CATHOLIC SOCIAL INTERVENTION AND ITS IMPACT ON PEOPLE LIVING WITH HIV/AIDS (PLWHA) IN AFLAO AND DZODZE

BY

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DECLARATION

I hereby declare that this thesis, with the exception of materials quoted from other scholarly works which have been duly acknowledged, is the original production of research work by the researcher undertaken under the supervisions of Dr. Ben-Willie Golo and Dr. Lawrence Boakye of the Department of the Study of Religions, University of Ghana. Any errors in this thesis are fully acknowledged as that of the researcher.

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DEDICATION

I dedicate this work to the Sacred Heart of Jesus and to my family and all who continue to support and pray for me. I love you all Mary, Franca, Cypriano and Worla. God bless you.
ABSTRACT

The HIV and AIDS have spread so rapidly that within three decades and it has taken millions of lives. Generally, the seroprevalence of HIV in Ghana in recent times has decreased. However, most of us care little for People Living with HIV/AIDS (PLWA) due to strong stigma attached to the disease. This implies that the community support spirit which hitherto was part of African cultural ethics has diminished for the PLWA. However the Keta-Akatsi Catholic Diocese has taken up the holistic support to the PLWA through its Community Collaborative, Care and Support Programme (COMCASUP) in its coverage area. This study examines the impact of this programme on PLWA at Aflao and Dzodze and their environs. The work of COMCASUP was viewed within the remit of empathy and the theological orientations of the Catholic Church’s social intervention. Methodologically the study adopted the qualitative study approach in which scholarly works were reviewed. Owing to grave concern for stigmatisation of PLWA, data was gathered mainly through interviews with the PLWA, caregivers and directors of COMCASUP and through observation of the PLWA. The research found that financial constraints have been a serious threat to the care and support the Catholic Church have deployed for the PLWA.
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LIST OF ABBREVIATIONS

AIDS - Acquire Immune Deficiency Syndrome
ART – Anti-Retroviral Therapy
CBO – Community Base Organisation
COMCASUP – Community Collaborative Care and Support Programme
CRS - Catholic Relief Service
EoP - Encyclopaedia of Philosophy
GAC – Ghana AIDS Commission
HIV - Human Immunodeficiency Virus
NGO – Non-Governmental Organisation
OVC - Orphans and Vulnerable Children
PLWHA - People Living with HIV and AIDS
SECAM - Symposium of Catholic Bishops’ Conference Africa and Madagascar
STI – Sexually Transmitted Infections
VCT – Voluntary Counselling and Testing
WHO – World Health Organisation
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CHAPTER ONE

1.1 Background to the Study

At the threshold of this millennium the epidemiologists of Pasture Institute in France and the Centre for Disease Control in the United States almost simultaneously discovered a very lethal disease: Human Immunodeficiency Virus (HIV) and Acquire Immune Deficiency Syndrome (AIDS). The disease constitutes a serious threat to the survival of the human race. It is one of the most serious health conditions that threatens the existence of the family in recent times.

The central governments of various countries affected by the deadly disease, churches and the civil society groups in general have been grappling with the issue of prevention and care for HIV/AIDS patients. HIV and AIDS are capable of affecting any member of any society, and its prevalence among the rural poor in a developing country cannot be overemphasized. Dyke posits that HIV/AIDS is a human catastrophe from which no single individual in sub-Saharan Africa is exempted. Unfortunately the cure for HIV/AIDS remains elusive. United Nations Programme on HIV/AIDS (UNAIDS) estimated in November 2012, that by 2015, 34 million people will be living with the disease. The death rate as of 2012, was estimated to be 1.8 million people including children. Current estimates indicate that 56,300 people are infected each year with HIV in the United States. This infection rate contributes to the already reported 1.5million individuals living with HIV or AIDS in the US at the close of the year 2007. Although HIV and AIDS cases are prevalent globally, sixty-seven percent of that number resides in

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the low and middle income countries of sub-Saharan Africa.\textsuperscript{4} DevelopAfrica asserts that Africa disproportionately bears the burden of the HIV/AIDS pandemic. There were 22.4 million people living with HIV and 1.9 million new HIV infections in 2008. An estimated 14 million children in Africa have been orphaned as a result of HIV/AIDS.\textsuperscript{5} In 2012, roughly 25 million people were living with HIV in sub-Saharan Africa, accounting for nearly 70 percent of the global total. In the same year, there were an estimated 1.6 million new HIV infections and 1.2 million AIDS-related deaths.\textsuperscript{6}

In Africa, specifically sub-Sahara, given the endemic multiple social ills such as poverty and scarcity, the HIV/AIDS epidemic is a real scourge for the people. The HIV/AIDS epidemic constitutes not only the worst scourge and onslaught which Africa’s people must contend with, the sub-region is beset with other problems. Notable among such problems are economic hardships, social and political injustices, chronic poverty, economic recessions, massive unemployment, underdevelopment, poor governance, poor infrastructure, inexperienced leadership to mention but few. Historically, Southern African countries were the last in the region to be hit by the pandemic, as it blazed its way relentlessly down the continent from East Africa.\textsuperscript{7} Uganda is the only African country to have succeeded in turning the tide on the epidemic, through early concerted awareness and strategies. Botswana, Zimbabwe and South Africa have become the hardest hit by the disease among all African countries.\textsuperscript{8} These numbers of HIV/AIDS infections and prevalence rates raise important questions about the growing population of people living with HIV or AIDS (PLWHA), as well as the prevention of this disease. For


\textsuperscript{5} DevelopAfrica, http://www.developafrica.org/hiv-aids-Africa?gclid=CN068faxisgCFYm4GwodMWQMrw

\textsuperscript{6} Avert, http://www.avert.org/hiv-aids-sub-Saharan-sub-Saharan-africa.htm#sthash.4zffKPV0.dpuf


\textsuperscript{8} Chirawu, \textit{Common Herbs}. 

University of Ghana  http://ugspace.ug.edu.gh
instance, what are the illness specific support needs for the people living with HIV or AIDS? Why does knowing how to prevent the transmission of HIV not translate into actually doing so? One concept that emerges in response to both of these questions is disclosure. Disclosure is the PLWHA ability to divulge his/her status to at-risks individuals. It is a communicative tool that can increase the social support for PLWHA and reduce further transmission of the virus.\(^9\) This will further help to improve the quality of life for people affected by the illness.

The consequences of the HIV/AIDS epidemic on the demography of these areas of Africa are worth noting. Most of these countries’ active labour force has been affected tremendously. In 1999, infant mortality rates due to HIV/AIDS for the sub-Region were nearly 70%. Child mortality rate has proved to be even greater, all due to the HIV/AIDS epidemic.\(^10\) By 2010, the rate of HIV infection in South Africa was projected to be more than twice as high as it would be without AIDS, and in Zimbabwe, three and a half times as high.\(^11\) Institute for Health Measurement postulates that during the mid-1980s, HIV and AIDS were virtually unheard of in southern Africa. Now, it is the worst affected region and widely regarded as the epicentre of the global HIV epidemic. In 2012, Swaziland had the highest HIV prevalence rate of any country in the world (26.5 percent). HIV prevalence is also particularly high in Botswana (23 percent) and Lesotho (23.1 percent). With 6.1 million people living with HIV resulting in a prevalence of 17.9 percent. South Africa has the largest HIV epidemic of any country. The remaining countries in southern Africa have a HIV prevalence between 10 and 15 percent.\(^12\) Key drivers of HIV transmission are identified as multiple partner relationships and polygamy. In effect, some African if not most communities encourage men to have

\(^12\) Institute for Health Measurement, Southern Africa. http://www.ihmafrica.org/AboutTechAreas
extensive sexual networks. Other factors identified as contributing to the spread of the HIV epidemic are unemployment, displacement as a result of conflict and labour migration, these projections alarmed the Southern African countries to adopt radical awareness measures to curtail the scourge.

In Ghana, HIV and AIDS have spread so rapidly that they have affected Ghana in such a way that within two decades, AIDS has taken thousands of lives in Ghana. According to the 2013 HIV Sentinel Survey Report, the National HIV prevalence is 1.3%. An estimated 224,488 persons made up of 189,931 adults and 34,557 Children (15%) are living with HIV in Ghana. There were 7,812 new infections of which 2,407 were children between 0-14 years and 5,405 adults. There were 10,074 AIDS deaths being 2,248 in children 0-14 years, and 7,826 adults.\textsuperscript{13} Comparatively, Ghana’s rate is one of the lowest in Africa estimated to be below the 5% threshold for a generalized HIV/AIDs epidemic. However a closer look at the 2013 Sentinel Report shows that HIV prevalence is higher in urban areas. In other words, it is still a concentrated epidemic occurring mostly among high-risk groups. WHO also reported that in the 2010 survey, there was a higher prevalence of HIV in the rural areas in Ghana. Further statistics also show that HIV/AIDS epidemic has reached every community and locality in Ghana.\textsuperscript{14}

Furthermore in Ghana, while awareness of the HIV/AIDS epidemic is thought to be over 95 percent, it has not yet translated into corresponding widespread behavioural change.\textsuperscript{15}

From the above statistics, Ghana has relatively low prevalence of the epidemic. The country therefore has a very important window of hope to curb the spread of infection

\textsuperscript{15}J. Osei-Agyekum, Behaviours that Place Junior Secondary Students at Risk of HIV/AIDS. Proceedings of the National HIV/AIDS Research Conference (NHACON), Accra, Ghana, 11th – 13th February, 2004.}
and to mitigate the impact of the epidemic on PLWHA. Anarfi postulates that while some of the available information on the HIV/AIDS and its related issues in general are important, there is the need to emphasis on developing and sustaining partnerships with People Living with HIV/AIDS (PLWHA). He asserts that HIV-related stigma is at the heart of many failed efforts by both the Church and civil society groups over the years to respond to the epidemic. Owing to stigma several interventions towards prevention, support and care, have been less effective.\textsuperscript{16}

The manifestation of the disease suggests that it can narrow or even wipe out the potent labour force of human capital of Ghana. The worst affected areas might experience development reversals. Ajuluchukwu et al in 2007 suggest that the HIV/AIDS infection has created a major public health problem in many parts of Ghana and it is now second to malaria in terms of scale.\textsuperscript{17} Further, it has been identified by Danso in 2010 that HIV/AIDS is not just a health issue, and that it is also a social, developmental and economic issue. The impact has a significant repercussion for development of the country which evokes some attitudinal and behavioural reactions from both the patient and the society in which the patient is found.\textsuperscript{18}

According to the Ghana Health Service, the disease continued to spread in Ghana in spite of the encouraging statistics provided by the Ghana AIDS Commission in recent times. During the last quarter of 2013 the Okomfo Anokye Teaching Hospital, Kumasi reported about 50 AIDS cases each month. Freiku indicated in that since then, more than 52,961 HIV/AIDS cases have been reported in the health institutions in Ghana. This represents

\textsuperscript{18}A.N. Danso, “The Negative Consequences of HIV/AIDS in Ghana,” in Daily Graphic (No. 16371) (13\textsuperscript{th} June 2010), 3.
30 percent of cases in the country as majority of the victims patronise the traditional health centres, prayer camps and others do not report their illnesses due to the fear of stigma and discrimination.\textsuperscript{19}

The HIV prevalence in Volta Region in the 2013 Sentinel Survey was 1.2%. Ketu South Municipal Health Sector in 2010 reports that: “Of greater concern is the high prevalence of HIV/AIDS in the municipality. It is difficult to assess the exact rate of the disease in the municipality since immigrants and patients across the Ghana-Togo border attend hospitals in the district for treatment.”\textsuperscript{20} The existence of commercial sex workers continues to pose a threat and serves as a challenge to the municipality’s anti HIV/AIDS programmes. The report also indicates that: “The municipality is collaborating with NGOs/CBOs in the campaign against HIV/AIDS and efforts are being made to support people living with HIV/AIDS. Some of the programs target institutions, long distance drivers, and commercial sex workers and identified groups like artisans.” \textsuperscript{21} Aflao and Dzodze are the two centres in the Municipalities of Ketu South and North where cross border activities are very dense.

Social support system for the infected people involves evaluating certain indices for maintaining good health and coping with the disease. These include care giver support, health promotion/prevention of illness (nutritional care, hygiene and sanitation, prevention of opportunistic infections) and early diagnosis/treatment. Care giver support for instance includes provision of daily needs of the victims. According to UNAIDS, care giver support should be encouraged to create support network of similar care givers such as religious groups, women’s groups, non-governmental organisations and community

\textsuperscript{21} Ketu South Municipality. \textit{District Analytical Report 2010.}
health workers who should help families to identify local resources.\textsuperscript{22} Health promotion/illness prevention connotes provision of healthy food capable of nourishing the infected persons. This will also help to prevent illness to enable them live with dignity and security.\textsuperscript{23} Unfortunately these structures do not exist in our local communities.

In September, 2006, the Catholic Diocese of Keta-Akatsi through the Catholic Relief Service established the Community Collaborative Care and Support Programme (COMCASUP) unit to provide care and support to our unfortunate brothers and sisters who are victims of this deadly disease. This project was to last five years and subject to renewal through the support of the Local Catholic Church. Since the expiration of the period the Church found it difficult to raise enough funds to support the project, owing to its capital intensive nature.\textsuperscript{24} In view of the foregoing, this study is to investigate the impact of the Catholic Church’s social intervention to the people living with HIV/AIDS and their dependents in Aflao and Dzodze.

1.2 Problem Statement

Recent overview of the reported cases of HIV/AIDS done by the Catholic Secretariat in 2013 at the District Hospital of Aflao, St. Anthony’s Hospital, Dzodze and Sacred Heart Hospital, Abor (all in the Southern part of the Volta Region) has suggested that most of the HIV victims who regularly patronise these health facilities, apart from the initial pre-test/post-test counselling and anti-retroviral drugs which are distributed, do not receive any other forms of supports in order to cope effectively with their situation.\textsuperscript{25} Hall asserts

\textsuperscript{24} Keta Akatsi Catholic Secretariat, \textit{Annual Report} (Akatsi: May 2103).
\textsuperscript{25} Keta Akatsi, \textit{Annual Report}, 2013.
that the Catholic Church is the largest provider of care to HIV/AIDS patients in the world. However, the Church is not in favour of the use of condoms as a major means of prevention and the spread of HIV/AIDS.\textsuperscript{26} Rather, she teaches that the surest way of avoiding the HIV infection is total abstinence from illicit sex and fidelity in marriage.\textsuperscript{27} The mission of the Catholic Church is to set standards in social intervention. Therefore she calls especially on the believers of the Catholic faith to seize the opportunity to alleviate the burden of the society when need arises.\textsuperscript{28} The Roman Catholic Church in most parts of the world including Ghana is considered the leading church in terms of the provision of education, justice and peace, poverty alleviation and also health provision and care. It is unimaginable the suffering, pain and misery HIV/AIDS have brought to PLWHA in the area of this research. Consequently this research is set out to examine the support system the Church has in place for PLWHA in Aflao and Dzodze.

1.3 Objectives

The main objective of the study is to examine the impact of the social intervention of the Catholic Church in Aflao and Dzodze on the People Living with HIV/AIDS. The following specific objectives have been set to meet the main objective. These are:

1. To examine the situation and the challenges of PLWHA, especially in Aflao and Dzodze in the Keta-Akatsi Catholic Diocese.

2. To explore the theological basis of the Roman Catholic Church’s teachings on social interventions.

3. To investigate the Catholic Church’s response to the plight of PLWHA in Aflao and Dzodze and their environs.


1.4 Research Questions

Based on the objectives stated the following research questions will be investigated;

a. What are situations and the challenges of PLWHA in Aflao and Dzodze in the Keta Akatsi Catholic Diocese?

b. What are the theological underpins of the Catholic Church’s social interventions?

c. What are the responses of the Catholic Diocese of Keta Akatsi to the plight of PLWHA in Aflao and Dzodze and theirs environs?

1.5 Scope of Study

The Catholic Church has been involved in various social actions and interventions with people living with various condition all over the country. However the focus of this study was confined to the Catholic Diocese of Keta-Akatsi’s response to the challenges that PLWHA face around Aflao and Dzodze communities. The strategic locations of the areas selected for the research provide a fertile reservoir for more HIV transmission. Aflao and Dzodze are border towns where cross border activities are very dense between Ghana and the Republic of Togo. Further, owing to grave concern for stigmatisation of PLWHA, the research was carried out to investigate the responses of the Catholic Church in the Volta Region.

1.6 Conceptual Framework

There have been many discourses on social exchange theory and empathy-altruism hypothesis. Some of these discourses have direct bearings on the basis of the Catholic Church’s mission towards the disadvantaged such as the PLWHA. This study will focus on the basis of the Church’s social support to the PLWHA from the perspective of the
concept of empathy. This concept must be understood as inner imitation of understanding other minds/humans. Empathy according to Oxford dictionary means the ability to understand and share the feelings of another. This concept has been closely advanced by scholars such as Edward Titchener, Theodor Lipps, Martin Buber and Edith Stein.

According to Stueber, the psychologist Titchener (1867–1927) introduced the term “empathy” in 1909 into the English language as the translation of the German term “Einfühlung” (or “feeling into”). Empathy according to him refers to interpersonal context whereby the individual thinks, understands and speaks as another individual does. This is a human phenomenon. Unless one feels and understands the other he/she cannot offer any meaningful help or support to his own kind. However it was Theodor Lipps who gave the right meaning to the term as emphasised by Stueber;

Theodor Lipps (1851–1914) scrutinized empathy in the most thorough manner. Most importantly, Lipps not only argued for empathy as a concept that is central for the philosophical and psychological analysis of our aesthetic experiences. His work transformed empathy from a concept of philosophical aesthetics into a central category of the philosophy of the social and human sciences. For him, empathy not only plays a role in our aesthetic appreciation of objects. It is also to be understood as being the primary basis for recognizing each other as minded creatures. Not surprisingly, it was Lipps's conception of empathy that Titchener had in mind in his translation of ‘Einfühlung’ as 'empathy.'

In the same vein Edith Stein has been identified as addressing the concept of empathy as the problem of other minds. She claims that there are persons other than herself, and she knows that these persons have various psychological states and experiences. One comes to this reality through inference. According to her, our knowledge of the inner lives of others is via the following considerations: “I am aware of my physical body, my internal

31 Stueber, “Empathy”.
psychological states, and the correlations between them. I can perceive the outward bodily motions of others, which I take to have some sort of cause.”

Again, McDaniel posits that Stein’s answer suggests that empathy enable us to be aware of psychological state of others. Empathy is an irreducible intentional state in which both other persons and their mental states are given to us. In an empathetic experience, we are presented with not mere bodies in motion, but rather with persons – and they are presented to us as persons who are angry, or who are grieving, or who are filled with joy. Persons and their mental states are not theoretical posits or unobservable entities – they are objects of which we have something akin to perceptions.

Likewise Martin Buber, in his Ich und Du (I and Thou) theory of 1923 defines human existence as in dialogue with each other, with the world, and with God. According to him, human beings perceive each other as engaged in holistic dialogue than as consisting of specific isolated entities in an I-Thou relationships. The I-Thou relation is a direct interpersonal relation base on love, which is not mediated by any intervening system of ideas. Buber argues that I-Thou relation has Love as its basis. In this relation individual constituents share unity of being and a sense of caring, respect, commitment, and responsibility. It is an inescapable relation humans must share in order to advance the world as the creator has planned it. Therefore when humans try to alter I-Thou relationship which is subject to subject, to that of I-It, which is subject-object, which is very common in our time and which hitherto has not been with traditional life, there will be alienation, stigmatisation and total rejection which has been the bane of PLWHA.

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33 McDaniel, Edith Stein.
34 Martin Buber, I and Thou, trans. by Ronald Gregory Smith (New York: Charles Scribner’s Sons, 1958), 26
35 Buber, I and Thou, 26.
Considering Stein’s assertion on empathy and Buber’s I and Thou concept and relating them directly to individuals who are afflicted by various predicaments we have no choice but to infer from their afflictions and transpose ourselves to the inner perceptions of their feelings.

1.7 Methodology

This researcher intends to use qualitative research approach to explore the understanding and meanings of the verbal narratives of the respondents. According to Merriam and Sharan, qualitative research strives for an in-depth understanding of situations and phenomena in their uniqueness as part of a particular context and the interactions, beliefs, attitudes, motivations and culture.\textsuperscript{36} They further asserted that, qualitative research tries to understand the nature of the contexts and settings, what it means for participants to be in a particular setting, what their lives are like, what goes on for them, and in the analysis to be able to communicate that effectively to others who are interested in that setting.\textsuperscript{37}

This study is also guided by the phenomenology which tries to describe the actual state of affairs as disclosed by the phenomena.\textsuperscript{38} Phenomenology afforded the researcher the opportunity to suspend his judgments and employ 	extit{epoche} \textsuperscript{39} in order to arrive at objective results. This process allowed the selected PLWHA and the caregivers to speak for themselves. Dahlin, equally opined that the phenomenological method is grounded in epistemology which strives towards neutrality concerning truth and value.\textsuperscript{40}

\textsuperscript{37} Merriam and Sharan, \textit{Qualitative Research}.
\textsuperscript{38} J. L. Cox, \textit{Expressing the Sacred: An Introduction to the Phenomenology of Religion} (Harare: University of Zimbabwe Publications, 1992), 15.
\textsuperscript{39} Cox, \textit{Expressing the Sacred}, 26-29. \textit{Epoche} is a method or tool whereby the observer could avoid value judgments. Thus the researcher brackets out his previous ideas, thoughts, opinions or beliefs and observes the phenomenon as they appear rather than as they are understood through opinions formed prior to observation
\textsuperscript{40} Olov Dahlin, \textit{Zvinorwadza: Being a patient in the Religious and Medical Plurality of the Mberengwa District, Zimbabwe} (Frankfurt am Main: Peter Lang, 2002), 22.
1.7.1 Sources of Data

This study makes use of both primary and secondary forms of data. These data were collected through guided interviews, observations, informal discussions, published and unpublished materials, journal articles, newspapers, internet sources and the Bible. These methods of data collection helped to answer the research question.

1.7.1.1 Primary Sources

According to Blaikie, primary data is generated by the researcher who has the sole responsibility for the design, collection and analysis of the research.41 The primary data of this study comprise guided interviews, informal discussions and observations. There were direct interviews with the authorities of Catholic Diocese of Keta-Akatsi in the Volta Region, which include some priests and the heads of the support group - COMCASUP project - the Church has established to meet the welfare of the HIV/AIDS affected people in the communities in the Diocese. There were also interviews with some PLWHA to ascertain their views on some of the impacts of the social intervention by the Church on them. The interview sessions were conducted in the HIV facilities of Aflao Municipal Hospital, St. Anthony’s Hospital at Dzodze and the Catholic Secretariat at Akatsi. Further, some interview sessions were also conducted in some villages around the Aflao and Dzodze communities where few PLWHA received home-based cares.

1.7.1.2 Secondary Sources

The secondary sources included published works such as books, journal articles, research papers, unpublished thesis on the topic under study by theologians, philosophers, Christian leaders and other authors. Newspaper articles were also utilized. The secondary data also captured the review of the Church’s social interventions in the world, Africa

and Ghana. Specifically, the study by Chinhanda in 2012 in assessing the Roman Catholic Response in Botswana was perused.

1.7.2 Population/Samples and Sampling Procedure

Bryman and Bell describe a population as “a discrete group of units of analysis.” The target population of this study comprises of the support group - COMCASUP, clergy in-charge of the Catholic Diocese of Keta Akatsi and the PLWHA in and around Aflao and Dzodze. The purposive sampling technique was used for in-depth interviews of persons for focus group discussions. Each individual is chosen based on already knowledge about the respondent as being a member of the expected sample enumerated above. Kumekpor asserted that in purposive sampling, the units of the sample are selected not by a random procedure, but they are intentionally picked because of their features or because they satisfy certain qualities which are not randomly distributed in the universe, but they are typical or they exhibit most of the characteristics of interest to the study.

1.7.3. Limitations of the Study

The qualitative method of data collection was chosen due to the difficulties encountered during the distribution of questionnaire to some of the PLWHA. On the account of sensitivity and confidentialities that surround issues of HIV/AIDS and owing to stigma of PLWHA in the area of this study, some of the caregivers who were to lead the researcher to identify the PLWHA categorically refused to do so and were not ready to distribute the questionnaire to the PLWHA. Secondly more than half of the seventy percent of the first batch of the questionnaires distributed through the caregivers could not be returned. Further, the returned answered questionnaires were not properly answered.

42 Bryman, “Barriers to Integrating.”
Again some of the key respondents were not easy to locate. They were most of the time on the move to other PLWHA and centres which are not in the coverage area of this study. It took several days to meet the twenty (20) PLWHA interviewed in the areas of this study. It was also very challenging to meet those PLWHA who are abandoned by their families and have become the responsibility of the COMCASUP project.

1.8 Literature Review

The concerns of PLWHA hinge around the unfavourable reactions they receive from the society. The complexity of HIV/AIDS phenomenon is related to stigma and discrimination which are often cited as a primary barrier for the limited response to PLWHA issues. This section review scholarly works which are relevant to PLWHA stigma and discrimination. There are some identifiable literature available on the stigma and empathy which can correlate to induce support and care for PLWHA that this research intends to address.

