

HIV/AIDS: The Expanding Ethical Challenge

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I broach anew the topic of HIV/AIDS with two central presuppositions. First, when Catholics hear the topic of Ethics and HIV/AIDS, they immediately think of “condoms;” in order to get beyond condoms, so as to appreciate the complexity of the ethics challenge of HIV/AIDS, I shall offer no fewer than 10 topics for us to consider. Second, conversely, when others hear about the expanding ethical challenge of HIV/AIDS, they see the challenge as so vast, so foreboding, and so confounding that they throw up their hands and say how can I do anything about this. For this reason I will focus the ten points to those who are in education, whether in theology, philosophy, nursing, secondary education, medical schools, university or graduate programming. I am speaking not as missionary, public health worker, physician, researcher, benefactor, etc. I speak precisely as an educator to other educators so as to confirm and to enlist my colleagues in the work of making HIV/AIDS an educational agenda item.

Let us begin then with the first topic: the urgency of the expanding ethical challenge as it impinges on us and our educational institutions.

1. The Exceptionalism of HIV/AIDS

On February 8, 2005, at the London School of Economics, Dr. Peter Piot, Director of UNAIDS directly confronted the exceptionalism of HIV/AIDS. He asked, “Is the AIDS pandemic so exceptional a threat that it is in a league altogether different to other infectious diseases or causes of ill health? Is the pandemic so exceptional a threat that its control should not be just one of many Millennium Development Goals but rather an overarching priority, a prerequisite to achieving the MDGs? Is the threat so exceptional that it demands a binding first

call on the attention of political leaders as well as on finances? So exceptional that it demands that we undertake fundamental changes on many fronts if we are to succeed? Ladies and gentlemen: AIDS is exceptional. The response to AIDS needs to be equally exceptional.”

Piot offered four reasons for his claim regarding the exceptionalism of HIV/AIDS. First, he stated: “an ‘epidemic equilibrium’ or plateau is nowhere in sight -- not globally, not at the level of epidemics in most countries, and not over the long term.”¹ The epidemic, then, is globalizing rapidly; moreover, we can no longer locate it in certain hotspots either within a nation or region. It is diffuse. Consider this epidemiological information.

Although it was recognized only in 1981, by 1999 HIV/AIDS has become the 4th greatest cause of death in the world, accounting for 4.8% of all deaths worldwide and 3 million deaths per year (8,000 each day). In Sub-Saharan Africa AIDS is the leading cause of death, accounting for more than 1/5 of all deaths.² Today, with 42 million people living with HIV/AIDS and 25 million persons having died, 67 million persons have had their lives dramatically changed by this viral epidemic. Nearly 14,000 new infections occur every day, with the vast majority of these occurring in developing countries, through heterosexual transmission, by persons who are largely unaware of their HIV status. Half of new infections occur in women, and 2,000/day in persons younger than 15. The disease is not spreading evenly, however. Between 1999 and 2001, percentage increases of HIV-infected persons in various regions of the world ranged from a negligible increase in Australia and a 4% in North America, to an 89% increase in South/Southeast Asia and a 138% increase in Eastern Europe and Central Asia.³

AIDS has had a dramatic impact on duration of life, with adult life expectancy dropping by 15-33 years in some countries.⁴ Although as recently as 2001 the U.N. had estimated that

by mid-century the world's population would be reduced by at least 300 million because of the AIDS epidemic, that reduction has recently been revised to 480 million, with 47 million of the increased number of deaths expected to come from India and 40 million from China.⁵ In short, not only has the epidemic not peaked in local areas, it has, instead, globalized: While Botswana, Swaziland, and elsewhere in So Africa there is 40 percent infection rate, we are seeing dramatic increases in Eastern Europe, India, China, Carribean. And now, India's 5.5 million people infected with the virus surpassed South Africa's 5.4 million.⁶

The second reason for insisting on the exceptionalism of HIV/AIDS is the exceptional nature of HIV's long gestation period that deceives us from recognizing until it is too late the extensiveness of the virus' presence. This factor is very unusual because the HIV virus can remain undetected for up to six months after exposure. Moreover, without anti-retrovirals, it will develop into full blown AIDS but maybe not for ten years.

