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BREAKING THE SILENCE: HOW CAN CHURCH  
LEADERS OVERCOME STIGMA AND PROMOTE  
COMPASSION IN RESPONSE TO  
THE HIV/AIDS EPIDEMIC?

Introduction

Serving an African-American Baptist congregation in Baltimore with a membership of 700, the writer is the counseling pastor and is part of the group referred to as “church leaders.” It is from this perspective that the forum’s question is addressed. The larger issue, how one “breaks the silence” in responding to the HIV/AIDS concern, is disassembled into a number of smaller questions for consideration before giving an overall response.

Understanding “Silence” in the Context of the Question

Donald E. Messer, in writing about the HIV/AIDS epidemic his book, *Breaking the Conspiracy of Silence, Christian Churches and the Global AIDS Crisis*, notes, “Twenty years into the epidemic, Christians have remained curiously silent and apathetic about the implications of a plague that has already killed 26 million people and is likely to eradicate 100 million more.”<sup>1</sup> Messer’s use of “silence” provides the context for our understanding. Essentially, in view of the worldwide devastation associated with the HIV/AIDS epidemic, the Christian church has covertly opted, from a proactive ministry stand-

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<sup>1</sup>Donald Messer, *Breaking the Conspiracy of Silence: Christian Churches and the Global AIDS Crises* (Minneapolis: Fortress Press, 2004), xvi.

point, to "stay on the sidelines." Messer, of course, is not suggesting that Christians are responsible for this "plague," but the loud inference is that had Christians been more vocal, HIV/AIDS would not have had this devastating impact.

As a Christian church leader, Messer's statement is a hard pill to swallow. All Christians and all Christian church leaders have not been mute and indifferent to the HIV/AIDS epidemic and the millions of people who have died. In fact, it is difficult to believe that most Christians and most Christian church leaders have been mute and indifferent. But certainly there has been some reticence. Regardless, HIV/AIDS continues to ravish millions of people worldwide and if having Christians break their "silence" will mitigate the impact, it must be done.

It will be helpful to have a more definitive understanding of "silence." Here it should be viewed from both the aspect of the speakers, in this instance, Christian church leaders, and the hearers, those who receive their words. If we say nothing about HIV/AIDS, in effect, acting if it is not there or it is not the church's problem, then there is "absolute silence." But if Christian church leaders speak about HIV/AIDS and/or homosexuality and other activities leading to HIV exposure in theologically negative terms; then, for some portion of our hearers "effective silence" is promoted. Some hearers will not receive the message and choose to exist in "effective silence." For a biblical example, God told Jonah to go to Nineveh, and "cry against it." Because of his biases, Jonah chose to exist in "effective silence" with respect to God's command. In either case, whether the silence is "absolute" or "effective," if breaking it has the effect of helping to alleviate the destructive impact of HIV/AIDS, it must be done.

### What Is the Effect of This "Silence"?

Initially, the Internet provided over one million hits. A second search, using "HIV/AIDS" and "church" generated 650,000 hits. However, adding appropriate descriptors ("African American," "stigma," "leaders," "compassion"), reduced this number substantially. A great number of sites are robust in coverage, particularly the Centers for Disease Control and Prevention (CDC) [cdc.gov]. Several sites, specifically oriented to African-American audiences, offered detailed guidance on ways to increase HIV/AIDS awareness in the local church. Chief among these are The Balm in Gilead, Inc. (balmingilead.org) and Health and Welfare Ministries, General Board of Global Ministries, The United Methodist Church (gbgmumc.org). In addition to these nationally-focused sites, there are a number of addresses for state-based groups with HIV/AIDS initiatives and local churches with ministries specifically designed to improve congregational awareness of the epidemic and/or directly to respond to the needs of persons have contracted the disease.

All of this laudable attention given to HIV/AIDS on national, jurisdictional, and local-church levels, gives strong indication that "absolute silence" regarding the HIV/AIDS epidemic, specifically among African Americans, has or is in the process of being broken. Yes, certainly, more attention is given to this epidemic today than ever before. Current statistics, however, suggest that there is yet an "effective silence," specifically among African Americans that still needs to be broken. Consider the following facts extracted from the CDC site:

- From 1998 through 2002, AIDS incidence steadily decreased among whites and Hispanics; however, AIDS incidence increased among Blacks.

