The Human in Human Immunodeficiency Virus:

A Focus on Domestic and South African Stigma

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Abstract

Human immunodeficiency virus (HIV) is a pandemic that has pressed undesirable stresses on our world’s societal structures, medical community, economic structures, and political circles. The stigma surrounding the disease has unceasingly fueled its spread, complicating all global aspects affected by HIV. At its core, stigma not only adds to the complication of the disease, but it also strikes at the inherent thread binding together all of humanity. It also breaks one of the Catholic faith’s central commandments. In light of its history, complexities, and faith implications, the stigma does not represent faith or reason, and therefore does not uphold the truth needed to see the essence of the human in human immunodeficiency virus.
Introduction

We as humans want to know everything. We want to know how our bodies work, why they work, what is the component of us that makes us who we are, and we want to know the same of everything external to us. These are the questions that drive our behavior. Since the early 1980s, we have been pondering these questions of a curious, but deadly global disease called human immunodeficiency virus (HIV). Historically, its origins go back to the 1950s to Africa’s Congo River Basin (Burroway, 2006). Specifically, HIV is a retrovirus known as a lentivirus. It is classified as such because of the long time it takes to reveal its symptoms. Retroviruses, in general, keep all their genetic material in a single-stranded RNA. They reproduce by building a double-stranded DNA model of their genes. This is incorporated into the host cell’s genetic material. HIV finds its home in a white blood cell, a type of immune system cell, called a CD4 T-lymphocyte. As it replicates, it kills these cells, thus suppressing the host’s immune system and the CD4-T cell count. HIV is scientifically classified as acquired immune deficiency syndrome (AIDS) when this count is depressed to less than 200 cells/mm$^3$ or when a patient with HIV presents with a typical AIDS secondary condition or infection (“A primer”, 2007). The virus spreads through exchange of infected bodily fluids such as blood, semen, vaginal fluids, breast milk, and amniotic fluid, a medium that supports a fetus in the uterus (Smeltzer & Bare, 2004).

The questions surrounding HIV and AIDS deal with everything from finding a cure to its role in the poverty/hunger cycle of third world nations. The
statistics surrounding the disease are mind boggling, but the stigma surrounding the disease is not typically the first connection or question of HIV. However, the stigma imposed on people living with HIV is a phenomenon that perpetuates the disease and, in effect, contributes to the mind boggling statistics, the deepening complexity of AIDS in the poverty and hunger of our nation and developing ones, and the press to find a cure. The stigma deserves to be examined. In revealing its history, definition, foundations, impositions, types, consequences, and language, a dimension of severe injustice is uncovered. When viewed through the lens of faith, the injustice is further substantiated: the stigma cuts to the core of man’s common humanity and divinity. An evil this strong and influential must be stopped. The end begins with faith and reason.

The History of the Stigma

In order to fully understand the stigma, one must understand its origins as it developed with the discovery of HIV. On June 5, 1981, the Center for Disease Control (CDC) Weekly Morbidity and Mortality Report documented “strange cases of cancer” (Behrman, 2004, p. 5) among young-middle aged men of homosexual status in Los Angeles and New York City. Tests upon death uncovered critically low T cell counts. During the next two years, the virus baffled doctors and scientists, and doctors had no way of saving these patients. The early cases involved gay men, so the virus was originally labeled “gay-related immunodeficiency disease” (Behrman, p. 6) or GRID. In 1982, the disease was identified among intravenous (IV) drug users and non users,
children, hemophiliacs, and heterosexuals. To update the disease’s label, in August of that year, the CDC replaced the name GRID with AIDS. Although the original gay title was phased out, the initial stigma lingered and allowed the illness to be viewed by many for years to come through a lens of distortion (Behrman).

During the mid to late 1980s, hate crimes against HIV positive people and outward signs of the stigma became apparent. This stigma infliction was nothing new for the realms of people living under the pressures of illnesses associated with moral consequences. Venereal diseases had long been associated with violations of moral codes and as punishments for promiscuity. Following the sequence of previous notable stigmas, AIDS first hit...those engaging in American society’s least tolerated, most hot-button activities: promiscuous homosexual sex, prostitution, IV drug use.

Perceptions of the modes of the disease’s transmissibility met a collective pathology of great anxiety and unease because so little was verifiably known about the disease. It was a recipe for hysteria and hate. (Behrman, 2004, pp. 25-26)

In 1988, a New York Times/CBS poll confirmed that the stigma was real and active. The results revealed that 75% of responders had “no sympathy for homosexuals suffering from AIDS,” and 19% “had no sympathy for any AIDS patients at all, even transfusion recipients and infants” (Behrman, p. 26).

In the United States (U.S.), the stigma was perpetuated among forerunning leaders. Ronald Reagan, U.S. President from 1981-1989 and
during the outbreak and uptake of the AIDS pandemic, barely acknowledged the disease and its foreboding implications. He first publicly mentioned it as a public health issue in 1985, but he did not refer to the large scale global complexity of the disease. He continued to make public mention of HIV again through his presidency, but, against advisement of World Health Organization experts, the United States Agency for International Development (USAID), and his council, Reagan never addressed global AIDS in the course of his tenure (Behrman, 2004). Also, and perhaps more importantly, Reagan’s administration ran a tight budget, which included extremely limited funding for public health, including requests from the CDC for HIV research. This was based on the belief that health care was a more suitable local issue and expense than a federal one (Burroway, 2006).