Third, the impact on labor, economic and social infra-structures, and on children, is staggering. Consider this "exceptional" data: by 2010, 1/10 children in sub-Saharan Africa will have lost one or both of their parents to AIDS (accounting for 29 million AIDS orphans). Countries such as the Central African Republic have closed more than 100 schools as a result of teacher deaths, and illness of parents often causes children (especially girls) to be pulled from school both because of lack of school fees and because their efforts are needed to manage family farms.⁷

In response to growing numbers of unparented or poorly parented AIDS orphans living in large cities, in recognition of shrinking economies due to AIDS, and with HIV prevalence in some military populations as high as 60-90%,⁸ the UN security council has met to discuss AIDS not to consider its health ramifications, but because of the security implications of these

numerous dramatic changes.⁹

Finally, HIV/Aids spreads predominantly through sexual activity and intravenous drug use. Inasmuch as there seems to be no soon to be expected vaccine on the horizon, for the most part, prevention becomes singularly important. But trying to persuade people to make behavioral changes in their lives and being confronted simultaneously with a moral judgmentalism from others, leaves the task of prevention with considerable handicaps.

These four factors--- the absence of any epidemic equilibrium on the horizon; the deceptively long gestational period; the devastating impact on social and personal infrastructure; and, the daunting behavioral challenges--- make HIV/AIDS exceptional.

2. The HIV/AIDS Needs the Help of Educators

As the pandemic advances relentlessly, we must examine ourselves critically, confronting the world, the church, and the academy by asking how, in 2007, after 26 years' experience, are we doing so poorly in the face of this epidemic? For those of us who work in educational institutes, we must especially ask: how well are we teaching?

This question was posed at a plenary session of the XVth International HIV/AIDS Conference held in Bangkok in July, 2004 by Dr. Mary Crewe of the Centre for the Study of AIDS at Pretoria University, South Africa. In light of such obvious failure, can we continue to educate as we do, or ought we to aim at a more transformative model of moral education?

In promoting the latter, Crewe reminds us that more than a third of all people living with HIV/AIDS are young people between the ages of 15 and 24, and almost two-thirds of these are girls. Crewe asks, "Why is it left to young girls" to bear the burden of the HIV/AIDS pandemic? But as she poses this question in South Africa, those of us in the north are left with another question: How do we in the industrialized world teach 15-24 year olds at a time when their own generation in the

developing world is so vulnerable?

As we entertain this question, that is, as we seek to recast our educational institutions so as to transform our cultures and social structures, we must never lose sight of the primary concern that directly affects our students. To them, she says, we need to give a vision “that they are valuable, rather than vulnerable.”¹⁰

I have noticed some developments, however. Last year, when I started teaching at Boston College, I offered a course for undergraduates entitled, "HIV/AIDS and Ethics." 57 students took it. What was particularly interesting is how much experience my students had. At least twenty students had already done immersion experiences in Africa, Latin America, or India. Others had done more local projects. But, what they all lacked was academic studies that could complement their experience. They needed to read about the virus and its transmission, the narratives of the people infected and the people at risk; the issues related to prevention strategies and the need to develop more holistic, humane ones; they needed to know the power of stigmatization and the role that cultures and churches have in promoting it; they need to understand the access programs for people in the developing world; the questions related to research and to patenting; and they needed to know where signs of hope are emerging. In short they needed an education.

This past year I offered the course again. I now have sixty-five students. Twenty-five of these have immersion experiences and many are going into such programs next summer or next year. As undergraduates, these students have not yet begun their professional degree programs and so they can listen to their classmates wondering about how their areas of interest can be shaped by the pandemic. I have many students who say, I think I'm going into business, medicine, nursing, public health, communications, administration, journalism, philosophy, or

theology, and I intend to see what I can do in that field for the people most immediately affected by the pandemic.

I have spoken at nearly two dozen universities on this very topic of the need for course offerings in HIV/AIDS. At BC, another faculty member, now in sociology is offering an undergraduate course and as I go around, one or two persons at each of these schools tell me how they too are starting up courses on HIV/AIDS. So as to further this project, a student run network, entitled FACE/AIDS, will begin posting faculty syllabi of course offerings in HIV/AIDS for undergraduate students. We expect to become a catalyst for further, much needed courses.