- According to the 2000 census, African Americans make up approximately 13% of the US population; however, in 2005, African Americans accounted for 49% of the estimated new HIV/AIDS diagnoses in the US.
- Of the people under the age of 25 whose diagnosis of HIV/AIDS was made during 2001-2004, 61% were African Americans.
- In 2005, the rate of AIDS diagnoses for African-American adults and adolescents was 10 times the rate for whites and nearly 3 times the rate for Hispanics. The rate of AIDS diagnoses for African-American women was nearly 24 times the rate for white women.
- Black children in the U.S. represent almost two-thirds (62 percent) of all reported pediatric AIDS cases.
- Between 1998 and 2002, reported cases of AIDS due to heterosexual contact with an HIV-infected person (non-injection drug user) increased 27% for Black male adults and 20% for Black female adults.

These statistics demonstrate that in spite of the growing focus being given to the HIV/AIDS epidemic, nationally, and locally, African Americans in significant numbers have not been effectively impacted.

The rates by which African Americans continue to contract the disease combined with a lowering of the average age of onset in connection with the rapidly increasing rate of transmission through heterosexual contact (between partners who are not drug users), if unchecked, over time could lead to this epidemic being propagated primarily through the normal reproduction processes of African Americans, as is the case currently in the sub-continent of Africa. The trends reflected here also confirm dramatically that some African Americans

have not heard the messages, have heard the messages and have not perceived themselves to be at risk, or have heard the messages and elected to ignore the attendant advice and warnings. In either case, in as far as the danger and destruction of HIV/AIDS are concerned, these groups exist in "silence" and that "silence" must be broken.

So, there is certainly a need for breaking any "silence" that continues to exist, in any form, "absolute" or "effective" that may be preventing the reduction of future incidences of this disease, by bridging the attention and knowledge gap of every American, and African Americans in particular, regarding the transmission and treatment of HIV/AIDS.

There are a number of institutions that can impact this "silence"—families, schools, the media, health and welfare groups, foundations, federal and local government agencies and, of course, the church. Before we consider the role the church and its leaders in breaking this "silence," it will be helpful to understand the impact of the phenomenon referred to as HIV-related stigma.

### **What Is HIV-related Stigma and How It Relates to This "Silence"?**

The Academic Education Development Center on AIDS and Community Health defines HIV-related stigma as:

HIV/AIDS stigma refers to all unfavorable attitudes, beliefs, and policies directed toward people perceived to have HIV/AIDS as well as toward their significant others and loved ones, close associates, social groups, and communities. Patterns of prejudice, which include devaluing, discounting, discrediting, and discriminating against these

groups of people, play into and strengthen existing social inequalities especially those of gender, sexuality, and race—that are at the root of HIV-related stigma.<sup>2</sup>

This site enables understanding the theory, practice, and impact of HIV/AIDS related stigma. It further categorizes this stigma into three categories:

- Instrumental HIV-related stigma: a reflection of the fear and apprehension that are likely to be associated with any deadly and transmissible illness
- Symbolic HIV-related stigma: the use of HIV/AIDS to express attitudes toward the social groups or “lifestyles” perceived to be associated with the disease
- Courtesy HIV-related stigma: stigmatization of people connected to the issue of HIV/AIDS or HIV-positive people<sup>3</sup>

These categories can be further enveloped into two categories: HIV/AIDS-related stigma is both systematic and specific. HIV/AIDS-related stigma is systematic since it does not have to be directed toward a specific individual to have impact. HIV/AIDS-related stigma is specific, directed toward a specific person or group of people. Systematic HIV/AIDS-related stigma is passively manifested, and specific HIV/AIDS-related stigma is actively shown. Systematic HIV/AIDS-related stigma is born out of our personal histories, beliefs, fears, biases, and prejudices and combines with the images, messages, stories,

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<sup>2</sup>The Academic Education Development Center on AIDS and Community Health, “HIV/AIDS Anti-stigma Initiative,” <http://www.hivaidsstigma.org> (accessed March 7, 2007).