The Moral Majority, founded in 1979 before Reagan’s ascent to the presidency, is a non-profit lobbying organization bringing together evangelical leaders and promoting pro-life, pro-family, and pro national defense issues. At the time, the organization included over 100,000 pastors, Catholic priests, and rabbis, and seven million families. The Moral Majority backed Reagan’s campaign and continued to support him throughout his tenure (“Moral majority timeline”, 2007). Although the organization is pro-life, the early Moral Majority did not support people living with HIV. In fact, prominent leaders spoke out against granting federal funding to the cause and even against allowing spiritual support. Ronald Goodwin, an early Moral Majority leader, stated “What I see is a commitment to spend our tax dollars on research to
allow these diseased homosexuals to go back to their perverted practices without any standards of accountability" (Behrman, 2004, p. 27). In 1983, Reverend Jerry Falwell, who is still the leader of what is now the Moral Majority Coalition, gave a television sermon declaring “AIDS is God’s punishment...The scripture is clear,’ Falwell preached. ‘We do reap it in our flesh when we violate the law of God” (Behrman, p. 27).

The Bush Administration of the early ‘90s did not hold much promise for those suffering from the pandemic. The Administration developed a “flagship policy” on global AIDS. It “stipulated that all foreigners with HIV or AIDS were to be kept out of the United States” (Behrman, 2004, p. 30). It was created for two reasons. First, it was principally based in “irrational fears about the modes of transmission” (Behrman, p. 30), and second, it arose from a fear that these visitors would place a burden on the country’s health system (Behrman).

Clinton’s administration of the late ‘90s was the first to truly focus on AIDS. But its attention was only on HIV on the home front. Global AIDS was a back burner issue, like most of his other foreign policy issues. However, Vice President Al Gore proved to be a groundbreaking diplomat in the arena of AIDS pharmaceuticals and beginning the institution of international accessibility. In 1996, UNAIDS emerged as the United Nations’ (UN) formal and coordinated effort at effectively and comprehensively responding to the crisis. However, it took almost two years for UNAIDS to become accepted among the UN’s member organizations (Behrman, 2004).
In 1999, around the time UNAIDS finally gained speed, the global AIDS issue caught fire with American media.

It was a humanitarian issue, a social issue, it had profound economic and developmental implications, it was a foreign policy issue and clearly had security or geopolitical ramifications. Until 1999, however, it had fallen through the structural cracks of the U. S. media and remained almost exclusively a health/science story. (Behrman, 2004, pp. 177-178)

The magic in the year 1999 as a spark for drawing attention and concern in the issue seemed to come of the opportune meeting of UNAIDS’s uptake and overt cries from AIDS activists. The next year brought another change of U.S. Presidents and administrations. The new George W. Bush Administration seemingly forecast a following of Bush, Sr.’s AIDS policy handling, but it would come to surprise many (Behrman). In 2003, during his State of the Union address, President Bush unveiled a $15 billion allocation over the following years to target global AIDS. At that time, this initiative was one of the largest AIDS contributions put forth by the U.S. (Burroway, 2006).

On a domestic level, from 1981 to 1999, 18 years passed before the American media turned its head to the issue. On a political and financial plane, it was 22 years before global AIDS became a major issue and budget allocation. As the years passed, the outspoken stigma claimed by the Moral Majority leaders would fade, but the ignorance, a key component of stigma, to global AIDS stood strong until, four years ago, President Bush declared our nation’s investment and dedication to combat AIDS abroad.
The Stigma

Beyond the science and politics of HIV and its stigma’s development, HIV has pressed some interesting implications upon American society. The first population of people to be diagnosed with it in the U.S. was homosexual men. Also, IV drug users were among the early ones diagnosed. Because of these two populations being the “first”, a correlation between HIV and homosexuals and IV drug users was cemented in the minds of people. The correlation became a negative moral connotation because HIV, to the society of the early 1980s, meant that people who had it were practicing socially and morally frowned upon promiscuous behaviors. Further negating the HIV positive population’s social status was the fear that the disease instilled. When it was first discovered, little was known about it, and doctors had no way of saving those who were seropositive. People became afraid of acquiring it even if they simply touched a person with HIV. All the early hysteria surrounding the disease has left lingering scars of a harmful stigma of people living with HIV. The stigma, at its deepest level, undercuts the human integrity of the person it affects. It strips that person of universal rights and privacy, and it tarnishes the divinity sacred to all people from the moment of conception. According to Visser, Makin, and Lehobye (2006),

Stigma is considered as one of the main reasons why people do not wish to know their HIV status, do not protect themselves and others from the virus, do not go for treatment and do not care and support people living
The Human with HIV --- it negatively affects all aspects of HIV prevention, diagnosis, treatment, and care. (p. 42)

In order to understand this juggernaut, one must first investigate the nature of stigma and its roots in HIV/AIDS.

*The Stigma Defined*

The word stigma was originally used in ancient Greece and Rome to describe the hot iron branded mark on unruly slaves and criminals. This word originated in the Greek verb *stizein* which referred to the act of tattooing (Webster’s, 2002; Visser et al., 2006). The modern definition identifies stigma as a social construct indicating a deviation from typical behavior and thus applying a label that changes the internal and external way that person is considered (Visser et al.). According to Reidpath and Chan (2005), “stigmatization is the process of marking individuals and groups judged to be unworthy of social investment” (p. 425). Visser et al. specifically define the AIDS stigma as a “prejudice, discounting, discrediting and discrimination directed at people perceived to have AIDS or HIV and individuals, groups and communities with whom they are associated” (p. 42). Stigma is related to both the disease and the behaviors that perpetuate it (Cao, Sullivan, Xu, Wu, & the China CIPRA Project 2 Team, 2006).