3. Many Graduate Students in Theological Ethics Are Already Writing Theses and Dissertations on HIV/AIDS

James Olaitan Ajayi is a Nigerian diocesan priest whose dissertation at the Gregorian University was published; it focuses on the issues of economic justice and gender power dynamics as key concerns for addressing the pandemic.¹¹ Last year, Orbis press published the dissertation of the Ursuline nun, Maria Cimperman's in which she proposed a vision of the type of people we ought to become in a time of HIV/AIDS, and central to her claims is the call to be merciful.¹² Patern-Auxence Mombe, a Jesuit from the Central African Republic has just published his first book which details comprehensive care for persons living with HIV: Rays of Hope: Managing HIV and AIDS in Africa¹³. The French Assumptionist priest and AIDS physician is doing his dissertation on an ethics of vulnerability in a time of HIV/AIDS using the work of the Irish theologian, Enda McDonagh. Another French priest and physician, the Dominican, Bertrand Lebouche is finishing his dissertation on HIV/Aids and religion and has already published a book with editions Cerf, Où es-tu quand j'ai mal?¹⁴ Ireland's Suzanne

Mulligan finished her post-doctoral research at Maynoth on AIDS in South Africa and is now teaching HIV/AIDS and ethics courses at Milltown Park. The prolific writer turned doctoral student Gillian Paterson is finishing her doctorate on stigma and HIV/AIDS here at Heythrop College. The Nigerian Jesuit, Agbonkhianmeghe E. Orobator, who did his dissertation in Leeds, has published with Paulines and now as the new rector of Hekima College in Nairobi teaches courses on HIV/AIDS and ethics at that school of theology. Incidentally, at the conference in Padova, the first International Crosscultural Conference for Catholic Theological Ethics, twelve of these new scholars were involved on panels on the specific topic of HIV/AIDS. Those papers prompted Mary-Jo Iozzio to invite thirty women moral theologians from across the globe to contribute to Calling for Justice throughout the World: Catholic Women Theologians Considering the Moral Ramifications of the HIV/AIDS Pandemic to be published next year by Continuum press.

Anyone looking to teach HIV/AIDS and ethics does not have to worry about a dearth of literature on the topic. New scholars world-wide are breaking important new ground in the field of HIV/AIDS.

4. What These Works Reveal Is that People Most Affected by the Virus Live in Very Unstable Environments

HIV/AIDS thrives where there is instability, a notion that is extremely important to appreciate. Those who are viewed as being “marginalized” in any society are commonly described as those most at risk for acquiring HIV infection, but this characterization, “marginalization,” doesn’t quite get to the core of vulnerability to becoming HIV-infected. HIV/AIDS breeds specifically where there is social instability, whether that means those who are affected by civil strife, military incursions or liberation armies in Uganda, Haiti, Sudan, or the Congo; those who are refugees in any part of the

world; those in the prisons of Russia; those married to South African or Indian truck drivers who themselves live in very unstable worlds; those in debt-ridden nations on the verge of economic collapse; heads of families forced to migrate for employment, and those at home who await them; those who are drug addicts, whose own apprehension of themselves is itself unstable; those who are forced into sexual activity to support their children, their families, or their school fees; those who are overseas workers and fishermen; those who engage in clandestine homosexual activity in homophobic societies; or those girls and young women who are faithful to their marriages or to other stable sexual relationships but whose husbands or partners put them at risk because of external sexual liaisons. In short, if we want to find persons at risk for the virus or who already are infected by it, they are not simply marginalized people. They are people who are vulnerable precisely because their lives and their social settings lack the stability needed to live safely in a time of HIV/AIDS.

The economist Jeffrey Sachs emphasizes the importance of this concept of instability when he writes, “Since September 11, 2001, the U.S. launched a war on terrorism, but it has neglected the deeper causes of global instability. The nearly \$500 billion that the U.S. will spend this year on the military will never buy lasting peace if the U.S. continues to spend only one-thirtieth of that, around \$16 billion, to address the poorest of the poor, whose societies are destabilized by extreme poverty.”¹⁵

Sachs also notes that disease locks these unstable environments in with a barrier called infectious disease. He writes,

Disease is not only a tragedy in human lives, disease is disaster for economic development... the major reasons why many of the poorest countries in the world, particularly but not exclusively in sub-Saharan Africa, are stuck in poverty is that the disease barrier is so great that it is blocking many different normal avenues of economic advance.¹⁶

