

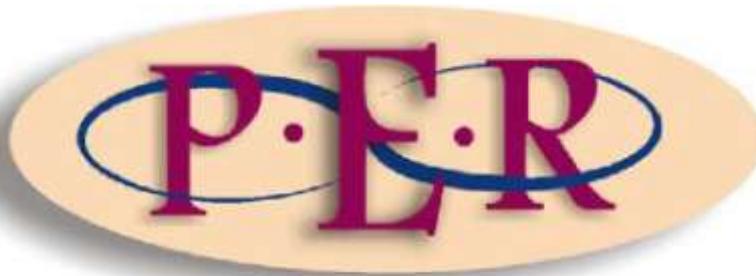
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**THE ROLE OF RELIGIOUS LEADERS IN CURBING THE SPREAD OF HIV/AIDS IN  
NIGERIA**

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## THE ROLE OF RELIGIOUS LEADERS IN CURBING THE SPREAD OF HIV/AIDS IN NIGERIA

O Oluduro\*

### 1 Introduction

I hope for a day when every church engages in open dialogue on issues of sexuality and gender difference. I hope for a day when every synagogue will mobilise as advocates for a global response to fight AIDS, when every temple will fully welcome people living with HIV, when every mosque is a place where young people will learn about the facts of HIV and AIDS. When that will have happened I am convinced that nothing will stop our success in the fight against AIDS.<sup>1</sup>

Nigeria, with a population of approximately 140 million<sup>2</sup> people, was one of the developing countries to be faced with the HIV/AIDS epidemic. The early years of the epidemic were characterised at first by mystery and rumour, followed by the discovery that HIV/AIDS was a disease, then a pandemic that resulted in an unprecedented tragedy.<sup>3</sup> Since 1986, HIV/AIDS<sup>4</sup> has had grave consequences and a direct impact on at least one in every ten households in Nigeria. The rate of infection worldwide has been alarming. HIV/AIDS prevalence in Nigeria rose from 1.8 per cent in 1991 to 5.8 per cent in 2001, and declined slightly to 4.4 per cent in 2005.<sup>5</sup> Less than 1 per cent of those who need antiretroviral drugs have access to them.<sup>6</sup> At the end of 2007, approximately 2.6 million people were infected with HIV/AIDS in Nigeria.<sup>7</sup> In the same year, approximately 170 000 people reportedly died from HIV/AIDS. Average life expectancy has declined significantly from 53.8 years for women and 52.6 years for men in 1991 to 46 for women and 47 for men in

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1 Piot P, Executive Director, UNAIDS – speaking at the Interfaith Pre-Conference session at the 2004 International AIDS Conference, Bangkok, cited by Ecumenical Advocacy Alliance 2006 <http://bit.ly/igRxup>.

2 The population of Nigeria was estimated to be 140 003 542 in the 2006 census figure. See Federal Republic of Nigeria National Bureau of Statistics 2006 <http://bit.ly/gTHVkk>.

3 Okware *et al* 2001 *International Journal of Public Health* 1113.

4 See Owuamanam *et al sa* <http://bit.ly/i2FXFM>. See also Odimegwu 2002/2003 <http://bit.ly/f7CWOE>.

5 Ogungbemi 2007 <http://bit.ly/guj38V>.

6 Peterson and Obileye 2002 <http://bit.ly/f7uZwX>; Aja *et al* 2010 *J Relig Health* 51.

7 <http://bit.ly/13spmr>.

2007.<sup>8</sup> The tragic toll of this epidemic "brings compelling urgency to the call for a renewed commitment by religious leaders to achieve Universal Access for All to HIV prevention, treatment, care and support as well as impact mitigation."<sup>9</sup> By the end of 2003, Nigeria ranked third globally after South Africa and India with its number of reported HIV/AIDS cases.<sup>10</sup> As statistics reveal, it is a worldwide disaster. HIV/AIDS causes unacceptable human suffering to the infected individuals, as well as to their families, communities and nations alike.<sup>11</sup> Its impact leaves nothing untouched. In an increasingly interconnected world, no State or community is immune to its ravaging effect; there are no safe havens. It does not recognise race, colour or creed, sex, economic status, political boundaries or religious association one belongs to. It is not just a health issue or an economic, geopolitical or human rights crisis. It is a human condition and therefore of great concern to the religious leaders.

Nigerian people are very religious. This was confirmed by a BBC 2004 survey, which revealed that an average Nigerian attends a church, mosque or other religious service more often than most other nationalities.<sup>12</sup> In essence, the article examines the response of Nigerian religious leaders to the challenge of HIV/AIDS and the adequacy or otherwise of these responses. It further explores ways in which the religious leaders can effectively meet the challenges of a disease that is not only a health problem, but also a crisis that affects and permeates the social, economic, spiritual and political lives of the people.

## 2 Why religious leaders?

HIV/AIDS poses new challenges to religions all over the world, including Nigeria. As HIV/AIDS-related deaths mount, the pandemic is challenging the world's mainstream religions as much as any event in modern history, setting at odds their core mission of assuaging human suffering and perfecting human morality.<sup>13</sup> The religious leaders and those associated with faith-based organisations have the formidable task of speaking out truthfully and taking the necessary action to curb the spread of HIV and alleviate the

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8 <http://bit.ly/13spmr>.

9 Reverend Mokhakhlane, the President Superintendent of Lesotho Evangelical Church, *afrol News* sa <http://bit.ly/ha8D69>.

10 UNAIDS 2005 <http://bit.ly/fQjswu>.

11 WCC *HIV and AIDS Curriculum* 6.

12 CEDPA 2005 <http://bit.ly/i63Ylh>.

13 De Young *Washington Post*.

suffering caused by HIV/AIDS. As trusted and respected members of the society, religious leaders are listened to; their actions set an example.<sup>14</sup> Their strengths and credibility, and their closeness to the communities afford them the chance to make a real difference in halting the spread of HIV/AIDS. Therefore, any messages on HIV/AIDS imparted by religious leaders are important in changing the attitudes and the behavioural patterns of their followers about the epidemic.

