HIV and AIDS and the stigmatisation of women by men in Nigeria: A pastoral care intervention strategy

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Declaration

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Dedication

This study is dedicated to the Triune God and all who are suffering from stigmatisation, especially women living with HIV and AIDS.

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All glory to God for His faithfulness which endures forever.

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Abstract

> *Stigma is known as negative beliefs, feelings and attitudes towards people living with HIV (PLHIV), groups associated with PLHIV and other key populations at higher risk of HIV infection. Stigma and discrimination are major barriers to testing, treatment uptake and adherence. (Odimegwu et al, 2017:2)*

The above quotation is a clear indication that stigma is a terrible phenomenon that causes set-backs in the fight against HIV and AIDS. This research investigates the role of men in the HIV and AIDS stigmatisation discourse from a pastoral care perspective. It is strongly argued that men are key stakeholders and players in the HIV and AIDS stigmatisation against women in Nigeria. Therefore, the research advances an argument that the utilisation of pastoral care in addressing the role of men in the HIV and AIDS stigmatisation against women, is a necessity.

The study discusses at length the concept of stigma. It determined that it is one of the many factors which boost the spread of the HIV and AIDS epidemic. The research also revealed that cultural, political, social, and religious factors sometimes aggravate the situation of women. Harmful cultural practices, especially patriarchy, were discovered to be major vehicles of stigmatisation against women in Nigeria, also increasing women's vulnerability to HIV and AIDS. The study argues that pastoral care and counselling is the best response to the menace of HIV and AIDS stigmatisation.

To elicit information that would assist in arriving at a reliable conclusion, the research employed a qualitative research methodology, using the practical theological framework of Richard Osmer (2008). The study further engaged relevant literature in theology, psychology, and other appropriate disciplines.

The motivation for this research emanated from the fact that women, like their male counterparts, are created in the image of God and, therefore, deserve to be treated with love, respect, and a high sense of decorum and propriety at all times, and more so when they are facing the challenge of HIV and AIDS or any illness. The research concludes that HIV and AIDS stigmatisation against women constitutes a significant threat to their fundamental human dignity. Consequently, recommendations are put forward to generate fundamental knowledge and awareness in the church and how it can objectively and urgently address the threat of HIV and AIDS stigmatisation of women by men.

Opsomming

> *Stigma word beskou as negatiewe oortuigings, gevoelens en houdings teenoor mense wat met MIV leef (PLHIV), groepe wat met PLHIV verbind word en ander belangrike groepe met 'n hoër risiko vir MIV-infeksie. Stigma en diskriminasie is die grootste hindernisse vir toetsing, en aanvaarding en nakoming van behandeling. (Odimegwu et al, 2017:2) [eie vertaling]*

Bogenoemde aanhaling is 'n duidelike aanduiding dat stigma 'n verskriklike verskynsel is, wat terugslae in die stryd teen MIV/vigs veroorsaak. Hierdie navorsing ondersoek die rol van mans in die MIV/vigs-stigmatiseringsdiskoers vanuit 'n pastorale perspektief. Daar word sterk aangevoer dat mans die sleutel-belanghebbendes en rolspelers is in die MIV/vigs-stigmatisering van vroue in Nigerië. Daarom voer die navorsing 'n argument aan dat die gebruik van pastorale sorg noodsaaklik is om die rol van mans in die MIV/vigs-stigmatisering teen vroue aan te spreek.

Die studie bespreek die konsep van stigma breedvoerig. Dit bevind dat stigmatisering een van die vele faktore is wat die verspreiding van die MIV/vigs-epidemie bevorder. Die navorsing bring ook aan die lig dat kulturele, politieke, sosiale, en godsdienstige faktore die reeds ontaarde situasie van vroue, soms vererger. Skadelike kulturele praktyke, veral patriargie, dra grootliks by tot stigmatisering van vroue in Nigerië en verhoog ook die kwesbaarheid van vroue vir MIV/vigs. Die studie voer aan dat pastorale sorg en berading die beste reaksie op die bedreiging van MIV/vigs-stigmatisering is.

Om inligting te bekom wat lei tot 'n betroubare gevolgtrekking, het die navorsing gebruik gemaak van kwalitatiewe navorsingsmetodologie, en die prakties-teologiese raamwerk van Richard Osmer. Die studie het verder gewerk met relevante literatuur in teologie, sielkunde, en ander toepaslike dissiplines.

Die motivering vir hierdie navorsing het voortgevloei uit die feit dat vroue, net soos hul manlike eweknieë, na die beeld van God geskape is en daarom verdien om te alle tye behoorlik en met liefde, respek, en 'n hoë vlak van waardigheid behandel te word, des te meer wanneer hulle die uitdaging van MIV/vigs of enige siekte in die gesig staar. Die ondersoek het tot die gevolgtrekking gekom dat die stigmatisering van MIV/vigs teen vroue 'n fundamentele bedreiging vir hul wesenlike menswaardigheid is. Gevolglik word aanbevelings gemaak om grondige kennis en bewustheid in die kerk te skep, en maniere voorgestel waarop die kerk

objektief en dringend die bedreiging van MIV/vigs-stigmatisering teen vroue deur mans, kan aanspreek.

Gabatarwa

> *Taɓo, wani illa ne da bashi da ƙyau, hali ne da akeji da mutanen da kerayuwa da ciwon kanjamo. Kungiyoyin da sukehulda da ma'aikata da masu cutar Kanjamo suna cikin hatsari mai yawan gaske wajen kamuwa da kwayoyin cutar kanjamo. Tabo na nuna bambanci ko wariya sun zamamanyamanyaabinoshehanyagagwaji, lura, fahimta da riko. (Odumegwuet, 2017:2)*

Bisa ga zancen da ke bisa, da gaske ne cewa tabo wani gaggarumar abu ne da ke da illa sosai da ke jawo koma baya wajen yaki da yaduwar cutar kanjamo. Wannan bincike ya mai da hankali akan hakkin maza wajen baza tabo da aka tattauna ta a sanin Fastoci. An yi jayayya sosai sosai cewa maza su ne ke kan gaba na tabon cutar kanjamo kan mata a Nijeriya. Don haka, binciken ya ci gaba da nuna muhimmancin ba da shawara ta amfanin da maganar Allah wajen yaki da damuwar tabon cutar kanjamo akan mata. Binciken ta tattauna da zurfi kan tunanin tabo. An tattauna cewa yana daya daga cikin abubuwa masu yawa da ke iza yawan yaɗuwar cutar kanjamo. Binciken ya sake bayyana cewa zancen al'adu, siyasa, rayuwar zaman jama'a da sha'anin addini wani lokaci na kara tsananta yanayin mata. Al'adu da ba ƙyau, musamman al'adun gargajiya da ke ba maza fifiko akan mata, an gano cewa sune kan gaba na sa tabo kan mata a Nijeriya kuma sake kara saka mata kamuwa da cutar kanjamo.

Binciken ya nuna cewa masu bada shawara da Fastoci, suke da fada aji akan hatsarin tabo na cutar kanjamo. Yadda ya kamata a iya jawo bayyani da zai iya zama da taimakon kai wa ga karshen bayyani, Bincike yayi amfani da ' kwarariyar hanyar bincike da kuma aikin Richard Osmer (2008). Bincike ta jinganta abin adabin ko litattafai da suka dace, ilimin halin ɗan adam da wasu horaswa da ta dace.

Muradin wannan bincike ta fito ne, da gasken cewa mata, abokan tarayar maza suke an haliccesu ne a cikin kamani da sifar Allah, don haka, ya cancanci a bi da su cikin kauna, biyayya, da ma'ana sosai da hali mai kyau a kowace lokaci musamman a lokacin da suke fuskantar kalubale. Binciken ta kammala da cewa tabon cutar kanjamo akan mata ya tsara muhimman hakkokin nuna martabansu.Saboda haka, an samo shawarwari da zasu kirkiro sanin muhimman hakkokin a wayar wa membobin Ikilisiya da kai kuma yadda za'ayi hanzari ko gaggawa bayyana hatsairin cutar kanjamo da tabo akan mata da maza.

Contents

Abbreviations

AIDS – Acquired Immunodeficiency Syndrome

AFPAC – The Armed Forces Programme on AIDS Control

ALHIV – Adolescent Living with HIV

APIN – AIDS Preventive Initiative in Nigeria

ART – Anti-retroviral Therapy

CAN – Christian Association of Nigeria

CID – Criminal Investigation Department

CISHAN – Civil Society for HIV and AIDS in Nigeria

CISOGHAN – Civil Society Organisation Group on HIV and AIDS in Nigeria

COCIN – Church of Christ in Nations

Col – Colossians

COVID-19 – SARS-CoV-2/Corona-virus

CPE – Clinical Pastoral Education

FBO – Faith-based Organisations

FEAP – Family Economic Advancement Programme

FGM – Female Genital Mutilation

FGN – Federal Government of Nigeria

HAART – High Active Anti - retroviral Therapy

HEAP – HIV and AIDS Emergency Action Plan

HIV – Human Immunodeficiency Virus

IDU – Injecting Drug Use

LACA – Local Action Committee on AIDS

LWF – Lutheran World Federation

MDG – Millennium Development Goal

MHRP – Military HIV Research Programme

MTP – Mass Transport Programme

NACA – National Action Committee on AIDS

NALDA – National Agricultural Land Development Authority

NEACA – National Emergency Agency for the Control of AIDS

NEEDS – National Economic Empowerment and Development Strategy

NEPA – Nigeria Electricity Power Authority

NEPWHAN – Network of People Living with HIV and AIDS in Nigeria

NGO – Non-governmental Organisation

NHS – National Health Service

NPEP – National Poverty Eradication Programme

NT – New Testament

NYNETHA – National Youth Network on HIV and AIDS

OED – Oxford English Dictionary

OFN – Operation Feed the Nation

OT – Old Testament

PEPFAR – President's Emergency Plan For AIDS Relief

PLWHA – People Living with HIV and AIDS

PMTCT – Prevention of Mother-to-Child Transmission

PWID – People who Inject Drugs

Rev – Revelation

SACA – State Action Committee on HIV and AIDS

SDG – Sustainable Development Goals

STIs – Sexually Transmitted Infections

UNDP – United Nations Development Programme

UNFPA – United Nations Family Planning Agency

USAIDS – United State Agency for International Development

UNAIDS – Joint United Nations Programme on HIV and AIDS

WCC – World Council of Churches

WHO – World Health Organisation

CHAPTER ONE

INTRODUCTION

1.1. BACKGROUND OF THE STUDY

Falola (2008:8) observes that the Federal Republic of Nigeria is known as a densely populated African country. According to Odeyemi (2014:11), it is also the richest black state worldwide. However, it is quite surprising that, with its rich mineral resources, many of its citizens are living in abject poverty, in a sense, living in a paradox. Therefore, Odeyemi (2014:10) calls Nigeria "a proverbial land of no tomorrow".

When it comes to issues of religion, culture, politics, and economics, Nigeria is a country of complexities. These complexities at times become harmful, in the sense that they create marginalisation and friction and sometimes promote stigmatisation of others, including women. Women are often blamed as offenders. They may be culturally and/or religiously accused of immorality simply for the way they dress and there is no government policy in place to protect these women as they are blamed, humiliated and stigmatised (Chiazor et al, 2016:7764). In short, Nigerian women undergo various forms of violence with very negative consequences. Such consequences may be psychological, social or physical and may include painful experiences of shame, embarrassment, and humiliation as part of their daily experiences (Esere et al, 2009:3). This is not surprising as, generally, Nigerians follow a strong honour and shame culture. In a very patriarchal society[1] it is also not surprising that women are often the objects of (men's) honour or shame. And, should men act upon the latter, e.g. by abusing their wives or girlfriends, they not only escape government justice (because laws are not implemented), but they are not even held accountable by society at large, including the church (Oluremi, 2015:25). Patriarchy is practiced in many societies worldwide (Dalerup, 2018: 93). Like many other African countries, Nigeria is also mainly a patriarchal society. Patriarchy traces the line of ancestors or descent through men with less regard for women (Ndupu, 2016:85).

Gender categorisation has always played an important role in Nigerian society, particularly during social events or interactions. Gender construction is not only patriarchal, but it also revolves around religion, culture, politics, and social activities. Such an androcentric country, according to Ofoha (2013:1), is ruled according to the biases and stereotypes that place most

[1] According to Meyers (2014:8), "patriarchy" is a concept in the social sciences that refers to male domination.

power in the hands of "the male gender". And forms of violence against women are often worse within contexts of patriarchal norms and structures (Oyediran, 2021:85). This is the context in which the study looks at HIV/AIDS and the stigmatisation of women.

1.2. MOTIVATION FOR THE STUDY

The motivation for this study emanated from my post-graduate research on the activities of Church of Christ in Nations (COCIN) AIDS Awareness and Care Programme (CAACP).[2] Looking through the daily reports, it became clear that stigmatisation is an obstacle that impacts people living with HIV and AIDS (PLWHA) as well as those affected by the virus from coming forward and publicly declaring their status. In some cases, such stigmatisation has resulted in infected persons being suspended or even expelled from their churches and schools on account of their status. This behaviour by the church contributes to people not seeking medical help, anti-retroviral therapy (ART), and thus spreading the virus and eventually dying. An example is that when HIV and AIDS was first identified, some infected people committed suicide because of the stigmatisation (Bolakale, 2016:198).

In the course of my duties as a pastor, I have witnessed many instances where men divorced their wives because the wives were HIV and AIDS positive.

It is, therefore, in the light of this predicament of Nigerian women and its related socio-cultural and religious context, that I have been encouraged to examine HIV and AIDS and the stigmatisation of women. I believe an appropriate way of dealing with this challenge and its social and religious context will be a practical theological study using the pastoral care and counselling approach.

1.3. BACKGROUND TO THE RESEARCH PROBLEM

It is noteworthy that gender inequalities are some of the major factors in the continuous spread of the HIV and AIDS epidemic. Chitando (2008:183) believes that gender inequality is often the source of stigmatisation in our societies and also in the church. He further points out that, as a result of patriarchy, sexually transmitted diseases are often labelled as "women's diseases" (Chitando, 2008:183). Consequently, women with HIV and AIDS remain silent in the face of such accusations. It has become common knowledge in scientific circles that in Africa, as Musa Dube's research (2003:15) has shown, women are more vulnerable to HIV and AIDS than men.

[2] CAACP is the unit under the department of Health and Social Services of the Church of Christ in Nations (COCIN) which creates AIDS awareness. For more information, visit http://lightbeareronline.com/home.html.

In fact, statistics show that the infection rate in women is five to six times higher than in men (Dube, 2003:15). Not surprisingly, this results in HIV and AIDS being seen as a gendered pandemic (Aniekwu, 2002:31). This is one of the reasons why a scholar such as Oluduro (2010:220) makes an appeal that church leaders must rise and condemn male stigmatisation against women who are HIV positive.

Of course, HIV and AIDS stigmatisation is only one of myriad of possible forms of stigmatisation. People are also stigmatised on the basis of race, gender, sexual orientation, religion, health status, culture, education, and many more (Summers, 2018: ii). However, according to Odimegwu (2018:2), research has shown that in Nigeria women suffer more stigmatisation and discrimination than men.