Buttressed against this barrier of disease within which instability thrives, more stable societies

and institutions (including churches) create their own protective barriers. Again, Piot reminds us that “the barriers to prompt and effective action are immeasurably magnified by taboo, denial and prejudice.”¹⁷ This strategy is remarkable because in an almost perverse way these defensive barriers on the part of leaders in strong, stable cultures are antithetical to the attempts of ethicists, public health officials and clinicians to keep the most vulnerable persons uninfected. As opposed to supporting those public health preventive strategies (condoms, needle exchange, preventive education) which protect HIV-vulnerable individuals, some leaders and members of their societies perceive that the better and more important shields are those that keep risky individuals distanced from “the general population,” or that are perceived as protecting social mores and orthodoxy from contamination.

5. The Work of Shame, Stigmatization and Moral Judgmentalism Manages to Keep Those Most Affected by the Pandemic in Their Dangerously Unstable Worlds

The strategy of keeping a distance is often backed by a deep moral judgmentalism, whether explicitly stated or not. In his new book, Breaking the Conspiracy of Silence: Christian Churches and the Global AIDS Crisis, the Evangelical theologian, Donald Messer examines compelling data from the HIV/AIDS pandemic and finds a church leadership that stands pathetically aloof, righteous, and judgmental. He appeals to several surveys, among them an informal one taken at a World Council of Churches gathering in Harare, Zimbabwe in 1998, in which 68 percent said they believed the pandemic to be a punishment from God. Only 48 percent were willing as leaders to respond to church members with the virus, and only 25 percent would educate youth about related issues of sexuality and drug use.¹⁸

Moral judgmentalism depends powerfully on the capacity to blame. This blame is deeply tied to the belief that those living in unstable situations cannot be trusted, and ought not to be admitted to the stable “inner circle” of society. Moreover, since their condition is in

many cases presumed to be their own fault, it does not merit the sympathetic, supportive, humanitarian response that other catastrophes prompt

For example, the number of lives lost to the Indian Ocean Tsunami approached 300,000. This tragedy generated billions of dollars of supportive response world-wide immediately. Although HIV/AIDS causes the same number of deaths every 37 days, the will to commit concomitant resources to prevent such loss of life simply does not exist. Not only that, but if every 37 days another tsunami were to occur, we would witness a global effort of the highest priority creating a wall protecting all of humanity against the threat of such tsunamis. Faced with the fact that the HIV/AIDS pandemic does sustain the loss of ten tsunamis a year, we find no such interest in building a wall against the “sea” of the virus. Desiring to protect ourselves from those at risk, we build a barrier against those living in unstable worlds.

The biblical tradition of Job, whose narrative contradicts the deep-seated belief that we are the authors of our own troubles, apparently has no claim here.

6. A Central Task for Educators Today Is to Help Humanize the Face of HIV/AIDS

Eight years ago I invited Kevin Kelly and Enda McDonagh to join Jon Fuller, Lisa Cahill, Bob Vitillo and me in Boston to discuss a book project which later became, Catholic Ethicists on HIV/AIDS Prevention. Today I use this book along with Donald Messer’s in my course on HIV/AIDS. In our book, there are eight essays on such topics as how both the Catholic moral and Catholic bioethical tradition develops, on how casuistry works, on what are the issues of gender inequity and social justice, and Enda’s fine essay on the Kingdom of God; there are also twenty-seven other ones that describe cases from specific countries about the difficulties people face in unstable environs concerning local issues regarding prevention. My students love these cases.

I just finished sixty-five oral exams this Monday and Tuesday and when I asked them what was the key learning experience for them in the first third of the course, it was not the data, but rather the narratives of these cases. For instance, they admire the character, described by Linda Hogan of the Irish nun, Sr. Mary who in trying to reach out to younger people in unstable families and settings teaches them all the strategies involved in prevention and in doing that jeopardizes her own relationship with the local church and even her religious community. Similarly they cite Nicholas Harvey's deeply troubling narrative about a woman who finally finds some stability in her life only to have it robbed by the diagnosis of HIV/AIDS contracted precisely as she lived a life of turmoil. But the church rather than acknowledging as Kevin Kelly notes in his essay, that the body of Christ has AIDS, distances itself from her life by a profound moral barrier that alienates her from what was once her community of faith.