### 3 Religious leaders and response to HIV/AIDS

Since 2000, "faith based" organisations have<sup>15</sup> come to the fore in terms of the fight against HIV/AIDS. Since then, whilst some of the religious organisations have been an integral part of the war against HIV/AIDS, many are yet to fully appreciate the complicated nature of this pandemic. Even whilst religion appears to show sympathy for people living with HIV/AIDS (PLWHA), it is sad to note that "it has blindly and steadfastly continued to refuse to fully accept the reality of preventing the spread of the virus through openness, advocacy and awareness. In this regard, the role of religion is limiting and greatly undermines the effectiveness of combating the pandemic by stakeholders."<sup>16</sup> Indeed, religious leaders are not doing enough to combat HIV/AIDS and many of their actions have greatly increased the stigma and discrimination against PLWHA.

The epidemic is interpreted by some religious groups as a punishment from God for sexual transgressions or as a divine curse for an immoral act,<sup>17</sup> that is, having premarital sex, being unfaithful to one's partner or behaving in some ways that are contrary to certain religious teachings. Thus, in the opinion of some religious leaders, lending a helping hand to PLWHA could be regarded as condoning the afflicted person's acts. Viewing PLWHA as "sinners" or equating the epidemic with a "curse" by our religious leaders rather than adopting a compassionate and caring attitude greatly contributes towards to the stigma, discrimination, guilt and blame suffered by PLWHA. However, it has been shown that

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14 UNICEF 2003 <http://bit.ly/fkAeoi>.

15 Faith-based organisations as used here include "religious and religion-based organisations and networks; communities belonging to places of religious worship; specialised religious institutions and religious social service agencies; and registered and unregistered non-profit institutions that have a religious character or mission." See Ecumenical Advocacy Alliance 2006 <http://bit.ly/igRxup>.

16 Okunna and Dunu 2006 <http://bit.ly/fKSh2z>.

17 Okunna and Dunu 2006 <http://bit.ly/fKSh2z>; See also Messer 2004 *National Catholic Reporter* 2, cited by Kelly 2009 *J Relig Health* 18.

HIV/AIDS cannot simply be equated with an individual lack of morality for several reasons. Many innocent children are born with HIV/AIDS, parents are infected through caring for their children without protective gloves and some people are victims of contaminated blood transfusions. Further, many faithful partners are infected by their unfaithful spouses, whilst innocent girls and women are infected through rape in and outside their homes.<sup>18</sup> Indeed, many poor women and young girls do engage in risky sexual behaviour for economic gains. The unwarranted judgment on those infected results in stigma and discrimination, which worsens the situation further .

There is also the incorrect assumption on the part of the religious leaders – particularly those who are of the Christian and Islamic faiths, which are the predominant religions in Africa and in Nigeria particularly – that the epidemic has not significantly affected their denominations or communities. Accordingly, they feel it was not their responsibility and adopted attitudes of passivity, inactivity, distance or mute indifference in the face of so monumental a catastrophe. This further explains why religious leaders have viewed PLWHA with judgment and condemnation. Studies from Nigeria and other African countries, such as Kenya, have confirmed this incorrect assumption. For example, baseline research carried out in Kenya by the Family Health International AIDS Control and Prevention Project to implement HIV/AIDS policy, communication and training activities for Kenyan religious leaders and members of their churches from 1994 to 1996 revealed that HIV/AIDS had already affected at least 70 per cent of local congregations.<sup>19</sup> The research also revealed that promiscuity was common even amongst church leadership and that churchgoing young people were as sexually active and as engaged in risky sexual behaviour as non-churchgoing youth.<sup>20</sup> Similarly, research carried out in Nigeria has demonstrated that most young people who tested positive were "deeply religious and take religion very seriously."<sup>21</sup> Arguably, no religion is free from this epidemic, as "all world religions have followers and leaders who are HIV positive."<sup>22</sup> All religions are living with and affected by the pandemic.

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18 WCC *HIV and AIDS Curriculum* 6–7.

19 Makinwa and O'Grady *Working with the church* 339.

20 Makinwa and O'Grady *Working with the church* 339. See Black *sa* <http://bit.ly/g3f1XW>. The research revealed that "32 percent of the pastors surveyed reported they knew other pastors who had been unfaithful to their spouses, and also that 49 percent of young churchgoers had had premarital sex."

21 Odukamaiya 2004 *Babcock Journal of Management and Social Sciences*, cited by Okunna and Dunu 2006 <http://bit.ly/fKSh2z>.

22 Ecumenical Advocacy Alliance 2006 <http://bit.ly/igRxup>.

Again, many religious leaders, in spite of their awareness of HIV/AIDS, maintain a culture of silence and denial of its existence. Often, this silence is a result of the harmful association between HIV/AIDS and immorality in the form of certain sexual behaviours, drug and alcohol abuse.<sup>23</sup> Some religious leaders have been disciplined or censured by their founder or "general overseer" for preaching or sermonising on the subject of HIV/AIDS to their congregations. In cases in which there is silence about the social and sexual issues that fuel the epidemic (including sex as a survival strategy and violence against women and girls, including rape and child abuse), people will continue to remain ignorant, powerless, exploited and silent.<sup>24</sup>

In addition, some religious leaders, particularly at grassroots level, just do not know what to say or how to handle the problem as they lack the requisite knowledge of HIV/AIDS or training in HIV/AIDS prevention, care or counselling. As such, they simply do not know how to provide the necessary care and counselling needed to meet the needs of their immediate communities. Further, in their consideration of the significant financial resources that may be required for health care and education of the infected and affected individuals, some religious leaders choose not to address the issue.<sup>25</sup>

It is also important to consider the factor or element of denominational divisions and lack of networking amongst the various religions, the Non-Governmental Organisations (NGOs) involved in health or human rights issues and the government. For example, amongst Christian Nigerians, there are different denominations with different beliefs. Further, Muslims and Christians do not have a cordial relationship in matters of faith. Consequently, there is an inability to form a common front to fight the spread of this disease. The need for cooperation and understanding between the different religions and amongst the various denominations within the same religion is critical in the fight against the pandemic. Mutual relationships and proper networking between the religious associations, the NGOs and the government will foster a combined effort against the common enemy and yield a better result than the present situation.

