

HOLINESS VERSUS MERCY: HOW THEOLOGY BOTH HINDERS AND FACILITATES THE CHURCH'S RESPONSE TO THE HIV/AIDS PANDEMIC¹

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Two theological forces propel the Christian church to action: compassion based on God's mercy, and a quest for holiness that stems from an awareness of God's inscrutable character. How the church views these two ideological poles guides its response to social phenomena. This study analyzes ethnographic focus-group interviews of a set of committed Latino church leaders of various Christian denominations in the U.S.A., and the theological implications of the church's practice of medical evangelism. The findings show that the Christian church's ideology simultaneously promotes acceptance (based upon its understanding of mercy) and rejection (based upon its understanding of holiness) of the HIV/AIDS population. The authors propose a model for helping the church commit itself to a more central sphere of action in fighting this pandemic.

Introduction

What the contemporary Christian church thinks of AIDS patients is parallel to what the NT church thought of lepers.² Leprosy was perceived as a cursed disease because of its origins in socially unacceptable behavior. Since the church's inception, it has been guided by theological ideology—what Scripture and tradition say about social phenomena. Concerning the HIV/AIDS pandemic, two main theological perspectives have informed the church's response. On one side, the church is moved to action by the doctrine of God's mercy toward all sinners, particularly those most despised by society. On the other side, the church, due to its understanding of holiness, is constrained from becoming involved with patients of a disease that is transmitted primarily through sexual practices despised by society at large and which the Bible condemns as immoral.

¹The authors gratefully acknowledge Nueva Esperanza, Inc., of Philadelphia, Pennsylvania for funding the various expenses involved in conducting the focus groups discussed in this article.

²Peggy L. Cockrum, "AIDS: An Issue for the Church," *Austin Seminary Bulletin* 105 (1989, Faculty Edition): 3-64.

While many have accused the Christian church of being cold and uncaring, K. Bockmühl defends the church by making a distinction between Christ and his true followers and the church and its theologians. He notes that "where Christianity is liable to such criticism, it is not in the perfection of Jesus Christ, but in the imperfections of those humans who constitute His church and who develop its theologies."³ Christianity is to concern itself with love of neighbor and hands-on concern for the neighbor's well-being. "Rather than enforcing an otherworldly theological inhumanity," he continues, the church is vitally concerned with "bodily works of mercy." Instead of enslaving humanity and denying human dignity, it sees humanity cooperating with God as his "vice-regent" on earth.⁴ Bockmühl's view of the church, engaged in "bodily works of mercy," is based on the mercy of God and the duty of the church to communicate such mercy.

Mercy: Moving the Church toward Action

The church, manifested in bodily works of mercy toward those despised by society, is solidly established upon Scripture. Of particular interest are those passages in the Gospels that describe Jesus and his dealings with lepers. It seems that Jesus went out of his way to reach out to and even touch lepers (cf. Matt 8:2-4). While social norms of propriety and health demanded that all healthy people maintain a distance from lepers, Jesus touched them as he healed their disease. This countercultural approach to leprosy has continued to inspire the church to help lepers throughout the ages.⁵

The comparisons between leprosy and HIV/AIDS are obvious. In 1986, Methodist Bishop W. W. White called the HIV/AIDS epidemic the leprosy of today.⁶ R. Lee, editor of *Engage/Social Action*, dedicated the Fall 1986 issue of that publication to the discussion of aspects of the HIV/AIDS pandemic

³K. Bockmühl, "Karl Marx's Negation of Christianity: A Theological Response," *Evangelical Review of Theology* 9/3 (1985): 251.

⁴Ibid.

⁵L. C. C. Stanley, "'So Many Crosses to Bear': The Religious Hospitallers of St. Joseph and the Tracadie Leper Hospital, 1868-1910," in *Changing Roles of Women within the Christian Church in Canada*, ed. E. G. Muir and M. F. Whiteley (Toronto: University of Toronto Press, 1995), 19-37; M. H. Gómez Reyes, "Un siglo de amor y de servicio en Agua de Dios (1892-1992)," in *Dominicos y el Nuevo Mundo siglos XVIII-XIX*, ed. John R. Sommerfeldt and Larry Syndergaard (Salamanca, Spain: Editorial San Esteban, 1995), 419-442; R. Palmer, "The Church, Leprosy and Plague in Medieval and Early Modern Europe," in *The Church and Healing Papers: 20th Summer Meeting and 21st Winter Meetings of the Ecclesiastical History Society*, ed. W. Sheils (Oxford: Blackwell, 1982), 79-99; H. H. Gwinn, "Life in the Medieval Leprosary," in *Studies in Medieval Culture*, ed. J. R. Sommerfeldt, L. Syndergaard, E. R. Elder (Kalamazoo: Western Michigan University, 1974), 225-232.

