The Church’s Voice in the Midst of the HIV/AIDS Pandemic

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Introduction

7Does the LORD take delight in thousands of rams,  
   In ten thousand rivers of oil?  
   Shall I present my firstborn for my rebellious acts,  
   The fruit of my body for the sin of my soul?  
8He has told you, O man, what is good;  
   And what does the LORD require of you  
   But to do justice, to love kindness,  
   And to walk humbly with your God?  
9The voice of the LORD will call to the city--  
   And it is sound wisdom to fear Your name:  
"Hear, O tribe. Who has appointed its time? (Micah 6:7-9 NASB)

Covenant Baptist Church ("CBC" or "Covenant") is located in Ward 8 of Washington, D.C. Covenant is a predominantly African American congregation famous for its progressive ministry. The church’s vision statement, recited by the congregation weekly during Sunday worship service “Affirming our African American heritage, our vision is to build an inclusive body of biblical believers who continue to grow in Christ as we love, serve, and fellowship with the community and each other” articulates the perspective from which it does ministry. Because of the community it serves and the issues with which Covenant is plagued coupled with its interpretation of Scripture to inform ministry, the church believes very strongly in social justice and a liberative ministry. The community in which it resides is one of the social contexts on which this paper focuses. Additionally, one of the prevailing threats to this community is this paper’s research topic. While Covenant Baptist Church itself will not be the focus for study and examination in this paper, I
introduce it because of my familiarity\textsuperscript{1} with the church and its work and service regarding the threat which is the focus of my paper.

The immediate context for the community Covenant serves is Ward 8, however, Covenant has a national and global reach in its ministerial programs. One of the prevailing threats to the Ward 8 community is the HIV/AIDS pandemic. According to the D.C. Department of Health, from 2001 to 2006, 1,092 persons newly diagnosed with HIV/AIDS living in Ward 8 accounted for 16.1 percent of new cases in the District of Columbia. Of the newly infected, 44 percent were women. African Americans in Ward 8 are disproportionately infected with HIV and account for 96 percent of the newly reported cases. Across Washington, D.C., African Americans are 84 percent of new cases reported. When evaluating modes of transmission, the greatest proportion of newly reported HIV/AIDS cases was attributable to heterosexual contact (39 percent), followed by injection drug use (IDU) at 22 percent and men who have sex with men (MSM) at 19 percent. Among all the wards in DC, the highest percentage population of African Americans resides in Ward 8. One can glean from these statistics that HIV/AIDS is a pandemic within the African American community and within heterosexual relationships.

Because of this tragic reality, Covenant Baptist Church maintains a Conversation Center to provide a safe space for those in the community who are infected with or affected (family and friends of infected persons) by HIV/AIDS. The Center employs an ordained minister who is a clinician in pastoral care to provide support, education, and resources at

\textsuperscript{1} I am an ordained minister in the American Baptist Churches, USA one of the denominations with which Covenant Baptist Church is affiliated. The United Church of Christ is the other denomination. I have been a member of Covenant Baptist Church since 2006 and was ordained by Covenant Baptist Church in 2007. I served in the capacity of Minister of Christian Education. Covenant Baptist Church also has a full-time Minister of Social Justice as well as a Conversation Center that focuses on providing support and education for those affected and infected by HIV/AIDS.
not charge to those of whom it serves. The Center also has a wicker basket filled with condoms on a coffee table and although there is no signage encouraging their use, they are available. This is a rare occurrence among African American mainline churches, particularly those of the Baptist denomination. It is one of the reasons Covenant is known as having a progressive ministry. In some circles the label “progressive ministry” is voiced as a sarcastic pejorative rather than a label of celebration of Covenant’s answer to God’s call of ministry. The Christian church in the African American community in the United States overall has chosen a different approach and response to addressing this pandemic.

The HIV/AIDS pandemic is a tremendous problem that embodies global and religious issues and implications. The disease crosses the secular and religious sphere and encompasses challenges that are multifaceted. This paper will examine the spread of the disease among African American women in the United States and women of color in Africa with a particular lens on South Africa and Western Africa. The paper discusses the elected affinity between the increased infection rate among these female populations and the role and response of the Church. The role and response of the African American and African Churches have impacted the spread of HIV/AIDS among women. I contend that a correlation exists between the traditional response of the Christian Church and the rate of infection of African American and African women. This paper does not aim to establish a causal relationship but rather to discuss and outline the elective affinity present.

In order to explore my thesis, I will present statistical data on the HIV/AIDS infection rate in the United States and Africa highlighting the infection rate among women of color. Next, I will to discuss the perceptions surrounding the virus, particularly in the ecclesiastical community. The paper will then demonstrate that these perceptions inform
the Christian church’s response to HIV/AIDS. Next, the paper will expound upon the role and response of the Christian church and derived connections to the increased infection rate. The conclusion will provide a summary of findings and assessment of my research.