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23 Kelly 2003 <http://bit.ly/hi9Apr>.

24 UNICEF 2003 <http://bit.ly/fkAeoi>.

25 UNICEF 2003 <http://bit.ly/fkAeoi>.

Accordingly, much needs to be done by the religious leaders. They should demonstrate the courage and conviction to act, particularly in partnership with the civil society, the national government, well-meaning individuals and corporate organisations, to halt the spread of this epidemic.

#### 4 Religion and culture

One of the ways to prevent the spread of HIV/AIDS is to encourage people to follow their own religious precepts, which usually promote strict sexual guidelines. Whilst Christianity only accepts sex within a monogamous marriage, Islam accepts polygamy, but again only endorses sex within marriage.<sup>26</sup> Traditional religions in Africa appear to propagate polygamous marriage, but with varying taboos regarding extra-marital sex. What this emphasises is that underlying traditional, cultural and religious values continue to be the foundation upon which behaviour is based. Thus, adjustments in these core values are very difficult to achieve.<sup>27</sup> For example, many Kenyan communities, both "traditional" and Christian, believe that HIV/AIDS has entered their communities simply because they have jettisoned traditional cultural practices, thereby displeasing the supernatural forces that are entrusted with protecting them. It is their belief that the only way to restore health (in a broad and holistic way) is to return to strict adherence to those practices.<sup>28</sup> Some of these centuries-old cultural norms and practices entail risky behaviour that greatly increase the possibility of transmission of HIV/AIDS, such as wife inheritance (a widow marrying her brother-in-law), polygamy and sexual "cleansing" (having sex with a designated person in the village as a "cleansing" ritual). These and other high-risk traditional practices are also practised in some parts of Nigeria, and may not always promote low-risk sexual behaviour.<sup>29</sup> The religious leaders are part of these communities and many of them are staunch defenders of such practices.

It is also important to note that most religions are based on patriarchy and so some of their religious teachings and customs increase women's vulnerability to contracting HIV. For example, many religions preach women's total submission and obedience to their

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26 Jackson *AIDS Africa* 134.

27 Makinwa and O'Grady *Working with the church* 340.

28 Makinwa and O'Grady *Working with the church* 340.

29 Makinwa and O'Grady *Working with the church* 340.

husbands even in instances in which they have been unfaithful.<sup>30</sup> Under these circumstances, women are therefore unable to reject unwanted sex or even negotiate for safer sex through the use of condoms. Consequently, many women become infected by their unfaithful and/or abusive partners who subjugate them in the name of religion.

In order to effectively reduce the threat of HIV/AIDS, people's behaviour based on their core values must be modified or changed positively. This is not a call for total abrogation of particular customs or practices, but rather, changing the damaging elements whilst retaining the overall custom, its symbolism and its meaning. So, instead of people feeling threatened by change, they can equally partake in the benefit of change and help to promote it.<sup>31</sup> An example of this is the sexual cleansing of widows in Zambia, which is being replaced with non-sexual rituals so that the overall ceremony continues and retains its value, and the same participants remain involved, but sex no longer takes place.<sup>32</sup> Religious leaders can help in advocating for the protection of the human rights of women, condemning gender-based violence and other cultural practices that subjugate women, and in providing care and support for victims of these practices. Gender bias, which remains deeply embedded in the teachings and practices of the religious leaders, and patriarchal religions that make women invisible, subordinate, and passive in the face of what destroys them, should be seriously addressed.<sup>33</sup>

## 5 Prohibitions of sex education and condom use by religious leaders

Despite an avalanche of evidence in favour of sex education, some religious faiths still oppose it and are firmly against the use of condoms. They condemn the use of condoms, as it is seen as condoning illicit sexual relations.<sup>34</sup> The use of condoms is depicted as an immoral, blunt and misguided weapon in the battle against HIV/AIDS. The Roman Catholic leaders who have been crucial players in virtually all aspects of the global response to HIV/AIDS since the disease was identified in 1981 have been at the forefront in the condemnation of the use of condoms. They see condom promotion as an affront to the promotion of marriage, monogamy and sexual morality, and equally tantamount to

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30 Messer 2009 <http://bit.ly/dLVGKJ>.

31 Jackson *AIDS Africa* 137.

32 Jackson *AIDS Africa* 137.

33 Farley 2004 *JFSR* 139.

34 Okunna and Dunu 2006 <http://bit.ly/fKSh2z>.

promoting sex amongst the youth and sending the wrong message to uninfected individuals.<sup>35</sup> These leaders choose to focus instead on encouraging abstinence and being faithful to one's partner.

Roman Catholic leaders and other religious groups are not alone in their approach to preventing the spread of the disease. Warnings that HIV/AIDS-related sex education and condom promotion will undermine individual morality and lead to societal destruction have come from Islamic leaders in Pakistan and evangelical Protestants in Jamaica.<sup>36</sup> Even the Zambian President, Frederick Chiluba, who has proclaimed Christianity as the state religion, has called condoms "a sign of weak morals".<sup>37</sup> In 2001, Zambian health officials cancelled advertisements prepared for state-run television and radio after religious leaders said their promotion of condoms would lead to promiscuity.<sup>38</sup> When the Kenyan government announced plans in 2001 to import 300 million condoms to prevent the spread of HIV/AIDS, Sheik Mohamed Dor of the Council of Imams and Preachers said the country was "committing suicide" and encouraging sexual experimentation amongst young people.<sup>39</sup>

Some religious leaders go as far as discrediting condoms through misinterpretation of data and serious manipulations. Helen Jackson,<sup>40</sup> a University student in Zambia,<sup>41</sup> described how, during a condom demonstration to students by a prominent faith organisation, the organisation had actually pricked holes in the demonstration condoms so they leaked when filled with water. The students became suspicious and uncovered the fraud. No leakage occurred when the demonstration was repeated with intact condoms. Moral condemnation of condoms and the widespread misinterpretation of their efficacy<sup>42</sup> are great barriers in the prevention of HIV/AIDS. It can arguably be stated that the spread of this pandemic amongst the youths may possibly be because of "religion's rigidity and negative stance towards some of the preventive measures that could be of use to them,

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35 See Wikipedia sa <http://bit.ly/g9WUId>.