⁶W. W. White, "Persons with AIDS: Today's 'Lepers,'" *Engage/Social Action* 14 (1986): 2.

and its parallels with the status of leprosy in the ancient world of the early church.⁷ R. W. Lyon calls contemporary Christians to assume the position of the NT church in regard to leprosy,⁸ because the stigma that characterized leprosy is now attached to HIV/AIDS. E. Rosenthal notes the now-obvious developmental stages of social stigma that many diseases go through. HIV/AIDS is dirty, unclean, and shameful; thus it occupies the former role of leprosy in the social psyche.⁹

Lepers, HIV/AIDS patients, and others rejected as unclean, dirty, and suffering from shameful conditions all have a common need for the mercy of society. The church has been called by God to extend his mercy to all in need.

Because of its strong tradition of mercy, the church has not completely ignored the HIV/AIDS pandemic. In fact, as a nongovernmental organization the church has, proportionally speaking, done much to help those suffering from HIV/AIDS. R. H. Phillips estimates that one third of the earliest agencies created to respond to and provide services for HIV/AIDS patients were faith-based organizations.¹⁰

Ken T. South, Executive Director of the AIDS National Interfaith Network, Washington, DC, however, finds a paradox in the overall response to AIDS by the spiritual community, noting that "religion's response to AIDS has been a best kept secret."¹¹ The popular headlines about Christian fundamentals, oppressive or outmoded church laws, and a conservative slant to certain "hot button" topics tends to give the impression that AIDS and the church have not mixed. But to the contrary, "religion has provided the largest, single non-governmental response to the AIDS epidemic."¹² Of the nearly 5,000 AIDS service organizations, more than 2,000 (roughly one-third) are founded and

⁷Lee Ranck, ed., "The Church in the Midst of the AIDS Epidemic," *Engage/Social Action* 14 (1986): 2-46.

⁸R. W. Lyon, "Becoming the New Testament Church to Serve These 'New Lepers,'" *Engage/Social Action* 14 (1986): 12-17.

⁹E. Rosenthal, "Better Watch Out—Which Illness You Get," *To Your Health: The Magazine of Healing & Hope* 11 (September-October 1999): 7. Not long ago, cancer was also a taboo subject. No one admitted to the shame of having it. Public opinion concerning cancer, though not as rabid as that surrounding HIV/AIDS, was just as derogatory. People with cancer were ostracized and considered dirty and somehow unclean. Little was known about the disease, including how it was transmitted and how it could be treated. Cancer was a death sentence, and those who had it merely waited to die.

¹⁰R. H. Phillips, "True Grace and True Grit," *AIDS, Medicine & Miracles* 8 (Winter 1997): 2.

¹¹Ibid.

¹²Ibid.

operated by the faith community. Rooted in churches of many faiths, the successful development and implementation of AIDS care teams and other related church organizations provide a variety of services from housing and meal programs to counseling, medical, and social services.¹³

To facilitate the transformation of attitude from stigmatization of people with HIV/AIDS to action in their favor, there was a need to see a theology of wholeness that encompasses people with HIV/AIDS. E. N. Senturias discusses how people within the church who are living with HIV/AIDS have forced the church to redefine wholeness by showing us "a way of looking at life in the midst of illness."¹⁴

Holiness: The Struggle to Find a Theology of Wholeness

The forces that emanate from theological convictions are simultaneously paralyzing and a catalytic for change. Being holy has been the call of the church from its very inception, but holiness—often interpreted as separation from the world—can motivate the church to abstain from anything perceived as sinful or as a source of contamination.

