

A review of the persistence of HIV stigma within faith communities



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Over time, human immunodeficiency virus (HIV) has evolved into a chronic condition. Stigma associated with HIV has fostered discrimination against individuals living with the virus, thereby leading to numerous adverse health outcomes. This article examined Christian narratives throughout the pandemic. The research employed a literature review methodology, encompassing the following steps: (1) refinement of the topic; (2) design a search; (3) location of literature sources; (4) utilisation of sources as references; (5) evaluation of the information contained in the various works. The findings highlighted the initial silence of Christian churches during the onset of the pandemic. Subsequently, there was an observed duality between the moral condemnation of individuals living with HIV and the compassionate care that should be extended to them. Recent scholarly works indicated that most churches have emerged as leaders in the efforts to combat HIV and its associated stigma.

Contribution: This manuscript contributes to the discourse on the persistence of HIV stigma within faith communities.

Keywords: AIDS; HIV; HIV stigma; South Africa; Christian narrative; religious organisation; churches.

Introduction

In South Africa, the human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS)-epidemic has not only represented a considerable public health concern but also revealed profound societal and religious tensions. As the HIV evolved into a chronic disease, the stigma associated with the virus persisted, intensifying discrimination. This article investigates the shift of the Christian narrative about HIV, focusing on the contributions of religious organisations and churches during the pandemic. Initially characterised by silence and moral judgement, the Christian response has progressively transitioned toward advocacy and compassionate care. Through a comprehensive review of the literature, this study indicates how theological interpretations and church-led initiatives have influenced – and continue influencing – the discourse on HIV stigma, providing essential information on the interrelationship between faith and health.

What is human immunodeficiency virus

The World Health Organisation (WHO) estimates that there were approximately 39.9 million people living with HIV (PLWH) worldwide at the end of 2023, of whom 65% live in Africa (WHO 2024). The HIV is a virus that infects cells of the human immune system, while AIDS occurs when HIV is in its last stage. Left untreated, HIV develops into AIDS – sometimes quickly, but sometimes over many years. Human immunodeficiency virus treatment occurs when a person takes antiretroviral therapy (ART). Antiretroviral therapy has changed HIV from a life-threatening disease to a chronic disease. When the viral load of a person is suppressed by ART, they are no longer infectious (WHO 2024). Human immunodeficiency virus infection is transmitted through penetrative sex, a blood transfusion, the sharing of needles and syringes, and mother-to-child transmission (UNAIDS 2024).

A framework for understanding stigma

Alonzo and Reynolds (1995:304) defined *stigma* as a significant and demeaning societal tag that dramatically alters both how individuals perceive themselves and their perception by others. Or, stated in another way, *stigma* suggests labelling individuals or groups as undeserving of being part of the human community, leading to their exclusion and unfair treatment (UNAIDS 2005:11). When people act on stigma, it becomes discrimination (UNAIDS 2015:44). In a study conducted

in 36 countries, more than half of the people aged 15–49 years, displayed discriminatory behaviour towards PLWH (UNAIDS 2020). Discrimination and stigmatisation remain major obstacles to the effective treatment of HIV (Kumar 2023:21).

The stance of religious organisations

At the 11th Assembly of the World Council of Churches (WCC) held 31 August to 08 September 2022 (UNAIDS 2022) PLWH activists and faith leaders expressed great worry regarding the present response to HIV. They note that young people remain vulnerable to HIV, that gender-based violence has become an additional worry, and the health focus of many governments has shifted away from HIV. Religious organisations are encouraged to continue the fight against HIV, including the HIV stigma (UNAIDS 2022). Although religious institutions have occasionally intensified the stigma by rashly linking AIDS with religious concepts of 'sin', there are significant instances where they have actively promoted acceptance and social unity through non-judgemental, fear-free strategies (UNAIDS in Olivier, Cochrane & Schimid 2006:45).