36 De Young *Washington Post*.

37 De Young *Washington Post*.

38 De Young *Washington Post*.

39 De Young *Washington Post*.

40 Jackson *AIDS Africa* 138. For more on the attitudes of religious leaders to condom use, see Pfeiffer 2004 *Medical Anthropology Quarterly* 77–103.

41 Cited by Jackson *AIDS Africa* 138.

42 Eves 2008 <http://bit.ly/gohMMC>.

such as condom use."<sup>43</sup> Paul Delay,<sup>44</sup> who heads HIV/AIDS programmes for USAIDS once said that:

What we've asked of the churches, particularly the Catholic Church, is that if you can't say anything nice about condoms, don't say anything at all ... concentrate on (abstinence and fidelity) ... but don't say that condoms don't work or they've got holes in them or they will break. Don't give misinformation.

No doubt, sexual abstinence and mutual fidelity are the cornerstone of HIV/AIDS prevention. In reality, there will always be people who will not be able to cope with or choose to conform to the religious teachings and standards of behaviour, thereby placing themselves and other people at risk of contracting HIV/AIDS. Such people needs to be educated and given correct information on avoiding contracting HIV/AIDS and spreading the epidemic, including the use of condoms and their proven effectiveness in preventing HIV/AIDS transmission, presented in the context of relevant doctrines and religious teachings. Should religious workers listen to NGOs and government workers involved in HIV/AIDS prevention, they will begin to see the impact of HIV/AIDS on society, and the need for the adoption of preventative measures, such as sex education.<sup>45</sup> Should some religious communities be uncomfortable in addressing the subject of condoms directly, it is possible to involve health-care professionals or NGOs to manage that part of the prevention programme.<sup>46</sup> We are reminded by Melinda Gates that: "In the fight against AIDS, condoms save lives. If you oppose the distribution of condoms, something is more important to you than saving lives."<sup>47</sup> What is important here is saving lives and halting the spread of the disease. In Nigeria, the former Director-General of National Agency for Food and Drug Administration and Control (NAFDAC), Prof Dora Akunyili, explained that the agency will hasten the registration of female condoms whenever they are manufactured in Nigeria. According to her:

We cannot run away from reality. As a Catholic, I will try to shy away from talking about condoms because my religion is against it. But when you remember that I'm working for the public, a condom is like any other product regulated by NAFDAC. It is a medical device. We are here to protect everybody regardless of faith.<sup>48</sup>

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43 Okunna and Dunu 2006 <http://bit.ly/fKSh2z>.

44 De Young *Washington Post*.

45 De Young *Washington Post*.

46 What Religious Leaders can do About HIV/AIDS (UNICEF 2003 <http://bit.ly/fkAeoi>).

47 Cited by Messer 2009 <http://bit.ly/dLVGKJ>.

48 Akunyili *The Guardian* 8.

## 6 Successes of government and education programmes

Abstinence, being faithful and condom use are complementary and inseparable elements in the prevention of HIV/AIDS. In Senegal, in which more than 90 percent of the population is Muslim, the spread of HIV slowed dramatically after Islamic and Christian leaders joined a government HIV/AIDS-prevention campaign advocating condoms along with abstinence and fidelity.<sup>49</sup> South Africa's Anglican Archbishop, Njongonkulu Ndungane, has been instrumental in promoting clerical HIV/AIDS education and prevention campaigns, including condom use.<sup>50</sup> The World Council of Churches, representing 342 Protestant and Orthodox Christian Churches around the world, is an outspoken supporter of all forms of prevention.<sup>51</sup> The monks who use Buddhist teachings on moral conducts for human behaviour do not prohibit condom use. Rather, discussion on condom use is normally left to lay educators in the hospital. Some Muslim leaders in Uganda (and elsewhere) apparently draw back from actively promoting condoms but do not condemn their use.<sup>52</sup> Studies on couples in cases in which one partner is infected reveal that, with consistent use of condoms, HIV infection rates for the uninfected partner are below 1 per cent per year.<sup>53</sup>

Uganda was one of the first countries to be devastated by HIV/AIDS, but with the government's effort of relentless campaigning of education and the endorsement of the ABC (abstinence, being faithful and condom use) approach, the HIV prevalence has decreased from 21.1 per cent to 6.1 per cent amongst pregnant women between 1991 and 2000.<sup>54</sup> In the words of Edward Green, a Harvard medical anthropologist:

Uganda has pioneered approaches towards reducing stigma, bringing discussion of sexual behaviour out into the open, involving HIV-infected people in public education, persuading individuals and couples to be tested and counseled, improving the status of women, involving religious organizations, enlisting traditional healers, and much more.<sup>55</sup>

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49 De Young *Washington Post*.

50 De Young *Washington Post*.

51 De Young *Washington Post*.

52 Jackson *AIDS Africa* 139.

53 WHO 2003 <http://bit.ly/icQWIP>.

54 Green 2001 <http://bit.ly/h6v3p6>.

55 Wikipedia *sa* <http://bit.ly/Gqcrq>.

The success could not, according to Ugandan government, be possible without the support of the religious organisations in the country.