As has been hinted above, stigmatisation is not present only in society; the church is also guilty of stigmatisation. Speaking on the reality of stigmatisation in the church in Nigeria, Oludoru (2010:218) laments that clergy who are HIV and AIDS positive have been dismissed from their pastoral responsibilities, ostracised, and shunned by their fellow pastors and members. In some extreme cases, male clergy who are HIV and AIDS positive are allowed to continue work with health assistance from the authorities, while female leaders in a similar situation are shown the door. According to Banda (2019:4), the church stigmatises PLWHA when it links HIV and AIDS, condom use, and immorality; thereby it labels PLWHA as “immoral” and “sinners”. This may result in church members distancing themselves from PLWHA. Some clergy may outrightly refuse to wed couples due to their HIV and AIDS status. In some churches, PLWHA are denied Holy Communion because the leaders are afraid that other members may contract the sickness as they share the same cups (Oludoru, 2010:222). In short, in Nigeria it seems that Oludoru’s (2010:208) hope for a day when the church, synagogue, and temple will warmly welcome and embrace PLWHA, and fight against HIV and AIDS stigmatisation, is still far in the future. This is also why this research attempts to explore how pastoral care and counselling can encourage men to take responsibility for their actions. From a preliminary perspective, this may, eventually, take the form of:

- Attitudinal change. Men must change their attitude and join the fight against stigma and discrimination. More, specifically, the attitude of men linking their partners’ HIV and AIDS status with waywardness and immorality should be changed to one of love, compassion, and empathy towards women living with HIV and AIDS (Olapegba,

2010:958) and an acknowledgement of their (men's) own part in and responsibility for spreading the virus.

- Compliance with national response policies on HIV and AIDS. In Nigeria, the Federal Government has developed policies to reduce or eliminate HIV and AIDS stigma and discrimination such as (1) the National HIV and AIDS policy which was launched in 2009 to, among other things, protect the rights of PLWHA against stigma and discrimination (Odimegwu, 2017:8); (2) the 2010-2015 HIV and AIDS National Strategic Plan; (3) the National Workplace Policy on HIV and AIDS; (4) Nigeria's HIV and AIDS Antidiscrimination Act of 2014; and (5) the National HIV and AIDS Stigma Reduction Strategy of 2016 (Odimegwu, 2017:8).
- Respect for their country's constitution. The 1999 Nigerian Constitution (amended) guarantees and upholds the rights of every person against stigma and discrimination (Odimegwu, 2017:9).
- Internalisation and living by the golden rule of "Do to others what you would want them do to you" (Matt 7:12)

1.4. RESEARCH QUESTION

In view of the research problem explained above, the research question to be investigated in this study is:

How can pastoral care assist in de-stigmatisation of women in Nigeria?

Sub-questions

For the research to find more and relevant data on the problem as highlighted above, the following sub-questions are hereby raised:

- What is the nature and the extent of the HIV and AIDS pandemic in Nigeria?
- What steps do men need to take in order to reduce or stop the stigmatisation of women living with HIV and AIDS?
- What role could pastoral care play in addressing the stigmatisation of women living with HIV and AIDS by men?

1.5. RESEARCH OBJECTIVES

The research objectives stated below are formulated in order to answer the research questions. The study therefore aims to:

- Examine the nature and the extent of the HIV and AIDS pandemic in Nigeria.
- Enumerate the steps men need to take in order to prevent the stigmatisation of women living with HIV and AIDS.
- Discuss the role pastoral care could play in addressing the stigmatisation of women living with HIV and AIDS by men.

1.6. RESEARCH DESIGN, METHODS, AND THEORETICAL FRAMEWORK

This study was designed to be a qualitative, non-empirical study. Therefore, it relied on existing secondary materials only, including books, journals, magazines, scholarly articles, news articles, and internet resources. Two theoretical frameworks were used: One is an understanding or theory of stigmatisation (what it is, how it works, why it happens), and the other is a theory/perspective on pastoral care (what it is, its strengths, and how it can address stigmatisation). Based on the goals of this research, the qualitative research method was used. Qualitative research is defined by Moser (2017:271) as any type of research that uses holistic and in-depth approach to gather data and focuses on people's experiences and tangible events which produces findings that cannot possibly be analysed quantitatively. Silverman (2020:3) says, "Qualitative research is the type of research that finds out about people's experiences. It helps us understand what is important for people". This method is preferred because it helps us to grasp the human side of social interaction (Stanfield, 2006) and its restorative effect triggers healing (Hayes, 2016:20). The qualitative research method was chosen because it will help this study to find out about the experiences of People living with HIV and AIDS and to understand what is important for them.

This research also employed the practical theological framework by Richard Osmer (2008). Osmer (2008) presents the fundamental tasks of practical theological interpretation as asking four questions that are geared towards responding to a critical situation and guiding interpretation. These questions are:

- What is going on?
- Why is this going on?
- What ought to be going on?
- How might we respond? (Osmer, 2008:4)

The answers to these questions reflect on the following four tasks of practical theology for research framework (Osmer, 2008:4):

- The descriptive-empirical task
- The interpretive task
- The normative task
- The pragmatic task

The research was, therefore, structured into three major areas, representing the three main chapters of the work.

1.7. THE MEANING OF THE STUDY FOR PRACTICAL THEOLOGY

Swinton and Mowat (2016:6) define practical theology as "a theological reflection that is critical of the church's activities as they interact closely with the world". Louw (1998:91) also points out that "practical theology is concerned and interested in bringing out praxis". Pastoral care is a discipline under practical theology. It, therefore, participates in a community, in order to provide direction to and wellbeing of that community (Rusell & Lyon, 2011:22).

Louw (2008:217) defines pastoral care as "a healing process that takes care of the whole person not just physically, but spiritually, psychologically and emotionally". Notably, this dimension is an important area of interest in practical theology, because human dignity, both in the church and society, is the point of departure for practical theology (Heitink, 1999:2-6).

Consequently, the goal of this research is to determine activities of men that contribute to the stigmatisation of women who are infected and affected by HIV and AIDS, and to show how the role of pastoral care, which is seen in two dimensions – *cura animarum* as faith care and *cura vitae* as life care – is significant in addressing HIV/AIDS stigmatisation (Louw, 2008:217).

1.8. LIMITATION OF THE RESEARCH

The scope of this research is limited – it focuses on stigmatisation perpetrated by men against women. However, this research is also limited to traditional behaviours of men which could be understood as male dominance or masculinity. The research does not include how pastoral care can empower women to resist stigmatisation. The study looked only in the Nigerian context.

1.9. SIGNIFICANCE OF THE STUDY

A lot of research has been done on HIV and AIDS stigmatisation. However, not much work has been carried out on the role of men as perpetrators of the stigma. This research wishes to add to the discourse on HIV and AIDS discrimination in Nigeria by making Nigerian men

aware of their role in it and their responsibility to change the current role many of them may play. It will hopefully provoke Nigerian men to take responsibility of their actions; therefore, it is intended to bring about change in the society. It is also intended to contribute qualitatively to the corpus of literature on HIV and AIDS and stigmatisation.

1.10. LITERATURE REVIEW

Much research has been conducted around HIV and AIDS stigmatisation. In Nigeria, scholars such as Odimegwu, Adedeni, and Ononokpono (2013); Odimegwu, Clifford, Akinyemi, and Olatunji (2017); Onyebuchi-Iwudibia, Oscar, and Amy (2014); Monjok, Simensy, and Essien (2009); Dahlui, Maznah, Nazar, Awang, Zaki, Oche, Adekunjo, and Chinna (2015), dealt with the causes and remedies identified for HIV and AIDS. These writers focused on secular intervention methods such as more campaigns in the media (Babalola et al; Monjok et al), and government policies (Odumegwu et al), while Dahlui et al focused on the magnitude of the stigmatisation. This research will focus more on women as subjects of HIV and AIDS stigmatisation, and pastoral care as the ideal way to alleviate stigmatisation.

Speaking on why people stigmatise others from a pastoral care perspective, Reynolds (2008:68) asserts that people have not represented the image of God properly; as a result, they abuse and maltreat one another. Stigmatisation of women who are infected and affected by HIV and AIDS has become a growing concern. HIV and AIDS must be understood by people as a sickness. Louw (2008:109) argues that sickness in the Old Testament can be understood against diverse perspectives or backgrounds such as harmony, integration, and integrity. Therefore, it can be said that illness is a type of disintegration which puts a person in a state of abnormality. That is why Yahweh comes in to restore, integrate, and reconcile frail humans with Himself (Louw, 2008:109).

In the New Testament, illness or suffering is associated with human conduct and behaviour, since it is perceived as evidence or a consequence of the immorality of human beings due to the fall of man in the Garden of Eden (Rom 5:12). Louw (2008:113) agrees but argues that not every sickness is a result of personal and/or human sin, for example, the story of the blind man in John 9, where Jesus made it clear that the blindness was not a result of sin.

Furthermore, the understanding of illness narrated in the biblical texts is not linked with HIV and AIDS – probably because the disease did not exist when the Bible was written. However, since it is an ailment that causes pain and discomfort as any other sickness, HIV and AIDS can also be perceived as a result of the fall of man as recorded in Genesis 3. Hasel (1983:1919)

believes that no matter what kind of sickness manifests, it is never a part of God's intention for humanity. Suffering and sickness deprive people of strength as well as normal functioning of the body. This puts victims in a vulnerable state, without strength or any form of defence (Louw, 2008:109).

In Africa culture, illness and suffering is seen as an unfortunate happening. Mathwasa (2021:135) reveals that Africans understand sickness as an indication of damaged relationships with the community, spirits, and God.

Contributing on the prevalence of HIV and AIDS in Nigeria, Oluremi (2018:17) notes that since the emergence of the first HIV and AIDS case in 1986, Nigeria's infection rate has grown steadily but surely, spreading over almost all the country. He further observes that the HIV and AIDS infection rate in Nigeria has grown from "a concentrated epidemic" to "a generalised epidemic and to the current mixed epidemic" (Oluremi, 2018:17). The HIV and AIDS crisis "reached its peak in Nigeria in 2001" with a percentage of 5.8 percent of the population testing positive. This number shows a significant increase from the initial low rate of 1.8 percent in 1999. In 2005, an estimated 3.6 million Nigerian citizens were living with HIV and AIDS, and the percentage rate in the 36 states of the country oscillated between 2 percent to 14.9 percent (National HIV and AIDS Epidemiology and Impact Analysis, 2014:7)). This growing HIV and AIDS infection rate in Nigeria has been attributed to poor education. This means that knowledge regarding this disease is limited, and it is still a mystery to many. An empirical study shows that in 2005, a new infection was being recorded every minute (Owotade, 2005:136).

The impact of gender on HIV and AIDS is a significant dimension in understanding the growth of the epidemic. In its broadest sense, gender concerns "what is meant to be male or female, and how that defines a person's opportunity" (Turmen, 2003:411). In what ways have gender inequality and discrimination against women affected the route of the HIV epidemic? There are biological, cultural, and social determinants that put women and adolescent girls at greater risk of HIV infection than men. Women's vulnerability to HIV and AIDS is often increased by violence or the threat of violence against women. An analysis of the impact of gender on HIV and AIDS reveals the significance of integrating gender into HIV discourse and finding paths to strengthen women through implementing programmes and policies that increase their opportunities to access education and information.

According to Gupta (2001:6), power is significant in relation to both gender and sexuality. The power imbalance in gender relations which favours men, results in an unequal power balance in all facets of interactions between women and men through a complex interplay of cultural, economic, and social forces which determine the distribution of power. The unequal power balance between men and women in gender relations limits women's sexual freedom and expands men's autonomy, thereby increasing women's vulnerability to HIV and AIDS. Patriarchy is another issue in gender and power relations.

Patriarchy comes from the Greek word *patriarkes* which means literally "father of a race". Patriarchy then means "the rule of the father" (Ademuluke, 2018:1). Patriarchy is simply the rule of men over women and does not in any way acknowledge that women and men are equal. Merriam Webster (2010:342) defines patriarchy as "social organisation marked by the supremacy of the father in the clan or family, the legal dependence of wives and children, and the reckoning of descent and inheritance in the male line. It is broadly the control of men of a disproportionately large share of power."

Patriarchal society traces the lines of ancestry or descent through the man with no regard to the female, even if the female happens to be the first child (Asiyanbola, 2005:3).

1.11. DEFINITIONS OF TERMS

In order to gain a clearer understanding of the research, some basic concepts will be defined below:

1.11.1 Intervention

The Oxford Dictionary (1995) defines intervention as "the action of becoming intentionally involved in a difficult situation, in order to improve it or prevent it from getting worse".

1.11.2 Strategy

According to the Oxford Leaners Dictionary (2010:1381), strategy is "a plan that is intended to achieve a particular purpose".

1.11.3 HIV and AIDS

The acronym HIV stands for the Human Immunodeficiency Virus. The mode of transmission of this virus is either by blood, vaginal fluids, or semen. This means it does not harm insects or animals. The function of the human immune system is to prevent all kinds of infections that may try to enter the body (Garland & Blyth, 2005:22). AIDS is an acronym for Acquired Immunodeficiency Syndrome. This is a group of diseases the body acquires due to the inability

of the body's immune system to protect the body (Bolla, 2013:103). HIV and AIDS has spread into a pandemic.[3]

1.11.4 Stigmatisation

The Oxford Learners Dictionary (2010:1381) defines stigma as "a mark of disgrace or shame". Adejumo (2011:3864) refers to stigmatisation and discrimination as a monumental obstacle in the war against HIV and AIDS. Goffman (2018:15) states that stigmatisation reduces a person to less than human. For him, the human dignity of the stigmatised person is trampled upon and eroded, destroying the person's social identity. Churches and religious institutions must be careful because they can stigmatise PLWHA without prior knowledge.[4] This can happen because religious institutions have a variety of ways and instruments to influence their members' behaviour either positively or negatively (Ganga, 2013:435). Speaking about non-liberating African cultures that stigmatise women, Kanyaro (2001:64) notes that, though religion and culture are dynamic, there are some harmful cultural norms that oppress women more.

1.11.5 Pastoral care

Pastoral care has been seen as the church's basic ministry. It includes, but is not limited to, healing, guiding, and helping people to reconcile to God and to each other (Gary Collins, 2007:36). Louw (2008:445) observes that one of the fundamental problems of people living with HIV and AIDS has to do with fear. They are afraid to disclose their status due to stigmatisation associated with it. Therefore, pastoral care is an avenue of help that can bring hope and change. Dortzbach and Long (2006:112) lament that the crisis of HIV and AIDS make even neighbours and communities reject PLWHA. But since God has uniquely endowed the church to respond to this malady, when the Body of Christ acts in faith, it becomes a domain of life that defeats fear and brings about a new hope. Waruta and Kinoti (2000:84-85) note that, in view of the fact that healing affects all aspects of the person, pastoral care should also be holistic in nature; it should not only focus on the spiritual to the detriment of other aspects. God is interested in the whole human and all its dimensions – spiritual, moral, and physical.

[3] Morens et al (2009:1018-1020) state "Almost all the usage of the word pandemic means diseases which extend over large geographical areas".
[4] Gillian Patterson (2005:5) observes that institutions of faith can stigmatise with a pure motive if they find out that the person living with HIV/AIDS has sinned, by excluding him or her from the fellowship.

1.11.6 Human dignity

Human dignity is described as the worth or value of the human person. It can also mean the special place a person has in nature (Kateb, 2014: Preface). Dignity[5] itself is a key concept[6] in ethics. This word is often used in connection with international relationships and documents. But it is an existential rather than a moral value (Kateb, 2014:10). There is much debate as to the religious roots of the word dignity.[7] Louw (2009:418), speaking on sexual abuse and relating it to human dignity within the practical theological dimension, says that human dignity in the field of theology can be viewed from three different angles: the constructive approach has to do with the idea of creation; the functional or pragmatic angle looks at the notion of function; while the hermeneutical dimension is concerned with meaning. John (2004:1193) points out that the word dignity is derived from the Latin words *dignitas* (worth) and *dignus* (worthy).

