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ORIGINAL PAPER

Saints and Sinners: Training Papua New Guinean (PNG) Christian Clergy to Respond to HIV and AIDS Using a Model of Care

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Abstract Papua New Guinea has experienced a growing HIV/AIDS epidemic. The Christian Churches have played a vital role in responding to HIV, through community support, encouragement and social change. Strong, effective Church leadership can help create safe environments of care and support for those infected and for prevention of HIV. *Method* A series of trainings in capacity development for clergy were undertaken by the National AIDS Council Secretariat (NACS)/National HIV/AIDS Support Project (NHASP). *Results* A model "Church's Response to HIV and AIDS in a Care Continuum" was developed to assist the training. This paper discusses the model and the lessons learned.

Keywords Papua New Guinea · Christian clergy training · HIV/AIDS prevention and care · Outreach

Introduction

Over the recent decades, the people and government of Papua New Guinea (PNG) have faced a devastating epidemic of HIV and AIDS, with infection estimates now at more than 2% of the population in some districts (McBride 2005; UNICEF 2005), The need for effective responses has reached crisis point (Cullen 2006; Worth and Henderson 2006). Many individuals and organisations have achieved much in combating the human immunodeficiency virus (HIV) (UNAIDS 2006), especially the National AIDS Council

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Secretariat (NACS) in association with National HIV and AIDS Support Project[1] (NHASP). However, in order to have a significant impact, we argue that it is necessary for a wider multi-faceted approach involving all sectors of society (Cullen 2006; Swan 2006).

Christianity is well established in PNG with at least 66% of the population belonging to a denomination (Flaws 2006). The Churches have played a vital role in responding to the threat of the HIV pandemic, through close contact with the community to provide support and encouragement to communities struggling to respond. However, in PNG, stigma and discrimination against people with HIV, and reluctance to address underlying factors have hindered appropriate responses. These factors include a sense of shame, weak social infrastructures, a reticence to discuss issues related of sex, suffering and death, and an inability to grapple with the complexities of HIV and AIDS (c.f. Marshall 2005). Under the auspice of NACS/NHAPS a series of training workshops were conducted in PNG for Church leaders and clergy in 2004–2006 to address some of these issues. Participants attending the Church leaders workshops represented the Anglican, Assembly of God, Baptist Union, Four Square, Lutheran, Roman Catholic, Salvation Army, Seventh Day Adventist, Pentecostal, and United Churches. In the clergy training workshops, participants came from the above denominations and included clergy, lay people and pastoral care workers. These workshops have informed this article and were the basis for developing the model to help clergy and lay people to respond to the challenge of HIV and AIDS in their communities.

This article begins with an understanding of why the Church needs to be involved in the response to HIV and AIDS. Three vital aspects are introduced—the theology of care and compassion in engaging with the epidemic; the unique role of the Church in understanding and educating about HIV; and the practical aspects of providing care and support in the context of community development and social change. This is brought together in the model that was used to help clergy develop strategies for an effective HIV program. An analysis of the model and lessons learned are presented.

Churches Level of Engagement

A three-level framework was used for exploring the engagement of religious communities in the context of HIV and AIDS: the ecological, the moral, and the religious (Moore 2004).

The Ecological Level

The ecological level relates to how religious communities form and act to define group identity and mission. Fundamental to shaping the sense of identity, are key worship events—regular public worship and worship activities that mark life-cycle events and other social concerns. Sometimes these occured spontaneously in response to a need, sometimes as an organised outreach program, or as regular activities. Moore (2004) argues that these social activities form and sustain a sense of community. The word "liturgy" means the work of the people, and it is more than the rituals and ceremonies. It is the gathering together, which forms community and a sense of belonging (Moore 2002, p. 266). Regular public worship also maintains the definitions of group identity and this is "an intentional

[1] A 5-year Australian Government sponsored program of HIV and AIDS technical support for the PNG AIDS Council Secretariat.

creation of boundaries: this is us—and they are not us" (Moore 2004, p. 510). In terms of HIV and AIDS, this boundary setting supports an often misplaced belief that congregations are exempt from the risk of infection because HIV is transmitted by those involved in "illegal" sex; i.e., activity beyond the providence of church members (Mageto 2005). This creates an environment that leads to rejection and discrimination of those sick with HIV (Kurian 2004).

Therefore the development of "inclusive" regular worship that welcomes and responds appropriately to people with the HIV virus, and their life-cycle events (especially death in the context of HIV) are essential aspects of the response to the threat of HIV. This requires clergy and church leaders to be informed and trained to respond appropriately to people living with HIV and those dying of AIDS-related conditions.