First it is important to understand the concept of stigma which has become a canker to PLWHA concerns. The word stigma actually refers to a tattoo mark or brand on Greek slaves who had been polluted and so had to avoid public places. According to Goffman, stigma can be perceived as a social or individual attribute to “devalue and discredit” in a particular way. To him, the stigmatised individual is literally isolated from all social acceptance. The relationships associated with the individual described to be stigmatised in the lenses of Goffman can be categorised into three contests; the stigmatised, the normal and the wise. The stigmatised refers to the individual bearing the stigma. The normal relates to those who do not bear the stigma and the wise describes those

45 Goffman, *Stigma*.
46 Goffman, *Stigma*. 
individuals among the normal who the stigmatised identifies as wise as they respond favourably to them. In effect, this three categories can be vividly identified in our communities which perpetuate the notion. Goffman further asserts that, stigmatisation does not occur in isolation, it is the individual, the normal and the wise who stigmatise one another.\textsuperscript{47} Even though HIV/AIDS was not a focus of Goffman’s theory of stigma and discrimination, elements of it can be highly grounded in it. HIV/AIDS related stigma refers to prejudice, negative attitude, abuse and maltreatment directed towards individuals infected with HIV/AIDS. In this study, the researcher intends to analyse Goffman’s notion in relation to PLWHA and see the possibility of the promotion of the stance of the wise in Goffman’s categorisation. This in a sense could promote care and support for PLWHA who have been abandoned and ostracised in our communities.

Many scholars have related the stigma issues to the issues of HIV/AIDS and PLWHA. Ramasubban, and Rishyasringa in 2005 asserted that HIV/AIDS stigma and discrimination exist around the world in a variety of ways, including ostracism, rejection, discrimination and avoidance of HIV infected people, compulsory HIV testing without prior consent or protection of confidentiality, violence against HIV infected individuals or people who are perceived to be infected with HIV and the quarantining of HIV infected individuals.\textsuperscript{48} They continue that HIV stigma related violence or the fear of violence prevents many people from either seeking HIV testing or returning for their results or from securing treatment thereby possibly turning what could be a manageable chronic illness into a death sentence and perpetuating the spread of HIV.\textsuperscript{49} HIV/AIDS stigma has also increased the negative attitude towards certain sessions of the society.

\textsuperscript{47} Goffman, \textit{Stigma}.
\textsuperscript{49} Ramasubban and Rishyasringa, \textit{“AIDS and Civil Society.”}
such as sex workers, homosexuals and other associates who are suspected as those who brought the pandemic.

An inference from Ramasubban and Rishyasringa’s assertion suggests that HIV/AIDS related stigma affects the wellbeing of people infected with the disease as well as their families and loved ones. This has been the concern for this study. The scholars’ assertion of the phenomenon has also been used to understand the process of stigma and discrimination as perceived and how it consequently impacts on the social and economic lifestyle in and the area of the study for PLWHA. The theory again emphasises the importance of analysing and assessing responses to stigma in terms of care and support and care to PLWHA.

Another scholarly work of Mahajan et al in 2008, entitled “Stigma in the HIV/AIDS epidemic: A review of the literature and recommendations for the way forward,” has also addressed the issues on stigma and discrimination that confront PLWHA in various societies all over the globe. They postulate after analysis of different reports on HIV-related stigma from the various parts of the globe that HIV stigma is a global phenomenon. Their literature indicates that despite the global recognition of the phenomenon there are different treatments of the PLWHA by various communities depending on the cultural traditions of various people. They made a strong claim that various actors in the societies had not been successful in the limitation of this canker all over the globe, in spite of conscientious efforts that are being made. They were further emphatic that most HIV/AIDS programmes had so far not prioritised stigma because it has often not had enough funding, however, they claimed that the founder and executive director of UNAIDS, Peter Piot in 2006 identified “tackling stigma and discrimination as

51 Mahajan, “Stigma in the HIV/AIDS”.

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one of five key imperatives for successful fight against the pandemic.” In effect, the recent spread of the HIV has been blamed largely on the silence of disclosure due to stigma related problems. They also noted that the inability of the various scholars to conceptualise and confine the HIV related stigma explicitly to its own domain precludes meaningful appraisal and comparisons of the concept. They continued that most literature base their argument on Goffman; “seminal theorisation of health-related stigma in the 1960s as an attribute that is deeply discrediting,” and that reduces the bearer “from a whole and usual person to a tainted, discounted one,” and have defined stigma cursorily as “a mark of disgrace”. Therefore, they postulated that HIV related stigma needs “a comprehensive conceptual framework that incorporates both the socio-cognitive and the structural aspects of stigma as well as captures the effects of pre-existing and overlapping stigma related to poverty, race, gender, sexual orientation, etc.”

Mahajan et al as they shed more light on the issues that surround the inability of people to offer support to PLWHA, although their literature does not cover the study area for this study, most of the assertions of Mahajan et al pertain to the cultural setting of Aflao and Dzodze. The work focussed on the fundamental issues that prevent risk reducing behaviours. The gap in their work is what the researcher intends to address in this work. There could be a close correlation between effective care and support to PLWHA and the reduction in stigma. Whenever an effective support system and dependable social welfare exist for PLWHA, there is likelihood that most people will identify with them and this will lower stigma and discrimination thereby prevent the spread of the pandemic enormously.

52 Mahajan, “Stigma in the HIV/AIDS”.
53 Mahajan, “Stigma in the HIV/AIDS”.
54 Mahajan, “Stigma in the HIV/AIDS”.
Furthermore, another group of scholars, Rankin et al in 2005 have also assessed HIV/AIDS stigma in their article entitled, ‘The Stigma of Being HIV-Positive in Africa’. They asserted that “stigma is part of the attitudes and social structures that set people against each other and impedes any countervailing forces for social equality.”\textsuperscript{55} They seem to suggest by this assertion that HIV-related stigma has created conflicts among communities on the African continent. But they were quick to indicate that in most rural settings on the continent when certain deities and ancestral spirits are aroused they bring illnesses upon individuals or communities in retribution for the offence. They claimed that: “… Punishment theories authorize communities to isolate or purge the “impure” - people whose illness or imagined “sinfulness” would contaminate the whole - while reassuring that virtue and social status will protect the righteous.”\textsuperscript{56} These scholars akin the HIV-related stigma to such traditional religious situations, because for considerable length of time in our rural communities, HIV/AIDS has remained a punishment from the deities for people who commit sexual misdemeanours precisely prostitution and other sexual pervasions. However, this view no longer holds in most of our communities with the amount of scientific information available on the condition.

The main concern of Rankin et al is the way to minimise the social oppressions that have been engendered by the erroneous conceptions about the disease and the plight of PLWHA in the various African communities where conditions such as poverty, sexism and ethnicity promote stigma especially those related to HIV/AIDS.\textsuperscript{57} They also noticed that HIV-related stigma should attract the attention of all because it is the main causal agent and catalyst for the continuous transmission and spread of the virus. They were emphatic that stigma has destroyed the very expressive family system in Africa: “HIV-


\textsuperscript{56} Rankin, “The Stigma of Being.”

\textsuperscript{57} Rankin, “The Stigma of Being.”
related stigma directly hurts people, who lose community support due to their real or supposed HIV infection. Individuals may be isolated within their family, hidden away from visitors, or made to eat alone.”

According them, HIV related stigma have both ends for the individual PLWHA. These are external and internal stigmatisation. The external pertains to the sigma PLWHA suffer from others and the internal explains the grave inner pains and struggle the PLWHA experience out of rejection and discrimination by families and close associates.

Comparatively, the assertions of Rankin et al are almost similar to the situation of PLWHA in the area of this study. Their view covers both the sociological perspective as well as the religious impacts of the HIV-related stigma in our local communities whereby people tend to moralise the cause and the effect of the pandemic. Their concentration on the social impact of the stigma on our communities in the sense that the people who have lived closely intertwined for many generations now fear to contact each other because some have contracted a “deadly disease.” this is of important interest to the researcher. Rankin et al have clearly pointed out the extent of which family life have been shattered to some PLWHA in the area of this study. This is a concern because if positive actions are not taken the family worth which is the foundation of both religion and society would be destroyed.

Rankin et al have also failed to address the motivation that care and support could be offered to break stigma and the silence and secrecy on the disease. This is what this work unearthed or intended to unearth through the examination of the Catholic Church’s intervention with PLWHA in Aflao and Dzodze.

58 Rankin, “The Stigma of Being.”
59 Rankin, “The Stigma of Being.”
In another scholarly work of Eric Y. Tenkorang and Adobea Y. Owusu in 2013 on factors that contribute to HIV-related stigma and discrimination through all the regions of Ghana, they identified a number of issues, which either heighten or reduce the phenomenon of stigma. First and foremost they postulated that stigma and discrimination constitute the third phase of the HIV/AIDS epidemic, behind the phases of the silent spread of the virus and the outbreak of epidemic respectively. According to them the stigma phase presents a serious challenge to delivering successful HIV intervention programmes. They also assert that this phase has remained the most poorly understood regime of the HIV pandemic because several identifiable and non-identifiable factors contribute to the phenomenon in Ghana. Some of these they classified under social, cultural, religious and psychosocial backgrounds of those who stigmatised. In effect, Tenkorang and Owusu were consistent with other scholars in other parts of the continent that psychosocial predictors such as myths that surround the HIV transmission in the local communities perpetuated the stigma and discrimination. Consequently, they stated that the more scientific knowledge people have about the HIV transmission the lower they endorse stigma and discrimination. This assertion has also been corroborated by scholars such as Olapegba and Adedokun et al of Nigeria. They suggest that HIV-related stigma is lower in the enlightened communities but endemic in rural ones where myths are predominant. In the same vein they indicated that the social class and cultural variables of people contribute enormously to access of information in

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61 Tenkorang and Owusu, “Examining HIV-related stigma.”
62 Tenkorang, “Examining HIV-related stigma.”
63 Tenkorang, “Examining HIV-related stigma.”
Ghana. These indices have affected the variation in the level of stigma in various parts of the country. In their consideration of ethnicity they assert that:

Among the Akans in Ghana, death resulting from the HIV disease is usually considered ‘bad death’ according to their tradition. Previous studies have also shown that myths surrounding HIV transmission are quite rife among the Akans in Ghana. For instance, the belief that HIV is transmitted by witches and other supernatural means is more common among Akan women and least common among the Ewes. Consequently, it is not too surprising that stigma was higher among Akans.66 This indicates that communities that were more traditional and superstitious in outlook and practices are likely to have higher HIV-stigma related incidences.

In their examination of the contribution of religious groups towards the HIV-related stigma, they found that with the alteration of the judgemental stance of Judeo-Christian groups towards PLWHA they have far less stigma intent than the Traditionalists.67 In effect African Traditional Religion is more prone to myths and superstitions in Ghana.

Secondly, Tenkorang and Owusu differ from the existing literature of the negative effects of HIV counselling and voluntary testing. For example, whilst Kalichman and Simbayi have asserted that HIV testing and counselling have contributed negatively to the HIV-related stigma in South Africa,68 Tenkorang and Owusu were of the view that in Ghana their research has indicated the opposite: “HIV testing usually comes with counselling that not only prepares individuals to cope with the disease psychologically and emotionally, if they test positive to the disease, but also exposes them to specialised

66 Tenkorang, “Examining HIV-related stigma.”
67 Tenkorang, “Examining HIV-related stigma.”
68 AIDS related stigmas create barriers to seeking voluntary counselling and testing (VCT) but not to learning one’s test results. Participants in the current study who were not tested for HIV held significantly more AIDS related stigmatising beliefs than people who had been tested, including negative perceptions of people living with AIDS, a sense that people with AIDS should feel ashamed and guilty, and the endorsement of social sanctions for people living with AIDS. It is important to note that AIDS stigmas were also prevalent among people who had been tested for HIV, although to a lesser degree than among those who had not been tested. These findings are consistent with research in the United States which shows AIDS related stigmas promote and foster social isolation and discrimination against people with HIV-AIDS.

knowledge about the disease, including dealing with stigma and discrimination,”69 which help in the reduction of stigma as earlier stated.

Tenkorang and Owusu’s postulations have enumerated several comprehensive issues through which the Ghanaian society can come to term with HIV-related stigma which continue to thrive in most of our communities. The limitation in their work is that they did not addressed the social intervention perspectives of religious groups and civil society organisations which could be the incentives to accelerate the reduction of stigma in Ghana. This study was intended to fill this gap with the Catholic Church social intervention with the PLWHA.

Olapegba in 2010 addressed some relevant concepts which are considered by this study. In his article entitled ‘Empathy, Knowledge, and Personal Distress as Correlates of HIV/AIDS-Related Stigmatization and Discrimination’, he discussed the HIV-related stigma and discrimination in relation to empathy, knowledge and personal distress which are possible indices to help reduce or aggravate the phenomenon. Considering his Nigerian cultural milieu (which has almost the same cultural patterns as the area of this study), Olapegba agreed with other scholars that most of the PLWHA do not divulge their seropositivity status because they are afraid to lose their social relationships due to HIV-related stigma and discrimination.70 He described the HIV-related stigma and discrimination impacts on socio-economic and cultural lives of people as the monster that prevent researchers from focusing on finding cure for the disease to mitigation of the impact of the phenomenon. Again, Olapegba agreed with Goffman’s notion of stigma, but he defined discrimination as a distinction made against a person that results in the

69 Tenkorang, Examining HIV-related stigma.”
70 Olapegba, “Empathy, Knowledge, 957
person being treated unjustly and unfairly on the basis of his or her belonging to or being perceived as belonging to a particular group.\textsuperscript{71}

Olapegba advanced the important concepts of empathy, knowledge and personal distress that are relevant to this study. He asserted that \textit{empathy} is a feeling of compassion and tenderness towards other people’s plight.\textsuperscript{72} He said this concept is not new to the African value system as it emphases the ingrained value of being one’s brother’s keeper.\textsuperscript{73} This effectively portrays the fact that the problem of one is the problem of all. Although HIV-related stigma and discrimination have down played this important value in our communities in recent times, the fact remains that one who is highly empathetic will never stigmatize or discriminate.

On the other Olapegba argues that \textit{personal distress} is an unpleasant state of arousal in which people are preoccupied with their own emotions of anxiety or helplessness upon viewing another person’s plight.\textsuperscript{74} He continues that this type of emotions of anxiety induce behavioural manifestations that are contrary to empathy. Consequently it could have been the source of many cases of stigma and discrimination against PLWHA. Flowing from above, we can conclude that the two emotional reactions result in very different motivations.

Olapegba defines \textit{knowledge} as the state of acquisition and understanding of what has been perceived, experienced, or learned.\textsuperscript{75} He opines that any process of stigma might have been started by individuals’ understanding of the target’s social and psychological states which are brought about by knowledge. Therefore empathy and personal distress

\textsuperscript{71} Olapegba, “Empathy, Knowledge, 958.
\textsuperscript{72} Olapegba, “Empathy, Knowledge, 960.
\textsuperscript{73} Olapegba, “Empathy, Knowledge, 960.
\textsuperscript{74} Olapegba, “Empathy, Knowledge, 961.
\textsuperscript{75} Olapegba, “Empathy, Knowledge, 960.
are induced through clear understanding of the situation of the receptors of these emotions.

The limitation of Olapegba resides in his inability to stress the importance of care and support to PLWHA. This study identifies with the finding of Olapegba, however it focused on the social interventions, which could effectively flow from empathy and Christian teaching on mercy.

A research conducted by Bond, Chase and Aggleton in Zambia in 2002 revealed that the household and the family setting stigma was very important and affected PLWHA very much.76 This is manifested in the forms of verbal abuse, rejection, eviction and imposed restrictions on the PLWHA. They are further subjected to blame, bitterness, anger, denial and withdrawal of treatment and care, sometimes leading to blatant neglect.77 They continue that the antithesis to this symbolization is that a lot of PLWHA are innocent persons and have contracted the disease through no fault of theirs. These include infants and young children, who are commonly positioned as devoid of any blame or guilt with respect to their infection. The distinction between innocent and guilty PLWHA is underpinned by the strong emphasis upon the association between lifestyle choices and health states that has emerged in medical and public health discourses over the past few years.78 This particular situation is not different from what happens to the PLWHA in Ghana. In the coverage area of this research some PLWHA recounted how they were abused, humiliated, rejected and driven out of their homes.

Brocke posits that Christians constitute the greater percentage of the entire Ghanaian population. Consequently, it is reasonable to assume that most of the PLWHA and those

who succumb to the disease are Christians.\textsuperscript{79} Therefore, the Church cannot remain indifferent in the fight against further spread of the disease and the care and support for the PLWHA. This responsibility lies directly at the doorsteps of the Church. Brocke’s assertion again seems to suggest that the Christian Church in general is lagging behind in the care and support to PLWHA. DeVoe on the other hand asserts that the Church perpetuated HIV/AIDS-related stigma at the initial stages of the pandemic through moralistic attitudes and its reinforcement of conservative ideologies.\textsuperscript{80} However some churches have managed to move towards action that makes a more positive contribution to HIV/AIDS management through promotion of various forms of social control for HIV prevention, contribution to the care and support of the PLWHA and provision of social spaces for debate on challenging stigma ideas and practices.\textsuperscript{81} The conclusion is that the Church leadership, have to play a key role in facilitating the creation of supportive social spaces to challenge stigma and provide relief for PLWHA. Much work remains to be done in developing deeper understandings of the multi-layered factors that enable some Churches to respond effectively to HIV/AIDS such as the Catholic in the coverage area of this study.

\textbf{1.9 Significance of Study}

This study is significant because it brings to bear the challenges the Catholic Church faces in venturing into one of its important ministry in the continuation of the healing ministry of Jesus Christ. Although several religious groups in Ghana have in recent times engaged in the provision of social services to various communities, there is not much documentation that captures the contributions of these groups’ attempt to meet the plight

\textsuperscript{81} DeVoe, “Making Life”.

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of the minority PLWHA in a specific ways as the Catholic Church in the country. This work is an attempt to focus and document this Christian apostolate as a current trend in Ghanaian religious communities. Secondly, the findings of this research would help provide deeper insight into the reasons for the increasing interest of the Catholic Church in alleviating the plight of PLWHA and the fight of HIV epidemics in Ghana. Finally, this study will also provide some guidelines for other religious groups and churches that are yet to undertake such programmes.

1.10 Ethical Considerations

This study is for academic purpose only and the anonymity of all the respondents was assured. By the code of ethics of disclosure and confidentiality, the researcher pledged never to reveal the identity of all the informants or make allusions or statements that might reveal their identities. Also informants are assured that the data collected will be used solely for the purpose of research and for no other intentions. The researcher further promised to abide by the ethics of privacy whereby personal issues of the informants are not revealed or disclosed.

1.11 Organization of Chapters

Chapter One serves as the introduction to the general background to the study. It discusses the statement of the problem, research question and objectives of the work. The chapter further discusses the conceptual framework for the study, scope of study, methodology, literature review and the significance of the study.

Chapter Two discusses the plight and challenges of people living with HIV/AIDS, the concept empathy, Christian teaching on some virtues in line with the concept. The chapter provides the philosophical background to the concept which is the basis wellbeing of PLWHA through interventions.
Chapter Three explores the theological orientation of the Roman Catholic Church’s teaching on social intervention. The chapter also discusses the theological underpinnings of the Catholic Church towards the PLWHA by perusing some theological reflections of the theologians of the Church.

Chapter Four analyses the findings of the study. It discusses the Catholic Church’s response to the plight of PLWHA in Aflao and Dzodze. The findings of the study are also analysed within the Catholic Church’s continuation of the healing ministry of Jesus.

The final chapter discusses the summary of findings, conclusions and recommendations regarding the Catholic Church’s social intervention with PLWHA.
CHAPTER TWO

THE PLIGHT OF PEOPLE LIVING WITH HIV/AIDS (PLWHA), EMPATHY AND CHRISTIAN TEACHING

2.0 Introduction

HIV/AIDS has virtually spread to all the regions of the world and has affected people of diverse statuses and backgrounds. Indeed it is regarded as the most widespread and devastating epidemic of the 21st century. Science has generated invaluable information in the last two decades on the modes of infection and transmission of the disease which are through the contact of body fluids of the infected individuals. Science has equally demonstrated beyond reasonable doubt that the disease cannot be spread through important social acts of kissing, sharing blankets or utensils that do not necessarily lacerate the body. Globally, from the moment scientists identified HIV and AIDS, social responses of fear, denial, stigma and discrimination accompanied the disease. Owing to these negative responses, many people have very distanced themselves from PLWHA.

Following the misconception that people with socially unacceptable morals acquire HIV/AIDS, many PLWHA have been rejected by their families and communities. PLWHA go through volumes of ordeals of rejection and ostracism, coupled with daily traumatizing burdens of physical and psychological experiences. Their situation is even rendered worse in areas of employment, education, individual liberties, access to health care, social security, insurance and other amenities which make life comfortable in the state become highly discriminatory of people living with HIV/AIDS. The society, especially Christians, cannot continue to leave their own kind to the mercy of these inhuman treatments. There is the need to respond positively and be proactive in order to

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curb the social menace this vicious disease begets. Interestingly, the majority of humanity are religious, and the various religions have the fundamental tenets of peaceful coexistence with all others, even non-members of their faith. Therefore, the reverence and the practice of these virtues cherished by the larger society which include the show of respect to the fundamental right for all, gratitude, hospitality and charity cannot be negotiated.\textsuperscript{83} It is for this reason that this section of the research is devoted to the review of the plight and challenges of PLWHA vis-à-vis the theory of Empathy, Christian teaching and their impact on the wellbeing on persons affected with the disease.

\textbf{2.1. Challenges Facing PLWHA}

\textbf{2.1.1 Economic Challenges of PLWHA}

Economic or financial worries are among the conspicuous challenges confronting PLWHA. Due to the misconception that only promiscuous people are victims of HIV/AIDS, PLWHA are most of the time deserted and neglected to fend for themselves even in their weak state. According to De Bruyn the work place remains a potentially unsafe environment for PLWHA, whether they are currently at work, returning to work, or looking for work for the first time.\textsuperscript{84} Adeyemo et al, assert that while HIV is not readily transmitted in the majority of workplace settings, the supposed risk of transmission has been used by numerous employers to terminate or refuse employment and perpetuate discriminatory acts such as pre-employment screening for HIV.\textsuperscript{85} For example, Tuwor and Sossou assert that in some countries in sub-Saharan Africa there has


been open workplace discrimination towards PLWHA. They noted again that in Zambia there have been the isolation and discrimination of PLWHA. Some institutions and organizations compel their would-be employees to undergo compulsory HIV/AIDS test. Consequently, they are stigmatized if tested positive.

Although, there have been a considerable level of improvement in HIV/AIDS awareness, the mind-set of most people towards PLWHA has not changed much. There is a very subtle but powerful resentment and rejection of PLWHA. Flowing from stigmatisation, the discriminations toward PLWHA have translated very much into economic and financial hardships. In Ghana, Ziem reports that it is a matter of life and death for many people living with conditions such as HIV or AIDS when they are unable to come by food after they take the antiretroviral drugs prescribed for them by medical doctors. Such is the plight of many people living with the HIV in Ghana. He continues to say that, lack of money and food, most of the time, is the bane of PLWHA. Therefore when these unfortunate people are consciously made jobless and discriminated against, their plight worsens.

In Ghana, national policies on termination and denial of employment and trade are favourable towards PLWHA. The 1992 Constitution of the Republic of Ghana, the Labour Act, the Criminal Code and the Social Security Act of 1991 (PNDCL 247) are generally opposed to the violation of a person’s human dignity, unfair termination of a worker’s appointment and support privacy of a person. Various governments of the

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87 Tuwor and Sossou, “Gender discrimination and education.
89 Ziem, “Poverty and the Plight.”
Fourth Republic have shown commitment and leadership in addressing HIV and human rights issues through the National HIV and AIDS Workplace Policy. However the reality at workplaces and on job markets is different. Price asserts that, “In the work environment PLWHA were isolated and gossiped about so much that they have to stop working.” 91 A PLWA recounted to me that whenever he goes to work nobody wants to sit or come close to where he sits. Whatever he touches no one wants to touch. Nobody in the immediate environment buys from his wife’s shop except those who are not aware of his HIV-positive status. 92 These situations do not only bring psychological worries but economic challenges to PLWHA and their dependents.

It is quite evident that apart from the emotional and psychological plight of PLWHA, financial/economic challenges form the basis of most of the woes that such individuals go through. It is therefore prudent that structures and policies are put in place to mitigate to some extent the ordeals experienced by PLWHA. Therefore the social security, insurance and credit facilities which are usually at the disposal of individuals who are not affected by this disease should be extended to PLWHA. 93 Further, legal regime and appeal systems of the labour sector should be strengthened and readily available to cater for cases of unjust dismissal of PLWHA.

2.1.2 Health Care Challenges

The health facilities which are supposed to be somewhat a refuge for persons infected with HIV/AIDS rather pose some enormous challenges to them. Reports suggest that some health providers are not circumspect about how they handle or treat the PLWHA. According to Ogola, there have been reports that several health care providers have been testing HIV/AIDS status of patients without their consent. This attitude breaches the

91 Price, “Infringements on the Rights.”
92 Respondent G, Appendix III.
93 Reportage from the Health Minister of Ghana. Citi FM, 19/11/2015.
patient-doctor confidentiality. \(^9^4\) He also contends that denial of treatment and care are direct recipe for stigma and discrimination. \(^9^5\)

The right to health care is part of the social right obligations which governments and states must observe carefully. Social right in this context implies the right to receive care and have access to the health care facilities when one needs it. PLWHA should not be denied treatment in the health centres because they are powerless in the sight of the authorities and health care providers. \(^9^6\) In Rwanda for example, there have been several reports of continual denial of medical services and the inadequate care and services for PLWHA. \(^9^7\) Bledon and Donelan assert that there has been evidence of negative attitudes and practices of healthcare workers towards PLWHA. In a survey conducted in four Nigerian states in 2002 among health workers, evidence suggests that lack of knowledge on HIV/AIDS transmission, ignorance and the fear of HIV/AIDS form the basis of denial of health care to PLWHA. This also includes unwarranted referral of PLWHA to other facilities, segregation and the utmost contempt exhibited by health workers towards them. \(^9^8\) Furthermore, there have been reports of non-attendance of hospital staff to patients affected with HIV as well as the denial of hospital facilities and medications. Clearly, the continuous existence of HIV/AIDS related stigma and discrimination in public health services is among the serious predicaments of PLWHA.

