The impact of AIDS on the community”, In S.S. Abdool Karim and Q. Abdool Karim (eds.), *HIV/AIDS in South Africa*, Cape Town: Cambridge University Press, 2005, p.352.

<sup>37</sup> UNAIDS, *2004 Report on the global AIDS epidemic: 4<sup>th</sup> global report*, 2004, p.47.

<sup>38</sup> Mhone, CZ Guy, “The economic impact of HIV/AIDS in Africa”, In Kevin Kelly, *HIV/AIDS, Economics and Governance in South Africa: Key issues in understanding response*, South Africa: USAID, 2002, p.78.

<sup>39</sup> Mhone, CZ Guy, “The economic impact of HIV/AIDS in Africa”, 2002, p.78, 79.

<sup>40</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.49.

sacking of workers thereby causing more havoc and economic problems to families. The UNAIDS 2004 report noted that, “in high-prevalence countries, the combined negative effects of AIDS on finances – of households, employers and key sectors are likely to have tangible macroeconomic impact.”<sup>41</sup>

“Economists have argued that the epidemic brings about a precipitous decline in productivity and savings.”<sup>42</sup> This statement cannot be over-stated because it is clear that as the health situation of people living with HIV continues to deteriorate, the time will come when they will no longer cope with active work. This therefore causes people to be absent from their jobs. Again, the little savings they had will be used for medication in order to keep them alive. All this diminishes their income. According to the report of the UNDP on human development in Nigeria, it is stated that “the HIV epidemic is undermining Nigeria’s development at a time when its economy is showing little or no growth.”<sup>43</sup>

Furthermore, “the feminization of poverty is another dimension of the economic impact of HIV”<sup>44</sup> in Nigeria and other African countries. It is on record that women are the majority in caring for people living with HIV. Though men also care for the sick persons, yet it cannot be compared to the kind of care, compassion and hard work that women offer to the sick persons in households. Therefore, in a household where women are responsible for subsistence farming, this will lead to:

Reduction of productive time on farms; threat to the food security of the family; withdrawal of the girl child from school to bridge the demand for additional unpaid labour in the household; increase in households headed by women – at times by girl children with little access to productive resources, which often drives them into sex for money.<sup>45</sup>

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<sup>41</sup> UNAIDS, *2004 Report on the global AIDS epidemic: 4<sup>th</sup> global report*, 2004, p.57.

<sup>42</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.48.

<sup>43</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.47.

<sup>44</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.48.

<sup>45</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.48.

As the epidemic continues to spread, “the family unit and the society at large are forced to spend enormous resources on people living with HIV and AIDS-related illness, orphans, and widows/widowers. Although there are no data on Nigeria, available studies in other contexts indicate that the average income falls by 52% to 67% when a family member has AIDS while the expenditure on health care quadruples.”<sup>46</sup>

## 2.4 Impact on life expectancy

According to Barnett and Whiteside, “human progress and development can be measured by a number of indicators. The most basic, and popular, are measures of life expectancy and infant and child mortality.”<sup>47</sup> While the overall life expectancy in the world has increased by 17% over the last half century, in most African countries “life expectancy is falling down dramatically due to AIDS.”<sup>48</sup> In sub-Saharan Africa, life expectancy has dropped from 62 years to 47 years.<sup>49</sup> In Nigeria, the life expectancy might not even be as high as 50 years.

Though the average life expectancy of Nigerians before the epidemic was not that high, the epidemic has made the situation worse as the nation does not have enough health facilities and structures that can help improve the health conditions of the citizens. As the policy document of the government of Nigeria puts it, “One important effect of the epidemic on the health of Nigerians is the reduction in the life expectancy. The epidemic has remarkably reduced gains in life expectancy which Nigeria had achieved over the past four decades since her independence.”<sup>50</sup> As at 1990, the life expectancy of Nigerians

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<sup>46</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.49.

<sup>47</sup> Barnett, Tony and Whiteside, Alan, *AIDS in the Twenty-First Century: Disease and Globalization*, 2002, p. 174.

<sup>48</sup> Millen, J.V., Irwin, Alec, and Kim Jim Yong, “Introduction: What is Growing? Who is Dying?” In Jim Yong Kim, Joyce V. Millen, Alec Irwin, and John Gershman, *Dying for Growth: Global Inequality and the health of the poor*, Boston: Common Courage Press, 2000, p.5.

<sup>49</sup> Avert, “The impact of HIV and AIDS on Africa”, accessed from <http://www.avert.org/aidsinimpact.htm> on 19th July, 2006, p. 5 of 8.

<sup>50</sup> FGN, *National Policy on HIV/AIDS*, Nigeria: FGN, 2003, p.3.

was 53 years as compared to 50 years in 2003 because of the HIV epidemic.<sup>51</sup> However, as the situation is now, who knows what it will be by the end of 2010 as the rate of infection is increasing both in the urban and rural areas.

In fact in the absence of HIV and AIDS, the life expectancy of Nigerians would have risen to 57 years and increased to 62 years by 2013.<sup>52</sup> But this hope seems to be far to reach as the epidemic is expanding. It affects the aspiration of people as they want to have children and see them grow, which is “a basic expectation and a component of their identity.”<sup>53</sup> These aspirations and expectations are thwarted by AIDS as the lives of people are cut short. It may be difficult therefore for most people to have children and see them grow up if the HIV prevalence continues to rise further and the epidemic is not adequately brought under control.

### 2.3.3 Impact of the epidemic on the health system

Kellerman citing WHO argues that, “health is a fundamental human right.”<sup>54</sup> The health systems in most of the countries in Africa were not working properly even before the detection of HIV. With the additional burdens of the epidemic, it seems that the affected countries are in for even worse health systems. As Weinreich and Benn put it, “health systems lack adequate resources and cannot offer appropriate, affordable and high quality care for their population.”<sup>55</sup>

In all affected countries, the epidemic is bringing additional pressure to bear on the health sector.<sup>56</sup> Citing Essex et al., Kellerman argues that “health care is affected by AIDS in

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<sup>51</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.46.

<sup>52</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.46.

<sup>53</sup> Barnett, Tony and Whiteside, Alan, *AIDS in the Twenty-First Century: Disease and Globalization*, 2002, p. 174

<sup>54</sup> Kellerman, Anso, “Health and Development”, In Erik De Beer and Hennie Swanepoel, *Introduction to Development Studies*, 2<sup>nd</sup> edition, Cape Town: Oxford University Press, 2000, p.186.

<sup>55</sup> Weinreich, Sonja and Benn, Christoph, *AIDS: Meeting the challenge, Data, facts, background*, 2004, p.45.

<sup>56</sup> Avert, “The impact of HIV and AIDS on Africa”, accessed from <http://www.avert.org/aidsimpact.htm> on 19th July 2006, p.1 of 8.

respect of both the supply and demand.”<sup>57</sup> This is because as the number of the infected people is increasing, it will place a heavier burden on health services because the infected need treatment for opportunistic illnesses occurring as a result of the HIV infection.<sup>58</sup> In addition, “the epidemic itself has contributed to rapid health-sector deterioration by increasing burdens on already-strapped systems and steadily depriving countries of essential health-care workers.”<sup>59</sup> A good example is Botswana. Studies there have shown that:

In several hospitals up to 80% of the adult patients and around 30% of the children have HIV-related diseases. Employees complain of burn-out, since the time demanded for diagnoses and examinations has increased by 30%, the demand for counselling has risen, and the care of the growing number of dying patients creates psychological problems. Staff shortages are becoming a problem in public hospitals.<sup>60</sup>

Even the medical personnel are not spared. They are also infected and affected. This increases the burden of the health sector. As UNAIDS report rightly put it, “staff losses and absenteeism caused by sickness and death means that health-care sectors must recruit and train more staff. At the same time, large numbers of uninfected workers are suffering from burnout and emotional exhaustion.”<sup>61</sup> This shows that the impact of HIV and AIDS on the health sector is alarming.

Barnett and Whiteside have noted that 5.5% of GDP is spent on health globally. Out of this percentage, 2.5% goes through public spending and 2.9% through the private sector.<sup>62</sup> This is not the case in Africa. In Africa, the percentages are 1.5% for public spending and 1.8% for private.<sup>63</sup> This means that people use their own resources to visit

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<sup>57</sup> Kellerman, Anso, “Health and Development”, 2000, p.202.

<sup>58</sup> Kellerman, Anso, “Health and Development”, 2000, p.202.

<sup>59</sup> UNAIDS, *2004 Report on the global AIDS epidemic: 4<sup>th</sup> global report*, 2004, p.54.

<sup>60</sup> Weinreich, Sonja and Benn, Christoph, *AIDS: Meeting the challenge, Data, facts, background*, 2004, p.45.

<sup>61</sup> UNAIDS, *2004 Report on the global AIDS epidemic: 4<sup>th</sup> global report*, 2004, p.54.

<sup>62</sup> Barnett, Tony and Whiteside, Alan, *AIDS in the Twenty-First Century: Disease and Globalization*, 2002, p.307.

<sup>63</sup> Barnett, Tony and Whiteside, Alan, *AIDS in the Twenty-First Century: Disease and Globalization*, 2002, p.307.



health care centres. Notwithstanding, health care services face “different levels of strain, depending on the number of people who seek services, the nature of their need, and the capacity to deliver that care.”<sup>64</sup> In fact, health sectors or systems in Nigeria are already finding it difficult in meeting basic medical care. For over the last two decades:

Nigeria’s healthcare system has deteriorated because of political instability, corruption and a mismanaged economy. Large parts of the country lack even basic healthcare provision, making it difficult to establish HIV testing and prevention services such as those for the prevention of mother-to-child transmission (MTCT). Sexual health clinics providing contraception and testing and treatment for other STIs are also few and far between.<sup>65</sup>

With poor health facilities and high poverty rate in the continent, lives are being lost on a daily basis as a result of the epidemic. As I have stated earlier, over 3.5 million Nigerians are living with the virus. It affects the life expectancy of Nigerians as statistics have shown that life expectancy has dropped from 53 years in 1990 to 50 years in 2003 due to the HIV epidemic.<sup>66</sup>

This epidemic is over-burdening health personnel and the health services in Nigeria. Resources that ought to be used for development projects are being diverted to tackle the epidemic.<sup>67</sup> HIV and AIDS come with serious needs for care and support for the infected unlike malaria. This additional care and support burden has further weakened the already weak Nigeria health system.<sup>68</sup> In addition, if the epidemic is not brought under control, there is the tension that resources needed to control the effects of the epidemic will exceed 35% of the health budget.<sup>69</sup> This shows the extent of the epidemic and the problem facing the health system in Nigeria.

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<sup>64</sup> Avert, “The impact of HIV and AIDS on Africa”, accessed from <http://www.avert.org/aidsimpact.htm> on 19th July 2006, p.1 of 8

<sup>65</sup> Avert, “HIV and AIDS in Nigeria”, accessed from <http://www.avert.org/aids-nigeria.htm> on 12th July 2006, p.4 of 8.

<sup>66</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.46.

<sup>67</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.50.

<sup>68</sup> FGN, *National Policy on HIV/AIDS*, 2003, p.4.

<sup>69</sup> FGN, *National Policy on HIV/AIDS*, 2003, p.4.

The epidemic also affects the bed utilization in hospitals. As a result of the serious and urgent need for medical attention of people infected, bed spaces are occupied by people living with HIV, resulting in reduced attention from medical personnel to other diseases. As they try to cope with HIV-related cases there is “little space to treat other important illnesses.”<sup>70</sup> According to UNDP report, “one major consequence of higher use of hospital in AIDS-related diseases is diversion of funds from other diseases.”<sup>71</sup>

Having discussed the impact of the epidemic on Nigerian society, the factors contributing to the spread of HIV in Nigeria will be discussed in the following section.

## **2.4 Factors contributing to the spread of HIV**

For any new infectious disease, a basic understanding of the factors that drive the transmission of the infection is a pre-requisite to designing intervention and control programmes.<sup>72</sup> Given the fact that the most common mode of HIV transmission is through heterosexual sexual relationships, one may be tempted to conclude that the virus is spreading because of the high level of unprotected sexual activity, the type of sex people are engaging in, and the multiplicity of sexual partners.<sup>73</sup> However, no one factor drives the epidemic, but rather a complex interaction between several factors.<sup>74</sup>

These factors can be classified into two groups – structural and behavioural factors. According to Olusoji Adeyi et al., “structural factors increase the vulnerability of groups of people to HIV infection while behavioural factors determine the chance that

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<sup>70</sup> FGN, *National Policy on HIV/AIDS*, 2003, p.4.

<sup>71</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.50.

<sup>72</sup> Ghani, Azra and Boily, Marie-claude, “The epidemiology of HIV and AIDS: Contributions to infectious disease epidemiology”, In George Ellison, Melissa Parker and Catherine Campbell (eds.), *Learning from HIV and AIDS, South Africa*: Cambridge University Press, 2003, p.61.

<sup>73</sup> Whiteside, Alan and Sunter, Clem, *AIDS: The challenge for South Africa*, Cape Town: Human & Rousseau Tafelberg, 2000, p.59.

<sup>74</sup> Piot, Peter and Bartos, Michael, “The epidemiology of HIV and AIDS”, In Max Essex, Souleymane Mboup, Phyllis J. Kanki, Richard G. Marlink, and Shiela D. Tlou (eds.), *AIDS in Africa*, 2<sup>nd</sup> edition, New York: Kluwer Academic, 2002, p.204.

individuals become infected.”<sup>75</sup> Behavioural risk factors include failure to use a condom when having sex and commercial sex among others. One of the structural factors is gender inequality which makes women more vulnerable to HIV infection than men. Beverley Haddad argues that women’s vulnerability to HIV and AIDS is a result of both social and biological factors.<sup>76</sup> According to her, “the disadvantaged and oppressive socio-cultural situations of women means the odds are stacked against them”<sup>77</sup> and this fuels the spread of the virus among women. These oppressive structures can be found in our cultures and religions. Daniela Gennrich adds that “cultural and religious beliefs such as those that insist that women should obey their husbands at all costs, and belief that men ‘naturally’ need more than one sexual partner, make it difficult for wives to insist on their husbands’ faithfulness or to refuse unsafe sex, even within marriage.”<sup>78</sup> This implies that when a man is already infected, it is his choice to infect his wife or not.

In Nigeria, the factors that contribute to the spread of HIV range from socio-economic and cultural factors, migration, urbanization and modernization, wars and conflicts, stigma and discrimination, ignorance, and behavioural and biological factors.<sup>79</sup> In addition, lack of sexual health information and education, and poor healthcare services to mention but few, contributes to the spread of the virus.<sup>80</sup> In this section, I will briefly discuss factors such as socio-economic, gendered cultural practices, lack of sex education and stigma and discrimination.

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<sup>75</sup> Adeyi, Olusoji et al, *Averting AIDS crises in Eastern Europe and Central Asia: A regional support strategy*, Washington, DC: The World Bank, 2003, p.15.

<sup>76</sup> Haddad, Beverley, “Gender violence and HIV/AIDS: A deadly silence in the Church”, In *Journal of Theology for Southern Africa*, 114 (Nov.), 2002, p.95.

<sup>77</sup> Haddad, Beverley, “Gender violence and HIV/AIDS: A deadly silence in the Church”, 2002, p.95

<sup>78</sup> Gennrich, Daniela (ed.), *The Church in an HIV+ World: A practical handbook*, Pietermaritzburg: Cluster Publications, 2004, p.13.

<sup>79</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.31-45.

<sup>80</sup> Avert, “HIV & AIDS in Nigeria” accessed from <http://www.avert.org/aids-nigeria.htm> on 12th July 2006, p.3 of 8.

#### 2.4.1 Socio-economic factors

Poverty has traditionally been understood to mean a lack of access to resources, productive assets and income resulting in a state of material deprivation.<sup>81</sup> Julius Oladipo gave a vivid definition of poverty as defined by UNDP in 1996 as:

A lack of productive resources, income, and capacities that contributes to individual and/or group isolation, vulnerability, and powerlessness; to income, political, and social discrimination; and to participate in unsustainable livelihoods.<sup>82</sup>

A widespread concept among my tribe (the Igbos of Nigeria) is that poverty is not just about the shortage of money. It is also about the denial of human rights and relationships, about how people are treated in the society, about powerlessness, and about those whose dignity has been trampled upon. Therefore, poverty could also be understood in terms of denial of access to opportunities for advancement<sup>83</sup> resulting in people doing whatever possible they could to get money in order to keep the body and soul together.

In our context of the HIV epidemic, one can argue that poverty contributes to its spread since it has always been a driving force of epidemics.<sup>84</sup> For example, “poverty is a major factor in the explosion of female sex work at oil exploration locations.”<sup>85</sup> A high level of premarital and extramarital sexual activity in most parts of Nigeria is usually occasioned

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<sup>81</sup> Cagatay, Nilufer, *Gender and poverty*, United Nations Development Programme (UNDP), 1998, p.2.

<sup>82</sup> Oladipo, Julius, “The role of the church in poverty alleviation in Africa”, In Deryke Belshaw, Robert Calderisi and Chris Snug Den (eds.), *Faith in development: Partnership between the World Bank and the churches of Africa*, Oxford: Regnum Books, 2001, p.219.

<sup>83</sup> White, Sarah and Tiongeo, Romy, “What has theology to do with development, peace and reconstruction?” In I.A. Phiri, K.A. Ross and J.L. Cox (eds.), *The role of the Christianity in development, peace and reconstruction: Southern perspectives*, Nairobi: All African conference of Churches, 1996, p.26.

<sup>84</sup> Piot, Peter and Bartos, Michael, “The epidemiology of HIV and AIDS”, In Max Essex, Souleymane Mboup, Phyllis J. Kanki, Richard G. Marlink, and Shiela D. Tlou (eds.), *AIDS in Africa*, 2<sup>nd</sup> edition, New York: Kluwer Academic, p.204.

<sup>85</sup> Oppong, R. Joseph and Agyei-Mensah, Samuel, “HIV/AIDS in West Africa: The case of Senegal, Ghana, and Nigeria”, in Ezekiel Kalipeni et al (eds.), *HIV & AIDS in Africa: Beyond Epidemiology*, UK: Blackwell Publishing, 2004, p.73.

by the need for material and economic assistance.<sup>86</sup> This does not mean that “poverty” is the only factor since the rich are also infected. But it implies that poverty causes people to make irrational decisions, which put them at risk of HIV infection. People choose to do whatever they can in order to survive. Indeed, it has been argued that, “poverty is the greatest single facilitator of HIV transmission in Nigeria and carries the epidemic to the remotest corner of the country.”<sup>87</sup>

Poverty denies people access to health services, as they cannot afford to pay medical bills. To many people, education is also inaccessible particularly amongst the women and girl children, since they and their parents cannot afford to pay the school fees. To give special attention to the reduction of poverty among women as stated in the NEPAD document may be a way to salvage the situation.<sup>88</sup>

The epidemic and poverty are twin terrors operating in mutual concert. Poverty emasculates the response against the epidemic, leaving it free to spread misery and death, especially to the productive force.<sup>89</sup> There is high unemployment rate in Nigeria and those working care for those members of their families that are without jobs. Women are more affected by poverty than men because our cultural practices have relegated them to the background. They depend mainly on their male counterparts for livelihood. As a result, they are disempowered from making decisions of their own. That denies them the power to say ‘no to unprotected sex’ when their male partners are under suspicion of having multiple sexual relationships. The following section will discuss some of these gendered cultural practices.

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<sup>86</sup> Oppong, R. Joseph and Agyei-Mensah, Samuel, “HIV/AIDS in West Africa: The case of Senegal, Ghana, and Nigeria”, 2004, p.73

<sup>87</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.32.

<sup>88</sup> NEPAD document signed at Abuja, Nigeria in October, 2001, p.28.

<sup>89</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.33.