The ability of the church to fully integrate within itself those who carried the HIV/AIDS virus has been slower to develop. While the church has been able to provide medical and social services to those suffering from this disease, it continues to struggle with active and meaningful social relationships with afflicted individuals. This hesitation emanates from complex ideological and theological ramifications of the concept of holiness, and especially its aspect of separation from the world. W. G. Britt describes holiness in the context of self-esteem. He argues that "God's holiness is defined and elucidated in relation to both Old and New Testament believers. The process by which believers partake of His holiness is tied to His dwelling among them."¹⁵ Since the self-esteem of the church depends on its perception of itself as holy, argues Britt, anything that detracts from this holiness is to be abandoned and excluded from its midst. Thus not only biblical theology, but also sociocultural perceptions permeate the church and influence what the church defines as holy, acceptable, and liable for rejection. Thus, rather than being immune from social stigma, the church is guided by it. Furthermore, the church multiplies the stigma by invoking the direct authority of God in condemning specific practices, particularly those related to the sexual impurity associated with the HIV/AIDS pandemic.

¹³Ibid.

¹⁴E. N. Senturias, "God's Mission and HIV/AIDS: Shaping the Churches' Response," *International Review of Mission* 83 (1994): 278.

¹⁵W. G. Britt, "God's Holiness and Humanity's Self-Esteem," *Journal of Psychology & Theology* 16 (1988): 213.

Not only the church, but society as well, treats behaviors such as homosexuality and prostitution as degenerate or illegal because they violate moral sanctions. Community and government responses to diseases such as AIDS draw from these preexisting reservoirs of stigmatization. "The overall impact of stigmas on public health continues to be dramatically underemphasized," says epidemiologist Bruce G. Link of Columbia University. "We need a new era of research into stigma and its health consequences."¹⁶ Thus both cultural stigmas and God-given rules of propriety bind the church—a situation similar to that of leprosy in the NT period.¹⁷

The Church's Response to HIV/AIDS

The church, along with all other faith-based organizations, is a "sleeping giant" in need of being roused up. Faith-based organizations are accused of promoting stigmatizing and discriminating attitudes, based on fear and prejudice; of pronouncing harsh moral judgments on those infected; of obstructing the efforts of the secular world in the area of prevention; and of reducing the issue of AIDS to simplistic moral pronouncements that have not made churches or mosques places of refuge and solace, but places of exclusion to all those "out there" who are but "suffering the consequences of their own moral debauchery and sin."¹⁸

To fully embrace HIV/AIDS outreach as part of the church's missionary agenda will require a paradigm shift within the church of God. The Christian church is being forced to reexamine its views of and approaches to despised sexual practices and their consequences. The HIV/AIDS pandemic is changing the North American church. The next section of this article will document the theological reflections that committed church leaders discussed as part of a series of focus groups. These reflections represent a living theology for addressing the ills of a society in sin.

Method

Following W. Wagner et al., this article defines a focus group as an ethnographic tool for the analysis of narratives.¹⁹ Focus groups were

¹⁶B. Bower, "Plight of the Untouchables," *Science News* 160 (October 27, 2001): 271.

¹⁷Ranck, 2-46.

¹⁸S. Parry, *Responses of the Faith-Based Organisations to HIV/AIDS in Sub-Saharan Africa: Report Prepared for the World Council of Churches Ecumenical HIV/AIDS Initiative in Africa* (Geneva: World Council of Churches, 2003), 3.

¹⁹W. Wagner, G. Duveen, R. Farr, S. Jovchelovitch, F. Lorenzi-Cioldi, I. Markova, and D. Rose, "Theory and Method of Social Representations," *Asian Journal of Social Psychology*

conducted in five major metropolitan areas of the U.S.A.: Philadelphia, New York, Los Angeles, Chicago, and Orlando. These cities were selected as a sample of convenience. All focus-group participants were committed to inner-city ministry. Nueva Esperanza, Inc., a nonprofit faith-based organization with headquarters in Philadelphia, Pennsylvania, through its regional directors for its Hispanic Capacity Building (HCP) project, invited all the focus-group participants for the study. These regional directors have access to interdenominational networks of churches in their respective cities. Regional HCP coordinators invited pastors, educators, healthcare professionals, and other Latino religious leaders through letters, telephone, and radio public-service announcements.

The use of focus-group methodology as a tool to learn church leadership's point of view, theological or otherwise, has been used by others in order to understand the incarnation of theological constructs in the life of the church. This approach has been particularly useful when addressing the response of the church, as instructed by its theology, toward various social ills and diseases.²⁰

The sampling frame used in each city was the list of pastors and other religious leaders whose names appeared in the regional network membership lists. As previously stated, no random sampling procedures were used to select participants. Everyone on the lists was invited, and it was up to the individual religious leader to decide whether or not to participate in the event. Participants received no remuneration or other incentive to participate in the study. Informed consent for participation was implied by the participant's willingness to express his or her opinion, and all participation was voluntary.