Stigma is not just one layer or one level; it is hierarchical and multi-layered (Ware, Wyatt, & Tugenberg, 2006). Above the health stigma are the stigmas that regularly plague societies like religion, socioeconomic status, race, ethnicity, gender, age, sexual preference, and occupation and multiply the
health stigma when present (Keusch, Wilentz, & Kleinman, 2006). For people who are stigmatized by more than one of these characteristics, it is known as double stigma or a stigma layering (Reidpath & Chan, 2005). However, the weight and application of these stigmas vary from community to community and culture to culture (Visser et al., 2006).

Stigma can be described as a sort of “social death” (Visser et al., 2006) where the afflicted people are no longer a part of the society; they isolate themselves to the point of not accessing the care and services they need to control HIV and its symptoms. Sometimes people living with HIV are more afraid of the societal stigma than of the disease itself. Further, this stigma is a social tool that preserves social injustice, creating a hierarchy legitimizing social inequality (Visser et al.). This denial, secrecy, and inequality bring about the major concern of the stigma: **it fuels the spread of HIV** (Rankin, Brennan, Schell, Laviwa, & Rankin, 2005).

*The Stigma’s Foundations*

The stigma is grounded in fear of the disease, embarrassment and blame, and ignorance and misapprehension (Cao et al., 2006). The main fear stems from the poorly understood, terminal, transmittable, and incurable aspects of the disease (Visser et al., 2006); other fears have arisen from the undesirable appearance of people living with AIDS who may have skin breakdown and take on a thin, frail, wasted appearance (Cao et al.). According to Vanier (1998), fear, at its most basic level, holds its roots in what is different from us or what challenges us; it is based upon the thought of losing something we deem
important, and it is created when we face change. In the case of HIV, people fear those who they perceive to be different and challenging. People living with HIV are looked at by some as counterculture, and thus, they are feared. Vanier says, “Fear always seeks an object” (Vanier, 1998, p. 73), and in this foundation of the stigma, the object is people who are HIV positive.

Shame and blame are associated with the behaviors that spread the disease. Some people think that HIV is simply a consequence of illegal drug use, homosexual activities, or promiscuous sexual habits (Cao et al., 2006). These are morally and religiously dictated behaviors; consequently, it is associated that HIV is acquired through morally or religiously deviant behaviors and is punishment for such actions. Thus, HIV is treated like a penance for a sin, and those infected are labeled as responsible for having acquired it. This attitude towards people living with HIV swells their personal guilt (Visser et al., 2006).

There are many misconceptions about transmission. It is thought to be contracted through casual contact in addition to sexual/blood contact. In South Africa, if a person has HIV, their family will designate a set of dishes and a blanket that is solely theirs. Some people, family and friends alike of people living with HIV, will make them wash outdoors and even use different toilets. Friends will ask them to take the cup that person used during their visit home with them. Others will discard food, a precious commodity in many areas of South Africa, after a person living with HIV has touched it (Timberg, 2005). Many people, not just internationally, but here in the U.S. as well, will ignore
HIV, denying its importance and existence. It is obvious that stigma serves as a substantial barrier both prevention and proper treatment (Reidpath & Chan, 2005).

**Imposing the Stigma**

The application of stigma requires power: power to have the ability to apply the stigma and power to take power away from the stigmatized person (Visser et al., 2006). People with little knowledge of HIV/AIDS are the ones, in general, who impose the stigma. Vice versa, people in contact with people living with HIV are less apt to impose a stigma on them (Cao et al., 2006). However, there still remain instances, here in the US, where nurses and other healthcare workers segregate HIV/AIDS patients, and even refuse to care for them (Kendall-Raynor, 2006). Even beyond the person living with HIV, the family, friends, or even community may be labeled and ignored, treated at subhuman standards (Keusch et al., 2006).

Visser et al. (2006) have identified variables that affect the level of stigma. A person’s race impacts the stigma insofar as Caucasians tend to impose the stigma more than African Americans because African Americans are exposed to the disease to a greater extent. Another variable impacting stigma is knowing someone with HIV, as aforementioned. Visser et al. found that people who know someone with HIV are less likely to impose a stigma than those who do not know someone. Gender also affects stigma. Females, especially those who are caregivers, are less stigmatizing than males. This is especially true in South Africa. Tradition dictates that one of a woman’s duties
is to care for the sick. Also, South African women hold the highest rate of female HIV infection in the world, according to UNAIDS (Suich, 2006). This fact overtly draws a connecting triangle between the facts that people who know people living with HIV are less apt to stigmatize and the fact that women impose the stigma less than men. 3.1 million of the 5.5 million people living with HIV in South Africa are women (Suich, 2006), and women assuming a caretakers role, and by default knowing a person living with HIV, are less likely to impose the stigma.