#### 2.4.2 Gendered cultural practices

A gendered cultural practice incorporates “those that are embedded in Nigeria’s social structure and those that can be regarded as the unintended consequences of rapid modernization and urbanization.”<sup>90</sup> For example, the traditional role given to women makes them depend on their husbands for both economic and social support. As a result, it is difficult for them to negotiate safer sex with their partners. In many communities in Nigeria, socially and culturally, women have little or no control over their sex lives and that of their husbands outside marriage. This empowers men to do whatever they want at the expense of their female counterpart. Haddad argues that:

Traditionally, women have little say over the kind of sexual practices they engage in. Cultural practices such as *lobola* (bride price) and polygamy may also contribute to women’s vulnerability. Conversations with women indicate that they are often treated by their husbands as if they were “owned” because the men paid *lobola* in order to marry them. This treatment extends to their sexual relationship, with the husbands expecting sex on demand. Requesting the use of condom often evokes anger and suspicion, so all too often women feel unable to insist on its use during intercourse.<sup>91</sup>

While Haddad is speaking into the South African context, it is the same in Nigeria. The payment of dowry is taken to be a right of ‘ownership’ of the woman by the man that pays the dowry. This is the reason for the return of the money paid for dowry during the dissolution of a marriage. Whenever there is quarrel between a husband and wife, one will hear the husband telling his wife that he paid her dowry. This tradition has disempowered women. The result is that these disempowered wives of those husbands who engage in unsafe sex are vulnerable to contracting HIV. “A married woman cannot say “no” to sex even when she knows that her husband is HIV positive. She is seen as an object of sex with no “say” in the matter.”<sup>92</sup> For justice to prevail, “culture should allow a woman to choose any opportunities to decide what to do with her own life and culture

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<sup>90</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.35.

<sup>91</sup> Haddad, Beverley, “Gender violence and HIV/AIDS: A deadly silence in the church”, 2002, p.95.

<sup>92</sup> Onyike, Nnennaya, “Who is to blame”, accessed from <http://www.warc.ch/update/up132/14.html> on 7th October 2006.

should also insist on the fidelity of both husband and wife to their marriage vows.”<sup>93</sup> It calls for urgent discussion by the stakeholders for a change in order to save the situation and reduce the high risk of infection this tradition has created for our women.

Furthermore, there are other traditional practices in Nigeria that enhance the spread of the virus. Examples of such practices include wife hospitality found in unbridled sexual intercourse between spouses of siblings. “Wife hospitality is the offering of one’s wife or wives as a sexual partner to honoured guest(s) by their hosts.”<sup>94</sup> This is a common cultural practice in Benue state, an area with one of the highest HIV infection rates. The unbridled sexual intercourse between spouses of siblings is the exchange of females married to males of the same family. This family is not limited to the children of the same mother only, but also extended family members. This practice is socially approved among some groups in Kogi and Benue states. There is no doubt that in the context of the HIV epidemic, it can be a contributory factor to the spread of the virus.

Included among the above-mentioned practices are various widowhood rites such as wife inheritance.<sup>95</sup> This is a practice whereby “a man inherits a widow as prescribed by the culture in order to keep the woman within the extended family and to procreate on behalf of the deceased.”<sup>96</sup> Christian women also participate in this practice of wife inheritance, though most of the time in secret. The wife inheritance starts with a sex ritual between a surviving kin of the dead man and the wife of the deceased. In fact, wife inheritance is a culture not only dehumanising, but contributes to the disparity between men and women and does not “promote respect for womanhood,”<sup>97</sup> but rather “promotes the passing on of the virus”<sup>98</sup> especially in the case where the man died of HIV-related illness.

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<sup>93</sup> Mbuy-Beya, Bernadette, *Woman, who are you? A challenge*, Nairobi, Kenya: Paulines Publications Africa, 1998, p.31.

<sup>94</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.38.

<sup>95</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.35-38.

<sup>96</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.36.

<sup>97</sup> Sheerattan-Bisnauth, Patricia, “HIV/AIDS: Nigerian Churches call for action”, accessed from <http://www.warc.ch/update/up132/13.html> on 7th October 2006.

<sup>98</sup> Garland, C. Jean, *AIDS is real and it's in our Church*, Bukuru: African Christian Textbooks, 2003, p.136.

In addition, forced marriages of young girls to older men as old as their grandfathers, which is particularly found in the northern part of Nigeria also increases the chances of the spread of the virus.<sup>99</sup> The “giving” out of these young girls into marriage is what Ruth Oke argues as “not taking into consideration the fact that marriage is a social institution that demands the emotional, rational and physical capability of both partners involved.”<sup>100</sup> Furthermore, “the biological vulnerability is exacerbated as her immature vaginal mucous membrane is damaged by sexual rites and practices forced upon her by early marriage.”<sup>101</sup> In fact, this may lead to complications during childbirth, which may necessitate for blood transfusion. As Nigeria is still having a problem with its health system, there is no assurance that the screenings of blood for transfusion are properly done. For example:

Nigeria’s paradox is best explained with the story of baby Eniola, delivered at a private hospital in a Lagos suburb on November 25, 2005. Little Eniola was referred to the Lagos University Teaching Hospital (LUTH), one of Nigeria’s leading teaching hospitals, for jaundice treatment. She received a blood transfusion as part of her treatment. The blood was from LUTH’s Blood Bank. Two months later, when she failed to either recover or thrive, she was tested for HIV as a last resort. She tested positive. This was not a major surprise...until her parents were counselled and tested for HIV. A shocker awaited everyone. They were negative! Eniola had apparently received tainted blood from LUTH. Who would think that was possible in this day and age?<sup>102</sup>

This may likely be the end product of cultural practices that allow older men to marry young girls. The Nigerian society is patriarchal and male dominated. This practice has its root in “culture and religion ensuring that women are unable to make positive sexual choices for themselves and makes them sitting ducks for HIV infection.”<sup>103</sup> Young girls

<sup>99</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.36.

<sup>100</sup> Oke, Oluwakemi Ruth, “Child marriage: A ticket to HIV/AIDS”, In Elizabeth Amoah, Dorcas Akitunde and Dorothy Akoto (eds.), *Cultural practices and HIV/AIDS: African women’s voices*, Accra-North, Ghana: Sam-Woode Ltd., 2005, p.37.

<sup>101</sup> Oke, Oluwakemi Ruth, “Child marriage: A ticket to HIV/AIDS”, 2005, p.42.

<sup>102</sup> Olujobi, Gbemisola, “Halting apocalypse in Nigeria: The HIV/AIDS fight”, accessed from <http://uscpublicdiplomacy.org/pdfs/hivaidsfight.pdf#search=%22wife%20hospitality%20in%20Nigeria%22> on 7<sup>th</sup> October 2006.

<sup>103</sup> Olujobi, Gbemisola, “Halting apocalypse in Nigeria: The HIV/AIDS fight.”



are at risk because they lack empowerment and “they have less control over when, where, whether and how sexual relations take place.”<sup>104</sup>

Clearly, dealing with issues of cultural discrimination and oppression of women will make a difference in combating the virus. Denis has rightly said that, “HIV and AIDS ultimately is a gender issue.”<sup>105</sup> The patriarchal character of the traditions, cultures and religions of the people of Nigeria as stated in this section has confirmed this bold statement. Therefore, in the context of HIV and AIDS, heterosexual marriages, be they monogamous or polygamous, have a high risk of exposing African women and in particular Nigerian women to HIV.<sup>106</sup> This highlights the need for relevant and gender-sensitive sex education.

#### 2.4.3 Lack of sex education

There has been a conspiracy of silence on matters of sex and sexuality in Africa. In many African cultures sexuality is surrounded with secrecy and speaking about it in public is a taboo, even between married couples.<sup>107</sup> “We are faced with comments like, “don’t talk about sex, we are Christians” or “don’t talk about sex, we are Africans.”<sup>108</sup> People are not allowed to share openly about things pertaining to sex. However, as Bayley puts it, “in public or in private, language ‘about’ sexuality is limited to the erotic body language of traditional dances, and the largely unspoken and often unconscious assumptions men and women make about their lives together.”<sup>109</sup>

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<sup>104</sup> Sheerattan-Bisnauth, Patricia, “HIV/AIDS: Nigerian Churches call for action”, accessed from <http://www.warc.ch/update/up132/13.html> on 7th October 2006.

<sup>105</sup> Denis, Philippe, “Sexuality and AIDS in South Africa”, In *Journal of Theology for Southern Africa*, 115 (March), 2003, p.75.

<sup>106</sup> Phiri, A. Isabel, “African women of faith speak out in an HIV/AIDS era”, 003, p.12.

<sup>107</sup> Weinreich, Sonja and Benn, Christoph, *AIDS: Meeting the challenge, data, facts, background*, 2004, p.47.

<sup>108</sup> Khathide, G. Agrippa, “Teaching and talking about sexuality: A means of combating HIV/AIDS”, In Musa W. Dube (ed.), *HIV/AIDS and the curriculum: Methods of integrating HIV/AIDS in Theological programmes*, Geneva: WCC Publications, 2003, p.1.

<sup>109</sup> Bayley, Anne, *One New Humanity: The challenge of AIDS*, London: SPCK, 1996, p.213.

Traditionally in Nigeria, sex is a private subject for cultural and religious reasons.<sup>110</sup> This same attitude is found in the church where sex is often associated with sin.

The challenges posed by HIV and AIDS have intensified this attitude because of the link established between sex and HIV infection. Up until now, there has been little or no sexual health education for young people in Nigeria and this has been a major barrier to reducing sexually transmitted infection (STI) and HIV rates.<sup>111</sup> Sexual health includes freedom from STDs, which in addition to pain lead to reproductive failures and serious health problems in children as well as increasing the risk of acquiring HIV.<sup>112</sup> Oppong and Agyei-Mensah citing Decosas assert, "Untreated sexually transmitted diseases are a major factor to the spread of HIV in Nigeria."<sup>113</sup>

It is the way sexuality is seen in the Nigerian context that fuels the spread of HIV. Because issues of sexuality are not discussed openly, it has created ignorance about HIV and AIDS among the youth. Coupled with the high number of STIs, the spread of the virus is faster.<sup>114</sup> The only known solution to this situation should be through formal and non-formal education. According to Kellerman, citing World Health Organization (WHO) document, "education is the key to AIDS prevention, because HIV transmission can be prevented through informed and responsible behaviour."<sup>115</sup> Education holds the key to addressing the cultural and gender issues that tend to impinge on the rights of women. This can only be possible if the bias and negative attitudes we have towards sexuality are changed. It will therefore enable us to discuss openly our sexual health. And the more we are well informed and educated about sexuality and HIV, the more success

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<sup>110</sup> Avert, "HIV and AIDS in Nigeria" accessed from <http://www.avert.org/aids-nigeria.htm> on 12<sup>th</sup> July 2006, p.3 of 8.

<sup>111</sup> Avert, "HIV and AIDS in Nigeria" accessed from <http://www.avert.org/aids-nigeria.htm> on 12<sup>th</sup> July 2006, p.3 of 8.

<sup>112</sup> Schoepf, G. Brooke, Schoepf, Claude, and Millen, V. Joyce, "Theoretical Therapies, remote remedies: SAPs and the political ecology of poverty and health in Africa", In Kim Jim Yong et al (eds.), *Dying for growth: Global inequality and the health of the poor*, Boston: Conman Cawage Press, 2000, p.109.

<sup>113</sup> Oppong, R. Joseph and Agyei-Mensah, Samuel, "HIV/AIDS in West Africa: The case of Senegal, Ghana, and Nigeria", 2004, p.73,74.

<sup>114</sup> Avert, "HIV and AIDS in Nigeria" accessed from <http://www.avert.org/aids-nigeria.htm> on 12<sup>th</sup> July 2006, p.3 of 8

<sup>115</sup> Kellerman, Anso, "Health and Development", 2000, p.201-204.

<sup>115</sup> Kellerman, Anso, "Health and Development", 2000, p.205.

in our prevention of the spread of the virus. Therefore, the key is to break the conspiracy of silence associated with sex as it contributes to stigma and discrimination associated to HIV.

## 2.5 Stigma and discrimination

Stigma has been described as a “quality that ‘significantly discredits’ an individual in the eyes of others and has important consequences for the way in which individuals come to see themselves.”<sup>116</sup> Stigma leads to discrimination and ostracization.<sup>117</sup> It marks the boundaries a society creates between “normals” and “outsiders,” and between “us” and “them.”<sup>118</sup> “Discrimination occurs when a distinction is made against a person that results in his or her being treated unfairly and unjustly on the basis of their belonging, or being perceived to belong to a particular group.”<sup>119</sup>

It has been shown that people living with HIV have been stigmatised and discriminated against largely because of religious and moral factors. The person is seen to have been engaged in promiscuous or deviant sex and therefore deserves punishment.<sup>120</sup> Stigma and discrimination associated with HIV and AIDS are very strong barriers that work against the prevention of HIV. It is a universal problem that is supported by many forces including:

Lack of understanding of the disease, myths about how HIV is transmitted, prejudice, lack of treatment, irresponsible reporting on the epidemic, the fact that

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<sup>116</sup> UNAIDS, *A conceptual framework and basis for action: HIV/AIDS stigma and discrimination*, 2002, p.8.

<sup>117</sup> Paterson, Gillian, “HIV and AIDS: the challenge and the context conceptualising stigma”, In *A report of a Theological workshop focusing on HIV-and AIDS-related stigma*, Windhoek, Namibia: UNAIDS, 2005, p.34.

<sup>118</sup> De Bruyn, Theodore, *HIV/AIDS and discrimination: A discussion paper*, Montréal, Québec: Canadian HIV/AIDS Legal Network and Canadian AIDS Society, 1998, p.12.

<sup>119</sup> UNAIDS, *A conceptual framework and basis for action: HIV/AIDS stigma and discrimination*, 2002, p.10.

<sup>120</sup> De Bruyn, Theodore, *HIV/AIDS and discrimination: A discussion paper*, 1998, p.12.

AIDS is incurable, social fears about sexuality, fears relating to illness and death, and fears about illicit drugs and injection drug use.<sup>121</sup>

All these fears make it difficult for people living with HIV to declare their positive status. It also inhibits people from going for HIV voluntary counselling and testing, which is an entry point to prevention of its spread. Stigma also hinders the care and support that should be given to people living with HIV.

Stigma and discrimination against people living with HIV is common in Nigeria. Both Christians and Muslims see immoral behaviour as being the cause of the HIV and AIDS epidemic. According to Mawdud, "Islam teaches that sexual pleasure is good and it is a gift from God which should however, be consummated within marriage"<sup>122</sup> and sex outside marriage is "evil and sin, punishable by God and man."<sup>123</sup> In addition to this, writing from a Christian perspective, Wilbur O'Donovan's remark is that "practices such as adultery, sexual immorality, homosexuality, incest, bestiality and other impure practices are all an abomination to God ...on which God has pronounced a severe judgement."<sup>124</sup> The UNDP report on Nigeria states that, "over 70% of infected individuals are unaware of their status, some who may still be engaging in high-risk behaviour."<sup>125</sup> The outcome of this is further spreading of the virus, and continuous endangering of people's health and lack of well being for people already infected. Therefore, stigma and discrimination contribute to the spread of HIV which if not tackled properly, means it will be more difficult to fight the epidemic.

Given the above discussions, it is important to understand the response of the government to the epidemic. This will be discussed in the next section.

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<sup>121</sup> UNAIDS, *A conceptual framework and basis for action: HIV/AIDS stigma and discrimination*, 2002, p.5.

<sup>122</sup> Mawdud, A. A., *Towards understanding Islam*, Lagos: Al-Wasilat Publishers, 1986, p.18.

<sup>123</sup> Yusuf, Bilkisu Hajiya, "Sexuality and the marriage institution in Islam: An Appraisal", In ARSRC, *Understanding Human Sexuality seminar series 4*, Lagos, Nigeria: ARSRC, 2005, p.2.

<sup>124</sup> O'Donovan, Wilbur, *Biblical Christianity in Africa perspective*, Carlisle, UK: The Paternoster Press, 1996, p.288.

<sup>125</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.43.

## 2.6 Government response

The initial response in the mid-1980s of the Nigerian federal government to HIV and AIDS was denial.<sup>126</sup> This contributed to the failure of those in leadership positions to think about what would be the outcome of this disease in future. According to Barnett and Whiteside, “most governments have preferred to ignore and deny the problem”<sup>127</sup> which gave the disease a conducive period for incubation. They added:

Politicians, policy makers, community leaders and academics have all denied what was patently obvious – that the epidemic of HIV/AIDS would affect not only the health of individuals but also the welfare and well-being of households, communities and, in the end, entire societies.<sup>128</sup>

The first case of AIDS in Nigeria came to light in 1986, and in 1987 the government established the AIDS/STDs control programme known as the National AIDS and STDs control programme (NASCP) as part of its response to the issue of HIV and AIDS.<sup>129</sup> NASCP has been responsible for the health system response to HIV and AIDS and other STIs in Nigeria. In addition to this, in 1991, Folayan noted that:

The then military Head of State launched the War against AIDS campaign in which he made a donation of 20 million Naira and promised that AIDS issues were going to be national priority. As a part of this initiative he directed all states and local governments to commit an annual sum of 1 million Naira and 500,000 Naira respectively to fight the disease. All state owned media were also directed to transmit all HIV related promotional broadcasts free, and the Ministry of Education should see to the inclusion of HIV/AIDS into the educational curriculum.<sup>130</sup>

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<sup>126</sup> FGN, *National Policy on HIV/AIDS*, 2003, p.6.

<sup>127</sup> Barnett, Tony and Whiteside, Alan, *AIDS in the Twenty-First Century: Disease and Globalization*, 2002, p.5.

<sup>128</sup> Barnett, Tony and Whiteside, Alan, *AIDS in the Twenty-First Century: Disease and Globalization*, 2002, p.5.

<sup>129</sup> Folayan, Morenike, “HIV/AIDS: The Nigerian Response”, 2004, p.91. See also. UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.56,57.

<sup>130</sup> Folayan, Morenike, “HIV/AIDS: The Nigerian Response”, 2004, p.91.

This initial response showed much promise, but as Folayan noted, “these promises were never fulfilled and neither were the proposed programmes implemented.”<sup>131</sup> The question one may ask at this point is this: why did the government fail to fulfil its promise? One view may be that “the government gave the impression that there were more pressing competing priorities and development needs.”<sup>132</sup> Another view suggests that a committed response was difficult due to an unstable political climate in Nigeria as the nation was (subsequently) under military coup from early 80s to 1999. However, the most likely cause is ignorance of the impact that the disease would cause to the society, as “neither were enlightenment campaigns nor care for people living with HIV considered national health priorities.”<sup>133</sup>

A more effective response to the HIV epidemic in Nigeria came into being with the inauguration of a democratically elected government in 1999 led by Olusegun Obasanjo. According to the Federal Ministry of Health (FMOH), “HIV/AIDS control was neglected and fragmented under previous governments.”<sup>134</sup> This is because “Nigeria lacked the political leadership necessary to confront the AIDS crisis.”<sup>135</sup> However, since 1999, the new government has placed high priority on prevention, treatment, care, and support activities.

To fulfil this priority the Obasanjo-led government established in January 2000 two key institutions, the Presidential Committee on AIDS (PCA) and National Action Committee on AIDS (NACA), which serve as a multisectoral response from both government and civil society.<sup>136</sup> One of NACA’s primary responsibilities is “the execution and implementation of activities under the HIV and AIDS Emergency

<sup>131</sup> Folayan, Morenike, “HIV/AIDS: The Nigerian Response”, 2004, p.91.

<sup>132</sup> Folayan, Morenike, “HIV/AIDS: The Nigerian Response”, 2004, p.91.

<sup>133</sup> Folayan, Morenike, “HIV/AIDS: The Nigerian Response”, 2004, p.91.