They are drawn in the same direction as they read the essays in Paul Farmer's landmark work, Women, Poverty, and AIDS.¹⁹ There too they vividly report the encounters they had in the people they met in these essays.

In one narrative after another the students meet a never before seen person and they enter into the narrative of her or his unstable life. One story was on the Ugandan Noreen Kaleeba, whose family went into a tail spin when her husband became infected, but Kaleeba, found stability for her and her husband and then built an international organization to welcome others into her world. Two students were so moved by it that they contacted the author, Uganda moralist, John Mary Waliggo, and are going to stay with her for the summer. They literally are entering these narratives!

Students already having had immersion experiences fill out these portraits with their own accounts of their own encounters. In returning home, they are reporting what they have

seen and what they have heard. I find these people are the new evangelizers, affirming our narratives, they are humanizing the face of HIV/AIDS. As their generation comes under greater and greater siege throughout the world, they are introducing their classmates and their families and their professors to the people beyond the barriers.

7. Facing Prevention and Specifically the Condom

Because rates of infection are outdistancing rates of treatment, the issue of effective prevention strategies is even more urgent today than ever. Among these, the ABC strategy is considered the most effective program: First, A: Abstain; delay onset of intercourse until marriage. If you can't abstain, or are already in a sexual relationship, then B: Be faithful to that partner. If you choose (or do not have the freedom to say 'no' to) sexual relations, then C: use a Condom.

How reliable is the condom? We should acknowledge that condoms are not 100% reliable and that they can break, degrade under improper storage conditions or with inappropriate (petroleum-based) lubricants, and be improperly manufactured and improperly used. However, arguments that condoms provide no protection are obviated by studies involving their actual use among humans.

The largest analysis of published, peer-reviewed studies looking at the question of condom effectiveness was produced by the National Institute of Allergy and Infectious Diseases of the National Institutes of Health, USA, in July, 2001. There it was noted that HIV is a very inefficiently transmitted infection when compared with other sexually transmitted diseases. For example, a single exposure to gonorrhea causes infection in 60%-80% of women. In contrast, after a single exposure to HIV, only 0.1% - 0.2% of women become infected. The study found that use of condoms reduces the already low transmission rate of HIV by 85%. If

one applied these data to 10,000 persons being exposed to HIV during sexual intercourse over a period of one year, in the absence of condoms 670 would become infected, while that number would be reduced to 90 if condoms were used consistently and correctly. The conclusion is clear: condoms are not perfect, but for those who choose (or are forced into) sexual contact, significant protection is afforded by this method.²⁰

Faced with the effectiveness of condoms, Monsignor Georges Cottier, O.P., then theologian of the papal household of Pope John Paul II and now, Cardinal president of the International Theological Commission, was asked in an interview with Vatican Radio whether condom distribution might qualify as a 'lesser of two evils' approach. He responded: 'This is the question that moralists are asking themselves, and it is legitimate that they ask it.'²¹

A few moral theologians, notably Kevin Kelly, have argued that any teaching on the condom inevitably must grapple with the teaching on contraception. Kelly argues that the teaching on birth control is itself the source of considerable dilemmas for Catholics and that the issue of HIV prevention helps highlight the need to develop a more responsible birth control teaching.²²

Others have argued differently applying casuistic moral principles (lesser-evil, double effect, cooperation) to demonstrate the compatibility of magisterial teaching on birth control with effective HIV/AIDS prevention methods.²³ These highlight that in the case of HIV, the condom is not being used as a contraceptive device, but as a prophylactic against transmitting a deadly disease. They show how traditional principles acknowledge the legitimacy of such a distinction, and defend condoms for HIV/AIDS prevention while upholding -- or at least not contesting -- the validity of church teaching on contraception.²⁴ That distinction -- between the therapeutic and the contraceptive -- is found in Humanae Vitae: 'The Church does not consider

at all illicit the use of those therapeutic means necessary to cure bodily diseases, even if a foreseeable impediment to procreation should result there from -- provided such impediment is not directly intended for any motive whatsoever (paragraph 19)'.