Types of the Stigma

There are several types of stigma, and stigmatizing actions can be subtle or outward (Visser et al., 2006). According to Cao et al. (2006), one type of stigma is “exclusion and isolation” (p. 521), and it includes ignorance and avoidance. It also encompasses people, even family members, expressing reluctance to touch or eat food prepared by people living with HIV. They may be rejected by their family who will refuse to help or take care of them, and they may even be abandoned by them. Visser et al. explain that the isolation of people living with HIV is a possible result of the fear imbedded in the stigma of contracting the disease; in a sense, it is a method of community disease defense. Exclusion and isolation stigma in Africa, in particular, is devastating and often coupled with stigmatizing violence. “In Africa, shame and denial of infection remains widespread, with expulsion of individuals from their homes (usually the wife who probably contracted the infection from her husband), and the occasional stoning to death of an infected individual (usually female as
well)” (Keusch et al., 2006, p. 525). Also, men will abuse or abandon their wives if they even suspect that their wife is HIV positive, or if she refuses sex, asks her husband to wear a condom, or asks him to get tested (Rankin et al., 2005). In her article, Suich (2006) cites Elizabeth Gordon of the United Nations Development Program in South Africa: “There was this woman who, when she tested positive and told her husband, her husband poured boiling water on her face, even on the child.”

A second type of stigma is “loss of resources/services” (Cao et al., 2006, p. 522). People living with HIV have been charged a higher than justifiable rate for services, and other resources have been minimized or taken away including jobs, healthcare, and even housing (Cao et al.). Cao et al. further elaborates on the types of stigma identifying “verbal stigma” (p. 523) as a third type. This includes gossip, name calling, and labeling. A fourth type of stigma is a “secondary stigma” (p. 523). It describes the discrimination and stigma imposed on neighbors, friends, and family members of people living with HIV. They will suffer the same stigmas as their loved one. This secondary stigma also extends to hospitals and clinics in some areas. They will sustain decreased patient populations if they are known to treat HIV patients.

A fifth type of stigma identified by Keusch et al. (2006) is a “secondary self-imposed stigma” (p. 525). It involves individuals who are infected and choose to deny their status by keeping it to themselves and refusing to seek treatment because of fear of being stigmatized. This results in a worsening of their condition and a nearer death sentence than they would have had if
treated (Keusch et al.). To substantiate the reality of this secondary self-imposed stigma, Timberg reports on a survey of 144 HIV positive patients conducted at two hospitals in Johannesburg, South Africa. It revealed that 38% of those surveyed had not informed any members of their family and 21% had not informed their partners (2005).

Consequences of the Stigma

As a result of the stigma, there are consequences and repercussions that weigh on people living with HIV. According to Ware et al. (2006), “marginalization is a social consequence of stigma” (p. 906). This population will spend all their time treating the disease: going to appointments with their physician and counselor, adhering to the frequent medication schedule, getting prescriptions filled, etc. Meeting the demands of HIV leaves little time for things outside of HIV. Marginalization repercussions for an HIV positive drug user typically include little money and little energy for anything beyond drugs. Similarly, recovering drug users are consumed by getting and staying clean, and they only seek to socialize with people in their same situation. Homosexual men are actually feared by their own, and reluctant to disclose status and acknowledge the disease. Those in poverty who live with HIV face limited options. According to Courtenay-Quirk, Wolitski, Parsons, Gómez, and the Seropositive Urban Men’s Study Team (2006), youth living with HIV who were exposed to stigma were at a heightened probability to participate in prostitution, use illicit drugs, and were less apt to inform their sex or drug partners of their serostatus. These same youth experienced greater levels of
depression and anxiety and used negative coping mechanisms. This group also had an increased account of suicide attempts.

In particular, in Africa, the fear instilled by stigma thwarts prevention efforts, like mothers who are pregnant not getting tested and if they are positive, passing it onto their baby through their breast milk. Or another common circumstance is that if they know they are positive, some mothers will still opt to breastfeed because of the fear of people finding out because they are using formula to feed their baby instead. The fear also curbs the use of condoms because a man or woman who suggests condom use may be seen by their partner as HIV positive. Couples may also not opt to use a condom because of denial (Rankin et al., 2005). Particularly, in South Africa, the society is a patriarchal one and wives have no reason, according to social norms, to ask their husbands to use a condom (Suich, 2006). Also, denial is perpetuated insofar as newspapers not reporting the cause of death when someone dies from AIDS (Rankin et al.). “South Africa’s newspapers are filled with death notices that refer euphemistically to a ‘prolonged illness’” (Timberg, 2005).

This marginalization of all populations of people living with HIV coupled with the intense desire for social relationships outside of their marginalized niches spikes the person’s vulnerability for potential rejection in disclosing their serostatus. Being afraid to tell people their status may result in missed medication or even non-adherence to treatment, appointments, and other demands of HIV. Also, withholding their serostatus from others puts sex and drug partners at risk. Other consequences of the stigma include financial
instability, feelings of guilt, low self-image, and depression (Ware et al., 2006). Even beyond social attitudes affecting their attitude about themselves and the health struggle that marks their lives, people face a major internal battle with themselves. “They may eventually cease to be who they were, instead becoming a unitary ‘person with an illness’ or-more damning—an ‘ill person,’ a thing in which personhood and illness have completely fused” (Rankin et al., 2005, p. 703).

The Language of the Stigma

The language used to describe people living with HIV is a component of the stigma itself. Rankin et al. (2005) reports that people in Africa will call a person who is HIV positive a “walking corpse” (p. 703), or they will plainly say “she is an HIV” (p. 703). In Tanzania the word “nyambizi” (p. 703) is used to label people living with HIV. It means submarine and suggests that person to be “stealthy, menacing, and deadly” (p. 703). Women in Africa are frequently misconceived to be typical HIV carriers. In Malawi, the word to describe sexually transmitted diseases means “women’s disease” (p. 704).