The Senegalese government responded to the first cases of HIV/AIDS reported in 1980s. It launched a national HIV/AIDS programme including prevention campaigns in the media and screening of blood transfusions.<sup>56</sup> The religious leaders in Senegal, including Muslim clerics, became the first in Africa to join the prevention effort.<sup>57</sup> They were trained to equip them with knowledge for advocacy work. As a result, HIV/AIDS became a regular issue during Friday prayer sermons in mosques throughout Senegal and religious leaders talked about HIV/AIDS in radio and televisions with brochures and information distributed through religious teaching programmes.<sup>58</sup> Since the early 1980s, Senegal has been able to keep its HIV prevalence rates low at less than 1 per cent in 2005 compared to other countries in Africa.<sup>59</sup> Following a sponsored workshop by the United Nations Population Fund (UNFPA), six Christian denominations in Zimbabwe announced that condoms could be used within the family to prevent HIV transmission.<sup>60</sup> This was a major shift from statements in recent years that "condom use was a sin".<sup>61</sup> The churches have come together to coordinate HIV prevention activities, voluntary counselling and provision of care to PLWHA.

The same success was achieved in Ethiopia and Jamaica. Religious leaders in Nigeria can follow the examples of these countries in the fight against the pandemic in the country.

## 7 Stigmatisation and discrimination against PLWHA and religion

Stigmatisation and discrimination are one of the biggest obstacles to HIV prevention for individuals and communities as well as political, business and religious leaders. Clergy with HIV have been dismissed from their jobs, and shunned and ostracised by members of their religious groups. PLWHA and their families have been excluded from churches,

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56 UNFPA *Preventing HIV Infection* 13.

57 UNFPA *Preventing HIV Infection* 13.

58 <http://bit.ly/flgpH8> 2006.

59 <http://bit.ly/flgpH8> 2006.

60 UNFPA *Preventing HIV Infection* 23.

61 UNFPA *Preventing HIV Infection* 23.

mosques and their various places of worship, publicly exposed, refused pastoral care and funeral rites, and in extreme cases, have been killed.<sup>62</sup> The stoning and stabbing to death of Gugu Dlamini in December 1998 highlights people's ignorance and is a brutal testimony of the hatred and resentment towards PLWHA.<sup>63</sup> Dlamini was a young activist living with HIV/AIDS in a township near Durban who had declared her HIV/AIDS status on World AIDS Day in 1998. She was attacked three weeks later by a group of fellow residents, partly, it is believed, as a result of her declaration. In Nigeria, several cases of discrimination against PLWHA have been documented in most areas of life, including the educational sector, health-care sector, allocation of housing, employment, the community and the family.<sup>64</sup>

Sometimes whilst addressing their members, religious leaders make a false distinction between "us" and "them." In other words, presuming there to be a group of people infected with HIV/AIDS ("them" or "other") and the rest of the community, whose own personal behaviour does not place them at risk and who would therefore normally be untouched by the epidemic and would have a "right" to be protected from the actions of "others."<sup>65</sup> This assumption is not only false, but also dangerous, as it fosters discrimination, stigmatisation, condemnation, and prejudice, and jeopardises the cooperation needed to collectively fight the epidemic. As rightly noted by Kofi Annan: "We cannot deal with AIDS by ... making out it is their fault ... Let no one imagine that we can protect ourselves by building barriers between them and us. For in the ruthless world of AIDS, there is no 'us' and 'them'"<sup>66</sup>

There is no "them", there is only "us", as each of us will be affected in one way or another by the epidemic. This is because, apart from the fact that the Christians, for example, see themselves as belonging to one body or one family in Christ, caring for a loved one, for a person with HIV/AIDS and orphaned children is an important task that Christians must

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62 Paterson 2002 <http://bit.ly/flixDe> 14.

63 Cameron 2000 *Health and Human Rights* 9.

64 See CRH *HIV/AIDS and human rights* 5, cited by Durojaye 2007 *Law, Democracy and Development Journal* 133.

65 Hamblin "HIV and public health policy" 112.

66 Secretary-General Annan K addressing a special session of the United Nations, 2001, cited by Kopelman 2002 *Journal of Medicine and Philosophy* 232.

fulfil.<sup>67</sup> As long as one member of the human family is afflicted, the whole family is affected.

Religious leaders should further avoid the use of language as a tool for stigmatising and excluding. Terms such as "HIV/AIDS victim" and "HIV/AIDS sufferer" suggest powerlessness and increase stigma, whereas a "person living with HIV/AIDS" emphasises life and hope.<sup>68</sup> Religious leaders should show love, care and compassion, and provide a supportive environment for the excluded and rejected. They should raise awareness about moral obligations to children orphaned by HIV/AIDS. Religious leaders who stigmatise and exclude PLWHA discriminate against their own body, and the religious faith organisation loses its strengths and credibility.

Cases in which people with HIV/AIDS-related illness are not looked after and are instead shunned not only sicken and die earlier, but also others who witness their fate become scared of seeking HIV/AIDS-related counselling, testing and treatment. These people go underground, for a silent explosion of the epidemic that fear of identification with HIV/AIDS brings.<sup>69</sup> An all-out effort against stigma by the religious leaders will not only make those infected or affected feel better, happier and improve their quality of life, but will also improve the social cohesion, harmony in the faiths and make people want to voluntarily come for testing, thereby meeting one of the necessary conditions of a full-scale response to HIV/AIDS.

Religious leaders must be courageous and highly committed to taking a public stand. In November 2004, the Anglican Church in Tanzania, Dodoma Diocese, announced that twelve of its priests were HIV/AIDS positive. Three of these priests declared their status to the public, whilst the remaining nine were expected to do so at an "appropriate" time.<sup>70</sup> Recently, the Ugandan Anglican priest, Gideon Byamugisha, was canonised by the church of Uganda after he risked scandal and discrimination by coming out and living openly with HIV/AIDS.<sup>71</sup> Byamugisha became the first African clergyman to openly declare his

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67 Hamblin "HIV and public health policy" 112.