These theologians have taken the casuistic position simply to acknowledge that bishops could support condom use without opposing Humanae vitae. Yet, twenty years later moral theologians and many other Catholics are confounded by their hierarchy who persist in opposing condom usage by invoking the immutability of the birth control teaching. Catholics are astonished not simply because they are convinced of condom efficacy, but because their bishops seem to value their own teaching over the lives of those at risk: the present crisis is ultimately a threat to life itself, and not just a threat to sexual mores. The issue of protecting life, the heart of HIV/AIDS prevention strategies, does not appear to be at the forefront of their priorities. Thus, Melinda Gates echoed well the sentiments of many Catholics when she stated at the XVI International AIDS Conference: "In the fight against AIDS, condoms save lives. If you oppose the distribution of condoms, something is more important to you than saving lives."²⁵

Because of continued pressure from ethicists, public health officials, world leaders, and some of their own more enlightened brother bishops, these bishops will inevitably recognize the moral validity of the condom as part of a prevention strategy. As they do, they will need to decide whether to repudiate the birth control teaching entirely or to take the casuistic road and distance condoms as therapeutic from condoms as contraceptive. In any event, until they do, they undermine their own authority and leave many millions of lives in considerably worse risk than they need to be.²⁶

8. Concepts, Language and Advocacy Regarding Prevention **and Access to Treatment**

By this point, as educators we are realizing how relevant concepts and language are for broaching the subject of HIV/AIDS. As the casuist Albert Jonsen notes, “The public language . . . of AIDS is as important as the science.”²⁷

In 1997, Jonathan Mann reflected on this claim and argued that the issue of casting a conceptual framework for ethically and politically analyzing HIV/AIDS was urgent. To make his point, Mann put before public health officials a long recognized but rarely addressed insight: “it is clear, throughout history and in all societies, that the rich live generally longer and healthier lives than the poor.”²⁸

Why then was the issue of poverty so rarely incorporated into the language of public health ethics? If poverty is so much a cause of the spread of disease, why wasn't poverty incorporated into the analyses and strategies of public health officials? Mann answered that “Public health has lacked *a conceptual framework* for identifying and analyzing the essential societal factors that represent the conditions in which people can be healthy.”

The language of bioethics until that point was based on principles like autonomy, beneficence, and non-maleficence; these principles gave the shape of a bioethics primarily concerned with the individual physician-patient relationship. But Mann was looking at the developing world where many people do not have a physician let alone a relationship with one. Rather than using a language driven by individual relationships, he was looking for something that could analyze the social context in which people were both sick and poor. That is when Mann discovered in the language of human rights its integral comprehensiveness and moral urgency.

Human rights language could link global campaigns for the right to access available medical treatments with equally effective and local strategic movements to obtain greater equality in political, economic and social forms of life.

His work generated two subsequent claims. First, Paul Farmer looked at the inequity of social institutions and how they embody “virulent pathologies of power.” Reflecting on the deep connection between poor health and poverty, he saw the root causes of disease as being more connected to economics than to biology. He became particularly aware of the underlying social issues which made possible “structural violence” against women and girls.²⁹

From a different perspective, Jeffrey Sachs studied how disease affects social structures, that is, how disease makes people poor. While poverty certainly creates the conditions by which people become at risk for poor health, disease destroys their ability to escape from the very context that made them susceptible to ill health in the first place. “Disease is not only a tragedy in human lives, disease is disaster for economic development.”³⁰

Coming from contrary perspectives, Farmer and Sachs did not contradict one another: rather, they keep us on track to see the deep and interlocking connections between poverty and disease.

Theological ethicists have paralleled these developments by bringing the language of the common good, social justice, solidarity and the option for the poor into their discourse. In many ways Lisa Sowle Cahill pioneered this shift, by engaging the traditional language of Catholic social justice so as to prompt us to be more attentive to issues of power and the distribution of resources.³¹ Like public health officials, we ethicists realize that we cannot make the claims of what is fair unless we have the conceptual framework to understand and

analyze why there are inequities and how they can be resolved.