Personal Reflections on the Stigma

Recently, I was exposed to the HIV/AIDS crisis of South Africa. I visited the country with a group of eight freshmen through DeSales’ Character U Program over the winter break. One of our destinations in South Africa was a desert outpost called Upington. In Upington, our group served in the shantytowns that sat around the small city. Our service consisted of visits to families in the shanties via the ChrisTanna AIDS Hospice and the St. Vincent
de Paul Society. Our visits with the families ranged anywhere from five to twenty minutes, and each family shared a piece of their story with us as we gently listened. The memories of a few are engraved brightly into my mind.

**One man’s faith**

During a ChrisTanna visit in one of the outlying towns called Pabellelo, we witnessed the tremendous amount of optimism and faith that was inspired within one man by his condition. He shared with us that he had been brought to Pabellelo from Cape Town to be with his family when he had fallen severely ill. Since his time in Pabellelo, his strength has returned, and he won a small battle in his fight for health over his HIV. He told us that he believes God has brought him through his illness and that God supplies his strength. This man also shared with us that he is looking for an opportunity to talk to the youth of Pabellelo about his fight and his faith, and also about protecting themselves from the spread of HIV and getting tested. This man is very lucky to have a supportive family and a town like Pabellelo where HIV is so prevalent that it affects everyone in some way. Because of the disease’s infiltration and chiefly through the work to reverse the stigma by ChrisTanna, the stigma is low. Pabellelo provides a unique example of communion and a belonging for those that live there. Because poverty, hunger, and disease strike all the families there, they recognize the need to help one another and to ultimately love their neighbors like they love themselves.

**Rosalin: In her shoes**
My clearest memory is of a young lady my age (21) named Rosalin. We talked with her outside her house on her front cement patio. With her were two shy children, a boy and a girl of approximately four and six. I immediately noticed that Rosalin’s demeanor was down-trodden and despairing. Her head was down, her face was sad, and her uncertainty was overwhelming. We learned that she has been grieving the loss of her sister, whom she recently lost to AIDS, and she was now taking in her sister’s children. This young woman of 21 was putting her life to the side to take up the role of a mother for her niece and nephew. As I realized all of this, I could not help but place myself in her shoes. If my sister died, would I just as willingly take in her children and learn the role of a mother? Or would I work to find them foster homes instead, too consumed with my life and remain a distant aunt? In Upington, we learned that it is common for the family, particularly the female relatives, of those who have died to take in their children so they do not have to live in orphanages. Again, it is a testament to the shared sense of belonging, and the respect for the common thread of humanness valued in each person.

**Beauty and hope amidst deformity**

I also remember a beautiful older woman. I was immediately struck by her face. It was deformed and swollen, but her eyes burned with a love and a hope unlike any I had ever witnessed before. We were invited into her tiny kitchen to present her with a food parcel from the St. Vincent de Paul Society. She was eligible for this parcel because her family only eats every other day. This woman was taking care of her children and her grandchildren. Her
children are now at working age, so their meager incomes help keep the household afloat. She cares for her grandchildren. Her husband used to be a mine worker and would go to the mines for months at a time. She would hardly ever see his income. When she learned she was HIV positive, she told him once when he came home. He left their home within hours, and no one in the shantytown ever saw or heard from him again. Recently, one of her sons has followed suit, leaving the shantytown with no word of his whereabouts. This woman is left to take care of his children. She sees it as her duty. This woman is an example, again of the community and the tight-nit family structures common to small African villages. Sadly, her husband is typical of the sentiment toward women in Africa who are HIV positive. His abandonment, while a blow to the whole structure of the family, is characteristic of male behavior upon discovering that their partner is positive.

**Learning to unconditionally love**

My final, and perhaps most lasting memory, from our ChrisTanna and St. Vincent de Paul visits is one involving my peers from DeSales. We split into different groups with the other volunteers or caretakers. When we reconvened and reflected one of the evenings after our visits, Jaime Gerhart, Director of Social Outreach and one of the staff leaders on the trip, pointed out an important occurrence. Like all groups, her group was invited to sit down when they came into people’s homes. It is essential to understand that these families’ furniture was tattered, dusty, and in many cases, the one bed in the home that a dying family member rested on was also the family’s couch. The students in
her group often declined. I will admit that I, too, declined, often insisting that a person older than myself among our group or in the family take the seat instead. One man caring for his sister invited the students of Jaime’s group to take a seat on the bed/couch bedside his sister, who he was supporting as she sat in obvious pain on the side of the bed. The students refused. The man proceeded with his family’s story, but stopped after only a minute or so, and addressed his concern. He said to the students, “You know, you come here from the U.S., and you want to see AIDS. You want to know what it does. Well, here you are, and now you just want to stand in the corner. You refuse a seat next to my sister. It’s like you’re here, but you might as well not be. If you want to know what AIDS is, you must touch a person with AIDS. You must show them compassion. You can’t be afraid of it.” As he said this, he stroked his sister’s face, driven by the passion of his feelings, and the annoyance at our students’ stigmatizing fear. This story, although I was not even there to witness it unfolding, provided the most important lesson I learned in South Africa. All these people are worthy of the very same attention, affection, and love that I would show my own family. From that day on, I hugged the families I met without reservation. I shook the hands of people I met with a tender touch and attentive heart. I listened as if I was listening to the heartaches or triumphs of my best friend, and as I departed, I verbally offered my intent to pray for that person already having said a prayer for the Spirit’s gentle presence to rest on them.

The Faith
Those who are stigmatized feel threatened, demeaned, cheapened, and, ultimately, at a subhuman level than the rest of their fellow men. This is the chronic infection of stigma: the humanity of those subject to it is undercut and devalued. It is a problem that must be understood and stopped. In taking the first steps of understanding, in addition to examining this stigma, one must have knowledge of the aspects of human dignity and the common connectedness that flows forth from it.