The Moral Level

The moral level refers to a theological understanding of liturgy and worship as the foundation for seeing moral purpose as service to humans. However, most of the time "liturgies are more works *on* the people than works *of* the people" (Moore 2004, p. 515), and are more concerned with maintaining community exclusivity than as a springboard into service.

Hence, including HIV and AIDS in public worship as a focus for prayer and ritual are valuable aspects of ministry. These events, such as candlelight vigils; World AIDS Day liturgies; healing and wholeness liturgies; relationship celebrations including marriage; intercessory prayer for the sick, the dying and the bereaved; dignified funeral liturgies that honour those who died from AIDS related conditions; as well as providing the sacrament of the Eucharist, laying on of hands and anointing, confession, and prayer for individuals and families become a basis for care and support.

This requires resources and capacity building of clergy, lay assistants and ministers as well as congregations. The basis for such a strategy is the work *of* the people coming out of being grounded in worship and then lived out in action. It is not so much that care is done *on* people, rather it needs to be done *with* people with HIV, their carers and families. It then becomes the work of the whole community, not just the work of the ordained clergy, and as such the health of the community is enhanced.

The Religious Level

The religious level of responding relates to cultural ways of understanding sin and transgressions; judgement and salvation; and understandings of the divine (Moore 2004; Strassberg 2004). HIV is not only located within a medical framework. The epidemic is connected to "far-reaching transformations of labour patterns, courtship, erotic life, marriage, childbearing and child rearing, family life, household arrangements, patterns of discrimination, health care, cultural production, and the national and international economy" (Strassberg 2004, p. 455). HIV is therefore complex and problematic and beliefs that the divine is somehow removed from the impact of the epidemic is to understate both the relevance and the power of religion in the response (Swan 2006). The often-repeated refrain that AIDS is a punishment from God for sins committed (Marshall 2005) simply reinforces a victim mentality leading to hopelessness and despair. With reference to the South Africa situation De Waal (2004) states: "The level of behaviour change needed to

stop the epidemic is extraordinarily high, and infection so widespread that most people treat HIV simply as an occupational hazard of life. Indeed, they ask, is it worth living to a lonely old age if all one's peers have died?" (De Waal 2004, p. 34). This defeatist thinking undermines prevention, sours communities and is not life enhancing. Many people became infected unknowingly, and for many women, infection is often the result of virtuous living as becoming "passive victims" (Stassberg 2004, p. 449). This is when people turn to their faith to make sense of what is happening, and to come to terms with suffering. If the church cannot provide a realistic and helpful process for understanding, then people will seek non-Christian explanations and solutions from miracle workers, witch doctors and charlatans (Mageto 2005). The response of the Church to HIV continues to be characterised by fear of contagion; ostracism of HIV positive people and their families; and on the whole ignores issues of prevention and vulnerability (Mageto 2005).

In some areas of PNG, for example, Lelet in Central New Ireland, apocalyptic Christianity acts as the operative framework for a Pentecostal understanding of AIDS. Apocalyptic Christianity places heavy emphasis on an expected disastrous end of the world (Eves 2003). This approach teaches concepts of hell as punishment for wrong doing and heaven as reward for good deeds; and uses such as a means to compel people to follow certain creeds (Eves 2003, p. 254). HIV, natural disasters, economic and social crises are portrayed as the results of immorality or immoral behaviour, and this emphasizes the impending end time. The apocalyptic narrative builds on stories of sexual prohibitions and shame which restrict public contact and interaction between the genders. However, behind the public discourse on shame lies a hidden realm of illicit sexual liaisons and encounters, which is exposed when a child is born out of wedlock or an illness reveals a moral transgression (Eves 2003, p. 257). The apocalyptic discourse is maintained with examples of miraculous cures for converts as a result of conversion; but when illness befalls them, the explanation is that the converts had slid back to "bad old ways", with sickness as the consequence (Eves 2003).

Although there were elements of apocalyptic discourse in the workshops we conducted, the focus was more on action that would save souls. The conundrum then arose that people with AIDS eventually became more and more ill, in spite of apparent repentance and deliverance from sin. The way to address this was to reconstruct the "victim theology" of AIDS (Mageto 2005, p. 3) to an approach that provided a rationale to help clergy appropriately acknowledge and interpret the dynamics of the pandemic. Inevitably such theologising leads to a response that includes social change (Hicks et al. 2005). Indeed, social change is at the forefront of any response to HIV, be it in the church or civil society. Hunt (2004) warns that theologising tends to serve the needs of those in power. Rather than "doing theology", the more appropriate course would be to use participatory approaches, to listen to the voices of those most affected and marginalised by this disease. This would yield an understanding of the "varied strains of divine and human suffering as an essential step toward their eradication" (Hunt 2004, p. 469).

