**Stigma and Compassion**

**Religious Responses to HIV/AIDS**

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# Abstract

This document before you is a Bachelor Thesis, conducted in the field of Religious Studies. It concerns the different discourses that have formed around HIV/AIDS, as formulated by religious leaders, and the stigmatising effects these discourses can have. This study was inspired by a statement made by Gillian Patterson, claiming that the discourse of compassion is often deeply stigmatising. The research question therefore asks: What did Patterson mean when she wrote that the discourse of compassion, as formulated by the Roman Catholic and Anglican communities in sub Saharan Africa, is merely another (unintended) way to stigmatize the people infected with HIV/AIDS?

This thesis compares the discourse of compassionate hope to the concept of stigma and the discourses that have been known for their stigmatising effects. The discourses that have been singled out for this purpose are the discourse of morality and the discourse of war. These discourses, along with the discourse of compassionate hope, have been analysed by statements made by Roman Catholic and Anglican church leaders in sub Saharan Africa.

# Introduction

“Let the heathen spill theirs, On the dusty ground. God shall make them pay for, Each sperm that can't be found”

– Monty Python 1983

The text above is part of a musical sketch from the movie *Monty Python's The Meaning of Life.* The song is called *Every Sperm is Sacred* and in the clip that accompanies it, you see a Roman Catholic man in a house full of children. The man together with his sixty-three children, who even occupy the kitchen cupboards, sing about the conviction of the Roman Catholic church that sperm should not be wasted. It intends the position of the Roman Catholic Church that does not approve the use of condoms or the consummation before marriage.

This conviction has larger implications than a funny song in popular media; in fact it plays a major role in the HIV/AIDS epidemic and the prevention thereof. AIDS is a sexually transmitted disease (STD) and therefore the use of a condom could significantly aid in the prevention of the spreading of AIDS during intercourse. This is a well-known scientific fact, but regardless of that, the Pope as a spokesman of the Roman Catholic Church continues to disapprove of the use of a condom and instead propagates what is called the AB method: Abstain and Be Faithful: no sex before marriage and faithfulness within marriage. The implication being that those who comply, will not become infected with HIV or AIDS. As a result, the implication also seems to be, that people who do not conform to these God-given rules, and have contracted HIV through sex, are considered sinners.

This creates a discourse in which the people who are affected with HIV/AIDS are suddenly no longer victims, but, as it were, ‘deserving of their fate’. Being HIV infected becomes something to be ashamed of; this creates a stigma that prevents the affected from seeking help or medical care. This example of the Pope and the Roman Catholic church is one of many examples of how religious leaders can become/act as obstacles to the prevention of HIV/AIDS.

At the same time however, the Christian Church in the form of a wide variety of international and local organisations provides about twenty-five per cent of the care given to the people infected with HIV or AIDS worldwide (Olivier & Paterson 2011, 29). Many Christians perceive it as their religious duty to help the poor and suffering and they believe their God to be compassionate. This compassion must be reflected in His clergy and church, so more and more Christians are urged to be compassionate towards the people infected with HIV/AIDS.

But is this an adequate response to the AIDS epidemic? Gillian Paterson, a theologian, writer and consultant on health and development, does not think it is. In her essay on HIV/AIDS and stigma she claims: “Religious discourses of compassion may be well-meaning but they are often deeply stigmatising” (Paterson 2011, 361). In this thesis I want to test Patterson’s claim with the following research question: What did Patterson mean when she wrote that the discourse of compassion, as formulated by the Roman Catholic and Anglican communities in sub Saharan Africa, is merely another (unintended) way to stigmatize the people infected with HIV/AIDS?

In order to do this research the scope of it will be limited to statements made by religious leaders in sub Saharan Africa. More specifically statements of leaders from the Roman Catholic and Anglican church. Chapter two, after the theoretical frame, will discuss the different discourses of AIDS. This includes both the negative discourses (morality and war) and the positive discourse (compassionate hope).

 The third chapter will focus on comparing the concept of compassion to the concept of stigma. Following with a discourse analysis of the discourse of compassionate hope as found in the statements of several religious leaders in sub Saharan Africa, and a comparison with the negative discourses of AIDS to see what Patterson means when stating that compassion is stigmatising.

As Paterson noted in 2011 this subject needs more exploration, not only does the concept of compassion need to be more thoroughly discussed, but also an investigation is needed what it means to be a compassionate community (Paterson 2011, 361). So, compassion and its effect on stigma need more research but, research has been abundant regarding stigma, and also regarding stigmata in relation to HIV/AIDS (Paterson 2011, Shelp 1987, Frederiks 2011) or stigma in relation to disease (Sontag 1987).

 Therefore the discourse of compassion should be studied in light of the literature on stigma and the different discourses in which these stigma’s are formulated. Literature on the discourse of compassion is scarce, while there is one useful/crucial article for this thesis by Jill Olivier, that analyses the discourse of compassionate hope. Olivier’s article ‘Where does the Christian stand?: Considering a public discourse of hope in the context of HIV/AIDS in South Africa’ (2006) and the thesis defended in it, as tools for detecting stigmatisation processes, will make it possible to answer the research question of this thesis, even without a grand body of literature on the specific subject. The discourse of compassion and compassionate hope are considered as being the same, thus from hitherto the discourse will be called the discourse of compassionate hope.

# Chapter 1: Theoretical Frame

The purpose of this theoretical frame is to shortly elaborate on the chosen methods of research used in this thesis. Shortly because they are rather obvious and mostly the same throughout the whole thesis. In addition, this section of the thesis will be used to define some of the key-concepts that will be used throughout. This concerns the concepts of stigma and compassion. This theoretical frame will also follow up on the setting of boundaries for this research as hinted at in the introduction. The subjects will be handled in the same order as in this introduction.

## Type of Research

The research of this thesis will be conducted through qualitative research. As Steiner Kvale makes clear, qualitative research is about meaningful relations to be interpreted (1996, 11). Since the present thesis tries to interpret the connection among HIV/AIDS, stigma and religion this line of research seems to be the best qualified. Qualitative research entails a set of tools that is convenient for use in regard to this thesis, namely: textual analysis (of scriptures, theological debates or academic literature) and discourse analysis (of church leaders or newspapers articles).

Restricting this thesis to these methods of research is most convenient and logical due to the time frame of this thesis and its purposes. The literature on the other hand will not be restricted to one discipline. Because, like African theologian Agbonkhianmeghe Orobator says “To treat HIV/AIDS simply as a medical matter is an oversimplification” (Orobator 2010, 9). The subjects of this thesis concerns an interdisciplinary problem that benefits from insights from social, ethical, theological, philosophical and cultural studies. This is also in line with the concept of qualitative research since it is mostly interdisciplinary, interpretive, political and theoretical in nature (Brennen 2013, 4).

Even though the literature that is used comes from a variety of disciplines, the thesis is positioned in the field of religious studies. With the field being interdisciplinary in nature this should be no problem. Since this thesis will be studying Christianity in an African context we will be studying World Christianity which entails paying attention to how a wide range of issues like politics, culture, migration, globalisation, shape and transform Christian individual and collective identities and practices in the changing modern world (Irvin 2008, 1).

## Stigma

Central to this thesis is the concept ‘stigma’; therefore, before proceeding with the research question, the meaning of stigma should be explored. The Greek word ‘stigma’ in its original meaning meant the branding of the slaves with a sign of their inferior status and with details of their owners (Paterson 2009a, 7). Thus a stigma can be seen as a tool to keep a certain group in an inferior status, which aims at making it harder for them to escape their situation. The Dutch Van Dale dictionary gives a similar meaning, defining stigma as “something that degrades one’s reputation”.

Stigma’s differ from stereotypes and discrimination. Stereotypes can be both negative and positive and are used to explain social events or the behavior of the other group (Tajfel 1981). Since stereotypes do not necessarily degrade one’s reputation they differ from stigma. Stigma also differs from discrimination because stigmas are (often) related to deeply held cultural or social norms while discrimination is dynamic and maybe even a result of existing stigmas (Patterson 2009a, 8). Discrimination and, thus victimization as well, are causal effects of stigma rather than sides of the same coin.

Stigma’s derive from cultural and social norms like those prescribed by a church. In the case of HIV/AIDS, a number of churches have constructed HIV/AIDS as a moral issue instead of a public health issue (Patterson 2009a, 4). In doing so these churches contributed to the creation of certain stigmata. Religion is often used as a way of reinforcing or ritualizing the boundaries of taboos and thus placing them within a supernatural context. In this way the stigmatising beliefs are deeply embedded in the minds and daily lives of the community and are thus part of people’s identities (Patterson 2009a, 4). Because “what stigma does is to set people apart: the HIV-positive from the HIV-negative, the clean from the unclean, and above all ‘them’ from ‘us’” (Patterson 2009a, 6). It is in this way that the fields of stigma, religion and HIV/AIDS intersect.