*Humanity and Community*

According to the late Pope John Paul II, man shares in the divinity of Jesus Christ; all humans do by their nature. At the moment of every man’s conception, with no exceptions, man is brought into this mystery of divinity (John Paul II, 1979). From this divinity, the threads of humanity are woven and a human dignity is set in place. “The dignity of the human person is rooted in his creation in the image and likeness of God” (*Catechism of the Catholic Church*, CCC, p. 474). Following from this, a “divine image” exists in all people. It truly manifests when people commune, “in the likeness of the unity of the divine persons among themselves” (CCC, p. 475). Thus, we are called to community and to fulfill a call to belonging.

Jean Vanier, in his book *Becoming Human*, teaches that belonging is the place where we find out what it means to be a human. He further maintains that belonging comes at the center of one of life’s central tenets: we are all part of a “common humanity, the human race” (Vanier, 1998, p. 36). As part of this massive common thread, we all have the need to be valued and understood. On
the most basic level, our needs are identical to those of every other human on this earth (Vanier, 1998). Thus, we must be open to all aspects of other people and other cultures (Vanier, 1975).

Vanier, while defining the essentials of humanity, also points out its common misconceptions: “Humanity is not an ideal group of people living together. It is you and me and all of us, with our faults and our qualities, learning to accept, so that none of us is crushed by an ideal which we cannot live up” (Vanier, 1975, p. 83). However, our social standards dictate this “crushing ideal”; we correlate being human with power, success, and attaining knowledge. By these same standards, humanness equals power, not weakness. “The image of the ideal human as powerful and capable disenfranchises the old, the sick, the less-abled” (Vanier, 1998, p. 45). Further still, we live in a society where putting on a façade of happiness is encouraged. Thus, we reject the weakness, an inevitable sadness, in ourselves and others, pretending it is not there (Vanier, 1998). This directly applies to the perpetuation of the stigma of HIV/AIDS. In our ignorance, rejection, and fear of weakness, we alienate those living in the complete vulnerability of their serostatus. In upholding the correlation of being human with having power, we strip away the humanity and, with it, the divinity of the so-called weak, the people living with HIV.

In overcoming this stigma through the recognition of our common humanity, we must seek truth and reflect on humanness. These actions will lead us to reality. “Reality is the first principle of truth. To be human means to remain connected to our humanness and to reality” (Vanier, 1998, p. 15). Part
of embodying humanness is accepting ourselves wherever we are and wherever we have come from, and accepting the same of others. “The point of inclusion is the belief that each of us is important, unique, sacred, in fact” (Vanier, 1998, p. 95). This is the only way to relate to others: to include them (Vanier, 1998).

Beyond the societal level, the Spirit is what ultimately brings us into community with each other; it is the Spirit that changes our hearts to love and accept (Vanier, 1975). The Spirit facilitates the fulfillment of our common humanity and the call to belonging.

**Loving one another**

In the Gospel of Matthew (22: 37-39), Jesus teaches us the two greatest commandments. “You shall love the Lord, your God, with all your heart, with all your soul, and with all your mind. This is the greatest and the first commandment. The second is like it: You shall love your neighbor as yourself” (Senior, Getty, Stuhlmueller, Collins, 1990). The problem with the stigma attached to HIV/AIDS is a principle opposition to the second commandment. How can someone love their neighbor if they are labeling them and acting against their humanness and their divinity, ultimately that person’s inherent common link to them, for their serostatus?

Vanier, in his book *Becoming Human*, provides seven keys for love. First, we are called to reveal. Loving someone means revealing their beauty to them, giving them your time and attention. Tell them that they are unique and special. Be present and open for them, especially through the actions of speaking and listening to the person. If we judge and select whom to ignore
and whom to welcome, we are not moving towards a greater humanness. We are, in fact, regressing away from it. Second, Vanier says love requires understanding. Taking the time to understand someone leads to growth and inner peace; this in turn will foster a relationship with that person built on trust. A third key to love is communication, which Vanier holds is “at the heart of love” (Vanier, 1998, p. 24). While communication alleviates confusion, it is a process involving teaching, learning, and exchange. It is the vehicle of understanding. Fourth, Vanier offers celebration as an essential. Every person needs to know that they bear joy to others. A fifth cornerstone of love is empowerment. This aspect of love is guiding others to help themselves and thus discover their own life’s meaning. Love’s sixth component is communion. Vanier says of communion: “Communion is mutual trust, mutual belonging; it is the to-and-fro movement of love between two people where each one gives and each one receives...Communion is mutual vulnerability and openness one to the other...Communion is at the heart of the mystery of our humanity” (Vanier, 1998, p. 28). Flowing from communion is Vanier’s seventh and final element of love: forgiveness. While communion may seem the most important, forgiving someone takes precedence of all the other aspects of love. Communion, indeed, involves forgiveness (Vanier, 1998). I believe it is these things that can begin in alleviating the stigma attached to HIV/AIDS. A person living with the disease lives in a highly vulnerable state. It only follows that these people need the revealing of their beauty, the time put in by another to understand their struggle, the growth of learning that will come of
communication, the joy of celebration for that person, the empowerment to seek a better life for themselves, the essential communion of humanity, and the forgiveness to continue to move beyond bitterness and doubt that relationships can inflict.