Developing a Theology of HIV

Any theology of HIV must be embedded in the liturgy of the people; an acting arising out of worship. The prerequisite for any action in the context of illness and suffering is compassion. Compassion has been variably defined as "suffering with" (literally *com* (with) *passion* (suffering) (Moore 2004, p. 515); being aware of other people's pain; understanding the pain; and being moved to do something about it (Steffen and Masters

2005; Strassberg 2004). This requires an awareness of the issues causing the pain and an ability to prioritise the suffering of others. If there is no prioritising, other issues can distract compassionate action, or other matters take priority, such as raising funds, and being unaware and not able to act appropriately when there is a crisis (Moore 2004).

For compassion to be evoked, certain requirements must be met: that the suffering be perceived as serious rather than trivial; that the person does not deserve the suffering; and that the person who experiences the compassion is in some way similar to the sufferer (Nussbaum 2001).

One obvious problem with compassion is that it requires that one person become aware of another's suffering. When silence surrounds HIV and AIDS, as demonstrated in the church by people not declaring their status or their needs, the risk of shaming and stigma is not surprising (Mageto 2005). As a result, people withdraw from community activities with the consequence that people suffer alone and in silence (c.f. Nathanson 1992, pp. 317–321).

A second problem is that compassion is often seen as a one-way activity. Yet the basis for Christian behavior is the Golden Rule—"Do to others as you would have them do to you" (Luke 6:31; Matthew 7:12 New International Version), which assumes a level of reciprocity. It goes something like this, "If I experience the same suffering as others, I would hope for similar compassionate treatment from others in the future" (Moore 2004).

The third problem is the issue of who is deserving of compassion. Compassion is an emotion and must contend with other deeply felt powerful emotions of shame, anger, disgust, betrayal, guilt and fear (Moore 2004; Nathanson 1992). It is thus possible to understand the negative responses to people with HIV and AIDS if ethical norms consider the behaviors associated with contracting the disease as deserving of shame and disgust. In fact, compassion will be next to impossible to generate if we believe that those who suffer do so because they deserve to suffer—at the most extreme, a punishment from God for sin (Marshall 2005).

Such insidious responses that come from these emotions are not simplistic moralising by individuals, but indeed are formed and reinforced by claims to religious identity, that are in turn reinforced again and again in common worship.

A claim can be made that such norms are accepted cultural norms, but the reality is that within a religious setting, such reactions of disgust will not allow true compassion to surface. Indeed any reluctance to act in the face of enlightened self-interest (when congregations are being depleted by deaths to HIV) or out of a slowness to be motivated by compassion will be disastrous (Moore 2004).

But the most incapacitating aspect towards acting compassionately is lack of empathy; that people are moved to act only when they themselves are suffering. The dilemma is that one tries to imagine the suffering of another, whilst at another level, the suffering of another is perceived as a warning. Herein lies the problem with faith communities undertaking HIV prevention, and providing care and support. The dilemma also forms the basis for stigma and discrimination—i.e., in order to act, the individual (and by implication the community), must be aware of the suffering of the other and the causes of that suffering, must overcome the feelings of disgust, and most importantly feel that they could well be in the same situation, quite apart from any reasonable acceptance of likely threat (Moore 2004; Strassberg 2004). For the pastor/priest/liturgist/caregiver engagement with people is core business, which has its varying levels of connectedness and recognition. Empathetic caring to a person stricken with AIDS is most difficult when recognition of suffering and death is so starkly drawn; and at the same time this caring raises questions of vulnerability and threat for the carer (Purnell 2004).

The individual and the community therefore construct boundaries around those people who are perceived as high-risk; to close off the threat. This creates an unsafe environment for anyone wanting to disclose their infection and/or their risk, thus ensuring the exclusiveness of congregations (Mageto 2005; Kurian 2004).