Research question, methods and ethical clearance

This article focuses on the Christian responses to the HIV and AIDS pandemic from its origin to the present in order to answer the research question: *In what sense have the Christian narratives addressed the HIV stigma throughout the pandemic?* The literature review methodology of De Vos et al. (2011: 135–137) will be utilised. Its steps are as follows: (1) define the topic; (2) design a search; (3) locate sources of literature; (4) use sources as references; and (5) evaluate the information contained in the various works. As part of the evaluation, the empirical work of the authors linked to this study is also referenced.

A short introduction to human immunodeficiency virus and acquired immunodeficiency syndrome

The United States of America

In 1981, AIDS was medically recognised for the first time in the USA, although it was not until 1984 that the HIV was identified by French scientists (Francis 2012:295). The administration of Ronald Reagan did very little to fight the pandemic, publicly saying it was one of their top priorities, but in reality, cutting funding to AIDS research (Francis 2012:297; Weinraub 1986). President Reagan's conservative consultants viewed AIDS as an issue of moral and religious significance instead of a public health concern (Tumulty 2021:3). This was mainly observed in the first years among illegal drug users and same sex couples with multiple sex partners. In 1986, President Reagan appointed Everett Koop to compile a report on AIDS (Weinraub 1986). The report

employed straightforward terminology, clarifying that AIDS spread via 'semen and vaginal fluids' as well as through 'oral, anal, and vaginal intercourse' (Tumulty 2021:10). Koop was criticised for his openness to educating children and the framing of AIDS as a medical rather than a moral issue (Tumulty 2021:11). In 1988, 'Understanding AIDS', a brochure originating from the Koop report, was distributed to each household across the United States (Davis 1991:656) and marked a turn in the fight against AIDS in the USA. By the close of 1988, it is estimated that a total of 62 418 Americans had succumbed to complications associated with AIDS (Francis 2012:293).

In South Africa

During the Apartheid period, there was a conspicuous absence of comprehensive AIDS and public health policies. After 1992, a policy was developed; however, its implementation was impeded by prevailing homophobia and racial biases (Fourie 2006:100). Throughout the Mandela administration (1994–1999), the HIV and AIDS issue received inadequate attention amid the manifold challenges confronting the fledgling government (Fourie 2006:100). Although a comprehensive, multifaceted strategy was devised in 1994, its execution was largely ineffective, primarily owing to a lack of sufficient capacity at various governmental levels (Fourie 2006:100). At the commencement of Mandela's presidency, the HIV prevalence rate in South Africa was 7.6%, which had risen to 11.7% by the time of its conclusion (Zeit 2007:20).

In 2000, President Thabo Mbeki of South Africa publicly endorsed the views of AIDS dissidents, contending that HIV does not serve as the causative agent of AIDS (Fourie 2006:100; Healey 2011:6). In a notable address, President Mbeki remarked, 'As I listened and heard the whole story told about our country, it seemed to me that we could not blame everything on a single virus' (Zeit 2007:20). It is estimated that by the end of 2002, approximately 5.3 million South Africans were living with HIV (UNAIDS/WHO 2003). Following a period of hesitancy, the South African government commenced the provision of free antiretroviral treatment in 2004 (Healey 2011:6). By 2007, under substantial pressure from multiple sources, President Mbeki's administration had initiated a comprehensive strategy to address HIV and AIDS (Zeit 2007:20).

The dialogue of churches on human immunodeficiency virus and acquired immunodeficiency syndrome

1981–1989: The beginning of the pandemic

The onset of the pandemic was marked by the silence of religious institutions (Shelp & Sunderland 1985). During this initial phase, HIV and AIDS were largely disregarded by churches, except for certain individuals who perceived AIDS

as a divine retribution for immoral behaviour (Shelp & Sunderland 1985). Some individuals regarded AIDS as a punishment from God for engaging in promiscuous behaviour, homosexual lifestyles, or substance abuse (Meilaender 1988:13). Meilaender (1988:14) articulates the absence of a correlation between illness and sin in the New Testament, while also acknowledging the consequences of lifestyles that may lead to illness. Meilaender (1988:15–16) appears conflicted between morally judging individuals living with HIV and AIDS and demonstrating compassion. The prevailing response of both the general public and political figures to AIDS had predominantly been characterised by fear and apathy, rather than empathy (Shelp & Sunderland 1985). Numerous individuals afflicted with AIDS had encountered abandonment due to fear of their illness, disapproval of their sexual preferences, or hostility toward their chosen lifestyle (Shelp & Sunderland 1985). However, as early as 1985, religious organisations facilitated HIV and AIDS prevention campaigns with seminars specifically focused on PLWH (Denis 2011:65).