**Compassion for those living with HIV/AIDS**

For Catholics, there is a very specific call to compassion for those living with HIV/AIDS. As early as the mid to late 1980s, the authorities of the Church were responding with practical responses for the social consequences of HIV/AIDS. In November of 1989 at the National Conference of Catholic Bishops, there was a call to Catholics, as both members of society and the Church, to extend themselves in compassion and to maintain unity to people living with HIV and their families (*Called to compassion*, 1990). The Church called people without faith to look to the human dignity, not the suffering, of those who are seropositive. At this conference, violent and discriminating actions directed toward PLWHIV were declared morally wrong and unreasonable. Also, the disease was disconnected as castigation from God for immoral acts (*Called to compassion*, 1990).

In his 1987 address, Cardinal Basil Hume stressed the importance of Catholics extending infinite and pragmatic compassion (Hume, 1992). A 1986 address by Cardinal Joseph Bernardin referenced Jesus’ unconditional compassion in healing the sick and accepting the socially unacceptable as practical examples for Catholics of our time. In a time when HIV was still largely associated with homosexuals, Cardinal Bernardin made it clear that it
is “a human disease, not a specifically homosexual one” (Bernardin, 1992). He also clarified that discrimination is in no way acceptable towards people living with HIV: “At the present time, there is no medical justification for discrimination against these people, and, in fact, such discrimination is a violation of their basic human dignity and inconsistent with Christian ethic” (Bernardin, 1992).

Jean Vanier, in his book *Be Not Afraid*, paints a picture of a modern day parable of Lazarus. In the parable of Lazarus and the rich man, Lazarus, the leper, went unseen by the rich man. We do not see the Lazarus’s of our society either because we do not want to see them. The prisons, ghettos, or hospitals keep them unseen and away from us. We in turn, isolate ourselves into our comfort zones where we do not have to see them. It is easier this way. “Our immediate reaction to all sad and impossible situations is to shut our hearts, to create a world of excuses to avoid being inconvenienced” (Vanier, 1975, p. 15).

Vanier says that it is imperative that we are open to compassion. It is the isolated person who needs someone to simply listen, because in anyone’s suffering, the first thing one seeks is a friend to talk to who finds what they say important and expresses their caring for them. Jesus calls us to present hope, foremost to those broken and oppressed. He calls us to share our food and shelter with them, to ease their sufferings and to guide them to confidence and freedom. We are called to present the love of God, the Father, to them. It all begins by praying for our isolated and hurt brothers and sisters (Vanier, 1975).
My Reason

Stigma strips away humanity. It is fed by fear, fear of those who are different and fear of something people chose to ignore and learn little about. This fear builds the stigma, which in turn breeds more fear by allowing misconceptions and myths to spread. It is a vicious cycle, and it will continue to have a hold on the spread of HIV/AIDS unless it is stopped. We need to rid fear; we need to be guided by the actions of love and compassion in light of our faith’s human standards. It begins with change. On a faith level, change occurs by looking to the divinity in each person, the common divinity that ties all of us to the human race. On a societal level, change occurs through awareness and education. With these tools, the stigma can begin to be stripped away.

Change agents often incorporate a combination of the two levels. Change agents, people willing to sacrifice for a cause they fully believe in, are examples to our world that it takes just one person to promote and uplift our humanity. Mother Teresa and Bono are modern change agents that we can look to for inspiration. Change agents sacrifice who they are; they sacrifice as Jesus sacrificed himself to save us, redeeming our sins and preserving our divinity. Like Jesus, the change agents preserve and grant hope for all humans. Some would argue that it takes a multi-millionaire to be a change agent in the capacity needed for the kind of change to solve global problems. However, change agents are not concerned about solving the world’s problems; they are engaged in alleviating suffering and offering real solutions. Mother Teresa was
no multi-millionaire, and Bono is not interested in simply giving a portion of his rock-star’s salary.

*Mother Teresa’s love*

“Let us conquer the world with our love. Let us interweave our lives with bonds of sacrifice and love, and it will be possible for us to conquer the world” (Mother Teresa, p. 106). As a Missionary of Charity, an order she herself founded, she never possessed more than the impoverished people she served. She lived her life in poverty, among the lowest of the low, and in accordance with Christ’s teachings. Mother Teresa’s life signifies love in action. She is a recognized symbol of an agent for world peace (Vardey, 1995).

She dedicated herself to heal the suffering of others and extend love into the world through this healing ministry. Her order, which has attracted 4,000 plus men and women to become Missionaries of Charity Sisters and Brothers, helps a largely non-Christian population. Among the reach of the Missionaries and Mother Teresa in India: a house for leprosy patients called Gandhiji Prem Nivas outside of Calcutta, where the patients learn to care for one another; a children’s center in Calcutta called Shishu Bhavan which cares for approximately 300 ill or starving children at any given time and also has an outpatient clinic and a soup kitchen providing meals for about 1,000 people per day; and Nirmal Hriday, which is a home for those who are dying in Calcutta where a dignified death and a respectful burial is ensured. The reach of her work and homes also extends to the U.S., Britain, China, Columbia, Spain, Portugal, Brazil, and Honduras (Vardey, 1995).
“Mother Teresa’s modus operandi is to relieve Christ’s suffering as she sees it in the eyes of all who are poor and who suffer” (Vardey, 1995, p. xxx). She sacrificed her entire life to serving the poor, embracing those who no one wanted to, and teaching 4,000 people to do the same. There is no telling how many others she has inspired toward change and service.