In order not to get lost in the grand body of literature that is written on stigma and HIV/AIDS, the analysis of these stigmata and the discourses on HIV/AIDS will be limited to 4 categories of discourses which have been formulated after studying Martha Frederiks’ essay ‘Statements by religious organizations on HIV and AIDS: Intersecting the public realm’ (2011), Susan Sontag’s book *AIDS and Its Metaphors* (1987) and Gillian Paterson’s essay ‘HIV, AIDS and stigma: Discerning the silences’ (2011). These text all concern the different realms of the discourses of AIDS, sometimes in line with each other and sometimes differing. In the following table one can see the differences and similarities:

|  |  |  |
| --- | --- | --- |
| **Frederiks** | **Sontag** | **Paterson** |
| Morality | Defilement | Sex and sexuality |
| War | War | War |
| Hope |  | Compassion |
|  | Risk Groups | Economic and Social marginalization |

Therefore these are the discourses that will be used and described in this thesis. Surely there are more discourses and more framings of HIV/AIDS but this thesis has decided upon these four. Firstly AIDS will be considered in the framing of a socio-economic problem with a description of the groups that are seen as high-risk. This will be done within this chapter. Then, in chapter two the discourses of morality, war and compassionate hope will be discussed and analyzed to see why and how they can be stigmatising.

## Compassion

Another concept central to this thesis is ‘compassion’, thus this concept will be explored in a similar way as done above with the concept of stigma before proceeding with the body of this thesis. The word of compassion comes from the Latin ‘compassio’ composite of com (meaning: together) and passio (meaning: to suffer), compassion therefore would mean to suffer together. The Dutch Van Dale dictionary translation seems to confirm this. The World English Dictionary describes compassion as “a feeling of distress and pity for the suffering or misfortune of another, often including the desire to alleviate it”.

 Compassion is often translated in pity, spare or mercy. However, Patterson argues that compassion is not the same as pity, which implies condescension towards the person who suffers, because compassion is neither condescending nor patronizing and should be “an intelligent long-term commitment to seeing the person brought back to the fullness of life and restored to their own community” (2009b, 32).

 The teaching of compassion in the Christian tradition are frequently attributed to the teachings of Christ and the ‘Good News Gospel’, which proclaims that a new and inclusive community is already here (among and within us) instead of being for away (Luke 17:21). Christ is highly esteemed for his compassionate lifestyle and teachings of the Golden Rule of “Do unto others what you would like others to do to you”. The Gospels shows how Jesus reached out to ‘sinners’ and the vulnerable without judgement (Armstrong 2011, 47-8). Therefore all his followers should do the same.

 In the Christian tradition compassion, thus, is both a divine and a human quality. Not only Jesus but also God is compassionate to His people. Therefore expects His people to be compassionate towards others. This can be both their fellows, a foreigner amongst them or the sinful men. But, especially the poor/the weak, like the fatherless, the widows, and also those in poverty or the afflicted (Douglas 1980, 308, Hastings 1963, 774). Others do not describe compassion solely as a duty to God but also as a natural impulse and therefore as a duty to oneself (Mertens 1968, 83-8).

Thus it seems pretty clear that the people of God are to be benevolently disposed to the their fellows, the weak, the poor or the other. These groups are often accumulated into the notion of the vulnerable, which stand for the “easily wounded” . They are vulnerable because they are indeed weak, poor, sick, unable to cope or stigmatised by the majority of the population (Patterson 2009b, 51). Jesus Christ had compassion for these vulnerable ones, because they were ‘like sheep without a shepherd’ (Mk. 6:34).

Some groups are more vulnerable than others in the context of HIV/AIDS, these are mostly women, but others include migrants, refugees, asylum-seekers, prisoners, drug-users, street children, sex workers, transgendered people and men who have sex with men (Patterson 2009b, 52) In the following text of this chapter the characteristics of AIDS in sub Saharan Africa, its spread and the contextual vulnerable are explored.

## Sub Saharan Africa (SSA)

The discourse analysis in this thesis will be limited to the written statements made by Roman Catholic or Anglican church leaders in sub Saharan Africa. This is because of the high prevalence of AIDS and the large amount of Christians in this area. Of all the people living in sub-Saharan Africa 63 percent is now Christian, this makes up for about one-in-four of all the Christians worldwide (Pew Research Center 2011).

Sub Saharan Africa is a group of countries geographically situated south of the Sahara Desert. Most of those countries are developing countries. The region that is called SSA therefore consists of most of the countries on the African continent except for those officially belonging to the Arab World/bordering the Mediterranean Sea and has an population of 910.4 million (World Bank 2013). Image 1, situated below will clarify the countries that are part of SSA:



1 Map of Sub-Saharan Africa| Source: Progress in Palliative Care 21(1).

Since the initial upsurge of AIDS the disease was mostly associated with the 4 H’s groups, which were homosexuals, heroin addicts, (w)hores and Haitians. But, now SSA is the region that is most infected with HIV/AIDS en the infected are mostly common heterosexuals. With less than a seventh part of the world’s population (round and about 14 percent) SSA accommodates 70 percent of all the people living with HIV worldwide and suffers 90 percent of its deaths. Stigma, fear and ignorance play an important role in the spread of and death by this disease (WHO 2013). The following figure shows the initial spread of AIDS under adults in sub Saharan Africa from 1984 till 1999:



2 The spread of AIDS among 15-49 year olds in SSA| Source: *The Global Impact of AIDS*

As can be seen the initial spread of HIV/AIDS has been pretty rapid. But in recent years the number of new HIV infections has declined. This becomes apparent in the following figures of the Global AIDS report of UNAIDS of 2013:



3 Declining numbers of new HIV infections | Source: UNAIDS 2013

The decline in new HIV infections has indeed also resulted in a declining percentage of people infected with HIV/AIDS as figure 4 indicates. Note however that figure 2 concerns a population of 15 to 49 year-olds while figure 4 only concerns 15 to 24 year-olds. Nevertheless the figure is still portraying a declining trend in the number of HIV-positive people.



4 Percentage of 15-24 year-olds with HIV in SSA | Source: UNAIDS 2013

Even though the numbers are declining, they are still very high in comparison to the rest of the world. One can imagine the devastating effects AIDS must have on the population, since almost everyone is likely to have an infected person among their family or friends. If stigma and fear are preventing the sick for getting better and are causing healthy people getting infected, it becomes clear that the breaking of taboos and stigma are necessary to prevent a growth of the infections. It is because of this that SSA is chosen as the focus for this thesis.

In SSA HIV/AIDS is mostly transmitted sexually, and then again mostly through heterosexual sex. It is argued that this happens because of cultural norms that govern the sexual behaviour of the people. One of these cultural norms is that you don’t talk about sex which may/can enhance the spread of HIV/AIDS. This is one of the ways in which religion contributes to the spread of AIDS by reinforcing cultural norms and taboo’s (Patterson 2011, 350). In other instances the spread of HIV/AIDS in SSA is explained through certain African sexual practices of which some are part of the African traditional culture and others that are based on stereotypes of unrestrained African sexuality, formulated on myths and colonial notions of the continent. More nuanced are the notion of some who, like Nyokabi Kamau author of the book *Researching AIDS, Sexuality and Gender*, argue that most of these cultural norms are fortified by deep-rooted gendered power dynamics (2011, 267)

In most of SSA, gender relations are unequal, with women having fewer rights and less access to education, training, income, property and health services and no or little say in sexual matters. This influences both their access to information about HIV/AIDS and their knowledge on how to prevent infection (Kamau 2011, 258). The highest infection rates can therefore also been found in cultures where women have little decision-making power over their sexual behaviour. Globally, 52% of all people living with HIV in low- and middle-income countries are women, However, in sub-Saharan Africa this number is estimated at 57% (UNAIDS 2013, 78).

 This can be explained by the common notion that men are culturally allowed to have extramarital sex while women are not. HIV infection among men is strongly associated with their sexual behaviour, or more accurate their voluntary risky sexual behaviour. While the infection of women is found to result of socio-demographic characteristics such as low income, low education, living alone or not being able to negotiate safe sex within a marriage, because asking for a condom would show a lack of trust (Kamau 2011, 259-60).

As becomes clear not only gendered power relation but also poverty is a central issue to the spread of AIDS, since it are the economic or social marginalized groups that get infected with HIV faster. Sub-Sahara Africa can be considered as one of the poorest regions of the world. An estimated 50 percent of the population have to make ends meet with less than $1,25 a day (UN Report 2011, 6). Women are one of these impoverished and marginalized groups, but others entail homosexuals in homophobic societies (secrecy as mentioned above), heads of families forced to migrate for employment and those at home who wait for them (women living alone as mentioned above) (Patterson 2011, 359). Women are not only susceptible to getting infected within the marriage but most specifically when forced into prostitution by poverty. In this way many young girls and women become infected.

Another cause for the spread of AIDS in sub Saharan Africa are the civil wars that ravage the continent. In some regions warfare has known a systematic use of rape or forced impregnation as tools of war for centuries (Brownmiller 1989, 31) and this is also prevalent in the civil wars in SSA. It is like the former United Nations Force Commander for the Eastern Democratic Republic of Congo declares “it is now more dangerous to be a woman than to be a soldier in modern conflict” (Cammaert 2009). Mass rapes are often carried out with the aim of total destruction of communities through the bodies of women. Soldier sometimes deliberately spread AIDS because this will not only disrupt or destroy the current community but also the next generation (Taylor 1999, 43).