In this paper I will use two different versions of the word “church,” Church and church. The capitalized word Church denotes the universal Christian church, the whole body of Christian believers, whereas the lowercased word church pertains to a particular body or a specific group or denomination. The scope of this paper confines the term “universal Christian church” to mainline Christian Protestant denominations especially those prominent in the African American and African communities. Although this paper focuses exclusively on African American and Black African women, this is not an indication that I discredit or do not recognize the devastation of HIV/AIDS in other cultures. Moreover, this paper does not intend to provide a foundation for a feminist or womanist critique of the theological problem by solely examining the impact of HIV/AIDS on women. Rather, I have chosen to limit the scope of my research as delineated above because of the exponential infection rate among women of color. This is not simply a medical problem but a religion and globalization problem to which the Church must respond accordingly.
Background: HIV/AIDS Statistics

The HIV/AIDS situation has grown from an epidemic to a pandemic. The increasing infection rate across the world has garnered much attention. Moreover, as the world becomes more educated on HIV/AIDS, a philosophical shift—albeit slowly—is occurring. The terminology associated with HIV/AIDS has evolved and the vocabulary has expanded. At one time, the language used to describe someone infected was *a person dying from AIDS*, however, the language *a person living with AIDS (PLAs)* has emerged. At one time this disease was viewed solely as a terminal disease isolate to a specific group of people and now it is identified as a pandemic because of the vast number of persons being infected with the HIV virus worldwide. The impact of this disease is so vast it now receives global attention from both the secular and the religious spaces. One last example of the paradigm shift and change in language is that at first, the focus was only persons infected with HIV/AIDS, but now research, prevention and literature must address not only those *infected* with HIV/AIDS but also those *affected* by HIV/AIDS. Both the emerging and the traditional terminologies are utilized in this paper in their appropriate context.

The focus of this paper remains on the African women in South Africa primarily and African American women in the United States. The infection rate among these groups is alarming and the church must be engaged in the fight against HIV/AIDS. Traditionally, the Christian Church has played an influential role in the lives of African and African Americans and is often the voice heard foremost among all voices as agents of transformation and healing. Sub-Saharan Africa is the region hardest hit by this disease. It is reported that two-thirds (67 percent) of the population is living with HIV even though the region only represents roughly 12 percent of the world’s population with South Africa having the
highest number of people living with HIV in the world at 5.7 million (almost one in five South African adults is HIV-positive). In December 2002, a report was released by the United Nations Programme on HIV/AIDS stating that women accounted for almost half of the 42 million people worldwide living with HIV/AIDS and of the 3.1 million people who died of AIDS in 2002, 1.2 million were women (WORLD Health Organization 2003).

Women are being infected at an alarming rate and African American women are being infected and affected by HIV/AIDS disproportionately. In 2000, 63 percent of all women reported with AIDS were African Americans and African American children represented almost two-thirds (65 percent) of all reported pediatric AIDS cases (McNeal and Perkins 2007, 220). Although these statistics are now a decade old, the infection rate among African American women remain steady. In fact, according to the Center for Disease Control and Prevention’s (CDC’s) data in 2002, African American women were projected to be 23 times more likely to be HIV-positive than white women (Melby 2004, 4). CDC’s projection was realized and the likelihood of African American women being infected with the HIV virus continues to increase. Furthermore, it is reported that African American women are more than 50 percent of the newly infected persons of HIV\(^2\) annually.

Ironically, the number of PLAs and the rate of infection are even higher in the southeastern part of the United States known as the “Bible Belt.” This is significant because this paper will focus on the elective affinity between the African American\(^3\) Church’s

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\(^2\) This fact was cited in numerous articles who gathered data from the CDC for 2003 – 2005 timeframe. These figures point to African American women in the United States.

\(^3\) Some articles will say use the term “Black church” rather than African American Church. Unless citing a direct quote, for consistency in this paper, I will use the term “African American” Church exclusively to refer to what has been traditionally called the “Black Church.”
practice, doctrine, and preaching and the infection rate of African American women in the United States.

Generally speaking, African American Churches embrace a conservative and fundamentalist theology. The African American Churches discussed in this paper believe strongly in a literal translation and inerrancy of Scripture. The theology and doctrinal teaching—Southern Christianity—of the Bible Belt churches are the same practiced in most African American churches. Traditionally, the African American Church has been the prophetic voice and agent of change in its community. Prior to the Civil Rights movement and "[e]ven prior to their formal organization in the nineteenth century, Black religious leaders and communities in ‘invisible institutions’ served as prophetic voices and advocates for liberation and justice" (Sommerville Jr. 2007-08, 247).

The African American church can be an influential partner in the fight against HIV/AIDS in the African American community. Initially, the Church’s response was silence. Then it began to respond; unfortunately, the public response was a counterproductive message rooted in fear, ignorance, and conservative doctrine. Consequently, women of color in these Churches’ communities paid the price.

