BLACK CATHOLIC THEOLOGY

Topic: HIV/AIDS and the Bodies of Black Peoples: An Interdisciplinary Dialogue
Convener: Jamie T. Phelps, Xavier University of Louisiana
Presenters: Justina Ogbuokiri, Xavier University of Louisiana and Charity Hospital, New Orleans
James F. Keenan, Boston College
Respondent: Bryan Massingale, Marquette University

Justina Ogbuokiri opened the session with a dynamic historical overview of the HIV/AIDS Epidemic that impacted the United States in 1980 in the white male homosexual community. In the interim years the HIV/AIDS virus has become "the most significant infectuous disease" of the 20th century. Currently, this disease infects black women on the African Continent and the African American Community in the United States disproportionately. More than half of the 38 million people living with HIV/AIDS, including 57 percent of those living with HIV/AIDS in resource-poor settings in sub-Saharan Africa, are women who for the most part have been infected via heterosexual intercourse. Black women in the United States account for 69 percent of female HIV/AIDS diagnosed in 2000–2003. The proportion of Black Women having HIV/AIDS is 18 times higher than white women and five times higher than Latina women.

According to Ogbuokiri, societal and church responses to the pandemic have been lethargic because the original "victims" of the disease were judged to be morally reprehensive white male homosexuals and/or drug users. Some states' legislation prohibits the use of Medicaid funds until AIDS is full-blown, thus condemning the infected to death unless they find alternate sources for their medication. The currently highest-infected group in the U.S. is married African American heterosexual women, who have been "trapped by poverty, unemployment, drugs and substance abuse, lack of education and job training, and poor access to healthcare." Similarly, those most infected in sub-Saharan Africa are women "who lack financial independence; who are subjected to the threat of violence; and have no way of saying no to sex or condom use because of cultural factors." Ogbuokiri ended with a query and challenge which challenges our moral claim of making a fundamental option for the poor. She asked, "What is the stand of our churches? Are we still going to be out there on our moral high ground, frowning at our HIV-infected brethren, closing our doors, condemning and stigmatizing? Or are we going to listen to the words of Jesus when he says 'Whatsover you do to the least of my brethren, that you do unto me'?"

James Keenan's presentation echoed Ogbuokiri's but expanded the description of the *why* and the *what* of an actual strategy to ignore and marginalize those immediately affected by the HIV/AIDS crisis.

> First, HIV/AIDS is perceived as a multilayered threat. . . . At a first level, because HIV is an infectious (though not easily transmissible) virus, every society's

> self-understanding finds it necessary to perceive the virus as inevitably coming not from within "our society," but from outside of it. Second, the virus particularly thrives where there is instability, a notion that we believe is extremely important. Third, against this threat of instability, more stable societies and institutions (including churches) have attempted to create protective barriers. . . . these defensive barriers on the part of leaders in strong, stable cultures are antithetical to the attempts of ethicists, public health officials and clinicians to keep the most vulnerable persons uninfected. As opposed to supporting those public health preventive strategies (condoms, needle exchange, preventive education) which protect HIV-vulnerable individuals, some leaders and members of their societies perceive that the better and more important shields are those that keep risky individuals distanced from "the general population," or that are perceived as protecting social mores and orthodoxy from contamination. Fourth, this isolation is often backed by a deep moral judgmentalism. . . . This "morality" of exclusion, moreover, identifies as morally compromising and not clinically helpful the very instruments which have in fact been shown to be capable of providing HIV/AIDS protection (condoms, needle exchange, and more-than-just-abstinence-based education). Just as some believe that unstable individuals need to be cordoned from society, so, too, they believe, should these instruments. . . . [A]ny society that tolerates or welcomes these instruments is perceived as putting their population at risk. Fifth, moral judgmentalism depends powerfully on the capacity to blame. This blame is deeply tied to the belief that those living in unstable situations cannot be trusted, and ought not to be admitted to the stable "inner circle" of society. Sixth, silence is frequently integral to a strategy of protecting orthodoxy, and is particularly problematic when questions of sexuality are addressed.