But sexual violence during wars is also embedded in the gendered culture as mentioned above. Since one of the theories concerning sexual violence during war time is called the patriarchal militarism theory. This theory proposes that during wartime, sexual violence is motivated by the desire to exert control and power over women and men who are perceived as feminine. Sexual violence is by thus seen as a by-product of the patriarchal society where power relations are hierarchal (Carlsen 2009, 481).

So gender inequalities seems to contribute greatly to the spread of HIV/AIDS in SSA. No surprisingly therefore the stigma’s of AIDS are also gendered because disease and uncleanness are associated with women’s bodies, in some communities STD’s are referred to as women’s diseases and most of the times women are seen as the transmitters of HIV (Dube 2004, 11).

In this chapter the concept of stigma and of compassion have been discussed. Next to that the theoretical approach has been described and defended, just as the most important literature that has been used in this thesis. Followed by an explanation of the chosen case study and the reasons of the spread of HIV/AIDS in that area. With all this done and out of the way it is possible to focus more on the stigma’s of AIDS. Therefore this is the next step this thesis will undertake and it will be done by discussing the discourses of AIDS in the following chapter.

# Chapter 2: Discourses of AIDS

“What hope remains for us to combat an evil as fearsome as AIDS?”

- Kanyamachumbi 1992, 38

## Introduction

According to Gillian Paterson it is shame rather than illness, that kills in the case of HIV and AIDS. She hereby alludes to the existing stigmas that surround the disease. These stigmas have a great influence on the lives of the people living with HIV/AIDS (PLWHA). In this chapter some of the discourses of HIV/AIDS that contribute to shaping these stigmata will be discussed. The focus in this thesis will be on the discourse of morality, the discourse of war and the discourse of hope and compassion. In the short statement above one can find elements of all these discourses. There is talk of hope (although in a negative form), AIDS is compared to something evil and the use of the word combat hints at the discourse of war. These three discourses will be discussed more elaborately in the chapter below, starting with the discourse of morality, followed by the discourse of war and the discourse of hope and compassion.

## Discourse of Morality

In her book *Aids and its Metaphors* Susan Sontag, a well-known writer and political activist, remarks: “There seems to be a need within a society to have an illness at hand which can be identified to evil and which puts the blame with those who are infected by it” (Sontag 1989, 104). In the case of HIV/AIDS, the sick are seen as deserving of their fate as a consequence of their behaviour. Disease and stigma thus seem to be inextricably linked to each other.

We have seen before that stigma is contextual and deeply rooted in cultural or religious values. Stigma therefore is often connected to the convictions of the nature of God and how we should live our lives (Paterson 2011, 350). What is seen as punishable behaviour is therefore also contextual. When the AIDS epidemic first struck, mostly homosexuals, prostitutes and drug users were infected. These groups were already considered ‘sinners’ in the eyes of many, so therefore it is not so difficult to imagine that a discourse developed in which the infected themselves were blamed for their fate (Patterson 2011, 352). An attitude like this one fits within the discourse of morality as is explained by Martha Frederiks. This discourse connects HIV and AIDS to individual behaviour and is dominant – amongst others - in the Roman Catholic and Russian Orthodox Church (Frederiks 2011, 121).

According to Philippe Denis, a professor in History of Christianity, religion influences the discourses of HIV/AIDS in two ways. Firstly religious institutions contribute to the perception that HIV infection is caused by individual behaviour, like mentioned above. And secondly they propagates the idea that HIV is moral problem (Denis 2011, 60). Which means that they both individualise and moralize the problem. This framing also suggest that individual behaviour is a free choice, which is, as mentioned in the theoretical frame, not always the case; at times the infection is the result of for instance gender violence, wars, poverty and inequality.

 In the most extreme forms of moral discourse, this discourse considers HIV/AIDS to be a divine punishment, also known as ‘retribution theology’. Though it is commonly frowned upon nowadays, there was a time when AIDS was seen as God’s personal punishment for those who did not conform to his laws. This was the case in particular with regard to homosexuals; in the early years AIDS was commonly referred to as the ‘gay disease’ (Shelp & Sunderland 1987, 19). Jerry Fallwell founder of the Moral Majority, a right-winged Christian political organization, called AIDS “a lethal judgement of God on America for endorsing this vulgar, perverted and reprobate lifestyle” (Fallwell in Shelp & Sunderland 1987, 19). This no longer is a widely shared/ accepted point of view and thus few people believe nowadays that AIDS is a punishment of God. However, they still are convinced that AIDS is a moral problem and that the disease is caused by individual immoral behaviour.

 This variation of the discourse of morality can be seen as the milder form, which takes its point of departure in the conviction that God does not want its people to suffer. But this type of discourse does reiterate the conviction that the lack of adherence to God-given sexual norms is the cause of the disease. This becomes apparent from the following quote of the Primates of the Anglican Communion: “AIDS is not a punishment from God, for God does not visit disease and death upon his people: it is rather an effect of fallen creation and our broken humanity” (Primates of the Anglican Communion 2003).

In quotes like the one above, HIV/AIDS is no longer framed as a punishment of God, but as a punishment for *behaviour* that violates accepted social conduct and therefore moral judgement is passed on the sick (Manda 2011, 203). HIV/AIDS infection is seen as a product of adulterous life, and sexual promiscuity is judged because it is considered contrary to a Christian lifestyle (Kamau 2011, 267). This is confirmed by the following quote of the Catholic Bishop Slatterly of South Africa:

AIDS is the price we may pay for the ‘benefit’ of the permissive society, which helped by the pill, liberal legislation [etc.] has demolished the last defences of sexual restraints and discipline (Slatterly 2001, 75).

Even nowadays the discourse of morality that connects HIV/AIDS with sin is present in sub Saharan Africa, be it in a less feisty manner and mostly in statements from the Roman Catholic Church, focused on the use of contraceptives and the making of responsible choices. The RCC in sub Saharan Africa emphasizes the dangers of promiscuity and stresses the need for renewed teachings on Christian sexual ethics, marital fidelity, self-discipline and abstinence from premarital sex (Frederiks 2011, 121).

Strict adherence to Christian sexual ethics it is argued, would prevent a further spread of the disease. As mentioned before the Catholic church fervently condemns the use of condoms, by arguing like the Catholic Bishops of South Africa that: “The promotion and distribution of condoms as a means of having so-called "safe sex" contributes to the breaking down of the moral fibre of our nations” (Catholic Bishops of South Africa 2001). The translation of these Christian ethics into public policy has lead to the propagation of the so-called AB-method, meaning Abstain and Be faithful, claiming that this approach “is the human and Christian way of overcoming HIV/AIDS” (Ibid).

Other religious institutions, like the Anglican church, that have not condemned or banned the use of condoms in the way the Roman Catholic Church has, has a slight variation on this method, known as the ABC-method: Abstain, Be faithful and Condomize. The Anglican primates defend the use of condoms by saying “We know that condoms can save lives and prevent the spread of the virus. The morality of condoms is about preserving life” (Anglican Primates 2002). Hence if one abides to these moral rules (whether you include condom or not), one will not get infected with HIV/AIDS. This is the essential meaning of the discourses of morality.

## Discourse of War

In the concluding chapter of her book *AIDS and its Metaphors* Sontag expresses her concern about what she perceives to be the most destructive metaphor in relation to disease, being the ‘war’ metaphor. In Sontag’s opinion the war metaphor leads to “overemotional and unnecessary exaggerations of perceived threats”. The war metaphor is also a motor behind the excommunication and stigmatisation of the ill (Sontag 1989, 182).

 But what exactly is this war metaphor in relation to HIV/AIDS? Emmanuel Katongole, an associate professor at the University of Notre Dame gives the following explanation: “The rhetoric of a ‘war on AIDS’ sustains the impression that HIV/AIDS is a temporary if serious nuisance that will eventually be overcome” (Katongole 2007, 169). The following quote of the Roman Catholic bishops of Ivory Coast who are dreaming about the *conquest* of AIDS, exemplify what Katongole means: “I have this astonishing dream, of a day which I hope will come very soon when all those who marvel that they have vanquished the scourge of AIDS will shout a ‘Eureka!’ of final *victory* in an enormous concert of horns and drums” *[emphasis added]* (Catholic bishops of Ivory Coast 1997, 51). The bishops regards the epidemic as a temporary problem that can be conquered, which will be ‘a victory’. In other examples of the discourse of war people are often asked to ‘join the fight’ against AIDS, or help the world be ‘liberated’ from HIV/AIDS. Furthermore, military terms are used when speaking about ‘mobilising workers’ or ‘set up and equip units’ (Frederiks 2011, 122).

 The discourse of war can be found on three different levels. For instance it is used in a biological level which portrays the virus as invading the body. The second level can be found in talk of prevention and treatment strategies. This can be seen in statements like mentioned above about ‘mobilising workers’ etc. The third level is in a broader context of world powers, which is put in a terms of imperialism of the US over Africa. All three of these levels will be explored, starting with the first biological level.

According to Sontag the metaphor of war is used when an illness is seen as ‘the enemy attacking the body’ with its foreign viruses. The response of the human body to this ‘foreign invader’ is also embedded in military terms: the body ‘mobilises’ its immune system who starts ‘fighting’ the virus. There is a certain “science fiction flavour” because the invasion of the virus is often formulated in ways an alien invasion is narrated in science-fiction films (Sontag 1987, 106-7).