The latter part of the twentieth century and the dawn of the twenty-first century have seen a call for the Church to break its silence and to take a more positive role in the fight. Not only is the church dealing with the challenge of the pandemic, the academy has become engaged as well. The Interdenominational Theological Center (ITC) committed one issue of its biannual journal to the conversation of getting the African American church mobilized and engaged in this arena.
The same elective affinity between Southern Christianity and an increased HIV rate among Black African women can be seen in South Africa and Western Africa. In Africa, the Church is also being implored to play a definitive and transformative role to impact the infection rate of African women. Ironically, the Church has already played a role and now while on the surface the call is for the Church to *commence* its role, the essence of the call is to *change* the role the Church has played traditionally. The stigma attached to the virus and those infected, along with nonexistent educational programs and support for African women, have established an environment that has caused an increase in the infection rate and thus the population of those infected with and affected by HIV/AIDS. In Africa, “combating HIV requires bold, steadfast leadership. To stop the escalating slaughter of African peoples by HIV, we must seek and receive leadership from the Church. The Church remains the cornerstone of the African global community” (Seele 1995, 551). Fifteen years later after Steele’s⁴ statement, one can analyze the elective affinity between the Church’s involvement and the HIV infection rate. With evidence of an increasing infection rate among African women over the last decade, there is still work or an appropriate work for the Church.

The HIV/AIDS pandemic has two components that are relevant to this study. It has both a religious and a global component when focusing specifically on women. Globalization affects women differently than men when looking at several factors—health, economics and politics to name a few. In the developing world, women’s vulnerability to HIV/AIDS illustrates the negative consequences of globalization and why we need a more

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⁴ Pernessa C. Steele is founder and C.E.O. of *The Balm in Gilead, Inc.*, a not-for-profit, independent organization in New York City. The organization works to prevent the further transmission of HIV among African peoples by mobilizing the religious community to address HIV appropriately and effectively.
ethical and rights-based approach to the pandemic if we are to contain its spread and mitigate its impact on women and girls (Gupta 2004). This realization exists among scientific scholars but has been slow to reach the Church. Unfortunately, the African and African American churches, while being faced with this reality, still struggle with how to effectively engage this conversation. It is a tremendous challenge to the Church—one not readily acknowledged—to be a transformative agent and hold to its doctrine and Church practices. A tremendous factor in the struggle is that the Church believes that much of the HIV/AIDS prevention education is in conflict with doctrinal teaching.
Preventive Methods

The discussion regarding the best methods for preventing the spread of the HIV virus is evolving and in some respects controversial. One of the prevalent approaches to prevention is “ABC.” ABC is a global approach in the secular and religious arenas and is recognized in both the United States and Africa. However, ABC is not an approach accepted wholeheartedly and fully by the Church. ABC is an acronym for a three-pronged preventive method. The A is for Abstinence, B stands for Being faithful to one’s partner and C advocates the use of Condoms in situations where A and B are not possible or observed. African American and African Christian churches preach and teach abstinence and faithfulness. The division in principle lies in the promotion of condom use. The Church associates the promotion of condom use with an endorsement of sexual relations outside of marriage. It becomes a matter of priority—the Church’s priority lies with the spiritual health of its members and the medical profession’s priority is the physical health of its constituents.

In Nigeria, there are medical practitioners who feel strongly that religion has negatively impacted the HIV/AIDS infection rate. Some have expressed that “the position taken by some religious groups with respect to condom use has been seen as subversive, myopic, and unrealistic” (Aguwa 2010, 209). The medical field does not disavow that abstinence and faithfulness are worthy opponents in the fight against HIV/AIDS yet does recognize that abstinence and faithfulness are not viable options for all relationships. Medical practitioners recognize that a third option must be present for those who are engaging in sex outside of marriage. To stop the educational message at abstinence and
faithfulness in their opinion is to be reckless. This recklessness, they contend, has led to the exponential spread of HIV/AIDS over the last twenty years.

One reality that is emerging from the pandemic is that married women are at an equal or greater risk of contracting the virus than are single women. Apparently, the male partner brings the virus into the marriage. It is, therefore, not surprising to learn that in some African communities, the number of HIV/AIDS cases for married women is higher than for single women (Gichaara 2008, 189). The marital construct challenge the notion of the first two elements of the ABC approach. Abstinence is not a realistic option in African marriages particularly when the cultural standard is that the wife’s body belongs to the husband. Moreover, in Christian African marriages, scripture advocate sexual relations between husbands and wives as often as the partner requests except for times of fasting and praying. Consequently, the promotion of ABC is met with great challenges and seldom works in the context of marriage.

The assumed formulae of: A—for Abstinence; B—for Being Faithful and C—for using Condoms has not worked in Africa chiefly because:

• Abstinence is not desirable in marriage. Sexual relationship is generally accepted as an essential element in marriage.
• Being faithful, especially with men, can only be assumed.
• Wearing condoms is not something that women can insist upon when the sexual relations are starkly unequal and unfair (Gichaara 2008, 189).

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6 Reference 1 Corinthians 7:3-6
The cultural dynamics in African families challenge the efficacy of the preventive method, ABC. The failure of ABC in Africa has negatively impacted the infection rate among women.