Upon arrival at a focus-group site, participants were assigned to a focus group. Focus-group discussions took place in English and/or Spanish, depending on the preferences of the participants. One to two focus-group discussions were held per site, depending on the number of participants. As dictated by standard qualitative-research procedures, the size of focus groups ranged between six and twelve participants. Discussions were recorded with

2 (1999): 95-121.

²⁰ A. M. Villarruel, L. S. Jemmott, M. Howard, L. Taylor, and E. Bush, "Practice What We Preach? HIV Knowledge, Beliefs, and Behaviors of Adolescents and Adolescent Peer Educators," *Journal of the Association of Nurses in AIDS Care* 5 (1998): 61-72; K. L. Braun and A. Zir, "Roles for the Church in Improving End-of-Life Care: Perceptions of Christian Clergy and Laity," *Death Studies* 25 (2001): 685-704; B. W. McRay, M. R. McMinn, K. Wrightsman, T. D. Burnett, and S.-T. D. Ho, "What Evangelical Pastors Want to Know about Psychology," *Journal of Psychology & Theology* 29 (2001): 99-105; P. Isaac and M. Rowland, "Institutional Barriers to Participation in Adult Education among African Americans within Religious Institutions," *Journal of Research on Christian Education* 11 (2002): 101-119.

audiocassette recorders and were subsequently transcribed. The research team then analyzed the transcribed discussions.

Discussion

The church has traditionally regarded “fullness of life” to be a spiritual pursuit (Col 1:9). The church seeks fullness and health as a reflection of the works of God on earth.²¹ This search has led to an enhanced definition of the term “fullness of life” and to the conviction that the church’s response to current health needs in the world should be determined by how the healer, Jesus of Nazareth, would respond to those same needs. For many years, the suggestions of those who spoke in favor of an active ministry among the sufferers of HIV/AIDS were rejected. As poignantly narrated by one of the focus-group respondents, those proposing such an approach to ministry were reprimanded.

I stood up and said, “Please bless those who are suffering from AIDS and God please console their families.” Oh my God! . . . [T]he teacher . . . called the principal, [who] took me out of the class, took me over to the rectory, . . . [and] sat me down: “Why, why did you mention that word, did you not know you are not to mention that word?” They called my parents; it was a big thing. They did a whole conference with the other kids’ parents. They basically excommunicated me.²²

The voices of the focus-group respondents testify to the attitudes and ideas that shape the church’s responses to the unprecedented health crisis of HIV/AIDS. The church has focused so exclusively on “spiritual” responses to the needs of the world that the idea of preaching the word of God through medical approaches and asking questions of health and healing of the body has come slowly to the North American church.²³ It took a paradigm shift from the “send a preacher” style of evangelism to a “send a medical missionary” approach to see that medical work could be a part of the overall goals of mission. Later, the two approaches were combined.²⁴ Medical outreach and the establishment of hospitals and clinics became a way to evangelize the world.

While the church of today recognizes the death experience of HIV/AIDS patients and responds medically and even socially to that need, it is not quick to respond to the whole life experience of those who suffer

²¹M. Marty, “The Tradition of the Church in Health and Healing,” *International Review of Mission* 83 (1994): 227.

²²Anonymous respondent, Chicago focus group #1, Chicago, Illinois.

²³G. Crawley, “A New Paradigm for Medical Mission: A North American’s Perspective,” *International Review of Mission* 83 (1994): 303-312.

²⁴*Ibid.*, 303.

from the disease. The first faith-based organizations' responses to the HIV/AIDS pandemic were framed by moral repulsion and calls to sexual purity.²⁵ In June 25-27, 2001, a United Nations special session on HIV/AIDS was unable to reach agreement on a plan to halt or reverse the spread of the disease by 2015.²⁶ The impasse came as a result of a religious coalition between representatives of the Islamic nations and the Vatican. The Vatican joined the majority of Arab nations in objecting to a paragraph that calls on governments to develop national strategies by 2003 in order to protect the most vulnerable. The objection raised by the Vatican and Arab nations was moral in nature. The majority of individuals most vulnerable to HIV/AIDS are primarily those who practice socially unacceptable behavior: homosexuals, people with multiple sex partners, intravenous drug users, and prostitutes.²⁷ This coalition of Muslim and Catholic believers objects to the special treatment of those who are perceived as being outside of God's grace and kingdom. How can a faith-based organization, which believes that there is a set of appropriate sexual behaviors, help a group perceived as being outside of God's grace?