In a qualitative study that utilised focus groups consisting of a sample of sixty (60) HIV-infected mothers recruited from a large maternity hospital and STD clinic in Chennai, India, “…the outcome of the study revealed that, discrimination by physicians and other

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\(^9^5\) Ogolo, “Tanzania, hope”.
\(^9^6\) Herek and Glunt, “Public Attitudes,” 257.
health care workers have been the major concerns for mothers living with HIV.\textsuperscript{99} This is really embarrassing because the healthcare officials who are supposed to know how to treat and care for PLWHA are now at the forefront of stigma and discrimination. The study further showed that, mothers living with HIV are increasingly concerned about how and when to disclose their HIV status to their children and the repercussions which could result from this disclosure.\textsuperscript{100} Similarly, Turan et al explore how fears related to HIV/AIDS affect women’s uptake and health workers’ provision of labour and delivery services in Kisumu in Kenya. This study showed that many women do not want to deliver at health facilities because there would be an involuntary test of HIV which will be followed by stigma.\textsuperscript{101}

These studies are indicative of the fact that many PLWHA may not be willing to go to the hospital for fear of stigma and discrimination. This can aggravate their condition and lead to not only serious complication of AIDS but further spread of the epidemic. Further, the situation can easily promote the world of traditional witch doctors who usually assert that the disease is a punishment of the deities and could be resolve through traditional spiritual means.

\textbf{2.1.3 Social Challenges}

The incidence of HIV/AIDS and people affected of its menace vary differently within various societies. Usually, the kind of treatments meted out to PLWHA depend on the cultural backgrounds and social orientations of various societies. We can identify two categories of societies when it comes to the issue of HIV/AIDS, namely individualistic

\textsuperscript{100} Thomas, Nyamathi and Swaminathan, “Impact of HIV/AIDS.”
and collective societies. Warwick et al postulates that the individualistic society perceives the contraction of HIV/AIDS as an individual irresponsibility for which victims should be solely blamed. On the other hand, PANOS disagree with this notion and contends that society is based on the features of collectivism. They see the contraction of HIV/AIDS as a family and communal irresponsibility for which the community should be blamed. These varied perceptions especially on the contraction of HIV/AIDS would have effect on stigma and discrimination in the various societies. Thus, if a society sees a contraction of the disease as a family and communal responsibility the level of stigmatization and other accompanying negativities would be lessened. The contrary would however be for a society which cherishes the values of individualism.

Warwick further contends that cultural belief systems and their respective explanations on the causes of HIV/AIDS may also contribute to the level of stigma and discrimination. For instance, the cultural belief system which postulates that the contraction of HIV/AIDS is as a result of improper behaviour will sternly reinforce stigmatization and discrimination. This kind of community and its associated construct also have stigma repercussions on PLWHA. The media which often act as an umpire within the public sphere occasionally publish incendiary lies about the disease HIV/AIDS which consequently creates an uncomfortable environment for people living with HIV/AIDS.

Africa finds itself in dilemma concerning the plight of PLWHA. Traditionally the African is a family person and lives collectively. The community care and support are very essential in almost all aspects of life. Stigma and discrimination are minimal when it comes to illness. However, this has not been the case in the plights of PLWHA. Some

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104 Warwick et al, “Household and Community Responses,” 299.
communities manifest stigma in forms of blame, scapegoating, gossiping and rejection. PLWHA are referred to by derogatory terms. They are excluded from benefitting from the social structure, safety nets, solidarity and other benefits produced by the community. For example in Ghana, they are not allowed to use the same washrooms and common facilities with co-tenants in rented apartments. Sometimes they cannot shop in the markets as people refuse to touch their money. Again, they cannot trade as nobody will patronise their wares in the community. Owing to this unfortunate social construct they become wretched, together with their dependents, in their own communities.

According to Campbell et al, the extent of stigmatization in Africa, especially in response to the negative stereotypes associated with the contraction of HIV/AIDS, creates a very desperate situation for PLWHA. Various communities have coined derogatory and humiliating names for people considered as having contracted the HIV/AIDS disease. They are sometimes referred to as ‘walking corpse’. In Uganda they are referred to as kamuyoola - meaning ‘caught in a trap’. In Nigeria they are known as ‘ashawo’ meaning prostitute, and in Ghana they are called ‘Tootoo’ also meaning prostitute. AFAO asserts that women are the most affected by these name-callings. Consequently, PLWHA are adamant in disclosing their HIV/AIDS status to avoid being isolated from participating in the socio-cultural aspect of food production since food preparation and consumption is regarded as expression of support and acceptance. PLWHA across societies are seen as evil reflections of sin leading to the justification of any punishment meted out to them. Another important observation is that the limited efficacy of HIV/AIDS voluntary testing programme across our sub-region can be associated with

106 Campbell et al, “Stigma and HIV/AIDS.”
107 Campbell et al, “Stigma and HIV/AIDS.”.
communities’ cold reception of those who visit such centres. For example, most PLWHA in Aflao and Dzodze do not visit their respective HIV-centres openly for fear of stigma.

2.1.4 Individual/Personal Challenges

This refers to the challenges PLWHA go through individually when they become aware of their status. The most important thing for a PLWHA is the acceptance of his/her seropositive conditions and work towards it in order to live a better life. Most PLWHA react in different manners when their seropositive status is divulged to them. Some deny it, others break down in shock, and still some others threaten suicide or commit it.110 Some recover from their shock and denial but some others do not. For example, from St. Anthony’s Hospital in Dzodze, only a negligible percentage of PLWHA have readily accepted their seropositive status immediately it is divulged to them. However, most of them only accept that their health conditions have been altered after the post HIV-test counselling and they need to live as such.111

One of the notable personal challenge of a PLWHA is the internal stigma. This flows from the societal negative reactions towards PLWHA. It is the internalisation or acceptance of experienced stigma. The degree of the effect of stigma on an individual is dependent on the individual psychological make-up and his/her relationship with family and the community as a whole. Given the widespread negative community and family responses, many people choose not to reveal their seropositive status. While the need to confront internal stigma is universal for those infected and affected by HIV, the individual manifestations of feelings, emotions, and reactions can vary greatly from person to person. Internal stigma is a complex process that is affected by one’s sense of self, as well as external and physical influences. In response to stigma perpetrated by

110 Respondents Ea and F, Appendix III.
111 Respondents C and G, Appendix III.
relatives and community towards PLWHA, the latter may adopt protective actions that, in turn, tend to reinforce and legitimise internal stigma.\textsuperscript{112}

Ken Morrison elaborates on the internal stigma by asserting that it is a conceptualised cycle of three significant categories: the experiences of context, self-perception, and protective action.\textsuperscript{113} Experiences of context include the physical and environmental situations in which PLWHA live. This means that there were several interacting elements that led to an overall sense of loss of control for PLWHA. These elements included: the amount of information the individual has about the HIV and AIDS.\textsuperscript{114} For example the anxiety about losing a job due to one’s HIV status and concerns about how this would affect access to treatment, and physical deterioration of one’s health place intense worries on PLWHA. The internalised stigma worsens when the PLWHA have experienced visible manifestations of the disease, such as weight loss or opportunistic infections. In the area of self-perception\textsuperscript{115}, he uncovered several recurring elements; in particular, shame and guilt were extremely common, as was a sense of self blame. Added to these emotions were many deep-seated fears that included the following: fear of dying; fear of hurting or infecting others; fear of being discovered; and fear of causing pain, disappointment, or suffering to family members.\textsuperscript{116} Given the experiences of context and the sense of self-perception, PLWHA adopted different means of self-protective action. Avoidance and self-exclusion, for example, included such things as avoiding making long-term plans, avoiding activities in general, and avoiding seeking health services or treatment. Isolation and self-withdrawal meant that HIV-positive people tended to keep

\textsuperscript{113} Ken Morrison, “Breaking the Cycle: Stigma, Discrimination, Internal Stigma, and HIV.” produced for review by the United States Agency for International Development” (USAID), file://AppData/Local/Temp/breaking_the_cycle.pdf
\textsuperscript{114} Morrison, “Breaking the Cycle.”
\textsuperscript{115} Morrison, “Breaking the Cycle.”
\textsuperscript{116} Morrison, “Breaking the Cycle.”
to themselves, avoiding social activities, even family activities, and intimate encounters and relationships. Subterfuge and denial were common: hiding or misleading others, for example, as to one’s seropositive-status, sexual orientation, or livelihood. Morrison finally concludes that the three categories described above interact in a cycle of internal stigma, each feeding on or building on the effects of the others. For PLWHA who are from marginalised or stigmatised populations, this internal stigma was often exacerbated.

Lee, Kalichman and Sikkema also conducted a study looking at the internalised stigma and discrimination among PLWHAs in Milwaukee and Madison, Wisconsin and New York City. They found out that the majority of the sample experienced internalised stigma related to their HIV positive status. They mentioned that individuals who experienced high internalised HIV stigma were less accepting of the illness by their families and they were less likely to ever have attended an HIV support group meetings. They knew fewer people with HIV, and worry more about spreading their infection to others. HIV stigma contributed significantly to levels of depression, anxiety and hopelessness.

2.2 PLWHA, Stigmatization and Discrimination

A lot of concerns have been raised by various studies into the persistence of high prevalence and inability to curb the transmission of HIV. Notable among the factors which are facilitating the spread of the pandemic in many parts of the world is HIV/AIDS-related stigma and discrimination.

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117 Morrison, “Breaking the Cycle.”
118 Morrison, “Breaking the Cycle.”
120 Lee, Kalichman, and Sikkema, “Internalized Stigma”.

Chitando and Gunda noted that stigma is to be understood as a form of branding or marking out and that, lately, so much has been said about the dangers of stigma in the fight against HIV and AIDS. In this regard, they are inclined to agree with others who observed that one of the most powerful blocks to the prevention of HIV transmission, and to effective treatment of HIV/AIDS is the stigmatisation and discrimination that PLWHA encounter. In many health conditions, stigma is receiving increasing attention. Following Goffman, many authors such as Rankin et al and Mahajan et al, describe stigma as an undesirable or discrediting attribute, reducing an individual’s status in the eyes of society. Stigma and discrimination thus produce social inequality. Therefore, the society cannot conclusively fight HIV and AIDS without fighting the social phenomena and inequalities it has created over the years in our societies.

Kitara and Aloyo assert that HIV/AIDS-related stigma still exists in many communities in Africa. Stigma perpetuates discrimination and this may be a key contributor to the spread of HIV/AIDS in many countries. Right from the beginning, HIV/AIDS epidemic has been accompanied with fear, ignorance and denial, leading to stigmatisation and discrimination against PLWHA and their families. Mphumela in his research establishes that PLWHA Stigma Index produces a significant impact of stigma and discrimination on the health and ability of PLWHA to be active members of their community. On average, one in eight PLWHA reports that they are denied health services and one in nine is denied employment because of their HIV-positive status. An average of six percent

122 Chitando and Gunda, “HIV and AIDS.”
123 Rankin, “The Stigma of Being.”
124 Mahajan, “Stigma in the HIV/AIDS.”
reported to have experienced physical assault because of their HIV status. PLWHA who are important members of the society face a double stigma from their immediate surroundings and the larger society. Their HIV-positive status increase their risk of experiencing violence, being denied services or being excluded from community activities. Discriminatory attitudes are common in many parts of the world. But evidence suggests that where knowledge of HIV is higher, discriminatory attitudes towards PLWHA are lower.

The above assertion of Tenkorang and Owusu that, where people have enough knowledge on HIV, there is low stigma, has not been the case in the area this study has been conducted. My motivation for this research was based on HIV-related stigma one of my counselees experienced from health professionals. She recounted that she was abused, stigmatized and discriminated against by some nurses when her HIV status was disclosed to them at St Anthony’s Hospital in Dzodze. Nurses are thought of as people who have much knowledge about the disease. Healthcare providers and health professionals are sometimes the source of the stigmatisation of PLWHA. Examples include neglecting patients, provision of different quality of treatment based on one’s HIV-positive status, denial of care and breaching of confidentiality. Instances of verbal abuse by health-care staff have been reported in a number of studies. This has been one of the bane of the PLWHA that the researcher encountered in some health facilities.

Thomas et al, postulate that, the nature and intensity of AIDS stigma are shaped by the social construction of the epidemic in different localities. Stigma therefore needs to be

127 Mphumela, “HIV/AIDS-Related Stigma.”
128 Tenkorang and Owusu, “Examining HIV-related stigma.”
discussed in its cultural context.\footnote{B. E. Thomas, et al, “Stigmatizing in the Life of People Living with HIV: A Study on HIV Positive Individuals from Chennai, South India,” \textit{BMC Public Health} (17)2005:795–801. doi: 10.1080/09540120500099936.} Their assertion was based on a study they conducted in a clinic aimed at understanding stigma among 203 HIV positive individuals from Chennai, South India in 2005, and on the impact of stigma on the quality of life among PLWHA in India. The outcome of the study revealed that the actual stigma experienced among those infected with HIV was much less, twenty-six percent (26\%), as compared to the fear of being stigmatized (perceived stigma) which is around ninety-seven percent (97\%).\footnote{Thomas, “How stigmatizing is stigma.”} Internalisation of stigma was found to have a highly significant negative correlation with quality of life in the psychological domain and a significant negative correlation in the environmental domain. However, individuals who did experience actual stigma seemed more determined to live and experience an above moderate quality of life.\footnote{Thomas, “How stigmatizing is stigma.”} The implication of this study demonstrates that much of the effects of the HIV-related stigma and discriminations rest on the psychological make-ups and dispositions of the PLWHA. It is clear from this study that most of the concerns of PLWHA on stigma and discrimination were perceived rather than actual. However, as mentioned above it is important that the interpretation of the phenomena of stigma and discrimination must consider the particular social context and the particular cultural milieu.

A similar study was conducted by Danso-Bio in Sunyani municipality in 2010 to assess the extent to which PLWHA are stigmatised and discriminated against. A case study approach was used to collect data with a sample size of two hundred household respondents. The survey revealed that stigma is deeply-rooted in the community as fifty-eight and half percent (58.5\%) of those interviewed were not willing to disclose their HIV status if tested positive, whereas forty-one and half percent (41.5\%) respondents...
were willing to disclose their HIV-status to spouse and children and other close relations.\textsuperscript{132} The outcome of the study further revealed that, none of the respondents were willing to disclose their status to their friends if they were tested positive. This particular survey evidently reveals that stigmatisation of PLWHA in our country is an alarming situation considering the percentages in the local community and consequently needs to be looked at.

The outcome of Danso-Bio’s study in Sunyani is unlikely to be different from the situation in other parts of Ghana. In the coverage area of this research similar situations exist. When a PLWHA’s identity is disclosed, s/he is virtually shunned or ostracised. Friends and extended family members who are usually great supports in times of sickness and sorrow do not want to come close. They sometimes erroneously believe that any contact with a PLWHA might get them infected. Again, the victim becomes the object of gossip everywhere in the community and derogatory remarks and value judgements are made about the person and the family. Sometimes PLWHA are denied services openly. For example a PLWHA recounted that when her seropositive identity became public in her community, a driver’s mate refused any contact with her, let alone collect her lorry fare from her village to the city. On her return, and he did not want her to join the vehicle again.\textsuperscript{133} Further, they are ejected from the rented apartment and family houses as other co-tenants and family members do not want to use the same facilities with them. Some are even thrown out of their marital homes. Usually women suffer this fate much more in our Ghanaian communities as they are usually accused of infidelity and loose moral lives and responsible for their husbands’ contraction of the disease.

\textsuperscript{132} Kwabena Danso-Bio, Minimising stigmatisation of HIV/AIDS persons in curbing, the spread of the pandemic in the Sunyani Municipality: The role of relations, friends and other community members (Masters Thesis, Kwame Nkrumah University of Science and Technology, 2010).
\textsuperscript{133} Respondent Ga, Appendix III.
Konadu Adjei explores the socio-economic impacts of stigmatization on young women (16-24 years old) infected with HIV in Accra (Ridge hospital). She reported that stigma and discrimination have negative impacts on the socio-economic status of the young women the research sampled. The study showed that, the respondents surveyed were afraid of future refusal or dismissal from work due to their HIV status. The fear of economic and social suffering due to family and spousal neglect, as well as many other challenges associated with their HIV status and pregnancy clouded the respondents’ answers. The study also revealed that, stigma and discrimination is a huge problem that all the respondents reacted to as being an obstacle to their social and economic wellbeing.\(^{134}\)

Also consistent with the above study, Simbayi, et al in their anonymous surveys in South Africa found that 40% of persons with HIV/AIDS had experienced discrimination resulting from having HIV infection and one in five had lost a place to stay or a job because of their HIV status. The results of the study further revealed that, more than one in three participants indicated feeling dirty, ashamed, or guilty because of their HIV-positive status. A hierarchical regression model that included demographic characteristics, health and treatment status, social support, substance use, and internalised stigma significantly predicted cognitive–affective depression. The findings of the study also showed that, internalised stigma accounted for 4.8% of the variance in cognitive–affective depression scores over and above the other variables.\(^{135}\) This implies that, HIV/AIDS related stigma affects people living with HIV/AIDS in their psychological wellbeing.


\(^{135}\) L.C. Simbayi et al, “Internalized Stigma, Discrimination.”
2.3 The Theory of Empathy

As alluded to in the first chapter, the basis for the Church’s social support to the PLWHA is within the framework of empathy. Empathy relates to the driving emotion that leads individuals to care for others, to understand others, and validate others’ emotions. Edith Stein posits that empathy is the experience of foreign consciousness. This consciousness relates to the possibility of human beings being able to comprehend the psychic life of their fellows. This will make one individual to be able to project him/herself into the emotions of another and feel what the other individual feels.

Jakob Håkansson asserts that people who have studied empathy were largely influenced by the view of Lipps and Titchener. Their views are on the affective domain which dwells on the German word ‘Einfühlung’- feeling into. This is when an individual tries to project himself/herself into the process of humanising the feelings of another individual and tries to comprehend the latter’s emotions and reactions. This view leans more to the sharing of the emotions of others. Likewise, Wondra and Ellsworth assert that the essence of empathy, agreed upon by most empathy researchers, is feeling what another person feels because something happens to them. They again posit that this conceptualisation of empathy is equivalent to affective resonance/experience sharing in multi-component models. In this sense, they point out other dimensions of the empathy theory which some empathy theorists believe contribute to emotion sharing, such as perspective taking, self-regulation, mind perception and concern for another person, which is called compassion or sympathy. In effect, empathy with PLWHA relates to

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trying to understand their plight and challenges and relates positively to them in order to offer constructive support and assistance.

Arguably, the contemporary usage of empathy encompasses the notion of sympathy. According to the Encyclopaedia of Philosophy (EoP) the words ‘sympathy’ and ‘empathy’ have some vast controversial distinctions and this must be made more precise. The EoP asserts that sympathy is frequently used to mean one person’s response to the negative affects such as suffering and distress of another individual, leading to pro-social helping behaviour towards the other. In contrast, empathy generally includes responding to positive affects as well as negative ones without necessarily being required to do anything about it. “Sympathy is understood to include approbation and specific affective responses such as compassion or pity whereas empathy often means a relatively neutral form of data gathering about the experiences and affects in general including negative ones such as anger, fear, or resentment.”

Again EoP posits that it is a positive technical error that E.B. Titchener captures the German *Einfühlung* with a neologism ‘empathy’ which some earlier researchers used as a substitute for sympathy. “Martin Hoffman captures an aspect of the truth as the word ‘sympathy’ itself as used by David Hume and Adam Smith included the communicability of affect and emotional contagion, which today we would also count as inputs to ‘empathy’ without, however, reducing empathy to emotional contagion and low level transmission of affect without remainder.”

The largely agreed affective notion of empathy poses some difficulties, as it is not easy to share emotions. For one to perceive the physical and emotional circumstances of other

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141 Internet Encyclopedia of Philosophy, *Empathy and Sympathy*.
142 Internet Encyclopedia of Philosophy, *Empathy and Sympathy*.
143 Internet Encyclopedia of Philosophy, *Empathy and Sympathy*. 
individuals and to take on the role of the latter demands a lot of effort. In our discussion, we need to perceive the physical, mental and psychological dispositions of the PLWHA vis-à-vis the reactions of their social environments in order to feel and share their emotions. In this sense one can easily share or not share any emotions for them. This can also lead to embarrassment, favourable or hostile reactions towards them. These emotions are what Wondra and Ellsworth call vicarious emotions. However, Singer and Lamm’s assertion postulates a clear distinction between empathic and vicarious emotions. According to them empathy represent a small amount of vicarious emotions people may experience while interacting with their social environment in everyday life. This means vicarious emotions represent all emotions that one feels by observing other individuals’ situations and circumstances. Freider Paulus et al suggest that vicarious and empathic emotions originate from the simulation processes mirroring and mentalising that depend on anchoring and adjustment. For them empathic emotion must be reserved exclusively for incidents where perceivers and social targets have shared affective experience, whereas vicarious emotion offers a wider scope and includes non-shared affective experiences.

Håkansson agrees that Kohler took the argument of empathy to the cognitive level, which exposes another dimension of this concept. Kohler was the first to argue that rather than continuing to focus on affective “feeling into” the experiences of another, empathy was more the understanding of the others’ feelings than a sharing of them. Kohler’s view might stem from the huge difficulty posed by sharing the emotion of others. It is possible to be affected by the mood of people around you but sharing their emotions is another thing all together. For example one can easily be affected by the sight of the pain and

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146 Jakob Håkansson, “Exploring the phenomenon,” 2.
suffering of a PLWHA. This easily leads to sympathy which can evoke some compassion, pity and support as alluded by Wondra and Ellsworth. In this vein the thin line between sympathy and empathy which is the crux of our current discourse is notably expressed in Theodor Lipps assertion as being the primary basis for recognizing each other as minded creatures.

To share the emotions of other individuals we must first all establish how these individuals relate to us. In this sense we transcend the family relation of blood and perceive these other individuals as our own kind. The concept of empathy emphasizes the interpersonal dialogues between the objects concerned. This is what Martin Buber perceives as ‘I and You’ relation in which subjects share the unity of being. The divine initiative leading to creation of humans in the image of God in Genesis 1:26 is very expressive that those who are affected by HIV/AIDS and those who reject and ostracise such persons share the same imago Dei. This presupposes that as we share the same imago Dei, we equally share a sense of caring, respect, commitment, and responsibility towards each other. Therefore humans have no choice but to support PLWHA because our nature rightly determines and demands so.

Again Kohler’s argument rightly points to the cognitive direction of the concept of empathy which other scholars share. However, Håkansson asserts that Herbert Mead recognized the self-other differentiation in empathy and added a cognitive component.\(^{147}\) Mead’s work placed a huge emphasis on the individual’s capacity to take on the role of other persons as a means of understanding how they view the world.\(^{148}\) Wondra and Ellsworth quickly warn that the distinction must be made clear about cognitive empathy and the empathy we are validating as the drive for the support to the PLWHA:

\(^{147}\) Håkansson, *Exploring the phenomenon*, 4. 
\(^{148}\) Håkansson, *Exploring the phenomenon*, 3.
Although you can feel sad with someone else who is sad (empathy) and also feel concern (compassion), you can also feel happy with someone who is happy (empathy) and feel no concern because nothing bad had happened. Our use of the term empathy does not require understanding another’s internal state, which is sometimes called cognitive empathy.\(^{149}\)

Martin Hoffman, one of the contemporary theorists on empathy was able to explain the dichotomy between the cognitive and the affective notions of empathy. He asserts that the interaction between affect and cognition promotes prosocial motivations towards emphatic responses to human situations.\(^{150}\) According to Håkansson, Hoffman is convinced that certain affects and motives result from the interaction of empathy, causal attribution and situational contexts: sympathy, guilt, empathic anger and feelings of injustice.\(^{151}\) Also of great interest to Hoffman was the interaction of empathy and abstract moral principles, such as justice, and the interaction between affect and cognition in general. Hoffman’s argument situates rightly into why empathy must leads humanity to be concerned for PLWHA.

It must be noted that since the inception of the empathy concept, it has been discussed under various disciplines of human sciences. However, it has been very phenomenal since clinical psychologists such as Carl Rogers and Heinz Kohut popularised it as the core central ingredient in their therapeutic personality change theory.\(^{152}\)

Much of empathy’s popularity today within psychology can in some way be traced back to phenomenological philosophy, according to which a person’s actions are determined by his or her perceptions of the surrounding world. Thus, for Rogers it was important to understand how clients viewed the world rather than to understand the factual circumstances. Naturally, empathy played a fundamental role in the theory.\(^{153}\)

\(^{150}\) Håkansson, “Exploring the phenomenon,” 10
\(^{151}\) Håkansson, “Exploring the phenomenon,” 10
\(^{152}\) Håkansson, “Exploring the phenomenon,” 3.
\(^{153}\) Håkansson, “Exploring the phenomenon,” 3.
As already discussed above, empathy conveys the idea of awareness and trying to obtain knowledge and subjective feelings of another individual. This awareness and knowledge must be translated into an action towards the latter because of the distress that accompany this awareness. This empathic distress is the drive behind the concern, the support and the positive action towards people in distress such as PLWHA.

2.3.1 Empathy and Support for the Well-being of PLWHA

From our discussion we can conveniently infer that empathy is a sufficient basis for concern for others and extension of healthy hand to help those in distress. Likewise Håkansson agrees that even though diverse opinions and conceptualisations have appeared in the discourse of empathy in various disciplines, many researchers relate empathy to prosocial motivation, to altruistic behaviours and improved interpersonal relationships. Håkansson notes that: “A substantial body of research has been generated in the last decades on how empathy relates to things such as altruistic motivation, moral development and similar experiences”154 Unless a person has a stale conscience he/she cannot look unconcerned when his own kind is in distress. This is an inbuilt sense of responsibility that the creator has put into every person, defined as empathy and the motivation to support the vulnerable and the less privilege.