When the illness concerns not just an individual but when more people are affected, the disease becomes something that is ‘attacking the nation’ resulting in a discourse of war, where the nation must ‘fight to save’ the ill from death and prevent the healthy from being infected. This is the second level of the discourse of war, which is nicely illustrated in the following statement of the Catholic Bishops of Zambia: “The HIV and AIDS pandemic continues to *devastate* families in Zambia and is still one of the greatest *threats to our survival* both as a nation and as a continent” (Catholic Bishops of Zambia 2012). HIV/AIDS, devastating like a war, is seen as a threat to survival of the nation and even the entire African continent.

The metaphor of war in this level provides a sense of urgency, which in turn legitimizes desperate measures. This sense of urgency is exactly what one needs in order to make a change and instigate collective action (Sontag 1989, 99). So therefore the discourse of war is often used in combination with talk of prevention and treatment strategies. Like Sontag mentions, the war against diseases is basically a metaphoric appeal for a concerted effort and knowledge to cure the sick and keep the healthy ones from being infected (Sontag 1989, 99). The sociologists Robert D. Benford and David A. Snow, who specialise in framing processes and social movements, would classify calls such as the ones mentioned above, into what they call ‘the motivational frame’. Motivational frames are something like a ‘call to arms’. It is the last step to collective action, which propagate a sense of severity, urgency, efficacy and propriety, resulting in a now-or-never moment for actual action (Benford & Snow 2000, 617). This discourse of war with relation to HIV/AIDS and this motivational frame are also apparent/evident in statements of African religious leaders. The following statement of the Catholic Bishops AMECEA can serve as an example:

We are greatly concerned by the magnitude of the HIV/AIDS pandemic [...] We call upon all the people of God to radically change their sexual behaviour, as the fully assured means to fight against HIV/AIDS (Catholic Bishops of AMECEA 2002, 87).

Again a sense of urgency is formulated within the statement as well as the sense that the actions should be radical. This need for radical measures confirms the metaphor of war, since desperate times, like war, call for desperate measures. This statement, with the mentioning of sexual behaviour, is also an example of how the discourse of war can be used in the discourse of morality. Other ‘calls to arms’ can be found in the statements of the Bishops of Cameroon:

The bishops of Cameroon are appealing to the entire community, the government authorities and ordinary citizens from all walks of life to resolutely strive for concerted and concrete action in the fight against AIDS”( Catholic Bishops of Cameroon 1999, 60).

The bishops of Cameroon repeat the notion that to overcome AIDS everyone should join the fight against the disease. In this statement the religious community, the government and ordinary citizens are all asked to join, but many other statements are not that inclusive, rather exclusive because, as in most wars, polarization occurs.

In relation to AIDS this polarization happened in various ways. First of all the virus is seen as something foreign that is invading the nation/continent. This idea, which is the third level of the discourse of war, contributes to a power struggle between the First- and the Third World. Americans claim the virus comes from Africa, while on the other hand the Africans claim it was the US who generated the virus in a laboratory. This theory of conspiracy claims that the US wanted to control the African population growth with AIDS, but that the plan backfired when homosexual American priests who were accidently infected returned to the US (Sontag 1989, 140). These theories builds upon the already existing divide between the First- and the Third World, between the Centrum and the Peripheries. Katongole agrees with this view saying that the epidemic is a sign of larger global injustices in politics, economics and resources and should, therewith not be seen as an event in itself but as a part of global relations (Katongole 2007, 169).

 The second polarization occurs between those who are sick and those who are not. This has to do with the blaming of the ill for their disease. According to Sontag this is an integral part of the discourse of war. Saying, “The metaphor implements the way particularly dreaded diseases are envisaged as an alien ‘other’ as enemies in a modern war; and the move from the demonization of the illness to the attribution of fault to the patient is an inevitable one, no matter if patients are thought of as victims” (Sontag 1987, 99) . This means that even if the patients are seen as passive victims, they are still attributed blame as a logical consequence of the discourse of war. Thus, even without the discourse of morality, the AIDS-victims would have been blamed through the discourse of war. In the case of HIV/AIDS the patients are blamed by both discourses.

## Discourse of Compassionate Hope

Sontag thus claims that the discourse of war leads to the polarization of the sick and those who are not, often formulated as ‘them’ and ‘us’. But, Gillian Paterson claims that this polarization does not only happen in the discourse of war, but also in the discourse of compassionate hope. Before this thesis can elaborate further on Paterson’s bold claim, the discourse of compassionate hope will be discussed in a similar fashion as the two discourses above.

The discourse of hope, which has appeared as a reaction against previous stigmatisation and Othering (Olivier 2006, 91), is mostly based on the Theology of hope, as formulated by the South African theologian Thinandavha Derrick Mashau. It seeks to stand in solidarity with the people that are infected with HIV/AIDS and wants to provide them with hope, that can enable them to deal with their present state (De Grunchy 2011, 180). It is grounded in the ideas of the life, suffering, death and especially the resurrection of Christ. The Cross was not the end for Jesus, therefore HIV/AIDS is not the end for the infected. The discourse of hope wants to make the infected believe in a new, positive life that will bring new possibilities (Patterson 2009b, 54).

This hope, thus, consists of the notion that one can still live positively with HIV/AIDS. It should inspire the notion that death is not the only possibility for the infected and should remind one that there is life after death. Subsequently hope supports that the PLWHA should not feel alone or abandoned. In fact Christians are urged to walk in solidarity with the infected.

The discourse of hope is mostly prominent in texts with a Christian view more particularly in statements of Anglican church leaders. The Anglican church sees it as its mission to fight the existing stigmata, stating that:

Our Church is not in the business of judgment. Judgment belongs to God! Ours is a loving God. As the Church, we are called to be mirrors of God's mercy and heralds of God's compassion. Churches are places of love, acceptance and hope (Council of Anglican Provinces in Africa 2002).

This statement argues that the church should not be judgemental towards the people infected with AIDS, instead the church should be compassionate. Hope and compassion are often treated as being the same, or at least being means to same end. This is confirmed in the following statement of the Catholic Bishops of Sudan:

As a faithful teacher, the church must instruct and give support to the practice of the virtues of compassion, love, healing, reconciliation and hoping, knowing that these are healing values for people suffering from this disease (Catholic Bishops of Sudan 2005)

In this statement compassion and hope are seen (among other things) as healing values. Like hope, compassion is about solidarity and caring for the less fortunate in a giving society. Hope can thus be a means of compassionate care.

This can be explained by either linking hope to the will to live, which makes hope into a health resource (Olivier 2006, 90), or to the overall happiness of a person, since some claim that the best healing occurs when the PLWHA know that they are accepted and unconditionally loved instead of stigmatised (Demissie 2008, 9). Compassion fits into the discourse of hope as the unconditional acceptance of every human being, infected or not, as a member of the community and as a child of God. This becomes apparent in the following quote: “In whatever manner the AIDS was caused, the person stricken with AIDS is always a human being, with all the rights of any man or woman” (Bishops of Angola and S. Tomé 2002) In the statement above it is made clear that everyone, including the people infected with HIV/AIDS, are a human being, made in the image of God, and therefore part of the community. This shows the compassionate component of the discourse of hope.

Herewith, Jill Olivier distinguishes the discourse of hope from the discourse of compassionate hope. This version of the discourse is a combination of compassion and the discourse of hope as illustrated above. This version is most prominent in the mainstream media and statements of the religious leaders(Olivier 2006, 91). Compassionate hope therefore has extended (or at least tried to extent) the discourse of hope to those who hitherto were considered as sinful. This is illustrated in the following quote:

To all who are infected or affected by HIV/AIDS we address a message of hope. You can still live positively with AIDS. The church will strive to sustain you in your difficult struggle [...] We therefore encourage everyone to overcome fear and shame and come out to be tested and receive the necessary care and treatment. Life can go on positively for those who dare join the life-serving program of HIV/AIDS (Catholic Bishops of Sudan 2005).

Statements of compassionate hope, like these, try to move beyond stigma and Othering by inviting the people that are infected to come and join.

In the context of HIV/AIDS hope should not solely be seen as an emotion but as part of a discourse which is socially constructed (Olivier 2006, 83-4). Because at first the AIDS victims were portrayed as hopeless and with the emergence of the new discourse of hope the same people are now supposed to have/find/hold onto/not lose hope (Olivier 2006, 89). Hereby the experiencing of hope is formulated as an individual challenge, so like the discourse of morality the discourse of compassionate hope individualizes.

## Conclusion

Three of the many different discourse of AIDS have been brought under attention the this chapter. An attempt has been made to discuss these discourses separately, while at the same time showing some of the overlaps. Of course in reality these divides are not as clear-cut nor black and white, but often these discourses intersect or are used at the same time, as illustrated in the opening quote.

The discourse of morality in essence is about attributing the infection with HIV/AIDS to individual behaviour. The claim is that this individual behaviour in immoral and the discourse thus makes HIV/AIDS a moral issue. It both individualizes and moralizes HIV/AIDS. The discourse of war is the use of military terms and metaphors in the statements on HIV/AIDS. This is done at three different levels. Namely, first as the alien infection attacking the body’s immune system. Secondly in the statements made on prevention and treating strategies. Finally the discourse of war is formulated in power struggle between the US and Africa in the context of HIV and AIDS. The discourse of war polarizes the US from Africa, but also on an individual scale it separates the healthy from the infected, the ‘us’ from ‘them’.