Prevalent cultural taboos and misconceptions about HIV/AIDS, sexuality, and prevention are often compounded by theological views about sin, God's retribution, and judgment. A mix of cultural mores and theological views can produce a powerful anesthetic that prevents the church from acting or even talking about the HIV/AIDS pandemic. A focus-group respondent, who finds such attitudes disturbing, is hopeful that the church can move from total rejection to encompassing grace. He outlines a possible three-phase process:

I cannot speak for the other churches, but [for] my church, which is in Manhattan, lower side, the first stage was silence. People were passing away. We went to their funerals, but there was a silence. . . . The second stage was awareness. I was able to bring some health care [workers] to do workshops with the leadership early on [in] the process[, but] it was a secret workshop, because they [members of the church] didn't trust the person [who] was . . . talking about AIDS. . . . Then the third phase. My pastor started saying, . . . "We have to do something about this."²⁸

The most difficult question for the church to address is the most basic

²⁵Senturias, 277-285; A. N. Somlai, T. G. Heckman, J. A. Kelly, G. W. Mulry, K. E. Multhauf, "The Response of Religious Congregations to the Spiritual Needs of People Living with HIV/AIDS," *Journal of Pastoral Care* 51 (1997): 415-426; n.a., "Religion, Morals Stall Efforts Against AIDS," *Health & Medicine Week*, <www.otohns.net/default.asp/id=8262> (May 4, 2005).

²⁶"Religion, Morals Stall Efforts Against AIDS."

²⁷Ibid.

²⁸Anonymous respondent, New York focus group #1, New York, New York.

one. Is HIV/AIDS a church problem? As a focus-group respondent comments: "They [members of the church] are saying it is not our problem; we have to take care of our own, and our own are not doing that kind of stuff."²⁹

However, the same theological mores that can immobilize the church can also facilitate the church's active response to the present need. "The church," declares another focus-group respondent, "now sees HIV/AIDS as a legitimate and necessary area of ministry"; therefore, the church should have trained elders and leaders who are committed to the ministry of HIV/AIDS outreach. "When a person walks into a church," he notes, it should be a "one-stop shopping" experience.³⁰

Although many contemporary churches are ready to confront the HIV/AIDS pandemic, most have theological scruples about sexuality and the best ways of approaching prevention and sex education. Because there are no easy answers to these dilemmas, the reported approaches acknowledge these ideological conflicts. A focus-group respondent notes that "we are not thinking about how [to] protect a young person from dying." Instead, he notes, all that people worry about is whether their children are virgins. "We think about protecting ourselves from sinning," but sinning isn't the only problem. However, he continues, it is possible to shift from one paradigm to the other. But in order for this to happen, it is necessary to provide a safe place for pastors and the church to revise their theology.³¹ Thus the first barrier in the church for addressing the prevention of HIV/AIDS is ideological and theological in nature. It will take education and time to properly address this challenge; "it is a process."³²

The second barrier for doing something for those who are living with HIV/AIDS has to do with financial resources and an organization's ability to access public and private funding. One focus-group respondent laments:

The money for these types of programs does not exist. . . . I spent two years trying to find money . . . [by] looking through all [available] grants, looking for who had money, who would give something away.³³

But even if funds did materialize, he continues, the process of actually receiving awarded money takes time and organizations are in desperate need of funding right now.³⁴

²⁹Anonymous respondent, New York focus group #1, New York, New York.

³⁰Anonymous respondent, New York focus group #1, New York, New York.

³¹Anonymous respondent, New York focus group #1, New York, New York.

³²Ibid.

³³Anonymous respondent.

³⁴Ibid.

The scarcity of resources turns many committed leaders away from action. Even those who are successful in finding resources report spending an inordinate amount of time in securing them.

With two formidable barriers blocking the alleviation of suffering among HIV/AIDS patients, what is the church to do?

Prevention: A Possible Solution

A cheaper, more immediate approach to the AIDS/HIV pandemic—and one that the church is particularly well equipped to address—is prevention. Many church leaders are emphasizing prevention because they see the church as an effective vehicle for prevention. The question, then, is how best to present the issue of prevention, both within the church and without.