Empathy positively varies with altruistic behaviours and responses by the empathiser. Some researchers have studied the whole process that takes place between the empathiser and the target of empathy – in our case, between PLWHA and those who support and care for them. Wondra and Ellsworth assert that Hoffman has provided the most comprehensive theory of five mechanisms through which an empathiser becomes

distressed when he/she observes an individual or a target in distress. This presupposes that the distress those who feel empathy experience drive them to empathise and support their targets. According to Wondra and Ellsworth, in Hoffman’s first three mechanisms, which are mimicry, classical conditioning, and direct association, the empathiser perceives the target’s emotional experience directly. In this vein the observers have direct contact with the targets and this enables them to feel discomfort and distress, which may be more or less motivation to positive altruistic behaviour. These first three mechanisms suggest the experience of those who have direct contact with PLWHA and feel their pain and worries. This group usually comprises of the direct family and close friends and associates who empathise and sympathise with PLWHA and offer the necessary assistance of care and support to them in our various communities.

The last two mechanisms according to Hoffman are mediated association and role-taking. Although their objectives are the same as the first three mechanisms which is to empathise with their target, they contrast the first three mechanisms in their methodology. They do not require the direct perception of the target’s emotional experience. For this reason, they are considered to involve more advanced cognitive abilities. This advanced cognitive ability requires the capacity of imagination through which the observer perceives the experience and the feeling of the target through words and memories of past experiences. In effect the majority of the people in the catchment area of this research might never have had any direct contact with PLWHA. However through the power of mediated association and role-taking they are more conversant with the situation and circumstances of PLWHA. Håkansson also asserts that: “Hoffman’s highlights are the psychological processes involved in empathy’s interaction with certain

155 Wondra and Ellsworth, Appraisal Theory of Empathy, 11
156 Wondra and Ellsworth, Appraisal Theory of Empathy, 11.
157 Wondra and Ellsworth, Appraisal Theory of Empathy, 10-11.
behaviours that foster moral internalization. These psychological processes are involved in empathy’s relation to abstract moral principles.” He continues to say that the mechanisms account for altruism that are flexible enough to consider the pros and cons of a potential helping effort for the helper as well as for the person being helped. Empathy, according to Hoffman, is a phenomenon that meets this requirement.” The basic assumption of Hoffman’s argument lies in the fact that empathy contributes to altruism and compassion for others in physical or psychological distress such as PLWHA.

In relation to positive behaviour and responses towards PLWHA in this research, Håkansson’s assertion that some philosophers and psychologists consider empathy as a source - if not the source - of altruistic motivation, is noteworthy. They have identified a link between empathy towards a target and concern for that target. People tend to help others more frequently under conditions of empathetic concern and distress in what usually appears to be an altruistic motivation and effort to improve the life and well-being of other people. The correlation between discussion of empathy for PLWHA in this research concerns building relationships, listening, and caring for others who are more disadvantaged (PLWHA) than the empathiser(s). Most PLWHA have severed relationships with their families and communities. Rebuilding the lost relationships of care between PLWHA and their social environment cannot come easily owing to the position usually taken by those who reject and ostracise them. However, through and with empathy mending lost relationships, this could be achieved through the distress we feel for our own kind who are in distress. Empathy situates the process of support to the PLWHA in its right perspectives. In effect PLWHA need a lot of support from their

159 Håkansson, “Exploring the phenomenon,” 10.
160 Håkansson, “Exploring the phenomenon,” 24
social environment in order to live a healthy life. Empathy is the right framework through which this support can be realised.

The concept of empathy has the subtle tone of the virtues of mercy and compassion. These virtues are the drive behind the reality of care and support empaths perceive. Thomas Aquinas defines mercy as the compassion in our hearts for another person’s misery and the compassion which drives us to do what we can to help others.\footnote{161} Robert Stackpole asserts that Aquinas’ notion of mercy has affective and effective aspects. On the former, it is an emotion: the pity we feel for the plight of another which comes from our vulnerable nature. However, the effective mercy relates to the positive actions we take for the good of another. The processes we use to relieve the miseries or meet the needs of others.\footnote{162} Stockpole further argues that, for Aquinas, the human virtue of mercy must necessarily be authentic such that it must manifest two additional characteristics. First, the ‘right reason’ which in the truth is about the sufferings of others, and what is in fact the objective ‘good’ for the other whom we seek to help. Secondly, the virtue of mercy must be proven in effective action for the good of others, as circumstances permit. If we merely ‘sympathize’ with the plight of another and share their pain without making the best of the opportunities we have to help them, then the virtue of mercy does not abide in us in any significant degree.”\footnote{163} This argument is akin to our discussion above on empathy. It suggests that the philosophical reflection on empathy is not at variance with Christian teachings. In effect Thomas Aquinas postulated his ideas several years before the word empathy saw its birth in the twentieth century. Clearly, the concept of empathy is very much related to the Christian teaching on the corporal and spiritual

\begin{footnotes}
\item[161] Thomas Aquinas, \textit{Summa Theologiae} II-II.30.1
\item[163] Stackpole, “St Thomas Aquinas.”
\end{footnotes}
works of mercy which are relevant to all responses to our disadvantaged brothers and sisters, such as the PLWHA.

2.4 Christian Teaching, Empathy and Support for PLWHA

God has always been sensitive to the plight of humanity after The Fall, when our first parents lost their place of glory through disobedience as explained by the Genesis account of creation. The essence of Jesus’ incarnation is the empathy that God has for an estranged and suffering humanity. Ann Jervis asserts that empathy connotes not just listening to another’s story but also to participate in the other’s story. God participates actively in the life of his people and Jesus has demonstrated this quality of God by nurturing the divine kind character, good virtues and divine principles in his followers. The virtues that Jesus preached and lived continue to lead people to actually feel for others and to choose good acts over bad ones. There can be no more important trait of authentic awakening and acceptable living among humans than living the qualities that Jesus portrays. These qualities, which can be identified in both Christians and non-Christians alike, induce altruistic behaviours that make a person to do good and alleviate the plight of others in his/her community.

Stassen and Gushee assert that a good person has integrity and seeks justice. In the same vein, the article Teacher of Teachers affirms that integrity awakens us to authentic reality of consistency and purity of thought without which peace of mind remains an affirmation instead of an actual experience. Therefore integrity, which is a divine quality bequeathed to humankind, can induce distress when an individual’s thoughts and actions are not in line with the divine purpose. According to Stassen and Gushee justice

166 Teacher of Teachers’, *Integrity: Living in Divine Purpose*, https://miracleshome.org/supplements/integrity_divinepurpose_459.htm
requires that we seek the well-being of those in distress.\textsuperscript{167} The justice expressed by Stassen and Gushee is not akin to secular meaning of the word as in judgement. Rather, they emphasise that while some versions of the Bible equally translated the Hebrew word *tsedaqah* with the notion of judgement, “*tsedaqah* means delivering, community restoring justice…thus judgement that vindicates the right especially of the poor or powerless”\textsuperscript{168}

This understanding of ‘justice’ situates the concept within the empathy framework and the positive response towards the restoration of PLWHA within the divine purpose of God and plan of salvation. This, we must all carry out by offering authentic support and assistance to PLWHA in order that they may live a healthy and fulfilled life. Stassen and Gushee further posit that when we take the biblical meaning away from ‘justice’, what remains or replaces it is the infiltration of ungodly secular ideologies of retribution, “to everyone his due” and the philosophical concepts of liberalism of individual autonomy and utilitarianism of the greatest happiness for the greatest number fill the vacuum.\textsuperscript{169} This, according to them, does not fulfil and communicate the will of God which is the salvation of the world which is incorporated in the works of mercy.\textsuperscript{170} So far the responses of the majority of the world toward PLWHA fulfil the secular ideologies and philosophical concepts and are devoid of Godly justice. Empathy is the key that brings the divine purpose and can unlock the door of authentic passion for kindness, compassion and mercy towards PLWHA. It is worth noting that this concept hitherto is the undercurrent that drives traditional communities whereby the care and support for those who are sick and disadvantaged are imperatives.

\textsuperscript{167} Stassen and Gushee, *Kingdom Ethics*, 32.
\textsuperscript{168} Stassen and Gushee, *Kingdom Ethics*, 345.
\textsuperscript{169} Stassen and Gushee, *Kingdom Ethics*, 346.
\textsuperscript{170} Stassen and Gushee, *Kingdom Ethics*, 346.
Stassen and Gushee affirm that the justice of God around which the central will of God for humanity revolves is the most recurrent concept in the Bible and it should catch our focus in our duties towards each other.\textsuperscript{171} According to Stassen and Gushee the biblical meaning of justice of the Lord which is our focus in this research has four dimensions which are: deliverance of the poor and the powerless from the injustice that they regularly experience; lifting the foot of domineering power off the neck of the dominated and the oppressed; stopping the violent and establishing peace; and restoring the outcasts, the excluded, the Gentiles, the exiles and the refugees to community.\textsuperscript{172} Consequently, we cannot overlook our responsibilities towards PLWHA which can be identified with the four dimensions of tsedaqah and take the stands of secular ideologies mentioned above. God created us to know him and to do his will. His will is to continue to renew the world through restoration of the divine justice or tsedaqah.

Jervis asserts that empathy is the beginning of change and the distinctive character of Christianity, and it is to be socially active and to evolve society positively.\textsuperscript{173} She continues that in sending Jesus, God turns out to be empathic beyond anything we could ask and imagine.\textsuperscript{174} This change which God wants, is effected by and through Jesus’ capacity to understand human experience and to actively engage human experience by translating God’s will through practical acts. Apostle Paul is very expressive of this in his letter to the Philippians 2:1-7

\begin{quote}
1 So if there is any encouragement in Christ, any incentive of love, any participation in the Spirit, any affection and sympathy, 2 complete my joy by being of the same mind, having the same love, being in full accord and of one mind. 3 Do nothing from selfishness or conceit, but in humility count others better than yourselves. 4 Let each of you look not only to his own interests, but also to the interests of others. 5 Have this mind among yourselves, which is yours in Christ Jesus, 6 who, though he was in the form of God, did not count equality
\end{quote}

\textsuperscript{171} Stassen and Gushee, \textit{Kingdom Ethics}, 345.
\textsuperscript{172} Stassen and Gushee, \textit{Kingdom Ethics}, 349.
\textsuperscript{173} Jervis, \textit{Empathy and the New Testament}.
\textsuperscript{174} Jervis, \textit{Empathy and the New Testament}.  

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with God a thing to be grasped, 7 but emptied himself, taking the form of a servant, being born in the likeness of men.\footnote{Philippians 2:1-7 RSV.}

In this sense God has become very much approachable through the exercises and the practices that Jesus communicates directly. Jervis reminds us that what is remarkable in the Christian teaching on empathy is that Jesus empathises not only with humanity but he also empathises with God’s experience to be heard by humanity.\footnote{Jervis, *Empathy and the New Testament.*} Therefore it is a two way relation; Jesus takes on human character and admonishes humans to take on God’s character by helping one another to surmount our difficulties. This rightly places the PLWHA within the purview of the Church and our unconditional positive support to relieve them of their pains and anxieties. Thus authentic faith must translate into works of mercy which are a display of empathy. Pope Francis asserts that a little bit of mercy makes the world less cold and more just.\footnote{Pope Francis said this during the blessing March, 18, 2013 at St Peter’s Square, Vatican.} This means that the entire humanity needs mercy to actualise its purpose. The justice and mercy God wants for humanity was mentioned by Jesus in the seven corporal works of mercy embodied in “Jesus’ manifesto” in Luke 4:18 and Matthew 25:34-36: feed the hungry, give drink to the thirsty, clothe the naked, shelter the homeless, visit the sick, ransom the captive/ visit the prison and bury the dead (ref: CCC/Compendium).\footnote{Compendium of Catholic Catechism University of Ghana http://ugspace.ug.edu.gh} This captures the humans’ responsibilities towards PLWHA.

Furthermore, the vulnerability and helplessness of humankind is emphasised in Jesus’ quest to seek *tsedaqah* and mercy. In all the teachings and corporal works of mercy, Jesus did not identify any specific race as the target for empathy and altruistic actions. This presupposes that our positive acts must never discriminate and be limited. This is confirmed by the parable of the Good Samaritan (Luke 10:25-37). Empathy has the undertone of love which is the central ingredient of all altruistic actions. Stassen and
Gushee suggest that love is not a single principle like a song sung in a monotone, but it is a complex drama with different dramatic actions as the characters grow and interact.\textsuperscript{179} This assertion explains the essence of love in the corporal works of mercy that Jesus teaches. Again Stassen and Gushee postulate that love has special regard for those who are in bondage to others or their own sin.\textsuperscript{180} In effect the situation that confronts PLWHA, suggest that they do not receive justice and they are vulnerable and oppressed because they are powerless vis-à-vis the ill reaction of the majority of the people towards them. Empathy as Christian love and divine justice are the virtues that can induce altruistic help and support for them.

\textbf{2.5 Religion and PLWHA}

Religious institutions especially those in Africa should have been the final solace for people confronted by the menace of HIV/AIDS. Many religious institutions instead of fighting the stigmatisation and discrimination associated with HIV/AIDS, have rather become catalysts in worsening the stigmatisation scare. According to Singh, the international symposium organized under the religious health organization to break the silence on HIV/AIDS revealed that many religious doctrines and ethical positions regarding sexual behaviours, sexism, homophobia and the denial of realities of HIV/AIDS have helped in the creation of the misconception of infected persons as sinners who deserve punishment.\textsuperscript{181} Campbell, et al. also asserted that one of the machineries used by some religious institutions to regain their lost moral authority is vigorously linking sexual transgression and HIV/AIDS with immorality.\textsuperscript{182} They also say that sexual activity which is often perceived as the evident cause of HIV/AIDS, is

\textsuperscript{179} Stassen and Gushee, \textit{Kingdom Ethics}, 333.
\textsuperscript{180} Stassen and Gushee, \textit{Kingdom Ethics}, 335.
somehow the view of religious bodies as an unacceptable activity. However, sex is a biological and social act which reflect and challenge strong public, private, religious and political misconceptions. It is quite surprising to see religious bodies that should be the moral authorities and a home for PLWHA rather stigmatizing and referring to them as sinners, impure and persons excluded from salvation. This posture adopted by some religious bodies strengthens the social stratifications within which stigmatization of PLWHA flourishes.

Chitando and Gunda try to understand the basis of hostile reaction of some Christian groups towards the PLWHA which still persists. They therefore assert that the church was caught up in a moralistic approach of which it finds it difficult to part with. The church’s problems are the result of the early negative interpretations of the mode of transmission of the disease which was used to stigmatize those affected and the infected. At the early stage of the disease, the African Christian was made to believe that it was exclusively spread through sexual intercourse and therefore, those who abstained and were faithful could not be infected. It was believed that PLWHA were immoral and disobedient. This discourse had a massive impact, and to this day some PLWHA refuse to be actively involved in the life of the church.

Chitando and Gunda further postulate that stigmatization of PLWHA in Africa was and continues to be informed by some readings of the Old Testament that saw some people as being less equal than others. Key texts they quote at this stage are Deuteronomy 7:12-15, 28:27-29. In these texts they assert that it is clear that the Lord inflicts sickness upon those who disobey his statutes and ordinances such as PLWHA. This has been central

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183 Campbel et al, “Stigma and HIV/AIDS.”
185 Chitando and Gundab, “HIV and AIDS.”
186 Chitando and Gundab, “HIV and AIDS.”
in the understanding of HIV and AIDS by some Christian groups and they use this as a benchmark in discriminating against, and sometimes to ostracise PLWHA from their assemblies. Some Christians to date have continuously used the Bible to legitimize the stigmatization of PLWHA.

In Ghana these Biblical verses were the basis of stigma and discrimination against PLWHA by some Christian Churches. For example a PLWHA testified that he was humiliated and dismissed during a religious service in front of his congregation by his head pastor when he divulged his HIV status to the latter. Further, some pastors and overseers in some churches in Ghana insist that their would-be couples undergo compulsory HIV testing during premarital counselling sessions. Although, this is a very laudable idea, the manner in which it is communicated and handled suggest serious stigma and discrimination. Those who test positive are rebuked and ridiculed by church leadership. They are humiliated and regarded as promiscuous people for that matter they are cursed.

It is also important to observe that the African indigenous religious notion of illness does not differ from the Deuteronomist idea. While indigenous African religions concentrate on the quest for abundant life, they regard illness as a curse from the ancestral realm and from the deities out of disobedience to their rules.\textsuperscript{187} As such, indigenous worshippers take urgent measures to bring healing and integration of the persons whose health have been compromised.\textsuperscript{188} In effect this has been the notion in some rural communities about the HIV/AIDS and PLWHA. This notion continues to persist among some rural folks in spite of many scientific publications and dissemination of realities about HIV. Stigma is

\textsuperscript{187} Torgbui Galeagbelime (traditional linguist at Dzodze), in a discussion with the researcher, February 2016.

\textsuperscript{188} Torgbui Galeagbelime, \textit{discussion}.
not accepted in African Traditional Religions let alone those who are affected by HIV.\textsuperscript{189} However, one cannot tell at what point stigma and discrimination towards PLWHA has surfaced among the rural indigenous people. This is a worry to Adogli. He postulates that there are some kinds of sexual activities accepted by some Ewe traditional religious cults. However, he agrees that stigma and discrimination which have now characterised PLWHA have come due to the effects of globalisation.\textsuperscript{190} He again asserts that the open acceptance of the truth that the sexual act is the main cause of the incurable emaciating terminal disease of HIV/AIDS has changed the reaction of indigenous rural religious people’s attitude towards those who show signs associated with HIV disease and PLWHA.\textsuperscript{191} Therefore the PLWHA in traditional indigenous communities are stigmatized and discriminated against for their loose attitudes which attracted the wrath of the ancestors and deities.

It is common knowledge that religion, especially some Christian denominations, have played and continue to play vital roles in responding to the threat of the HIV pandemic, through close contact with communities to provide support and encouragement to communities struggling to respond in most parts of Africa. Currently, owing to their impressive support for PLWHA there has been a gradual shift from denial to constructive engagement.

2.6 Conclusion

The PLWHA experience enormous challenges which are both internal and external. These challenges get worse when people who could defend and intercede for them feel reluctant to do so due to stigma and discrimination which have pervaded our local communities. It has been identified above that empathy can become the heartbeat to

\textsuperscript{189} Hunor Adogli (traditional Priest), in an interview with the researcher, March 2016.
\textsuperscript{190} Adogli, Interview.
\textsuperscript{191} Adogli, Interview.
induce altruistic care, support and motivation towards PLWHA in order to minimise their plight and help them live acceptable life. The significant expose of the various scholars on the concept situate it as part of the integral part of Christian teaching on the work of mercy and love. All those who believe in mercy as divine purpose captured by Christianity and other religions live the actual experience of empathy, mercy and love and are able to bring hope and change the story of those in bondage such as PLWHA. Nancy Snow believes that empathy can aid and abet practical reasoning, and we have the moral duty to hone and refine our empathic skills so that we can be appropriately become sensitive to the emotional needs of others.\footnote{Nancy E. Snow, “Empathy,” \textit{American Philosophical Quarterly}, vol. no. 1, 37 (2000), 75.}
CHAPTER THREE

PLWHA AND THE ROMAN CATHOLIC CHURCH’S SOCIAL INTERVENTION

3.0 Introduction

The account of Jesus Christ and his desire to redeem humanity from the abyss of hopelessness is the main basis of the Catholic Church’s mission in the world. The Church believes that as she traces her heritage back to Jesus Christ who the Bible affirms as the incarnation of God into the world, she must continue the saving act of God through her missions. Jesus in Matthew 10:7-8 commanded his disciples to go into the world and preach, heal the sick, raise the dead, cleanse lepers and cast out demons. The Gospel accounts are replete with examples of how Jesus intervened and restored hope to those he encountered. He cleansed a man from leprosy (Matthew 8:1-40; Mk 1:40-42), gave sight to the blind (Mt 20:29-34; Mk 10:46-52), gave speech to the speechless (Mark 7:31-37; Lk 11:14), cured a woman from haemorrhage (Mt 9:20-22; Mk 5:25-34) and gave life to the dead (Mark 5:21-43; John 11:38-44). These accounts give credence to the essence of God’s continuous redemption of the world He has created and the healing of people from their respective ailments and diseases.

Wilson has argued that faith and science are variants. However, the consultation between medical science and Christian faith is directed primarily to the betterment of the human race. It presupposes that science and faith do not contradict each other. Both are grounded in respect for truth, freedom and the liberation of the sick and the weak in the

It is in this sense that this section of the study will examine why the Catholic Church engages herself in social intervention and especially her quest towards the mitigation of the plight of People Living with HIV/AIDS. Matthew 25:40-45 explains the real essence of Christian life. Further the Gospel message of Christ advocates that Christianity does not confine itself to abstract theology rather on the practicality of Christian dogma or doctrine in question. In verse 45, Jesus answered them by saying “go into eternal punishment: but the righteous into life”. This stems from the fact that when he the lord personified in human was sick, hungry, prisoned and naked... some Christians did not visit him. However those who visited him are rewarded. This biblical expose, rooted on the corporal works of mercy, forms the basis for the Catholic Church’s endeavour into social intervention especially to the vulnerable people.

3.1 Origins of Catholic Social Teaching

Reflections on the origins of the social teachings of the Catholic Church takes us back to the Bible. The life and teachings of the historical Jesus point directly to social justice which Stassen and Gushee assert as tsedAQAh – the restoration of justice that vindicates the right especially of the poor or powerless, and the redemption of humanity through love. The first believers learnt very well from Jesus and related their new faith to their lives. This enabled them to change their attitudes towards the need of their neighbours in place of property as recorded by the book of the Acts of the Apostles 2:42-47. Later the Christian society had to evolve through the power of love in the face of persecutions

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196 Statssen and Gushee, Kingdom Ethics, 335.
and wars in order to have a worthy Christian moral society. Stassen and Gushee again assert that: “for Christians, love is the heart of living of human being. Love is at the heart of the life of Christ, his teaching and his death on the cross.”

Around AD 425 St. Augustine wrote the first greatest treatise on Christians’ social life in his *City of God*. This came in the wake of the fall of Rome in AD 410. He sought to assert that without God there is no basis for universal justice that seeks the well-being of every single individual in the world. He again opined that the purpose of the Christian revelation is not just to redeem individuals from evil but to build up a society which could be divine, because, “A single divine power of God the father, is the source of all the world of appearances.” For Augustine, the single source of meaning and value in the world could only be an agreement on moral principles which emanates from God. He seems to suggest that moral discord is the sure sign of disintegration of the world. In view of this the church must be the temporal institution in the service of a higher moral principle in order to live the kingdom here on earth.

In the middle ages there were inconsistencies in the approach of the Church towards social justice. The influences of the warring princes and the climate of the time directed the attention of the Catholic theologians who attempted to restrict the violence unleashed by the princes by developing the theory of ‘The Just War’.

It must be noted that Francis of Assisi’s rethinking of the Gospel message in relation to the natural world through the rejection of his father’s wealth to a life of a mendicant reawakened the Church’s mission on social justice till the period of the renaissance. Until the 19th century

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198 Stassen and Gushee, *Kingdom Ethics*, 327.
200 O’Donnell, “Augustine Christianity and Society.”
201 O’Donnell, “Augustine Christianity and Society.”
202 Duncan, “What the Just War.”
203 Duncan, “What the Just War.”
the tradition of Catholic social teaching seems to depict the society and the principles that
govern the particular era.\textsuperscript{204}

The rebirth of Catholic social teaching began afresh in the latter part of the 19\textsuperscript{th} century.

It became evident that the Church must act due to the disruptions and the impact of
industrialisation on communities that hitherto existed peacefully. The Catholic Bishops
Conference of England and Wales noted that: “…it is necessary to examine the social
conditions which are most suited to human flourishing and fulfilment because we live in
one world and we are increasingly interconnected and interdependent.” They added that
humans all over the globe are conditioned to tune to the right social conditions.

Consequently, the demand of human dignity precludes suffering and degradation that are
tolerated all around the world today.\textsuperscript{205} The Church further noted the demeaning and
inhumane tenets in the economic theories of laissez-faire, capitalism and Marxism and
communism which govern the progress of industrial revolution at that time. In the name
of social justice the Church found much to object to in each of them.\textsuperscript{206} It was realized
that each of these theories viewed human society as an object to extract from and always
at the mercy of harsh inevitable economic laws. These inhumane economic determinisms
prompted Pope Leo XIII to issue the encyclical letter \textit{Rerum Novarum}- “Of New Things”
in 1891. This became the basis of which “the Church set out to restore in contemporary
industrialized society the urgency of the humans over the economic benefits, and the
spiritual and moral over the material things.”\textsuperscript{207}

Pope Leo XIII decries the situation of the vulnerable. He states several important guiding
principles that should direct our response to our vulnerable brothers and sisters in the

\textsuperscript{204} Catholic Social Teaching, \textit{Faith in the Better World},
http://www.catholicsocialteaching.org.uk/principles/history/
\textsuperscript{205} Catholic Bishops’ Conference of England and Wales, \textit{The Common Good and the Catholic Church’s
Social Teaching: Consultation on Outline Framework for Proposed Social Teaching Document}, (London:
England and Wales Catholic Conference, 1996), [6].
\textsuperscript{206} Catholic Bishops’ Conference of England and Wales, \textit{The Common Good}.
\textsuperscript{207} Catholic Bishops’ Conference of England and Wales, \textit{The Common Good}. 66
society. These include the principle of true dignity that resides in moral living. Rights must be religiously respected wherever they exist, and it is the duty of the public authority to prevent and to punish injury. The rights of individuals, the poor and the vulnerable have a claim to special consideration.²⁰⁸ Pope Leo’s assertion still remains relevant to the plight and challenges of PLWHA who are mostly poor and vulnerable and whose basic human right must be protected.