The discourse of compassionate hope combines the discourse of hope with the concept of compassion. Hope consists of the notion that one can still live positively with AIDS, that an infected person is still a complete human, that death is not the only possibility for the infected and that the PLWHA should not feel alone or abandoned. Compassion in this case means the unconditional acceptance of every human being, infected or not as God’s child and a member of the community. But the discourse of compassionate hope also individualizes, just like the discourse of war. This individualizing aspect is one of the downsides of the discourse of hope according to Olivier (2006, 89-90).

In the next chapter this will be elaborated on, among other things, to establish what Patterson meant by writing that the discourse of compassion is stigmatising.

# Chapter 3: The Ambiguity of Compassionate Hope

“The battle against AIDS ought to be everyone’s battle”

- Catholic Bishops of Zimbabwe 1998

## Introduction

In a world that needs compassion so desperately “we” have failed to live up to these ideals accordingly to Karen Armstrong, writer of the book *Twelve Steps to a Compassionate Life*, “our” inability to do so may have contributed to the increased sum of suffering in the name of religion (Armstrong 2011, 2-5). While the discourse of compassionate hope seems to be formulated with the best intentions to right the previous wrongs of stigmata, Gillian Patterson argues that, nevertheless, the discourse still is stigmatising and thus that “we” have failed to be truly compassionate (Patterson 2009b, 33). This chapter investigates how something that is intended to be positive (compassion) results in something quite different. This will be done through discourse analysis, which will show in what way the discourse of compassionate hope can contribute to stigmatisation of the persons infected with HIV/AIDS.

 As seen before stigma can be explained as an image or label that degrades one’s reputation. It is a sort of label that is attributed/attached to a person which keeps the person in his/her inferior place. Furthermore stigma creates a gap between those stigmatised and the rest. Stigma’s derive from cultural and social norms like those prescribed by a church. In the case of HIV and AIDS, as we have seen, stigma separates the HIV-positive from the Church and the rest of the community. In this chapter these characteristics of stigma have been used in order to establish if the discourse of compassionate hope has indeed contributed to stigmatisation. Starting with an analysis of the message of the discourse of compassionate hope, followed by an analysis of the vocabulary of the discourse.

## The Message of Hope

As seen in the previous chapter the message of hope consists of the reassurance that one can still life a full and hopeful life with HIV/AIDS. The statements intend to underscore that infection does not solely mean death and even if death is imminent, that there is life after death. Above all the messages intend to communicate that that the people living with HIV/AIDS are not alone and need not feel abandoned. Only, one can rarely find messages of hope that contain solely this. Suffering is, still, often seen and described as a deserved punishment for sin. Even in the statements of the religious leaders emphasising compassion, it becomes apparent that they continue to attribute sin to the people infected with HIV/AIDS, by stating or implying that they deserve compassion despite their past sins. This becomes prominent in the following statement of the Catholic Bishops of Kenya:

We are particularly distressed by the stigma attached to people living with AIDS and their families. We call upon all Christians to overcome any prejudice they feel towards AIDS victims. Even when contracted through immoral behaviour (Catholic Bishops of Kenya 1999, 61).

This statement calls upon the ‘good’ Christians to be compassionate towards AIDS victims, but still judges these victim by saying that they ‘deserve’ compassion *despite their ‘immoral behaviour’*. Compassion then does not lose the judgmental tone of the discourse of morality.

This judgemental tone can be found in more statements, like for instance in the ‘Declaration of AIDS’ by the bishops of Cameroon. They start their declaration by explaining that God is compassionate and that the Christian community should follow His example, but when explaining the source of AIDS they fall back into judgemental statements by claiming “Immunodeficiency goes hand in hand with moral deficiency” (Catholic Bishops of Cameroon 1999, 59-62). Statements like these still connect words such as ‘sin’ to the behaviour that leads to the infection of HIV/AIDS, even though it encourages compassion and openness which would mean the eradication of stigmata. Instead it continues to contribute to the formation and endurance of stigma.

These cited statements of suffering, infection by HIV as deserved punishment for sins and of AIDS as an example of this deserved punishment, thus make the discourse of compassionate hope ambiguous. In general the discourse of compassionate hope still links infection with promiscuity and sees HIV/AIDS as a punishment for this sexual misconduct. This results in statements with mixed message stating that Christians should be more compassionate, while at same time re-affirming the conviction that those at the receiving end of the compassion are not truly worth this compassion, for they are sinners and the infection is the result of their own objectionable behaviour.

The following message of hope also contributes to this stigmatisation by insinuating that the people infected with HIV/AIDS have strayed from God’s chosen path by promiscuity and a ‘condom mentality’:

We will expand our programmes of HIV/AIDS awareness to stem this pandemic, and through sermons and pastoral letters, instil in our people a compassionate response to those suffering from this condition. In place of a condom mentality, we advocate a return to God’s plan for human sexuality which demands pre-marital continence and fidelity in marriage (Catholic Bishops of Nigeria 2001, 69).

With this statement the Bishops of Nigeria suggest that if one would follow God’s rules of “pre-marital continence and fidelity in marriage” one would not get infected and that indeed the “condom mentality” has corrupted human sexuality. This is a good example of how the discourse of compassionate hope is connected to the Catholic policy of the AB-method (Abstain and Be faithful) and therefore to the discourse of morality. Again it is confirmed that the behaviour that lead to the infection is not considered as good/Christian behaviour. Moral judgement thus prevails.

The debate on condoms resurfaced when in 2010 Pope Benedict XVI stated, in his book *Light of the World*, that condom use could be justified in certain situations, like for instance by prostitutes who are HIV-positive, who might use condoms as a first step towards moralisation and responsible behaviour. This is a big step for the Roman Catholic Church, who prior condemned condoms fervently. The Pope continues by explaining that condoms are still not the true and proper way to overcome HIV/AIDS, so this progressiveness is still full of judgement. What is necessary instead, according to the Pope, is ‘the humanisation of sexuality’ (Catholic News Agency 2010). These statements, which are still connected with judgement and morals, are therefore still stigmatising because they connect the disease and condom use with sin and promiscuity, even though they are progressive as well.

 As one might guess, this conditional acceptance of condoms has not had a great influence on the local Catholic Church leaders in sub Saharan Africa. As Caroline Teti, a sexual and reproductive health advocate working with civil society initiatives in Kenya, claims: “Local Catholic officials still fail to consistently support condom use as a means to protect against HIV transmission”, instead they still offer information alone and thus promote abstinence and faithfulness. According to Teti, this is due to the prevailing stigma, fear and shame on the disease, especially in Catholic communities (Joyce 2012). This is confirmed by Bishop Kumalo of South Africa who argues that condoms help spread HIV because they teach young people to be promiscuous (Crane 2012).

Otherwise the judgemental tone can be found in statements where religious leaders claim that the fault of getting AIDS is not really with the patients, for they cannot help themselves. The following statement could lead to this conclusion, part of it was already discussed in chapter two under the discourse of morality:

We know that condoms can save lives and prevent the spread of the virus. The morality of condoms is about preserving life. To sentence a person to death because of an error of judgment about sexual activity is not the way to save lives. We are human; we make mistakes, and live in a fallen world. We must *ask forgiveness* and commit ourselves to *responsible sexual behaviour*. These behaviours will go a long way in preventing the spread of HIV/AIDS *[emphasis added]* (Anglican Primates 2002).

This statement is particular for on the one hand it appeals to the readers not to judge those infected with HIV/AIDS because they are like everyone human and therefore they make mistakes, but at the other hand the insinuate that the people infected with AIDS should ask for forgiveness and should commit to responsible sexual behaviour. Responsible sounds less judgmental than moral behaviour but it implies the same.

 As one might have noticed the statements used in this chapter are not very topical. In recent years the Catholic Bishops of SSA have shun away from making explicit statements that attribute blame, in fact statement on HIV/AIDS in general have become less abundant. This in confirmed by the Catholic Bishops of AMECEA, saying:

The pandemic continues to ravage our populations while in many instances it has slipped from a prominent place of concern and response on the agenda of governments, civil society and even the Churches. (Catholic Bishops of AMECEA 2010)

This was confirmed while looking for more recent statements to illustrate this thesis. On the website of the Catholic Bishops of Nigeria there was hardly any statement concerning HIV/AIDS, in fact they seemed to avoid it. The following text is from a statement that condemns the decision of the government of Nigeria to spend 11,3 million on family planning devices (e.g. contraceptives), the Bishops describe this as a “huge waste of scarce resources”, claiming that more urgent intervention is needed for “malaria, hepatitis, tuberculosis, diabetes” (Catholic Bishops of Nigeria 2013). Nowhere in this text do they mention HIV or AIDS. The same goes for the Catholic Bishops of Kenya, only one article on their site mentions HIV/AIDS and then only one sentence is dedicated to the disease. This article, like in the case of Nigeria, is about investments in family planning, but the Bishops of Kenya only mention HIV/AIDS as one of their arguments for opposing the investments, saying “At a time when our people are greatly affected by HIV/AIDS and preventable road carnage, we cannot go further to condone efforts at reduction of life” (Catholic Bishops of Kenya 2012). This is rather peculiar.