68 UNICEF 2003 <http://bit.ly/fkAeoi> 5.

69 Buchanan 1994 "Public health"; Hamblin "HIV and public health policy" 103.

70 Okema 2004 *The East African*, cited by WCC 2005 <http://bit.ly/hNMBNM> 24.

71 Okema 2004 *The East African*, cited by WCC 2005 <http://bit.ly/hNMBNM> 24. Canon Gideon Byamugisha was the first religious leader in Africa to publicly disclose his HIV/AIDS-positive status. The

HIV/AIDS-positive status. Since then, he has sought to eliminate HIV/AIDS-related stigma and discrimination by advocating the "four Es" of empathy, empowerment, equipment and engagement; and the "six Ps" of prayers, policies, plans, programmes, personnel and partnerships.<sup>72</sup>

Clergymen in Kenya have recently begun to implement Canon Byamugisha's approach with the support from the President's Emergency Plan for AIDS Relief through USAID. The Kenya Network of Religious Leaders Infected and Affected by HIV/AIDS (Kenerela) was established in February 2004 at a retreat in Limuru, Kenya, by forty-four religious leaders as the first such network in East, Central and Southern Africa.<sup>73</sup> The membership now totals 1 000 in eight provinces and includes HIV/AIDS-positive religious leaders, clergy who have lost or are caring for close relatives with HIV/AIDS, fellow religious leaders, congregants and friends of the organisation. Kenerela encourages congregations to provide home-based care, counselling and peer education for PLWHA, and for local orphans and vulnerable children. They also provide accurate information, communication, positive role models and nonjudgmental support to PLWHA.<sup>74</sup> Religious leaders in Nigeria should take positive steps to encourage HIV/AIDS-positive pastors to reveal their status, as they could serve as a powerful agent of change in their congregations and communities in combating stigma and discrimination.

## 8 Religious leaders and marriage

Marriage is seen as an institution ordained by God for everyone who wishes to take advantage of it. Marriage is equally cherished at common law. Under the common law, marriage is defined as the voluntary union of a man and a woman for life to the exclusion of others. What is important here is the free consent of both parties. Under the *Marriage*

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breaking of the stigma-induced silence by Byamugisha has greatly helped in demystifying the epidemic in the religious circle. He has since been working with policy makers, civil society groups and other religious leaders on ways in which to prevent HIV/AIDS and combat stigma not only in Uganda but across Africa, thus demonstrating the leadership role a religious leader can play in the fight against HIV/AIDS. In the mid-1990s, Byamugisha founded the African Network of Religious Leaders living with or personally affected by HIV/AIDS. The network is known for its doggedness in providing care and support for people living with HIV/AIDS. It has more than 1 300 members in eleven countries and includes both Roman Catholic and evangelical Christians, as well as Muslims and other faiths. See Ecumenical Advocacy Alliance 2006 <http://bit.ly/igRxup>.

72 USAID 2005 <http://bit.ly/eVYX1h>.

73 USAID 2005 <http://bit.ly/eVYX1h>.

74 USAID 2005 <http://bit.ly/eVYX1h>.

Act<sup>75</sup> in Nigeria, the consent of the parents of the parties is required for there to be a valid marriage under the law. The traditional marriage is equally treated with respect, hence the elaborate ceremony that often accompanies it.

However, religious organisations in Nigeria are now making it a condition for betrothed couples to undergo mandatory HIV/AIDS tests before they are joined together as husband and wife. They are requested to provide HIV/AIDS-free certificates to the religious authority before they are wed. Since the late 1990s in Nigeria, the Orthodox and Pentecostal churches began to require mandatory premarital HIV/AIDS tests for those who wished to marry in the church. This requirement dates back to 2000 amongst both the Catholic communion and the Anglican communion, in which mandatory testing became a policy across all Anglican dioceses in Nigeria in 2000.<sup>76</sup> This practice began in Uganda in 2006 and became the official Catholic Church policy in Burundi in 2006.<sup>77</sup> There is a lack or absence of pre-marital test and post-test counselling because church marriage counsellors are ill-equipped to counsel on HIV, and often times, the results of such testing are not kept confidential. For example, in the Orthodox and Pentecostal churches in Nigeria, the intending couples need to take the test under the supervision of a representative of the church marriage committee, and results are disclosed directly to the church prior to notification to the couple.<sup>78</sup> Clergy, imams and other religious leaders have refused to marry many intending couples because of their HIV/AIDS status. Religious institutions have often justified this requirement of HIV/AIDS testing for intending couples by claiming that it is aimed at further curbing the spread of the epidemic in the society and averting calamity for the intending couples.<sup>79</sup> However, this is not true, as many who have tested positive are rejected and neglected by the religious organisations. They are made the subject of stigma and discrimination.

The question is: Why should there be compulsory pre-marital testing? It is submitted that such an act violates the right of the individual to marry. In accordance with Article 16 of the

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75 S 18 of the *Marriage Act* CAP M6 Laws of the Federation of Nigeria 2004 provides that: If either party to an intended marriage not being a widower or widow, is under twenty-one years of age, the written consent of the father, or if he be dead or of unsound mind or absent from Nigeria, of the mother, or if both be dead or of unsound mind or absent from Nigeria, of the guardian of such party, must be produced annexed to such affidavit aforesaid before a licence can be granted or a certificate issued.

76 Open Society Institute 2008 <http://bit.ly/dSejZg>.

77 Open Society Institute 2008 <http://bit.ly/dSejZg>.

78 Open Society Institute 2008 <http://bit.ly/dSejZg>.

79 Durojaye 2003 *CRH-Touch Magazine* 16.

Universal Declaration of Human Rights,<sup>80</sup> the right to marry and to found a family encompasses the right of a man and a woman of full age, without any limitation due to race, nationality or religion, to marry and to found a family and both have equal rights as to marriage, during marriage and at its dissolution and to protection by society and the state of the family as the natural and fundamental unit of society. Further, Articles 2, 3 and 18 of the African Charter on Human and Peoples' Rights (Enforcement and Ratification)<sup>81</sup> contain provisions that appear to respect the right of an individual to marry and to raise a family. Section 37 of the 1999 Constitution of the Federal Republic of Nigeria also recognises the right to private and family life of all citizens. Compulsory pre-marital testing for HIV/AIDS will no doubt invade the right to privacy of the intending couples, as the information may not only be shared between the intending couples, but may also be shared directly or indirectly between their immediate families.<sup>82</sup> More importantly, it has been shown that church leaders did not keep the test results confidential, but revealed these to members of their congregation, thereby compounding the problem of stigmatisation for PLWHA.<sup>83</sup> It therefore follows that a condition, policy or law that purports to limit or prevent a PLWHA from exercising his or her right to marry will be contrary to the Constitution and therefore void and of no effect.<sup>84</sup>