<sup>134</sup> Nigeria: Rapid Assessment of HIV/AIDS Care in the Public and Private Sectors, August, 2004, Partners for Health Reformplus (PHRplus) accessed from [http://www.phrplus.org/pubs/Tech049\\_fin.pdf](http://www.phrplus.org/pubs/Tech049_fin.pdf) on 31st July 2006, p.1.

<sup>135</sup> Oppong, R. Joseph and Agyei-Mensah, Samuel, “HIV/AIDS in West Africa: The case of Senegal, Ghana, and Nigeria”, in Ezekiel Kalipeni et al (eds.), *HIV & AIDS in Africa: Beyond Epidemiology*, UK: Blackwell Publishing, 2004, p.73.

<sup>136</sup> FGN, *National Policy on HIV/AIDS*, 2003, p.7. This can also be found from “HIV and AIDS in Nigeria” accessed from <http://www.avert.org/aids-nigeria.htm> on 12th July 2006, p. 5 of 8.

Action Plan (HEAP), introduced in 1996 for long-term strategic plan.”<sup>137</sup> Furthermore, its responsibilities include “advocating the government’s proactive response whilst coordinating all sectors involved in controlling the epidemic through resource mobilization, supervising, monitoring and evaluating programmes as well as ensuring there is a capacity to build necessary coalitions for controlling the epidemic.”<sup>138</sup>

The two main strategic components of HEAP include, the “creation of an enabling environment and specific HIV and AIDS interventions.”<sup>139</sup> In creating an enabling environment, four strategies or areas of work to be done were identified. The first strategy is the removal of socio-cultural barriers by mobilizing key influential groups like the political opinion leaders and sensitising the general public to respond to HIV and AIDS.<sup>140</sup> This was important because it would ensure “the development of legislation and policies centred on human rights of people living with HIV, women and girls.”<sup>141</sup>

The second strategy speaks of the removal of information barriers.<sup>142</sup> This is because one of the causes of the spread of the virus is lack of information on how it is transmitted and on how one can protect oneself from getting infected. Well-designed information disseminated to the public will help to curb the spread of the virus. This will contribute to the flow of information to policy makers, programme managers and the public in general in the “designing and implementing of proactive interventions for the prevention and mitigation of HIV and AIDS.”<sup>143</sup>

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<sup>137</sup> [http://www.phrplus.org/pubs/Tech049\\_fin.pdf](http://www.phrplus.org/pubs/Tech049_fin.pdf) on 31st July 2006, p.2.

<sup>138</sup> Folayan, Morenike, “HIV/AIDS: The Nigerian Response”, 2004, p.92. This could be found on the Human Development Report on Nigeria (2004) by UNDP, “HIV and AIDS: A challenge to sustainable human development,” p. 58.

<sup>139</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.58.

<sup>140</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.59.

<sup>141</sup> Folayan, Morenike, “HIV/AIDS: The Nigerian Response”, 2004, p.93.

<sup>142</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.59.

<sup>143</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.59.

The third strategy is the removal of systemic barriers by developing organizational capacities within the national, state and local government areas.<sup>144</sup> This involves “capacity development of NACA, and specifically its state (SACA) and local government (LACA) arms, in order to ensure the implementation of concrete activities of HEAP programmes.”<sup>145</sup>

The fourth strategy deals with community-based response.<sup>146</sup> Under this strategy, it is believed that local communities will be engaged in implementing community-based action plans with technical support given by LACA through funding of the programme from SACA.<sup>147</sup> In essence, all this is to make sure that an enabling environment is created in all spheres of leadership which will further create a positive response.

The second main component of HEAP was the ‘specific HIV and AIDS intervention,’ which deals mainly with prevention, care and support programmes. “Prevention is fundamental to defeating HIV and AIDS.”<sup>148</sup>

It is important for people all over the world to be informed or know how they can avoid getting infected and spreading the disease, and be empowered to act on such knowledge.<sup>149</sup> The significance of prevention is that it enables one to avoid the disease, premature death and the socio-economic impact of the HIV epidemic.<sup>150</sup> The strategy is targeted at high-risk populations, for example, youths, women, armed forces and police, sex workers, pregnant women and other risk groups of the general population.<sup>151</sup>

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<sup>144</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.59.

<sup>145</sup> Folayan, Morenike, “HIV/AIDS: The Nigerian Response”, 2004, p.93.

<sup>146</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.59.

<sup>147</sup> Folayan, Morenike, “HIV/AIDS: The Nigerian Response”, 2004, p.93.

<sup>148</sup> UNICEF, *What Religious Leaders can do about HIV/AIDS: Action for children and young people*, New York: UNICEF, 2003, p.13.

<sup>149</sup> UNICEF, *What Religious Leaders can do about HIV/AIDS: Action for children and young people*, 2003, p.13.

<sup>150</sup> Weinreich, Sonja and Benn, Christoph, *AIDS: Meeting the challenge, Data, facts, background*, 2004, p.55.

<sup>151</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.59.



Furthermore, intervention programmes stated in the HEAP programme centre on care and support for people infected with HIV and AIDS, and people affected by HIV and AIDS.<sup>152</sup> The reality is that if the nation only embarks on prevention without adequate care of the infected and affected, it may be difficult to arrest the situation as some already infected may infect others as a way of showing their bitterness. The tendency there is that the action may affect other intervention programmes resulting in failure of the programmes.<sup>153</sup>

Although one can say that there has been some progress towards the objectives of HEAP, “there are still huge gaps in HIV prevention, treatment and care services, particularly at the community level.”<sup>154</sup> Thus, coupled with the rising HIV prevalence and AIDS-related deaths, the lessons learned from the implementation of HEAP led to the review of the national policy on HIV/AIDS in 2003.<sup>155</sup> The policy highlights five major strategic components: prevention of HIV/AIDS, law, human rights and ethics, care and support, communication, and programme management and development.<sup>156</sup> However, there are other problems that still need to be tackled in the government’s response to HIV and AIDS. Thus, the formulation of the national HIV/AIDS policy of the Church of Nigeria (Anglican Communion) complements the government response to the epidemic.

## 2.7 Conclusion

This chapter has attempted to give the history of HIV in Nigeria. HIV and AIDS have a socio-economic impact on the country. It has reduced the life expectancy of the citizens and, as well, affects the health system by over-burdening health personnel and the health services. The chapter also dealt with some of the factors that contributed to the spread of the virus in Nigeria such as the socio-economic, gendered cultural practices, and lack of

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<sup>152</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.59.

<sup>153</sup> UNDP, *HIV and AIDS: A Challenge to sustainable Human development*, 2004, p.81.

<sup>154</sup> Avert, “HIV & AIDS in Nigeria” accessed from <http://www.avert.org/aids-nigeria.htm> on 12th July 2006, p.5 of 8.

<sup>155</sup> [http://www.phrplus.org/pubs/Tech049\\_fn.pdf](http://www.phrplus.org/pubs/Tech049_fn.pdf) on 31st July 2006, p.2.

<sup>156</sup> FGN, *National policy on HIV/AIDS*, Nigeria: FGN, 2003, p.17.

sex education. In addition, it also discussed the issue of stigma and discrimination that contributes to the spread of the disease and the response of the Federal government of Nigeria towards the epidemic.

Before discussing the national HIV/AIDS policy document of the Church of Nigeria, it is important to reflect on a positive theology of HIV and AIDS. The reason for this is because it will help the Church to respond to the epidemic in a more helpful way. This includes reflections on sexuality, *imago dei* and *shalom*. This is the subject of the next chapter.

## CHAPTER THREE

### THEOLOGIZING THE HIV/AIDS EPIDEMIC

#### 3.1 Introduction

Since the HIV epidemic is seen as “largely a human sexuality issue,”<sup>157</sup> generally, the Church has viewed it as a punishment from God for humanity’s immoral behaviour. This view has contributed negatively to the Church’s attitude towards the epidemic. For the Church to respond appropriately to the epidemic there is a great need to start by theologizing the epidemic in a more helpful way. This is because of the negative reactions that are meted out to people who are HIV positive. The society stigmatises them to the point of discrimination and abandonment. But humanity is sexually created and sexuality is a gift from God. It is therefore of utmost importance that the issue of sexuality be properly addressed in response to the HIV epidemic. Hence, theologising the epidemic in a more helpful way will require a better understanding of who humanity is and what is God’s desire for humanity. Therefore, this chapter attempts to theologize the epidemic by discussing sexuality, the notion of *imago dei* and *shalom* as well-being.

#### 3.2 Sexuality

Sexuality is an integral part of human identity.<sup>158</sup> Everyday life and its practice contribute towards shaping the lives and indeed the history of a people. Sexuality is a part of everyday life. It defines the very essence of one’s humanity including one’s self-image, and one’s definition of being male or female, physical looks and reproductive capacity, which “cannot be separated from its emotional, intellectual, spiritual and social dimensions.”<sup>159</sup>

Michel Foucault has defined sexuality in the following way:

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<sup>157</sup> Khathide, G. Agrippa, “Teaching and talking about our sexuality: A means of combating HIV/AIDS”, In Musa W. Dube (ed.), *HIV/AIDS and the curriculum: Methods of integrating HIV/AIDS in Theological programmes*, Geneva: WCC Publications, 2003, p.1.

<sup>158</sup> WCC study document, *Facing AIDS: The challenge, the Churches’ response*, Geneva: WCC Publications, 1997, p.30.

<sup>159</sup> WCC study document, *Facing AIDS: The challenge, the Churches’ response*, 1997, p.30

Sexuality must not be thought of as a kind of natural given which power tries to hold in check, or as an obscure domain which knowledge tries gradually to uncover. It is the name that can be given to a historical construct.<sup>160</sup>

This implies that sexuality is not something to be defined only biologically. Rather it connects to power. According to Foucault, “sexuality is a transfer point for relations of power. It is this power that produces and constitutes sexual desire much more than it controls it.”<sup>161</sup> Fulata Lusungu Moyo supports this view by citing Greeta Rao Gupta who asserts that, “In Africa, sexuality issues are power issues. Those who determine the ‘what, when, where and how’ of sex are those who have power- in this case, men.”<sup>162</sup> This explanation, as it concerns this study, may not be appropriate as sexuality is more than that.

Lewis B. Smedes in his book *Sex for Christians* sees sexuality as “communion, the possibility of pleasure, transgenital and a mystery.”<sup>163</sup> According to him, what we experience in our sexuality is a need for communion. Our sexuality offers us fantastic pleasure. It is God’s gift of creative grace that he made bodies so bent on having and giving pleasure. Nevertheless, to Stephen C. Barton, sexuality has to do with “how we communicate desire for ‘the other’ through our bodiliness.”<sup>164</sup> But what does he mean by communication? This needs to be explained especially in our highly sexualized social context, where there is a tendency for personal freedom to be idolized at the expense of social cohesion.

Notwithstanding, the African Regional Sexuality Resource Centre (ARSRC) has adopted an omni-bus explanation of the term sexuality proposed by the World Health

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<sup>160</sup> Foucault, Michel, *The History of Sexuality, Volume 1: An Introduction*, (translated from the French by Robert Hurley), New York: Vintage Books, 1980, p.105.

<sup>161</sup> Foucault, Michel, *The History of Sexuality, Volume 1: An Introduction*, 1980, p.92-102.

<sup>162</sup> Moyo, L. Fulata, “Threats and challenges to life: An African woman’s perspective” in World Alliance of Reformed Churches, *Celebrating Hope for life in fullness: challenges for the Church*, Accra, Ghana: World Alliance of Reformed Churches, 2005, p.86.

<sup>163</sup> Smedes, B. Lewis, *Sex for Christians: the limits and liberties of sexual living*, Grand Rapids, Michigan: William B. Eerdmans Publishing Company, 1976, p. 99-101.

<sup>164</sup> Barton, C. Stephen, *Life together: family, sexuality and community in the New Testament and Today*, Edinburgh & New York: T&T Clark, 2001, p.73.

Organisation (WHO). According to Eno Blankson Ikpe, citing ARSRC, sexuality is defined as:

A central aspect of being human throughout life and encompasses sex, gender, identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles, and relationships.<sup>165</sup>

This definition seems to be all encompassing as sex, eroticism, pleasure and fantasies are ways of showing our sexuality. It is an interesting aspect of humanity that needs not to be ignored or kept in the dark but should be openly acknowledged and appreciated. The way it is practiced may differ from one culture to another. This may be the reason Jeffrey Weeks has argued that “sexuality is the cultural way of living out our bodily pleasures.”<sup>166</sup> This may mean that one’s sexuality is controlled by one’s culture. But, the fact still remains that it is part of humanity and may be expressed in diverse ways. As a result of connecting sexuality with culture, Ikpe therefore asserts that, “sexuality and gender (which is a cultural construct) are so intricately related that it might be difficult to speak of one without the other.”<sup>167</sup> This contributes to the human definition of the self, and people’s relationships with each other. Because sexuality seems to be so encompassing, it has influenced the family, the community and even the nation. This influence is negative as religious laws and taboos have been webbed around the subject of sexuality making it difficult to discuss sexuality openly. It has contributed in a great measure to the negative attitude people express to the people living with HIV as they are seen to be immoral people. It therefore calls to ask whether sexuality in itself is sinful.

According to Dorcas Olu Akintunde *et al*, “the mere mention of the word ‘sex’ always sends some negative signal.”<sup>168</sup> This is because sex is seen as something that should not

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<sup>165</sup> Ikpe, Eno Blankson, “Human Sexuality in Nigeria: A historical perspective”, in ARSRC, *Human sexuality in Nigeria: Understanding human sexuality series 2*, Lagos: ARSRC, 2004, p.2.

<sup>166</sup> Weeks, Jeffrey, *Sexuality*, 2<sup>nd</sup> edition, London: Routledge, 2003, p.5.

<sup>167</sup> Ikpe, Eno Blankson, “Human Sexuality in Nigeria: A historical perspective”, in ARSRC, 2004, p.3.

<sup>168</sup> Akintunde, O. Dorcas *et al*, “Sexuality and Spirituality: Possible bedmates in the Religious terrain in Nigeria” in ARSRC, *Understanding Human Sexuality seminar series 4*, Lagos, Nigeria: ARSRC, 2005, p.2.

be mentioned openly. It is a secret matter. Today, many people associate sex with AIDS. And because HIV is mostly transmitted through sex, it has contributed more negatively to the way society views sex rather than its positive social significance. Kenneth Plummer rightly observed that researching into the subject “sex” makes the researcher morally suspect.<sup>169</sup> This desire to remain morally clean has made sexuality in Nigeria a taboo subject not to be touched, unless it has to do with the spread of diseases when it is discussed as a public health issue. In addition, “sexuality discussions in Nigeria are centred on marriage which is the accepted and respected space of the only expression of sexuality.”<sup>170</sup> However, the emergence of the HIV epidemic has shown that there is danger if the issue of sexuality is not brought into the limelight as the number of people being infected is increasing every day especially among the youth. Limiting sexual discussion to marriage only will continue to hamper the contributions being made in response to the epidemic. The society needs to be taught what sexuality is all about if the prevention method in response to HIV is to make a positive impact. The fact that technology and globalisation has brought the issue of sexuality right in our sitting rooms calls for open and proper education on sexuality in the society.

It is a fact that Christianity has made an undeniable contribution in shaping attitudes towards sexuality. Barbara Schmid citing Carter Heyward goes on to argue that:

Most historians, sexologists, and others who are interested in how sexual practices and attitudes have developed historically seem to agree that in the realm of sexual attitudes, Western history and Christian [sic] history are so closely linked as to be in effect indistinguishable. That is to say, the Christian church has been the chief architect of an attitude toward sexuality during the last seventeen-hundred years of European and Euroamerican history – an obsessive, proscriptive attitude.<sup>171</sup>

The above reasons from various scholars may account for why HIV has been seen as a punishment from God by people of the Christian faith. However, Pat Caplan citing

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<sup>169</sup> Plummer, Kenneth, *Sexual stigma: An interactionist account*, London: Routledge & Kegan Paul, 1975, p.4.

<sup>170</sup> Ikpe, Eno Blankson, “Human Sexuality in Nigeria: A historical perspective”, in ARSRC, 2004, p.4.

<sup>171</sup> Schmid, Barbara, “Sexuality and Religion in the time of AIDS”, In ARSRC, *Understanding human sexuality seminar series*, Cape Town: ARSRC, 2005, p.2.

Foucault, argues that, “Christianity has not invented its own code of sexual behaviour, but rather that Christianity has accepted an already existing code, reinforced it, and given it a much larger and more widespread strength than it had before.”<sup>172</sup> Based on this view, Schmid citing Dan Maguire therefore asserts that, “efforts to teach sexual or reproductive ethics on the alleged basis of ‘what the Church has always taught’ in this area is historically naïve.”<sup>173</sup> But he suggests that “the main challenge is to find a way of looking at our sexuality which goes beyond genital activity, but as sacred, as a gift to be valued; and considering love, not legalism, as the context for a sexual ethics.”<sup>174</sup> It has therefore become necessary to question the fundamental principles underlying the notion that placed sexuality within the confines of marriage from the Christian perspective. Sexuality has more to it than reproduction, immorality and disease. Nicholson puts it clearly that:

Churches need to affirm that sex, in all its aspects, pleasurable, social, as well as procreative, is in itself a good gift from God. The old Christian suspicion of the senses needs to be corrected by an incarnational emphasis on God being in the world, and in human sexuality. Sex is not just an animal drive within us needing to be curbed and controlled, but also a search for the tenderness and relationship underlying the sensual experience.<sup>175</sup>

Christian faith is a response to a story, which reveals God. Our thinking about sexuality has to begin with God. As Barton puts it:

The Christian vision of God as a Trinity of love, where the love between the Persons of the trinity is characterized by desire for union with the other, a love characterized also by faithfulness, mutual indwelling, interdependence and trust, flowing over in the creation and redemption of the world.<sup>176</sup>

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<sup>172</sup> Caplan, Pat (ed.), *The Cultural construction of sexuality*, London & New York: Tavistock Publications, 1987, p.89.

<sup>173</sup> Schmid, Barbara, “Sexuality and Religion in the time of AIDS”, 2005, p.3.

<sup>174</sup> Schmid, Barbara, “Sexuality and Religion in the time of AIDS”, 2005, p.7.

<sup>175</sup> Nicolson, Ronald, *AIDS: A Christian Response*, Pietermaritzburg: Cluster Publications, 1995, p.21.

<sup>176</sup> Barton, C. Stephen, *Life together: Family, sexuality and community in the New Testament and Today*, 2001, p.75.

It is important to say that the desire we have for union with the other whether of friendship, or of intimacy, or of sexual intercourse is a desire, which expresses the divine nature in us in accordance with that with which we have been created. If God is love, as the first epistle of John affirms (1 Jn.4: 16), then there is *eros* in God, and God's love shows us what *eros* means and how it is to be directed.

The Old and New Testaments both view sexuality as part of the goodness of creation. "Our bodiliness, sexuality and sexual differentiation are expressions of God's play in creating the world: 'male and female God created them.'"<sup>177</sup> Given the repeated affirmation in Genesis 1-2 of the goodness of what God made, this tradition represents the strongest possible affirmation of human sexuality. "Male and female are blessed with the capacity to multiply through their sexuality."<sup>178</sup> The intimacy of sexual relationship is consecrated in the Bible and expressed by 'to know' as a way of mutual disclosure and understanding.<sup>179</sup> For example, "*And Adam knew Eve his wife and she conceived and bare Cain*" (Gen. 4:1). The word "to know" means much more than the actual physical sexual act. It stresses intimacy and mutuality.

The Song of Songs describes in detail the romance and the erotic dimensions of a sexual relationship as an explanation of human love. For instance, "*Your two breasts are like two fawns, twins of a gazelle that feed among the lilies*" (SS. 4:5) and "*O that you were like a brother to me, who nursed at my mother's breasts! If I met you outside, I would kiss you, and no one would despise me*" (SS. 8:1). This reveals the emotional and physical expressions of human love and sexuality. The two partners engaged in such an intimate relationship experience joy and fulfilment.