 While the eradication of stigma is often described as breaking the silence of AIDS, it seems that the Catholic Churches in SSA are currently falling back on silence. Furthermore it becomes clear that the message of the discourse of compassionate hope has been ambiguous and still attribute sin to the person that is infected with HIV/AIDS. One could therefore say that although the statements propose the eradication of stigmata, in fact they do little to change the reality and thus these statement reaffirm the stigma and thus keep the infected in their inferior status. Since that is one of the characteristics of stigma, statements with mixed messages, like those above, or making no statements at all contribute to stigmatisation.

## The Body of Christ helps those with AIDS

As we have seen in the previous chapter, a genuine compassionate response to the HIV/AIDS pandemic would be inclusive, and without judgement. Such a message would be sounding like the following statement by the Anglican Communion across Africa:

We are living with AIDS. As the body of Christ, confronted by a disaster unprecedented in human history, we share the pain of all who suffer as a result of AIDS. Faced by this crisis, we hear God’s call to be transformed. We confess our sins of judgement, ignorance, silence, indifference and denial (Anglican Communion across Africa 2002)

The message says that “As the body of Christ” they share in the pain. In other instances this is sometimes formulated by African theologians as “The body of Christ has AIDS”. This refers to the symbolic body of Christ being the holy Communion, the Church, and all humanity and the whole of creation (van Klinken 2010, 446). This would not only entail the Church’s understanding that the disease also spreads among those that belong to the Church and that thus the Church is not immune to the disease, but also the idea that if one member of the church is infected, the whole church is has HIV/AIDS.

While this would be a compassionate response, the opposite often happens. Religious leaders often claim that their own communities are not prone to the disease (Gill 2009, 117). As a result, those infected with HIV/AIDS are placed outside of the Church or the rest of the community, at times literally, at times verbally. This is done through a verbal form of dualism that forms clear-cut lines between ‘us’/‘the Church’ and ‘them’, ‘those infected’ or ‘the AIDS victims’. It is as such that the discourse of compassionate hope can have the same effects as the discourse of war.

This tendency to see the people infected with HIV/AIDS as outside of the Christian community becomes apparent through the use of ‘those living with AIDS’, instead of ‘those among us living with AIDS’ or even better ‘we who are living with AIDS’. This is also portrayed in the following statement of the Catholic Bishops of Cameroon:

To *those* *with HIV/AIDS*: the *Church* reminds *them* of Christ’s invitation: ‘Come to me, all you who labour and are overburdened, and I will give you rest’ (Mt 11:28). They must not give in to discouragement [..] nor the spirit of vengeance [...] Have courage, hope and steadfast faith in God for he loves you. It is thanks to God Almighty that the whole world is currently mobilising to help *you and your families*. *The Bishops of Cameroon and the whole Christian community* is by *your* side; *they* are working now and will continue to work in the future in order that you may preserve *your human dignity* *[emphasis added]* (Bishops of Cameroon 1999, 60).

The emphasized words illustrate the polarizing effects of this statement that establishes two groups. The first are ‘those with HIV/AIDS’ and their families, the second is the Church, the Bishops of Cameroon and the Christian community. Uses of such terms thus implies an inferior position for the people that are infected with HIV/AIDS because they are not seen as equal members of the community. In this statement the idea that one group is valued over the other is especially obvious in the part “*they* are working now and will continue to work in the future in order that you may preserve *your human dignity*”. This suggests that the people infected with HIV/AIDS are passive victims and the Christian communities as hard-working do-gooders. Gillian Patterson acknowledges that the discourse of compassion can acquire a self-congratulatory character, which stresses the holiness of the helper in contrast to the sinfulness of the sinner (Patterson 2009b, 32). It might be, that she has statements like the one above, in mind when she wrote this.

Jill Olivier notices this stigmatising tendency as well. According to Olivier, the discourse of compassionate hope individualizes and therewith separates the ill from the healthy. According to Olivier the mass media reporting about AIDS is guilty to portraying the ill as “other than self” (Olivier 2006, 90). Susan Sontag confirms this by stating that large numbers of articles assert that it is a disease of ‘them’ not ‘us’ (Sontag 1989, 170). ‘Them’ and ‘us’ are examples of clear opposites, that can be found in many of the statements of religious leaders, like in the following statement of the Catholic Bishops of Sudan:

To all who are infected or affected by HIV/AIDS *we* address a message of hope. *You* can still live positively with AIDS. *The church* will strive to sustain you in *your difficult struggle* (Catholic Bishops of Sudan 2005).

This statement has been used earlier in Chapter 2, but is a good example of how in the discourse the ill are set apart; they are not (part of) the church but are ‘the others’ whom the church will aid. The emphasized words indicate that HIV/AIDS is ‘their’ struggle and not ‘ours’ i.e. the churches. The following quote has the same effects: “Do not despair – you are not abandoned by Christ nor by us” (Bishops of SACBC 2001, 79), this statement by the Bishops of South African Catholic Bishops Conference clearly separates ‘us’ from the people infected with HIV/AIDS.

 Therefore religious communities continue to struggle to communicate positive messages that promote inclusiveness (Mabizela 2014, 24). Anthropologist Tony Simpson at the University of Manchester, who worked in Zambia for long periods of times, confirms this prevailing stigmatisation. Instead, Simpson proposes, that the Church should take the lead in ensuring that HIV/AIDS could happen to anybody, even to priests (Joyce 2012). Like mentioned earlier, it should be acknowledged that ‘the body of Christ has AIDS’.

 This is done more often in statements made by the Anglican church in SSA. Earlier we have seen the following statements: “We are human; we make mistakes, and live in a fallen world” (Anglican Primates 2002) and “We are living with AIDS. As the body of Christ, confronted by a disaster unprecedented in human history, we share the pain of all who suffer as a result of AIDS” (Anglican Communion across Africa 2002) these are both examples of inclusive statements. Another good example of a statement that does include the people infected with HIV/AIDS is the following: “I believe that HIV/AIDS has challenged us like no other disease. It has given us no rest. Our journey is not yet over” (Catholic Bishop of Swaziland 2014). In contrast to the statements before, these quotes use terms like ‘we’, ‘us’ and ‘our’, indicating that everyone suffers and not just the people that are infected.

Most of the examples above, except for the last three, indicate the ways in which the discourse of compassionate hope can be stigmatising through the use of certain words. These words separate the ill from the healthy or the Church from the people that are infected, and thus seen in this light the discourse of compassionate hope, again, contributes to stigmatisation. These stigmata still prevent local Church leader from successfully reaching out to PLWHA. But that some statements of the discourse of compassionate hope contribute to stigmatisation, does not mean that all of the statements do. The last three statements have, and many more can, confirm this. But, the purpose of this chapter was to answer the research question, which is trying to explain Patterson’s statement, not prove it.

Conclusion

The main research question of this thesis asked: What did Patterson mean when she wrote that the discourse of compassion, as formulated by the Roman Catholic and Anglican communities in sub Saharan Africa, is merely another (unintended) way to stigmatize the people infected with HIV/AIDS? This chapter has provided an answer to this question.

Because, as we have seen the discourse of compassionate hope shares some characteristics with the other discourses of this thesis. Like the discourse of morality, the discourse of compassionate hope is often judgemental even if it does not intend to be. It connects the infection of HIV/AIDS with promiscuity and thus with immoral behaviour and still at times sees HIV/AIDS as a punishment.

 Furthermore, the discourse of compassionate hope, like the discourse of war has a tendency to polarize groups. In the case of HIV/AIDS there are two groups. The first is the group of people that are infected or affected with HIV/AIDS, the PLWHA. They are set apart from the second group which consists of the Church, religious leaders and the Christian community.

 Therefore the discourse of compassionate hope, though intended to lift people up, can have the opposite effect of contributing to stigmatisation. On the one hand it keeps the PLWHA, but mostly just the people that are infected, in their inferior places by judging them and labelling them as sinners. On the other hand the discourse contributes to stigmatisation through the separation of the HIV-positive from the HIV-negative, the ‘bad’ from the ‘good’ or the ‘sinners’ from the ‘faithful’. The concluding postulation of this thesis therefore is that Patterson had these arguments in mind while she wrote the statement that inspired this thesis.

# Chapter 4: Conclusion

This thesis has been a qualitative research project that has used textual- and discourse analysis to answer the question: What did Patterson mean when she wrote that the discourse of compassion, as formulated by the Roman Catholic and Anglican communities in sub Saharan Africa, is merely another (unintended) way to stigmatize the people infected with HIV/AIDS?

 In order to be able to answer this question first the concepts of stigma and compassion had to be made clear. So this was done in the first Chapter. Stigma was formulated as a label that degrades one’s reputation and has to ability to set people apart. Stigma is always negative; stigma is therefore different from stereotypes and discrimination; the latter are not always negative, are linked to cultural settings and discrimination can be the result of stigma. The other crucial term used by Patterson is ‘compassion’ which is defined as ‘suffering together’ and ‘being in solidarity with the sufferer’.