Again, in *Rerum Nevarum* number 26, Leo asserts that the Church can no longer be content with pointing out the remedy, she must strive to also apply these remedies.²⁰⁹ Therefore the church in her utmost duty must teach and train men, and educate people by the intermediary of her bishops and clergy. She must also seek to diffuse her salutary teachings far and wide. It is precisely in this fundamental and momentous matter on which the relevance of the Church depends. The Church possesses her own peculiar power in her well informed human resource and her ability to affect the informed and affect the world of God’s purpose for creation.²¹⁰ This sets the tone for Catholic social intervention in the modern world to alleviate the pain and the hopelessness of the world. Further, *Rerum Nevarum* articulates and refocuses the Church’s primary duty which is to intervene positively in the life of the world especially to remedy the situation of the disadvantaged people. This means that the true worth of the Church lies in the quality of the life of the people she has been able to transform. Jesus Himself is inclined to the vulnerable and has displayed important love towards them. From the contemplation of Jesus as the model of the virtues of love and charity, the church must stand firm in support of PLWHA. In effect if PLWHA were to meet Jesus, the latter would have done what most of us fail to do: that is to relieve them completely of their worries and

anxieties. It must be noted that all modern social teachings of the church flow from
*Rerum Novarum*.

### 3.2 Understanding Roman Catholic Church’s Social Intervention

John Ryan answers the question on whether the responsibility of the Catholic Church is different in this age than in former ages by asserting that the Church’s responsibility does not differ now from what it has always been. The Catholic Church admits, indeed insists that the unchanging principles require new applications to fit new conditions.\(^{211}\) The Church’s ministry is rooted in the love, support and promotion of human dignity, because the Church believes that:

> A just society can become a reality only when it is based on the respect of the transcendent dignity of the human person. The person represents the ultimate end of society, by which it is ordered to represent: ‘Hence, the social order and its development must invariably work to the benefit of the human person, since the order of things is to be subordinated to the order of persons, and not the other way round’. It is necessary to ‘consider every neighbour without exception as another self, taking into account first of all his life and the means necessary for living it with dignity’.\(^{212}\)

Considering this view we can assert that the Church acquitted herself very well with the quest to respect the sacredness of human life. The church continuously seeks to reintegrate God’s commandment as given in the Bible with new situations such as the plight of PLWHA, without altering the substance.

The U.S. Catholic Conference of Bishops (USCCB) postulates that the dignity and preservation of human life flows from the creation of humans in the icon of God – *imago Dei* - in Genesis 1:26.\(^{213}\) We can infer that human beings therefore, are the most

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\(^{212}\) Compendium of the Catholic Social Doctrine of the Church, no. 132.

important creatures of God as they are given dominion over every other created thing. It will be unjust for humans to subjugate their own kind.

Further the mandate to care for the poor and the vulnerable is biblical and founded on Matthew 25:34-46. Christians are required to express this injunction in concrete terms and actions at all levels of our social life. This mandate prompts the Church to work to ensure that every human person is given adequate care to live his/her divine mandate. Catholic institutions all over the world pay particular attention to the poor and the vulnerable. This is evident in the amenities provided by the Church all over the world. In Ghana, the Catholic Church leads in the provision of educational facilities and health institutions, in most of the villages and cottages where the government has not even dared. The Church has also initiated other programmes to alleviate the pain and the hopelessness of the poor and the vulnerable such that, throughout the world the Catholic Church is the largest single provider of care for people affected by HIV and AIDS, serving twenty-five percent (25%) of those who suffer from the disease. Further, the Catholic Relief Service (CRS) current AIDS projects serve approximately four million people affected by HIV/AIDS in thirty (30) countries. Activities of CRS are concentrated in Africa. In Ghana, CRS was able to establish HIV/AIDS relief programmes for PLWHA in almost all the Catholic Dioceses in the country.

It is important to note that faced with the reality of HIV/AIDS, the Catholic Church has not altered its moral teachings but has rather strengthened them through the deployment of love. This is because, according to Catholic teaching; “...love is the truth of man, and the Church proclaims faith in God of love who offers men salvation that is

215 United States Conference of Catholic Bishops, “Quotes from Church Documents,” USCCB.
simultaneously liberating and healing.”

The Church recognises the necessity and the urgency of the challenges of HIV/AIDS and contemplate on how to speak of love, healing and salvation of God to PLWHA who are confronted with desperation, rejection, suffering and death. Faced with this reality the church has adopted pragmatic, realistic and coherent engagement by going alongside Christ footstep. It must further be noted that: “…Although the initial response of the Catholic Church was somewhat timid, it was nevertheless among the first social institution to engage in the fight against AIDS in Africa, in particular with regard to outreach to persons infected and affected by the virus within a number of social structures.”

Mukoko further asserts that it is impossible to effectively combat an epidemic, which concerns the behaviour of individuals, without taking into consideration the cultural environment of such individuals. This means that when the Church failed to take into account the various cultural context of PLWHA in her earlier responses to them, the initiatives yielded little or no effect. Therefore recalling the meeting of the Symposium of the Catholic Bishops from Africa and Madagascar (SECAM) held in Dakar in 2003 and several pastoral letters by the African Bishops, the Church no longer hesitates to confirm the social support and intervention to PLWHA in its pastoral agenda.

However, every Diocese determines what programmes are suited for their cultural context.

3.3 The Building Blocks of Catholic Social Teaching

In a document *Sharing Catholic Social Teaching*, the USCCB has highlighted a number of principles that flow from their understanding of Catholic social teaching which are

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found in the Church’s documents. These principles are developed based on the insights of the Church’s mission to accentuate several current issues. However, William Byron has categorised and postulated these principles into ten (10) foundational principles which flow from fundamental anthropology and guide the social operations of the Catholic Church. These principles enable the Church to focus her attention on her authentic and meaningful relationship with humanity as a whole. It is worth indicating that these principles that guide the Church’s social orientations are in bit and pieces in the encyclicals, pastoral letters and other Church documents. Further Cardinal Martino in his reflection on 2 Peter 3:13 asserts that: “The Church is an expert in humanity as she anticipates the ‘new heaven’ and the ‘new earth’.” Consequently, she must indicate to every person, the dimension of authentic meaning. The human person who fully lives his or her dignity gives glory to God, who has given this dignity freely to humanity as a whole. This section will peruse the principles identified by Byron as the building blocks of the social teaching of the church and guide to its social operations.

3.3.1 Principle of Human Dignity

Pope John XXIII teaches in the Encyclical Mater et Magistra — ‘Mother and Teacher of all nations,’ that the cardinal point of social life is that, the individual humans are necessarily the foundation, cause and end of all social institutions. This means that all individual humans have worth and value. Byron asserts that according to the church, every person regardless of his/her origins, orientations and achievement or any other

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223 Renato Raffaele Martino, “Presentation”, in Compendium of Catholic Social Teaching. (Vatican City, Italy: Libreria Editrice Vaticana, 2001)
differentiating characteristic is worthy of respect. An inference from the above assumption presupposes that it is not what you have or what you do that gives you the audacity to claim respect but by virtue of you being a human establishes such dignity. This principle reminds us of the creation story. Every person is created in the image of God the creator.

3.3.2 Principle of Respect for Human Life

In the *Evangelium Vitae*—‘The Gospel of Life,’ John Paul II posits that every individual, precisely by reason of the mystery of the Word of God who was made flesh is entrusted to the maternal care of the Church. Therefore the Church cannot allow any threat to human dignity because every human life is at the very heart of the Church and it is for every human individual that the Redemptive act was performed by Christ. John Paul II continues that the proclamation of the Gospel of Life is urgent because of the extraordinary increase and gravity of threats to the life of individuals and peoples, especially where life is weak and defenceless, and also compounded by the ancient scourges of poverty, hunger, endemic diseases, violence and war, new threats are emerging on an alarmingly vast scale.

Byron also emphasises the sanctity of human life which is inhibited in human dignity. He based this principle on this statement in the “Sharing Catholic Social Teaching” of the U.S. Catholic Bishops Conference that every person, from the moment of conception to natural death, has inherent dignity and right to life consistent with that dignity. The Catholic Church sees the sacredness of human life as part of any moral vision of a just and good society. Human life at every stage of development is precious and therefore

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needs to be protected and respected. The innocent attack on human life is broadly frowned upon by the Church. Therefore, the Church cannot allow denigration of the PLWHA in any sense.

3.3.3 Principle of Association

The Roman Catholic Church’s tradition proclaims that the person is not only sacred but social. How the human society is organized in terms of economics and politics, in law and policy directly affects human dignity and the capacity of individuals to grow in community.\(^{229}\) The family is the first point of contact in any society. All efforts must be geared towards the protection of the family and all social institutions that foster growth, protect dignity, common good, self-esteem, freedom from servitude etc.

3.3.4 Principle of Participation

The Compendium of Catholic Social Teaching (CST) asserts that the participation in community life is not only one of the greatest aspirations of the citizen. Every individual is called to exercise freely and responsibly his civic role with and for others.\(^{230}\) Byron has also asserted that the Church believes that people have right and duty to participate in society, seeking together the common good and well-being of all, especially the poor and vulnerable.\(^{231}\) Per the moral standards of the Church, all human persons have the right not to be shut out from participation in those institutions that are necessary for human fulfilment. This principle by extension applies to the conditions associated with work. Work here pertains more than a way to make a living; rather as another medium of continuing participation in God’s creation.\(^{232}\) If work connotes a continuation of God’s creation, then the right of workers must be upheld thus the right to productive work, to

\(^{229}\) Byron, “The Key Themes,” 4.
\(^{230}\) *Compendium of the Social Doctrine of the Church*, (Vatican City, Italy: Libreria Editrice Vaticana, 1961), [190].
\(^{231}\) Byron, “The Key Themes,” 4.
decent and fair wages, to organize and join unions, to private property, and to economic initiative. Therefore the Church must fight for PLWHA to secure their employment.

3.3.5 Principle of Preferential Protection for the Poor and Vulnerable

Without the protection of the poor and the vulnerable, the balance needed to keep society in one piece will be broken to the detriment of the whole. This is because the opposite of rich is poor and powerful is powerless. Should the good of all, the common good, prevail, preferential protection must be directed towards those affected negatively by the absence of power and the presence of privation.233

3.3.6 Principle of Solidarity

CST defines this principle as; “Solidarity highlights in a particular way the intrinsic social nature of the human person, the equality of all in dignity and rights and the common path of individuals and peoples towards an ever more committed unity.”234 This principle moves the individual from loneliness to the family of belongings. We are one human family. Learning to practice the virtue of solidarity means learning to love our neighbours. This has global dimensions in an interdependent world. John Paul II asserts it all in his Sollicitudo Rei Socialis that:

The Social Concern of the Church: “it is above all a question of interdependence, sensed as a system determining relationships in the contemporary world, in its economic, cultural, political and religious elements, and accepted as a moral category. When interdependence becomes recognised in this way, the correlative response as a moral and social attitude, as a "virtue," is solidarity. This then is not a feeling of vague compassion or shallow distress at the misfortunes of so many people, both near and far. On the contrary, it is a firm and persevering determination to commit oneself to the common good; that is to say to the good of all and of each individual, because we are all really responsible for all… a commitment to the good of one's neighbour with the readiness, in the gospel sense, to "lose oneself" for the sake of the other instead of exploiting him, and to "serve him" instead of oppressing

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234 Compendium of the Social Doctrine of the Church, [192].
3.3.7 Principle of Subsidiarity

This principle of subsidiarity was explicit in Pope Pius XI’s *Quadragesimo Anno* – ‘Forty Years After’ at it represents that:

> It is a fundamental principle of social philosophy, fixed and unchangeable, that one should not withdraw from individuals and commit to the community what they can accomplish by their own enterprise and industry. So, too, it is an injustice and at the same time a grave evil and a disturbance to right order to transfer to the larger and higher collectivity functions which can be performed and provided for by lesser and subordinate bodies. Inasmuch as every social activity should, by its very nature, prove a help (*subsidium*) to members of the body social, it should never destroy or absorb them.\(^{236}\)

Byron asserts that this principle put a proper limit on government but insisting that no higher level of organization should perform any function that can be handled professionally and effectually at a lower level of organization by human persons who individually or in groups, are closer to the problems and closer to the ground. Domineering governments are always in the contravention of the principle of subsidiarity; overactive governments frequently contravene this principle. In the same vein the Church cannot neglect caring for PLWHA to governments and other organisations. The Church is capable with its resources to care and support PLWHA effectively.

3.3.8 Principle of Human Equality

The Catholic Church’s catechism teaches that we are created in the image of the one God and we are equally endowed with rational souls. Therefore all humans have the same nature and the same origin.\(^{237}\) Redeemed by the sacrifice of Christ, all are called to

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\(^{235}\) Pope John Paul II, *Sollicitudo Rei Socialis*: Encyclical Letter on the Occasion of the Twentieth Anniversary of *“Populorum Progressio”* (Vatican City, Italy: Libreria Editrice Vaticana, 1987), [38].

\(^{236}\) Subsidiarity, Catholic Encyclopaedia.com, eBook

\(^{237}\) Catechism of the Catholic Church, [1934 – 1937].
participate in the same divine beatitude: all therefore enjoy an equal dignity. The equality of humans rests essentially on their dignity as persons and the rights that flow from it. In *Gaudium et Spes* – ‘The Joys and Hopes’, the Church asserts that every form of social or cultural discrimination in fundamental personal rights on the grounds of sex, race, colour, social conditions, language, or religion must be curbed and eradicated as incompatible with God's design. However in the face of this equality the Church recognizes some differences. Therefore she again teaches that we need one another in order to live a healthy authentic life in the reality of the differences which flow from our divine origin.

Byron asserts that principle of equality flow directly from this teaching as he posits that treating equals equally is one way of defining justice, also understood classically as rendering to each person his or her due. One comes to understand therefore that undergirding the notion of equality is the simple principle of fairness; one of the earliest ethical stirrings felt in the developing human person is a sense of what is ‘fair’ and what is not. In this sense do we need to translate this fairness to PLWHA.

### 3.3.9 Principle of Stewardship

The Church is conscious of the responsibility which all of us have for our world and for the whole of creation, which we must love and protect. There is much that we can do to benefit the poor, the needy and those who suffer, and to favour justice, promote reconciliation and build peace. God created the world, but entrusts it to human beings. Therefore humans must respect and care for the life of world. They must also enhance the gifts that make life to flourish and then shield it from threat of violence and assault.

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238 Catechism of the Catholic Church, [1934 – 1937].
With this principle, Byron brings to bear the essence that the steward is a manager and not an owner. In this era of raising consciousness about our physical environment, what is required of us is a sense of moral responsibility for the protection of animate and inanimate environments thus humans and other living organisms, croplands, grasslands, woodlands, air, water, minerals and other natural deposits.\footnote{242} The responsibility of a steward is towards our use of our personal talents, our attention to personal health and our use of personal property. We can infer from Byron’s assertion the equal responsibility of humans towards themselves especially those who are sick, the needy and the vulnerable.

### 3.3.10 Principle of Common Good

Human families and the various groups which make up the civil community are aware that they cannot achieve a truly human life by their own unaided efforts. They see the need for a wider community, within which each one makes his specific contribution every day towards an ever broader realization of the common good.\footnote{243} For this purpose they set up a political community according to various forms. Indeed, the common good is to be understood as the sum total of social conditions which allow people, either as groups or as individuals, to reach their fulfilment more fully and more easily.\footnote{244} Again the Catholic Catechism teaches that the common good concerns the life of all. It calls for prudence from each, and even more from those who exercise the office of authority. However it consists of three essential elements: respect for the person as his/her fundamental and inalienable rights, require the social well-being and development of the

\footnote{242} Byron, “The Key Themes,” 4.  
\footnote{243} Compendium of the Social Doctrine of the Church, [164-166].  
\footnote{244} GS, 74.
group itself, require peace, stability and security of a just order.\textsuperscript{245} This presupposes that no one can be denied his/her right to what is common good.

Byron acknowledges the principle of common good. However he posits that what actually constitute the common good is always a subject to debate.\textsuperscript{246} The absence of any concern for or sensitivity to the common good is a clear indication of a society in need of help. In reality, as a sense of community is battered, concern for the common good dwindles. The concern of a proper communitarian concern is the panacea to unbridle individualism, which, like unrestrained self-centredness in personal relations, can destroy balance, harmony and peace within and among groups, neighbourhood, regions and nations.\textsuperscript{247}

We can summarise these ten building blocks of Catholic social teaching in Pope Paul VI assertion that various forms of discrimination continually reappear – ethnic, cultural, religious and political. In fact, human rights are still too often disregarded, if not scoffed at, or else they receive only formal recognition. In many cases legislation does not keep up with real situations. Legislation is necessary, but it is not sufficient for setting up true relationships of justice and equity. The Gospel however instructs us in the preferential respect due to the poor and the special situation they have in society: the more fortunate should renounce some of their rights so as to place their goods more generously at the service of others. If, beyond legal rules, there is really no deeper feeling of respect for and service to others, then even equality before the law can serve as an alibi for flagrant discrimination, continued exploitation and actual contempt. Without a renewed education

\textsuperscript{245} Catechism of the Catholic Church, [1907-1909].  
\textsuperscript{246} Byron, “The Key Themes,” 4.  
\textsuperscript{247} Byron, “The Key Themes,” 4.
in solidarity, an overemphasis of equality can give rise to an individualism in which each one claims his own rights without wishing to be answerable for the common good.\textsuperscript{248}

3.4 Theological Orientation of the Catholic Church’s Response to HIV and AIDS.

Catholic theologians firmly agree that HIV and AIDS pose three major theological challenges to the Church.\textsuperscript{249} First, the sheer number of the people infected and affected by the disease means that the Church cannot ignore the problem. This means that the Church is infected with HIV/AIDS. This underlines the validity of the Church’s response almost in every continent. Secondly, the negative economic impact of the disease on the people, affects the fortunes of the Church as well. Thirdly behind the epidemic lie serious concrete situations of human misery, suffering, pain and death which the Church cannot overlook.\textsuperscript{250} However Agbonkhianmeghe contends that the earlier theological reaction of confining the debate on the disease to the prioritization of sexual ethics and morality of preventive devices like condoms have weakened the theological argument.\textsuperscript{251}

The current theological orientation of the Catholic Church on HIV/AIDS is multifaceted or multisector response approach. Agbonkhianmeghe notes that the community of faith is not just a sector among many others in society, but is itself a ‘mosaic of sectors’ or ‘community of sectors’.\textsuperscript{252} He further asserts that if the Church is unable to work alongside other religions, Christian denominations and secular organisations, she might wall out sessions of what God is doing. “We could draw from this the conclusion that in the time of AIDS there would be no basis for reinventing the First Vatican Council’s

\textsuperscript{248} Pope Paul VI, \textit{Octogesima Adveniens}: Apostolic Letter (Vatican City, Italy: Libreria Editrice Vaticana, 1971)


\textsuperscript{250} Agbonkhianmeghe, \textit{From Crisis to Kairos}, 121.

\textsuperscript{251} Agbonkhianmeghe, \textit{From Crisis to Kairos}, 122.

\textsuperscript{252} Agbonkhianmeghe, \textit{From Crisis to Kairos}, 125.
appropriation of St. Cyprian’s *extra ecclesiam nulla salus.*” This multifaceted theological approach adopted by the Church in tackling HIV/AIDS menace brings out clearly the theological meaning of the church as the Body of Christ which Paul postulates in 1Corinthians 12. Over here we must consider the term exclusively to mean the unity of the Church not as in other theological interpretations of the same text. This again highlights the relevance of the Church’s collaboration with other religious and civil society organizations to fight the pandemic of the HIV/AIDS disease. The timing of this approach has helped the Church in Ghana to respond to the disease effectively and it is clear that this theological orientation “drove the Christian Council of Ghana (the country’s oldest and largest Protestant ecumenical body), Catholic bishops, Muslim leaders, and the Ghana HIV/AIDS Network to design the Compassion Campaign to raise awareness and address HIV/AIDS stigma, particularly in the religious community.” Therefore, through the common effort of the whole body of Christ challenges are easily overcome.

Theological expression of the body of Christ connotes the dynamics of solidarity. As Vogt writes, solidarity involves ‘acquiring true knowledge about the world’ and how it works, so that our ‘situation of interdependence is transformed.’ The mystery of the human person is continually confronted by new issues and challenges such as that of the HIV/AIDS. In the salvation history the Grace of Christ enables men and women to overcome their mutual challenges. In this vein Shuman opines that the body of Christ is reconstituted at its most fundamental level through the two liturgical practices of baptism and Eucharist. Through these practices, the Christian is so bound to the bodies of other

253 Agbonkhianmeghe, *From Crisis to Kairos,* 125.
baptized persons and becomes part of the body of Christ.\textsuperscript{256} The Church seeks understanding of the solidarity between various sectors of the society in this noble fight so that the interconnectivity that exist between the Father, the Son and the Holy Spirit or in the Triune God is very expressive in our social relationships. The theology of solidarity fulfils the principle of common good in such a way that the interconnectivities between oppression and privilege, the healthy and sick, the haves and the have-nots are strengthened and ameliorated in order to bridge the gaps in confronting the menace of HIV/AIDS. Communities divided by HIV/AIDS stigma and discrimination must be rebuilt from within on the theology of solidarity and common good. This will enable the Church to liberate herself from the limitations of the past, and yet be able to form the humanity of the future for the eternal kingdom of God.

Altman referred to HIV/AIDS as the most political of diseases.\textsuperscript{257} HIV has pervaded all continents. In Ghana it was initially described as a punishment from God because it was mostly associated with sex workers and sexually promiscuous people. It was seen as an effect of the long carried moral flaw. These punishment narratives, and others like it, have dominated discussions regarding religion and HIV. Kopelman asked a thought provoking question that: “If HIV/AIDS is a punishment, who is bad? And nobody is also good. The fact is that nobody can loudly blow the trumpet of self-righteousness since we are all human.”\textsuperscript{258}

Chimhanda asserts that the Church’s response to the mission of God in a situation of HIV and AIDS is undergirded by the great commandment of love that Jesus enjoins on his disciples in Luke 10:27-28 “Love the Lord your God with all your heart and with all your

\textsuperscript{256} Joel Shuman, \textit{The body of Compassion: Ethics, Medicine and the Church} (Colorado: Westview Press 1999), xviii.
strength, and with your entire mind; and your neighbour as yourself.” Thus, the Christian God is the God of love. Pope Benedict XVI has also highlighted the love commandment as the theological basis for the Church’s response towards HIV/AIDS and other vulnerable situations. He asserts that love of neighbour is grounded in the love of God and that is the first and foremost responsibility for each individual member of the faithful, but it is also a responsibility for the entire ecclesial community at every level: from the local community to the particular Church and to the Church universal in its entirety. He continues that the duty of the Catholic Church vis-à-vis the vulnerable should not be a kind of welfare activity which could equally well be left to others, but is a part of the Church’s nature, an indispensable expression of her very being. In this sense the Church’s deepest nature is expressed in her three-fold responsibility: of proclamation of the word of God, celebration of the sacraments, and exercise of the ministry of charity. These duties presuppose each other and are inseparable.

Kelly relays Sr. Tarcisia Hunoff’s assertion in her work on the theology of the Catholic Church’s response to HIV and AIDS in Papua New Guinea that:

AIDS is a sign of our time. As religious, we are supposed to be able to read the signs of the times. The Church, over the centuries, has always responded to special signs of their times, to specific needs such as epidemics. If you think of history, it was the church who responded. Church has always responded to a special need. Being faithful to the Gospel means that we read and respond to the needs of our times in specific ways.

She further posits that the Church’s quest to respond to the plight of HIV and AIDS can be critically examined in the three theological virtues of faith, hope and love which are...
crucial in the time of HIV/AIDS. These virtues she claims must be accompanied by practical care which does not only concern about improving on people's quality of life within their community, but also demands action in their wider world.\textsuperscript{263} According to Kelly and Sr. Hunoff, the Church does not require special biblical knowledge to respond to HIV and AIDS. Instead, HIV and AIDS are considered as part of a wider theological praxis of care and compassion, which has developed and evolved with the history of the Church. Responding to HIV and AIDS is the work of a faithful Church, not an optional extra duty. The history or precedence of such work can be found in the Gospels.\textsuperscript{264}

From the discussion above, we can infer that although the Catholic Church’s theological orientations towards PLWHA is eclectic, three approaches have emerged. The first approach takes cognisance of the human nature and dignity. Human life is very important in the sense that it participates in the life of God as we are created in the image of God - \textit{imago Dei} and God equally participate in our life through the incarnation of his son Jesus Christ. “God did not create man as in solitary, for from the beginning "male and female he created them" (Gen. 1:27). Their companionship produces the primary form of interpersonal communion. For by his innermost nature man is a social being, and unless he relates himself to others he can neither live nor develop his potential."\textsuperscript{265} The Church’s insistence on fellowship – \textit{koinonia} and the mutual reciprocal relationship that should exist between humans especially towards PLWHA portrays that the Church consider its response to PLWHA in her theological anthropology.

The second approach resides in the life and ministry of Jesus. Therefore it is Christological. Pope Francis teaches in his apostolic letter \textit{Misericordiae Vultus} – ‘Jesus Christ is the face of the Father’s mercy’, that “Patience and mercy are two words which

\begin{thebibliography}{9}
\bibitem{264} Kelly, “The Body of Christ,” 22.
\bibitem{265} GS, 12.
\end{thebibliography}
often go together in the Old Testament to describe God’s nature. His being merciful is concretely demonstrated in his many actions throughout the history of salvation where his goodness prevails over punishment and destruction.”