The fundamental mind shift required in the Church is to realise that religious people cannot be expected to act swiftly with compassion in respect of HIV and AIDS until there is a readiness to accept, without reservation, that: HIV is in the Church; domestic violence and reckless sexual behaviours are commonplace; and men, (as much if not more so than women), are 'bearers' of HIV (UNICEF 2005, p. 4). The problem is more than not knowing what to do, or not being able to act, or even to touch; it is linked with unwillingness, or inability, to accept solutions that violate people's sense of decorum and deeply felt norms. Marshall (2005) calls for trans-disciplinary and multi-sectoral approaches that utilise the insights from theology, medicine, the social sciences, education and economics (Marshall 2005, p. 146).

The evidence from the United States indicates that health programs conducted by faith-based organisations can produce positive health effects for communities (DeHaven et al. 2004). Steffen and Masters (2005) found that having a compassionate attitude was related to positive psychosocial health outcomes. One of the key aspects enjoyed by faith-based organisations is the familiarity with the local community—and this is particularly true of the situation in PNG where the church has considerable influence (Flaws 2006). However, in the workshops we conducted in PNG, it became clear that the clergy and pastoral workers did not know how to address the issues of HIV and AIDS. They wanted a model to help them understand how they could best respond to the epidemic within the ethic of valuing and helping the other, and to help their congregations address their fears of contagion.

However, even if we build on this ethic of valuing the other for whatever reason, be it by injunction of scripture, self-interest, or compassionate empathy, nothing will be accomplished without an understanding of the disease we are dealing with. This means understanding what HIV and AIDS are; how the virus is transmitted; how to prevent oneself becoming infected and passing it on; how to access the means of prevention and of reducing vulnerability; and when, if infected, how to be supported and nurtured through the process of illness. Hence, accurate information and addressing the myths around HIV are fundamental to being able to undertake any program (Harman-Cromwell 2005).

Method

As part of the NHASP faith-based program three 5-day workshops were conducted to provide an opportunity and a space for clergy and church leaders to develop skills in using scripture, sermons and liturgies to address issues of HIV and AIDS, and hopefully reduce the level of fear. The primary focus was on providing an appropriate vocabulary for workshop participants to address prevention, sexuality, suffering, disease, death and fear of HIV/AIDS. This was done through Bible studies, discussion and clarification of the aetiology of HIV and disease progression. The workshops we conducted utilised participatory methods with group exercises and discussion that were well received, as has been the findings of others (Kareithi et al. 2005). The training program undertaken with pastors and church leaders in Port Moresby and Madang, PNG, 2004–2006.

Results

The Church's Response to HIV and AIDS in the Care Continuum

A model was developed in conjunction with Church leaders and pastors at a training workshop in Port Moresby in 2004 to better understand how the churches could be involved in the response to the epidemic.

The continuum of care in an HIV response was a model developed to provide integrated services for clinic and home and community-based care for people infected and affected by HIV and AIDS based upon HIV testing as an entry point to a range of health services (Odgen et al. 2004). Although HIV testing is highly desirable, testing sites and counsellors for voluntary confidential counselling and testing (VCCT) for HIV were not widely available or easily accessed in PNG (McBride 2005). The care continuum developed for the churches was based on the notion of community-based care responding collectively to the needs of people within church congregations. The training was to inform the participants of the content area, and to provide opportunity to discuss and develop ideas for outreach and activity within church communities (Fig. 1).

We started with participants' experiences of HIV and AIDS—sickness and death.

Death and Bereavement

The life cycle and end-of-life events are core aspects of the Church's liturgical action. In the training of pastors, we started with reflecting on the pastoral practice of funerals and the bereavement aspects of death in the context of this epidemic, and the implications for self, family and community (Holt et al. 1999). We then explored how this was different when AIDS was suspected and the implications for families and other community members. In this section, the honoring of people who had died due to AIDS-related conditions was a