Furthermore, Paul in his teaching to the Corinthians used a full chapter (1 Cor. 7) to explain the idea of human sexuality. "In an era when Greek women were often deprived both emotionally and sexually, Paul insisted that the Christian husband should recognize

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<sup>177</sup> Barton, C. Stephen, *Life together: Family, sexuality and community in the New Testament and Today*, 2001, p.77.

<sup>178</sup> Chinemelu, Benjamin et al, A Theological Response on HIV/AIDS Epidemic, A class paper presented at UKZN, Pietermaritzburg on 15<sup>th</sup> March, 2006, p.10.

<sup>179</sup> Mahoney, Ralph (ed.), *The Shepherd's Staff*, USA: World Map, 1993, p.54.



and fulfil the needs of his wife”<sup>180</sup> (1 Cor. 7:3-6). It means that both husband and wife were forbidden from using sex as a means of control, but were to enjoy mutuality in that aspect of their marriage. “In the church’s witness to the world regarding the HIV epidemic, we must make it clear that God calls us to celebrate sex as God’s gift. Christians should not be against sex, only its misuse.”<sup>181</sup>

The misuse of sex remains the challenge to our theology. Along with its potential for bringing the richness of intimacy and joy to human relationships, “sexuality makes people vulnerable to each other and to social forces in connection with HIV.”<sup>182</sup> This is why communities and churches have always provided guidelines for the protection of individuals and society. However, as Nicolson puts it:

Churches need to locate sex within a relationship of love, not of legalism. Because it is important in AIDS ministry that women should be empowered to have some control within relationships, we need to move our people away from a mentality that sees sex as a man’s right and a woman’s duty, something which men have a right to demand of women.<sup>183</sup>

What is still true is that sexual love belongs within the context of integrity, concern and faithfulness. The best way to discuss sexuality in a religious context is to link it to physical, spiritual and moral health. In a religious context, “it is not enough to consider the physical consequences of HIV, without considering the spiritual, psychological and social consequences of sex outside or before marriage.”<sup>184</sup> Therefore, there is need to redefine or reassess the current ethic on sexuality. As Schmid quoting Roger Burggraave suggested, “the Christian ethics on sexuality needs to aim for meaningful sexuality and this implies sexuality that is relational, appropriate, not based on fear of consequences or

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<sup>180</sup> *The Word in Life Study Bible, New Testament Edition*, Nashville: Thomas Nelson Publishers, 1993, p.590.

<sup>181</sup> Garland, C. Jean, *AIDS is Real and it’s in our church*, Bukuru, Nigeria: African Christian Textbooks, 2003, p.246.

<sup>182</sup> WCC, *Facing AIDS: The Challenge, the Churches’ Response*, 1997, p.31.

<sup>183</sup> Nicolson, Ronald, *AIDS: A Christian Response*, 1995, p.21.

<sup>184</sup> Schmid, Barbara, “Sexuality and Religion in the time of AIDS”, 2005, p.7.

the instrumentalisation of persons.”<sup>185</sup> This is due to the fact that sexuality is part of being human and God’s gift to humanity to be enjoyed.

The way forward should be to unite and take the current context into theological reflection and/or vice versa. This will enable us to firstly throw light on sexuality. As Khathide puts it:

The blanket of mystery on sex and related issues needs to be removed. The cultural and spiritual barriers prohibiting any discussion on sexuality must be destroyed and discussing sex, which is very much part of us, will go a long way in helping us grapple with the scourge of HIV/AIDS in a meaningful way.<sup>186</sup>

Secondly, it will be of great help if we vernacularise our message or contextualise accurate terminologies of sexuality. This means calling the sexual part of our body by its local name rather than using codes or non-verbal words when we want to mention the sexual organ. For example, instead of saying ‘something in between the two tights,’ one should be bold to call it ‘penis’ (*amu* in Igbo language) and vagina (*ohu* in Igbo language). This is what I mean by saying vernacularise our message. This will help in dealing with the taboo that is associated with sexuality and empowers people to talk about it. The church needs to activate sexual terminologies that will reflect its positive theological reflection. For example, Khathide asserts that, “when we name sex-related objects by their vernacular names – the penis, the vagina, intercourse – people tend to listen.”<sup>187</sup> Sex is not necessarily evil, whereby they act as if sex does not exist as they worship on Sundays. Thirdly, it is also important to avow sexual or gender equality. This will enable women to feel free to express themselves sexually.

Teaching and talking about our sexuality is an explicit acknowledgment that as much as we are spiritual people, we are equally sexual and it creates an enabling environment to

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<sup>185</sup> Schmid, Barbara, “Sexuality and Religion in the time of AIDS”, 2005, p.7.

<sup>186</sup> Khathide, G. Agrippa, “Teaching and talking about our sexuality: A means of combating HIV/AIDS”, 2003, p.6.

<sup>187</sup> Khathide, G. Agrippa, “Teaching and talking about our sexuality: A means of combating HIV/AIDS”, 2003, p.7.

express sexual feelings without experiencing guilt. The implication of this as it concerns the epidemic is that it will reduce the sexually mode of transmission of the virus as people discuss openly their sexuality and share sexual problems with one another without fear of being termed immoral or wayward person. We should be open and bold in talking about sexuality because it is all that we are and it is a gift from God who created humanity in God's own image.

### 3.3 Imago Dei

The Psalmist asked a very pertinent question about humanity: *what are human beings that you are mindful of them, mortals that you care for them? (Ps. 8:4).*<sup>188</sup> The way humans think of themselves and of the society reveal both the value system and the philosophical basis of the thinking. Genesis 1: 26 and 27 attributes to humanity an inherent likeness to God acquired in the creation activity. The Bible records that human beings were created in the image of God (Genesis 1:26, 27). The *imago dei* as it is commonly known "entails that human life has a greater sanctity than animal life, which in essence express in some way humanity's peculiar dignity."<sup>189</sup> This implies that every person male or female, whether healthy or sick, living with HIV or not, has the right to a full life and dignity. The HIV stigmatisation and discrimination hinders people from this full life and dignity as those living with the virus are separated from the rest of the society by the way people relate to them. But as Paul articulated in Romans 8: 35-39, nothing shall separate one from the love of Christ. The image of God in humanity is not based on ones merit or physical appearance.

The Biblical doctrine of *Imago Dei* (human beings made in the image of God) as stated in the Old Testament and references to Jesus Christ as the second Adam and his redemptive work in the New Testament<sup>190</sup> are related to the concepts of dignity and identity. These

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<sup>188</sup> All biblical texts are quoted from the New Revised Standard Version.

<sup>189</sup> Buttrick, George Arthur (ed.), *The Interpreter's dictionary of the Bible: An illustrated encyclopedia*, Nashville: Abingdon Press, 1962, p.683.

<sup>190</sup> Ajulu, Deborah, *Holism in development: An African perspective on empowering communities*, 2001, p.32, 33.

are inseparable human attributes that contribute to the makeup of the personality of an individual.<sup>191</sup> In fact, as the biblical narrative in Genesis 1:26, 27 and Psalm 8:5-8 has shown the *imago dei* links humanity's status to kingship. It affirms the dignity and worth of all humanity not just kings or lords (for the elites). God creating humanity in his own image has given humanity his dignity and identity. Every person irrespective of HIV status has the image of God, which is the basis of humanity's dignity and identity. And it enables one to sincerely worship the creator, live a godly life and attain eternal happiness.<sup>192</sup>

Though the image of God in humanity was marred and distorted by humanity's fall, Jesus' death and resurrection brought reconciliation between God and humanity. Before Jesus' death, the New Testament portrays him as attacking and challenging aspects of the social structure of his day that undermined human dignity and identity in others.<sup>193</sup> Jesus crossed status boundaries to give a new identity to those who were discriminated against and marginalized. The Church should learn from Christ's example by crossing the boundaries in this era of HIV epidemic to make sure that people living with HIV are not stigmatized and discriminated against because they still remain God's creatures created in God's own image. The notion of *imago dei* calls for a responsible relationship that cares for one another as humanity is created in God's image.

The understanding of this *imago dei* notion will empower the Church to be more proactive in its response to the epidemic. It will further quicken the Church to seek for the well-being of the people living with the virus by using all available means at its disposal to achieve it.

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<sup>191</sup> Ajulu, Deborah, *Holism in development: An African perspective on empowering communities*, 2001, p.32.

<sup>192</sup> Weidner, Revere Franklin, *The doctrine of man*, Chicago: Wartburg Publishing House, 1912, p.3.

<sup>193</sup> Ajulu, Deborah, *Holism in development: An African perspective on empowering communities*, 2001, p.37.

### 3.4 Shalom as well being

The word *Shalom* is the Hebrew word for peace in the Old Testament with the root meaning 'well-being' or 'wholeness' in all aspects of life.<sup>194</sup> To Phil Nel it means prosperity or bodily health as stated in the following passages: Gen. 29:6; 43:27; Ps.38:3; Isa.57:18 and is also used in expressing social or commercial relations between friends, parties, and nations.<sup>195</sup> It really signifies bodily health or well-being.<sup>196</sup> According to Nicholas Walterstorff, "shalom is the human being dwelling at peace in all his or her relationships: with God, with self, with fellows, with nature."<sup>197</sup> This incorporates right harmonious relationships to other human beings and delight in human community.<sup>198</sup>

Perry Yoder gives a vivid meaning of *shalom* and *eirene* from the Hebrew and Greek texts, which are, translated 'peace' in English. He argues that *shalom* has material, social, moral or ethical dimensions.<sup>199</sup> From the material perspective, it focuses on the well-being and prosperity in someone's affairs. For example, the consideration of the use of *shalom* by Jacob to Joseph as he was sent to check on his brothers and cattle's well being in Genesis 37:14 and Joseph's quest about the *shalom* of their father as found in Genesis 43:27,28.<sup>200</sup> *Shalom* can also be referred in a positive way to bodily good health as in Psalm 38: 3 – 'There is no soundness in my flesh because of your indignation; there is no health in my bones because of my sin.' In actual fact, *shalom* in the Hebrew Bible refers to things as they ought to be in the material world which "is marked by the presence of physical well-being and by the absence of physical threats such as war, disease, and famine."<sup>201</sup>

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<sup>194</sup> Onwu, Nleananya, "Biblical perspectives for peace, development and reconstruction", in Phiri I.A, Ross K.A, Cox J.L, *The role of Christianity in development, peace and reconstruction: Southern perspectives*, Nairobi: All African Conference of Churches, 1996, p.32.

<sup>195</sup> Nel, Philip, "Shalom", In W.A.Van Genereen (ed.), *The New International Dictionary of Old Testament Theology and Exegesis*, Grand Rapids: Zondervan, 1997, p.131.

<sup>196</sup> Von Rad, Gerhard, "Shalom in the OT", in G. Kittel (ed.), *Theological Dictionary of the New Testament*, Grand Rapids: Eerdmans, 1964, p.402.

<sup>197</sup> Walterstorff, Nicholas, *Until Justice and Peace embrace*, Grand Rapids: Eerdmans, 1983, p.69.

<sup>198</sup> Walterstorff, Nicholas, *Until Justice and Peace embrace*, 1983, p.70.

<sup>199</sup> Yoder, Perry, *Shalom*, 1989, p.10-13.

<sup>200</sup> Yoder, Perry, *Shalom*, 1989, p.11.

<sup>201</sup> Yoder, Perry, *Shalom*, 1989, p.13.

Furthermore, the social aspect of *shalom* depends on the “relationship among people within a society.”<sup>202</sup> The presence of oppression and injustice in a society is a sign of the absence of *shalom*. In this case, it is justice granted to the oppressed that can restore *shalom*.<sup>203</sup> The concern of God for justice is rooted in his intrinsic nature and character,<sup>204</sup> and according to Ajulu “justice calls for, among other essentials, just treatment of the poor.”<sup>205</sup> This just treatment can also be applied to people living with HIV as the sick have a right to life in the accorded justice of God. The term justice and righteousness are used interchangeably in the scripture. Justice and righteousness are attributes of God, and his throne is established on these attributes (Isa.5:16; Ps.89:14). Social justice in the bible is based on the idea of neighbourly love shown in creation and redemption (all human beings are creatures made in God’s image; all, then, are in principle redeemed by Christ and destined for fellowship with God. The purpose for justice as revealed in Jesus, is the common good of all, and the ultimate good of all beings created in God. God demonstrates his justice as deliverance. This was seen in the history of Israel. Providing for the needy means setting them back on their feet. It also means giving them a home, leading to prosperity, restoration, and ending oppression. Justice removes oppression.

Thus, one can say that *shalom* in the bible involves a “much wider and more positive state of affairs.”<sup>206</sup> In fact, as it relates to justice, it demands that the rights of people living with HIV should not be taken away from them as that will amount to oppression. They are created in the image of God despite testing positive to HIV. Their right to employment, participation in Church activities and other social involvement should be unbroken. The removal of their rights either directly or indirectly goes contrary to the notion of *shalom*. One part of the rights of people living with HIV is the access to treatment. HIV has become a manageable disease since effective application of treatments helps in restoring the health and prolonging the life of one living with the

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<sup>202</sup> Yoder, Perry, *Shalom*, 1989, p.15.

<sup>203</sup> Yoder, Perry, *Shalom*, 1989, p.15.

<sup>204</sup> Ajulu, Deborah, 2001. p.59.

<sup>205</sup> Ajulu, Deborah, *Holism in Development: An African perspective on empowering communities*, 2001, p.57.

<sup>206</sup> Yoder, Perry, *Shalom*, 1989, p.15.

virus. It is essential that people living with HIV have access to quality treatment. This is the essence of well-being. If treatment is not made available, it implies oppression, which beckons for justice and deliverance.

As a religious concept, *shalom* is “an essential part of Yahweh’s plan for salvation.”<sup>207</sup> The prophets in looking forward to God’s help and the restoration of their nation expected that justice would be done; oppression removed, and *shalom* results.<sup>208</sup> The liberating act of God in the book of Exodus is the pattern of God’s salvation because it deals with the liberation of slaves from their foreign oppressors. This act of salvation transformed the oppression of the status quo, which according to Hugo Echegaray “embraces all the dimensions of the human.”<sup>209</sup> Thus, *shalom* in its moral perception refers to “the presence of integrity and straightforwardness, the opposite of deceit. And it is the absence of fault, guilt, or blame.”<sup>210</sup> Since the spread of the virus is enhanced by several factors as stated in chapter two, integrity and straightforwardness demands that such structures and factors be dealt with in order to reduce or stop the spreading of the virus. It is not a matter of blame and fault finding, for the basic note in *shalom* is positive relation in all aspect. The moment the Church begins to look for fault, guilt or blame in people living with HIV, the church may not achieve its goals and objectives in its response to the epidemic as the well-being of the people living with the virus will not be taken seriously.

The central view of *eirene* in the New Testament is the positive concept that Jesus came so that “things might be as they ought to be” both among people and between people and God as well as nature. The deeds of Jesus are basically signs of the coming of the kingdom, which has the decisive connotation of liberation (Luke 4:18-19). It is against his will that there be a society in which people are segregated or discriminated against as a result of their health condition. Through Jesus Christ, God’s love, salvation, and justice

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<sup>207</sup> Nel, Philip, “Shalom”, In W.A. Van Genereen (ed.), *The New International Dictionary of Old Testament Theology and Exegesis*, 1997, p.132.

<sup>208</sup> Yoder, Perry, *Shalom*, 1989, p.15.

<sup>209</sup> Echegaray, Hugo, *The Practice of Jesus*, Maryknoll, New York: Orbis Books, 1984, p.xi.

<sup>210</sup> Yoder, Perry, 1989. *Shalom*, 1989, p.16.

was made manifest as a continuation of *shalom* which stands for “completeness, health, peace, welfare, safety, soundness, tranquillity, prosperity, perfectness, fullness, rest, harmony, and the absence of agitation or discord.”<sup>211</sup> The Church should continue with this message and act of *shalom* as the heart of *shalom* is life which God brought into being, and the desires to ensure that it is respected, nurtured and enjoyed.<sup>212</sup> *Shalom* is against all kind of oppression such as abandonment, stigma, discrimination and deprivation of right, which people living with HIV do experience in our society. Indeed, the moment the Church gets a clearer understanding of the notion of *shalom*, its response to the HIV epidemic will be a positive and more helpful one.

### 3.5 Conclusion

This chapter has attempted to show that sexuality is all that we are and it is a gift from God. Sexuality is an integral part of human identity. The secrecy about sexuality contributes to its misuse and makes it a tool in the spreading of HIV as people do not have a clear understanding of sexuality in all its fullness. On the notion of *imago dei*, it shows that every person irrespective of his or her HIV status is created in the image of God, which is the basis of humanity’s dignity and identity. And that people living with HIV should not be treated as outcasts, because they still have the image of God in them. It also showed that *shalom* (well-being) of humanity is the concern of God which needs to be applied in our response to the HIV epidemic.

If this is not adhered to, the implication for the Nigerian Church is that adequate education on ways to avoiding being infected will continue to elude its congregation and the Nigerian society in general. There will be apathy on the side of the Church on its response to the epidemic. Furthermore, the Church will not be able to provide well-informed information to its congregations, thereby resulting in not adequately tackling

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<sup>211</sup> Silver, David, “The meaning of the word Shalom”, accessed from [http://www.therefinersfire.org/meaning\\_of\\_shalom.htm](http://www.therefinersfire.org/meaning_of_shalom.htm) on 5th October 2006.

<sup>212</sup> De Gruchy, Steve, “Integrating Mission and Development: Ten Theological Theses”, In *International Congregational Journal*, 5.1, 2005, p.31.



the root cause of the epidemic. With this insight, the next chapter will discuss the national HIV/AIDS policy of the Church of Nigeria.

## CHAPTER FOUR

### NATIONAL HIV/AIDS POLICY OF THE CHURCH OF NIGERIA

#### 4.1 Introduction

So far, chapter two has looked at the history of the epidemic in Nigeria, the impacts, the factors that contribute to its spread and the responses from the Nigerian government. Chapter three is on theologising the HIV/AIDS epidemic in a more helpful way. This will enable the Church to respond appropriately to the epidemic. This chapter intends to present the National HIV and AIDS policy document of the Church of Nigeria (Anglican Communion) in its response to the epidemic. A brief history of the Church of Nigeria (Anglican Communion) will be outlined. The chapter will also explain the process that led to the policy document and the essence of the document. Furthermore, I will present a critical analysis of the policy document and its reception within the Church.

#### 4.2. Brief history of Church of Nigeria

Christianity came to Nigeria in the 15<sup>th</sup> century through the efforts of Augustinian and Capuchin monks from Portugal, but without a strong positive impact.<sup>213</sup> However, the influence of Anglicanism began on “the 17<sup>th</sup> of December 1842 when Henry Townsend of the Church Missionary Society (C.M.S) landed in Badagry from Freetown, Sierra Leone”<sup>214</sup> to sow the seed that led to Anglicanism in Nigeria. He was not alone in this journey, but was accompanied by many other people; among them was late Rt. Rev. Samuel Ajayi Crowther (a Yoruba ex-slave). With the untiring efforts of these evangelists:

Nigerians began to believe in Jesus as the Lord and Saviour of the entire world. And so, on December 25, 1842 in Abeokuta, Nigerians were able to celebrate for

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<sup>213</sup> The Church of Nigeria (Anglican Communion): History, accessed from <http://www.anglican-ng.org/history.htm> on 27th June 2006.