One of the most important concerns of the ministry of Jesus was to confront concrete situations of human misery, suffering, pain and death. Jesus as God is believed to be the creator and sustainer of and the world. Jesus has never turned a blind eye to human suffering. He humbly identified himself with the sick and the disadvantaged. He brought relief and redemption to them. Paul expresses it very well in his letter to the Philippians 2:7 “... emptied himself, taking the form of a servant, being made in the likeness of men.” Therefore the Church cannot turn a blind eye to PLWHA. She must equally identify herself with them in the imitation of Christ.

The circumstances that prevailed at the birth of Jesus and his life devoid of affluence of tax collectors, Scribes and Sadducees reflect the condition of the poor and his passion for the struggle of the sick, the poor and the oppressed against injustice. Christ ministry is generally fused together with his salvific work. Jesus broke the social barrier by healing people with diverse kinds of diseases and sicknesses, as well as those who were seen as social outcasts (Mt. 20:20). His association with those considered as sinners and social misfits proved his passion for the injustice in society (Lk.5:31). Vincent Mainelli asserts that the Church has received from Christ the mission of the Gospel message “…universal brotherhood and a consequent demand for justice in the world. This is the reason why the

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266 Pope Francis, *Misericordiae Vultus*: the Father’s Mercy (Vatican City, Italy: Libreria Editrice Vaticana, 2015), [6].
Church has the right, indeed the duty to proclaim liberty, social justice and to denounce instances of injustice.”\textsuperscript{267}

The Catechism of the Church asserts that “Christ’s compassion toward the sick and his many healings of every kind of infirmity are a resplendent sign that God has visited his people and that the Kingdom of God is close at hand. “Jesus has the power not only to heal, but also to forgive sins; he has come to heal the whole man, soul and body; he is the physician the sick have need of.”\textsuperscript{268} Jesus’ compassion toward all who suffer goes far that he identifies himself with them: ‘I was sick and you visited me.’ His preferential love for the sick has not ceased through the centuries to draw the very special attention of Christians toward all those who suffer in body and soul. It is the source of tireless efforts to comfort them.”\textsuperscript{269}

The third approach is based on the ecclesiological reflections of the Church. The church has a very old tradition of caring for the sick. The Catholic Church’s concern for social justice is unparalleled. It is a well-placed religious group that plays a crucial role in HIV prevention and care at every level. In many countries, the Catholic Church is involved in this work. The Church’s theologians and leaders have formulated various theological principles that determine their response to the epidemic if this is to be seen to be well-founded.

3.5 Conclusion

The HIV disease since its inception has had enormous effects on the world’s population. The projected number of PLWHA has still not met its decreasing frequency. This will however mean that the demand for health workers and donor agencies across the globe


\textsuperscript{268} Catechism Catholic of Church, [1503].

\textsuperscript{269} Catechism Catholic of Church, [1503].
will be needed. The Catholic Church has taken a lead in such endeavour. The Church in response to this epidemic has taken inspiration from the example of St. Paul the Apostle and Jesus Christ especially from Mathew 25 which talks about the real essence of Christianity or being a Christian. The theology of the Catholic Church especially in the context of social intervention is living theology. This is because the Church is committed to a comprehensive HIV/AIDS care and assistance which is deeply rooted in her faith and belief in addressing to the needs of today. As Kelly quotes Musa Dube “…theologies should seek to enable faith communities to effectively to counteract the spread of the infection; to provide quality care; to counteract stigma and discrimination; to advocate for accessible and affordable treatment as well as to reduce the impact of epidemic”.  

It must be noted that the Catholic Church’s response to the PLWHA is placed in the broader spectrum of its healing ministry. This does not only mean the restoration of health and remedy to PLWHA. Rather the church seeks restoration of wholeness which is characterised by physical, mental, emotional and spiritual integration of individual PLWHA. The Catholic Church as the earthly representation of Jesus takes after the latter who asserts in John 10:10b that he came that people may have life, and have it abundantly. St. Irenaeus of Lyons posits that God is the source of all activity throughout creation and the glory of God is fully manifested in humans. Therefore it is impossible to live without life, and the actualization of life comes from participation in God, while participation in God is to see God and enjoy his goodness. This means one can only enjoy God and life if only if he/she is fully integrated physically, mentally, emotionally and spiritually to God. The Catholic Church through its healing ministry provides the opportunity for people to become whole and integrate themselves to God and live. This

mission of the Church again resides in the mission of the twelve in Luke 9:2. In this sense the Church has provided various health institutions to cater for people’s physical, psychological and spiritual health needs. The various health institutions such as Hospitals and health centres, rehabilitation centres and social integration centres that the Catholic Church has provided in Ghana give credence to this mission of the Church.
CHAPTER FOUR

PLWHA IN AFALO AND DZODZE, AND THE RESPONSE OF THE
CATHOLIC CHURCH: PRESENTATION AND DISCUSSION OF FINDINGS

4.1: Introduction

From our previous chapters we can infer that the principles of empathy, compassion, and moral responsibility are imbedded in Catholic theology and social actions. It is in this direction that the Catholic Church in Africa demonstrated a genuine engagement and commitment to the cause of the fight against HIV/AIDS epidemic and its impact through SECAM (Symposium of Catholic Bishops Conference Africa and Madagascar) in October 2003 in Dakar. Although pockets of actions have earlier been taken by various dioceses and bishops’ conferences in various countries to fight the epidemics and to alleviate the plight of PLWHA, the Church in Africa through SECAM has sought to unite its efforts in tackling the pandemic and issues related to PLWHA through theological reflections and pastoral care programmes.

“...we call to join together in confronting the pandemic whose gravity no one can ignore. May this solidarity be matched by a keen awareness of the seriousness of the threat facing us. Millions of lives have already been lost prematurely, whole families dismembered and untold numbers of children orphaned and/or infected by HIV. As heads of our Christian communities, we commit ourselves to making available our Church’s resources be they our educational and healthcare institutions or social services. We will work closely with all funders who are disposed to support and work with Christian and other faith-based organisations. We are open to partnerships with them and others who are happy to put their resources to work in the struggle, and do so knowing well that we work according to our Gospel convictions. For ‘man does not live by bread alone, but by every word that issues from the mouth of God’ (Mt 4: 4)“

This decision by SECAM to make the plight of HIV/AIDS an integral part of the Church’s theological and pastoral lives saw the birth in Ghana of the National Catholic

271 Symposium of Episcopal Conferences of Africa and Madagascar (SECAM), The Church in Africa in face of HIV/AIDS Pandemic Message (Dakar, Senegal 7 October 2003)
HIV/AIDS Commission (NCHAC), which is responsible for the co-ordination, policy development, resource mobilization, monitoring and evaluation, advocacy and research in HIV/AIDS, on behalf of the Church, and secondly the Community Collaborative Care and Support Programme (COMCASUP) which was launched in Aflao in August 2006. The latter was a five-year programme which had been funded by the Catholic Relief Service (CRS) and have been implemented by various Arch/Dioceses in Ghana. It must be noted that after the expiration of the funding by the CRS of COMCASUP, the various Arch/Dioceses must take over both funding and implementations.

The COMCASUP programme sought to develop the capacity of the Arch/Dioceses to cater for the PLWHA and their families directly. It has been very effective in providing leadership, integral support, and pastoral care in schools, parishes and families. It has also enabled education for orphans and vulnerable children (OVC), advocacy for treatment for PLWHA, value-based education for communities which is a solid basis for prevention of stigmatisation and effective social and cultural interaction of PLWHA in the various communities. However it came to light after the expiration of the five years that the programme was no longer functional in most of the Arch/Dioceses owing to funding difficulties. Among the few dioceses that the programme is still active is Keta-Akatsi Diocese.

This chapter will attempt to analyse the responses of some PLWHA, some caregivers and some authorities of the Catholic Church in-charge of COMCASUP, the Church’s outfit which coordinates the support and care to the PLWHA in the Aflao and Dzodze communities in the Keta-Akatsi Catholic Diocese. Thematic content analysis was used to analyse the interview data of the respondents.
4.2: Presentation and Analysis of the Responses on the Catholic Social Intervention with PLWHA

The study sought to identify the type and kind of help the Catholic Church has been offering to people living with HIV/AIDS in the Aflao and Dzodze communities in the Volta region of the Republic of Ghana. In this regard, interviews were scheduled with some of the PLWHA, as well as their caregivers in the health facilities and also some of the officials of COMCASUP. The findings and analysis of the interview data will be presented thematically in this section. The researcher adopted qualitative data gathering owing to the problems he encountered in his attempt to collect quantitative data. The caregivers through whom the researcher could have access to the PLWHA either refused to lead him to them or asserted categorically that most of the PLWHA would not be ready to divulge their identities to him. Further, two caregivers indicated that some of the PLWHA were not ready to divulge to their own children and siblings their seropositive status let alone the researcher. They regarded their condition as highly confidential. Therefore, he sought to concentrate of the qualitative data collection.

The participants of the interviews consisted of twenty (20) people living with HIV/AIDS, seven (7) caregivers and three (3) officials at the various desks of COMCASUP (See Appendix III for a short profile on the respondents). These samples were chosen because the study sought to get an in-depth knowledge about the kind of support the people received from the Catholic Church and how this support was impacting on their lives. In this regard, the data from the PLWHA will be analysed separately from that of the caregivers and officials to ensure that each of the themes is adequately dealt with.
4.2.1 Opinions of the PLWHA on the Catholic Church Support.

As already mentioned, the number of PLWHA interviewed were twenty (20) in all. Out of this, sixteen (16) of them were females and four (4) were males. This does not necessarily mean that more females were infected with the disease than males since the researcher has not come across any study in the area which proves that point. Rather, it could be that the female patients were more willing to partake in the interviews as compared to the males. It is also known in our culture that females are more open to conversation than males, thus the high number of female respondents as compared to the males. Besides, it is worth knowing that this was just a sample of the patients who were willing to grant the researcher interview audiences and as such, this might not represent the true picture of the rate of infection between the sexes in the area of the research.

It must also be noted that on the level of formal education, it was observed that most of them had education up to the primary and junior high levels, and very few of them, four (4), had had secondary education. Two (2) were trained teachers. None of the PLWHA interviewed had had university education. However, one of the caregivers intimated that from her estimation, most of the PLWHA who were not ready to grant audience to the researcher were highly educated. Demographically, the average age of the respondents was 32 years. The oldest amongst them was 72 years and she is a female, whilst the youngest amongst them was 25 years, also a female. This also indicates that the age groups of the respondents varied widely. It was surprising to find a 72 year old woman who had contracted the disease recently. This confirms that HIV is no respecter of age and status. However, with a very good care and personal hygiene a PLWHA can live a healthy longer life.
Table 1. When were the Respondents Diagnosed of the Disease?

<table>
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<th>Percentage (%)</th>
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<td>5.0</td>
</tr>
<tr>
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</tbody>
</table>

Source: Field Work, 2015

From the above, four (4) or twenty percent (20%) of the respondents claimed that they were diagnosed in 2007 and they have had the condition for more than nine (9) years. The majority of the respondents, nine (9) representing forty-five percent (45%) asserted that they knew of their status in 2011. Three (3) respondents each, representing fifteen percent (15%) each, claimed they were diagnosed in 2013 and 2014 respectively. However one of the respondents (5%), who was also abandoned could not tell of the year she was diagnosed. She revealed that she was abandoned by her family since 2008 when her identity was divulged to them after the death of her husband.

Although the researcher has not been able to have audience with more recently diagnosed PLWHA, some of the caregivers have indicated that the number of seropositive diagnoses were on the increase in the two communities of Aflao and Dzodze. This signifies that albeit the various education the infection rate is on the increase. It is believed that the strategic location of the two border towns and the dense cross border activities might be the contributing factors in spite of the down prevalence rate the country continue to register.
Table 2: The Initial Reaction of the Respondents when they were First Diagnosed as Seropositive

<table>
<thead>
<tr>
<th>First Reaction of the Respondents as seropositive</th>
<th>Number</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Surprise</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>Surprise/Disbelief</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Fear and Attempted Suicide</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Fear and Denial</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>Fear, Denial and Contemplated Suicide</td>
<td>8</td>
<td>40</td>
</tr>
<tr>
<td>Pain and Anguish</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100</td>
</tr>
</tbody>
</table>


Table 2 shows the various reactions of the respondents when their seropositive status were disclosed to them. They expressed myriads of reaction on their initial seropositive diagnoses. Three (3) respondents representing fifteen percent (15%) said that they were not surprised because their spouses had been earlier diagnosed with the virus. This shows that these respondents knew even before their HIV test that there was a high likelihood that they were infected since their partners had already been infected with the disease. Consequently, they experienced no panic when they learnt that they had the condition. Two (2) or ten percent (10%) percent of the respondents said that they could not believe the result of the HIV test as they were certain that they did not have the virus. They still could not tell how they got the virus because their partners were negative and they were extra careful with issues that could make them contract the virus. However after a few counselling sessions they have accepted their seropositive status. Five percent (5%) or one respondent claimed that she experienced fear and even attempted suicide. She expressed gratitude to her mother who had chanced upon her and saved her. Twenty-
five percent (25%) or five (5) respondents asserted that they denied the test result. However they were frightened. Forty percent (40%) or 8 respondents claimed they experienced fear, denial and contemplated suicide. They did not have the courage to attempt suicide as other respondents did. Another respondent, representing five percent (5.0%), was bitter towards her spouse who she opined was the one who infected her because he had other wives and several concubines. She claimed she had had pain and anguish so much so that she was still not ready to see her spouse or have any interaction with him.

The various reactions of the majority of the respondents confirm Carter and Hughson’s assertions that it is difficult to predict the emotions and feelings experienced by the PLWHA during the first few hours and days when they discover their seropositive conditions.\textsuperscript{272} They continued that the most commonly reported reactions include feeling numb, fright, upset, confused, shocked, desperation and anger and sometimes the urge to commit suicide.\textsuperscript{273} Some of the respondents regarded their seropositive status as a horrible revelation that they could hardly come to terms with the diagnosis and even though they had been taken through counselling. More needs to be done to allay the fears of some of these respondents. One might not be certain on the number of PLWHA who had committed suicide when they learnt that they were seropositive.

\textsuperscript{272} Michael Carter and Greta Hughson, Just Found Out You Have HIV. www.mobile.aidsmao.com. 
\textsuperscript{273} Carter and Hughson, Just Found Out.
Table 3. The Reaction of Close Relatives to Respondents’ HIV Status

<table>
<thead>
<tr>
<th>Reactions of Relatives and Associates of PLWHA</th>
<th>Number</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accepted PLWHA status and supported/supporting them</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>Stigma and Rejection of PLWHA</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Ridiculed the PLWHA</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>No relative or associate are aware of PLWHA</td>
<td>12</td>
<td>60</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100</td>
</tr>
</tbody>
</table>


The reactions of the dependents, close relatives and friends of PLWHA were also varied when they became aware of the latter’s HIV-status. It was not surprising that most of the respondents agreed that they were not ready to disclose their seropositive identity to their friends and associates owing to stigma and discrimination. On the other hand less than fifty percent (50%) of them claimed they had disclosed their status to their close relatives. Few among this category have regretted that they have done this. However, majority of them are not ready to divulge their identity to even their parents, siblings and children. This shows how potent the issues surrounding HIV-related stigma are. Table 3 portrays that twenty-five percent (25%) or five (5) respondents asserted that their close relatives have accepted their condition and were offering the necessary support and care to them. This is the best practice that is expected from relatives and friends of people diagnosed with the condition. This shows that the relatives and friends of these respondents have had a better understanding of how to deal with PLWHA and this attitude must be encouraged within our various communities. There is the possibility that some of these relatives had enough knowledge about issues on the disease. On the other hand two (2) or ten percent (10%) of the respondents claimed that their relatives who were aware of their condition had chosen to stigmatise and reject them. One respondent
said that they cunningly did not allow her son to interact with their children. The other
said that she had been abandoned by her relatives. Another respondent, representing five
percent (5.0%) equally claimed that her siblings had stigmatised her, ridiculed her and
eventually drove her out of the family house. Sixty percent (60%) of the respondents said
they would not disclose their identity to anybody except the caregivers. This shows that
in spite of the massive education aimed at reducing stigmatisation against PLWHA, it is
still rampant in our society. This means that the religious bodies, Ghana AIDS
Commission and the Ministry of Health need to do more in terms of public education to
ensure that stigma against PLWHA is drastically reduced or else, it will lead to an
increase in suicide rates amongst people diagnosed with HIV/AIDS.

Table 4. Respondents’ Sources Income Prior to and after they have been Diagnosed
as Seropositive

<table>
<thead>
<tr>
<th>Sources of Income of PLWHA</th>
<th>Number</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Employed</td>
<td>8</td>
<td>40</td>
</tr>
<tr>
<td>Employed by Public/Private Organisations</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>Unemployed</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>School/Apprenticeship</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Field Work, 2015

As Table 4 shows, respondents were asked questions about their sources of income. Eight
(8) respondents or forty percent (40%) indicated that they were self-employed. From five
(5) of these respondents, they were involved in petty trading. One was a hairdresser,
another a weaver and a third a welder. They were all unanimous that although their
sources of income were not sufficient vis-à-vis their seropositive status, they could
manage to care for themselves and their families. Four (4) respondents or twenty percent
(20%) asserted that they were teachers. Three (3) respondents or fifteen percent (15%) were apprentices and a student. Five (5) respondents or twenty-five percent (25%) were unemployed and depended on the benevolence and their families and the Church.

Majority of the respondents in Table 4 were involved in some economic activities. However, their level of income were not consistent and sufficient given their seropositive condition. Most of them lamented on their poor conditions which could be ameliorated if they could have consistent viable sources of income. Considering the fact that most of them tried to involve themselves in various economic activities in spite of all the odds about their conditions suggest a positive sign of engagement with their lives. It must be indicated here that the COMCASUP office of Keta-Akatsi Catholic Diocese had been very much involved in setting up most of the 40% of the respondents who were engaged in petty trading. In effect most of the respondents were able to fend for themselves and their conditions did not let them to become burdens on others. At the same time, they kept themselves busy and made sure they did not spend much time thinking about their condition. This was a very positive development and these PLWHA must be commended and encouraged.

Table 5. The Effect of the Seropositive Condition on the Livelihood of the Respondents.

<table>
<thead>
<tr>
<th>Seropositive Effects on PLWHA</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Negative Effects</td>
<td>8</td>
<td>40</td>
</tr>
<tr>
<td>Feel weak and intermittently sick</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>Feel weak after work</td>
<td>7</td>
<td>35</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Source: Field Work, 2015
It should be noted that almost all the respondents in this research were on Anti-Retroviral Treatment (ART). Most of them asserted that with the ART their condition did not have any significant adverse effect on their livelihood, however they eat a lot when they took the drug. On how their seropositive condition have affected their lives and livelihood, Table 5 shows that: Eight (8) or forty percent (40%) of the respondents indicated that the condition had not affected them much. They went about their duties diligently and took necessary precautions as they were advised by their physicians and caregivers. This shows that they were not significantly perturbed about their condition. This was positive and they must be encouraged. The fact that one is diagnosed with HIV/AIDS does not mean the end of one’s life. All PLWHA must endeavour to have a positive outlook about their lives.

However five (5) or twenty percent (25%) of the respondents indicated that in spite of the ART they felt weak and were intermittently sick. This shows that these respondents had allowed their seropositive status to get at them, or they do not observe precautions with their condition. Some of them had even indicated that they spent much time thinking about their conditions instead of them to focus their attention on how they could stay strong and healthy. These have been affected by internal stigmatisation which we already alluded to in Chapter Two. Ken Morrison would assert that these respondents’ attitudes lie in the negative prejudices, self-denigration, social pressures, self-blame and guilt.\textsuperscript{274} The deep-seated fears that they have accumulated over time can lead to physical deterioration of their health. Morrison again opined that internalised stigma is worse than when PLWHA experience visible manifestations of the AIDS, such as weight loss or opportunistic infections.\textsuperscript{275} More needs to be done in terms of counselling services to allay the fears of these respondents who continue to brood over their condition so that

\textsuperscript{274} Ken Morrison, 4.
\textsuperscript{275} Ken Morrison, 5.
they spend a lot of their time thinking about it. Again, seven (7) or thirty-five percent of the respondents said they felt weak after work. It must be noted that some of these respondents did not have enough food to satisfy themselves after they took the ART. Some of them were unemployed and lived on the benevolence of their families and benefactors. This shows that poverty had compounded the problems of these latter respondents despite the resolve of some of them to engage in economic activities. This is where the Church and civil society group need to come in to offer the necessary help and support.

Table 6. The Respondents and their Dependents

<table>
<thead>
<tr>
<th>Dependents of the PLWHA</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No dependants</td>
<td>4</td>
<td>20.0</td>
</tr>
<tr>
<td>1 Dependant</td>
<td>7</td>
<td>35.0</td>
</tr>
<tr>
<td>2 Dependants</td>
<td>2</td>
<td>10.0</td>
</tr>
<tr>
<td>3 Dependants</td>
<td>5</td>
<td>25.0</td>
</tr>
<tr>
<td>4 Dependants</td>
<td>1</td>
<td>5.0</td>
</tr>
<tr>
<td>9 Dependants</td>
<td>1</td>
<td>5.0</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Field Work, 2015

Table 6 indicates the dependants of the PLWHA. Four (4) or twenty percent (20%) of the PLWHA had no dependant. Although they did not have dependants they would have to care for themselves; they struggled to support themselves financially. In Ghana, there had not been any appropriate social welfare in times of difficulties such as sicknesses. The social welfare of people usually depended on their children and close families. These respondents might not be fortunate when their situation deteriorate. For example, from
the discussion on Table 3, one of the respondents asserted that she had been ridiculed and had even been driven out of her family house by her siblings. In times like these, one’s children might not possibly abandon him/her. Further, seven or thirty-five percent (5%) of the respondents said they had one dependant. Two (2) or ten percent (10%) of the respondents claimed that they had two (2). Five (5) or twenty-five percent (25%) respondents indicated they had three (3) dependants. Finally, one or five percent (5%) each respondents claimed they had four (4) and nine (9) dependants respectively.

It must be noted that some of the dependants of the respondents were mature adults and they took care of themselves. Rather, the latter had to support their parents as our culture presumes. However majority of the respondents who had dependants claimed that they were below eighteen years and depended on them. This means that in the event of their demise or incapacitation, they would be leaving behind young lads, who would have to be taken care of by others. Already most of them could not effectively cater for themselves, how much less their dependants. The respondent with nine (9) dependants indicated that the mothers of his children were helping him to care for them. This is very negative and bad. Some of the COMCASUP officials have mentioned that they had to look for sponsorship for most of his children so that they would not drop out from school. On the other hand, most of the respondents were trying to maintain their dependants in school themselves. This was very encouraging and must be emulated by other PLWHA. One of the respondents asserted that her dependant was also seropositive. This means that the child was infected with the disease through the mother-to-child transmission. This is why it is imperative that pregnant mothers be tested for HIV/AIDS in the early part of their pregnancies so that measures could be taken to avoid mother-to-child transmission.
Table 7. Who Takes Care of the PLWHA?

<table>
<thead>
<tr>
<th>Those who Care for PLWHA</th>
<th>Number</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLWHA Themselves</td>
<td>8</td>
<td>40</td>
</tr>
<tr>
<td>Families</td>
<td>9</td>
<td>45</td>
</tr>
<tr>
<td>Friends</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>COMCASUP</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Field Work, 2015

In Table 7, respondents were asked to mention those who support them as most of them could not earn much to support themselves effectively in their seropositive condition. Eight (8) or forty percent (40%) of the respondents said they took care of themselves. This shows that quite a number of respondents were on their own and had not yet become burdens for others. Nine (9) or forty-five percent indicated that their very close family members had been supporting them. Some of this category of respondents mentioned their spouses, parents, siblings and children as sources of their solace. This means that even though some family members were mean and stigmatised their PLWHA brothers and sisters, a very high percentage were ready to protect, support and care for them. Three (3) or fifteen percent (15%) claimed that COMCASUP had been their salvation since all their family members had abandoned them. No respondent had mentioned that friends or associates supported them. This goes to buttress the fact that the PLWHA were not ready to divulge their identity to friends owing to stigma and rejection of those who had tried to share their experience. However, more than half of the respondents equally mentioned that COMCASUP had been remitting them with some food items, medications and cash intermittently.
Table 8. The Catholic Diocese of Keta-Akatsi’s Engagement with the Respondents

<table>
<thead>
<tr>
<th>Kinds of Intervention from the Catholic Church</th>
<th>Number</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heard of Interventions but never Took Part</td>
<td>6</td>
<td>30</td>
</tr>
<tr>
<td>Received Some Interventions from the Church</td>
<td>12</td>
<td>60</td>
</tr>
<tr>
<td>Had not Heard of the Church’s intervention</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100</td>
</tr>
</tbody>
</table>


The table above identifies those who had and had not received some form of supports from the Catholic Church. The Catholic Diocese of Keta-Akatsi has engaged in the COMCASUP project to alleviate the plight of PLWHA since 2006. The Church, through COMCASUP, had periodically distributed food items (rice, beans, maize, garri, cooking oil, etc…), toiletries, cash and medications to PLWHA, and paid the National Health Insurance premium for some of them. She had also organised several seminars, group counselling sessions and interactive meetings with PLWHA, and had been caring for the abandoned PLWHA and their dependants. Furthermore, some of the dependants of the PLWHA received regular school fees from the Church. As shown in Table 8, six (6) or thirty percent (30%) of the respondents asserted that they had not received any support from the church although they had heard that the Church used to distribute some foodstuffs and medication, and had organised several seminars for some of their peers. Most of these respondents claimed the Church had stopped the programme by the time they were diagnosed. This shows that the Catholic Church used to support PLWHA but had stopped before the aforementioned respondents visited the facilities. They wished that the Church renewed her programme as soon as practicable. Also two (2) or ten percent (10%) of the respondents indicated that they had not heard of the Church’s programme. These respondents are from Aflao community. On the other hand twelve
(12) or sixty percent (60%) of the respondents had indicated that they had been receiving some form of intervention from the Church. Most of the respondents in this category have enumerated the above mentioned interventions they and their dependants had received from the Church.