<sup>3</sup>Ibid.

and myths we have experienced and continue to experience, to produce a mindset about the illness. Systematic HIV/AIDS-related stigma informs and motivates specific HIV/AIDS-related stigma as we are required to make decisions for ourselves or about others in situations where HIV/AIDS is an obvious issue.

HIV/AIDS-stigma, systematic and specific, can contribute to an individual's choice to exist in "effective silence." HIV/AIDS-stigma can result in biases that motivate individuals to exist and behave in "effective silence" regarding warnings about the dangers of the disease and behaviors impacting exposure to the disease. An example is a woman or man who, believing that they are not HIV-positive, makes the choice to enter into a heterosexual relationship without considering HIV implications because they believe that their potential partner is not an exposure risk. Another example are "church people" who believe that they are at risk of exposure through any contact with someone who is HIV positive, or "church people" who believe that someone who is HIV positive has been cursed by God and have gotten what they deserve.

Systematic HIV/AIDS-related stigma is continually interactive. Key components in its development are one's beliefs, which serve as a filter for what comes into this dynamic process. For example, not everyone who hears the same negative HIV-related myth develops a bias toward HIV/AIDS and people we associate with the disease. Because we are created as "God seeking beings" (Romans 1), helps form our own beliefs, having great influence on how we filter things we experience, read about, and see in the media, learn in school, etc. If we believe that God condemns homosexuals, intravenous drug users, sex out of wedlock, etc. then we will be more open to receive and store negativity about them: systematically devel-

op a stigma, condemn, or as Messer stated above, at least be “silent and apathetic” about their plight.<sup>4</sup> Church and our experience of it are major belief in our lives. Church leaders, therefore, through their sermons, teaching, and personal actions play a substantive role in either mitigating or enabling systematic HIV/AIDS-related stigma. They can, thereby, either help break or build the “silence” that contributes to the HIV/AIDS epidemic.

### Why Are Church Leaders Having Difficulty in Breaking This “Silence”?

The African-American Church is uniquely positioned in having a major role in breaking the “silence.” This value-shaping role of the church has its origins in a time past when it was the school, social center, etc. Even in this era of improved access and privilege for African Americans, the church is still uniquely positioned to help break this “silence,” because of its divine calling and continuity. The core of the challenge and continuing difficulty that church leaders have in breaking this “silence”—both “absolute” and “effective”—in relation to HIV/AIDS, rests in how to present God’s holy love.

God is simultaneously, concurrently, complementary, perfectly, and eternally holy and loving. Robert Kellemen, writing of God’s holiness and God’s love, notes, “They are equally infinite, therefore [God] maintains them in perfect harmony.”<sup>5</sup> John Stott captures the same thought when he writes, “We must picture [God] neither as an indulgent God who compromises [God’s] holiness in order to spare and spoil us, nor as a harsh, vindictive God, who suppresses [God’s] love in order to crush and destroy us.”<sup>6</sup> Both Stott and

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<sup>4</sup>Messer, *Breaking the Conspiracy of Silence*, xvi.

<sup>5</sup>Robert Kellemen, *Soul Physicians: A Theology of Soul Care and Spiritual Direction* (Taneytown, MD: PRM Books, 2005), 70.

<sup>6</sup>John Stott, *The Cross of Christ* (Downers Grove, IL: InterVarsity Press, 1986), 170.



Kellemen seem to suggest that God goes out of God's way to assure this revelation. They both list numerous scriptural couplets that picture these two inseparable aspects of God's character: Exodus 34:6-7; Psalm 26:3, 40:10-11, 62:11-12, 63:2-3, 85:10; Isaiah 40:10-11, 45:21; Habakkuk 3:2; Micah 7:18; John 1:14; Romans 2:4-5, 3:6, 11:22; Ephesians 2:3-4; and I John 1:9.