In order to implement an effective prevention program in South Africa, HIV/AIDS prevention must address the social, religious, economic, and medical implications. First, one must understand the importance Africans place on the communal life and the understanding of self (the individual) in the context of community. The African community is the extended family, thus “according to this conception, the human does not become human by *cognito* (thinking) but by *relatio* (relationship) and *cognatio* (kinship)...these relations can best be summarized and understood through the phrase, ‘I am because we are; and since we are therefore I am.’” (Gichaara 2008, 190). The establishment of community provides the foundation for family life and hierarchical structure based upon traditional gender-based roles. The extended family not only includes the living, but also the dead; not only humans but also the divine. Consequently, African ancestors and God are very active and respected members of the African communal society.

Honoring traditions is a part of honoring and respecting the ancestors. Within the African community, traditions are hard to erase; they do, however, evolve over time ever so slowly. The traditional roles of male and female, husband and wife, are steeped in traditions that have evolved slowly and directly impact the HIV/AIDS pandemic and challenge ABC. African cosmology not only “affects the way Africans view their interconnected relationships with God, ancestors and spirits, but also they way Africans treat and view their horizontal relations with each other” (Gichaara 2008, 192). One way this manifests is that the father is a more powerful force than the son, the husband is a stronger life force than the wife and the chief is the greatest of them all. This ultimately
contributes to the cultural mindset that allow men to continually embrace the misconception that they have a right over women’s bodies and, therefore, disempowered wives have no right to insist upon condom use.

Charlotte Vallaey, in her award-winning essay, “Awareness is Not Enough: Gender in the HIV/AIDS Pandemic in Africa,” addresses this phenomenon. Vallaey acknowledges that educating the African populations on how the virus is transmitted is important but alone is inadequate. To African men, the promotion of condom use and admonitions to decrease the number of their sexual partners among African men attacks their notion of masculinity. African men will not embrace and abide by a prevention methods that require a change in behavior that reduces their traditional masculine standing in society especially methods associated with a disease that has been incorrectly stigmatized as a white male homosexual disease. Vallaey argues that prevention and education need to instead encompass favorable cultural and economic environmental factors that will encourage African men to make the necessary changes in behavior. For men, this means that the cultural concept of masculinity needs to correspond with the messages of the awareness campaigns. Women, on the other hand, need the economic and social independence necessary to have control over their bodies and their sexual relations (Vallaey 2001).

Undoubtedly, a reduction in the number of PLAs and infection rate requires a multifaceted approach and multiplayer approach.
**Perceptions Surrounding HIV/AIDS**

The Church’s role in HIV/AIDS prevention and education is closely associated with the perceptions of this dreadful and deadly disease. In African countries and African American communities in the United States, the myths and stigma associated with the HIV/AIDS pandemic have had tremendous influence on the theology developed by the Church as well as on the educational programs and messages the Church will teach. First, the Church needs to overcome the misconception that HIV/AIDS is primarily a white homosexual male disease. When the HIV/AIDS global epidemic commenced in the early 1980s, it was mostly understood to be a disease that attacked the gay community and, within the community, primarily white males. The African American community paralyzed by the stigma of homosexuality and sex, particularly outside of marriage, remained silent and shackled by fear due to lack of education. To engage in the fight and become educated about the disease required this community to entertain realities that the African American Church did not want to readily admit or even discuss. The Church would have to converse about sexual practices, contraception and homosexuality. The Church chose the more comfortable position of ignorance and avoidance with a deadly incorrect justification that HIV/AIDS was a disease that was not a tremendous threat to its community. Choosing silence has been very costly to African American women because the “the virus once referred to as ‘gay-related immunodeficiency disease’ has become increasingly gender-blind, especially in the black community, where heterosexual transmission accounts for 25 percent of male infections and 78 percent of female infections” (Kalb, et al. 2006, 42).

Another perception hindering the religious community is the view that those who have been infected have received God’s judgment or punishment for their immorality. This
stigma derives partially from the aforementioned perception. Most Churches\(^7\) judge the “practice of homosexuality” or the “engagement in a homosexuality lifestyle”—as these churches would term such sexual relationships—a sin. Condemning homosexuality as well as maintaining the belief that AIDS was a gay disease, caused a person who contracted the virus to be seen as having received punishment for his or her sexual sin. As HIV/AIDS education matured, as the spread of the disease was also connected to intravenous drug use and the sharing of infected needles, and as the world saw an increased infection rate among heterosexuals, the Church’s stigmatization worsened. The Church adhered even more strongly to the stance that the spread of the virus was due to a sinful lifestyle containing one or more of the following: promiscuity, abuse of illegal drugs or homosexuality. Sermons and HIV/AIDS education focused primarily on living a holy and godly life as the most effective means of prevention.