1.11.7 Patriarchy

Patriarchy is derived from the root word patriarch. The Greek word *arche* means dominion or rule (by the fathers), thus power exercised over someone or something. It connotes the kind of beliefs, structures, and practices that guarantee the dominion[8] of men over women (Gupta, 2015:9). From a radical feminist's view, Joan Acker (1989:235) notes that patriarchy is considered a global phenomenon that cuts across cultural and historical boundaries. Everywhere men oppress women almost in the same way.

1.12. AN OVERVIEW OF THE STUDY

The research was arranged in such a way that the thought flowed smoothly and transited from one chapter to the other coherently.

Chapter One is the general introduction of the research.

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[5] *Duden*, the German dictionary (1997:821), defines dignity as "a value inherent in human beings that commands respect".

[6] Sensen (2011:4) opines that "dignity is not supposed to be just any value, but a very special kind of value: a value that not only justifies the requirements to respect human beings, but also one that trumps other considerations, and one that a person cannot forfeit".

[7] Many have assumed that dignity is primarily religious, but this is difficult to justify from the Hebrew and Greek scriptures. The Hebrew word translated as "dignity", *gedula*, occurs rarely in the Hebrew scriptures and means something more like nobility of character or personal standing in the community. In Greek, the word best translated as "dignity" today, *aksioprepeia*, is not used in the New Testament at all (Sulmasy, 2007:10).

[8] Mary O'Brien, in Gilerner (1986:46), observes that men developed institutions that empower them to dominate women in order to meet a psychological need that will compensate for their lack of ability to conceive and bear children.

Chapter Two discusses the nature and extent of the HIV and AIDS pandemic in Nigeria and the presence of HIV and AIDS stigmatisation. It also looks at the biblical concept of illness. The chapter further digs into the aetiology and background of HIV and AIDS in Nigeria.

Chapter Three deals with the concept of stigmatisation and why people stigmatise others. The chapter discusses the factors that are responsible for women/girl-children's vulnerability to HIV and AIDS. The chapter further looks at the challenges women face as a result of the stigmatisation.

Chapter Four considers the relevance of pastoral care in addressing the problem. The chapter discusses the different models of pastoral care. It also deals with pastoral care in the African perspective and examines pastoral care for PLWHA.

Chapter Five discusses the findings of the research and the contribution of the research. Suggestions for further research are given in this chapter.

CHAPTER TWO

HIV AND AIDS AND STIGMATISATION IN NIGERIA

2.1. INTRODUCTION

HIV and AIDS has existed globally for more than 35 years now. Many sectors such as employment, criminal justice, welfare, education, and health have been greatly affected by the pandemic. The illness has had a great impact on ethnic and social groups all over the globe.

Epidemiological research has shown that HIV and AIDS is still a serious public health challenge that wrecks economies and has claimed over 25 million souls in the past 30 years (Kolawole et al, 2016:2). Statistics reveal that in 2019:

- 42.5 million adults were living with HIV and AIDS
- 2.2 million children were HIV positive
- An estimated of 7.1 million people were ignorant of their HIV and AIDS status
- Between had 690,000 and 970,000 lost their lives to illnesses related to HIV and AIDS globally.[9] (UNAIDS Fact Sheet, 2020)

In Africa, the HIV and AIDS pandemic has continued to circulate and spread. The HIV and AIDS epidemic is very much a health threat in sub-Saharan Africa; some 1.8 million new cases were recorded in 2017 with a total death toll of about 1 million. As a result of the persistent challenge of HIV and AIDS in Africa, the World Health Organisation (WHO); the Joint United Nations Programme on HIV and AIDS (UNAIDS), and most of the African countries that are most affected by HIV and AIDS, have agreed to commit both human and financial resources to ensure that HIV and AIDS is defeated by the year 2030. Nigeria is a party to this arrangement (Charnmartin et al, 2020:1).

In 2019, the number of people living with HIV and AIDS in Nigeria stood at 1.9 million.[10] Though there seems to be stability in the spread of HIV and AIDS in Nigeria because of good monitoring, new infections are still being recorded, and the challenge remains (Osemwengie, 2020:111).

This chapter will focus on the descriptive-empirical task adopted from the methodology of Richard Osmer. It will, therefore, discuss the extent and nature of HIV and AIDS in Nigeria.

[9] See also unaids.org/en/resources/fact-sheet.
[10] See Appendix A for the detailed HIV/AIDS prevalence rate in Nigeria.

HIV and AIDS stigmatisation will also be explored in this chapter, with some examples and stories.

Nigeria is a Christian country that believes strongly in the Bible as a canon of life. So, the biblical understanding of sickness will be first explored.

2.2. THE BIBLE AND THE NOTION OF SICKNESS

This section tries to discuss the understanding of illness from a biblical perspective. The words illness, sickness, and disease will be used interchangeably. There are many renderings in the Bible that indicate the understanding of illness. Edwards (2015:65) says for the ancient Jews, illness, which has physical effects on the general well-being of the individual, was usually seen as a punishment for sin, separation from God, or violation of some divine standards. Louw (2008:109) argues that in the Bible sickness is viewed through its effects on the individual. Sickness destroys the psychological and physical wellness of the person. The Bible describes sickness by its destructive effects (Ps 38:6-9). The power and sting of sickness is also seen in Job 30:27. Collins (2007:442) observes that, though God in His sovereignty and knowledge created man with the mechanism of the body to fight diseases and defend itself, the body is usually weak and frail, making it vulnerable to different kinds of diseases and infirmities. It does not stay forever. So, everyone will experience some form of illness at some point in life. The degree varies from individual to individual. Some get sick often while others are fortunate to fall sick less often. To understand the true perspective of HIV and AIDS as an illness, we must place it in the overall context of sickness in the Bible.

2.2.1. The idea of sickness /disease in the Old Testament

In the Old Testament, illness has a wide spectrum of meanings. People of old became sick as do humans today. But the way of describing their conditions were totally different from modern medical language. Fortunately, some of the ailments that afflicted the children of Israel in the Old Testament have been known through biblical history and the archaeology (Williamson & Arnon, 2005:895). Croft (2014:1) succinctly echoes that, no matter the form in which sickness appears, it is never part of God's intention for humanity.

2.2.1.1. Concepts of disease and sickness

The general understanding is that sickness robs a person of strength and causes pain. This makes the person vulnerable without the strength for defence (Louw, 2008:109). Caroll (1995:130) argues that sickness in the Old Testament is characteristically attributed to God, with sin and disobedience as the cause. Aster (2015:457) supports the view that God is the

cause of sickness since He can smite and also heal (Isa 19:22; Deut 32:39). Dube (2004:25) notes that *challah*,[11] which is the Hebrew word for sickness, connotes a situation of weakness of the body and the inability to perform optimally. Louw (2008:109) asserts that sickness in the Old Testament can be understood against diverse perspectives or backgrounds such as harmony, integration, and integrity; the whole concept of illness in the Old Testament has to do with the covenant of Yahweh with Israel. So, illness is a type of disintegration of the normal. That is why Yahweh comes in to restore, integrate, and reconcile frail creatures to Himself.

2.2.1.2. Sickness as punitive measure from God

It is clear from some passages of the Pentateuch that sickness was sometimes a punishment of Israel by God. God is seen as the cause of sickness. The Lord warns:

> But if you will not listen to me and carry out these commands, and if you reject my decrees and abhor my laws and fail to carry out all my commands and so violate my covenant, then I will do this to you; I will bring on you, sudden terror, wasting diseases and fever that will destroy your sight and sap your strength. (Lev 26:14-16, NIV)

The fulfilment of this declaration can be seen in the Old Testament books. God afflicted the son of David with sickness because of his sin with Bathsheba, the wife of Uriah. Though the child was innocent, he suffered for the sin of his parents (2 Sam 12:13-15). Kunhiyop (2008:321) agrees that there are instances where children suffer for the sins of their parents as shown in Exodus 20:5. A nation could also be afflicted with disease or plague because of the sin of its leader, as recorded in 2 Samuel 24:1-17. Gehazi, the servant of Prophet Elisha, inherited the leprosy of Na'aman because of his greed; his sin brought sickness on him as depicted in 2 Kings 5:20-27. King Jeroboam was afflicted with sickness that shrivelled his hand because he stretched out the hand to molest the Prophet of God (1 Kgs 13:4-6). In the Old Testament, there is a connection between sickness and sin. And this connection was seen in a causative way as in Psalm 41:5 (Louw, 2008:111). The Jews saw sickness and pain or suffering as punishment from God for violating His norms, so sickness was considered a moral evil (Aluede, 2009:159). Louw (2008:112) concludes that in the Old Testament it is glaringly clear that people linked illness with the wrath and judgement of God (Ps 38:3).

[11] Wilkinson (1998:32) also notes that *challah* denotes weakness as a result of illness or disease and the noun *choli* means bodily weakness.

2.2.1.3. Sickness as a consequence of the fall and part of normal existence

Even though the Old Testament records instances where individuals suffered sickness because of their sin, this principle is not generally and rigidly applied. There are many individuals in the Old Testament who suffered illness not because of their personal sin. The case of Job is a relevant and clear example of this. God Himself declared Job as a perfect and blameless person (Job 1:8). However, there is no individual in biblical history who was afflicted like Job. Supporting the view that sickness was not necessarily the result of personal sin, Louw (2008:111) echoes that it is obvious there is a link between sickness and sin. But immediately cautions that this causative connection between illness and sin should not and must not be seen that illness was necessarily and always a consequence of sin. Kunhiyop (2008:321), in agreement with Louw, states that at the foundational level, sin is the cause of every human suffering including illness. But when referring to individuals and specific sins, it is worthwhile to understand that, while it is true that there is a connection between illness or human suffering and sin, individuals do not necessarily fall ill because of their personal sin. Hillman (2002:21) also contributes that, though sickness should not be directly linked to sin, it is obvious that illness came as a result of the fall of man in the Garden of Eden.

2.2.2. The idea of sickness/disease in the New Testament

In the New Testament, illness is also seen as evidence or the consequence of the depravity of human beings due to the fall of man in the Garden of Eden. However, special emphasis is placed on the effect of demonic forces (Luke 13:11). And when Paul had a thorn in the flesh, he attributed it to Satan's angel. The association of evil powers with illness is clear. The New Testament points to three fundamental causes of sickness or illness: God, sin, and Satan or demons (Thomas, 2002:297). However, this research will discuss only one, sin, since HIV and AIDS is believed to be transmitted in immoral ways, which makes it a sin, and so stigmatisation is considered justified.

There are several New Testament passages that connect sin with illness. The New Testament not only acknowledges original sin[12] as the cause of illness, but also sees a connection between personal sin and illness. In numerous instances (1 Cor 11:30; John 5:14; James 5:1) it is clearly assumed that the sick person understands that sin is the cause of the sickness and, therefore, makes amends by either confessing and/or making restitution. The biblical texts studied do not

[12] Original sin here refers to the tendency in human beings to do evil as a result of the fall in the Garden of Eden.

seem to suggest that the sufferer was taken by surprise. Hence, Jesus asked the man to, "stop sinning", Paul told the person to "examine", while James exhorted the sick person to "confess".

Nevertheless, the New Testament agrees that there is a limit to the association of sin with illness. Not every sickness is a result of personal sin (Louw, 2008:113). Caroll (1995:139) contends that in both John 9:1-3 and Luke 13:1-5, Jesus clearly and absolutely refused to accept the assumption that illness is always caused by sin. It is understood that sin and illness can be closely related, however, the types of healing in the gospels rule out any approach that explains all sickness as the product of sin. Carrol observes that most of the healing sessions of Jesus in the Bible, especially in the synoptic gospels, were exorcisms.[13] This means the condition was not the outcome of the victim's sin, but oppression by evil spirits that had to be dealt with. HIV and AIDS as a sickness is real and it is in Nigeria.

2.3. HIV AND AIDS IN NIGERIA

2.3.1. Preamble.

It is no longer news that HIV and AIDS has devastated many countries in the world. The prevalence of the infection differs in Africa. The continent of Africa comprises over 75 percent of the total infections in the world, even though its population is just 10 percent in the globe. Southern Africa and Eastern Africa have the highest rates of infections globally, with Swaziland and Botswana showing a prevalence rate exceeding 35 percent. However, West Africa's rate has been low, ranging from 1 to 5 percent. No country in Africa has exceeded a 10 percent infection rate (Kharsany, 2016:34). Kanki (2018:1) concurs that the infection rate is really high in Southern and Eastern Africa, especially among young women between the ages of 15 and 24 years, who constituted 26 percent of new infections in the year 2016. In that year more than 7 million people were HIV positive in South Africa, making it the highest infected nation in the world. What is the prevalence rate of HIV and AIDS in Nigeria?

2.3.2. The origin of HIV/AIDS in Nigeria

Nigeria recorded its first two cases of HIV and AIDS in 1985 in the largest commercial city of Lagos. The incidents were reported at the International AIDS Conference in Paris the next year, in 1986. A young girl of 13 from a neighbouring West African country was one of those

[13] This is a spiritual exercise that aims to cast out evil spirits in a place or person (Oxford South African Dictionary, 2010:214).

diagnosed. When the incidents were reported to the Federal Ministry of Health, it caused great fear.

2.3.3. The prevalence of HIV/AIDS in Nigeria

Since its first HIV and AIDS case in 1986, Nigeria's prevalence rate has grown steadily, spreading almost all over the nation. Oluremi (2018:17) observes that HIV and AIDS prevalence in Nigeria has grown from "a concentrated epidemic" to "a generalised epidemic and to the current mixed epidemic". The HIV and AIDS crisis "reached its peak in Nigeria in 2001" at a 5.8 percentage rate. This shows a significant increase from the initial low rate of 1.8 percent in 1999. In 2005, an estimated 3.6 million citizens of Nigeria were living with HIV and AIDS. And the percentage rate in the 36 states of the country oscillated between 2 and 14.9 percent (Owofala, 2016:699).

The growing prevalence rate of HIV and AIDS in Nigeria has been attributed to poor education concerning the disease and the frequency of stigmatisation and all sorts of discrimination. An empirical study shows that in 2005, a new infection was recorded every minute (Ogunbodede, 2005:85). New survey statistics released on 14 March 2019, showed that the prevalence rate of HIV and AIDS in Nigeria was declining. The infection rate stands nationally at 1.4 percent among adults aged 15 to 49 years. This is lower than the previous rate of 2.8 percent in 2014. Both the National Agency for the Control of AIDS (NACA) and UNAIDS reported that in 2019 1.9 million people were infected with HIV and AIDS in Nigeria. The President of the Federal Republic of Nigeria, Muhammadu Buhari, "received the news with excitement and later launched the Revised National HIV and AIDS Strategic Framework 2019 – 2021", (Adeyinka et al, 2019:348), to serve as a roadmap for the country in her response to the HIV and AIDS epidemic in the country. As at 2020 there were 1.9 million Nigerians living with HIV and AIDS (Olusola, 2021:1).

2.3.3.1. Prevalence from 1991-2018

Owofala (2016:4), showing the progressive growth of the HIV and AIDS epidemic in Nigeria from 1991 to 2013, says that in 1991 the prevalence rate was only 1.8 percent, rising to 3.8 percent in 1993 and 4.5 percent in 1996. The percentage kept rising, and in 1999 it was 5.4 percent and in 2001 5.8 percent, marking the peak of the pandemic in Nigeria. However, the rate started declining and a percentage of 5.0 percent was recorded in 2003, "4.4% in 2005, 4.6% in 2008, 4.1% in 2010 and 3.4% in 2013". This indicates a significant decline in the prevalence rate of HIV and AIDS in Nigeria. According to UNAIDS data 2019, the ravaging

rate of HIV further dropped to 1.5 percent in 2018 with "130,000 new HIV and AIDS infections, 53,000 AIDS-related deaths, 55% adults and 35% children on antiretroviral treatment respectively".[14]

2.3.3.2. Prevalence by states and the Federal Capital Territory

The prevalence rate released by NACA in August 2020 by states, is:

- Abia – 2.1 percent
- Adamawa – 1.2 percent
- Akwa ibom – 5.5 percent
- Anambra – 2.4 percent
- Bauchi – 0.5 percent
- Bayelsa – 1.9 percent
- Benue – 5.3 percent
- Borno – 1.2 percent
- Cross River – 2 percent
- Delta – 1.9 percent
- Ebonyi – 0.8 percent
- Edo – 1.9 percent
- Ekiti – 0.8 percent
- Enugu – 2.0 percent
- Gombe – 1.3 percent
- Imo – 1.8 percent
- Jigawa – 0.3 percent
- Kaduna – 1.1 percent
- Kano – 0.6 percent
- Katsina – 0.3 percent
- Kebbi – 0.6 percent
- Kogi – 0.9 percent
- Kwara – 1.0 percent
- Lagos – 1.4 percent

[14] See avert.org/infographics/hiv-and-aids-nigeria [Accessed 01/08/2020].