These concepts were analysed in the discourses as formulated in sub Saharan Africa (SSA). This region is chosen for its high prevalence of HIV/AIDS and Christianity. In SSA the spread of HIV/AIDS has several causes among which unequal gender relations, poverty, migration and war. The statements that have been analysed were either from Roman Catholic of Anglican church leaders.

 In order to understand Patterson’s observation, first a number of negative and therefore stigmatising discourses of HIV/AIDS were studied; after which the discourse of compassion, which could be seen as a positive discourse, could be analysed and compared to the previous two. The discourse of morality attributes the infection with HIV/AIDS to individual behaviour, and more specifically promiscuous sexual behaviour which is labelled as ‘immoral’ behaviour. Therefore AIDS is considered a moral problem. HIV/AIDS is either a punishment by or a judgement of God. Thus the discourse both moralizes and individualizes the disease.

The discourse of war is a discourse that frames the prevention and treatment of HIV/AIDS in terms of a ‘war against HIV’ or a ‘war against AIDS’. This discourse has three different levels. The biological level (virus invading the body), the prevention and treatment level, and the global level which fuels the power struggle between the US and. The discourse is stigmatising because it uses a negative imagery to frame HIV and because it separates people, it separates Africa from the rest of the world and it separates the HIV-positive from the HIV-negative.

The discourse of compassionate hope combines the discourse of hope with the concept of compassion. Hope consists of the idea that living positively with AIDS is possible, that the infected are no less human than those not-infected and that humans (infected and not-infected) are in solidarity. Furthermore it emphasises that the HIV infection is not final. The discourse of compassionate hope stresses the unconditional acceptance of every human being, infected or not as God’s child and a member of the community.

Although this is a positive reaction to the HIV/AIDS pandemic, discourse analysis done of different statement of SSA church leaders has shown that the message and the vocabulary used in the discourses of compassion can contribute to existing stigmata instead of fighting them. The message of the discourse of compassionate hope is often ambiguous, claiming on the one hand that everyone should be compassionate to the people infected with AIDS while still attributing sin to the latter. The discourse connects the infection of HIV/AIDS with promiscuity and thus with immoral behaviour. The message of the discourse of compassionate hope therefore does not lose the judgemental tone of the discourse of morality. Furthermore, the vocabulary of the discourse of compassionate hope has a tendency to separate ‘the Church’ or ‘Christians’ from ‘them’, ‘those’ or ‘the infected’. Therefore the discourse of compassionate hope can, again, contribute to stigmatisation for it separates the stigmatised from the rest of the community.

These are the arguments that explain Patterson’s statement that the discourse of compassionate hope is stigmatising, for it explains that the discourse of compassionate hope is often still judgemental and exclusive. Of course this does not mean that the discourse of compassionate hope is always stigmatising, it just means that it can be. In this thesis statements of the Roman Catholic and the Anglican church have been used to both illustrate the discourse of compassionate hope as it is intended, and were it went wrong. One therefore cannot conclude that the Roman Catholic Church or the Anglican Church in SSA are stigmatising, some statements are while others are not. Further research is needed on the subject in order to get a more comprehensive understanding of the point of views of the Roman Catholic or Anglican Church in SSA, if such a shared view exists in the first place, for this thesis was not able to so inclusive, but then again this thesis never intended to be all-inclusive, because that was not the point of this thesis. It intended to bring to light certain mechanism of stigmatisation within the discourses of AIDS in order to explain Patterson’s opinion on the discourse of compassion. Besides the limited scope of this thesis, it has succeeded in doing so.

# References

Anglican Communion Across Africa. 2002. All Africa Anglican AIDS Planning Framework

"Our Vision, Our Hope" The First Step. *Oikoumene*. Retrieved 22-02-2014. http://www.oikoumene.org/en/resources/documents/other-ecumenical-bodies/church-statements-on-hivaids/anglican-communion-africa

Anglican Primates. 2002. Report of the meeting of primates of the Anglican Communion. Appendix

III : Statement of Anglican primates on HIV/AIDS, 17 April 2002. *Oikoumene*. Retrieved 08-02-2014. http://www.oikoumene.org/en/resources/documents/other-ecumenical-bodies/church-statements-on-hivaids/anglican-primates?set\_language=en.

Armstrong, Karen. 2011. *Twelve Steps to a Compassionate Life*. London: The Bodley Head.

Benford, Robert D., and David A. Snow. 2000. Framing Processes and Social Movements.

*Annual review of Sociology* 26: 611-639.

Brennen, Bonnie S. 2013. *Qualitative Research Methods for Media Studies*. New York: Routledge.

Brownmiller, Susan. 1989. *Tegen haar wil : mannen, vrouwen en verkrachting*. Baarn: Anthos.

Cammaert, Major General Patrick. 2009. Facts & Figures on Peace & Security. *UNWOMEN*.

Retrieved 25-01-2014. http://www.unifem.org/gender\_issues/women\_war\_peace/facts\_figures.php.

Carlsen, Erika. 2009. Ra/pe and War in the Democratic Republic of the Congo. *Peace Review*

21 (4): 474-483.

Catholic Bishops of AMECEA. 2002. “You Will Be My Witnesses”. In *Speak Out on HIV & AIDS:*

*Our Prayer is Always Full of Hope,* eds. Catholic Bishops of Africa and Madagascar, 87. Nairobi: Paulines Publications Africa.

Catholic Bishops of AMECEA. 2010. Communiqué of the Second AMECEA Youth Communication

Workshop. *Uganda Episcopal Conference*. Retrieved 08-03-2014. http://www.uecon.org/AMECEA.html

Catholic Bishops of Angola & S. Tomé. 2002. The Church and AIDS. In *Speak Out on HIV & AIDS:*

*Our Prayer is Always Full of Hope,* eds. Catholic Bishops of Africa and Madagascar, 84-86. Nairobi: Paulines Publications Africa.

Catholic Bishops of Cameroon. 1999. Declaration on AIDS. In *Speak Out on HIV & AIDS: Our*

*Prayer is Always Full of Hope,* eds. Catholic Bishops of Africa and Madagascar, 59-60. Nairobi: Paulines Publications Africa.

Catholic Bishops of Ivory Coast. 1997. The Church and AIDS: Facts, Commitment. In *Speak Out on*

*HIV & AIDS: Our Prayer is Always Full of Hope,* eds. Catholic Bishops of Africa and Madagascar, 51. Nairobi: Paulines Publications Africa.

Catholic Bishops of Kenya. 1999. On the AIDS Pandemic and its Impact on our People. In *Speak Out*

*on HIV & AIDS: Our Prayer is Always Full of Hope,* eds. Catholic Bishops of Africa and Madagascar, 61-62. Nairobi: Paulines Publications Africa.

Catholic Bishops of Kenya. 2012. Lets Uphold Human Dignity. *Kenya Conference of Catholic*

*Bishops*. Retrieved 04-03-2014. http://www.kccb.or.ke/home/KCCB/hivaids/

Catholic Bishops of Nigeria. 2001. No to Use of Condoms and Programmes on AIDS In *Speak Out on*

*HIV & AIDS: Our Prayer is Always Full of Hope,* eds. Catholic Bishops of Africa and Madagascar, 69. Nairobi: Paulines Publications Africa.

Catholic Bishops of Nigeria. 2013. Wasteful Spending on Family Planning “Commodities”: Reaction

of the Catholic Bishops Conference of Nigeria. *Catholic Bishops Conference of Nigeria*. Retrieved 04-03-2014. http://www.cbcn-ng.org/docs/g11.pdf.

Catholic Bishops of SACBC. 2001. A Message of Hope. In *Speak Out on HIV & AIDS: Our Prayer is*

*Always Full of Hope,* eds. Catholic Bishops of Africa and Madagascar, 79-81. Nairobi: Paulines Publications Africa.

Catholic Bishops of South Africa. 2001. Letter on HIV/AIDS. In *Speak Out on HIV & AIDS: Our*

*Prayer is Always Full of Hope,* eds. Catholic Bishops of Africa and Madagascar, 70-72. Nairobi: Paulines Publications Africa.

Catholic Bishops of Sudan. 2005. Statement on HIV/AIDS. *SCBRC Secretariat*

*BlogSpot*. Retrieved 03-02-2014. http://scbrc-secretariate.blogspot.nl/2007/03/sudan-catholic-bishops-conference.html.

Catholic Bishops of Swaziland. 2014. Book Launch. *Google Docs*. Retrieved 08-03-2014.

https://docs.google.com/file/d/0BxCa4S3fxNV0R2FhUXdJcHlJYmM/edit.

Catholic Bishops of Zambia. 2012. That they may have abundant life (John 10:10): A Pastoral

Statement. *Zambia Episcopal Conference*. Retrieved 01-03-2014. http://www.catholiczambia.org.zm/index.php?option=com\_docman&task=cat\_view&gid=61&Itemid=84

Catholic Bishops of Zimbabwe. 1998. Working for the Common Good. In *Speak Out on HIV & AIDS:*

*Our Prayer is Always Full of Hope,* eds. Catholic Bishops of Africa and Madagascar, 55-56. Nairobi: Paulines Publications Africa.

Catholic News Agency. 2010. Pope Benedict advocates right sexuality, not condom use, in fight

against HIV. *Catholic News Agency*. Retrieved 01-03-2014. http://www.catholicnewsagency.com/news/pope-benedict-advocates-right-sexuality-not-condom-use-in-fight-against-hiv/.