This stigmatization of PLAs negatively impacted the infection rate among the African American Church community due to several repercussions of their doctrinal stance. African Americans were hesitant to get tested because “testing takes initiative, time, and a willingness to overlook stigma on the part of both sexes” (Kalb, et al. 2006). Fewer people were aware of their HIV status (also known simply as “status”) because many could not brave the stigma of being tested. Being tested, unfortunately, was synonymous with being engaged in some illicit or risky behavior denounced by one’s church. Instead of being applauded for being responsible for wanting to know one’s status, a person desiring to be tested was seen as guilty at least of intent, if not, action. Unfortunately, one’s holiness and

\(^7\) Most Christian denominations in the 1980s and 1990s viewed homosexuality as sin. For the purposes of this paper, I am focusing on mainline Christian denominations with a particular lens on the African American Baptist church and a few other mainline denominations.
right standing in the religious community was maintained as long as the ignorance of one’s HIV status was maintained. For this reason, clinics in African American communities were often located off the beaten path and hidden in isolated, low-key areas in order to serve the community and at the same time protect privacy. The ignorance and stigmatization became powerful and fatal partners. Few people were getting tested and those who were unaware of their status were infecting more people. Women were left to learn of their status through prenatal tests, when donating blood, or other unrelated medical visits.

Stigmatization and denial were not isolated to the United States. Unfortunately, this fatal pair had a global reach and they sank their clutches into African communities. In Africa, HIV/AIDS was relegated to a disease among men sleeping with men and sexual immorality. Those women who were being infected, it was believed, were those involved in prostitution. Both segments of society were deemed to have gotten the punishment they deserved for illicit behavior. The African Church’s role in HIV/AIDS prevention was preaching and teaching against sin that led to God’s punishment of death. Similarly, the sinful cloud cast over this deadly disease rampantly ravaging Africa was a crippling incentive for African women and men to remain ignorant of their HIV status and the spread of the virus. For women, getting tested was akin to wearing a scarlet letter on their chests. “The dynamics of stigmatization and discrimination in African societies are complex and not easy to overcome” (Vallaeps 2001) and the results were catastrophic.

Relegating the virus to the immoral segment of society and not acknowledging its presence and victims in the core of society allowed pastors in traditional African American denominations to remain ignorantly disengaged and to leave their congregations in harmful ignorance and fear. Studies show that ignorance related to HIV/AIDS is a major
factor in the vulnerability of Africa’s young women. Research by the United Nations
Children’s Fund (UNICEF) found that among girls 15 to 19 years old, 70 percent in Somalia
and more than 40 percent in Guinea-Bissau and Sierra Leone had never heard of AIDS
(Vallaefs 2001). Females, regardless of age, are the most vulnerable to this ignorance and
fall prey to the virus.

A attitude held by both the African American community in the United States and
Africans in South Africa and Western Africa is distrust of the medical profession
particularly in regard to infectious diseases. Due to past oppression and victimization from
the dominant cultures of their respective countries, these communities are suspicious of
global threats, as well as of the government programs and education intended to combat
these threats. Black South Africans suffered greatly because of apartheid. The hands of
apartheid dealt a forcible blow to Black South Africans--they were disenfranchised,
disempowered, economically disadvantaged, marginalized, oppressed, and in some cases
killed. Black South African women suffered doubly because they endured both gender and
racial discrimination. Pragmatically, this had an immeasurable toll on South African
women’s health and economic stability. Many women and children succumbed to untreated
or maltreated diseases and/or malnutrition. Apartheid ended in the 1990s but the
devastating effects still linger decades later.

Similarly, in the United States, African American males suffered an unspeakable
atrocity at the hands of the medical community. For forty years between 1932 and 1972,
the U.S. Public Health Service (PHS) conducted an experiment on 399 black men in the late
stages of syphilis. These men, for the most part illiterate sharecroppers from one of the

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8 Read more: [Tuskegee Syphilis Experiment (History, Facts, Bad Blood, Bad Science) — Infoplease.com](https://www.infoplease.com)
poorest counties in Alabama, were never told what disease they were suffering from or of its seriousness. Informed that they were being treated for “bad blood,” their doctors had no intention of curing them of syphilis at all. It is widely believed in the African American community that some men in that experiment were unknowingly and intentionally infected with syphilis by the government to serve as subjects in this experiment. In 1997, President Clinton apologized to the remaining eight survivors, “The United States government did something that was wrong—deeply, profoundly, morally wrong. It was an outrage to our commitment to integrity and equality for all our citizens... clearly racist.”

Today, the African American community has tremendous distrust of the medical community and the federal government. When the HIV/AIDS epidemic hit, suspicions ran rampant. These communities suspected that the government had created the virus in order to annihilate the African American and African communities. Fear, distrust and memories from past atrocities were raw and people of color treaded cautiously. They were fearful of being intentionally infected with the virus. Safety, it was believed, rested in avoiding the government and medical institutions, thereby avoiding the disease.