- Nassarawa – 2.0 percent
- Niger – 0.7 percent
- Ogun – 1.6 percent
- Ondo – 1.1 percent
- Osun – 0.9 percent
- Oyo – 0.9 percent
- Plateau – 1.6 percent
- Rivers – 3.8 percent
- Sokoto – 0.4 percent
- Taraba – 2.9 percent
- Yobe – 0.4 percent
- Zamfara – 0.5 percent
- FCT Abuja – 1.6 percent [15]

For the map of Nigeria showing the prevalence rate of HIV and AIDS, see Appendix I.

2.3.3.3. Prevalence according to the six geographical zones of Nigeria

- South-South – 3.1 percent; South-East – 1.9 percent; South-West – 1.2 percent; North-Central – 2.1 percent; North-West – 0.6 percent and North – East – 1.1 percent[16]

For the map of Nigeria showing the prevalence rates according to geographical areas, see Appendix II.

2.3.3.4. Prevalence rate by age

A few years ago, HIV and AIDS infection was most prevalent among women and men aged 25 to 29. However, the percentage went down from 5.6 percent in 2005 to 3.9 percent in 2014 among men and women aged 20 to 24. It is worthy of note that the HIV and AIDS prevalence has been consistently decreasing in the age group 15 to 19, while the infection rate has remained stable at 3.9 percent among people aged 40 to 49 (Oluyemi et al, 2018:65).

For the statistics on new infections by age and sex, see Appendix III.

[15] https://naca.gov.ng/allafrica.com/stories/201903200030.html [Accessed 01/08/2020].
[16] Ibid.

2.3.3.5. Prevalence by marital status

The prevalence of HIV and AIDS infection has been reported to be higher among divorced, separated, and widowed people. The married category shows a lower prevalence compared to the single group, though each category maintained a consistent prevalence over the years.

For the details of the prevalence rate among women adults from 2008-2018, see Appendix IV.

It is evident that the prevalence rate of HIV and AIDS in Nigeria cuts across different categories with devastating magnitude. What is the impact of this devastation on Nigeria? This will be the burden of the next section.

2.4. THE IMPACT OF HIV/AIDS IN NIGERIA

The devastation of HIV and AIDS in Nigeria has affected many sections and levels of relationships. But this research will look at the impact of the disease on only the economy, education, and families or households

2.4.1. Impact on the nation's economy

Both government and the private sectors have been affected by the scourge of HIV and AIDS in various ways.

2.4.1.1. Impact on human capital

The presence of HIV and AIDS in Nigeria has impacted on the economy. Every economy relies on many factors for growth, including human capital. Mai Jamaá and Mohammed (2013:12) state that the reality of HIV and AIDS in Nigeria and its threat to the economy is no longer in doubt. HIV and AIDS has affected the stability of Nigeria's economy. This can be seen in the inability to save lives, incapacitated productivity, and the high ratio of public expenditure. Citizens are overstretching their budgets due to the pandemic.

It goes without saying that the impact of HIV and AIDS has "spared neither the infected nor the affected persons from its devastation" (Mahal, 2008:95).

2.4.1.2. Impact on businesses

The impact of HIV and AIDS on businesses can take diverse forms. Since successful businesses boost the economy, the impact of HIV and AIDS may affect revenues and costs, specifically the labour cost. The product cost of items per unit may increase when there is a decrease in worker output or productivity. This occurs when employees are not able to work or perform their regular assignments in order to maintain the production capacity because of illness or

because they are taking care of friends or relations who are infected with HIV and AIDS. The cost of production of goods may also increase because, when employees die, they have to be replaced, which means employing and training fresh workers (Okwonkwo, 2004:177).

The HIV and AIDS problem contributes to a decrease in the growth of the Gross Domestic Product (GDP) in Nigeria. Consequently, the general performance of the economy is adversely affected (Mai Jamaá & Mohammed, 2013:16).

Table 1: The impact of HIV and AIDS on Nigeria's economy from 1990 to 2012.

Year	**Real GDP growth percentage %**	**HIV/AIDS percentage %**	**Recurrent expenditure on health in millions of naira**	**National percentage % impact on economy**
1990	8.2	1.0	500.7	2.69
1991	4.6	1.8	618.2	2.79
1992	3.0	2.8	1,389.9	3.14
1993	2.0	3.8	2,326.0	3.36
1994	1.3	4.1	2,094.0	3.32
1995	2.4	4.5	3,320.7	3.52
1996	3.4	4.5	3,175.3	3.50
1997	3.8	4.8	4,702.3	3.67
1998	2.4	5.1	5,333.6	3.72
1999	2.7	5.4	8,793.2	3.94
2000	3.8	5.6	11,579.6	4.06
2001	3.9	5.8	24,533.5	4.38
2002	3.3	5.4	50,543.2	4.70

2003	9.6	5.0	33,254.5	4.52
2004	6.6	4.7	34,198.5	4.53
2005	6.2	4.4	55,663.0	4.74
2006	5.6	4.5	65,663.0	4.81
2007	6.5	4.5	66,607.0	4.82
2008	6.0	4.6	77,551.7	4.89
2009	7.0	4.4	78,495.0	4.90
2010	7.9	4.1	88,195.5	4.95
2011	7.4	4.0	90,383.2	4.96
2012	6.5	4.0	92,271.7	4.97

Source: National Bureau of Statistics Annual Abstract of statistics; National Action Committee on AIDS – National HIV prevalence rate; Central Bank of Nigeria annual report and statement of accounts; UNAIDS/WHO Epidemiological Fact Sheet on HIV and AIDS.

2.4.1.3. Impact on agriculture

The agricultural sector also suffers from its share of the HIV and AIDS devastation. Research conducted by Hilhost et al (2006:382-393) revealed that HIV and AIDS affected the agricultural output of the country as a result of the mortality related illnesses. According to Oladele (2012, 47), women farmers in Benue State had to reduce the size of their farms due to the impact of the HIV and AIDS scourge. Enugu State likewise saw a decline in farming activities and production of goods by women as a result of HIV and AIDS. The consequence was a poor harvest season, resulting in an increase in the poverty level of the state, which led to social vices that affected other areas of human existence (Dauda & Olaniya, 2017:36). The production capacity of farms and agricultural goods in Adamawa State, Nigeria, was drastically reduced because farmers were either infected themselves or busy taking care of relatives who were infected by HIV and AIDS. About 120 PLWHA were interviewed on the impact of the sickness on their livelihood. And the result indicates that most of them were rural farmers who said their farming activities were crippled because of their inability to actively engage in the normal farm work due to HIV and AIDS related ailments (Iya et al, 2012:245-252).

It has been determined that HIV and AIDS has affected the economy of Nigeria negatively. This assertion came after careful analysis of the effects of HIV on Nigeria's economy over a period of ten years (1990-2010) (Dauda, 2012:48-64). Dauda and Olaniyan (2017:45) observe that there was a significant decline of about 19 percent in the degree of output in Nigeria as a result of a 100 percent rise in the number of people living with HIV and AIDS.

Women farmers have been affected seriously.

2.4.1.4. Impact on women farmers

In Nigeria, women play a significant role in the development of many sectors including agriculture – this was recently acknowledged. The key actors in this sector are the rural women who engage in different agricultural activities such as poultry and animal husbandry (rearing goats, pigs, and sheep) to augment the income of the family. In Nigeria, among the "pastoral" Fulani, women keep calves, milk cows, and use the processed milk for commercial purposes. In short, women are the preparers, preservers, processors, and distributors of agricultural goods in Nigeria. They are involved in pre- and post-harvest activities. Research has revealed that almost 95 percent of the farmers in Nigeria who in practice feed the country do not operate as businesses or gigantic firms, but as "small scale farmers and about 55% of them are women" (Ugwu, 2009:1617). But HIV and AIDS has reduced their efforts by its ravaging impact on women farmers. Ugwu (2009:1622) enumerates some areas in which HIV and AIDS has affected women:

- *Loss of women's active participation in agricultural activities*

  In Enugu State, Nigeria, women form 61 percent of the total number of small-scale farmers. To lose these women through disease related to HIV and AIDS, will exacerbate food insufficiency. In 2009, in Nigeria, 60 percent of women who were active farmers died of HIV and AIDS-related problems.
- *Household income reduction*

  HIV and AIDS affects the working capacity of farm women. Hence, they do not have the strength to participate fully in their normal farm activities in order to generate income for the family.
- *Increase in family problems*

  Since the women who are farmers are not able to work because they are looking after a family member or mourn those that have died, the income of the family is significantly

reduced, leading to an inability to meet financial obligations. This can create further health problems that may be a threat to the family.

- *Sale of household assets*

  When family burdens become unbearable and there is no other way to generate income due to the impact of HIV and AIDS on the women who were bread winners for the family, most families resort to selling their assets like farm equipment and their savings to meet their financial demands. In 2009 in Enugu State most women who were farmers (56 percent) lost their assets because of the HIV and AIDS scourge.

There is a negative and noticeable link between HIV and AIDS and the level of output in the economy of Nigeria. Once an economy is crippled, this affects many other sectors since it is the engine room and driving force of those sectors.

2.4.1.5. Impact on education

Education is another sector that has been affected by the HIV and AIDS epidemic. Beasley (2008:210) looking at Lagos state education sector, could identify the following as areas in which HIV and AIDS affects education:

- Children with parents who are infected with HIV and AIDS drop out of school to take care of their ill parents.
- Children drop out of school to generate income for the family since their parents, who were the bread winners, are either sick or dead.
- Children drop out of school because they are unable to pay the tuition fee as a result of their parent's ill health or death.
- Children with sick family members live with emotional problems like trauma and hallucinations. They spend most of their time thinking about their sick ones.
- Children with HIV and AIDS are unable to continue with their studies. They stay at home or are forced out of school. New research conducted has shown that one in every five children dropping out of school in the world, is a Nigerian.
- Teachers who are HIV and AIDS positive do not come to school and that also affects the learning process. So, teachers' absenteeism because of HIV and AIDS related illness is a threat to the future of education in Nigeria.
- The content of the curriculum has to change in order to meet the needs of the pupils in the new atmosphere of HIV and AIDS.

It is obvious from the above that HIV and AIDS has affected education in Nigeria. But the impact of HIV and AIDS is not limited to these sectors alone, households have been visited too.

2.4.1.6. Impact on households

Households in Nigeria have felt the impact of HIV and AIDS. Speaking on the impact of HIV and AIDS on households, Mahal et al (2008:193) observe that the epidemic of HIV and AIDS has crushed many families financially, emotionally, and socially. Apart from the personal expenditure of the infected person, every family suffers a psychological cost associated with the illness and demise of a member of the family. The social impact of stigma and discrimination associated with the illness and a break in family structure are more ways in which households are impacted. The morbidity and fatality rates associated with HIV and AIDS have serious implications for the family. In the first place, the household spends less money on non-health related consumption budgets in order to save enough money to care for the infected member of the family. This can eventually lead to a lower degree of health and educational accomplishments because the family channelled the resources meant for these items to medical bills and burial expenses.

Adding their voices to the issue of the impact of HIV and AIDS on households, Hilhost et al (2006:1) reveal that in Benue State, Nigeria, some households with family members living with HIV and AIDS lamented the amount of money they spent on caring for their relatives and burial expenses when they eventually pass on. These continued forms of spending have diverse effects on productivity and income.

2.5. THE RESPONSE OF NIGERIA TO HIV AND AIDS

2.5.1. Nigerian government's response

After reporting the first case of HIV and AIDS at the International AIDS Conference in Paris in 1986, the Nigerian government immediately formed the National Expert Advisory Committee on AIDS (NEACA) and sought help from the World Health Organisation (WHO) (Oguh, 2021:40). With assistance from the WHO and the United Nations (UN), the Nigerian government was able to fund the committee. In 1987, the government instituted the National HIV Counselling and Testing Program in some hospitals and health care facilities across the nation. The Federal Government of Nigeria, through the Federal Ministry of Health in conjunction with WHO, developed and executed a more comprehensive and all-encompassing medium policy plan. NEACA had oversight of the policy and played a significant part in

providing epidemiologic knowledge that helped Nigeria to develop new strategies, not just for prevention, but also for control (Odoh et al, 2018:10). According to Oguh (2021:40), NEACA was replaced by the National AIDS Control Program. In 1991 the Federal Ministry of Health expanded the programme to include all sexually transmitted infections (STIs). The programme deviated a little from the approach of NEACA and focused its attention on the responses of the health sectors to HIV and AIDS pandemic. It developed many guidelines and significant interventions like voluntary counselling and testing (VCT), syndrome management of STIs and administration of anti-retroviral and home-based care.

The President further established the National Action Committee on AIDS (NACA), which later became an agency renamed the National Agency for the Control of AIDS, maintaining its acronym. Its responsibility was to co-ordinate all units and sectors working in the prevention and control of the HIV and AIDS threat (Oruonye, 2011:108). Odoh et al (2018:11) elaborate that the responsibility of NACA was to implement "the three 'ones' – one multi sectoral strategic framework, one strategic plan and one monitoring and evaluation framework". The Federal Government directed the Federal Capital Territory (FCT) Abuja and the 36 states, including all local governments, to establish action committees on AIDS on their various levels accordingly. To combat any hindrance to the prevention of HIV at the grassroots level and garner support, a medium-term plan was developed called HIV and AIDS Emergency Action Plan (HEAP). HEAP was replaced by the National HIV and AIDS Strategic Framework in 2004. This framework developed a five-year plan from 2005 to 2009. The plan was renewed for 2010 to 2015. Presently, a strategic plan for 2016 to 2020 is still functioning.

2.5.2. Civil society organisations' response

Non-governmental organisations (NGOs), faith-based organisations (FBOs), and community-based organisations have played and still play a key role in HIV/AIDS prevention and control. In 2000, under the auspices of civil society organisations (CSOs), a national network of organisations was established called Civil Society Organisation Group on HIV and AIDS in Nigeria (CISOGHAN). This was a coalition of more than 74 local NGOs. The network has been renamed Civil Society for HIV and AIDS in Nigeria (CISHAN) with a total membership of about 3 000 organisations across the 774 Local Government Areas in Nigeria (Odoh et al, 2018:11).

2.5.3. Armed forces' response

The armed forces of the Federal Republic of Nigeria – the air force, army, navy, and police, the prison services, and immigration and customs have been involved in the prevention and control of HIV and AIDS spread in the country. Most are deployed to different places for emergency assignments like peace-keeping in or outside the country. In order to address HIV and AIDS among the uniformed group, the Nigerian armed forces established the Armed Forces Programme on AIDS Control (AFPAC). This has really made a giant contribution within its parameters and also among civilians as part of its civil relations in controlling HIV and AIDS in Nigeria (Odoh et al, 2018:11).