The difficult challenge for church leaders in preaching, teaching, and providing pastoral care in relation to HIV/AIDS is keeping God's holiness and God's love in "perfect harmony." Thomas Oden describes this challenge as a tension between the law and the gospel—"a recurrent pastoral dialectic."<sup>7</sup> He further notes that "[t]he balance between the sternness of the law and the mercy of the gospel remains a continuing perplexity for situational pastoral judgment."<sup>8</sup> Oden's commentary includes a quote from Luther, describing what often results with this challenge: "But when it comes to experience, you will find the Gospel a rare guest but the Law a constant guest in your conscience, which is habituated to the Law and the sense of sin; reason too supports this sense."<sup>9</sup> Too often in connection with HIV/AIDS church leaders overstate the law and understate the gospel, or only state the law while omitting the gospel, or because of the weight of the tension Oden references above, say nothing at all. This is equivalent to "effective silence" or "absolute silence."

This challenge to church leaders, of maintaining this balance between God's holiness and God's love, is particularly

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<sup>7</sup>Thomas C. Oden, *Classical Pastoral Care*, vol. 3, *Pastoral Counsel* (Grand Rapids, MI: Baker Books, 2004), 199.

<sup>8</sup>Ibid.

<sup>9</sup>Ibid.

acute in matters having to do with sexuality. In relationship to HIV/AIDS the specific areas of tension are homosexuality and use of condoms. Sympathy, a desire to be perceived as inclusive and/or an encompassing view of liberation theology may lead some leaders to posit homosexual practices as being consistent with God's holiness. This is not the case and such a position is a reinterpretation of the word of God.<sup>10</sup> Homosexuals should represent no limit for God's love, however. Condom use to prevent the spread of HIV/AIDS is another area where the holiness/love challenge must be faced. Church leaders should endorse Messer's ABCs: A for abstinence, B for be faithful, and C for condoms.<sup>11</sup>

### How Can the Church Break the "Silence," Overcome the Stigma, and Promote Compassion in Relation to HIV/AIDS?

Church leaders can break the silence, overcome the stigma, and promote compassion in relation to HIV/AIDS, by objectively embracing the test of discussing this epidemic in a manner that harmoniously balances God's holiness, the law and God's love, and the gospel. Christ provides the model. With the woman at the well, the woman caught in adultery, the infirmed man at the Pool of Bethesda, the man with the withered hand, the man with the palsy, the lepers, Jesus' holiness and his love was in perfect harmony. He would take the same approach in ministering to anyone suffering from HIV/AIDS, substance abuse/addiction, promiscuity, stigma, (and thank God) even with us "church leaders." Should we do any less? And in

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<sup>10</sup>Bruce Field, *Introducing Black Theology: Three Crucial Questions for the Evangelical Church* (Grand Rapids, MI: Baker Academic, 2001), 98-100.

<sup>11</sup>Messer, *Breaking the Conspiracy of Silence*, 97-104.

embracing this model we must assure that it permeates everything we do in the church: preaching, teaching, singing, budgeting. Every ministry will be impacted—the beliefs of everyone in the church, particularly our children, youth, and young adults. Jesus' ministry of holiness and love was responsive and both reactive and proactive: going to the suffering or their coming to him. But in every case he was responsive. Should we do less?

As church leaders we should be the same way regarding HIV/AIDS. Providing all of the pre-marital counseling for my church, not once in the past has the subject of HIV/AIDS and testing been raised. Neither has it been identified for the men's ministry. We have given STDs and HIV/AIDS prominent consideration at our annual health fairs. But it is time to proactively raise the subject. It is time for a separate stand-alone HIV/AIDS awareness event. Jesus would be proactive and so should we.

### Conclusion

Over fifteen years ago, our church experienced its first AIDS death. The congregant impacted was involved in a ministry of public service in the church. Over time the wear and tear of the illness became publicly obvious. The leaders of the church tried to gather information about AIDS, but there was little to be had, and we had trouble separating fact from fiction. As the congregant's energy began to wane, she continued to work on the sidelines and meet sporadically with the ministry. When she was eventually hospitalized, church members went to visit as they would with any other ill congregant. Coming home from the hospice care, the visitations continued. When she passed away, the funeral service was attended by most of the congregation and by the hospital and hospice care providers involved with her case. There was a sense of

partnership during her care and her farewell. In retrospect, this was a beautiful picture of reactive ministry. Maybe we got it right because, not knowing much about HIV/AIDS at the time, we just led with love.

How can church leaders break the "silence," overcome stigma, and promote compassion? Lead with love—all the time!