Lastly, the Church was hindered by its inability to balance its fear and refusal to discuss sex with the necessity of educating its body for the sake of its spiritual, emotional, and physical health. The HIV/AIDS pandemic had successfully threatened and attacked the health of Church members. Traditionally, the Church was content to confine its sex education programs to marriage counseling. Sex between a husband and wife was a conventional and noncontroversial topic. The advent of the HIV virus challenged the Church to embark upon unfamiliar and less traditional territory. Additionally, it challenged

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9 Ibid.
the Church to contend with and address its prejudices, stereotypes, and miseducation of person living with HIV/AIDS. The Church hesitantly and with great reservation engaged in this conversation because it wrestled with the question of what appropriate prevention methods were. The Church wrestled with the question of how to implement HIV/AIDS education programs that did not cast the Church as promoting sexual intimacy outside of marriage and among youth as well as the use of condoms, even in the context of marriage. The dynamics were complex and the Church was feeling the pressure from the increasing numbers of persons infected with and affected by HIV/AIDS and at loss for direction. The most natural and sensible solution for the Church was to maintain its doctrinal stance and create education programs founded in abstinence and faithfulness. Unfortunately, the Church’s message was neither effective nor relevant and was defenseless against the virus that was claiming the lives of women at an astronomical rate.

The Church is poised to play a crucial role in HIV/AIDS prevention. Today, Christian churches in Africa are engaged in HIV/AIDS prevention and care. In order to be effective transformative agents, the Church must address its negative perceptions, combat fear, mobilize, and facilitate candid conversation about sex and the HIV/AIDS virus. A study done by African women theologians seeking to effect ecclesiastical change argue that “churches need to reflect on, and possibly reformulate, the theological and ecclesiological principles that determine their response to the epidemic if their involvement is to be seen as well-founded” (Björk 2006).

The Church has impacted the HIV/AIDS infection rate. However, most who have been examining the elective affinity with the Church’s role and the increased infection rate argue that the Church’s impact has been negative. The great influence that the Christian
church possesses in the African American and African communities can be a great influence on HIV/AIDS prevention and a formidable ally in the war against HIV/AIDS. In some communities, the Church has been an invaluable healing agent for those living with the virus. People have found a support system, a place of refuge, encouragement, love and acceptance. In these instances, the journey of a PLA has been more bearable—instead of isolation, they had community; instead of condemnation, they found love; and instead of pain, they received healing. The loving and nurturing embrace of the Church helped PLAs to live a more wholesome and meaningful life.

The African American Church’s ability to be a healing presence for PLAs is still a work in progress. Less than ten years ago, persons infected with HIV/AIDS would have been ostracized due to the perceptions discussed earlier. A person infected with HIV suffered and lived with the disease in silence. Out of fear of being judged and condemned as a sinner or abomination before God, PLAs were reticent to let their church community know of their HIV status. A person’s faith can be key to feeling whole when journeying through trials and tribulations or living with a terminal disease. When one cannot turn to his or her faith community for encouragement, support, and reassurance of God’s unconditional love and faithfulness the struggle becomes lonely, isolating, miserable, unbearable, and sometimes not worth living.

Over the years, the Church has become more adept at and comfortable with being a healing refuge. With the HIV infection rate increasing drastically among African American and African women, the Church must expand its definition and implementation of what it considers to be “healing ministry.” The ministry of healing cannot solely focus on physical or emotional healing but must also focus on liberation. Liberation is also a form of healing.
The Church can save and heal more lives by helping to decrease the number of women infected and affected by HIV/AIDS. It can do this by working towards liberating women from the oppressive factors that cause them to be victimized by this disease. Prior to discussing what the Church can or should be doing, I will examine the Church’s role historically.

**The Christian Church’s Responses to the HIV/AIDS Pandemic**

Due to the number of people infected with HIV and dying from complications of AIDS, the Church needed to respond. Globally, communities were being devastated—children were being orphaned, PWAs were being stigmatized, women were being infected at exponential rates—and the wounded and broken body of Christ sought healing, compassion and comfort. The Church had a number of responses that impacted the spread of the disease and the ensuing HIV/AIDS pandemic. Next, I will discuss the Church’s responses to the HIV/AIDS pandemic and the impact they have made and are making on this global epidemic.

Björk engages several African female theologians on this topic. According to some of the African women theologians, “Muteness, denial, and indifference have been some of the responses of the Church to HIV/AIDS. Silence, fueled by denial, played a significant role in the stigmatization discussed earlier” (Björk 2006, 311). The refusal to speak on the issue nurtured the perceptions of sin, punishment, impropriety and shame surrounding persons infected by the HIV virus. One of the theologians, Denise Ackermann contends, “Not only

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10 Some of the prominent African theologians Björk cites in her article are Denise Ackermann, Musa Dube and Isabel Apawo Phiri. Both Ackermann and Dube attest that silence and denial are noticeable responses from the Christian church.
has the Church ignored the fight against stigmatization of the people living with HIV/AIDS, but ‘stigma is a sin to which the Christian Church has contributed significantly’” (Björk 2006, 311). She argues that the silence and stigmatization are driven by the erroneous self-righteous perception that HIV/AIDS is a problem for sinners outside the Church and does not affect the holy within the Church. This response creates a dichotomy that for a church member infected with HIV/AIDS; under the stigma a woman infected with the virus is led to believe she is unholy and a sinner, outside of God's church. The entity that should welcome her and provide, inflicts psychological, emotional, and spiritual pain and casts her out, if not literally, then definitely metaphorically.