2.6. THE METHOD OF TRANSMISSION

HIV/AIDS is transmitted in many ways, and this is the same worldwide.

Heterosexual sexual activity is the major form of transmission of HIV and AIDS in Africa (DeCock et al, 2012:1210). HIV and AIDS can also be transmitted through bodily fluids such as blood and semen. The most common means of being infected, is by having unprotected sex with a person who is HIV positive. Receiving blood from an infected person and the use of unsterilised medical equipment also plays a role in the transmission of HIV and AIDS (Kunhiyop, 2008:316). Hinga et al (2008:86) concur that HIV and AIDS is transmitted heterosexually. Matholeni (2012:1) agrees that HIV and AIDS is massively transmitted sexually. Odoh et al (2018:13) enumerate the means in which HIV and AIDS is mostly commonly transmitted in Nigeria:

- *Sexual means of HIV/AIDS transmission*

  In Nigeria, as in many other regions in sub-Saharan Africa, heterosexual intercourse has remained the HIV epidemic's greatest driving force. HIV and AIDS "may be transmitted through the lining of the vagina, vulva, penis, rectum, or mouth during vaginal, anal or oral sexual intercourse". People who practice '"low-risk" sex cause about two-fifths or 42 percent of HIV infections in Nigeria because this group frequently does not use condoms, so they acquire HIV and also infect their partners. Homosexual intercourse is another means of getting HIV and AIDS, which is why the prevalence rate of HIV and AIDS among men who have sex with men (MSM) has risen significantly, "from 13.5% in 2007 to 17.2% in 2010 and 22.9% in 2014". It is important to note that most MSM also practice heterosexual activity which further exacerbates the chances of transmission.

- *Transmission through blood contact*

  Another major means of HIV and AIDS transmission in Nigeria towards the end of 1990, was blood transfusion. It ranked as a second major route of HIV and AIDS transmission after unsafe sex. The establishment and increase in illegal and profitable blood banks created this problem.

- *Transmission through unsterilised needles and other sharp objects*

  A third noticeable source of HIV and AIDS in Nigeria is injecting drug use (IDU). People who inject drugs (PWID) are seen to be at a serious risk of acquiring and transmitting HIV and AIDS.

- *Mother-to-child transmission (MTCT)*

  Children can get the HIV/AIDS from their mothers. In 2018, 90 percent of all new HIV and AIDS cases in Nigeria were contracted this way. During the period 2010 to 2015, Nigeria had the greatest number of "vertically transmitted"[17] infant HIV and AIDS cases globally, representing 30 percent of the universal tally. MTCT can take place in two ways:

  - *Infection through the placenta* (Dibua, 2011:43)
  - *Transmission through breastfeeding* (ibid)

It can be said that HIV and AIDS is transmitted in diverse ways in Nigeria as shown above. There are other factors that are responsible for the persistence of HIV and AIDS in Nigeria. Some of them will be discussed in the next section.

2.7. FACTORS MILITATING AGAINST HIV/AIDS CONTROL AND TREATMENT IN NIGERIA

The fight against the HIV and AIDS epidemic in Nigeria has met with some significant challenges. Kanki (2004:9) suggests three major challenges confronting Nigeria in its attempt to contain HIV and AIDS. These include:

- *Pervasive poverty*

  The income of Nigeria is below average and so it is tagged a "poor" country. In 2003, the United Nations Development Programme (UNDP) place Nigeria in the 152nd

[17] Vertically transmitted disease is an infection that is caused by a virus or bacteria and uses mother-to-child means of transmission. It is transmitted directly from the mother to the foetus, embryo, or baby in pregnancy or at birth (Ghanotakis et al, 2012:1)

position in the Human Development Index. This means Nigeria is very far behind in development. The citizens live on less than US$1 a day.

- *A populous and youthful country*

  The population of Nigeria has been on the rise in the past years. In August 2020 the Nigerian population stood at 206,660,846,[18] which is 2.64 percent of the global population.

- *Diverse dimensions of the epidemic*

  HIV and AIDS in Nigeria has a multi-dimensional face. The prevalence rate varies across geographical locations, states, and local governments. For the prevalence rate of HIV and AIDS in Nigeria and its spread, see 2.1 in this chapter.

Some people have false beliefs about HIV and AIDS, so the next section looks at some myths about HIV and AIDS.

2.8. TREATMENT AND CARE OF HIV/AIDS IN NIGERIA

The Nigerian government received the report of the first case of HIV and AIDS in 1986 with a sense of shock, denial, and scepticism. But as time went by, the reality dawned that it needed to do something about the pandemic.

The years 1981 to 1987, when ARV drugs had not been developed yet, were considered years of helplessness. Then Zidovudine (AZT) was made available to manage HIV and AIDS. It was the only drug available from 1987 to 1993, known as mono-therapy. Zidovudine actually helped people living with HIV and AIDS. It was shelved when it became possible to combine two medicines in therapy –dual-therapy (from 1994 to 1996). Even with this therapy, the potency was minimal. Many people in Nigeria who were infected, had to obtain drugs at exorbitant cost from the United States or Europe (Odoh et al, 2018:16).

The management of HIV and AIDS in Nigeria became easier in 1997, by which time many drugs were available and a combination of three drugs was possible. With active ART (HAART)[19] and other drugs like protease inhibitors, a relatively high level of effective care of PLWHA was achieved in Nigeria, but it was very expensive. President Olusegun Obasanjo became president of Nigeria in 1999 and increased the HIV and AIDS treatment fund from US$100,000 to US$20 million. He further launched the HIV and AIDS treatment programme

[18] Source: worldometers.info/world.population/Nigeria-population/.
[19] HAART stands for Highly Active Antiretroviral Therapy.

in Nigeria with the government of Nigeria providing free treatment for 10 000 adults and 5 000 children at the cost of 500 million naira. Nigeria became the first country in Africa to purchase drugs on such a large scale (Odekunle et al, 2016:1).

2.9. EXAMPLES OF HIV STIGMATISATION AGAINST WOMEN IN NIGERIA

The word "stigma" is not a recent innovation. The aetiology of the word goes back to the ancient Greeks, who used the term to describe who were considered to possess negative traits. It was also used for slaves (Abduxamitovich, 2021:26). The root word for the English word stigma comes from the Greek *stigmatos*, which connotes a spot or distinguishing mark created by a sharp instrument. The mark made a discriminating feature on the individual (Burke & Burke, 2006:2). Since then, stigma has also evolved into the word "designation" which makes a person different from others through connecting the designated person with negative traits (Chavez, 2006:1). But with time, stigma as a word evolved, taking on a figurative dimension. So, when the word stigma is attached to anything, it means disgrace or shame (Skoda, 2016:60). This is the meaning used in this work.

Many women have suffered stigmatisation by their spouses or partners because of their HIV and AIDS status. Studies in epidemiology of HIV in Nigeria revealed that "women suffer a higher degree of stigmatisation than men" (Odimegwu, 2012:24).

These stories will suffice to portray the reality of HIV stigmatisation against women in Nigeria:

- A young woman related that she had to resign her job because of HIV stigma. She was a member of the medical personnel at a private health clinic and she had to go and hide somewhere due to the shame. Her family rejected her and her two children. She was abandoned for three years by the father of the children (Kanki, 2006:217). A former commercial sex worker in Nigeria recounts her story of stigmatisation by men and owners of the hotels thus: *"*I know when they told me my HIV test result, I was asked to leave the hotel and go outside Abuja. They knew my status and treated me badly. But God has been with me and given me a new place and life. I am alone with my baby and my God*"* (Munoz et al, 2010:57). Another FSW[20] said: "Many times when policemen come here to raid, they force sex (rape) on us. When they force sex on us, they do not use condom. They bring AIDS to us and claim we are the ones that gave it to them and deserve to be maltreated*"* (Munoz et al, 2010:57). A 21-year-old

[20] Female Sex Worker.

stigmatised woman told of her ordeal: *"*As a lady born with HIV, I have faced stigmatisation many times which made me feel people living with HIV are never humans. The worst of them all was when a laboratory scientist revealed my status to my friend and the entire community got to know about it. It was a depressing period for me, and the only thing that kept me going was my courage*."* (*Premium Times Magazine*, May 25, 2019:26).[21] A teenage girl narrated her stigma experience as follows: *"*At age 10, I saw a medical doctor at the University College Hospital, Ibadan writing HIV positive and viral load on a form. As I was going out, I asked my mum. Do I have HIV? And her response was, yes; you have HIV. She said it carelessly, in a stigmatised manner, and that was how I knew about my status*."* (*Premium Times Magazine*, May 25, 2019:26).

- Another young girl who experienced HIV and AIDS stigmatisation, said: *"*Once people know you are positive to the virus; the stigma comes in consciously or unconsciously. Stigmatisation is nothing new to people living with HIV. If you do not experience it from family members, you will get it from health workers or the society. I was called a walking ghost*."* (*Premium Times Magazine*, May 25, 2019:26).
- A commercial sex worker in one of the hotels in Kubwa, a suburb in Abuja, lamented that, "The reaction of some nurses in the hospital suggests that people living with HIV and AIDS (especially sex workers) are sinners. Once they know you are a commercial sex worker, they stigmatise, gossip among themselves and you will know from the way they look at you*."* (*Premium Times Magazine*, May 25, 2019:26). A 28-year-old woman living with the virus was reportedly denied a job in a bank due to her HIV status: "Out of the many people who came for the interview, I made it through to the final stage. We were later asked to come for medical assessment, and that was the last I heard of them. I later found out that I was HIV positive*."* (*Premium Times Magazine*, May 25, 2019:26). In Abuja some patients were recently denied treatment because of their HIV status. One Ogocha (other credentials withheld) revealed that: "We lost someone about four weeks ago in Wuse General Hospital because of the person's HIV status; it was becoming difficult for the person to be given the appropriate treatment. The case became complicated, and she died*."* Ogocha continued, "We also had a case of a couple preparing for their wedding in two weeks' time only for the woman to discover she was

[21] For more information, visit premiumtimesng.com/health/health-features/331616-hiv-stigma-is-affecting-hiv-treatment-in-nigeria.html.

> HIV positive. And the man refused to go ahead with the wedding, thereby pushing the woman into depression*."* (*Premium Times Magazine*, May 25, 2019:26).

Men are mostly in the forefront of HIV and AIDS stigmatisation against women. Research by Mbonu (2010:4-7) revealed some cases that attested to the fact that men stigmatise HIV positive women in Nigeria:

- A female, married nurse observed that, "Here in the hospital you hardly find any wives who abandon their husbands. Look, here in the male wards, you see their wives by the bedside, but when you go to the female ward, it changes. You hardly see their husbands. They abandoned their wives because of their (wives') HIV status*."*
- A female married legal practitioner lamented that, *"*If a man has HIV, nobody may hear about it because the wife will keep it secret. She will find a way of managing the situation, but if it is a woman that has it, the first thing the man will do will be to drive the woman away from the house*."*
- A male, single medical doctor said, "The sex of the HIV person matters. I have a woman who is HIV positive and the man HIV negative, it is hell for the woman. As we were trying to console the woman, we looked around for the man; he was long gone. I was shocked that he could not show a little sympathy*."*
- "A woman contracted HIV and AIDS and men stigmatised her. In Nigeria, some people do not believe a man can carry HIV and AIDS; they say it is only women," said a female, single, company worker.
- According to a female married medical doctor, "…we wanted to discharge a HIV positive woman, but she said we should call her husband and tell him everything about her HIV status. In her mind she knew she has been faithful to her husband and she has no history of blood transfusion, so if she has that kind of disease, the husband must have given it to her. But the husband, instead, showed no sign of remorse."
- A female widow, a petty trader, who is HIV positive, lamented that, "my husband's family do not even come close to us (me and my children). I am staying alone with my children; I am not happy that they behaved this way. I am suffering with the children."
- "If a married couple is HIV-positive, the man is kept aside from blame. It is only the woman that will be blamed," said a female married nurse.
- According to a male married medical doctor, "The woman is different due to societal pressure. If a man has HIV, people do not question him so much, so they can hide it

> because nobody pressures them to say anything, but when a woman gets HIV, the first thing people or a health care professional will say is, 'You should tell your husband or relatives'."

HIV positive workers in Nigeria also suffer some form of stigmatisation. In 2012 45 percent of PLWHA in Nigeria lost their jobs because of their status, while 27 percent who qualified, were denied opportunity for employment.[22] Women living with HIV and AIDS in Nigeria are also stigmatised by naming. They are called *Karuwa*[23] because many believe that the disease is commonly contracted through an immoral lifestyle. And men are the ones giving the names.[24] Women in Kano State revealed that the high frequency of divorce in the Muslim community is because women are HIV positive. Men divorce their wives arbitrarily, but if it is the man who is HIV positive, the woman is forbidden from divorcing him.[25] Okwon (2010:221) agrees that in Nigeria the frequency of divorce is on the rise. Men are not ready to stay with a HIV and AIDS partner; after all, the culture allows men to marry as many wives as they choose. If a husband does stay with his HIV positive wife, she is isolated with her children and he will have nothing to do with her. Rankin et al (2005:2) agree that women are stigmatised if they are HIV and AIDS positive. But if it is the husband who is infected, religious, social, and cultural norms interplay to allow him to have sex with his wife without protection. And these restrictions are put in place and managed by "male dominated religious organisations". Women experience stigmatisation when they are referred to as "the victims of HIV transmission". Numerous husbands have humiliated and abandoned their wives to suffering because of their HIV and AIDS status regardless of the fact that some of these women were infected by their husbands. Men regard themselves as winners in this practice, because public, religious, and cultural structures within assist them "to sustain the entire unjust system" (Abel, 2007:104).

With the emergence of COVID-19, HIV and AIDS treatment and care has been disrupted.

2.10. CORONA-VIRUS (COVID-19) AND ITS IMPACT ON HIV AND AIDS

The world is currently engulfed in a pandemic called COVID-19. This virus was initially known to be restricted to the species of animals but has now spread to human beings with unprecedented fatalities. Taking into cognisance the scope of this problem and the fact that the

[22] avert .org/professionals/hiv-social-issues/stigma-discrimination [accessed 21/08/2020]. nebi.nlm.nih.gov/pmc /article/nmc 3740595.
[23] This means prostitute (ibid).
[24] nebi.nlm.nih.gov/pmc/article/nmc 3740595.
[25] Ibid.

recently identified delta variant seems even more dangerous, it has garnered overwhelming attention. Human energy, scientific experiments, cognitive intelligence, and financial resources are now being used to mitigate the instant economic and health consequences of COVID-19. Political, religious, and traditional leaders, scientists, and health caregivers are working around the clock to respond appropriately to this new challenge. Of course, less attention, resources, and care is now available for other illnesses, especially HIV and AIDS (Valdiserri & Holtgrave, 2020:1980). This means another resurgence of HIV and AIDS may be on the way (Nachega,[26] 2020:2).

On 4 April 2020, the Global Fund released information, permitting beneficiary countries to utilise HIV, malaria and TB funds to engage or fight the COVID-19 pandemic. This will affect the response to HIV and AIDS. The disruption of services for PLWHA for six months will have serious consequences for the HIV and AIDS response. Studies in 13 countries, including Nigeria, show that after three months of disrupting the supply of ART to each individual with HIV and AIDS due to COVID-19, there was a rise in the mortality rate. The mortality rate may range from 35 to 131 percent in 2021 if the trend continues (Cairns, 2020:1-4).

2.10.1. The impact of COVID-19 on women and HIV

The lockdown regulations and restrictions imposed on nations in order to contain COVID-19 will have a great impact on women. It will provide an environment conducive to the transmission of HIV and AIDS. The compulsory staying at home creates opportunity for sexual assault such as rape which places women and girl-children at a higher risk of HIV infection. Small (2020:5) observes that, "HIV disproportionately impacts women and is often concentrated in socially marginalised and disenfranchised communities". Sexual abuse and violence in the home or domestic violence increase the HIV risk for women "since violence is already known to be an independent risk factor for HIV infection". It has been observed by Joska (2020:2) that intimate partner violence, especially rape, increased within the first week of the lockdown in many countries.