For this reason, ethicists have been able to examine many issues, for instance, the issue of patenting and access to anti-retroviral medicines. What was once considered a simple issue of intellectual property is now confronted by the claims of the human right to basic urgent life-saving goods.³²

This attentiveness to social justice and human rights also offers us analytical resources to address the underlying causes for on-going transmissions and therein lead us to more effective and comprehensive strategies for prevention. Here especially we can investigate better why women are so at risk today and why gender equity is such a needed component to HIV/AIDS prevention. The languages of human rights and social justice not only reveal to us that sexism and classicism are causes of HIV/AIDS transmission, they also provide us a framework to investigate the proper ways of bringing such power inequities to an end.

9. Critically Considering the Care, Cultural Context, and Actual Delivery of Healthcare

As we become more familiar with the unstabilizing worlds where HIV/AIDS thrives, we are still going to need to respect the integrities of those environs. One of the most fundamental areas of investigation concern the use of industrialized medicine and technology to respond locally to the crisis both to prevent transmission and to treat those already infected. While the initiatives are gravely needed, questions regarding the context of the local culture and the humaneness of the care being offered have been repeatedly raised by theological ethicists.

Occasionally, the attempt to respond to the HIV/AIDS crisis looks like an industrialized western military operation seeking to correct and remedy all that it perceives as wrong in a local setting. The language of “targeting populations” and “destroying the virus’ capabilities”

contribute to this perception. More problematic, however, are the way these operations often overrun existing infrastructures of local health-care. These problems often arise from a failure to appreciate that healing and health care occur and are determined by local culture.

Four examples from Catholic Ethicists on HIV/AIDS Prevention help highlight how western technology has overlooked local context in HIV/AIDS treatment: Tanzania's Laurenti Magesa writes of the alienation of witch doctors and other African religion leaders from local prevention and treatment programs in his native Tanzania; Mark Miller describes how the failures and successes in prevention strategies in western Canada depended on a direct engagement of first nation communities there; James Good recounts the unanticipated problems that faced those seeking to treat nomads in Kenya; and Paul Farmer and David Walton described the naivete of condom distributors working in Haiti. Many, many other instances abound.³³

Inevitably, the turn to local culture raises a question regarding the quality and humanity of health care: does technology promote or reduce the humanity of health care delivery?³⁴ For instance, the hype that accompanies pharmacological capabilities often becomes more fascinating than the predicament in which HIV infected patients find themselves to be. The Ugandan theologian Emmanuel Katongole has raised a ringing critique of the inhumanity of certain policies that singularly rely on drugs and impoverish the overall tenor of health care in Africa.³⁵ (This is like focusing singularly on condoms without looking at the more comprehensive issues of sexuality, a point made brilliantly by CAFOD's Ann Smith in the Tablet). These critical stances highlight how moral theologians must be vigilant to the possibility that the mode of delivery of much needed drugs could dangerously compromise local values and customs as well as objectify and dehumanize the recipients of care as well as

their care givers. In the light of the stigma still so deeply attached to HIV/AIDS, the question of the humanity and the context of healthcare is paramount.³⁶

Moreover, theological ethicists need to be vigilant also about the research that more and more pharmaceuticals are conducting in the developing world. In 1997, for instance, an extraordinary debate arose over experiments concerning drug programs to inhibit transmission from mother to fetus.³⁷ That debate examined whether there were any grounds for compromising research protocols that normally hold universally. Do dire straits prompt us to suspend standards? If so, who bears the burdens when these standards are compromised? Our vigilance is imperative especially as microbicide investigations get underway.

10. Let Us Bridge the Gap and Become Sensitive Educators of HIV/AIDS

If bridging the gap between unstable and stable environs is what we must do, how do we do it? First, we must advance greater dialogue among advocates of these two very different strategies: those who are bridge-builders and those who are barrier builders. Through education and respectful conversation we must find appropriate means to build common ground, and especially to name and to raise up as models effective bridge-builders. Here I think of Kaleeba, Katongole, Cahill, McDonagh, Fuller and many others already mentioned. But I also think of the work of CAFOD (the Catholic Fund for Overseas Development of the Bishops of England and Wales) through its brave and well-argued attempts to confront the contemporary Catholic tendency to retrenchment and purity as opposed to the risks of mercy³⁸; of Yale Divinity School's Margaret Farley, a Sister of Mercy, who established a circle of women in Africa to share in discourse about their experience of the pandemic and their role as care-givers in it;³⁹ and, finally, of Bishop Kevin Dowling's relentless efforts to move his brother bishops in South Africa to endorse effective prevention strategies and to promote a healthy and realistic discourse on sexuality.⁴⁰

In his attempt to bridge the gaps, Donald Messer confronts the churches' need to advance AIDS prevention. He specifically challenges them to ask whether the messages of mercy, forgiveness and compassion have not been compromised by a barrier-driving agenda of purity, law, and judgment. Messer argues that not only is the welfare of those at risk for HIV infection being threatened by these approaches, but that the very integrity of the Christian character is also being jeopardized.