Council of Anglican Provinces in Africa. 2002. Statement from CAPA AIDS board meeting.

*Oikoumene*. Retrieved 25-02-2014. http://www.oikoumene.org/en/resources/documents/other-ecumenical-bodies/church-statements-on-hivaids/anglican-provinces-in-africa.

Crane, Patrick B. 2012. South African bishop backs Pope against condoms in AIDS crisis. *Catholics*

*For Choice*. Retrieved 01-03-2014. http://www.catholicsforchoice.org/topics/hivaids/bishopsopposecondoms.asp#

Denis, Philippe. 2011. HIV, AIDS and Religion in sub-Saharan Africa: An historical Survey. In

*Religion and HIV and AIDS: Charting the Terrain*, ed. Beverley Haddad, 57-77. Scottsville: University of KwaZulu-Natal Press.

Demissie, Yohannes. 2008. The Church as a Healing and Compassionate Community: An

Ecclesiological Reorientation. In *A Theology of* *HIV & AIDS on Africa’s East Coast*, eds. Edwina Ward & Gary Leonard, 2-13. Uppsala: Swedish Institute of Mission Research.

Douglas, J.D. 1980. *The Illustrated Bible Dictionary*. Leicester: Inter-Varsity Press

Dube, Musa W. 2004. Grant me Justice: Towards Multi-sectoral HIV/AIDS readings of the Bible. In

*Grant me Justice!: HIV/AIDS and Gender Readings of the BibleI*, eds. Musa W Dube and Musimbi Kanyoro, 3-24. Pietermaritzburg: Cluster Publications.

Frederiks, Martha. 2011. Statements by Religious Organizations on HIV and AIDS: Intersecting the

Public Realm. In *Religion and HIV and AIDS: Charting the Terrain*, ed. Beverley Haddad, 108-132. Scottsville: University of KwaZulu-Natal Press.

Gill, Robin. 2009. Jesus, community compassion and HIV prevention. In *HIV PREVENTION: A*

*Global Theological Conversation*, ed. Gillian Patterson,113-120. Geneva: Ecumenical

Advocacy Alliance. *Michah Network*. Retrieved 06-02-2014.

http://www.micahnetwork.org/resources/hiv/hiv-prevention-global-theological-conversation-gillian-paterson-ed-eaa.

Gruchy, Steve de. 2011. Systematic Theological Reflection on HIV and AIDS: Mapping the Terrain.

In *Religion and HIV and AIDS: Charting the Terrain*, ed. Beverley Haddad, 170-197. Scottsville: University of KwaZulu-Natal Press.

Hastings, James. 1963. *Dictionary of the Bible: Second Edition*. Edinburgh: T.& T. Clark.

Irvin, D. T. 2008. World Christianity: An Introduction. *The Journal of World Christianity* 1 (1): 1-26.

Joyce, Kathryn. 2012. The Catholic Church, Condoms, and HIV & AIDS in Africa. *Church and State*.

Retrieved 01-03-2014. http://churchandstate.org.uk/2012/12/the-catholic-church-condoms-and-hiv-aids-in-africa/.

Kamau, Nyokabi. 2011. African Cultures and Gender in the Context of HIV and AIDS. In *Religion*

*and HIV and AIDS: Charting the Terrain*, ed. Beverley Haddad, 257-272. Scottsville: University of KwaZulu-Natal Press.

Kanyamachumbi, Mgr Patient. 1992. World AIDS Day. In *Speak Out on HIV & AIDS: Our Prayer is*

*Always Full of Hope*, eds. Catholic Bishops of Africa and Madagascar,38-39. Nairobi: Paulines Publications Africa.

Katongole, Emmanuel. 2007. AIDS in Africa, the Church, and the Politics of Interruption. In *Heil und*

*Befreiung in Afrika. die Kirchen vor der Missionarischen Herausforderung durch HIV/AIDS*, eds. F. X. DʹSa and J. Lohmayer, 167-183. Wurzburg: Echter.

Klinken, Adriaan van. 2010. When the Body of Christ has AIDS: A Theological Metaphor for Global

Solidarity in Light of HIV and AIDS. *International Journal of Public Theology* 4, 446-465.

Kvale, Steiner. 1996. *InterViews: An introduction to qualitative research interviewing*. Thousand

Oaks, CA: Sage.

Mabizela, Phumzile. 2014. Living with or Dying of: Building Resilience Social Capital. In *HIV and*

*AIDS in the New Global Era: A Holistic Approach for Dignity of Life*, eds. World Council of Churches, 24-25. *Aids Office SACBC*. Retrieved 01-03-2014. http://aidsoffice.sacbc.org.za/wp-content/uploads/2014/02/Contact-194\_EN\_WCC.pdf.

Manda, Domoka Lucinda. 2011. Comparative Ethics of HIV and AIDS: Interrogating the Gaps. In

*Religion and HIV and AIDS: Charting the Terrain*, ed. Beverley Haddad, 201-212. Scottsville: University of KwaZulu-Natal Press.

Mertenss, Jos. 1968. *Pastoraal Bijbels Woordenboek*. Roermond: J.J. Romen & Zonen Uitgevers.

Monthy Python. 1983. *The Meaning of Life*. DVD. Directed by Terry Jones & Terry Gilliam. Los

Angelos: Universal Pictures.

Olivier, Jill. 2006. Where does the Christian Stand? Considering a Public discourse on hope in the

context of HIV/AIDS in South Africa. *Journal of Theology for Southern Africa* 121: 81-97.

Olivier, Jill, and Gillian Patterson. 2011. Religion and Medicine in the context of HIV and

AIDS: A Landscaping Review. In *Religion and HIV and AIDS: Charting the Terrain*, ed. Beverley Haddad, 25-51. Scottsville: University of KwaZulu-Natal Press.

Orobator, Agbonkhianmeghe E. 2010. Contextual theological methodologies, in *African Theology on*

*the Way: Current Conversations*, ed. Diane B. Stinton, 3-11. London: Society for Promoting Christian Knowledge

Patterson, Gillian. 2009a. Stigma in the context of development: A Christian response to the HIV

Pandemic. *Progressio*. Retrieved 10-10-2013. http://www.progressio.org.uk/sites/default/files/HIV+stigma\_2009\_0.pdf.

Patterson, Gillian. 2009b. *HIV PREVENTION: A Global Theological Conversation*. Geneva:

Ecumenical Advocacy Alliance. *Michah Network*. Retrieved 06-02-2014.

http://www.micahnetwork.org/resources/hiv/hiv-prevention-global-theological-conversation-gillian-paterson-ed-eaa

Paterson, Gillian. 2011. HIV, AIDS and Stigma: Discerning the Silences. In *Religion and HIV and*

*AIDS: Charting the Terrain*, ed. Beverley Haddad, 350-365. Scottsville: University of KwaZulu-Natal Press.

Pew Research. 2011. Global Christianity – A Report on the Size and Distribution of the World’s

Christian Population. *Pew Research Forum*. Retrieved 14-01-2014. http://www.pewforum.org/2011/12/19/global-christianity-exec/.

Primates of the Anglican Communion. 2003. Pastoral letter from the Primates of the Anglican

Communion. *Oikoumene*. Retrieved 25-02-2014. http://www.oikoumene.org/en/resources/documents/other-ecumenical-bodies/church-statements-on-hivaids/anglican-primates-may-2003.

Shelp, Earl E., and Ronald H. Sunderland. 1987. *AIDS and the Church*. Philadelphia: The Westminster

Press.

Slatterly, Hugh. 2001. HIV/AIDS: A Call to Action. In *Speak Out on HIV & AIDS: Our Prayer is*

*Always Full of Hope*, eds. Catholic Bishops of Africa and Madagascar,74-76. Nairobi: Paulines Publications Africa.

Sontag, Susan. 1989. *Illness as Metaphor* and *Aids and It’s Metaphors*. New York: Anchor Books.

Tajfel, Henri. 1981. Social stereotypes and social groups. In *Intergroup behaviour*, eds. John C.

Turner & Howard Giles, 144-167. Oxford: Blackwell.

Taylor, Christopher C. 1999. A Gendered Genocide: Tutsi Women and Hutu Extremists in the 1994 Rwandan Genocide. *PoLAR* 22 (1): 42-54.

UN Report. 2011. The Millennium Development Goals Report 2011. *United* Nations. Retrieved 07-

01-2014. http://www.un.org/millenniumgoals/pdf/(2011\_E)%20MDG%20Report

%202011\_Book%20LR.pdf.

UNAIDS. 2013. Global Report: UNAIDS report on the global AIDS epidemic 2013. *UNAIDS*.

Retrieved 01-02-2014. http://www.unaids.org/en/media/unaids/contentassets/documents/

epidemiology/2013/gr2013/UNAIDS\_Global\_Report\_2013\_en.pdf.

WHO. 2013. Overview. *WHO on AIDS*. Retrieved 07-01-2014. http://www.afro.who.int/en/clusters-a-

programmes/dpc/acquired-immune-deficiency-syndrome/overview.html.

World Bank. 2013. Population Sub Saharan Africa. *Worldbank*. Retrieved 08-01-2014.

http://data.worldbank.org/region/SSA.