<sup>214</sup> Oduyoye, Modupe, “The Church in Yorubaland 1842-1992”, In Akinyele Omoyajowo (ed.), *The Anglican Church in Nigeria: 1842-1992*, Lagos, Nigeria: Macmillian Nigeria Publishers, 1994, p.1.

the very first time, the glorious annunciation that the Saviour, who is Christ the Lord, was born. They gave glory to God Almighty, experiencing the peace and joy of the Lord; Anglicanism had been born in Nigeria.<sup>215</sup>

The Anglican Church began to expand to other areas of the country leading to the establishment of the Lagos Mission in 1852 and Niger Mission at Onitsha in 1857 under the Episcopal jurisdiction of the Diocese of Sierra Leone.<sup>216</sup> These two missions later became Dioceses in 1919 and consequently from 1952 to 1977 gave birth to other fourteen Dioceses to make a total number of sixteen Dioceses in Nigeria.<sup>217</sup>

As time went on, the bishops in Nigeria in one of their meetings in Ado-Ekiti in 1974 articulated the idea of having a province of Nigeria which was independent from Sierra Leone. This idea came to fulfilment in 1979 when "the bishop of Ibadan Diocese, the Rt. Revd. Timothy Olufosoye was elected and presented as the first Archbishop, Primate and Metropolitan of the Province, which was designated as "The Church of Nigeria (Anglican Communion)."<sup>218</sup>

Since then, the Church of Nigeria (Anglican Communion) has grown to over 95 Dioceses which are divided into ten Provinces with ten Archbishops and one Primate that oversees the Church of Nigeria (Anglican Communion). It is part of the worldwide Anglican family with a membership of over 17 million of the 70 million members worldwide.<sup>219</sup> In its effort to participate in sharing the good news of Christ's redemption of the world (Colossians 1:13,14), the Church of Nigeria has evolved a vision, which elements include, "bible-based, spiritually dynamic, united, disciplined, self-supporting, committed

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<sup>215</sup> The Church of Nigeria (Anglican Communion): History, accessed from <http://www.anglican-ng.org/history.htm> on 27th June 2006.

<sup>216</sup> Olufosoye, T.O., "Preface", In Akinyele Omoyajowo (ed.), *The Anglican Church in Nigeria – 1842-1992*, Lagos, Nigeria: Macmillian Nigeria Publishers, 1994, p. xvii.

<sup>217</sup> Omoyajowo, Akinyele, "The creation of Dioceses", In Akinyele Omoyajowo (ed.), *The Anglican Church in Nigeria – 1842-1992*, Lagos, Nigeria: Macmillian Nigeria Publishers, 1994, p.111-116.

<sup>218</sup> Omoyajowo, Akinyele, "The creation of Dioceses", 1994, p.117.

<sup>219</sup> Church of Nigeria, "Introduction", accessed from <http://www.anglican-ng.org/introduction.htm> on 27th June 2006.

to pragmatic evangelism, social welfare and a church that epitomizes the genuine love of Christ.”<sup>220</sup>

Christ did not abandon the marginalized and the needy during his earthly ministry, rather he was able to reach them as they were identified through his movement from place to place (Acts. 10:38). It is imperative that the Christian community should continue with this ministry of caring for the need of the people. These and other reasons may be adduced to the formation of the church’s national HIV and AIDS policy in response to the epidemic as part of its social involvement in society.

#### **4.3 Process leading up to the formulation of the HIV/AIDS policy**

Prior to the epidemic nature of HIV and AIDS in the world, the Lambeth Conference (which is an organ that brings together all Anglican Bishops worldwide every ten years) of 1988 recognised that:

The disease AIDS poses a catastrophic threat to every part of the world, and that unless preventative measures are taken, the disease can spread rapidly (though the long latency period may mask its presence, thus giving a false sense of security). The conference asks bishops to accept their responsibility to witness to Christ’s compassion and care, in response to this crisis, by giving a lead.<sup>221</sup>

The conference did not end by only recognising the devastating nature and threat to humanity by the disease, but also made a commitment to respond to the crisis. A resolution was passed at this meeting which resolved that the Church should act in the following way:

1. The promotion of, and co-operation with, educational programmes both of Church and state concerned with the cause and prevention of the disease, in a loving and non-judgemental spirit towards those who suffer.

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<sup>220</sup> The Church of Nigeria, “History”, accessed from <http://www.anglican-ng.org/history.htm> on 27th June 2006

<sup>221</sup> Lambeth Conference Resolutions Archive, “Resolutions from 1988: Resolution 29”, accessed from <http://www.lambethconference.org/resolutions/1988/1988-29.cfm> 9th August 2006.

2. The development of Diocesan strategies: to train and support pastoral helpers; to give direct personal support to those living with AIDS; to identify and try to resolve the social problems leading to and arising from the disease; to reaffirm the traditional biblical teaching that sexual intercourse is an act of total commitment which belongs properly within a permanent married relationship.
3. The need to work together: to encourage global co-operation between Churches, governments and non-government agencies in the fight against the disease; to develop ways in which the Churches can share information and resources; to press where necessary for political action; to promote prayer for all concerned, not forgetting those active in research to discover a cure.<sup>222</sup>

It was expected that all bishops present would go back to their Dioceses and put into motion the necessary structures that would enable the various Anglican provinces to carry out the resolution. However, it seems that at that time the church, especially the Church of Nigeria (Anglican Communion), lacked the will to confront the disease. This may be as a result of the initial denial of the disease in Nigeria and “lack of appropriate HIV and AIDS knowledge within the country, the Church and the clergy.”<sup>223</sup>

The Anglican Communion worldwide did not end the issue of HIV and AIDS with the 1988 resolution, but subsequently kept reminding the Church of the need to participate in response to the epidemic. In fact between the years 2000 and 2002, the Anglican Communion leaders worldwide met several times. In one of these meetings, Archbishop Njongonkulu Ndungane from Cape Town, South Africa and the Rev. Canon Gideon Byamugisha from Uganda presented the primates with HIV and AIDS statistics and called on the Church to become actively involved in addressing the epidemic.<sup>224</sup> There and then Archbishop Ndungane was mandated to develop a “Communion-wide understanding of the scope of HIV and AIDS epidemic in Africa and making it a top priority for the Church.”<sup>225</sup> It was this mandate that resulted in the gathering of ‘All Africa Anglican Conference on HIV and AIDS,’ which was held in August 2001 in

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<sup>222</sup> Lambeth Conference Resolutions Archive, “Resolutions from 1988: Resolution 29”, accessed from <http://www.lambethconference.org/resolutions/1988/1988-29.cfm> 9th August 2006.

<sup>223</sup> The Church of Nigeria, *National HIV/AIDS policy*, Abuja: JODEZ Nigeria Limited, 2004, p.5.

<sup>224</sup> Church of the Province of Southern Africa (CPSA), *HIV and AIDS ministries - From Boksburg to Canterbury: Steps to putting HIV and AIDS on the Anglican map*, South Africa: CPSA, ND., p.27.

<sup>225</sup> Church of the Province of Southern Africa (CPSA), *HIV and AIDS ministries - From Boksburg to Canterbury: Steps to putting HIV and AIDS on the Anglican map*, ND, p.27.

Boksburg, South Africa. The conference resulted in, firstly, a pledge that future generations “will be born and live in a world free from AIDS” and secondly, in the formation of a six-fold commission of ministry in response to AIDS.<sup>226</sup> This six-fold commission included prevention, pastoral care, counselling, care, death and dying, and leadership.<sup>227</sup>

In response to the call by the Anglican Communion worldwide, coupled with the growing rate of HIV infection in Nigeria and the “vision imperative of the Church of Nigeria as a caring church, it became mandatory for us to seek ways of being better informed on the scourge so as to be better prepared to care.”<sup>228</sup> This led to a series of activities and efforts towards the formation of the policy document.

The process included activities such as clergy workshops on HIV/AIDS education.<sup>229</sup> This was important because the Church of Nigeria recognised that a key factor that affects the epidemic in Nigeria is the “lack of appropriate HIV and AIDS knowledge within the Church and the Clergy.”<sup>230</sup> Equipping the clergy and the Church members with accurate information on HIV and AIDS would enable them to play a leading role in responding to the epidemic.

In addition to the above, the Church of Nigeria collaborated with ‘Action Aid and Christian Aid’ who are in partnership with the Church to develop a concept paper that would enable the Church to produce a policy document.<sup>231</sup> This according to the primate was because “the Church cannot afford to plan and implement interventions without

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<sup>226</sup> Church of the Province of Southern Africa (CPSA), *HIV and AIDS ministries - From Boksburg to Canterbury: Steps to putting HIV and AIDS on the Anglican map*, ND, p.5-8.

<sup>227</sup> Church of the Province of Southern Africa (CPSA), *HIV and AIDS ministries - From Boksburg to Canterbury: Steps to putting HIV and AIDS on the Anglican map*, ND, p.6.

<sup>228</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.2.

<sup>229</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.2.

<sup>230</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.5.

<sup>231</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.2.

involving other denominations, the government, non-governmental organisations and agencies that are already involved in the work.”<sup>232</sup>

As part of the process, the Church of Nigeria set up a National HIV and AIDS committee comprising different sections of the Church (men, women, youth, education, health, legal, clergy, and laity).<sup>233</sup> Among them were bishops, clergy, medical and legal professionals, people living with HIV, and representatives from the ten Ecclesiastical provinces that make up the Church of Nigeria.<sup>234</sup> Moreover, the Church of Nigeria also involved the services of the Policy Project Nigeria, Society for Family Health (SFH) and the CMS West Africa Regional office. These groups provided the technical assistance for the development of the national HIV/AIDS policy document.<sup>235</sup>

The Church of Nigeria thus needs to be commended for involving people living with HIV in this process. The inclusiveness in the process shows the seriousness of the Church of Nigeria in responding to the issue. In fact, it is an acknowledgment that HIV and AIDS is no more in the distant places; rather it is also at forefront of the ministry of the Church.

To make sure that the policy document would address the required need, six Dioceses were selected for situational analysis. The outcome from these selected Dioceses, a national workshop, and drawing from the wider experiences and responses of the larger Church, governmental and non-governmental organisations, a draft policy was drawn up.<sup>236</sup> This draft was reviewed and finally approved by the house of bishops. Thus, it became an official document of the Church of Nigeria in its response to HIV and AIDS epidemic in Nigeria.

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<sup>232</sup> ACNS3669 AIDS planning workshop opens in Abuja, accessed from <http://www.wfn.org/2003/11/msg00076.html> on 13th October 2006.

<sup>233</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.2

<sup>234</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.2,3.

<sup>235</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.3.

<sup>236</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.2

#### 4.4 The HIV/AIDS policy document

The policy document centred on six areas of ministry or “six thematic areas.”<sup>237</sup> They are: prevention; pastoral care; counselling; treatment, care and support; death and dying; and leadership.<sup>238</sup>

In order to successfully implement the policy, the Church outlined its goal and objectives as a plumbline to the Church’s involvement in the issue. The goal is “to contribute to the elimination of the spread of HIV and AIDS in Nigeria and provide Christian care and support to those infected and affected by HIV and AIDS.”<sup>239</sup> The objectives are twelve in number. They are:

- To increase awareness and knowledge of HIV and AIDS among members of the Church of Nigeria (Anglican Communion), and the country in general;
- To empower people living with, or affected by, HIV and AIDS within the Church of Nigeria to cope with their circumstances;
- To contribute to the elimination of stigma and discrimination directed against PLWHA and people affected by AIDS (PABA);
- To provide care and support to PLWHA, PABA, the dying;
- To contribute to the elimination of harmful traditional practices that increase the spread of HIV and AIDS;
- To foster behaviour change within the church and Nigeria, especially sexual behaviours, that put people at risk of HIV and AIDS;
- To facilitate access to voluntary counselling and testing (VCT) services;
- To facilitate the formation and effective functioning of support groups for people living with or affected by HIV and AIDS;
- To establish networks and linkages within and outside the Anglican Communion to enhance the response of the church to the HIV and AIDS epidemic;
- To mainstream HIV and AIDS activities into church programmes, and curricula of the Church of Nigeria (Anglican Communion);
- To establish an effective programme management system for the church of Nigeria’s response to the epidemic;
- To advocate for equity, transparency and accountability in the design of national policies and plans and the implementation of programmes to effect them.<sup>240</sup>

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<sup>237</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.10.

<sup>238</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.10.

<sup>239</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.10.

<sup>240</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.9.



The goal and objectives of this policy document as outlined above seems to speak of the church's desire to make a positive contribution towards changing the plight of people living with HIV. They are important ideals; but some of the objectives may be difficult to actualise. For example, how can the Church of Nigeria contribute to the elimination of stigma and discrimination attached to people living with HIV as it often sees the issue as a 'moral' issue? The call for behaviour change may be difficult to actualise as long as sexuality is not discussed openly in the church. It will rather create a kind of tension or conflict between the church's expectation and that of the people living with HIV.

Nevertheless, it is important to assess the six thematic areas of the policy document and see where it can be strengthened. The following section will discuss the six ministry areas of the Church of Nigeria in response to HIV and AIDS.

#### **4.4.1 Prevention**

The Church of Nigeria recognises the fact that "all life is sacred."<sup>241</sup> This causes the Church to "commit itself to do everything possible to prevent the further transmission of HIV/AIDS within the country."<sup>242</sup> Therefore, to preserve the sacredness of this life, the Church of Nigeria as part of its HIV preventive method, has committed itself to "systematic teaching, which promotes abstinence from sex for the unmarried and mutual fidelity among married couples."<sup>243</sup> In order to achieve this, the Church of Nigeria mapped out strategies, in order to "increase awareness and knowledge of the modes of transmission of HIV and the methods through which persons within the Church and community, especially the youth, may protect themselves."<sup>244</sup> The Church stated that it shall "work to eradicate cultural and traditional practices that increase the vulnerability and susceptibility of youth to HIV."<sup>245</sup>

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<sup>241</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.10.

<sup>242</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.10.

<sup>243</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.10.

<sup>244</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.10.

<sup>245</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.11.

A further strategy is “to encourage voluntary donation of blood by members of its congregation and promotion of safe delivery of blood and blood products to patients in need by health facilities under its supervision.”<sup>246</sup> The church also advocates voluntary counselling and confidential testing as part of its preventive method.<sup>247</sup> Additionally, the document suggests that the Church will develop practices within the health facilities under its supervision that will lead to the reduction of mother to child transmission of HIV.<sup>248</sup> Furthermore, the Church states that it will “encourage prevention of mother-to-child transmission (PMTCT) as a method of protecting children from HIV infection and encourage better health-seeking behaviour by its flock and the community.”<sup>249</sup> Also, the Church targets activities towards persons at risk, especially the youth, sex workers, uniformed services, persons within prison etc.<sup>250</sup> The final aspect of the church’s strategy towards prevention is to “increase the institutional capacity of its health facilities to correctly diagnose and treat sexually transmitted infections.”<sup>251</sup>

#### 4.4.2 Pastoral care

The point of pastoral care is to ensure that “all who come to it for succour in the time of trouble will be provided with care and support in line with the teachings of the Lord Jesus Christ.”<sup>252</sup> Citing from Saint Matthew and John in the King James Version of the bible, the document stated “*Come unto me, all ye that labour and are heavy laden and I will give you rest... (Matt. 11:28) ... and him that cometh to me I will in no wise cast out (John 6:37).*”<sup>253</sup> The church should therefore through its ministry be involved in the daily activities of the people in an effort to meet them at their points of need.

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<sup>246</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.11.

<sup>247</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.11.

<sup>248</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.11.

<sup>249</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.11.

<sup>250</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.11.

<sup>251</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.11.

<sup>252</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.11.

<sup>253</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.11.

In essence, pastoral care supports “spiritual growth of church members, with the aim of developing wholesome and holy relationships with God, and humanity.”<sup>254</sup> Affirming the dignity and worth of each human being and making clear the claim of God in our lives will achieve this.

Furthermore, the Church of Nigeria boldly speaks of observing and respecting the fundamental human rights of all her members and the community at large.<sup>255</sup> In addition to that, no member of the church whether clergy or laity that tested positive to HIV should be denied access to spiritual needs, including Holy Communion.<sup>256</sup> It also maintained that the church’s ministry should be open both to non-members who are HIV positive and those who are not. The church should also reach the people that are not able to attend services as a result of ill health, through visitations and prayers offered for them for spiritual rehabilitation.<sup>257</sup> It is further added that clergy shall actively participate in support group activities.<sup>258</sup>

#### 4.4.3 Counselling

According to the Church of Nigeria, “Christian counselling equips people to live in line with God’s invitation to wholeness, free from the burdens of the past, and moving towards the perfection promised in Christ’s example with confidence and determination.”<sup>259</sup> It is based on this fact that the Church of Nigeria “obligates itself to providing godly counsel aimed at reducing the transmission of HIV, reducing the negative impact of the epidemic on those already infected or affected and bringing all persons into a closer relationship with the Almighty God.”<sup>260</sup> In order to meet the challenges of this epidemic, the Church is to “train and equip the clergy and the laity so that they will be able to appropriately take on the challenges involved in counselling

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<sup>254</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.11.

<sup>255</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.11.

<sup>256</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.11.

<sup>257</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.11.

<sup>258</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.11.

<sup>259</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.12.

<sup>260</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.12.

persons at risk of contracting the virus, those already living with the virus, or have started manifesting the symptoms of AIDS.”<sup>261</sup> This counselling shall include “spiritual counselling, counselling for the dying, the bereaved, and other counselling that brings persons into a closer relationship with God.”<sup>262</sup> By so doing, they will be empowered to handle their circumstances and live positively.<sup>263</sup>

In order to achieve this, the Church of Nigeria promises to enhance its capacity to facilitate voluntary care, counselling and testing.<sup>264</sup> The Church will encourage couples who are preparing for marriage to go for voluntary counselling and confidential testing.<sup>265</sup> Though it is not meant to be a compulsory requirement for a Church wedding, this will help to prevent the transmission of the virus during marital life. Besides, it is left for the couple to make their result public or not.<sup>266</sup> To this end, the Church states that it will encourage the setting up of voluntary counselling and testing centres throughout the country for easy accessibility at an affordable price by both the church members and the community.<sup>267</sup> In addition to this, the Church will form links between its voluntary confidential counselling and testing (VCCT) centres and support groups for persons living with HIV, and ensure that its VCCT services is in line with national and international standards.<sup>268</sup> Finally, there is a commitment to make sure that all screening and testing facilities shall apply the national guidelines for HIV testing as instructed by the Federal Ministry of Health.<sup>269</sup>

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<sup>261</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.12.

<sup>262</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.12.

<sup>263</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.12.

<sup>264</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.12.

<sup>265</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.12.

<sup>266</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.12.

<sup>267</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.12.

<sup>268</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.12.

<sup>269</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.12.

#### 4.4.4 Treatment, care and support

The Church of Nigeria, in recognition of its role in the country to provide care and support for the hurting, sets out its objective as, “to ensure that persons already infected or affected by the epidemic live the rest of their lives positively, overcoming the burden associated with the epidemic.”<sup>270</sup> The strategies to achieve this noble intent include “providing access to quality health care within its health institutions and increasing access to resources to improve the lot of people living with HIV and people affected by AIDS.”<sup>271</sup>

In view of the fact that it has a biblical mandate to care for the sick and the needy, its medical care consists of “establishing systems to improve the access to health care services for people living with HIV within the health care services of the Church.”<sup>272</sup> In addition to this, through its health care services and the social welfare system, the Church shall “establish home-based care services to cater for those who are too weak to regularly attend hospitals.”<sup>273</sup> In keeping with this Christian responsibility as stated in the document, under the medical aspect of the Church’s care, it further decided to:

- Establish home-based care (HBC) activities at every level of the Church;
- Recruit volunteers including people living with HIV to provide home based care services to those who require it;
- Improve the capacity of health care workers within the Church’s health facilities to care and manage HIV, and AIDS diagnosis;
- Make drugs for the care of HIV/AIDS available and accessible within its health facilities;
- Establish linkages with established service delivery groups aimed at strengthening the Church’s ability to care for the sick and redirect those the Church is unable to manage;
- Educating people living with HIV on Nutritional needs;
- Provide education on prevention of Mother to Child Transmission (PMTCT).<sup>274</sup>

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<sup>270</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.12.

<sup>271</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.12.

<sup>272</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.13.

<sup>273</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.13.