Messer insists that AIDS is not a dirty word, and exhorts us to follow the example of Jesus. He outlines and examines seven stages to a platform for a call to action: challenge the sexual practices of men; provide behavioral change education for men and women; reach out to the most impoverished women; reject patriarchal structures of church; champion human rights legislation and eradicate gender inequities; help women to protect themselves against HIV/AIDS and receive proper health care; protect the well-being of children.

Echoing both Mary Crewe and Enda McDonagh,⁴¹ Kevin Kelly has proposed a new theology of AIDS and of sexuality that will reawaken us not only to the needs of those infected or at risk of becoming infected, but indeed to the very kenotic essence of the church.⁴²

Toward that end, we need then to draw our attention not only to those at risk, but also to those who create the barriers. We must remind them that for their own sakes they must bridge this gap. This is what the Gospels command, whether in the last judgment of Matthew 25 or in the Lucan Good Samaritan parable. In these and other instances, Christ's fundamental command is to be merciful. And as we see in the Good Samaritan story, the call to be merciful often requires us to sacrifice our desire to maintain purity.

What is mercy? I define it as "the willingness to enter into the chaos of another." I believe mercy embodies the heart of Catholic moral education.⁴³ On this note, then, I close by commenting on the church's merciful historical response in the face of another dangerous epidemic transmitted

through sexual relations wherein instability and barriers played a very important role: the syphilis epidemic at the end of the fifteenth century.

In 1497, the Compagnia del Divino Amore (Confraternity of Divine Love) was founded in Genoa in 1497 by Chancellor of the Republic Ettore Vernazza as a group of laity and clergy committed to working for those suffering from shame: the poor, the prostitute and the syphilitic. Victims of syphilis, having been abandoned both by their families because of shame and by hospitals because of fear of contagion, found a welcome in the confraternity's "gli ospedali degli incurabili" (Hospitals for the Incurables). In 1499 they built the first hospital for the incurables in Genoa. In 1510 Saint Gaetano da Thiene built a hospital for the incurables in Rome at the church of Saint James on the Via Flaminia, so as to care for the pilgrim who fell victim to syphilis on the pilgrimage to Rome! In 1517, the confraternity built "the Hospital of Mercy" in Verona. Shortly thereafter, Gaetano went to Vicenza to reorganize "the Hospital of Mercy" there to serve the syphilitic. In 1521 the ospedale degli incurabili was opened in Brescia. In 1522 Gaetano opened a hospital, still standing today, in Venice. In the same year a Confraternity chapter is founded in Padova and within four years they open their hospital for syphilitics. In 1572, a hospital opens in Bergamo and in 1584 another in Crema.⁴⁴

As did Christians in the early sixteenth century, we also find ourselves confronted with an "incurable disease." No one today remembers the narratives of those who excluded the victims of syphilis by establishing physical or social barriers of protection based on moral judgments of blame. Rather, history teaches us about the self-understanding of those who realized they were compelled by Christ's demand for mercy to identify with the burden of those at risk and to provide them with effective relief, comfort and companionship. They welcomed the incurables into their more stable world.

As educators in a time of HIV/AIDS, we are learning to appreciate the critical importance of attending to the concepts of justice, human rights, the common good, and the option for the poor. If we can be faithful to the need for a broadening and deepening of our approach, assuredly we will be able to develop a more competent and comprehensive strategy that encompasses bioethics, sexual ethics, public health policy and medical care. Similarly, by retrieving the lessons of mercy, we might be able to coax those who are afraid and entrenched in isolation into extending their hands and their resources from their firm centers of stability to those who live unstable lives in unstable settings. That movement, animated by mercy, is certainly what we need today, not only for those living in chaotic lands, but just as importantly for those living in the stable ones like our own.

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