Similarly, within Björk’ article, Musa Dube highlights the fact that the Church’s silence is rooted in the belief that the Christian Church is holy and the world is sinful. Consequently, Church ministers preach that God is penalizing those infected with HIV/AIDS for their immoral and sinful lifestyles. Dube asserts that by “preaching that HIV/AIDS is God’s punishment for sin, the churches are fighting the victims instead of the disease” (Björk 2006, 311). Dube challenges the fallacy in this retributive theology by highlighting the fact that in the African context, many children are born with HIV/AIDS and many faithful women are infected by their unfaithful husbands. Moreover, many innocent girls and women are infected by rape inside and outside their homes. Based upon Dube’s argument, I challenge the Church’s stance of a person being infected with the virus as having received divine punishment. While the Church might argue that the men infecting these girls and women in the aforementioned situations live immoral lifestyles and therefore have been punished by contracting the HIV virus, the Church cannot—at least not reasonably and via support of sound doctrine and theology—claim that these girls and
women who have been victimized were rightfully deserve the disease. What immoral lifestyle has an innocent girl lived that deserves rape as punishment? What about a faithful wife who is infected by her philandering husband? The Church is silent. Additionally, the Church is silent on the injustice and stigmatization birthed from its preaching and teaching.

The Church’s silence regarding the stigmatization and injustice has negatively impacted prevention programs and has indirectly facilitated the deaths of millions of women. Additionally, it inflicts suffering on those already infected with and affected by HIV/AIDS. In this instance, according to Dube, the Church “has failed at its task to show compassion, acceptance, a willingness to practice justice and to side with the oppressed, and in particular women with HIV/AIDS” (Björk 2006, 311). This silence has also muted the voice of the infected and is a disincentive to seeking to know one’s HIV status. Thus, leading to more persons being infected by those who do not know that they themselves are HIV-positive. Denis explains this twofold dilemma well:

Stigma as a social construct has a significant impact on the life experience of individuals. It encourages denial and prevents HIV infected people from seeking support and care. The church, in other words, is caught in a dilemma. It has the duty to teach moral values in sexual matters and, by doing so, it may reduce risk behavior, thus preventing [sic] the spread of the disease. But at the same time, its moral discourse can lead to stigma and discrimination, a phenomenon which contributes [sic] to the spread of the epidemic (Denis 2009, 76).

The stigma is a disincentive for a wife to publicize that her husband has infected her, and thus he continues to infect other women with whom he engages in sexual relations. The silence intensifies, the stigmatization is fortified and the infection rate thrives.
The Church has offered the resounding message of abstinence in response to the pandemic. Some Churches have chosen the ABC philosophy discussed earlier in this paper. Denis challenges Christian churches who believe that promoting abstinence until marriage and faithfulness while married is sufficient prevention work.11 This message falls short of being effective prevention for women in South Africa. Denis argues that in a patriarchal society, the surest route to HIV infection is marriage. In Björk’s article, both Ackermann and Kamergrauzis note that heterosexual marriages, whether monogamous or polygamous, have become the highest risk factor for African women in being exposed to HIV/AIDS. This unusual phenomenon is attributed to high incidence of not adhering to the “B” and “C” of the ABC approach. It is noted that most African men are not faithful and in some villages, it is culturally acceptable for the African husband to have multiple wives. In these instances, an infected husband spreads the HIV virus to women who are being faithful and do not have the option of abstinence because of marital obligations to engage in sexual relations with their spouses.

At the core of the failure as well as the challenge of this teaching and preaching is the inequity toward and disenfranchisement of women. The religious and global dynamics operative illuminate the economical and societal injustices from which women suffer. Women marry in order to achieve economic security that affords them shelter, food, and clothing. In order to have their basic needs met, African women are at putting their lives at risk. Consequently, even in limited circumstances where a man’s status is known, a woman

who does not have a voice or economic wherewithal finds herself entering a marriage that may cost her her life. An effective response in the fight against HIV/AIDS cannot simply entail abstinence and faithfulness exclusively—it also needs to address and tackle the injustice, marginalization, and oppression under which women suffer. These are powerful allies of the HIV virus that abstinence and faithfulness alone cannot successfully combat. Therefore, focusing solely on abstinence and faithfulness correlates with an increased infection rate among women in these societies who live under challenging circumstances.