The assumption that pre-marital HIV/AIDS testing reduces new infections ignores that at the time of testing, intending couples may be in their window periods, thus both, even though they may be positive, may yet test negative.<sup>85</sup> There is a further dangerous assumption that couples will continue to be faithful after marriage. However, this is not the case, as it has been shown that many women who become infected are infected by their husbands as a result of extra-marital sex.<sup>86</sup> As noted by Sippel,<sup>87</sup> "many men across cultures consider extra-marital sex as an important component to social acceptance, a

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80 1948.

81 Chp 10 Laws of Federation of Nigeria (LFN) 1990, now Chp A9 LFN 2004. A 2 provides that: "Every individual shall be entitled to the enjoyment of the rights and freedoms recognized and guaranteed in the present Charter without distinction of any kind such as race, ethnic group, colour, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or other status". A 3 provides that: "1. Every individual shall be equal before the law. 2. Every individual shall be entitled to equal protection of the law". A 18 provides that: "1. The family shall be the natural unit and basis of society. It shall be protected by the State which shall take care of its physical, health and moral ...".

82 Malhotra *et al* 2008 *Indian Journal of Medical Ethics* 73.

83 Public Agenda 2009 <http://bit.ly/1ns7EN>; Durojaye and Balogun 2010 *IJLPF*.

84 Durojaye 2003 *CRH-Touch* 9.

85 Durojaye and Balogun 2010 *IJLPF*.

86 Durojaye and Balogun 2010 *IJLPF*.

87 2007 <http://bit.ly/eNMEij>.

condition for achieving successful masculinity, and a reality that coexists with migrant labor practices". Thus, mandatory pre-marital testing for HIV/AIDS is a violation of the rights of PLWHA and it should not have any place in an effective response to the control of the epidemic, since the benefit of proper counselling is often not provided.<sup>88</sup>

In addition to fuelling stigma and discrimination against PLWHA, mandatory pre-marital testing for HIV/AIDS has led to an increase in fake HIV/AIDS certificates showing false negative status.<sup>89</sup> Experiences of countries that began pre-marital HIV/AIDS testing may be helpful in this regard. For example, mandatory pre-marital HIV/AIDS testing strategy was contemplated by approximately thirty states in the USA, although only adopted by two states, Illinois and Louisiana, and even in both these states, it was implemented only for a brief period before it was repealed.<sup>90</sup> Apart from the prohibitive cost involved in identifying a single HIV/AIDS positive case,<sup>91</sup> it resulted in people avoiding being solemnised in the states in which such policies existed. The policy was also implemented in Ghana by a number of churches for intending couples and was condemned by the Ghana National Anti-AIDS Commission. As a result, these churches backed down, claiming that they had shifted their stance to a policy of voluntary counselling and testing.<sup>92</sup>

Testing should not be made mandatory. Rather, couples should be encouraged to go for voluntary testing and counselling, in which they will be effectively counselled on the issue and thereafter be left to decide for themselves.

## 9 The way forward

There should be constant and regular training of religious leaders on HIV/AIDS prevention, as well as care and/or counselling, as many of them have not undergone any type of HIV/AIDS training. Equipping religious leaders with accurate information on HIV/AIDS will

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88 Durojaye 2003 *CRH-Touch* 16.

89 There have been documented reports in Burundi and Malaysia of couples offering fake HIV/AIDS certificates in order to circumvent the policies of religious bodies on production of HIV/AIDS certificates. See Open Society Institute 2008 <http://bit.ly/dSejZg>.

90 Malhotra *et al* 2008 *Indian Journal of Medical Ethics* 73.

91 Louisiana, in 1988, identified two HIV/AIDS-positive marriage licence applicants and the average cost of one HIV/AIDS positive identification was estimated at US\$70 000 to US\$85 000. Consequently, the number of people seeking marriage licences in Illinois dropped sharply, as many of them decided to marry in other states or not to marry at all. See Open Society Institute 2008 <http://bit.ly/dSejZg>; Goodman 1989 *DePaul L Rev* 106.

92 Open Society Institute 2008 <http://bit.ly/dSejZg>.

enable them to pass accurate information on the pandemic to their congregations. A counselling and behaviour-change project implemented by the Catholic Diocese of Nakuru in Kenya is assisting young people in preventing the transmission of HIV/AIDS. This project is supported by the UNFPA and disseminates information through schools and parishes, trains health workers in the diagnoses and treatment of sexually transmitted infections in young people, and works with parents and church members to increase understanding of the threat posed by HIV/AIDS.<sup>93</sup> It is important to discuss what "spiritual counselling, education and other services and support orphans and caregivers require, and how this can be provided fairly when other children may also be in great need."<sup>94</sup> In Namibia, the Catholic AIDS Action pioneered a national movement in providing home-based care and counselling for PLWHA and regular support for children orphaned by HIV/AIDS.<sup>95</sup> It recruited and trained several volunteers for this purpose.