1990–2010: The progression of the pandemic

In 2002, the WCC (2025) initiated the Ecumenical HIV & AIDS Initiative in Africa (EHAIA) to address the HIV pandemic. This initiative facilitated the involvement of numerous faith communities and religious organisations in the provision of health care services (Long 2016:34).

A significant proportion of cases acquired HIV through heterosexual transmission and were associated with having multiple simultaneous partners. Women constituted 60% of individuals living with HIV (Healey 2011:7). The stigma surrounding HIV was intricately linked to gender-related stigma. It was predominantly women, due to their marginalised social status, who were scrutinised and held accountable for *immoral* behaviours (Ackermann 2005b:389). Married women encountered a heightened risk of acquiring HIV due to gender stereotypes (Ackermann 2005b:389). The marginalisation of PLWH occurred globally across all sectors of society, including religious organisations. Additionally, clergy members, such as priests and ministers, often denied pastoral care and burial rites to PLWH and to those who have succumbed to HIV and AIDS. This aggravated the atmosphere of fear and secrecy among PLWH (Vitillo 2007).

Significant efforts are made by the Catholic clergy to combat the HIV stigma, such as Pope John Paul II's denunciation of discrimination and his emphasis on the divine love bestowed upon all individuals, including those living with HIV (address in 1989 at Mission Dolores in Vitillo 2007). The bishops of the Southern Africa Catholic Bishops' Conference underscored that HIV should not be construed as divine retribution (Vitillo 2007). Despite the persisting rejection and condemnation of PLWH, there exists no theological foundation supporting such discrimination and stigmatisation (Vitillo 2007). Although there are prevalent narratives that detail the adversities faced by PLWH, the converse is equally valid, as substantial endeavours have

been undertaken by clergy to advocate for and support PLWH (Vitillo 2007). It remains a pivotal concern that HIV is often perceived as a moral issue rather than a medical condition (Long 2016:36).

2011–2025: The end of the pandemic

To enhance the effectiveness of the HIV campaigns, faith leaders must demonstrate a personal commitment to addressing HIV (Long 2016:41). Narratives of personal experiences serve to affirm both dignity and identity, and through the articulation of lived experiences, stigma associated with HIV can be effectively challenged (Ackermann 2005a:47).

The discourse surrounding the utilisation of condoms has been unequivocally controversial in certain religious institutions (Olivier & Paterson 2011:36), notably within the Catholic and Protestant denominations (Denis 2011:46). While the promotion of abstinence was deemed acceptable, the utilisation of condoms, regarded as an optimal biomedical strategy, persisted as a polarising issue (Olivier & Paterson 2011:37). Certain individual clergy discreetly endorsed the employment of condoms; however, they exhibited reluctance to overtly oppose institutional teachings (Denis 2011:67).

There is a great deal of grey literature on HIV education in faith communities, but its effectiveness has not been empirically measured or tested. In addition, the taboo on sexuality in faith communities, makes it very difficult for some faith leaders to talk about HIV and AIDS (Olivier & Paterson 2011:37). Churches tend to be silent or even resistant to sex education, especially in terms of sexual orientation, gender identity, reproductive health, and barriers of contraception (Long 2016:40). However, if we believe that sexuality is a gift from God, churches become the ideal place to talk about sex education. Emphasising shared, caring relationships and acknowledging that sexuality is a gift from God are both significant when confronting the HIV stigma and discrimination (Ackermann 2005a:49).