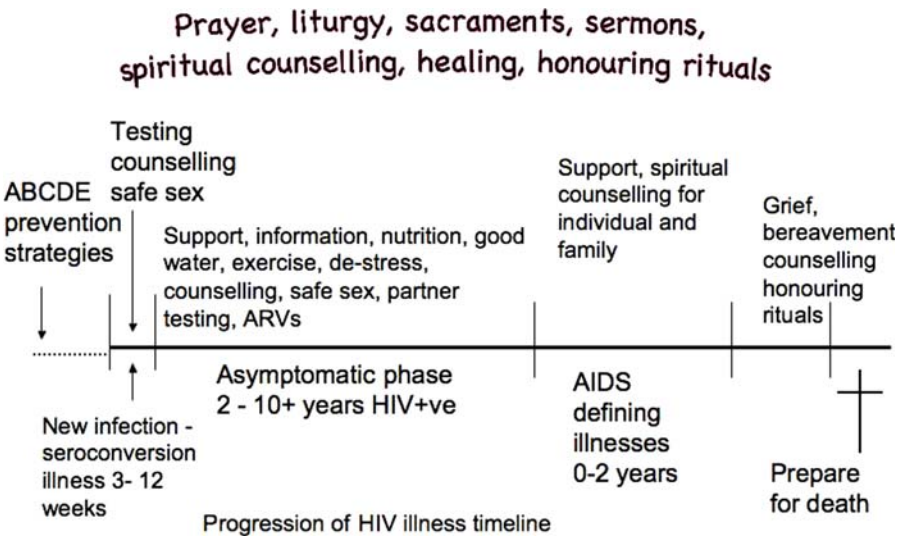

Fig. 1 The role of the church: responding to HIV/AIDS in a care continuum

crucial aspect to reduce shame and social isolation often experienced with HIV (Eves 2003). Being able to prepare dying persons with the sacraments can be the beginning of such an honoring.

Prevention

The training focus then shifted to prevention; using Bible stories (John 9: 1–3; Luke 6:31; Matthew 22: 34–39) in group discussions. Condoms, sex education, and the myths and silence around these issues were reviewed, often with heated debate. The discussion included the ABCDE of prevention. A = abstinence, B = be faithful to one partner, C = condom use, D = do something else other than unprotected penetrative sex (with particular reference to young people), E = educate about HIV, condoms and sexuality. Although consensus was not always reached on these issues the discussions did reveal the myths and fears held by the pastors, often due to lack of accurate information. It also became obvious that people needed a language (vocabulary) and a space to practice discussing these issues. The small groups then shared learning from Bible studies and developing sermon points which helped considerably in developing a lexicon (WCC 1997).

Understanding HIV Testing

We found that most participants understood the meaning of the HIV test, but the timing and delays associated with detecting antibody seroconversion were more problematic. This aspect was addressed with lecture and discussion. The importance of accurate information about how HIV can be prevented and especially accessing condoms was again highlighted. There was considerable debate over a perceived need to know who was infected with HIV, so that people could be warned and thereby avoid risky contact. This led to an animated discussion over the absence of any visible identifiers for HIV, and that people could be infected without their or anyone else knowing.

Asymptomatic Phase

This phase of the progression of the disease was presented with discussions about how the community could ensure access to fresh water, good nutrition and the establishment and care of vegetable gardens, and the importance of exercise, counselling and stress management. Support for prevention strategies and maintaining family relationships led into a Bible study (Matthew 7:1–5; 1 John 1: 8–10) which focused on stigma and discrimination.

The Symptomatic Stage

When people developed symptoms and were experiencing increasing bouts of sickness, support and care for individuals and families became necessary. Treatments with antiretroviral medications and traditional medicines were discussed. It was reported that herbal concoctions were being peddled as AIDS cures in some districts. Spiritual guidance and spiritual counselling were seen as particularly valuable, as was medical assistance with symptoms if possible and available.

The Overarching Framework of the Care Continuum—the Worship and Prayer Life of the Community

The religious practice of the community wherein people are offered the sacraments, teaching, spiritual guidance, and rituals and actions for healing, honouring and supporting, was discussed. In terms of addressing stigma and discrimination, welcoming and inclusion of all people in the community, was highlighted as vitally important, regardless of health status, which brings this discussion back to theologies of compassion and care. As Strassberg (2004) notes, AIDS is cultural and linguistic and not just biological and biomedical, and as such requires an interpretation within a specific cultural context and discourse. Public worship and pastoral care of people at any point on the care continuum provides one opportunity for such a such discourse.

At present there is no cure or vaccine for HIV or AIDS (Holmes 2005) and healing is not the same as cure. Providing a cure is about removing the cause of the disease. Whereas healing is about transformation of the whole person, when, in spite of the presence of the illness, the person's attitude to life changes from misery to liveliness, from despair to hope, and for some, release from suffering. When healing occurs, negative emotions of anger, shame, fear and grief are replaced with the peace, joy and love that are necessary to fulfil that person's potential in relation to the world (Garrett 2002). However, in the context of HIV, when a person is surrounded by stigma and feels discriminated against, such healing will be difficult—that requires a transformation of the whole community, and this becomes the task of the church. This model seeks to provide a practical means to bring about that transformation by breaking the silence surrounding HIV (Harman-Cromwell 2005).