2.11. CONCLUSION

This chapter examined HIV and AIDS and stigmatisation in Nigeria. It confirmed that HIV stigmatisation exists in Nigeria. It showed that HIV positive women are stigmatised, and men are the perpetrators of such stigmatisation. The chapter further explained the origin,

[26] Nachega is Associate Professor of epidemiology, infectious diseases and microbiology at the University of Pittsburg and Extraordinary Professor of medicine at Stellenbosch University.

transmission, and the prevalence of HIV and AIDS in Nigeria. It was noted that HIV and AIDS is still a health challenge in Nigeria. Despite efforts by governments, the menace still exists in many quarters. Some of the challenges hindering the control of the epidemic were also discussed, such as poverty and false beliefs about HIV and AIDS. It was shown that the government of Nigeria has tried to control and gather information on HIV and AIDS. In 2019 the government carried out the largest survey ever in population and sectional diversity (Adeyinka, 2019:348). The chapter also discussed the possible impact of COVID-19 on the funding and treatment or care of HIV and AIDS in Nigeria.

A great challenge hampering the combating of HIV and AIDS, which also discourages voluntary counselling and testing, is stigmatisation. The next chapter will unravel the theory of stigmatisation.

CHAPTER THREE

THE CONCEPT OF STIGMATISATION

3.1. INTRODUCTION

The preceding chapter provided insight into the extent and nature of HIV and AIDS in Nigeria. It highlighted the devastating effects of HIV and AIDS on many sectors in Nigeria. It also discovered that one of the major challenges of the HIV and AIDS predicament is stigmatisation. The focus of this chapter is to examine the concept of stigmatisation and why people stigmatise others. The chapter will engage the interpretive task to discuss the theoretical concept of stigmatisation and to determine why people stigmatise others. The point of departure for this research is that any inclination or activity that suggests inferiority, debasement, violation, or abuse of women, or which pushes them to a lifestyle that undermines their dignity, is considered as stigmatisation.

3.2. DEFINITION OF STIGMA

The word "stigma" emanated from the Greek word designating a brand, commonly impressed upon people by means of a hot iron, to indicate that they were committed to the work of the temple (Mason-Whitehead, 2008:98). Later it was used in the secular sense to designate the marking of a person as a criminal or a slave and to expose something bad or unusual about the moral status of the individual bearing the mark (Goffman, 1963:34). Presently, the term is loosely used to refer more to the shame of having unacceptable attributes than to physical bodily evidence thereof (Goffman, 1963:34). According to Chalcraft (2020:201), stigma refers to a distinguishing social mark which points out individuals or groups for disgrace, rejection, and humiliation. Stigma has been defined by Dube (2004:125) as a condition which causes a person to be humiliated, shunned, or discriminated against, for perceived ethnic, gender, economic, health, physical, social, or religious impropriety. The "condition" is seen as a threat to society in some way; this threat can manifest in diverse forms. The descriptive task in Chapter Two confirmed that HIV and AIDS stigmatisation exists in Nigeria.

Stigmatisation is seen as a set of social procedures of which the significant feature is identifying something different in the person (Smith, 2002:8). Every society has rules regarding behaviour. Any breaking of such laws during interactions by individuals which resulted in an atmosphere, can be considered as stigma (Dodor, 2008:1049). When individuals or groups perceive others as possessing socially irritable or unacceptable attributes, they attribute negative qualities to

the individual, which results in serious devaluation of that person. Hence, the word stigma refers to moral judgment of a person which usually results in total devaluation of the individual. The devaluation is often based on observation and conclusion that the individual has devalued social attributes, like being a member of a devalued tribal or racial group. The social environment, not nature, defines the attributes that are considered as stigmatising and the context in which the devaluation of the person happens (Dodor, 2008:1049)

The attribute considered as a mark of shame and the extent of the disgrace vary historically and continuously between cultures (Mason-Whitehead, 2008:98). This happens because stigma, being a socially constructed idea, changes with society, and attributes seen as stigmatising now, may be normal in the future (Dodor, 2008:1050). Thus, attributes considered as stigmatising differ from one society to another and it all depends on what a culture defines as normal at a particular point in time.

3.3. CONCEPTUALISATIONS OF STIGMA

Ervin Goffman (1963) is widely known for providing a significant exposition that conceptualises stigmatisation as the total devaluation of a person or group that possesses a deviant characteristic. According to this perspective, every society has a method of establishing ways of categorising persons using characteristics that are generally acceptable for members to possess. The characteristics which the society expects of the individual, is the "virtual social identity". During interaction with the society, if the person is discovered to possess the "actual social identity" instead of the virtual social identity, they differ from societal expectations, usually in a way that is devalued. The individual is "hence reduced in our minds from a total and normal person to something discounted and tainted" (Goffman, 1963:12). The person's social identity is damaged, and they are considered not capable of meeting the role requirement of social interactions. Hence, the discrepancy between attributes or characteristics that the society expects ordinary members to possess, and what they actually exhibit, is stigma (Goffman, 1963:12).

Building on Goffman's work, Jones and colleagues utilised the term "mark" to refer to a variety of situations considered deviant by a community which might set the stigmatisation process in motion. According to them, stigmatisation occurs when a sign (deviation from a norm) possessed by an individual links them to "dispositions that discredit the bearer". Such a mark of deviance sets in motion an attributional process by which people interpret activities of the persons and respond to the stigmatised persons on the basis of their stigma to the detriment of

their individuality (Jones et al, 1984:24). Crocker and colleagues also propose that "stigmatised individuals have (or are believed to possess) certain characteristics or attributes that carry a social identity which is devalued in some particular context" (Crocker et al, 1998:505). They point out that, although there is usually an objective behaviour, characteristic, or trait of an individual that makes it possible for them to be stigmatised, the conviction held by the stigmatised persons or others is a major ingredient which leads to stigmatisation. Hence "the dilemma of stigma does not reside in the stigmatising characteristic, or the person who has that attribute, but rather in the unfortunate circumstances of having a characteristic that leads to devaluation in a particular social context" (Crocker et al, 1998:506). They also point out that power plays a fundamental role in the process of stigmatisation and mention that being in a position of power reduces one's vulnerability to being stigmatised. Link and colleagues (Link and Phelan, 2001:367, Link et al, 2004:513) formulated some interrelated components that must converge to produce stigma:

> Society identifying and labelling human diversities or differences, based on dominant societal and cultural beliefs, connect the labelled persons to undesirable attributes; usually to negative stereotypes, placing labelled individuals in separate categories, leading to some level of separation of "us" from "them". Emotional reactions, such as anxiety, anger, pity, fear, and irritation are involved in identification of human diversities, the connecting of those differences to undesirable characteristics, and separation of identified individuals into "us" and "them". Experiencing of discrimination and status loss by the labelled individual that leads to unequal outcomes. This may happen in the form of structural discrimination or personal discrimination, in which institutional policies and practices work against the stigmatised groups, even without purposeful discrimination by individuals. Access to political, economic and social power that allows full implementation of the above-mentioned components.

However, evolutionary scholars do not agree that stigma varies from culture to culture. Such scholars posit that characteristics that are stigmatising, are similar across cultures. Their argument is based on the fact that humans everywhere have the same psychological systems; there is commonality across cultures in which characteristics are stigmatised (Kurzban and Leary, 2001:187; Park et al, 2003:65). They believe that attributes which lead to stigma-based social exclusion are derived from evolved adaptations meant to cause individuals to avoid interactions that may likely impose fitness costs. They reiterate that, considering the potential cost of interacting with persons who are diseased, a population would adapt to identify diseased

individuals and try to avoid contact with them. From this view, stigmatisation is a functional way of avoiding persons who might pose interpersonal danger of some sort, and this is the same in many cultures (Kurzban and Leary, 2001:187; Park et al, 2003:27).

Major and O'Brien (2005:56) contend that, even if the capacity of humans to exclude or stigmatise others is an evolved adaptation mechanism, cultural beliefs are the main factors that influence which attributes are singled out and give the specific context of the stereotypes that are linked to those stigmatised characteristics (Major and O'Brien, 2005:56).

3.4. ORGANISATION OF STIGMAS

Stigmas are commonly organised into meaningful categories which capture the various dimensions in which stigmatising attributes differ from each other. Ervin Goffman (1963:14) groups stigmas into three main categories:

- Abominations of the body, which are physical attributes that convey a devalued social identity, such as disfiguring body conditions and physical handicaps.
- Defamation of the individual character, which is connected to an individual's behaviour or personality and considered as weak-willed, such as unemployment, mental disorders, and dishonesty.
- Tribal stigmas, which are familial, (passed on from generation to generation), and involve membership of a devalued religion, nation, or race.

According to Goffman, if the stigma the individual possesses is known or can be seen instantly, it is known as discredited stigma. However, if the characteristic is neither already known by those present or cannot be seen immediately by them, it is referred to as discreditable stigma (Goffman, 1963:12). Jones and colleagues (Jones et al, 1984:24) go further to identify six dimensions of stigma as follows:

- *Concealability* refers to the extent to which the stigmatising characteristic is visible or hidden from others as well as the extent to which the individual will want to hide it from others.
- *Course of the mark* refers to whether the sign will become more noticeable or steadily deteriorate with time and explores what the anticipated social consequences of the results are. Irreversible conditions tend to produce more negative behaviours than others. For example, a person with serious burn scars may heal with time, while a person with leprosy may experience the condition deteriorating by the day.

- *Disruptiveness* refers to the level to which the stigmatising condition interrupts and interferes with the smooth flow of interpersonal communication within the social interaction network. Some forms of mental illness that affect the capacity of the person to enjoy uninterrupted communication with others are a good example of disruptive stigma.
- *Aesthetics* reflects the manner in which the stigmatised person reacts to the unattractiveness of the stigma – the extent to which the marks and symptoms of the situation make the person upsetting, ugly, and repellent in some way, such as facial deformities.
- *Origin* of the stigmatising sign refers to the root of the circumstances that led to the present condition and how the person is seen to be responsible for the mark. *Peril* relates to the extent to which the present condition is perceived as a threat to the society.

People stigmatise for various reasons. This research will discuss three functions of or reasons for stigma.

3.5. A UNITARY THEORY OF STIGMATISATION

The unitary theory of stigmatisation was formulated by Rahman Haghighat. In view of the reality that different origins of stigmatisation point to individuals' pursuit of personal benefit, unitary theory of stigmatisation believes that self-interest is the fundamental foundation of all stigmatisation. When people no longer pursue self-interest, there will be no stigmatisation. But as long as people pursue self-interest, they must be ready to face the repercussions and consequences of stigmatisation (Haghighat, 2001:208). Haghighat (2001:209) further believes that stigmatisation involves self-seeking and self-sheltering behaviour. It is a defensive and protective tool for the stigmatiser but in many instances a horrific and dehumanising experience for the stigmatised, as the latter may just be a victim of circumstances such as rumour (Haghighat, 2001:207). According to Haghighat (2001:209), the stigmatiser "draws primary benefit" from reducing the level of anxiety in their mind and thereby reinforcing themselves powerfully. The stigmatiser also "draws secondary gain" from stigmatisation through avoiding possible danger, victimisation, and loss, thereby increasing their opportunity for economic survival. Haghighat concludes that all origins of stigmatisation (constitutional, psychological, evolutionary, and economic) make up a paradigm for a better understanding, but they all overlap, intermingle, interrelate, and work together.

3.6. FUNCTIONS/CAUSES OF STIGMA

Stigma is generally denounced by everyone but practiced by all (Stangor, 2000:9). It is a known fact that stigmatisation exists in every society and the attributes are found in every community. It is possible that those who stigmatise may benefit or have reasons why they stigmatise (Crocker et al, 1998:505). Those who stigmatise others are aware of what they are doing and normally base their actions on particular legal, moral, ethical, or social beliefs, which empower them to continue stigmatising with a clear conscience (Stangor, 2000:9).

The next section examines three functions that are relevant to HIV/AIDS stigma.

3.6.1. Promotion of self-enhancement

Crocker and colleagues point out that, as individuals stigmatise others, they tend to believe that they are better than those they stigmatise, and this may enhance and improve their self-esteem (Crocker et al, 1998:505). They argue that in-group members may devalue those who do not belong to their group (out-group) in order to enhance their personal self-worth. The in-group members normally achieve this by establishing a lower group with which they compare themselves, engaging the principles of downward comparison. According to these principles, when persons find themselves in circumstances that threaten their self-esteem, "they tend to compare themselves with a less fortunate other, and this enhances their self-image" (Wills, 1981:90). In doing so, the in-group members see themselves as superior and use it to justify the stigmatisation of the out-group members (Crocker et al, 1998:505).

3.6.2. Promotion of in-group enhancement

According to Crocker and colleagues (1998:505), some people stigmatise in order to enhance the superiority of their group over other groups. Humans have been living in groups for ages since this enables them to gather and share resources for survival. Living in groups promotes the formation of social identity with other in-group members. But when a strong affiliation is developed to the in-group, it can encourage the devaluation of the out-group (Hinshaw, 2006:56). This is done by favourable comparison of the in-group to the out-group in order to affirm the superiority of the in-group and hence the social identity of the in-group members. This method is also used by in-group members to justify stigmatisation of the out-group (Crocker et al, 1998:12).

3.6.3. Terror and anxiety management

Jones and colleagues argue that every society believes in a shared system of meaning by which they perceive, identify, and group the universe around them. This collective knowledge of how

things work, is accepted as the reality and becomes the basis of how the members view and interpret issues. This "symbolic universe", as it is called by Berger and Luckmann (1966), (quoted in Jones et al, 1984:82) translates into the frame of reference upon which the interpretation and meaning of every facet of social life is predicated. They argue that this collective system of meaning protects the in-group from foreign threats and empowers the members of the group to establish a sustainable relationship with their environment. Stigma also functions through gender stereotypes.

3.7. TYPES OF STIGMA

A study carried out by Blessed et al (2013:436) in Imo State in Nigeria suggests a number of forms of stigma:

- *Internalised or self-stigma*

This is a stigma that the infected person experiences from within. It can be in the form of fear of intimidation or adverse reactions from outsiders. It is also known as "negative self-judgement" which culminates with the individual remaining silent and committing suicide. Self-stigma leads to the devaluation of the self and reinforces the attitude of "non-disclosure" (Pantellic, 2015:3). The internalised stigma is the infected person's perception of themselves in relation to the world. Most of them see themselves as dirty, guilty, and useless.

- *Disclosure stigma*

This is a situation whereby the infected person keeps information secret from public consumption. UNAIDS, in 2006, lamented that this kind of stigma "drives HIV out of the public sight" and has an adverse effect on the possibility of people changing their behaviour. It can discourage people from getting tested.

- *Government/community or public stigma*

This is stigma experienced by PLWHA from the public. It includes not allowing PLWHA access to government property, community interaction, and even family relationships. This is the most common stigma that PLWHA experience. Women experience a greater degree of stigmatisation than men because of cultural factors stated earlier.

Stigmatisation is very real in our society and has consequences.

3.8. EFFECTS AND CONSEQUENCES OF STIGMATISATION

Stigmatisation affects the family and society adversely to a great degree. Once a person's status is known, the family and society become afraid and create a "social distance" from the victim. Louw (2008:423) views the practice of stigmatisation as hypocrisy, full of prejudice. It implements self-righteousness which regards HIV and AIDS persons as people who are only "reaping what they sow". Many PLWHA suffer rejection from society at the micro, meso and macro levels and it sometimes leads to marginalisation. HIV positive persons who are confined by relatives, may find it difficult to go out in public or find employment. It may further prevent people from access to health care or assistance. "Stigmatisation has the power to negatively impact the post-incarcerated in reintegration process" which further delays the opportunity for care (Brikley, 2015:167).