Table 9. The Frequency of the Catholic Church’s Engagement with Respondents

<table>
<thead>
<tr>
<th>Frequency of the Church Engagement with PLWHA</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once a Month</td>
<td>12</td>
<td>60</td>
</tr>
<tr>
<td>Never Received any Support therefore were not Aware</td>
<td>8</td>
<td>40</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Field Work, 2015

Table 9 indicates the frequency of the Church’s engagement with the PLWHA. Whilst eight (8) or forty percent (40%) of the respondents had indicated that they had not received any support from the Church and were not aware of the frequency of the Church’s support, twelve (12) or sixty percent (60%) were unanimous that they met the COMCASUP officials once a month and received various packages from them. On the other hand, little above half of this category of respondents were emphatic that the Church had stopped her engagement with them for close to 3 years at the time of the interview. Others in this category claimed the officials intermittently met them not as often as they used to do, sometimes few times in the year. These responses suggest that the Church has abruptly stopped the support they used to give to the PLWHA or she is inconsistent with her engagement with them. Three (3) abandoned PLWHA said the COMCASUP officials were consistent with their support and they visited them often not necessarily to offer any item but just to interact with them.
When the researcher asked the respondents about what factors they thought might have contributed to the Church to abruptly end her intervention with them, some of the respondents indicated that they suspected the number of PLWHA had increased such that the Church’s resources could not provide for all of them. The best the Church could do was to end the whole programme in order not to create conflict among them as they claimed only few of them were Catholics and most of them were from other religions and denominations. Others speculated that the officials in charge of the programme might have mismanaged the funds, thus the Bishop and his collaborators may have decided to withhold the programme until appropriate audits were conducted for the programme to restart. They were optimistic that the programme would restart soon. Moreover, some of them were emphatic that the Church lacked funds to continue with the project. Two of the respondents alleged that most them were not Catholics and the Church might now be concentrating its support on Catholic PLWHA in secret. From the above perspectives of the respondents, the Church might have discontinued the support she was giving them due to lack of funds, donor fatigue, lack of accountability and the increased number of PLWHA. Some of the opinions of the respondents might not be true. From the researcher’s observation it seems most of them were speculating as none of them was sure about their assertions.
Table 10. The Expectations of Respondents from the Catholic Church

<table>
<thead>
<tr>
<th>Expectations of Respondents from the Catholic Church</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restart the Intervention Programme</td>
<td>5</td>
<td>35</td>
</tr>
<tr>
<td>Need Funds from the Church to Expand Business</td>
<td>13</td>
<td>60</td>
</tr>
<tr>
<td>Don’t Need/Expect anything from the Church</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100</td>
</tr>
</tbody>
</table>


Respondents were asked to express their expectations from the Catholic Church. Table 10 above indicates that, five (5) or twenty-five percent (25%) of the respondents were eagerly waiting for the Church to restart the support she had abruptly ended. This suggests that quite a number of the PLWHA were not interested in helping themselves but wanted to depend on the Church’s subventions. Two (2) or ten percent (10%) of the respondents asserted that they did not expect anything from the Church as they might have been more or less capable to carry on with their lives without any help from the Church. It could also imply that they had given up all hope and were just patiently waiting for the last moment to breathe their last. However, thirteen (13) or sixty-five percent (65%) of the respondents expected funds from the Church to either start viable economic ventures or to expand their existing petty businesses. This was highly encouraging. This means that majority of the respondents wanted to do something economically productive for themselves. They were aware that their condition was for the rest of their remaining years on earth. They were also conscious that the support and care from the Church might entirely cease in the event that the Church would change its policies towards them. In effect the various reactions of the respondents suggest that most of them were not happy that the Church has halted or relapsed on its activities with
some of them. They were looking forward to the Diocese restarting the support she used to give to them.

Also, some of the respondent have indicated that quite a number of their colleagues PLWHA no longer went to the care centres for their medication because they could not get enough food to accompany the medication they took. They asserted that they ate a lot when they took the ART. This was a very startling revelation since it is expected that people think more about their health and welfare but this was not the case for these PLWHA. Therefore, the absence of food and transportation which the Diocese hitherto gave to the PLWHA prevented some of them from coming for their medication as they should. This again confirms that the Church has played a very vital role in giving hope and life to PLWHA in these communities. This also suggests that some PLWHA did not have any plan for their own lives and families but looked up to others for their basic needs.

Majority of the respondents again blamed the society for their predicament. They come to understand that their conditions were like other ailments but owing to stigma and rejection they could not reveal themselves openly for people to accept and help them. Few of them lamented on the ordeal they go through from the health professionals when they visited in the clinics for minor ailments and treatments. From this assertion of the respondents it could be deduced that most of the PLWHA wanted stigmatisation against them to reduce drastically. This shows that stigmatisation against PLWHA was really a big issue in these communities. We need to be conscious of it since it was one of the main challenges that they all lamented about. Most of them also wanted the help that the Catholic Church was giving to be emulated by other churches, organisations and individuals.
4.2.2: Presentation of Responses of Caregivers

This section presents and analyses the data collected from the respondents who were the caregivers of the PLWHA. They were the officials of COMCASUP and workers at the health and HIV/AIDS centres of Aflao, Dzodze and the Catholic Secretariat of Akatsi. As already mentioned above ten (10) caregivers were interviewed: three (3) from Aflao Municipal Hospital, three (3) from St. Anthony’s Hospital in Dzodze and four (4) from COMCASUP and the Keta-Akatsi Diocesan Health Directorate. (Refer to Appendix IV for short profile on the respondents)

Almost all the respondents agreed that the COMCASUP outfit of the Catholic Church has been providing systematic and holistic care and support to the PLWHA in the two communities except two newly recruited caregivers in the Aflao health facility, who indicated that although they have heard of COMCASUP they had not encountered them since they were at the facility close to two years. The first group of caregivers classified the care and support the Church used to give to the PLWHA in the following categories: financial, psychological, moral, medical, food support and homebased care for the abandoned PLWHA. They continued that the dependants of some of the PLWHA were also covered in the COMCASUP project. They further explained that except for the last two Christmas festivities when the Bishop was indisposed, he used to organise Christmas parties for the PLWHA every year since the inception of the programme. During this event the Bishop personally remitted every PLWHA with the packages of cash and foodstuffs. This assertion was corroborated by the PLWHA respondents.

When the researcher enquired about how the Bishop got funds to support all these activities of the Diocese organised for PLWHA, only the four officials from the COMCASUP and Diocesan Health Directorate could answer effectively. They asserted that the project was initially funded by CRS, however their sponsorship expired in 2011.
The Bishop has since been soliciting help from various parishes, diocesan institutions such as the hospitals, individuals and organisations both home and abroad. For example in an informal chat between the researcher and the parish priest of Saints Peter and Paul Catholic Church of Aflao, the latter corroborated the fact that the Diocese has collaborated with the Ghana AIDS Commission to register PLWHA for the NHIS programme. He also added that his parish has been paying for a number PLWHA’s NHIS premium within his community through COMCASUP. The rest of the caregivers at the hospitals gave wild suggestions. All the caregivers agreed that Ghana AIDS commission provided the ART drugs and occasionally some food supplements. The various assertions of the respondents indicated that different groups and individuals and organisations within and outside the Diocese and the government supported the PLWA. It is also observed that the support programme of the Diocese under which the PLWHA benefitted has been carried out by the COMCASUP outfit. It is also evident from the respondents that the Diocese has fully taken over the funding through its locally harnessed resources and with a little foreign support.

On the whole the support given by the Diocese to PLWHA was a very positive development. The project was not only aimed at providing financial and material support but also psychological and moral support to the PLWHA and their dependants. This kind of support must be encouraged as they were really targeted at the holistic wellbeing of PLWHA. Marika Fahlen asserted that to get the HIV epidemic under control is not a technical problem – it is fundamentally about social trust for the young people to have confidence in the future – it is about social cohesion and community neighbourhood.276

In this direction the Church must be applauded to have taken this bold decision to practicalise the virtues of love and empathy to the PLWHA as we mentioned in Chapters

Two and Three above. It must be noted that all the support that the Church has offered have empowered and promoted responsible behaviour among the PLWHA which in turn lowers the risks of the spread of the pandemic. “The AIDS Establishment has frequently asserted that poverty - not just material deprivation but food or economic insecurity and exploitive inequality - causes AIDS, and therefore the improvement of material conditions will lead to a decrease in AIDS.”

Table 11. The Frequency of Meeting with the PLWHA by Caregivers

<table>
<thead>
<tr>
<th>Frequency Meeting with the PLWHA</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Twice a Week</td>
<td>4</td>
<td>40</td>
</tr>
<tr>
<td>Once of Month</td>
<td>3</td>
<td>30</td>
</tr>
<tr>
<td>Once a Year</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Four (4) times in a year</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Field Work, 2016

Table 11 indicates the number of times the caregivers interacted with the PLWHA. Four (4) or forty percent (40%) of the respondents asserted that they met the PLWHA two times every week. They further clarified that they had classified their clients into different groups such that they met each group once a month. The respondents were health workers who were in charge of HIV/AIDS activities in the Aflao and Dzodze health facilities. They further mentioned that they distributed ART and other items from the Ghana AIDS Commission and organised seminars and psychological supports to the PLWHA. Some of these respondents equally doubled as care providers on behalf of COMCASUP. The outfit chose some of them because they were already interacting with

the PLWHA and they were much conversant with confidentiality and issues on stigma and rejection that PLWHA complained about. Three (3) or thirty percent (30%) of the respondents indicated that they met the PLWHA once a month. These were some of the COMCASUP officials. They further explained that they used to meet different groups of PLWHA at the various points of the entire Diocese such that they met each PLWHA on their programme once a month. However in recent times they have reduced the frequency at which they met them owing to the problem of funds and logistics. On the other notwithstanding the difficulties they have with funds and logistics, they consistently met the abandoned PLWHA more than twice a month. This was earlier asserted by some of the PLWHA in their responses above. Two (2) or twenty percent (20%) respondents agreed that they met them once a year especially during the Bishop’s Christmas parties. But the party could not take place in the last two Christmas festivities, therefore the last time they met them was more than two years. One respondent said that she met them four or five times in a year. She equally asserted that at the beginning of the programme they used to meet them frequently.

The above responses suggest that, from the beginning of the COMCASUP programme the meetings with the PLWHA were on a particular regular schedule. The disparities in the recent schedule of the programme were due to a number factors among which features prominently lack of funds and logistics as the programme coordinator and his assistants asserted. However, the Christmas celebrations of the bishop with the PLWHA had been regular barring the last two occasions.

Again, with the exception of the three COMCASUP officials who visited the PLWHA in their various homes most of the respondents indicated that they met them only when they visited the health facilities and care centres. This shows that these respondents only came into contact with the PLWHA when they reported to the clinics. This therefore
meant that these caregivers could not meet the PLWHA who were weak and abandoned if the latter did not show up at the health facilities. In effect caregivers were expected to follow up on their clients to ascertain how they fared. However, it is noteworthy that one of the caregivers intimated that most of the PLWHA did not want the caregivers to visit them because of the high stigma associated with the condition in their communities. This might be the cause of the lower number of the caregivers who visited the PLWHA in their homes. We must also indicate that owing to stigma the vehicles that COMCASUP officials use for their programmes were not labelled and they consistently altered vehicles in order to allay suspicions.

Table 12. The Reaction of the PLWHA to the Programme

<table>
<thead>
<tr>
<th>Reaction of the PLWHA to COMCASUP Programme</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLWHA were appreciative</td>
<td>5</td>
<td>50</td>
</tr>
<tr>
<td>Complained about the care</td>
<td>3</td>
<td>30</td>
</tr>
<tr>
<td>PLWHA showed Indifference</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Field Work, 2016

On the reaction of the PLWHA towards the support they received under the COMCASUP programme and how they perceived them, Table 12 indicates that five (5) or fifty percent (50%) of the respondents said that the PLWHA showed a lot of appreciation. They always prayed for caregivers and asked for strength and their wellbeing in view of what they do for them. One of the caregivers further said that some of the PLWHA had demonstrated their appreciation by offering them livestock (fowls, goats, etc.). She again asserted that one of the PLWHA had freely donated one of his bulls to be slaughtered for the rests of his colleagues during one the Christmas party.
Three (3), representing thirty percent (30%) of the respondents indicated that although the PLWHA appreciated what they did for them some complained a lot about the manner in which some of the caregivers treated them. They were not happy about the stigma they experienced from some of the health workers. This filtered through the answers of the other respondents. The researcher equally experienced the stigma from some of the health workers when they saw him come out of one of the HIV facilities. Several questions were addressed to him to find out his mission at the facility. Two (2) or twenty percent (20%) of the respondents claimed some of the PLWHA were indifferent about the care they provided them. One of the respondents further said that some of the PLWHA complained that even though they praised the caregivers openly, whatever they (caregivers) said in their absence they did not know. She further said that some of the PLWHA said that the caregivers were the same as their other colleagues who stigmatised them at the hospitals. From the respondents, although most of the PLWHA were content with the support they received from COMCASUP, the other unpleasant reactions suggest that they were not enthused about the stigma they experienced from other health workers. This would not promote healthy atmosphere for caregiving. These unpleasant reactions from some of the health workers might discourage some PLWHA from visiting the centres and health facilities.

Furthermore, when the researcher tried to enquire about whether the respondents provided care and support to only their church members, all the respondents were unanimous that their support cut across religion, ethnic and cultural backgrounds. The coordinator of COMCASUP was emphatic that there were more non-Catholics on the programme than Catholics. He again indicated that the religious background of the PLWHA on their records varied from Islam to Traditional Religion and other Christian denominations. We can deduce that the COMCASUP programme did not discriminate
against the religious or ethnic or cultural background of the PLWHA they served. The assistant coordinator affirmed that they served a number PLWHA who came from the Republic of Togo. She continued that on one occasion they followed up on a PLWHA whose condition was critical to Togo.

On the other hand when the caregivers were asked to react to the programme themselves, they all agreed that the project was appropriate, timely and had brought a lot of relief to the PLWHA. Some of them contended that although the care and support they gave were very demanding, difficult and time consuming, they were fulfilled especially when they saw those they thought might have passed on bounced back to life and one could visibly not find traces of the condition on them. However, most of them lamented on the stigma and discriminations they also experienced from their other colleagues in the health facilities. Some of them also hinted that although the programme was good, the financial and logistical constraints could not permit them to do more for the PLWHA and their dependents. One complained that sometimes some of the caregivers had to dip their hands into their personal resources to support the PLWHA. Most of them were unanimous in saying that in spite of the benefit PLWHA gained from the programme it might not be sustainable owing to the difficulties in the financial commitments of the Diocese to the project.
Table 13. Factors that Militated against the Work of the Caregivers

<table>
<thead>
<tr>
<th>Factors that Militated against Caregiving</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stigma and Discrimination</td>
<td>10</td>
<td>100</td>
</tr>
<tr>
<td>Lack of Funds</td>
<td>4</td>
<td>40</td>
</tr>
<tr>
<td>Lack of Incentives</td>
<td>6</td>
<td>60</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Field Work, 2016

According to Table 13, respondents were asked to identify the factors that militated against care and support for the PLWHA. All the respondents were unanimous on the point that stigma and discrimination were the main bane for both the PLWHA and the caregivers. One of them asserted that it was very disheartening and they found it very difficult to understand why their own colleagues in the same premises perpetrated stigma against them as if they were seropositive. Forty percent (40%) of the respondents indicated that the project lack funds. These include all the officials of the COMCASUP. They asserted that this was the reason behind their inability to continue the schedules they used to run when there was sufficient funds for the project. Sixty percent (60%) of the respondents also claimed that there were no incentives which would encourage them to exert themselves more than what they used to do.

By and large the responses above suggest that the caregivers have some pertinent challenges pertaining to their work. Notable among these were financial and stigma issues. From the Diocesan financial and health administrators the project needed urgent financial assistance in order to survive.
Table 14. The Future of COMCASUP Campaign

<table>
<thead>
<tr>
<th>Future of COMCASUP Campaign</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bleak Future</td>
<td>3</td>
<td>30</td>
</tr>
<tr>
<td>Optimistic about the Future</td>
<td>3</td>
<td>30</td>
</tr>
<tr>
<td>Programme was dead</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Indecisive/Unclear</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Field Work, 2016

Table 14 is illustrative of the views held by caregivers about the future of the COMCASUP project. Three (3) or thirty percent (30%) of the respondents asserted that the future of the project was bleak. These respondents believed that since the CRS withdrew their support for the project, scheduled activities of the project had changed for worse. They could not tell whether the Diocese could sustain the project for a long time to come. Likewise, twenty percent (20%) of the respondents were of the view that the project was dead. They were categorical that the Diocese could not raise enough funds to continue with the project vis-à-vis the increasing financial cost of the campaign, the increased number of the PLWHA and the continuous economic recessions of the country. Another twenty percent (20%) or two respondents had entirely refused to predict. One of them indicated that it was hard to predict the Church. Although the Church is a human institution it is as well divine. The Catholic Church could easily pull up surprises. Therefore it was better one remained quiet than try to predict a programme that has the endorsement of the divine. In spite of the above pessimistic stands, thirty percent (30%) of the respondents were very optimistic about the future of the programme. They reiterated the fact that although the project was saddled with financial difficulties, the Church would never entirely abandon the PLWHA. However they were unanimous that
the packages for the programme will be reduced to the level that the Diocese could easily afford. This reminds us of the Good Samaritan episode in the Gospel of Luke to which Pope John Paul II alluded to in his Apostolic Letter on the Christian Meaning of Human Suffering. “Human owes to suffering that unselfish love which stirs in his/her heart actions... The person who is a ‘neighbour’ cannot indifferently pass by the suffering.”

The last category of the respondents seemed to remind us of the empathy and Christian charity we reflected on in Chapters Two and Three of this thesis. Therefore the Church owes a responsibility towards the PLWHA who are suffering and are really in need of the support of the Church.

The above responses showed that funding has remained one the important hurdles for the caregivers at the various COMCASUP facilities in the Diocese. It is therefore expedient that the appropriate bodies and institutions in the Diocese that are affiliated to the project gear up their efforts to raise funds to secure the future of the project in the Diocese.

4.3. Discussion of Findings

From the analysis of the data of the PLWHA and the caregivers, it was established that the Keta-Akatsi Catholic Diocese has a support system in place for PLWHA, although few of the respondents were of different views. It was also found out that different sections under the Diocese such as individuals, groups and parishes provide various supports but the main outfit of the Diocese that channel all the supports and provide care directly to PLWHA is the COMCASUP. This outfit was not only established according

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In Karol Wojtyła’s Love and Responsibility (New York: Farrar, 1981) 202, Pope John Paul II, then a Cardinal, asserted that “Tenderness...springs from awareness of the inner state of another person (and indirectly of that person's external situation, which conditions his inner state) and whoever feels it actively seeks to communicate his feeling of close involvement with the other person and his situation. This closeness is the result of an emotional commitment: That sentiment enables us to feel close to another “I.”...Hence also the need actively to communicate the feeling of closeness, so that tenderness shows itself in certain outward actions which of their very nature reflect their inner approximation to another “I.” This is what we asserted as Empathy extensively in Chapter Two of this study.
to SECAM decision of October 2003 in Dakar but also to continue and to make Christ healing ministry a reality to those who are sick and disadvantaged by HIV related stigma and discrimination. John Paul II is very expressive in his Encyclical *Dives in Misericordia* – “Rich in Mercy” that the authentic evangelisation is not just spiritual transformation which is realised once in one’s whole life but it consists of constant discovery and perseverance in the practice of love. Therefore the work of COMCASUP in question is the praxis of the merciful love and creative empathy of the Keta-Akatsi Diocese towards the disadvantaged and the vulnerable people.

It is evident in COMCASUP project over the few years that it has been able to carry out major activities in the areas of homebased care relating to HIV/AIDS/STI, distribution of foodstuffs and other basic PLWHA necessities. The programme has also been aimed at community education on stigma, discrimination against PLWHA as well as counselling and testing for HIV/AIDS/STI. These activities of the project are the continuation of the healing ministry of Christ. Recalling our discussion in Chapter Three above, the Diocese has seen the care for the sick as the signs of the presence of the Kingdom of God; “…homebased care has been a traditional, though often unrecognized, ministry within the Church. To be compassionate, generous and self-sacrificing in the name of Christ is to be Christ for others.”

Collins further, asserts that those who show concern for the weak, the rejected and sometimes for the strangers, ought to be praised for the extraordinary generosity which human frailty can call forth. The provision of such care must not be thought of as simply the responsibility but the mission of the Church.

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Furthermore, from the COMCASUP reports of 2013, 2014, and 2015, there has been an increase in the availability of homebased care and psycho-social counselling services to the PLWHA and OVC in the Keta Akatsi Diocese.\footnote{Keta-Akatsi Catholic Diocese, Summary of 2013, 2014 and 2015 Reports on the Progress of Community Collaborative Care and Support Project (COMCASUP) to the Diocesan Health Council.} The reports have indicated that, counselling services, treatment adherence, nutrition, HIV infection and re-infection prevention, referrals, status disclosure and positive living during monthly socialization and experience sharing meetings have been extended to an average of 250 clients monthly at various service provision centres.\footnote{Keta-Akatsi, Summary of 2013.} The reports mention all the three Catholic Hospitals in the Diocese (St. Anthony’s Hospital-Dzodze, Sacred Heart Hospital- Weme (Abor) and Fr. Richard Novati Hospital- Sogakope), Catholic Secretariat, Akatsi and Keta Government Hospital as the major centres. The reports further indicate that other clients were attended to during the home visits by COMCASUP officials. They gave continuous homebased care to 14 females and 3 males during the period under review in the following communities; Dabala, Akatsi, Atsiavi, Tsiame, Abusakope, Anloga, Ave-Afiadenyigba, Anlo-Afiadenyigba, Dzivorkope, Abor, Aflao, Keta, Dzita, Dzodze, Tegbi and Tadzewu. They have also indicated that total number of 1325 community members (440 males and 885 females) were reached.\footnote{Keta-Akatsi, Summary of 2013.} This shows that the project initiatives were very positive. The reports also claimed that, all those who were tested positive to HIV were referred for treatment and supported under the COMCASUP programmes. It is worth to mention that COMCASUP activities stand tall in the southern part of the Volta Region. The data given above cover the whole of the Diocese which is made up of two (2) municipal assemblies and six (6) administrative districts.

Evidently, from the responses of the interviewees, the Catholic Church has lend its support to the Ghana AIDS Commission through the promotion of behaviour change.
activities towards prevention, education, stigmatisation and discrimination against PLWHA and reduction of HIV/AIDS cases in the Keta-Akatsi Diocese and for that matter in eight (8) political administrative municipalities and districts in the southern part of the Volta Region. The Church has also helped in increasing the knowledge and skills of caregivers and psycho-social counsellors in basic home cares needed by PLWHA in the communities. The educative programmes of COMCASUP project have encouraged people in the communities to test for their HIV-status which reduces stigma tremendously. This confirms Tenkorang and Owusu view in one of our earlier assertions that if people goes through VCT, they are exposed to specialised knowledge about the disease which help to lower stigma and discrimination. In the official report of the project it has been asserted that: “Sixteen (16) family members of PLWHA were trained in homebased care on HIV infection, prevention and stigma reduction.” This was to help the families to give the needed care and support to the PLWHA so as to let them feel accepted and loved and this also shows positive results since most of them were able to help their close relative PLWHA to live with their conditions. It must be noted that one of the important hurts of PLWHA is when the stigma emanates from close relatives.

The COMCASUP reports have also revealed that, the Church has been supporting PLWHA by increasing their access to nutritional and health care. This was supported by earlier responses of PLWHA and their Caregivers. In table 8 above more than sixty percent (60%) of the PLWHA have indicated that they had received various packages of foodstuffs, toiletries, supplements and cash from the Church. This suggests that the Church has tackled the plight of PLWHA holistically; “The Catholic Church has gained a wealth of experience on how best to reach out, how best to empower, how best to involve

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285 Tenkorang, “Examining HIV-related stigma.”
and how best to make people in need enjoy their human rights, and their inherent human dignity – rights which belong to us all, but which are so unevenly available in a world which has yet to manage the injustices in people’s access to prevention and care.”

Likewise majority of caregivers also confirmed that they have helped the Church to distribute some of these items to the PLWHA. This act relates closely to the mission of the Church we have discussed above in Mathew 25: 31-40. The admonition of Jesus in this periscope is to bring relief to those who suffer one misfortune or the other.

From the above findings, the Church has not discriminated on the backgrounds of the PLWHA. PLWHA of different nationalities, religions and ethnic backgrounds have visited the COMCASUP facilities and have also benefited from homebased cares. Two of the PLWHA in the discussion on Table 9 and majority of the caregivers in Table 12 have indicated that most of the beneficiaries of the COMCASUP project did not belong to the Catholic Church. This important gestures of the Catholic Diocese of Keta Akatsi towards the PLWHA is in line with the solidarity action plan of the decision the Catholic Bishops of Africa took in Dakar in 2003; “Make sure that the health services of the Church, the social services and the educational institutions respond appropriately to the needs of those who are ill with HIV/AIDS.” The Diocese HIV/AIDS apostolate is targeted to imitate Jesus’ mission to the whole of humanity and not to people of particular religious groups or backgrounds. The Church with this single act defies the assertion that it was too often an obstacle in the fight against HIV pandemic as it did not sanction condom as effective means to fight the disease.