Most Churches have a strict response to the promotion of condom use—they are fervently against this message. This is true particularly of the African American Church, and within it, especially the Baptist denomination. The Church’s perspective resides in mythological assumptions: The Church believes that if it supports the use of condoms in the battle against the HIV/AIDS pandemic that it will be seen as publicly sanctioning premarital and/or extramarital sex. Unfortunately, the church has confused/coupled the message of life with a message of promiscuity. In a scenario where the Church believes it must decide between its doctrine and practical prevention, the Church chooses doctrine. In fact, to hold effective prevention hostage to the assumption that pragmatism threatens spirituality places the lives of African American women in these church communities at great risk. Additionally, to reduce this argument to a simple decision of whether or not to use or not to use condoms is to be naïve.

The argument is complex because it incorporates several perceptions discussed earlier in this paper. One, when the Church views the virus as punishment for sexual sin, then to promote condoms as a preventive method is seen as supporting the habit of a sinner. Two, when the Church views the disease as being prominent among the
homosexual community or as a homosexual disease, then the Church does not want to support a preventive method that facilitates immoral sex. Moreover, this perception prohibits the Church from addressing the reality that the HIV virus in now primarily spread via heterosexual sexual intercourse and that women are the primary victims of contracting the disease. Consequently, the Church’s deliberate policy has impacted the infection rate of African American women. Again, we see an elective affinity between the ecclesiastical response and the high infection rate among African American women. The underlying assumptions and myths need to be challenged in order for the Church to develop a holistic theology. While it is not an easy feat, if it hopes to be in the service of saving the lives of African American women, the Church must explore and formulate a theology that manages to not compromise its values, moral code, or doctrine, while providing adequate prevention of HIV/AIDS. When this balance cannot be achieved, I argue that the Church should effect the physical, mental, spiritual, psychological and emotional wholeness of its followers rather than choose to adhere to and protect its doctrine. Ultimately, it is the call of the Church to bring healing to its members, salvation to the lost and resurrection to the spiritually dead. The achievement of healing, salvation, and resurrection in the context of the HIV/AIDS pandemic involves adequate prevention methods taught and preached in the church, the removal of the stigmatization that victimizes persons living with HIV/AIDS and the removal of the marginalization and injustice that leave African American women more vulnerable to HIV/AIDS.

Perhaps, it was this realization that motivated Pope Benedict XVI to issue a statement on condom use in the context of preventing the spread of HIV/AIDS. In November 2010, the pope shifted his position and declared the permissibility of condom
use on a case-by-case basis to prevent the transmission of the HIV/AIDS. Not surprisingly, the pope’s comments have generated great discussion, debate and controversy. Some of the loudest dissent to this position has come from the African American mainline Church. The pope’s statement, while not an unequivocal endorsement of prevention via condom use, is a step toward saving lives, while the Church’s dissention remains an ineffective response to the spread of the virus.

**Conclusion**

The infection rate of HIV/AIDS among Black African women and African American women continues to increase at an alarming rate. HIV/AIDS is a pandemic with global and religious implications that has impacted the spread of the deadly disease. Just as it does in politics and economics, globalization negatively impacts women in the fight against HIV/AIDS. One topic discussed in class factors directly in the conclusions derived from my research: namely Southern Christianity.

Southern Christianity embodies a conservative and fundamental theology. Therefore, Southern Christian churches are more apt to respond with a sin and punishment theology and the prevention method of abstinence and faithfulness. The conservative doctrine of Southern Christianity that informs the preaching and teaching of it constituent Churches has created a response that has negatively impacted its fight against HIV/AIDS. The conservatism of the South led to the responses of silence, stigmatization and marginalization discussed earlier, which have victimized women particularly in the HIV/AIDS pandemic.
An elective affinity is also observed between Southern Christianity in the Bible Belt states and the high infection rate of African American women living in these states. The Bible Belt states record the highest infection rate among all the other states in the United States. This is directly related to the Church’s responses outlined above.

Fundamentalist and conservative Christian centers—in response to the growth of liberal Christianity—have begun to establish a strong conservative Christian base in other countries like Africa. Consequently, I observed that African Churches had similar responses in the fight against HIV/AIDS as the African American church in the United States and realized the same unfortunate result—an exponential infection rate of HIV/AIDS in Black African women. Because of the disproportionate rate at which African American and Black African women are being infected with the HIV virus and dying from AIDS-related illnesses, it is time for the Church to examine its response in the fight against HIV/AIDS. I have demonstrated that the Church’s traditional message has negatively impacted the fight against HIV/AIDS.

The Christian church is poised to be an influential voice in the African American and African communities regarding the fight against HIV/AIDS. Now, the Church must formulate an effective religious and global campaign that addresses all the factors contributing to the increased infection rate among women. An effective prevention campaign must address the injustice, gender-based roles and inequity of medical treatment and availability of medication among those economically disadvantaged. The fight against the HIV/AIDS pandemic is complex and requires a multifaceted response. Because the Church’s voice is highly respected in the African American and African communities, an effective religious campaign will have global implications if it tackles the aforementioned
factors. The longer the Church adheres to its traditional responses, women will continue to suffer from and succumb to HIV/AIDS.
**Bibliography**