Another ultimate effect of stigma on PLWHA is that some of them contemplate suicide, or actually commit suicide, due to rejection by their family (Chikezie et al, 2012:1).

Stigmatisation is fuelled by a number of factors.

3.9. FACTORS EXACERBATING STIGMA

There are various pseudo-beliefs that fuel the practice of HIV/AIDS stigmatisation. Matholeni (2012:35) enumerates some as follows:

- HIV and AIDS is God's punishment for immorality. Those who are infected are regarded as sinners. HIV is confined to certain groups such as homosexuals or those whose behaviour has been tagged as abnormal. HIV is covered in a kind of "mystery" since medical wizardry and knowledge is limited in dealing with it. Despite the development of ART, the virus is spreading. PLWHA are an economic burden on the government, NGOs, and families.

Other factors (Ricther, 2011:11) may include:

- Dichotomy in the means of transmission (particularly in vertical transmission from mother to child) and a sense of defencelessness as portrayed by the media. Sheer ignorance has created an unnecessary phobia regarding the disease. Some still believe that the virus can be transmitted by mosquitoes.

Gender inequality and power relations play a vital role in HIV and AIDS stigmatisation.

3.10. THE UNDERSTANDING OF GENDER IN NIGERIA

Gender is seen as political, economic, cultural, and social attributes and favourable conditions that are linked to being a man or a woman. Socially, the definitions vary from culture to culture and change with time. It "is a socio-cultural expression of particular characteristics" and duties associated with people based on their sex (Falb et al, 2014:1). For this research, gender is used to show differentiation in the roles played by men and women in society.[27]

3.10.1. Gender stereotyping in Nigeria

Nobody has the power to determine or choose his or her gender; it is determined divinely or biologically (according to belief). The categorisation of gender plays an important role in society, particularly in the area of social functions or interactions. In Nigeria, the gender construction is mainly patriarchal, and it revolves around religion, culture, politics, and social activities. Meyers (2014:8) observes that the concept of patriarchy is a foreign idea of the domination of the male that was coined by some 19th century anthropologist. This misguided trend is passed from one generation to the other. According to Ofoha (2013:1), Nigeria is a nation with widespread biases and stereotypes that give a high degree of attention to "the male gender". Once a child is born, the family begins educating it based on gender roles and functions. Male children are seen as assets which are regarded highly by many homes in Nigeria. Because the culture perceives men as future breadwinners in almost every facet of life, they are given priority over women. Women are regarded as inferior due to the cultural belief that someday they will go to their husbands' houses and be under the control of men. Fakunmoju et al (2016:58) lament that gender stereotypes in Nigeria have empowered men to control many sectors in economic and social life, "while women are relegated to the home as their official Office". Resources are spent on men, but women are "beggars". The wife has no right over her husband's money, but her money belongs to the husband. A husband is not supposed to enter the kitchen and cook. He waits for his wife to cook no matter how exhausted she may be because it is her traditional duty to cook for her husband. Okafor et al (2011:6717) concur that men in Nigeria dominate every aspect of women's lives.

Yusuff (2014:271) laments that, with all the worldwide campaigning and awareness raising against gender stereotyping, Nigerian women have been denied access to high positions because of their gender. This applies to politics. Women are the majority of the voters in Nigeria, but since independence in 1960 there has been no woman vice-president or president

[27] Gender,jhpiego.org/analysis toolkit/gender-concepts-and-definition.

of the country. That is why Ikweugbe (2006:23, 33) believes that women are unable to occupy leadership positions because of gender stereotypes. This cultural belief also suggests that women should be seen, but not heard. He therefore refers to gender stereotypes as "cankerworm" that has infiltrated all areas of human endeavour globally. There are many stereotypes. Common among them (Ofoha, 2013:2) are:

- The general acceptance that women are not as strong as men. The general acceptance that women's education is a waste of money. The general acceptance that men are the ones who provide for the family. The general acceptance that if you educate a girl, she will lose her moral principles. The general acceptance that a woman's education, wealth, and beauty will eventually culminate in the kitchen. The general acceptance that girls cannot support their parents in old age like boys.

It is true that females and males cannot be the same biologically, but countless man-made differences and the exaggeration of these differences constitute profound barriers for female development. The long rule by the military in Nigeria contributed significantly to insensitivity to gender roles and policies. Women are key contributors to the development of political, economic, social, and cultural sectors in Nigeria. In spite of the hardships and poverty, women have strived with responsibility to build their homes, communities, and the nation. But despite all these efforts, they are seen as intruders, especially in the media (Oyinade, 2013:93).

The concept of masculinity in Nigeria has a colonised bias. Therefore, the concept of men and masculinity needs to be highlighted.

3.11. THE CONCEPT OF MASCULINITY

The concept of masculinity has long been debated. It is sometimes argued that the function of men in the home or family is closely connected with the characteristics of masculinity (Silva, 1999). Masculinity has been described by Mfecane (2016:3) as "practices associated with being a real man".

3.11.1. Africa and masculinity

Masculinity in Africa can be defined biologically and culturally. Biologically, the basic distinguishing feature of a human male from a female "is the presence of male genitals and accessory male sexual characteristics" (Aronson, 2004: xviii). In African communities, numerous cultural attributes are seen as signs of masculinity.

In Egypt, men are identified by their intelligence and all its ramifications and skills in craftsmanship. Laziness has never been tolerated among the male youth of Egypt.

For the Zulu male of South Africa, masculinity is demonstrated through honesty, bravery, wisdom, and respect, and certainly not sloth. The males go through ceremonies that lead them to manhood known as *Qhumbuza Izindlebe* (piercing of the ears). Militarism was also an expression of their masculinity (Uchedu, 2008:8). And any form of sexual intercourse or penetration before marriage is unmasculine.

Mfecane (2016:1) posits that the meaning of masculinity within the isiXhosa traditional culture is embedded in the "practice of *ulwaluko,* which is the statutory 'rite of passage from boyhood to manhood'". This ritual involves many things, including circumcision of boys 18 years and older. After the circumcision, these youths are secluded in an *ishoma* lodge for a period of three to six weeks. The separation period gives them the opportunity to learn from *ikhankatha,* a trusted guardian.

The male Taureg of Algeria puts on veil as a sign of aloofness and refuses to collect money in the presence of women, demonstrating their maturity as men.

In pre-colonial Nigeria, masculinity was seen as a status that must be earned through initiation rites to manhood. The period of initiation differs from culture to culture, but the main thrust is to prepare them into adulthood. The passage rites are mostly done in the dry season. Among the Buji tribe of Plateau State, the youth were taken to the bush in a secret vicinity for seven weeks under the watch of *aghare* (guardian). During that period, they wore no clothes, only leaves known as *macham,* and were subjected to various kinds of endurance training, including severe whipping by the *dodon jankai* (masquerade) who invaded the camp every morning with a bunch of whips (Andzayil, 2003:205).[28] The youth in Nigeria understand masculinity as connected the "to male gender category". Some of the characteristics of masculinity include firmness, decisiveness, physical strength, being principled, ability for self-control, and bravery (Uchedu, 2007:280).

However, with the coming of colonialism, most of these practices were either changed or stopped. British colonialism came with formal education to the detriment of the informal way that was in practice where children would gather in a determined place and time for absorbing

[28] See also Blench 2008:2.

cultural values (Utoblo, 2017:19), hence the need to decolonise the African understanding of masculinity.

3.11.2. Decolonising masculinity in Africa

Many scholars (Connell, 2014; Ratele, 2017) advocate the need to lean less on Northern scholarship for an African understanding of masculinity. They argue that this dependence deprives scholars and researchers of "locally situated knowledge about boys and men". Mfecane (2020:5) laments how Africans depend on foreign scholarship in defining manhood. He further reveals that within the isiXhosa culture of South Africa, "a man is collectively defined as *umtu owalukileyo* – an initiated person". Therefore, a man in isiXhosa society must be traced through visible marks on his body. Such understanding confronts the belief that bodies are not permanent markers of gender (Bertz, 1987; Kimmel, 1984; Connell, 2012).

3.12. JESUS AND THE WORTH OF WOMEN

The Bible does not only reveal cases of abuse of women; it also portrays instances of acknowledging the dignity of women. The reality is that both men and women are created in the image of God (Gen 1:26-27). Even though some scholars like Theodore[29] do not share this perspective; that debate is not within the scope of this research. The Bible portrays women as partners and not inferior to men (Mal 2:16 GNB). The writer of Proverbs says women are priceless and of great value (Prov 31:10). The woman is an equal recipient of God's Spirit (Joel 2:28). Women and men are the same and equal in the sight of God (Gal 3:28). On the cross of Calvary, suffering excruciating pain for humanity, Jesus delayed his death to talk to and for a woman, his mother (John 19:25-27). By that singular act, Jesus demonstrated that women are too precious to be abandoned and neglected. Jesus, on his way to Galilee, had to divert his journey to Samaria for the soul of a woman (John 4:4). Many Christian writers believe and agree that women are fully human and created in the image of God with the same dignity as men. The early fathers also believed that women are in the image of God. For them, this understanding agrees with the biblical text of Genesis 1:27 (Eissfeldt, 2001:205-249). Oduyoye (2001:69) contends that passages of the Scripture like Genesis 1:26, Psalm 8, and the Christ-event strongly support women's claim of equal importance for all humanity and help in dealing with the problem of diversity in the world. Harrison (2001:205-249) asserts that the *imago Dei* (image of God) is seen in patristic theology as the essence of human dignity and necessary for

[29] Harrison (2001:205-249) says Theodore believes that women are created in the image of God, but the divine image in them is the imitation, not the original.

the process of receiving salvation. To deny its presence in women, would mean that women are not real humans and so cannot be saved, which is a precarious position and conclusion.

Other women who experienced Jesus' tender care, are Mary and her sister, Martha (John 19:25-27); Jesus' mother (John 2:1-12; 19:25-27), and Mary Magdalene (John 11:1-44). The passages clearly unmask Jesus' care and acceptance of women. This inspired the women to be followers of Christ (John 11:27; John 20:18) (Burridge, 2007:337). So, the belief that if women are treated kindly and gently, they will misbehave and disrespect men, is only a myth. As can be seen from these passages, the women responded with love and total commitment to Christ's mission by using their resources to help him (Luke 8:1-3).

The story of Jesus and the Samaritan woman is another instance which reveals how Jesus respected the value of women. He went against cultural and patriarchal norms to engage the woman in a discourse. The woman herself was dumbfounded that a male Jew was speaking with her in public. Jews regarded Samaritan women as "menstrual from the womb".[30] But Jesus did not approach her as dirty or unclean, instead He engaged her in "one of the most significant theological discussions" in the Gospel of John (Okure, 2009:408). All these women responded with faith and commitment to Christ. The Samaritan woman instantly abandoned all she was doing and went to share the Good News of Christ, while the disciples were busy searching for physical food. Mary Magdalene, on the other hand, was commissioned as "apostle to the apostles", being the earliest witness of the resurrection (Bagacz, 2014:34).[31] If the church follows in the footsteps of Jesus, stigmatisation will be reduced.

3.13. VIOLENCE AGAINST WOMEN AS STIGMATISATION

In this research, violence is seen as a method of stigmatisation. Women have suffered at the hands of men in different ways and magnitude. For information on gender-based violence against women, see Appendix XX.

3.13.1. Conceptual framework

There are many ways in which women are stigmatised and battered. The Beijing Declaration gave the definition of violence against women as:

> Any act of gender-based violence that results in or is likely to result in physical, sexual or psychological harm or suffering to women including threats of such acts, coercion

[30] This means that from birth Samaritan women were seen by the Jews as unclean and outcasts.
[31] See also Burridge (2007:337).

> or arbitrary deprivation of liberty whether occurring in public or private life. (Abayomi, 2013:52)

It is no longer uncommon to see men violating women at various levels in different ways. Recently, Nigeria witnessed many cases of violence meted against women. There are many women moving silently with bruises as a result of the brutality of their male counterparts. Women have been subjected to inhuman treatment and subordination. The phrase "this is a man's world" only reveals the pride of men in dealing with women (Nnadi, 2012: 48). According to Abama and Kwaja (2009:23), violence against women "is a consistent damage to the fundamental human rights, health, freedom and well-being of women. It manifests in many places and acquaintances like friends, parents, employees and relatives." Many of the incidences of maltreatment of women in Nigeria are kept silent.

A former woman activist and adviser on war to the Red Cross Committee states that violence against women is about "where the power lies". She maintains that if women are battered in times of peace, they will be mutilated in times of war (Mackinnon, 2017:60). Ijeoma (2006:46) says "violence against women is the consequence of the economic, social, political and cultural inequalities that exist between men and women. It is perpetrated by legal and cultural systems that have historically discriminated against women." It is obvious that each definition is given from the perspective of the person giving it. However, all indicate harsh treatment of women.

The research will now look at some types or forms of violence against women.

3.13.2. Types of violence against women

As already stated above, there are multiple dimensions of violence against women. This section will take a look at some of them more closely.

- ***Sexual harassment***

Women in Nigeria face different types of sexual harassment on a daily basis. These may include incest, indecent assault, and rape (Nnadi, 2012:51). Sexual harassment or assault is a reality in Nigeria with perpetrators changing the methods and patterns. This is a serious traumatic experience that significantly affects both women and young girls disproportionately; it involves the lack of consent of the victim and the employment of force, threat, or deceit by the assailant. The most common feature of sexual assault is penile vaginal penetration or an attempt to penetrate. Other forms of sexual assault may include the forceful touching or fondling of the breasts or genitalia and penetration of the vagina (Ezechi, 2016:2-3). The WHO has revealed

that one in every five women has suffered some form of sexual assault and 35 percent of women globally have gone through the experience of harassment either physically or sexually. In Nigeria, the percentage rate ranges "from 13.8% among female students in Maiduguri[32] to 15% among young females in Ibadan".[33] (Audu, 2009:64) Sexual assault seems to be commonly experienced by females. Rape is a frequent and common form of sexual assault.

- ***Rape***

As stated above, rape is a common form of sexual harassment. Rape is defined by the Oxford Dictionary (2010:493) as "to force somebody to have sex when the person does not want to; Unlawful sexual intercourse or any other sexual penetration of the vagina, anus or mouth of another person with or without force by a sex organ or other body part or foreign object, without the consent of the victim". Rape has also been described as "having carnal knowledge of or sexual intercourse with a woman or a girl without her consent or under duress" (Nnadi, 2012:51). In Nigeria, women are raped without any thought to their age or dignity (ibid). People indulge in rape for many reasons which may include mental impulse, drugs or alcohol, the victim's precipitation, and uncontrolled desires (Suzuki, 2014:1).

The practice of child rape of children under ten years is common. (Ogunwale, 2019:4). Investigating the dimension and scope of rape in Nigeria, Achunike et al (2014:32) lament that:

> There are several cases which are very irritating. Now and then, it is reported that a teacher has raped a student. A religious leader has raped his flock. Robbers have raped a victim. A man has raped a sister-in-law or daughter-in-law. A master has raped a housemaid. A security man has raped his master's wife. A boss has raped his staff. A father has raped his daughter. A young man has raped a grandmother. A traditional ruler has raped a subject. A minor has raped a fellow minor. An 80-year-old man has raped an 8-year-old girl.

This assertion indicates clearly that rape is really pervasive in Nigeria. Among the victims of rape, it has been discovered that a significant number are adolescents living with HIV and AIDS (ALHIV). That means their perpetrators or assailants are in danger of contracting the disease. There is clear proof of the presence of rape in Nigeria with its lasting effects.