<sup>274</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.13.

The Church of Nigeria, further, is unswerving in its resolve to reduce the hardships associated with the epidemic.<sup>275</sup> Part of its action towards this end includes “reducing the level of stigma and discrimination directed towards people living with HIV and training people living with HIV and people affected by the epidemic to be resourceful and live positively.”<sup>276</sup> The Church will carry out activities that will be targeted at eliminating stigma and discrimination. It intends to show support to people living with HIV by “making counselling available to meet their needs and provide psychological and emotional support for both persons living with HIV and those affected by the epidemic.”<sup>277</sup> It is also the view of the Church to foster the formation and sustenance of support groups for people living with HIV, and empower them through skills acquisition and income generation activities.<sup>278</sup>

Further action of support and care of the Church of Nigeria in response to the epidemic is to “encourage integration of orphans who still have relations into family/community settings and establish orphanage homes for those children who are yet to be reintegrated into society.”<sup>279</sup> Finally, the Church of Nigeria also decided to provide orphans and other vulnerable children with funds for their education, health and other needs.<sup>280</sup>

#### 4.4.5 Death and dying

It is stated in the policy document that since “we are people who believe in the resurrection of the dead, our relationship with God does not end with physical death, but rather it is a passage from life on earth into eternity.”<sup>281</sup> The policy document states that it is the call of all Christians to support the dying as well as those they leave behind by our

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<sup>275</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.13.

<sup>276</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.13.

<sup>277</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.13.

<sup>278</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.13.

<sup>279</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.13.

<sup>280</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.13.

<sup>281</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.14.

love.<sup>282</sup> Although death may bring suffering and loss, “our faith in Christ can make it a time of enhanced relationship and growth for individuals and communities.”<sup>283</sup>

Based on this, the Church of Nigeria has committed itself to “providing physical care for people dying of AIDS-related illness within its capability.”<sup>284</sup> In addition, the clergy and laity will be trained in order to provide holistic care for the dying and prepare their families to live on.<sup>285</sup> Furthermore, the Church will provide “pastoral care and assist the dying affirm their Christian faith.”<sup>286</sup> When the person finally dies, the Church will provide “a Christian burial for those who die of AIDS within the Church and assist families to accept the death of their loved ones and live on positively.”<sup>287</sup>

#### 4.4.6 Leadership

According to the policy document, leadership is one of the necessary ingredients for success in the response against HIV/AIDS.<sup>288</sup> The Church of Nigeria has acknowledged that “Churches occupy a leadership position in society and should therefore play a leading role in the response to the epidemic.”<sup>289</sup> Recognising this, the Church of Nigeria resolves that “its leadership will lead the church’s response to the epidemic which should be by example and not by word of mouth only.”<sup>290</sup> It also resolves to “defend the rights of persons living with and affected by HIV and AIDS when such rights are denied them.”<sup>291</sup> In addition to the above-mentioned resolve, the Church of Nigeria under its leadership will “advocate for the elimination of harmful practices that increase the susceptibility and vulnerability to HIV or increase the vulnerability of people living with or affected by the epidemic within the community.”<sup>292</sup>

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<sup>282</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.14.

<sup>283</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.14.

<sup>284</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.14.

<sup>285</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.14.

<sup>286</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.14.

<sup>287</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.14.

<sup>288</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.14.

<sup>289</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.14.

<sup>290</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.14.

<sup>291</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.14.

<sup>292</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.14.

Further action that the Church of Nigeria will take through its leadership position is to “ensure that HIV activities are mainstreamed into church programmes such as Sunday school, youth and women’s programmes, sermons and other activities.”<sup>293</sup> The Church hopes to use the existing ecclesiastical structures to implement its HIV/AIDS strategy.<sup>294</sup> Moreover, the leadership pledges to utilise available modes and means of communication to eliminate existing myths and misconceptions about the epidemic.<sup>295</sup> To further achieve its aims and objectives in response to the epidemic, “it shall include HIV and AIDS education into the curricula of all the Seminaries, Theological Colleges and other mission schools; and the clergy incorporating the epidemic issues in their sermons and highlight these in their bulletins.”<sup>296</sup> The Church of Nigeria will also advocate for sound policies formulation that will positively impact upon the epidemic and the quality of life of Nigerians.<sup>297</sup> Finally, under its leadership ministry in response to the epidemic, it will “ensure transparency in the use of funds provided for the epidemic activities within the Church and advocate for such practice within the country.”<sup>298</sup>

Having stated in detail what the National HIV/AIDS policy of the Church of Nigeria is all about, the following section will present a critical analysis of the policy document.

#### 4.5 Critical analysis of the policy document

A call by Bishop John Paul for a compassionate presence emphasizes that “one death crisis confronting us today is the growing presence of the HIV and AIDS which its effects in terms of human suffering and death are alarming.”<sup>299</sup> We cannot live forever on earth. However, it is the dream of every person to live long. But the presence of HIV makes life shorter than expected.

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<sup>293</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.14.

<sup>294</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.14.

<sup>295</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.14.

<sup>296</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.14.

<sup>297</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.14.

<sup>298</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.14.

<sup>299</sup> Paul, John, “A call for compassionate presence”, accessed from <http://www.frpat.com/hiv aids.htm> on 8th August 2005, p.1.



Culturally, Africans understood death as something that comes to one in old age. When you are old and pass on, your life is celebrated as you have not died, “but have returned.” If you die before old age through illness, murder, or car accidents, there must be a reason.<sup>300</sup>

This cultural belief has been nullified by the presence of AIDS because “AIDS confronts us with untimely death. However, we are comforted with the fact of resurrection.”<sup>301</sup> This hope of resurrection was adumbrated in the Apostle Paul’s second letter to the Corinthians where he said:

So we do not lose heart. Even though our outer nature is wasting away, our inner nature is being renewed day by day. For this slight and momentary affliction is preparing us for an eternal weight of glory beyond all measure (2Cor. 4:16-17).

Christians believe that death is overcome in the raising to life from death of Jesus of Nazareth. However, it may be difficult and hard for persons living with HIV to believe that the suffering one experiences as a result of the infection is ‘light and momentary.’ On this difficult experience, Nicolson asks, “how are we to take this? Does it show that if we have faith in Jesus, and faith in the resurrection, then we can face death without fear, because we know we are going to a better place?”<sup>302</sup> It is true that as Christians our faith is “a redemptive faith with the resurrection offering us a way of understanding suffering in the world.”<sup>303</sup> However, when one receives his or her test result that shows positive, one thing evident to the person is that death is forthcoming as there is no cure for AIDS. It is at this point that the Church needs to convey the message of hope through the resurrection of Christ.

As humanity continues to battle for the development of curative vaccines for HIV, people living with HIV and their families have numerous needs. This includes treatment for

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<sup>300</sup> Haddad, Beverley, “We pray but we cannot heal: Theological challenges posed by the HIV/AIDS crisis”, In *Journal of Theology for Southern Africa*, 125 (July), 2006, p.87.

<sup>301</sup> Nicolson, Ronald, *God in AIDS?* London: SCM Press Ltd., 1996, p.207.

<sup>302</sup> Nicolson, Ronald, *God in AIDS?* 1996, p.208.

<sup>303</sup> Haddad, Beverley, “We pray but we cannot heal: Theological challenges posed by the HIV/AIDS crisis”, 2006, p.88.

opportunistic infections such as tuberculosis, and provision of ARVs, which helps in prolonging the life of people infected, care and support both for the sick and their family members. The care and support needed varies from one household to the other depending on a “myriad of factors, including socio-economic status of the household, the sex and age of infected individuals and dependents, their household roles and responsibilities, and the treatment regimens they follow to control the disease.”<sup>304</sup> The focus today as humanity waits for curative vaccines is centred on prevention.

The policy document of the Church of Nigeria seems to provide some preventive methods that will help in reducing the spread of the virus. The good thing about its preventive strategy includes increased awareness and knowledge of the modes of transmission of the HIV and methods which people can use to protect themselves from getting infected. This is very important as the Church has acknowledged that lack of informed knowledge within the country contributed to the spread of the virus. However, the document seems not to be comprehensive on its preventive methods. For instance, under prevention, part of its strategy is to “increase awareness and knowledge of methods through which persons within the church and the community, especially the youth may protect themselves.”<sup>305</sup> But it is not clear from this strategy what the key preventive message is, whether the use of condoms is part of its preventive methods or not. The Church of Nigeria should state clearly if condoms are part of its preventive message.

The Church further advocates for “abstinence for the unmarried and mutual fidelity amongst married couples.”<sup>306</sup> This implies that the Church is looking at the epidemic from the ethical and moral point of view. Though this can yield a positive result in response to the HIV epidemic, it may only work in a society that is gender sensitive both in culture and traditions. The Nigerian society is not gender sensitive, rather it is patriarchal. For example, the widowhood rites such as wife inheritance and wife

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<sup>304</sup> Horizons Program, “Strengthening care and support services in the era of treatment: Symposium report,” 22-23 Nov., 2005, Johannesburg, South Africa, accessed from <http://www.popcouncil.org/pdfs/horizons/sacssymp.pdf> on 31st August 2006.

<sup>305</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.10.

<sup>306</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.11.

hospitality as shown in chapter two is a sign of the patriarchal nature of Nigerian society. Again, it is a manifestation that some cultural and traditional practices in the Nigerian society show no respect or dignity for womanhood. Unless such cultures and traditions are dealt with, the difficulty in abstinence and fidelity will still remain. I have argued earlier that a number of factors contribute to the spread of the virus which include socio-economic factors, gendered cultural practices and lack of sex education among others. As long as it is not a single factor that determines the epidemiological patterns of HIV infection, the response to it should be comprehensive. For instance, since lack of socio-economic power contributes to the spread of the infection, it is necessary to address the issue of the socio-economic life of people in a specific way that will arrest the situation. The HIV epidemic is extremely diverse across regions and an individual or community's inability to control their risk of infection is multifaceted. One can therefore say that, "no single prevention intervention will be effective on its own."<sup>307</sup> Widely and all-inclusive preventive measure is needed in order to control the epidemic and reduce its spread for it is important first to save life.

The demand that youths should abstain from sex till they get married<sup>308</sup> as the Christian teaching has proposed may be difficult in our modern world. For example, it has been argued that, "young people often have difficulty remaining abstinent."<sup>309</sup> This may be attributed to peer pressure, the availability of sex actions through the media that woo them into the act and that sex is not discussed openly in Nigeria and Africa in general. Any debate on the matter of sex is marred by taboos and prejudices.<sup>310</sup> The mere fact that "sexual activity begins in adolescence"<sup>311</sup> seems to contribute to the sexual activeness of the youth. Therefore, in order to prevent the spread of the virus among the youth, it is important to let them have a clear understanding of sexuality in all its fullness. This is the

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<sup>307</sup> UNAIDS, *2004 Report on the global AIDS epidemic: 4<sup>th</sup> global report*, 2004, p.71.

<sup>308</sup> Munro, Alison OP, "Responsibility: the prevention of HIV/AIDS", In Stuart C. Bate OMI (ed.), *Responsibility in a time of AIDS: A pastoral response by Catholic Theologians and AIDS activists in Southern Africa*, Pietermaritzburg: Cluster Publications, 2003, p.37.

<sup>309</sup> Avert, "Overview of HIV prevention", accessed from <http://www.avert.org/prevent-hiv.htm> on 16th August 2006.

<sup>310</sup> Whiteside, Alan and Sunter, Clem, *AIDS: The challenge for South Africa*, 2000, p.60.

<sup>311</sup> UNICEF, *What religious leaders can do about HIV/AIDS: Action for children and young people*, 2003, p.19.

important aspect of theologizing the epidemic as the discussion in chapter three, under Sexuality, shows. Part of the result of this understanding is the acquiring of the skills and the incentives that will enable them to protect themselves against the infection.

On the other hand, to be faithful to one partner in our African male-dominated context may also be a difficult thing. For example, male beneficiaries of the cultural practice of wife hospitality in some parts of Nigeria may not support the call to be faithful to one partner. This is because the practice favours male partners who have power over the sex life of their spouses and can sleep with the wives of their friends in the name of culture. Furthermore, the lack of economic empowerment on the part of the women as a result of their socially assigned role has contributed immensely to their disempowerment. This causes men to take advantage of their wives and behave as they like. Certainly, gender factors are obstacles to 'faithfulness' to one partner. More details on gendered cultural factors can be found in chapter two of this study. Nevertheless, the obstacle to abstinence and being faithful is that, "even if people have the knowledge, they may not have the incentive or the power to change their behaviour."<sup>312</sup> I think the important thing that needs attention is to tackle the underlying factors that make it difficult for behavioural change as well the factors that enhance the spread of the virus. These include socio-economic, gendered cultural practices, lack of sexual education, political factors, and organisational barriers.<sup>313</sup> These serve as hindrances to behavioural change which is needed for the control or eradication of HIV infection in our society as 'abstinence and being faithful' only cannot solve the problem. In fact, people need to be empowered in all dimensions of life in order to successfully arrest the spread of the HIV epidemic.

Still under prevention, it is commendable that the Church has recognised the role of cultural and traditional practices which result in the vulnerability of people to HIV infection and has stated its commitment to work towards eradicating such practices. However, it fails to name such cultural and traditional practices as well as the practical

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<sup>312</sup> Whiteside, Alan and Sunter, Clem, *AIDS: the challenge for South Africa*, Cape Town: Human & Rousseau/Tafelberg, 2000, p.19.

<sup>313</sup> Kebaabetswe, Poloko and Norr F. Kathleen, "Behavioural change: Goals and means", In Max Essex et al (eds.), *AIDS in Africa*, 2<sup>nd</sup> edition, New York: Kluwer Academic, 2002, p.517-519.

way to eliminating them. I feel that it is important for the Church of Nigeria to name such practices because by naming them the society will be aware of their danger. Providing a practical way of handling the issue will be a source of empowerment to not only its adherents, but the society in general.

The pastoral care of the Church of Nigeria also offers to observe and respect the fundamental human rights of all its members including those living with HIV without denying them access to spiritual needs.<sup>314</sup> This agrees with the view that pastoral care “is rooted in human life, and can never be isolated as a professional or even spiritual or religious preserve.”<sup>315</sup> It is a dialogical ministry, which is oriented to the healing process in pain and suffering.<sup>316</sup> It is supporting those who are in need, such as those living with HIV. The good part of the pastoral care action of the Church of Nigeria is that it can guarantee the human rights of those infected and affected by the epidemic and provide a meaningful life for them in the midst of the difficulties. In fact, the church’s pastoral role is like a bigger umbrella that encompasses all the actions that the church is called upon to undertake in relation to the physical, spiritual, economic, social and even political needs of those who are infected and affected by the virus. As the church responds to people living with HIV and AIDS, both ministering to them and learning from their suffering, “its relationship to them will indeed make a difference, and thus become growth-producing.”<sup>317</sup> In fact, the more the policy document has a solid theological foundation, the better the response of the Church will be. This is another reason why theologizing the HIV epidemic in a more helpful way is important to the Church’s response to the epidemic. It empowers the Church to be more proactive in its response to the epidemic.

Furthermore, the policy document made mention of counselling and confidential voluntary testing as part of the tool of the Church of Nigeria for the prevention of the spread of the epidemic. Although it is beneficial for one to know one’s HIV status,

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<sup>314</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.11.

<sup>315</sup> Wright, F., *Pastoral care for lay people*, London: SCM, 1982, p.9.

<sup>316</sup> Hulme, E.R., *Pastoral care and counseling*, Doornfontein: Orion Publishers, 1981, p.43.

<sup>317</sup> WCC, *Facing AIDS: the challenge, the churches’ response – A WCC study document*, Geneva: WCC Publications, 1997, p.77.

because it will empower one to always make an informed decision about his or her life, nevertheless, it may still be difficult or hard for people to go for counselling especially as it relates to one knowing one's HIV status. The difficulty may be as a result of stigma and discrimination that is strongly attached to the epidemic. As I have mentioned earlier on, the Church of Nigeria states in its policy document the intention to carry out activities targeted at eliminating stigma and discrimination. But the document does not seem to outline a strategy for that. It is unhealthy and limits people's aspirations in life as they are rejected and abandoned by closed relations as a result of being HIV positive. How does the Church of Nigeria intend to achieve its counselling objectives in the midst of stigma and discrimination surrounding HIV? Will the Church force her members to go for compulsory testing? Folayan has argued that "one of the present policies in the Anglican Church generating much controversy is the compulsory HIV testing for intending couples before marriage."<sup>318</sup> This claim may not be true because, the HIV and AIDS policy document of the Church of Nigeria stated categorically that, "the Church shall enhance its capacity to facilitate voluntary care and counselling and testing."<sup>319</sup> The Church cannot turn against its policy especially as voluntary counselling and testing is the currently accepted principle which will help to care for the infected and prevent infection of the uninfected. "Compulsory testing is unethical and does not serve the purpose of HIV prevention."<sup>320</sup>

I think that what the Church of Nigeria has stated concerning counselling and confidential testing in its policy document is in line with the UNAIDS and other World bodies that are in the frontline in response to the epidemic. However, what is not clearly stated is whether there will be post testing counselling or not. It would have been better had the policy document also talked about the post HIV test counselling. The discussion in the post-HIV test counselling will depend on the outcome of the result of the testing. For example, if the outcome is negative, counselling focuses on the need for one to make

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<sup>318</sup> Folayan, Morenike, "HIV/AIDS: The Nigerian response", In Nana K. Poku and Alan Whiteside (eds.), *The political economy of AIDS in Africa*, England, USA: Ashgate Publishing, 2004, p.93.

<sup>319</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.12.

<sup>320</sup> Weinreich, Sonja and Benn, Christoph, *AIDS – meeting the challenge: Data, facts, background*, 2004, p.61.

changes to his or her lifestyle that will ensure the person remains HIV negative.<sup>321</sup> When a test is positive, the counsellor will advise on various issues ranging from how to live a healthy life to delay the onset of AIDS; opportunistic infections – what they are, and how to treat them; how to deal with the issue of disclosure and how to know whether one needs to go for antiretroviral treatment, to mention but few.<sup>322</sup> Snidle and Yeoman succinctly put it that, “post-test counselling assists the person in moving from immobility, perhaps through fear, to action nurtured by hope.”<sup>323</sup> The person whose test read positive needs sympathy and empathy. This is because HIV and AIDS affects the whole being of a person.<sup>324</sup> Knowing that one will be cared for instead of being deserted, persecuted or condemned, one will be more receptive to prevention strategies and more compliant with voluntary testing projects.<sup>325</sup>

To counsel the person living with HIV means to provide a support system and to sustain the person through all the possible stages.<sup>326</sup> This calls for the Church to provide comfort and unconditional love to those infected and affected, as pastoral counselling involves compassion. To do this Mwaura argues, “the pastoral counsellor is called to participate in the inner turmoil, agony, frustration and hopelessness of the sick or troubled person.”<sup>327</sup> In order to do this properly, the Church has to deal with its own fear about the epidemic, get in touch with people living with HIV on the level of their basic needs, and give them hope which is rooted in the faithfulness of God and the resurrection power of Jesus Christ.<sup>328</sup> This hope should be encouraged through the scripture and fellowship thereby restoring a feeling of dignity.

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<sup>321</sup> Soul City, *HIV and AIDS: Prevention, care and treatment*, Johannesburg: Jacana Media, 2004, p.23.

<sup>322</sup> Soul City, *HIV and AIDS: Prevention, care and treatment*, Johannesburg: Jacana Media, 2004, p.24.

<sup>323</sup> Snidle, H and Yeoman, D., *Christ in AIDS*, Great Britain: Cardiff Academic, 1997, p.84.

<sup>324</sup> Chinemelu, Benjamin, An evaluation of HIV and AIDS pandemic in the Anglican Church of Nigeria: A case study of the Diocese of Katsina, Unpublished Honours thesis, UKZN, 2005, p.36.