Key Aspects for Implementing the Model

An essential aspect of implementing a response was to have a committed and willing leader who could set up a care committee in the local congregation or church, could ensure men as well as women were involved, could involve HIV positive people as early as possible, and could develop a strategy for implementation.

An assessment of the leader's or resource group's skills in the following areas would be required including: a theological understanding of HIV; creating informed sermons and liturgies; undertaking spiritual, and grief and bereavement counselling; creating honoring rituals; being able to educate accurately about HIV and the progression to AIDS; an ability to understand and incorporate ABCDE of prevention[2]; and counselling for HIV testing and support (if testing is available and easily accessed).

To enhance the community's capacity to respond, the following would need to be addressed by resource persons: the fostering of Christian commitment of compassionate caring; the capacity to deliver physical support through sharing of resources; an assessment of what was needed to undertake the activities—people, resources, materials; access to information and training.

[2] ABCDE: Abstinence, Be faithful to one partner, Condoms, Do something else other than penetrative sex, Educate people about HIV and prevention

Lessons Learned from Developing and Testing the Model in PNG

The Churches in PNG are in every community and village and had the potential for effective leadership in the response to HIV. The collaboration of Church leaders to address issues of stigma and discrimination was essential to consolidate trust and mutual respect. The Churches' mission to care for and support the weak and the poor was often compromised by fear of disease—ongoing accurate information and education were deemed necessary to counter myths. Cultural and theological understandings of causes of disease, based on concepts of punishment for sin and judgement and the need for salvation needed to be deconstructed and revitalised with a positivist approach, to ensure effective and appropriate responses to HIV. This was started in the workshops with Bible study and discussion. The ABC approach to HIV prevention was inappropriate where there was limited HIV testing, counselling and education, and lack of access to condoms.

Programs to support people in relationships to stay faithful were also found to be important. Issues of domestic and sexual violence increased the vulnerability of women and young people, and needed to be addressed by the Church. The disagreement of some denominations on the morality and effectiveness of condoms undermined the public health endeavours to protect the public. These lessons learnt highlighted the complexity and difficulties of responding effectively to HIV and AIDS in faith communities. There were no simple solutions—what the workshop provided was a process that enabled participants to engage with the issues, to find ways to discuss sensitive issues openly, and to have a framework within which to act.

Discussion

A model for developing effective strategies for responding to HIV within the PNG Christian Churches was embedded in a three-level framework. This structure consisted of the ecological, moral, and religious levels and was used for exploring the engagement of the religious communities in the context of HIV and AIDS. The model focussed on developing effective and appropriate patterns of care with the Churches. Responding to HIV and AIDS that required training and support for clergy and lay people. In the case of PNG, NACS and NHASP, with the help of the Australian Government, endeavoured to provide access to training for clergy and pastors with some success. Yet there have been problems with the divergent approaches and theological stances of many of the denominations in PNG. In the training workshops, the model was a useful tool to guide thinking and planning and highlighted the issues that needed to be addressed.

This program of training was most useful in presenting the facts and the general issues that needed to be addressed in any response to HIV. However, some of the complexities of caring for people with HIV and their families needed more exploration, especially in terms of local community response. Talking about sexuality and HIV publicly was problematic, although the small group discussion on sermon points helped considerably in providing a framework for thinking through the issues. The participants also expressed difficulty in accepting that a starting point for the model required them to take responsibility for their own behavior and their role as educators about HIV. They also had difficulty accepting that this might apply to their own families as well as their congregations. There was a tendency to want to act *on* people rather than work *with* people to meet their needs. Issues of cultural understanding and explanatory frameworks of disease, sorcery, gender, apocalyptic creeds, and gaining salvation were reoccurring themes throughout the workshops, as also reported

by Eves (2003). Notwithstanding the difficulties encountered, the model was warmly received as a strategy for local church communities to respond to HIV and AIDS.

Conclusion

Although models and strategies can provide a framework for planning and action, they can never be a substitute for willingness to engage compassionately with those who are outcast, the diseased, the dispossessed and the dying. Indeed it should be the core business of the Church, and the model presented in this article, as a small-scale initiative, is but one approach to delivering on that core business. HIV is a silent scourge devastating communities across the world. It is also in the church where religious sensibilities are no protection. What is required is within the grasp of any faith community: recognising the need for prevention; educating people about HIV especially the young; caring for the sick and dying; honoring all people; creating safe environments; and countering the impact of stigma and discrimination. HIV can be a source of great suffering, but it can also be an opportunity for the transformation of a community when it finds its own humanity and grows spiritually. In the face of death there is yet life.

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