Prevention is about communicating knowledge in order to change inappropriate behaviors; the business of the church has always been to change behavior. K. L. Braun and A. Zir learned from focus groups comprised of various lay and ministerial church leaders that when dealing with death and dying, “ministers are not trained” in how best to help patients go through the end-of-life process. “A clinical pastoral-care provider notes that ‘if the [church] leader is reluctant, that’s going to reflect on how we even talk about the issue.’”³⁵

Education of church leaders about HIV/AIDS will facilitate prevention of the disease. In educating church leaders, the first task is theological—even before talking about public-health concerns and approaches. The theological task may be seen as a three-step approach to promoting prevention via the preaching of the church. The first step is a theology of wholeness that includes people living with HIV/AIDS, the “least” of these brothers and sisters of Jesus (Matt 25:40, 45). The second step is public-health education about the prevention of the disease. The third step is reaching out to the world as a moral force of mercy and not of isolation. When the church chooses to engage the world, it has much to offer.

Conclusion

“Congregations and individual Christians need to interpret in their own context what it means to have a mandate of healing.”³⁶ Each congregation must engage in a theological redefinition of wholeness and the process of living with disease. Faith-based organizations are confronting a new challenge—a challenge they can face with great success—but this engagement

³⁵Braun and Zir, 702.

³⁶S. Møgedal and M. Bergh, “Challenges, Issues and Trends in Health Care and the Church’s Mission,” *International Review of Missions* 83 (1994): 276.

requires a reinterpretation process, a theological revolution. This revolution will encompass a redefinition of health as wholeness and the engagement of the church with the body of its members and the world. From a sole focus on “spirit,” faith-based organizations must shift to a holistic focus on “body.” This refocusing demands political and theological engagements.

Out of the above-mentioned focus groups, a model has emerged—a three-step process for engaging and responding to the HIV/AIDS pandemic.

STEPS	EXPLANATION	CHURCH'S RESPONSES
First Step		
THEOLOGY + Cultural Mores	→ BOTH facilitate and hinder the church's responses to HIV/AIDS.	ACKNOWLEDGE its limitations and biases.
Second Step		
EDUCATION + Open Theological Forums	→ WILL OPEN ideological doors to change.	CONFRONT theological ideology and its limitations.
Third Step		
The Church IS READY to address the HIV/AIDS pandemic and is willing to engage the challenge	→ WILL LEARN to live with and accept people living with HIV/AIDS.	Use a HOLISTIC APPROACH to engage people living with HIV/AIDS and to minister to their needs.

This model grows out of the expression of Latino church leaders and a church in movement—a church which desperately needs guidance, political will, theological direction, and financial help in order to accomplish its mission. The process documented in this article is already in motion; the church, as a living entity, is growing and developing the necessary theological and action steps.

While theology can be written in the cloister, the life of the church is conducted outside for all to see. The HIV/AIDS pandemic is a landmark in the life of the church. How the church responds determines its degree of adherence to the Jesus of the Gospels, the one who once created havoc by touching the untouchables. The church must respond.³⁷ The “long litany of the history [of] moral pretense that has been the frequent reaction to disease, reveals the sorry spectacle of authorities, political and religious, using the victims of disease as vectors of moral suasion.”³⁸

³⁷P. L. Allen, *The Wages of Sin: Sex and Disease, Past and Present* (Chicago: University of Chicago Press, 2000).

³⁸L. Stewart, review of *The Wages of Sin: Sex and Disease, Past and Present*, P. L. Allen,

Further, the need for proper education about HIV/AIDS is urgent because the HIV/AIDS pandemic is so pervasively deceptive that it not only fools the “righteous” who want to remain holy, but it also fools the statisticians who want to believe that the victims of the disease deserve what they get. “Many people, especially the church, fell silent on addressing HIV and AIDS based in part on the narrow view that the disease was a curse for practicing homosexuality, promiscuity and drug addicted lifestyles.”³⁹

The church has two options: to deceive itself by ignoring those perceived as unholy, or to connect with the Christ who suffers along with those who carry the disease of HIV/AIDS. Christ, in the “least of these” (Matt 25:31-46), has HIV/AIDS. Thus the question to be answered by the church of today is, Will the church touch the untouchables, the “least of these”?

Canadian Journal of History 37 (2002): 205-208.

³⁹Ibid.