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We also noted in the previous chapters of this study that some Christian leaders created unnecessary factions when they called PLWHA as sinners and often discriminated and ostracised them rather than embraced them. In many of these instances they have increased their suffering and the HIV prevalence rate, rather than ameliorated the fight against the pandemic. In effect, the COMCASUP project has confirmed 1995 UNICEF report that faith based organizations can play an important role in development practice.\textsuperscript{290} In truth, the Church has brought much relief to PLWHA and their families and many of the PLWHA respondents continue to demand more from the Church. Peter Okaalet shared that: “The Church recognizes that the pandemic has exposed systemic issues that are rightly in its domain: inequality, poverty, human rights, and social justice. The future holds great promise, building upon what the Church has already done in addressing HV/AIDS.”\textsuperscript{291} He continued that in Uganda it is not a mere coincidence that the period when the rates of HIV prevalence plummeted, 1991-1998, was marked by the involvement of Catholic, Anglican and Muslim religious organizations. Therefore, the Church through COMCASUP project indirectly invite other religious groups and Christian denominations to join the support system which has become capital intensive and it is very difficult for the Catholic Diocese of Keta-Akatsi to continue to bear it alone in the area of this study.

In our time many factors militate against altruism. Our culture has been adulterated by selfishness which was hitherto not part it especially when people suffered from calamities. We must note that the care for the sick is reflected in our traditional sayings. The Ewes saying “\textit{Wome kona dɔnɔ oɔ, elabena dɔlele megbena ameʃeke fe xɔ to nu o}” (No one mocks at the sick because everybody is susceptible to sickness). This saying

\begin{footnotes}
\end{footnotes}
implies that we are not immune to sickness therefore we must care for the sick. This is taken for granted in the case of PLWHA. It is believed that all who profess Christ will take after his teaching and practicalise his virtues of care and love for the PLWHA. However, we can scarcely exaggerate that the practical Christianity in our time is skin deep. In the Chapter Two of this study we realised that Chitando and Gundab and Campbell et al strongly asserted that most religious group were caught moralising the HIV/AIDS as they link the disease directly to sexual immorality in order to regain their lost moral authority. In doing so most of them were caught in the web of stigma and discrimination which have been identified as important barriers for the prevention of the epidemic. The Catholic Church must be encouraged and commended to have come up with the COMCASUP idea which encompasses important plausible means to fight the epidemic. The project could be identified as deliberate motivation to live the reality of the Triune God who continue to empathise with humanity.

In spite of all the achievements of the project mentioned by the PLWHA and caregivers interviewed, it has been saddled with some notable challenges that have threatened the future of the project. One of the important challenges from which several others flow is the huge financial cost of the project to the Keta-Akatsi Diocese. In Table 14 more than fifty percent (50%) of the respondents have given up on the project owing to financial difficulties. Some of this percentage claimed they have been waiting patiently for the last full stop owing to the fact that over the last few years, the rate at which most of the important projected activities of the campaign were suspended. Currently the Diocese finds it difficult to meet the annual budget of the project. This has resulted in COMCASUP’s inability to undertake all the activities they used to do frequently with PLWHA in Aflao and Dzodze. Logically, since the financial commitment of the project exceeded the budgeted income for about two or three conservative years the project
should have been abandoned. Yet the Church represented by some of the officials interviewed saw hope and favourable future for the campaign. They share the dream and the hope of John Paul II and St Paul that:

“Those who have the gift of faith live with confidence about things to come. They look to the future with anticipation and joy, even in the face of suffering and pain; and the future that they are ultimately looking towards is everlasting life with the Lord. This kind of hope was very prominent in the life of Saint Paul who once wrote: "We are afflicted in every way possible, but we are not crushed; full of doubts, we never despair. We are persecuted but never abandoned; we are struck down but never destroyed... We do not lose heart, because our inner being is renewed each day" (2Cor. 4, 8-9. 16).”

From the Diocese’s position, although we continue to live in a secular world where people share sparingly our Christian virtues, love, biblical justice – tsedeqah, altruism and empathy should not be relegated. God is presented as the ultimate caregiver. The divine dimension of care is at the core of the Diocese’s campaign. Two of the officials of COMCASUP who were priests were very optimistic that God will provide the Diocese with the necessary funds to continue the good work they have begun. We cannot underestimate the psychological underpinnings of the gesture of the Church to the PLWHA, their families and their communities.

Another setback that has been discovered from this study is the shocking revelation of stigma that all the caregiver respondents in Table 13 indicated that they suffer from other health staff and professionals at the hospitals in both Aflao and Dzodze. Some of them asserted that if their own colleagues could stigmatise against them, who were more possibly not seropositive, they could hardly imagine what the PLWHA had been experiencing with them. It has also been noted in some of the responses from PLWHA under table 10 above that they have equally complained about the ordeal they went

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292 John Paul II, *Teleconference of John Paul II with the Young People at Universal Amphitheatre (Los Angeles) on Tuesday, September, 15 198.*
through from some of the health professionals when they visited health facilities. This might be one of the reasons why some of the PLWHA would not like to grant audience to the researcher in this study. It was very appalling that trained health professionals who were expected to demonstrate high sense of decorum were the very culprits of the important negativity around the HIV/AIDS epidemics which the whole world was fighting against. In the real sense these health professionals leave much to be desired of their vocation as life savers. In a study conducted by Emmanuel Monjok et al in Nigeria which has a similar cultural pattern to the area of this study, they found out that a significant challenge to the success of achieving universal access to HIV prevention, treatment, care and support is HIV/AIDS stigma and discrimination.\(^{293}\) This assertion is confirmed by the responses of the respondents. Again the wicked reactions and inhuman treatment of PLWHA must be condemned since PLWHA are still humans and must be treated as such.

According to the Keta-Akatsi diocesan health administrator almost all the health professionals at their facilities were Christians. It is quite embarrassing and unacceptable that most Ghanaians have been professing religiosity, however their practical religious kindness and compassion mostly have not gone beyond their noses. Ethically health professionals should be compassionate and kind in order to carry out their duties effectively. This negative attitude of some of them could not give hope to patients. This goes a long way to question the candidates who are recruited to our health formation institutions and the type of formation our health practitioners receive and the kind of vocation they have. Our health directorates must take critical look at this discouraging

\(^{293}\) Emmanuel Monjok, Andrea Smesny and James Essien, “HIV/AIDS – Related Stigma and Discrimination in Nigeria: Review of Research Studies and Future Directions for Prevention Strategies,” *Africa Journal Reproductive Health* 13, Vol. 3 (September 2009), 21,
attitude which emanate from some of them which is not in line with the etiquette of health delivery.

On the whole from the responses of the PLWHA and the caregivers, the dependency syndrome which has been reported in other countries of PLWHA has not been a difficulty issue in the communities this study has been conducted. For example Charlton Tsodzo reported that in Zambia the dependency of PLWHA was so rampant that some of the development agencies working among them complained. The provision of food aid, clothing, free medication and school fees assistance for some of the PLWHA and families had virtually turned them into a community of people who no longer wanted to work for themselves, but just receive. He continued that several efforts to initiate income-generating projects among them had dismally failed as a result of no apparent effort being put towards their success by the intended beneficiaries. Cases were noted of some groups of individuals who had misappropriated funds meant to be used as capital in income-generating activities. Among the PLWHA of Aflao and Dzodze there is a little twist to this. From the discussion on Table 10 majority of the respondents wanted to be self-dependent and the Catholic Church has helped some of them to be involved in some productive economic ventures in order to care for themselves and their dependants.

4.4 Conclusion

This chapter has presented the position and opinions of some of the people living with the condition of HIV/AIDS, some caregivers and the officials at the desk of COMCASUP on the Keta-Akatsi Catholic Diocese’s support system put in place to alleviate the plight of PLWHA. The study has shown that the provision of material


supports and care to the latter by the Catholic Church has been motivated by theological factors and the imitation of Jesus’ injunction of corporal works of mercy captured by the Gospel Matthew 25:35-40 through which the concept of empathy is vividly demonstrated. In the quest to mitigate the plight of PLWHA, the Church has remained socially relevant as she has empowered close relatives of PLWHA and communities members to fight stigma which has become one of the stumbling block to fight the pandemic. However, it has become clear from the study that the Church leaders in health care and social work, hospital administrators and pastoral ministers must all be involved in discerning the future of the COMCASUP project owing to the huge financial commitment it has attracted.
CHAPTER FIVE
SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 Introduction
Globally, the Catholic Church has been touted as the pioneer and leading partner to engage in social work towards the disadvantaged and vulnerable people. This conclusion discusses the main findings of the thesis and the extent to which the Church has fulfilled its diaconal ministry towards PLWHA in the communities of Aflao and Dzodze in the Catholic Diocese of Keta-Akatsi. Recommendations that are believed to ignite responsible social action towards the PLWHA in these communities are also discussed.

5.2 Summary
As it has been the case, HIV and AIDS has spread rapidly throughout the world and has affected most African countries massively not excluding Ghana. The number of lives the disease has claimed in Ghana ever since its discovery is in thousands. The cure for this dangerous disease still remains elusive. The disease has left a trail of people living with the virus who continue to infect others out of lack of disclosure for fear of stigma and discrimination, and ignorance. Stigma and discrimination against PLWHA are found to be at the heart of many failed efforts over the years by governments, international organisations and social groups to respond to the disease. It is difficult to break the silence and denial surrounding the existence of HIV-virus in communities in Ghana.

Many interventions, whether for HIV prevention, care, support or treatment have also been less than effective due to this HIV-related stigma. Although the prevalence rate of the disease in Ghana is low, there is the need for effective social support system for the infected people in order to curtail further spread of the pandemic. This would involve the evaluation of the indices for maintaining good health and coping with the disease. These
encompass caregiver support, health promotion and prevention of illness (nutritional care, hygiene and sanitation, and prevention of opportunistic infections) and early diagnosis and treatment. The caregiver support for instance includes provision of daily needs of the victims. It has been said that caregiver support should be encouraged to create support network of similar caregivers such as religious groups, non-governmental organisations, social groups and community health workers who would help families to identify local resources. Unfortunately many of these structures do not exist in our local communities. However, the Catholic Diocese of Keta-Akatsi in line with the Catholic Church’s mission to continue the healing ministry of Jesus, through the initial intervention of Catholic Relief Service, has established the Community Collaborative Care and Support Programme (COMCASUP) unit to provide care and support to PLWHA who were victims of the disease since September, 2006.

In the second chapter the researcher sought to examine the plight and challenges of PLWHA vis-à-vis the concept of empathy in relation Christian teaching on mercy and love. The chapter catalogues the various challenges that PLWHA are confronted with such as economic/financial, health care systems, social/community and individual/personal difficulties. Empathy relates to the driving emotions that leads individuals to care for others, to understand others, and validate their emotions. Therefore the concept induces altruistic motivation and produces a distress in the empathiser – unless the individual has a stale conscience. Love and empathy are divine acts which are at the centre of the incarnation of Jesus among humans and define the parameters of his healing ministry (John 3:16-17). Further we have discussed empathy as the key that brings the divine purpose and can unlock the door of authentic passion for kindness, compassion and mercy towards PLWHA. In effect we have realised that empathy has the
subtle tone of mercy and compassion which have positive bearing on the concerns for the wellbeing and care and support for the PLWHA.

The third chapter examines the theological orientations of the Catholic Church’s social intervention. The chapter traces a short origin of the Church’s social intervention and firmly asserts that the Roman Catholic Church does not confine itself to abstract theology rather on the practicality of Christian dogma and teaching. The Catholic theologians agreed that HIV/AIDS pose three major theological challenges to the Church; 1. The sheer number of the people that has been infected and affected by the HIV/AIDS. 2. The negative economic impact of the disease on the people has affected the fortunes of the Church as well. 3. The HIV/AIDS has presented serious concrete situations of human misery, suffering, pain and death which the Church cannot overlook. Therefore the Church has altered its earlier reaction of confining the debate on the disease to prioritization of sexual ethics and morality of prevention, to the practical broader spectrum of its healing ministry as Jesus asserted in John 10:10b “I came so that people may have life and have it abundantly”. The Church now seeks restoration of wholeness which is characterised by physical, mental, emotional and spiritual integration of individual PLWHA vis-à-vis the adversities that confront them.

Chapter four discusses the opinions of PLWHA and caregivers on the Catholic Diocese of Keta-Akatsi’s support system to PLWHA in Aflao and Dzodze communities. Varied opinions were sample on the work of COMCASUP among the PLWHA. Issues that have been discussed hinge on what kind of support the Catholic Church offers to the PLWHA. Further, the chapter sought to identify the factors that militate against the Church’s intervention with PLWHA. The respondents were content with the Church’s psychosocial interventions and crave for more. However it came out that the project was saddled
with financial difficulties and this has affected the engagement of the Church’s positive actions.

5.3 Fulfilling the Objectives of the Study

This study was set out to achieve the following:

1. To examine the situation and the challenges of PLWHA, especially in Aflao and Dzodze in the Keta-Akatsi Catholic Diocese.

2. To explore the theological orientation of the Roman Catholic Church’s teachings on social interventions.

3. To investigate the Catholic Church’s response to the plight of PLWHA in Aflao and Dzodze and their environs.

The question of what are the challenges of the PLWHA has been discussed extensively in the second chapter. It has been identified that most of the difficulties that confront PLWHA stem from stigma. Most people find it difficult to change from their previous erroneous conception about the disease in spite of all the current information available on the HIV/AIDS, its mode of transmission and management. Inherent in the challenges is the internal stigma which affects the psychological make-up of individual PLWHA and destroys them. Again the objective has fulfilled by situating the plight of the PLWHA in the framework of empathy which is identified as divine act through which the latter could be repositioned in the image of God.

The discussion on the Roman Catholic Church theological underpinnings on her social intervention was taken through as short biblical tradition and the inconsistencies in the church’s approaches to social issues in the middle ages were identified. However the renewed attention of the church on social intervention came to limelight in Pope Leo XIII’s encyclical *Rerum Novarum*. From thence the Church has become a great crusader
on social justice and actions. The objective has been fulfilled by the identification of the William Byron’s categorisation of the ten underlying principles of the Church social actions. These principles were founded on respect of human dignity as *imago Dei*, love, empathy, mercy and compassion which are positive divine acts that the Church wants humanity to imitate.

In the area of care and support to PLWHA in Aflao and Dzodze, the study found out that the Church emphasises on the continuation of the healing ministry of Jesus. This has been related to the corporal acts of mercy that Jesus admonishes his followers to emulate in Matthew 25: 31-40. The study found out that the motivating factor for the Keta-Akatsi Diocese to support and care for PLWHA is her quest to practicalise the gospel message and continue with the healing ministry of Jesus. The study further revealed that the church gives a holistic support to PLWHA. She empowers the PLWHA both psychologically and physically. What was very encouraging and inspiring is that in spite of the financial and economic disadvantages of the Diocese, she continues to devote a much of her resources to support PLWHA. In this sense it is obvious that the Church is determined to fulfilling the mandate of Jesus Christ towards the sick and the vulnerable.

The work again found out that Aflao and Dzodze are two border communities in the south eastern part of the Volta Region, and in spite the low prevalence rate of HIV in the country they continue to register high number of HIV/AIDS cases in their hospitals owing to heavy cross border activities. Also it was clearly evident that there was no social or religious organised support system to the PLWHA apart from the COMCASUP project by the Catholic Church.
5.4 Recommendations

Based on the finding of this study the following recommendations are proposed to help the Keta-Akatsi Catholic Diocese in overcoming the challenges identified and encourage other religious groups and social organisations to join the crusade to alleviate the plight of the stigmatised and vulnerable people in our society.

It has been identified that from the inception of the intervention of COMCASUP almost all the PLWHA have been included in all the items distributed to them. In a society where economic conditions are difficult by each day, nobody can easily refuse a free lunch. In effect, some of the PLWHA may not necessarily need some of the basics provided by the Church. These latter PLWHA main concerns might be the psychological and medical supports. However, owing to the fact that these items were distributed freely, they partook in them. As a result the Diocese is faced with considerable pressure to raise funds to continue the interventions. If the earlier specifics of the support were given according to the need, the capacity and the vulnerability of every individual PLWHA on COMCASUP register, the financial pressure of the project on the Diocese would have been lessened and the project would also have been within the financial capacity of the Diocese. Therefore it is recommended that COMCASUP re-categorise PLWHA for appropriate interventions according to the needs and abilities of each of PLWHA.

Secondly, the majority of the PLWHA in the coverage area of this study have not reached the stage of AIDS, whereby the effects of the condition would have been very visible on them. Most of them are on ART and went about their activities and hardly could anyone identify them without prior information on their seropositive status. It is recommended that the project takes a closer look at empowering the PLWHA to engage
in viable productive activities than the periodic remittances the Church has been offering to them. The Church should rather empower them economically than periodic distribution of basics to them. Therefore the Church could look at the comparative advantages of the various localities of Aflao and Dzodze where the PLWHA reside and help them into business ventures which are less exerting physically vis-à-vis their medical conditions. In effect, from an informal chat with the financial administrator of the Keta-Akatsi Diocese the issue of the economic empowerment of the PLWHA on the COMCASUP project has come up a number of times but the main constraints of the Diocese has been her inability to secure funds for this particular empowerment project. It is important for the Church to fall on individuals, groups such as confraternities and societies in the Church and parishes to raise funds to settle each PLWHA in viable economic ventures. The Church must also explore the various national and international HIV support organisations and present specific concrete proposals to them on this issue.

Thirdly, the HIV stigma related issues from the other health professionals at the health facilities were found to be very worrying issues to both the PLWHA and the caregivers. It is very imperative that the Church and the health administrators of the various health facilities where the HIV centres were located, take concrete measures to address the perpetrators of these negative attitudes towards caregiving. It must be noted that although the scale of the occurrences of these HIV-related stigma at the health facilities might seem minimal, the consequences of these on the fight against the pandemic as whole may be very significant. Culprits of this ignominious acts are serious affront to the objective of the Diocese. Therefore, it is necessary that decisive measures must be taken in the health facilities to address this. It is recommended that culprits of this unprofessional acts be identified and sanctioned heavily with suspensions and dismissals to deter others. These elements must not be accepted in our health institutions.
Fourthly, the study asserts that PLWHA of different religions and cultural backgrounds benefit from the COMCASUP project. Also the concern for PLWHA should not be limited to the Catholic Church alone. It is important that the Catholic leads in the care and support. However, vis-à-vis the financial burden of the COMCASUP project, the Church must now consider a programme which could solicit the support of other faith based groups and organisations in order to expand the local support for the project and increase the funds and logistics for the project. This process could be channelled through the local ecumenical groups and the interreligious councils. Further, the Church could also solicit the help of the traditional authority to raise funds for the project.

5.5 Recommendation on the Areas for Further Research Work
The researcher has studied the Catholic Church’s intervention with PLWHA in Aflao and Dzodze. It is recommended that a further comparative study be conducted between the interventions of the Ghana AIDS Commission and that of the Catholic Church and the effect of these interventions on the individual PLWHA and their families in the entire Diocese of Keta Akatsi.

5.6 General Conclusion
This study focused on the Catholic social intervention with PLWHA, particularly in the areas support and care for the latter. The Church’s social intervention with PLWHA has been situated in the framework of empathy inferred from Chapters One and Two, to mean the service of love inspired by the driving emotions that lead individuals to care for others, to understand others, and to validate others’ emotions in the example of Christ. In the study, one cannot underestimate stigma as the factor that fuels the plight of PLWHA. The Church counteracts this by witnessing to Christ through Christian services of care and support. These are grounded in the theological concepts, tsedeqah -justice,
compassion and love which find expression in the Church’s mission to PLWHA. Data for this work was basically gathered and analysed through interviews, participant observation, and review of literature and secondary sources.

In the research, it was evident that most of the respondents commended the Catholic Church for the lead they have taken in the care and support of PLWHA. Through this practical application of theology and the continuation of the healing ministry of Jesus the Church’s teaching remains socially relevant in contemporary times. However, the economic challenges that confront the Keta-Akatsi Catholic Diocese in her quest to alleviate the plight of PLWHA could not permit her to continue effective scheduled care and support to all PLWHA although she has made and continue to make great impressions in her HIV/AIDS initiatives.
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APPENDIX I
UNIVERSITY OF GHANA
COLLEGE OF ARTS
DEPARTMENT OF RELIGIONS
INTERVIEW SCHEDULE FOR THE PEOPLE LIVING WITH HIV/AIDS

Introduction

This instrument seeks information on the Catholic Church’s support to people living with HIV/AIDS (PLWHA) in Aflao and Dzodze. The study is for academic purpose only and your anonymity is assured. Please response or answer the questions that will be asked as frankly as possible. You may decide not to answer questions that you don’t feel like answering. Thank you in advance.

PART A

1. Sex of the interviewee
2. Age of the interviewee
3. Level of education of the interviewee

PART B

1. When were you diagnosed of the disease?
2. What was your reaction?
3. What was the reaction of those close to you when they realised you are HIV positive?
4. What do you do for living prior to your current condition?
5. How has your condition affected what you do for living?
6. Do you have any dependents? Yes [ ] No [ ]
7. If yes how many?
8. How are your dependents faring currently?
9. Currently what do you for living?
10. Who takes care of you?
11. Does the Catholic Church engage in any intervention program to help you? Yes[ ] No[ ]

12. What type of assistance do they give to you?

13. How often do they support you?

... 

14. What factors do you think can prevent them from the support they give to you?...

15. What do you expect from them and they are not able to do/give you? ............

16. In your own view what other means of support do you think society can give to people living with HIV/AIDS?
APPENDIX II

UNIVERSITY OF GHANA
FACULTY OF ARTS
DEPARTMENT OF RELIGIONS

INTERVIEW SCHEDULE FOR THE CARE GIVERS

Introduction

This instrument seeks information on the Catholic Church’s support to people living with HIV/AIDS (PLWHA) in Aflao and Dzodze. The study is for academic purpose only and your anonymity is assured. Please response or answer the questions that will be asked as frankly as possible. You may decide not to answer questions that you don’t feel like answering. Thank you in advance.

1. Do you have any support systems/programmes in place for PLWHA?
2. Which outfit of the Diocese support the PLWA?
3. What kind of support do you give to the PLWA?
4. How often do you meet them?
4. What is the response of the PLWA toward the support you give them and how do they perceive the support?
5. How do you come into contact with the PLWA?
6. Do you provide support only to your church members?
7. What are the factors that militate against the care and support you give to the victims of the disease?
8. How do you perceive the support system?
9. Do you also support the dependents of the PLWA Yes [   ] No [   ]
10. What do you do for them?
11. What is the future for this programme?
APPENDIX III

Short Profile of the PLWHA Interviewee

For easy identification of the respondents, they will be signed pseudonyms relating to the alphabets so that it will be easy to identify one respondent from the other. In that regard, we have:

- **Respondent A**: a 26 years old female and who attended Vocational School and was interviewed at Aflao.
- **Respondent B**: a 48 years old female and only had Primary School education interviewed at Aflao.
- **Respondent C**: a 52 years old female also had Primary School education and was also interviewed at Aflao.
- **Respondent D**: a 72 years old woman and never had formal education and was interviewed at Dzodze.
- **Respondent E**: a 38 years old male, had Senior Secondary School education and was interviewed at Aflao.
- **Respondent Ea**: is a 32 years old female teacher interviewed at Aflao.
- **Respondent F**: a 35 years old female, had Qur’anic education and was interviewed at Dzodze.
- **Respondent G**: a 43 years old male who only had Primary School education and was interviewed at Dzodze.
- **Respondent Ga**: a 33 years old female, had Junior Secondary School and was interviewed at Dzodze.
- **Respondent H**: a 46 years old male who had only Primary education and was also interviewed at Aflao.
- Respondent I: a 46 years old female who never had formal education and was interviewed at Aflao.
- Respondent J: a 63 years old female, had Primary School education and was interviewed at Aflao.
- Respondent K: a 38 years female who had only Junior High School education and was interviewed at Aflao.
- Respondent Ka: a 28 years male trained teacher interviewed at the catchment of Dzodze
- Respondent L: a 26 years old female with Primary School education and was interviewed at Dzodze.
- Respondent M: a 36 years female with Primary School education was interviewed at Dzodze.
- Respondent N: a 56 year female who had Commercial education and was interviewed at Dzodze.
- Respondent O: a 38 years female with no formal education interviewed at Dzodze.
- Respondent P: a 35 years old female with only Primary School education and was interviewed at Aflao.
- Respondent Q: a 25 years old female with Junior High School education was interviewed at Aflao.

These will be the names by which the respondents in the interview will be identified. This is to help protect the identity of the interviewees and also help reduce confusion as long as the presentation and analysis of the interview data is concerned.
APPENDIX IV

Short Profile of the PLWHA Interviewee

For easy identification and to avoid confusion, these respondents have also been identified with letters of the alphabet in this order:

- Respondent A is a health worker and a caregiver at the Aflao health facility and she has oversight responsibility to PLWHA.
- Respondent B is also a health worker and a caregiver at the Aflao health facility and he also attends to PLWHA.
- Respondent C is a health worker at St. Anthony Hospital, Dzodze who provides home care for PLWHA.
- Respondent D is the Keta-Akatsi Catholic Diocesan Health administrator.
- Respondent E coordinates COMCASUP activities in the Keta Akatsi Diocese.
- Respondent F is financial administrator of the Keta-Akatsi Catholic Diocese. He is in charge of finances of the COMCASUP outfit.
- Respondent G is a female assistant to Respondent E.
- Respondent H is a health worker and a caregiver at the Aflao health facility. He facilitated COMCASUP programme in Aflao and she attends to PLWHA.
- Respondent I is a caregiver at the St Anthony Hospital at Dzodze. He also goes to town to provide home base care to PLWHA for COMCASUP outfit.
- Respondent J is also a health worker at St. Anthony Hospital, Dzodze who is in charge of the COMCASUP activities at the hospital.