Faith-based organisations can also support prevention and care through the distribution of information in local languages on HIV/AIDS. These materials can be developed locally or obtained from sources, such as the Ministries of Health, NGOs and faith-based networks. Religious leaders can help to issue press statements and grant interviews in the media (newspaper, radio and television) on the factors that fuel the epidemic and its effects on families and societies; and be committed to providing unconditional and non-judgmental love, care and support for those infected and affected by the pandemic.<sup>96</sup> The Redeemed AIDS Programme Action Committee of the Redeemed Christian Church of God, Nigeria was established with a vision to reduce the spread and transmission of HIV/AIDS and sexually transmitted diseases.<sup>97</sup> They seek to achieve this through their sermons, publications, drama, education and counselling. The Church of Nigeria Anglican Communion has recently set up what it terms the Diocesan Action Committee on HIV/AIDS to create awareness and sensitivity amongst the clergy and the congregations regarding the pandemic. Also, Catholic institutions are at the forefront of care for PLWHA, as the Vatican estimates that they provide 25 per cent of the total care given to PLWHA

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93 UNFPA *Preventing HIV Infection* 23.

94 UNICEF 2003 <http://bit.ly/fkAeoi> 33.

95 UNICEF 2003 <http://bit.ly/fkAeoi> 39.

96 UNICEF 2003 <http://bit.ly/fkAeoi> 49.

97 Adogame 2007 *Journal of Health Psychology* 475–484, cited by Awoyemi 2008 *Conservation Biology* 812.

worldwide.<sup>98</sup> While these efforts are commendable, they are still far from what is expected from the religious leaders in the face of the alarming increase in the spread of the epidemic in Nigeria.

There is a need for religious leaders to use their spiritual or religious teachings to emphasise compassion, healing and support for PLWHA.<sup>99</sup> They must also "work with other religious leaders, faith-based coalitions and community leaders to find common beliefs, spiritual teachings and moral, legal and social standards that can help prevent HIV and alleviate the sufferings of those affected by AIDS."<sup>100</sup> Christians needs to follow Jesus Christ by showing love and compassion to PLWHA.<sup>101</sup>

Religious leaders should be willing to channel some of the formidable resources for HIV work. Some of these religious institutions own schools, clinics, hospitals and orphanages which can be used for creating awareness about the pandemic and providing the necessary care and support for PLWHA. For example, in the education and health sectors in Lesotho, the strength of the Church is evident in its ownership of 90 per cent and 50 per cent of schools and hospitals respectively.<sup>102</sup> In Zambia, faith-based organisations provide approximately 40 per cent of health care.<sup>103</sup> In Nigeria, faith-based organisations deliver as much as 40 per cent of Nigeria's health services and some have already formulated HIV/AIDS policies (Christian Health Association of Nigeria 2004).<sup>104</sup> In the Democratic Republic of Congo, 70 per cent of health services are delivered by churches and church-related institutions, 50 per cent of hospitals in the country are owned and managed by local churches, and the Roman Catholic Church alone provides 25 per cent of all HIV/AIDS care, including home-based care and support of orphans.<sup>105</sup> Whilst some of these institutions may be unwilling to talk about issues of sexuality or promote the use of condoms, they can at least help in providing other services, especially in cases in which care and support are concerned.<sup>106</sup>

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98 See Ecumenical Advocacy Alliance 2006 <http://bit.ly/igRxup>.

99 UNICEF 2003 <http://bit.ly/fkAeoi> 11.

100 UNICEF 2003 <http://bit.ly/fkAeoi> 11.

101 CAFOD <http://www.cafod.org.uk>.

102 Afrol News <http://bit.ly/ha8D69>.

103 UNAIDS *Partnership with Faith-based organizations: UNAIDS Strategic Framework*, cited by Sidibé 2010 <http://bit.ly/fTTAOc>.

104 CEDPA 2005 <http://bit.ly/i63Ylh>; Aja 2010 *J Relig Health* 51.

105 Maman *et al* 2009 *Social Science and Medicine* 966; Haddad *et al* 2008 <http://bit.ly/eKCmjZ>.

106 AIDS Action *Religion and HIV/AIDS* 2–3.

There is a need for reconstructing the "victim theology" of HIV/AIDS and to be ready to accept, without reservation, that HIV/AIDS is within the household of faith, domestic violence and reckless sexual behaviour are commonplace, and men, (as much, if not more so than women), are the "bearers" of HIV/AIDS.<sup>107</sup> Religious leaders cannot afford to be bystanders or to be indifferent in the fight to halt the spread of the epidemic. They can help to challenge the economic, business and social systems that increase the vulnerabilities of people and be agents of change by mobilising governments to play their respective roles in terms of rights, resources and institutions.<sup>108</sup> Their uncompromising position against social injustice and inequality, which are fundamental to the spread of HIV/AIDS, will help in overcoming the barriers to halting the spread of the pandemic. Religious leaders have the power to improve services for the prevention of mother-to-child transmission, to end the stigma, denial, rejection and discrimination, to influence decision-making processes on HIV/AIDS, and above all, to be a voice for the voiceless or for those with a lesser voice.

## 10 Conclusion

We have seen from the discussion so far that HIV/AIDS is not just happening "out there", nor is it limited to one group, race, sex or a certain religion; Christians, Muslims and people of other faiths are all living with and affected by HIV/AIDS. We have seen some of the challenges facing religious leaders as they grapple with the consequences of this pandemic. The religious leaders therefore have a crucial role to play by using the trust and authority they have in their communities to help bring about healing and hope to all who are affected by the epidemic. Religious leaders must endeavour to move beyond the negative views of sex and sexuality embedded in much of the various religious beliefs, and towards embracing sex and sexuality as a gift from God. Religious leaders working zealously with committed governments, NGOs, media and well-meaning individuals, African countries, including Nigeria, can halt the spread of this pandemic.

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107 Benton 2008 *J Relig Health* 319.

108 UNFPA 2010 <http://bit.ly/eeEzej>.

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Wikipedia sa AIDS <http://bit.ly/g9WUId> [date of use 24 Nov 2010]

### ***List of abbreviations***

CAFOD	Catholic Overseas Development Agency
CEDPA	Center for Development and Population Activities
CRH	Center for the Right to Health
JFSR	Journal of Feminist Studies in Religion
J Relig Health	Journal of Religion and Health
IJLPF	International Journal of Law, Policy and the Family
PLWHA	People living with HIV/AIDS
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WCC	World Council of Churches
WHO	World Health Organization