Bono: rock star and humanitarian diplomat

Visit www.one.org and you will encounter a very powerful set of pictures with streaming phrases alongside of them. The phrases say: “We believe we can beat: AIDS, starvation, extreme poverty. We recognize ONE billion people live on less than ONE dollar a day. We commit ourselves-one person, one voice, one vote at a time-to make a better, safer world for all” (One, 2007). This is the dream child of one man: Bono of the cross-generational, international rock band U2. The campaign is a mission to unite Americans, of all standings and beliefs, to do something tangible about global poverty and AIDS. It is called “one” because of the vision and belief that dedicating an extra one percent of our nation’s budget for essentials like healthcare, food, water, and education to change the lives of the up and coming generation of impoverished countries for the better. The One campaign has approximately 60 governmental and non-governmental organizations, churches, and other organizations bonded together in creating a solid, unified effort to further the allocation of one percent to tackle global poverty, disease, debt cancellation for struggling countries, and other major issues which prevent people from living full, healthy lives. As Bono says, “It’s not about charity, it’s about justice” (One, 2007).
Faith and reason

In a world where we are called to be reasonable, we find a world trying to tackle global AIDS, an issue our world’s leaders have, in my opinion, sat on for far too long. The horrors of the stigma of HIV, let alone the extent, complexity, and enormity of the disease itself, have undercut the humanity of too many. In a place where each and every human is bound by a common thread—the thread of humanity and the tie of divinity—stigma has removed a piece of the commonality.

Is it reasonable to leave misconceptions uncorrected? Is it reasonable to blame the people with HIV/AIDS for their condition? Is it reasonable to call HIV “God’s punishment”? Is it reasonable to reject, ignore, abandon, or isolate someone just because they are HIV positive? Is it reasonable to deny healthcare to a person with HIV/AIDS in need of treatment? Is it reasonable to label these people? Is it reasonable to impose these very same stigmas on those people who are family or caretakers of people with HIV/AIDS?

According to Britannica online, in theology,

...reason is the human intelligence exercised upon religious truth whether by way of discovery or by way of explanation. The limits within which the reason may be used have been laid down differently in different churches and periods of thought: on the whole, modern Christianity, especially in the Protestant churches, tends to allow to reason a wide field, reserving, however, as the sphere of faith the ultimate (supernatural) truths of theology. (“Reason”, 2007)
A thing that, at its foundations shatters the Lord’s second commandment is not reasonable according to the dictate that reason must give way to the “ultimate truths of theology”. Thomas Aquinas believed that faith and reason come together to bring us truth. He believed that the two cannot clash, since both are rooted in God (“Thomistic philosophy”, 2007). From this lens, stigma, by rejecting a tenet of our faith and by not following the dictates of reason, is confirmed to be neither a product of faith nor reason, and ultimately, it is not truth. Thus, to reverse the stigma, a piece of truth originating in a combination of faith and reason must surface. This is where the modern day change agents guide us. It is easy to discern that Mother Teresa acted primarily out of faith, but also out of her reason that allowed faith to be her ultimate truth. Bono has taken on the roll of a political diplomat, engaging politicians and influential figures from the past two U.S. Presidents to the late John Paul II. For him, his actions of reason are geared toward adding a practical percentage of the national budget to reverse the ever too real and continuously staggering HIV infection and mortality rates. However, faith plays a major role in these actions. “I try to live it rather than talk about it because there are enough secondhand-car salesmen for God...But I cannot escape my conviction that God is interested in the progress of mankind, individually and collectively” (Tyrangiel, 2005).

Truth

Stigma is an example to us that we cannot rely solely on the facts at hand. The leaders of the early 1980s did and ended up prolonging a
desperately needed response to the AIDS epidemic. The result: a major juggernaut that is just beginning to be handled and a stigma that is still running deep and strong. Stigma also shows us that we cannot be guided by reason alone. The families and friends who ask their HIV positive loved ones to use their own dishes and different toilets are operating by misguided reason and are being blinded to the potential for saving faith actions. My own peers who cannot even sit beside a woman dying of AIDS are hard hitting examples that reason alone allows the fear fueling stigma to continue. Bono and Mother Teresa are inspiring examples that compassion and love of God and neighbor can show the world to love, through revealing beauty, understanding suffering, empowering those who downtrodden, communicating hope, celebrating each and every person, fostering communion, and lending forgiveness. We must follow our faith above all else in dealing with human immunodeficiency virus. Ultimately, it is our reason guided in the light of faith that decides our human connection, not simply reason alone. In doing so, there exists the potential to shatter stigma through the truth that faith coupled with reason will surface. This truth is passion that propels the dreams of change agents. It is this truth that reveals the human in human immunodeficiency virus.

**Conclusion**

Visser et al. (2006) described the stigma as a “social death” (p. 47); essentially, it is the qualified exclusion, ignorance, acted misconceptions and fear of the disease that are shutting people living with HIV out of the larger communion, the greater belonging. Stigma ultimately fuels the spread of HIV.
Among people, the imposed stigma shatters the Lord’s second commandment by creating a social injustice, enforcing a hierarchy, and through a select group or person assuming power over one whom they deem weaker.

In uncovering the stigma, its history, origin and elements, and the way in which it undermines man’s divinity and opposes the Lord’s second commandment, one comes to find injustice and an evil based in fear, not truth. Society’s best examples are found in change agents, people who sacrifice themselves to promote a cause they fully believe in and promote humanity. In their actions and in the actions called for to combat stigma, we are all called to actions of faith and reason. Combining faith and reason that foster truth, the reaction needed to stop the stigma are actions based in love and compassion for one’s neighbor, human partner, and comrade in divinity.
References