<sup>325</sup> Louw, Daniel, “Ministering and counselling the person with AIDS”, In *Journal of Theology for Southern Africa*, 71 (June), 1990, p.45.

<sup>326</sup> Louw, Daniel, “Ministering and counselling the person with AIDS”, 1990, p.45.

<sup>327</sup> Mwaura, N.P., “Healing as pastoral concern”, In D.W. Waruta and H.W. Kinoti (eds.), *Pastoral care in African Christianity: challenging essays in pastoral theology*, 2<sup>nd</sup> edition, Nairobi: Acton Publishers, 2000, p.92.

<sup>328</sup> Louw, D.J., *Illness as crisis and challenge*, Doornfontein: Orion Publishers, 1994, p.43.

On treatment, care and support, different bodies have advocated for availability of medication such as ARVs and medical needs for opportunistic infections. The Church of Nigeria in its policy document has also committed itself to making drugs available for the care of people living with HIV.<sup>329</sup> Furthermore, it also committed itself to the establishment of home-based care activities at every level of the Church for the adequate support of people living with HIV. For the Church to make drugs available in its health institutions for people living with HIV shows its readiness in response to the epidemic. Similarly, it is part of *shalom* that speaks of well-being in all aspects of life<sup>330</sup> and justice for the weak.<sup>331</sup> The weak in this sense includes people living with HIV as they need just treatment from the society as part of their human right. According to the WHO, “health is a fundamental human right.”<sup>332</sup> This implies that the right to health including the right to treatment is a basic human right.<sup>333</sup> Access to ARVs helps to prolong the life of people living with the virus. In addition, it restores strength to the people enabling them to continue positively with their daily activities. However, the church in its policy document failed to advocate for more significant reduction in the price of antiretroviral medications. The reduction of the cost of ARV’s and their availability to those that cannot afford the cost without any charge will allow more people to benefit from them and thereby reduce the mortality rate caused by the epidemic.

On the establishment of home-based care to support the people living with HIV, it is a good thing to do. What the church of Nigeria puts in its policy document is in line with Jesus’ practical earthly ministry as he cared about and supported the weak. As I have stated in chapter three, *Shalom* calls for right harmonious relationships with other human beings especially the weak, and delight in human community. This is the reason why theologizing the epidemic in a more helpful way is important for the Church. It

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<sup>329</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.13.

<sup>330</sup> Onwu, Nleananya, “Biblical perspectives for peace, development and reconstruction”, in Phiri I.A, Ross K.A, Cox J.L, *The role of Christianity in development, peace and reconstruction: Southern perspectives*, 1996, p.32

<sup>331</sup> Yoder, Perry, *Shalom*, 1989, p.15.

<sup>332</sup> Kellerman, Anso, “Health and development”, In Frik De Beer and Hennie Swanepoel, *Introduction to development studies*, 2<sup>nd</sup> edition, 2000, p.186.

<sup>333</sup> International HIV/AIDS Alliance care and support, accessed from <http://www.aidsalliance.org/sw7187.asp> on 31st August 2006.



demonstrates that God is concerned about humanity's well-being irrespective of one's HIV status, as humanity was created in the image of God. The Church's strategy to empower those living with HIV through skills acquisition and income-generating activities is highly recommended.

Additionally, the commitment of the Church of Nigeria towards 'death and dying' of people living with HIV needs to be commended. Providing physical care and pastoral assistance is in a way a mark of acceptance that people living with HIV are members of the Church. In fact, people living with HIV need to know that they are loved by the Church. The Church should accompany them on their journey without a sign of discrimination or rejection. The Church's resolution of providing a Christian burial when the person dies and assisting the family to live on positively is a step in the right direction. Indeed, as Nicolson has observed:

The church's duty in a time of AIDS is to comfort the dying and the bereaved with the hope of life after death. We have to learn to counsel people to prepare for death. Hope of resurrection helps us to approach death with dignity, rather than clinging to life fearfully.<sup>334</sup>

God is always ahead of humanity in all situations even in death. We can face the pains and griefs by taking into account the resources that are available within the church community and support one another in responding in faith, whatever that may mean for different individuals.<sup>335</sup> Therefore, it compels the Church to invoke the notion of *shalom* in its response to the epidemic as that will be laying a more solid theological foundation for its actions.

Moreover, the policy document states that the Church's leadership will defend the rights of people living with and affected by HIV. In addition to that, they will have to advocate for the elimination of harmful practices that enhances the spread of the epidemic, ensure that HIV/AIDS activities are mainstreamed into Church activities and eliminate the existing myths and misconceptions about HIV and AIDS. These resolutions are good and

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<sup>334</sup> Nicolson, Ronald, *God in AIDS?* 1996, p.220.

<sup>335</sup> Nicolson, Ronald, *God in AIDS?* 1996, p.221.

important in response to the epidemic. But it is the zeal and commitment of the leaders that can actually contribute positively in the church achieving its objectives as it concerns the epidemic in Nigeria. However, leadership is among the problems facing the continent of Africa. HIV epidemic came at the time when many countries in Africa were experiencing political, social and economic instability. Someone has observed that, “the HIV and AIDS epidemic would inevitably cause major problems for African governance.”<sup>336</sup> Overcoming the HIV epidemic requires a level of energy and passion<sup>337</sup> from those in leadership positions to tackle it with all seriousness and commitment. Unless the Church leadership takes the implementation of these strategies seriously, the policy might not be adhered to. It is important that the leaders of the Church should not remain only as the mouthpiece of the masses, but in addition, empower the masses to also speak out on issues concerning the epidemic. In essence, it will contribute immensely towards implementing the Church’s policy. This is because leadership is about empowerment and allowing the masses to be involved in leadership is a way of actualizing the leader’s objectives. A critical factor for successful prevention of HIV and AIDS is leadership.<sup>338</sup> This leadership is the kind that listens to the people’s opinion, and allows members participation in decision making.

But then, has the policy document of the Church of Nigeria addressed the issue of health as captured by *shalom* in relation to people living with HIV? There is no doubt that the church of Nigeria has articulated its way of response to the epidemic. In fact, the opening of the church’s door to provide prevention strategies, pastoral care, care and support, and medical assistance can be seen as part of the church’s work of *shalom*. It arose out of love and obedience to Christ’s command to love one another. Nevertheless, the Church’s response so far may not be absolutely perfect. This calls for a continuous reassessment of its involvement in doing the work of *shalom*. The presence of sickness is an encroachment on the life that God created. It calls for humanity to fight the encroachment

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<sup>336</sup> De Waal, Alex, “A disaster with no name: the HIV/AIDS pandemic and the limits of governance”, In George Ellison, Melissa Parker and Catherine Campbell (eds.), *Learning from HIV and AIDS*, South Africa: Cambridge University Press, 2003, p.238.

<sup>337</sup> De Waal, Alex, “A disaster with no name: the HIV/AIDS pandemic and the limits of governance”, 2003, p.241.

<sup>338</sup> Whiteside, Alan and Sunter, Clem, *AIDS: the challenge for South Africa*, 2000, p.138.

by taking responsibility for oneself and others. Since physical health is of much value, it is everyone's duty to promote health. This seems to be another reason for the Church of Nigeria's involvement in health care.

The Church of Nigeria document is informed by the notion of *imago dei* and *shalom* in its preventive, pastoral care, counselling, treatment care and support, death and dying approach. Indeed, the motivation for carrying out these ministries is the value of human life inherent in the value system of the policy. However, there is no strong attempt in the document to lay a theological foundation that informs its value system. Although the policy document has its strengths, yet it needs a solid theological foundation and an educative tool for the practise it recommends. It hence implies human dignity, as an authentic part of humanity, but fails to provide a theological premise to acknowledge the same.

One of the major weak points of the policy document of the Church of Nigeria (Anglican Communion) is that it does not address the issue of sexuality theologically and it does not employ an educative tool as these relate to a prevention message. In Nigeria, all indications show that the epidemic has continued to grow exponentially, mainly through heterosexual transmission.<sup>339</sup> One of the proposed solutions from the government, non-governmental organisations and the faith-based organisations, is behavioural change. For example, the Church of Nigeria argues that, "the sexually active population should adopt a more positive sexual behaviour in line with God's injunction."<sup>340</sup> This implies that sex must not be outside marriage, but within it. Although behavioural change is important in response to the epidemic, one wonders how people can change their sexual behaviour without first having a clear understanding of sexuality in all its fullness.

This is an issue, which the Church seems to be afraid to discuss openly. The Global Consultation on the Ecumenical Response to the Challenge of HIV and AIDS in Africa

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<sup>339</sup> UNDP, HIV/AIDS: A challenge to sustainable human development, 2004, p.31.

<sup>340</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, Abuja: JODEZ Nig. Ltd., 2004, p.6.

met in Nairobi, Kenya in 2001. The meeting resulted in a repentant acknowledgment that despite the fact that the Church in Africa is still an influential and powerful institution with the potential to bring about transformation, it has however unwittingly contributed both actively and passively to the spread of the virus that causes AIDS.

Our difficulty in addressing issues of sex and sexuality has often made it painful for us to engage, in any honest and realistic way, with issues of sex education and HIV prevention.<sup>341</sup>

This suggests that the deep moral and social beliefs that shape sexual behaviour and sexuality are not usually openly discussed and, therefore, the lack of open discussion on sex and sexuality has strongly contributed to the spread of the epidemic. Nevertheless, in the context of this epidemic the time has come for change. A clear understanding of sexuality in all its fullness will be as well part of the befitting starting point. This can be achieved by educating the society on human sexuality as stated in chapter three. The Church in its policy argues in support of abstinence for the unmarried and mutual fidelity among married couples.<sup>342</sup> It further calls for behavioural change without providing a practical way this behavioural change can be effected. For example, if there is any bible study resource material on sexuality, it will help in articulating or directing people on how to tackle the issue. Conversely, the call to abstinence and conjugal fidelity makes sense. These behaviour choices reduce exposure to the virus. But at the same time, as Denis noted, “too much emphasis on abstinence and fidelity strikes one as being simplistic and narrow-minded.”<sup>343</sup> We are in a global world where people are more sexually active than they were before. We cannot deny that any longer. Furthermore, these campaigns take no account of the factors, which lead people to behavioural patterns, which put them at risk, whether physiological, cultural, social or economic. Therefore, as Denis puts it, “if an ethical discussion about AIDS is to be taken seriously, there must be mention of the social, cultural and economic circumstances which form the

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<sup>341</sup> Global consultation on the Ecumenical response to the challenge of HIV/AIDS in Africa, *Plan of Action: The Ecumenical Response to HIV/AIDS in Africa*, Nairobi, Kenya, 2001, p.4.

<sup>342</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, Abuja: JODEZ Nig. Ltd., 2004, p.11.

<sup>343</sup> Denis, Philippe, “Sexuality and AIDS in South Africa”, 2003, p.74.

background to, and influence sexual behaviour.”<sup>344</sup> But mentioning it only without a practical guide is still problematic because it cannot provide the adequate knowledge needed to help one change one’s sexual behaviour that keeps one at risk of the infection. It seems to me that the issue of sexual behaviour may be difficult to deal with since sexuality itself is so difficult to speak about.

As a response to the inadequate prevention message in the Church, a religious organisation known as the African Network of Religious Leaders Living with or Personally Affected by HIV and AIDS (ANERELA+) has suggested a more helpful and holistic approach to mitigating the epidemic than the ABC method. This alternative preventive approach to HIV is called ‘SAVE.’<sup>345</sup>

Instead of speaking about “abstinence” and “being faithful” to one partner as the key preventive method, the ‘S’ of SAVE stands for “safer practices in relation to all modes of transmission.”<sup>346</sup> For example, “safe blood for blood transfusion, barrier methods for penetrative ‘high risk’ sexual intercourse, sterile needles e.t.c.”<sup>347</sup> This is in recognition that there are many factors that determine the epidemiological patterns of the HIV infection. Therefore, it is essential to address each factor in its own specific way. Furthermore, safer practices also entail proper and consistent use of condoms. This is because improper use of condoms can still lead to one getting infected. Although ‘abstinence and being faithful’ are safer practices, they can only be safe where the partners involved have never engaged in sexual activity before marriage. In this case they need to remain committed to one another throughout their marriage life without having multiple partners. But in a situation where one is having multiple sexual partners, it is pertinent for them to ensure safer practice in order to reduce the chances of getting infected because maybe one is already infected with HIV or other sexually transmitted disease. Besides, people can contract HIV through any unprotected sex including “sex

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<sup>344</sup> Denis, Philippe, “Sexuality and AIDS in South Africa”, 2003, p.74.

<sup>345</sup> ANERELA+, *Positive + Interfaith Talk*, A newsletter of the African Network of Religious leaders living with or personally affected by HIV and AIDS, Johannesburg: ANERELA+, ND, p.4.

<sup>346</sup> ANERELA+, *Positive + Interfaith Talk*, ND, p.4.

<sup>347</sup> ANERELA+, *Positive + Interfaith Talk*, ND, p.4.

within a faithful relationship, if their partner happens to be HIV-positive.”<sup>348</sup> There is an urgent need to promote responsible sexual relationships as we recognise that “HIV does not have morals, and it is not only transmitted by certain kinds of sexual activity.”<sup>349</sup> In actual fact, the argument for safer practices is that each of these needs to be addressed in specific ways to specific groups as other modes of HIV transmission also require safer practice in order to avoid the infection. Therefore, tackling HIV requires talking openly about the importance of having safer practices in all modes of HIV transmission. Abstinence and being faithful do not address other forms of transmissions such as those involved in injecting drugs and using one single needle for a number of people and unscreened blood transfusion. In addition, no space was provided for those that cannot abstain as a result of their cultural background and economic disparity. In essence, ‘SAVE’ provides such space. This is because HIV is not only transmitted through sexual intercourse, though it is the highest route of transmission in Nigeria and Africa in general. But it acknowledges that there are other ways of transmitting the virus. Based on this, as stated by ANERELA+, “religious leaders need then to get the correct and non-stigmatic facts on safer practices and share them with their followers.”<sup>350</sup>

Furthermore, the ‘A’ of ‘SAVE’ refers to “available medications such as anti-retroviral (ARV) therapy for people living with HIV and those already with AIDS-related disease, and medical needs for opportunistic infections and pathological tests.”<sup>351</sup> Prevention should not be limited to people that have not yet been infected, but should at the same time be extended to people already living with the virus. In doing this, medications to alleviate the sufferings of those already infected should be made available. As Nelson Mandela has stated, “we are all human, and the HIV and AIDS epidemic affects us all in the end. If we discard the people who are dying from AIDS, then we can no longer call ourselves people. The time to act is now. We can make a difference.”<sup>352</sup> There is no cure

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<sup>348</sup> Beetge, David, “A call to really look at our humanity in a very deep and positive way”, In *Southern Anglican*, Vol. 11, (December), 2006, p.40.

<sup>349</sup> Beetge, David, “A call to really look at our humanity in a very deep and positive way”, 2006, p.40.

<sup>350</sup> ANERELA+, *Positive + Interfaith Talk*, ND, p.4.

<sup>351</sup> ANERELA+, *Positive + Interfaith Talk*, ND, p.4.

<sup>352</sup> This quote is found at the back cover of “The awake project: Uniting against the African AIDS crisis, published by W. Publishing Group, Nashville, Tennessee, 2002.

yet for HIV or AIDS. But it is manageable. People can live longer and stay healthier by 'living positively' and using anti-retroviral medicines.

However, to make ARV's available to millions of infected Africans requires "radical changes of attitude among international donors and shifts of power in the pharmaceutical industry."<sup>353</sup> This call is as a result of the high cost of the ARVs, which makes it difficult for poor nations to provide ARVs free of charge to its citizens that need them. With the recent reduction in market prices of ARVs, they are still not within the reach of the poor. In some countries the treatment involves out-of-pocket costs, which may stand as obstacles to people who cannot afford it. For example, in Nigeria, "out-of-pocket costs for individuals who receive antiretroviral therapies at public clinics reportedly pay an average of US\$300 annually, a significant sum for the 91% of households in the country that live on less than US\$2 per day."<sup>354</sup> According to Iliffe, "by 2005 only a small minority of Africans needing ARVs were receiving them"<sup>355</sup> while the continent has the highest number of people living with HIV.

ANERELA+ believes that, "treating opportunistic infections results in better quality life, better health and longer survival."<sup>356</sup> The availability of medication also includes "nutrition, clean and adequate water supply for people living with HIV"<sup>357</sup> and the society in general. Though the policy document of the Church of Nigeria talked about ARV's and nutrition, it was not detailed as suggested by ANERELA+. The ANERELA+ view agrees with what UNAIDS have said pertaining to nutrition, "good nutrition has an important role to play in helping people living with HIV stay healthy, in counteracting physical wasting due to HIV infection and in boosting energy levels."<sup>358</sup> It also is beneficial for those not yet infected as their body system is strong to resist infections.

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<sup>353</sup> Iliffe, John, *The African AIDS Epidemic: A history*, Cape Town: Double Storey/ a Juta Company, 2006, p.138.

<sup>354</sup> UNAIDS, *2006 report on the global AIDS epidemic: A UNAIDS 10<sup>th</sup> anniversary special edition*, 2006, p.155.

<sup>355</sup> Iliffe, John, *The African AIDS Epidemic: A history*, 2006, p.138.

<sup>356</sup> ANERELA+, *Positive + Interfaith Talk*, ND, p.4.

<sup>357</sup> ANERELA+, *Positive + Interfaith Talk*, ND, p.4.

<sup>358</sup> UNAIDS, *2004 Report on the global AIDS epidemic: 4<sup>th</sup> global report*, Switzerland: UNAIDS, 2004, p.113-114.

This informed ANERELA+ to call upon religious leaders to advocate for availability of cheap and affordable drugs and effective distribution mechanisms of drugs in their respective countries.<sup>359</sup> In addition to this, to advocate for more scientific research on herbal and traditional drugs, which have recently been seen to be effective when it comes to opportunistic infections.<sup>360</sup>

The 'V' of 'SAVE' stands for voluntary counselling and testing (VCT), which is one intervention that, according to this group, can "mitigate HIV-related stigma and increase the effectiveness of HIV prevention efforts like 'abstinence.'"<sup>361</sup> People should be encouraged to go for counselling and testing as it is through testing that one can know one's HIV status. If the outcome of the test is negative, it empowers the person to always take precautionary steps in matters of sexual activity in order to remain negative. If it is positive, the person seeks for medical advice on how to live positively and also without infecting others. But people are not keen to know their HIV status. The lack of voluntary counselling and testing hinders or limits the 'ABC' method of prevention because this method fails to encourage people to know their HIV status. Knowing one's status is the first step to prevention. According to ANERELA+, "a person who knows his or her HIV status is in a better position to protect him or herself from infection or from infecting another depending on the person's status."<sup>362</sup>

The 'SAVE' model integrates voluntary counselling and testing as part of a preventive approach to reducing or eradicating the spread of HIV. It saves lives and prevents one from deliberately transmitting the virus to others and enables one to get access to treatment. Religious leaders are therefore called to "advocate and preach the benefits of going for VCT."<sup>363</sup>

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<sup>359</sup> ANERELA+, *Positive + Interfaith Talk*, ND, p.4.

<sup>360</sup> ANERELA+, *Positive + Interfaith Talk*, ND, p.4.

<sup>361</sup> ANERELA+, *Positive + Interfaith Talk*, ND, p.4.

<sup>362</sup> ANERELA+, *Positive + Interfaith Talk*, ND, p.4.

<sup>363</sup> ANERELA+, *Positive + Interfaith Talk*, ND, p.4.