Fortunately, the condemning attitude of churches has changed, and many are forerunners in HIV responses that are informed, understanding, and compassionate (Ajibade 2016:121). Globally, there are now Christian ministries dedicated to providing care and assistance to PLWH (Ajibade 2016:112). Faith organisations are established in every type of community, whether urban or rural, providing extensive outreach. They boast committed volunteers, knowledgeable leadership, and are both trusted and well-regarded. These organisations maintain robust networks ranging from global partnerships to local grassroots connections (Olivier & Paterson 2011:44).

A theological perspective

UNAIDS recognised the value and efforts of religious organisations in the treatment and care of PLWH. In December 2003, UNAIDS supported a workshop in

Windhoek, Namibia, with 62 Christian theologians to develop a framework on HIV- and AIDS-related stigma (UNAIDS 2005:11). Seven themes emerged (UNAIDS 2005:11–17) and are summarised here:

- **God and creation:** Is God depicted as a punitive entity imposing HIV as retribution, or as a deity embodying empathy, who delights in creation? God fashioned humans as sexual beings, yet following the Fall, this gift was misused. In a sinful world, sexuality is frequently dominated by the powerful, leading to women and children lacking autonomy over their sexuality and experiencing stigmatisation. God allies with the marginalised and stigmatised, urging us to reconceptualise our perception towards a God of love and compassion.
- **Interpreting the Bible:** Numerous biblical passages have been employed to endorse stigma. Nonetheless, it is imperative to interpret the Bible with a Christ-centric perspective; Jesus associated with the stigmatised and marginalised, acknowledging them as children of God. Texts within the Bible that perpetuate stigma ought to be examined within the historical context of their authorship and through the lens of Christ's teachings.
- **Sin:** All individuals have failed to uphold the glory of God and are therefore considered sinners, regardless of whether they are living with HIV. Stigmatisation occurs when individuals reject the divine image inherent in others. The connections drawn between sexual behaviour and sin have intensified stigma, as sexual transgressions are often perceived as more grievous than other sins. This distorted perception must be corrected, and the association of HIV with sexual sin must be dispelled from our consciousness. The notion of HIV as a punishment for sin is demonstrably inaccurate and is contradicted by the narrative of Job and multiple gospel accounts. Furthermore, individuals living with HIV are encouraged to exercise responsibility, ensuring the infection is not transmitted through oversight.
- **Suffering and lamentation:** The Church is tasked with addressing undue suffering and social stigma, as Jesus exemplified compassion towards those in distress and sought to help. The scriptural tradition of lamentation embodies hope and reliance on divine intervention to alleviate human suffering.
- **Covenantal justice:** Justice should reflect the covenant with God in societal structures. Society must advocate for the welfare of the impoverished and marginalised. While poverty cannot be addressed in isolation, the collaborative efforts and solidarity between the churches of the Global North and Global South are essential.
- **Truth and truth-telling:** Stigma flourishes in environments characterised by silence and denial. The realities surrounding HIV must be disseminated and not suppressed, as secrecy intensifies fear. Furthermore, it is essential to urge the church to embody transparency, even if it necessitates acknowledging the church's role in reinforcing stigma.
- **The church as a healing, inclusive, and accompanying community:** While numerous churches serve as sanctuaries of safety, others maintain stigmatising

attitudes towards individuals who do not conform, or who exhibit differences. The example set by Jesus should be emulated, prompting churches to critically evaluate whether they are truly fulfilling their mission.

South African realities

In South Africa, religious leaders exert influence in the community. Their actions are highly regarded and people believe what they say (Long 2016:41). For a very comprehensive compilation on what churches in South Africa have done to combat HIV and AIDS, please see the work of Sue Parry in the WCC's mapping report for South Africa (Parry 2005). In the conclusion, she states that stigma and discrimination unconsciously remain part of churches in South Africa. The language of stigma creates a 'us' and a 'them' attitude that keeps PLWH at a distance, and it is not part of the churches (Parry 2005:87).