Keenan concluded by stating that this resistence evidences both

> a lack of political will, but an actual active resistance to any real engagement with root-cause issues based on deep-seated fears of becoming contaminated at a variety of levels, and occurs among citizens as well as church people, and also, the leaders of both. When we compare this isolationism with the developing strategies of ethicists, public health officials, clinicians and researchers, we find a gap between these two mindsets as broad and as deep as the gap between those at highest risk for acquiring HIV infection and those seeking to be distanced from them.

Bryan Massingale's response acknowledged and affirmed some of the negative attitudinal and disheartening statistical data provided by the two presenters. He augmented the discussion by identifying some signs of hope signaled by the World Council of Churches' ecumenical gathering in Nairobi Kenya in 2001. During that conference African Church leaders rendered a "forthright confession that the attitudes, practices, ethic and theology of the Christian Church have contributed to their continents dire misery." The group called for the intellectual and moral conversion of churches. "Given the urgency of the situation and the conviction that the churches do have a distinctive role to play in response to the pandemic, what is needed is a rethinking of our mission, and the transformation of our structures and

ways of working."[1] Massingale noted that other voices of African and Black Christian and ecumenical and interreligious bodies such as the Advisory Board of the Balm in Gilead and Black theologians, notably Emilie Towns and Kelly Brown Douglas, united with the World Council of Churches to form a small chorus for prophetic justice as they identified the complicity of the black Christian community in the silent and alienating responses to homosexuality and the HIV/AID pandemic and called for a conversion in belief and ecclesial ministry.

Massingale further cited the traditional wisdom of inclusion and Resurrection faith and hope found in the texts in traditional Black American spirituals as they interpret the life, death and resurrection of Jesus as these signal resurrection faith and hope for people who have been marginalized and alienated.

He concluded his response by offering three observations and questions for discussion. (1) Resurrection faith, as mediated in the foundational expression of Black religion, is a harsh condemnation of attitudes of indifference in the face of massive suffering. Black Christianity's own cultural heritage requires that Black religious leadership move to the forefront of efforts on behalf of life. Faith in the resurrection also vehemently indicts the "compassion fatigue" and moral callousness of the privileged, both black and white, for whom the disease's perils seem more remote and distant. (2) Resurrection faith impels Pan-African religious leadership to break the silence imposed upon those who suffer the ravages of HIV/AIDS. In our preaching and catechesis, we are called to advocate and speak on behalf of those whose unjustly inflicted stigmas render them mute before the forces of indifference, self-righteous condemnation, and scapegoating. Can we hear the sounds of resurrection and, like the enslaved, form a choir of witnesses who announce new possibilities and proclaim an alternative vision beyond exclusion, discrimination, and stigmatization? Can we dare revise not only our pastoral practices, but even our current teachings on sexuality, in light of the limitless horizons opened by the resurrection? Can we dare *not* to? (3) Resurrection faith demands that we listen to the accounts of hope present in the midst of the travails of the present. It was in the crucible of suffering that the "black and unknown bards of old" composed and sang their noble songs. What testimonies of hope might we, the privileged, *not* be hearing now . . . voices that call us to move beyond paralyzing despair, that summon us not only to hope, but to engage in courageous proactive advocacy for the sake of those who now bear the lash of AIDS upon their crucified dark and dusky bodies?

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[1]World Council of Churches, "A Plan of Action: The Ecumenical Response to HIV/AIDS in Africa, Global Consultation on the Ecumenical Response to the Challenge of HIV/AIDS, Nairobi, Kenya, November 25-28, 2001," cited in Donald E. Messer, *Breaking the Conspiracy of Silence: Christian Churches and the Global AIDS Crisis* (Minneapolis: Augsburg Fortress, 2004) 24.

The session concluded with an animated discussion of the HIV/AIDS epidemic and the ecclesial and theological responses as they impact the lives of the Black and Latino/a-Hispanic community in the United States.

JAMIE T. PHELPS
Xavier University of Louisiana
New Orleans, Louisiana