Additionally, the 'E' of 'SAVE' according to ANERELA+ refers to 'empowerment through education.'<sup>364</sup> The educational disparity between men and women, poverty, gender and power imbalance caused by both cultural and religious beliefs between men and women has contributed greatly to the spread of the virus especially as it affects African women. Addressing the AIDS crisis in Africa and Nigeria in particular will require an emphasis on more than anti-retroviral drugs, ABC method of prevention, safer practices, voluntary counselling and testing, important as they are. What seems to be needed even more than AIDS drugs among others as we look for long term easing, is the alleviation of poverty and despair that are likely to motivate risky sexual behaviour.<sup>365</sup> This is because in many parts of Africa, "the spread of HIV among women and children is greatly enhanced by the cultural and economic powerlessness of women. The powerlessness of women in culture, economics and religion has a direct impact on their vulnerability to HIV infection."<sup>366</sup> People need to be empowered economically and socially. At the same time, they need well informed education on HIV and AIDS, and how they can protect themselves.

ANERELA+ believes that, "it is not possible to make an informed decision without all the facts."<sup>367</sup> The HIV and AIDS-related stigma can be said to be driven by the fact of misinformation and mis-action by most religious leaders.<sup>368</sup> For instance, "how can we ask our women to abstain or be faithful, or use condoms without empowering them?"<sup>369</sup> Religious leaders are therefore called upon to disseminate accurate information to all within their religious institutions as this will contribute to empowering people to make an informed decision in all they do in relation to the epidemic.

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<sup>364</sup> ANERELA+, *Positive + Interfaith Talk*, ND, p.4.

<sup>365</sup> Epstein, Helen and Chen, Lincoln, "Can AIDS be stopped?" In *The awake project: Uniting against the African AIDS crisis*, 2<sup>nd</sup> edition, Nashville, Tennessee: W Publishing Group, 2002, p.139.

<sup>366</sup> Maluleke, Sam Tinyiko, "Towards an HIV/AIDS-Sensitive curriculum", In Musa W. Dube (ed.), *HIV/AIDS and the curriculum: Methods of integrating HIV/AIDS in Theological programmes*, Geneva: WCC Publications, 2003, p.67.

<sup>367</sup> ANERELA+, *Positive + Interfaith Talk*, ND, p.4.

<sup>368</sup> ANERELA+, *Positive + Interfaith Talk*, ND, p.4.

<sup>369</sup> ANERELA+, *Positive + Interfaith Talk*, ND, p.4.

One way of doing this is by forming partnerships with organisations of people living with HIV and individuals who have a better understanding about what it means to live with HIV and its related illnesses, and becoming stigmatized in the process.<sup>370</sup> Furthermore, religious leaders need to “walk with and ‘be identified with’ people living with HIV and this should be from ‘tokenism - just involvement’ to ‘meaningful and fruitful’ participation of people living with HIV in the education and life of their religious institutions.”<sup>371</sup> A HIV ignorant person is not only dangerous to him or herself, but also to the people around him or her.

From the above discussions, it is evident that approaching HIV and AIDS entirely as a moral issue which ‘abstinence and being faithful’ tends to show, disregards the medical, socio-economical, and demographic political issues that surrounds the disease. The SAVE approach not only highlights these issues but at the same time suggests better ways to tackle them. Therefore, it is more holistic in nature and practice than the ABC method of prevention. The approach is more inclusive than the ABC method which carries a stigmatizing message. In fact, the SAVE approach provides space for all and provides a more helpful way to deal with the epidemic.

#### **4.6 The reception of the policy document within the Church**

It may be difficult to assess the impact of the policy now, as it was only formulated two years ago. However, the ten provinces that make up the Church of Nigeria have certainly begun to embrace the policy. For example, in December 2004, four provinces (about 30 Dioceses) within the Church of Nigeria organised a national workshop/training for Diocesan HIV and AIDS coordinators.<sup>372</sup> It was a big gathering as all the participants were eager to start work immediately. As at July 2006, the number of Dioceses that have

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<sup>370</sup> ANERELA+, *Positive + Interfaith Talk*, ND, p.4.

<sup>371</sup> ANERELA+, *Positive + Interfaith Talk*, ND, p.4.

<sup>372</sup> From an address presented by Ven. Dr. Christian Ebisike on the occasion of the National workshop/training organised by some provinces to train coordinators of their HIV and AIDS programme at Enbrocco hotel Awka, Anambra state, 6<sup>th</sup> – 10<sup>th</sup> December 2004.

trained their HIV and AIDS coordinators rose to over 70 Dioceses.<sup>373</sup> This shows that the policy document has been received positively. The churches are now ready to play a role in tackling stigma and discrimination that is associated with HIV and AIDS. It could be noted that in the early stages of the disease, the Church kept silence as they saw the disease as punishment from God. But now the involvement of the Church of Nigeria in response to the epidemic shows that it was lack of information and knowledge about HIV that made the Church in the past to allude to HIV as a punishment from God.

Clearly the policy has encouraged Church leaders to involve themselves directly in the issues surrounding HIV and AIDS. In some matters in the Church, leaders do not get much involved as members are delegated to carry out the tasks. However, in response to this epidemic, these agencies involve both the leadership structures among the clerics and the laity. At the leadership helm of the Church of Nigeria is the primate who orders the affairs of the Church with the members of the provincial committee that includes Archbishops, Bishops, clergymen and members of laity. They are known as members of the provincial committee of the Church of Nigeria. At this level, the agency responsible for carrying out the policy is known as the Provincial Action Committee on HIV and AIDS (PACA).<sup>374</sup> It is led by the Primate of the Church of Nigeria.

Furthermore, in each of the ten ecclesiastical provinces, a committee is also established respectively. The agency to carry it out is called the Ecclesiastical Provincial Action Committee on HIV and AIDS (EPACA).<sup>375</sup> This agency has the ecclesiastical Archbishop as the chairperson with members including the Diocesan HIV and AIDS coordinators and a multi-sectoral/multi-disciplinary membership that includes women, youth, and people living with HIV.<sup>376</sup> The good thing about this policy is that it makes people get involved in their areas thereby empowering them to work within their cultural

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<sup>373</sup> Religious leader last hope for persons with HIV/AIDS, accessed from [http://www.anglican-nig.org/Religious\\_leadershiv.htm](http://www.anglican-nig.org/Religious_leadershiv.htm) on 12th September 2006.

<sup>374</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.15.

<sup>375</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.15.

<sup>376</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.15.

and traditional backgrounds. This may bring positive results as the Church continues to respond to the epidemic.

A further impact of the policy has been the formation of the Diocesan Action Committee on HIV and AIDS (DACA) in all the Dioceses under the Church of Nigeria.<sup>377</sup> The Bishop of each Diocese serves as the chairman with the Diocesan coordinator and other representatives as members of DACA. It creates a kind of responsibility by every Diocese in the Church's response to the epidemic. Everyone in the leadership structure is involved in this response. In essence the policy document creates a kind of chain response from the top moving downwards to get everyone involved in the struggle against the epidemic. Part of the product of this policy document is commitment from both the ordained and lay people to use all available resources to tackle the issue of the HIV epidemic.

The policy document also made space for the local churches to be involved. The Church Action Committee on HIV and AIDS (CACA) has the parish priest as the chairperson with representatives of various groups within the Church as members.<sup>378</sup> These are to ensure that the Church activities on HIV get to the grassroots. In fact all the bishops are involved as they head their Diocesan agencies. Likewise, in all the local churches, it is the priest that heads the agencies. Without the policy document, it may be difficult for the bishops and clergymen to get involved to the extent of heading the agencies. They may support the programmes and nominate people to represent them as they do in some other things, but the commitment to this policy has ensured that they head the agencies.

Furthermore, the awareness the policy document has created has made the Dioceses to join in the celebration of 'World AIDS Day which comes up every 1<sup>st</sup> of December. Each bishop on this occasion sends a pastoral letter to all the churches under his jurisdiction, which is read to the members. For example, in the year 2004, the Archbishop of the province of the Niger and bishop of Awka Diocese sent a pastoral letter on the theme

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<sup>377</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.15.

<sup>378</sup> Church of Nigeria (Anglican Communion), *National HIV/AIDS Policy*, 2004, p.15.

“Women, Girls, and HIV and AIDS.”<sup>379</sup> In this pastoral letter, among many other issues he addressed, he challenged men and adolescent boys to make a strong commitment to preventing the spread of HIV, caring for those infected and affected and to eliminate harmful practices that put women and girls at risk of HIV and AIDS.<sup>380</sup>

Further evidence of the reception of the policy document within the Church is the involvement of the Church in the training of people for different activities in response to the epidemic. Many Dioceses have trained peer educators, trainers and supervisors. For instance, in Awka Diocese, over 20 people have received training for peer educators trainers/supervisors.<sup>381</sup> Furthermore, over 170 have received peer educators training from over 34 parishes.<sup>382</sup> It is also on record that in some Dioceses from South-East of Nigeria, over 7,858 people in one-on-one educational sessions have been reached, over 31,686 people in 178 group educational sessions reached and 267, 831 people reached in regular church activities.<sup>383</sup>

In many parishes, VCCT has already been established. Women organisations (especially during women’s conferences and their annual August meetings), youth fellowships and other organisations in the churches have integrated the epidemic into their programmes.<sup>384</sup> The priests now educate their congregations on HIV and AIDS through the use of sermons, bible studies and other special occasions or activities. Non-Anglicans are also reached. For example, in Nnewi Diocese, it was reported that over 250,000 non-

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<sup>379</sup> Anikwenwa, M.S.C., a pastoral letter to all the clergy and churches in the Diocese of Awka to mark the World AIDS day of 2004.

<sup>380</sup> Anikwenwa, M.S.C., a pastoral letter to all the clergy and churches in the Diocese of Awka to mark the World AIDS day of 2004.

<sup>381</sup> Okoye, J. Chukwudi, et al, “The Church in Community mobilization for effective HIV and AIDS programming”, In *Family Health International Nigeria*, Nigeria: FHIN, 2006, p.6.

<sup>382</sup> Okoye, J. Chukwudi, et al, “The Church in Community mobilization for effective HIV and AIDS programming”, 2006, p.6.

<sup>383</sup> Okoye, J. Chukwudi, et al, “The Church in Community mobilization for effective HIV and AIDS programming”, 2006, p.7.

<sup>384</sup> Anglican Diocese of Nnewi, *HIV and AIDS prevention: Care and counselling project*, Nnewi: UCECO Prints, 2004, p.8-13.

Anglicans have been reached through various means in secondary schools, markets, motor parks and “okada” riders outreaches.<sup>385</sup>

I will conclude by saying that the policy so far has started yielding results in various local churches, Diocesan levels and provinces. As I said earlier, it may be difficult to assess the progress made so far. Nevertheless, it is encouraging that the Church of Nigeria is ready to respond to the epidemic. With its population of 17 million members, the Church of Nigeria with compassion and commitment can contribute immensely towards reversing what the epidemic has done in Nigeria.

#### **4.7 Conclusion.**

This chapter has looked at the policy document of the Church of Nigeria (Anglican Communion). It gave a brief history of the Church of Nigeria and the processes it went through in formulating its national HIV and AIDS policy. Furthermore, the chapter presented the policy in detail as it touched the six thematic areas the Church has chosen in its response to the epidemic. In fact, these six thematic areas of the Church’s response are important and necessary for an effective response to the epidemic. However, the critical analysis section showed that the policy needs a more solid theological foundation especially as it concerns sexuality, which relates to a preventive message and a better educative tool. In addition, the ‘SAVE’ approach by ANERELA+ was employed as an educative tool for HIV prevention, which is more inclusive. Nevertheless, the impact of the document shows that it has some strength.

Having presented the preventive strategy of the Church of Nigeria in its response to the epidemic and critically analysing the policy document, the next chapter will suggest ways of strengthening the Church’s response by suggesting ways forward.

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<sup>385</sup> Anglican Diocese of Nnewi, *HIV and AIDS prevention: Care and counselling project*, Nnewi: UCECO Prints, 2004, p.12, 13.

## **CHAPTER FIVE**

### **STRENGTHENING THE HIV/AIDS POLICY DOCUMENT**

#### **5.1 Introduction**

The study has shown the situational analysis of HIV and AIDS in Nigeria which indicates that it is already an epidemic in the country. It has found that there are factors that enhance the spread of the virus in Nigeria such as socio-economic factors, gendered cultural practices and lack of sexual health information and education to mention but a few. This epidemic affects the Nigerian people as it reduces life expectancy, has an adverse effect on the health system, and the social and economic life of the Nigerian society. However, the Federal government of Nigeria has initiated its own programmes in response to the epidemic. But these programmes are not enough to tackle the situation squarely. Hence, some challenges still exist which call for collaboration with other stakeholders in order to effectively arrest the epidemic growth in Nigeria. The need for this collaboration prompted the Church of Nigeria into formulating its own HIV/AIDS policy in response to the epidemic.

The effort of the Church of Nigeria in putting together its HIV/AIDS policy document needs to be commended. The Church has shown that it has realised its mistake for not getting involved earlier, and the importance of its involvement in response to the epidemic. The Church, indeed, has the capacity and resources to intervene in such situations. In many ways, the Church's response to the epidemic is related to that of the Federal Government of Nigeria as stated in chapter two. For instance, while part of the government's strategy is the creation of an enabling environment which includes removal of socio-cultural barriers, the Church's preventive measure as stated in chapter four is also to eradicate cultural and traditional practices that increase the vulnerability and susceptibility of people to HIV. Furthermore, as the government acts to remove information barriers, so too is the Church committed to increasing awareness and knowledge on the modes of HIV transmission and methods people can use in order to

prevent them from getting infected. In addition, as the government involves the leadership of both the national and local government arms for a positive response in tackling the situation, the Church of Nigeria has also involved its leadership by creating an organisational structure that will enable leaders of the Church to be involved in the response against the epidemic. Furthermore, the main component of the government's intervention is five-fold, which includes prevention, law, human rights and ethics, care and support, that of the Church of Nigeria is six-fold including prevention, care and support, and leadership. The church leadership is committed to defending the rights of persons living with HIV which is similar to the government human rights. It will not be wrong therefore to say, as I have stated earlier, that both the government's response to the epidemic and the Church of Nigeria's response are related and therefore complementary.

## 5.2 Suggested ways forward

Having commended the Church of Nigeria on its response so far, suffice it to say that there are areas that need to be strengthened. The policy document needs to be strengthened primarily in two ways. Firstly, a more solid theological foundation needs to be outlined, and secondly, a more inclusive prevention and educative tool needs to be embraced.

The stronger theological foundation must be a springboard for the Church's response to the epidemic as it opens discussions on sexuality which is God's gift to humanity and looks at humanity through the eyes of *imago dei* and *shalom*. Indeed, this study has shown that every person irrespective of his or her HIV status has the image of God, which is the basis for humanity's dignity and identity. And that people living with HIV should not be treated as outcasts, because they are created in the image of God. Passing judgment of condemnation on people living with HIV while responding to the epidemic may not achieve the required result intended. It also showed that *shalom* (well-being) of humanity is the concern of God which needs to be applied in our response to the HIV epidemic. On sexuality, it is noted that it is a gift from God and an integral part of human identity. The secrecy on sexuality contributes to its misuse and makes it a tool in the



spreading of HIV as people do not have well informed knowledge of what it is all about. It is therefore important that sexuality be spoken about openly in order for people to make an informed decision on how to use it.

Undeniably, the policy document, as stated in detail in chapter four, has its positive contributions to make towards the response to the HIV epidemic. However, for this policy document to move the Church of Nigeria forward in its response, I suggest that the Church of Nigeria should learn from the policy document of the Church of the Province of Southern Africa and the Plan of Action: the Ecumenical response to HIV and AIDS in Africa produced by Global consultation on the Ecumenical response to the challenge of HIV and AIDS in Africa. The reason for saying this is the realisation of the importance of theology and ethics as touching HIV and AIDS which were included in the policy documents produced by these bodies.

In the African continent where Nigeria belongs, the most common mode of transmission is heterosexual. Therefore, in responding to the epidemic, there is every need to encourage theological and ethical discussions on sexuality. This will give a wider understanding of sexuality in all its fullness. As it is a gift from God, it may not be misused when a proper information and understanding is obtained. This may be part of the reason why the Ecumenical response envisaged the need to stimulate theological and ethical reflection, dialogue, and exchange on issues related to HIV and AIDS.<sup>386</sup> It is also important to include the issue of sin, stigma and gender especially as gendered cultural practices in Nigeria contribute to the spread of the HIV. The discussion on *imago dei* in chapter three showed that male and female are created in God's image and therefore every person deserves respect from each other. In addition to the above, there is every need to re-examine our understanding of love, dignity and compassion as they are important in response to the HIV epidemic and our dealings with people living with HIV.

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<sup>386</sup> Global consultation on the Ecumenical response to the challenge of HIV and AIDS in Africa, *Plan of Action: The Ecumenical response to HIV and AIDS in Africa*, Nairobi, Kenya: Oikoumene, 2001, p.7.

If the Church of Nigeria can reflect on the above mentioned issues, which are the bedrock in the response to HIV and AIDS, the result will definitely direct or suggest guidelines for the transformation of our Churches on how best to address the issues raised by the response to HIV and AIDS. Though the Church may find it difficult to reflect on sin and sexuality as it relates to HIV and AIDS, it is important for the Church of Nigeria to open its door for dialogue with other players. This will enable the Church to actually re-evaluate some of its teachings and doctrines on sin and sexuality. Reflecting positively on the above-mentioned issues will on one hand reduce the stigma and discrimination that is associated with HIV and AIDS, and on the other hand it will enable the Church to be more proactive in its response to the epidemic.

In order for the Church to embrace a more inclusive preventive and educative tool, it needs to address the complexity of the epidemic more fully. A fundamental departure from the traditional and more popular method of ABC is the SAVE alternative approach proposed by ANERELA+. This alternative approach is primarily educative and empowering, hence the need for the church to integrate it as a holistic approach to its response to the epidemic. This is in recognition of the fact that complex interactions between several factors are responsible for the spread of the virus. Therefore, workshopping in the Church of Nigeria in relation to prevention messages should shift in a cultural sensitive way from AB(C) method to a more helpful SAVE approach which is holistic both in nature and practice. The SAVE approach will serve the much needed synergistic methods needed by the Church of Nigeria in dealing with the epidemic.

As one of the factors that contribute to the spread of HIV is the socio-economic factor, the Church can be of help by using both its local and international connections to lobby and advocate for freedom of people from social practices that enhance the spread of the epidemic. The Church can also employ the use of seminars, public debates and writing of articles in the national daily press to enlighten the society on socio-economic ills. Furthermore, since the Church is rooted in communities, it should use its advantage to empower the communities where it finds itself irrespective of religion. This can be achieved through organising the communities into small economic groups and offering

them free-interest loans to establish businesses. The Church may claim that it has no money to do this, however, with its national and international connections, it would be able to achieve this. Through this act, many poor will be saved from endangering their lives through unsafe behaviour because they needed money to take care of themselves and their family members. Furthermore, the Church of Nigeria should be involved in advocacy campaigns against greed and the amassing of wealth by people in authority, which has left Nigeria without much development that is beneficial to the masses. In fact, there is need for further study on how the Church of Nigeria can give economical help to its members.

On the issue of gender inequalities, one may suggest that the Church has greater influence to gender equality than what the culture and traditional practices in most places in Nigeria can offer. If the Church holds to its faith that humanity (male and female) is created in the image of God, it has to open its door and use its prophetic voice against all the practices that dehumanise women in Nigeria. This can be achieved by empowering women through education which will in turn lead to their economic and social emancipation. There is no doubt that this will restore dignity to women.

### **5.3 Conclusion**

The HIV/AIDS epidemic in Nigeria has offered the Church an opportunity to re-examine its life, calling and obedience to God's command. God has given the Church a mandate, which it needs to accomplish. The Church, in particular the Church of Nigeria as the 'salt' and 'light' in Nigeria should really look at our humanity in a very deep and positive way. In effect, the Church of Nigeria should ensure that the space it occupies in response to the epidemic is a safe place where those who are HIV positive find love and acceptance. The Church needs to continue to increase its preventive message in ways that enable its members to change their behaviour amidst the challenges of their socio-economic life.

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