After more than 40 years of HIV awareness and research, stigma is still an issue within Christian communities in South Africa. One may ask: 'Why is this?' Literature provides the following explanations: Firstly, although there have been improvements in HIV education, numerous communities still lack awareness about the realities of living with HIV, which results in ongoing stigma (Mashile & Maake 2024:4). Secondly, HIV stigma continues to exist in South Africa's faith communities because of its links to death, immoral conduct, and cultural traditions. In addition, many religious communities hold traditional views that associate HIV with moral failings or divine punishment, thus sustaining stigma (Haddad 2005:32; Visser & Sipsma 2013:223). Lastly, in South African religious communities, stigma continues due to differing narratives about HIV from traditional healers and biomedical experts, as well as ineffective campaign planning and insufficient educational efforts about stigma at the community level. These elements fuel fear and misconceptions about the illness (Kang'ethe 2015).

The authors undertook an empirical investigation, documented in a separate publication, to examine the manifestations of the HIV stigma within faith communities in South Africa. Kruger et al. (2023) identify three predominant challenges faced by these communities in reducing stigma: firstly, a lack of awareness concerning HIV and the corresponding stigma; secondly, the tension between reconciling religious scriptures with scientific medical knowledge; and lastly, the cultural taboo in numerous African communities surrounding discussions of sexuality or sexual conduct. In a subsequent publication, Kruger et al. (2025) delineate the collaborations between faith communities and healthcare centres, highlighting the role of faith leaders in instances where healthcare workers are unable to engage with the community, and emphasising the presence of a collaborative spirit between faith leaders and healthcare workers. Both publications demonstrate that insufficient measures have been implemented to address the HIV stigma. The HIV stigma continues to persist as an issue within South African townships (Mokgatle & Madiba 2023:9).

Implications, recommendations and conclusions

Churches in South Africa should not lose momentum in caring for PLWH. Although the disease has been beaten, the stigma associated with it has not. Faith communities should not judge PLWH on the morality of HIV, but rather welcome them as people living with a medical disease.

Future studies could:

- Prioritise exploring partnerships between religious leaders and healthcare professionals, to lessen the stigma.
- Evaluating how spiritual or faith leaders may both reinforce and alleviate the stigma.
- Delving into distinctive cultural understandings of HIV and its associated stigma.
- Assessing the possible opposition from religious communities, which might interpret the HIV stigma as a moral or doctrinal concern.

Throughout the pandemic, churches have contributed to the HIV stigma by associating it with the morality of sin. On the other hand, many churches have become safe havens and hubs of treatment for PLWH. This duality has been the hallmark of the response of religious organisations to HIV and AIDS since the start of the pandemic until the present.

This article explores the evolution of the HIV stigma in Christian faith communities across three phases: the initial silence and moral judgement (1981–1989), increased engagement with the ongoing stigma (1990–2010), and contemporary compassionate leadership amidst challenges (2011–2025). Using a literature review and empirical investigations, it highlights seven theological themes from a UNAIDS workshop of 2003 that challenge punitive views and emphasise inclusivity, inspired by Jesus's ministry to the marginalised. In South Africa, stigma persists due to limited education, conflicts between faith and science, and cultural taboos around sexuality. Key challenges include HIV knowledge gaps, reconciling Scripture with medical facts, and barriers to discussing sexuality. Despite progress, faith communities both stigmatise through moralistic lenses and offer vital support. The article suggests future research on religious healthcare partnerships, spiritual leaders' dual roles in stigma, and cultural perspectives on HIV.

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Authors' contributions

All authors, G.K., E.A.J.G.V.d.B. and A.L.R., contributed to the conceptualisation of the article. G.K. conducted the methodology and wrote the first draft. E.A.J.G.V.d.B and A.L.R. reviewed and edited the manuscript; they also provided supervision.

Ethical considerations

An application for full ethical approval was made to North-West University Health Research Ethics Committee (NWU-HREC) and ethics consent was received on 22 November 2018. The ethics approval number is NWU-00107-17-A1.

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Data availability

The authors confirm that the data supporting this study, and its findings are available within the article.

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