[32] The capital of Borno State in Nigeria.
[33] The capital of Oyo State in Nigeria.

Sometimes women's bodies are mutilated.

- ***Mutilation of women's reproductive organs***

The practice of female genital mutilation (FGM), which is practiced in some parts of the world, reveals another dimension of violence against women. By 2020 more than 200 million women and girls had undergone this traumatic and inhumane experience. An estimate of 2 million cases are reported each year.[34] Female genital mutilation, also called female circumcision, can be performed in different ways. The WHO in 2020[35] noted different types of FGM:

- Type 1**,** which is also called clitoridectomy, is the partial of total removal of the clitoral glans, the most sensitive genital area of the female. Type 2**,** known as excision, is where both the clitoral glans and the interior part of the vulva (*labia minora*) are removed without necessarily tampering with the vulva outer skin. Type 3, sometimes referred to as infibulation, is done by creating covering or sealing in order to narrow the vaginal space or opening. This is done by cutting and trying to reposition the *labia majora* or *labia minora*. Type 4 involves all injurious practices on the genitals of the female which are not done for any medical reason.

Female genital mutilation is still being practiced in some parts of Nigeria. In 2018, the prevalence rate of FGM in Nigeria was 10 percent of the total global phenomenon, which means over 20 million girls and women have been circumcised. A recent report shows that the rate of FGM in Nigeria differs from state to state.[36] The South-West and South-East geographical zones have the highest occurrence. According to Okeke (2012:70), all the four types of FGM are practiced in Nigeria, with types 1, 2 and 3 frequently performed. A traditional form called *gishiri*[37] is practiced in the Northern part of the country. Unsterilized equipment is often used for the exercise, creating an enabling environment for the transmission of HIV and AIDS (Berg, 2014:7).

Violence against women is also practiced in the home.

- ***Domestic violence***

[34] Who.int/news.room/fact-sheets/detail/female-genital-mutilation.
[35] Ibid.
[36] Assets-publishing.service.gov-uk/government/ uploads/system/uploads/attachment -_data/file 825243/Nigeria-_FGM-_cpin-_v2.0_August.
[37] This literally means cutting during labour.

Domestic violence is any aggressive attack, injury, or suffering inflicted by a spouse or partner in the home. Ishola (2016:4) defines domestic violence as when a person is abused at home in such a way that injury is inflicted or distress experienced. It means the maltreatment of one member of a family by another, trampling on the person's human rights. These practices may manifest as rape, child abuse, partner battering, or any other damaging practices. This practice is a global phenomenon and manifests via diverse routes.

- ***Wife beating and maltreatment***

Domestic violence manifests in many forms. In Nigeria, most women have suffered at the hands of their husbands. Men sometimes suffer at the hands of their wives, but that is not the focus of this research. In 2015, Amnesty International presented a report on the incidences of wife beating and maltreatment in Nigeria. Their report indicates that every day "women are beaten and ill-treated" for various reasons that are not substantiated. Others are left with burns and faces disfigured from acid attacks. It is unfortunate that most of these acts of violence are perpetrated by fathers, partners, and husbands (Abayomi, 2013:55). Sunmola et al (2020:1) observe that wife beating is a current menace in Nigeria. Some of the men even justify their actions. Even worse, some women also justify wife beating as a result of the indoctrination of the patriarchal system. Oyediran (2016:11) reveals that in Nigeria wife beating is prevalent and accepted by both men and some women,[38] even though the percentage of women accepting wife beating is drastically decreasing. This means women are now recognising that the patriarchal system is an instrument of oppression. Abayomi (2013:56) notes that men in Nigeria may beat their wives for various reasons with divergent consequences. Some examples are:

- Mrs Titlayo Akolade, a banker, was killed by her husband, Mr Akolade Ogunjabi, who stabbed her 76 times. The husband stabbed her in the chest, abdomen, arm, and other body parts. The incident took place on 24 June 2011 in their residence. He could not give any reason for his action.
- On 17November 2013, Musa Yusuf murdered his wife because she refused to allow him to have sex with her. The wife took her husband food on the farm when he started making advances instead of concentrating on his work or eating the food she brought. When the wife resisted because it was a public space, she was killed.

[38] See also Oyediran and Isiugo-Abanile, 2005; Oyedokun, 2007; and Ogunjujigbe et al, 2005.

- A 300-level student of Ënugu State College of Education was a victim of an acid attack by her boyfriend for not allowing him to see their baby. The whole drama ensued when Egbo Nnamani was impregnated by her boyfriend, Suleiman. She was abandoned by Suleiman who claimed he travelled abroad. She struggled with the pregnancy and delivered the baby safely only for Suleiman to surface demanding to see the baby. Egbo refused and Suleiman poured acid on her which damaged and deformed her terribly.

These are just a few of numerous cases of maltreatment of women in Nigeria. To dispel the possibility of bias in the research, it is expedient to put on record that sometimes men are the victims of domestic violence, like in the case of Mrs Yewande Oydiran, who killed her husband on 2 February 2016. However, the number of female victims is much higher than men. Domestic violence has different dimensions (Obarisiagbon, 2019:52).

Domestic violence flourishes within patriarchal structures.

3.14. PATRIARCHY AND VIOLENCE AGAINST WOMEN

Most forms of violence against women exist within patriarchal norms and cultures. Patriarchy is practiced in many societies worldwide. Africa is mainly a patriarchal society.

3.14.1. The idea of patriarchy

Patriarchy is simply the rule of men over women and does not in any way acknowledge that women and men are equal. Patriarchal society traces the lines of ancestry or descent through the man with no regard for the female. So, if a man has no male child, he is considered childless, even if he has responsible female children. And in a situation where the male child arrives late, he is automatically given power over all the older females in the house (Onwutube, 2019:1). Hence, women are treated with less value by males who are young enough to be or are their grandchildren.

Merriam Webster (2010:342) defines patriarchy as "social organisation marked by the supremacy of the father in the clan or family, the legal dependence of wives and children, and the reckoning of descent and inheritance in the male line. It is broadly the control of men of a disproportionately large share of power."[39]

Patriarchy comes from the Greek word *patriarkes* which means literally "father of a race". Patriarchy then means "the rule of the father" (Ademiluka, 2018:1). According to the London

[39] Merriam Webster Dictionary: https://tinvuri.com/.

Feminist Network, patriarchy is a term that describes a culture or society with unequal authority between men and women. It is a practice that systematically oppresses women and puts them in a disadvantaged position. Male brutality against women is a characteristic of patriarchy.

Patriarchy has been described by Johnson (2004:29) as a power system that is gendered. It is a complexity of political, economic, and social relationships used by men to control and dominate females' reproductive and sexual life and also define the status, rights, and privileges of women in society. Rulership, authority, domination, and oppression are all inherent to patriarchy.

3.14.2. Patriarchy in Nigeria

Nigeria has been a patriarchal society since antiquity; patriarchy has been a fundamental feature in traditional Nigerian society. It is a system that gives men authority and dominion over women (Asuyabola, 2005:2). There are various levels at which men exhibit their dominance over women in Nigeria. This research will examine a few of them.

- ***Education***

Education is known to be a powerful instrument of poverty alleviation in any society. It leads to profound transformation in various areas of life. But in Nigeria, education opportunities for men and women are unequal. Some families see no reason to send girl-children to school but expend most of their resources on training male-children (Olarewaju, 2019:69). Based on the United Nations' report on human development, Nigeria has an existing gap in providing equal educational opportunity for boys and girls. With insufficient educational structures, educational accessibility is constrained for many citizens, especially women and girls. And this disparity can be traced back to the "colonial system of education" which primarily focused on providing "manpower" for the colonial administration, exempting women from educational opportunities (Mathew, 2020:5). In Nigeria, women are hit harder by economic challenges and poverty than their male counterparts due to the dismal emphasis given to the education of women and girl-children (Afolayan, 2019:63). Even the lopsided enrolment in institutions of learning is patriarchal in nature. The system operates in such a way that it favours male children. In 2005, education enrolment stood at 51.4 percent female and 74.4 percent male. This practice continues despite the commitment of government to equal opportunity to all as enshrined in Section 8 of the 1999 Constitution of the Federal Republic of Nigeria (Makama, 2013:120). Bauchi, Katsina, and Sokoto States recently had the lowest female enrolment with of 39 percent, 27 percent, and 15 percent respectively (Akinbi, 2015:14).

- ***Politics***

The 1999 amended Nigerian Constitution gives all citizens 18 years and above opportunity to vote and be voted for. Both women and men are free to join political parties of their choice. However, in praxis, this is far from reality. Men ask, "How can a woman rule over men?" Women are discriminated against because of their gender. Few women managed to attain positions in the 1999 and 2011 elections. Men used patriarchal systems existing in households and communities to manipulate and withhold women from power. As mentioned earlier, there are more women than men in Nigeria, but no woman has been either a vice-president or president of Nigeria from independence up to date.

Table 2 – Women elected in political positions in 2003, 2007, and 2011 polls.

POSITION	**NO OF SEATS AVAILABLE**	**NO OF FEMALES ELECTED IN 2003**	**NO OF FEMALES ELECTED IN 2007**	**NO OF FEMALES ELECTED IN 2011**
Presidency	1	0	0	0
Senate	109	3 (2.27%)	9 (8.26%)	8 (7.34%)
House of Representatives	360	21 (5.83%)	25 (6.94%)	12 (3.33%)
Governorship	36	0	0	0

Source: Gender Audit and IPU – PARLINE – 2012

In Benue State, the first and ever woman Speaker of any House of Assembly, Mrs Margaret I. Chan, was practically humiliated out of office by the majority male members. Women have been clamouring for 35 percent opportunities through an organisation called Affirmative Action for Women in Nigeria, but that has remained a mirage, a journey in futility. Patriarchy is one of the strongest factors militating against Nigerian women's full participation in politics (Makama, 2013:124).

- ***Economy***

In the Nigerian economy, women mostly participate in the informal sectors like "petty" commercial trading. Taking the population of Nigeria into consideration, women should supply up to 50 percent of the labour force. But in reality, they are only 31 percent of it. Women who work in the Federal Civil Service are given low positions (Mathew, 2019:5). Studies have also revealed that in the agricultural sector, men dominate because of the disparity in land acquisition. As stated earlier in this research, cultural practices prevent women from inheriting land. So, their male counterparts already have an advantage. Men as heads of households have access to agricultural information and training, but women only manage the little bits of land they receive to farm. Some of the women buy the land themselves (Odozi, 2012:6).[40] In terms of employment, some organisations only employ young girls as long as they agree to trade their bodies to gain customers for the company or organisation (Makama, 2013:122). Men demonstrate their dominance over women in many other spheres of life.

It is unfortunate that some religious institutions support patriarchy.

3.14.3. Patriarchy and religion

3.14.3.1 Christianity and patriarchy

In some parts of Nigeria, religion is seen as an institution that helps to perpetrate and reinforce patriarchy. Attoh (2017:159) says gender roles are part and parcel of the process of socialisation and religion uses patriarchy to support and undergird the system. The Catholic Church's doctrinal stand is still orthodox. It does not permit females to partake in some functions in the church. Though there are female priests known as "Reverend Sisters", none perform the sacraments. However, Pentecostalism[41] has allowed a handful of its female members to occupy priestly offices even though their number is comparatively low compared to that of men. Religion is regarded by most feminists as a patriarchal institution which propels the practice of inequality. Religious tenets work as patriarchal principles which permit the subordination of females.

Oduyoye (2001:80) highlights the patriarchal attitude of the church in poetic form thus:

[40] See also Otitugu and Arene, 2010; Fasorati, 2006 and Liverpool-Tasie et al, 2011.
[41] Pentecostalism refers simply to various church denominations which believe in the power and work of the Holy Spirit (Kay, 2011:3)

I am not giving up!
To Church I must go.
First worship day, I walk in with great hope.
But from the pulpit I hear from the preacher, 'Thus says the Bible "wives submit to your husbands in all things"'.
No woman is allowed to speak in Church.
Their husbands have all the answers to their questions.

Oduyoye (2001:81) then states that study on the teaching and attitude of churches concerning women reveals that the church is not what "it claims to be". The World Council of Churches (WCC) has conducted research and found that women worldwide experience the church negatively. There is no place in the church where men and women treated equally.

The church has been in Africa for a long time, and engages in preaching the total liberation of humanity, irrespective of race, social status, and sex. Yet, the women of Africa, with their excellent ideas that could better the continent, have been "locked up in a safe compartment" (Coquery, 2018:3). Again, Oduyoye (2001:82) opines that hypocrisy reigns in the church and it is men who need to change their ways. Often, women's power is denied, and their experiences rejected. Very often women work in the church and men take the credit for the outcome. The church is encultured and, regrettably, part of the oppressive patriarchal culture.

A respondent in Attoh (2017:168) agrees that patriarchy lives in the church. It is a culture that has existed since the time of Jews. The Jewish culture is patriarchal; the fathers are called patriarchs. Jesus tried to bring equality between men and women, but up till now that has not been achieved in the church. So, a time when everyone will be equally treated, exists only in heaven.

In Nigeria, the Lutheran and Anglican Communions still believe that equality of men and women is not biblical. Therefore, they exclude women from leadership positions, which encourages the structure of patriarchy (Attoh, 2017:289).

Essien (2012:168) contends that the containment of HIV and AIDS is not possible in patriarchal systems that expose women and girl-children to the disease almost on a daily basis. Hendricks et al (2012:34), in research done in Africa on "HIV and AIDS curricula and gender realities", are convinced that dealing with the epidemic of HIV and AIDS will not be possible without

first addressing the pandemic of "cultural bias" which currently exists within another evil known as the patriarchal system.

The statement of the late Pope John Paul II might have encouraged the church, especially the Catholic Church, when he said, "Jesus freely chose and established the apostles as priests, hence Jesus' exclusion of women from the twelve determined their unsuitability for priesthood" (Essien, 2012:288). And most of the perpetrators of violence through patriarchy allude to the Bible.

There are cases of violence against women in the Bible. And since this research is looking at violence against women, I have chosen to interact with the Bible texts from a feminist hermeneutical perspective. This perspective focuses on the interest of women and their well-being (Messings, 2017:235).

The abuse of women is not a secular or a recent phenomenon. There are instances in the Bible that reveal cases of assault on women. But the research will only consider two of them, one in the Old Testament and one in the New Testament. In Judges 19:1-30, the story of a Levite and his concubine is told. West (2018:2) says this story has no happy ending and describes it as "unspeakable tragedy "and "a text of terror".[42] When the mob came demanding to sleep with the Levite, the landlord, in an attempt to prevent homosexual practice, which he termed "awful" (19:24), offered to give his virgin daughter and the concubine for the men to "Do with them whatever you want" (19:24). The Levite intercepted and "pushed" (19:25) his concubine out for the men to abuse. After the husband gave her away to be raped, he arose the next morning "to go on his way" (19:27). Lasine (1984:44) observes that, looking at the situation at hand, at how the concubine suffered, the reality that her husband came out with the intention of going on his way is absurd and bizarre. As if he had a good night's rest while his concubine was being abused and gang raped. He stumbled over her on the ground at the entrance with her hands on the threshold, after struggling to reach the house (19:27) and insensitively said "Up, let's get going" (19:28). Lasine (1984:45) laments that it was the height of absurdity and callousness to ask her to rise up and go as if she was prepared for the journey.[43] According to Lasine

[42] This expression, "text of terror", was framed by Phyllis Trible (1984) in trying to describe passages in the Bible that show violence against women.
[43] Stuart Lasine (1984:44) echoes that the Levite behaves as if nothing happened the previous night, when the fact is that he personally handed her over to a raging mob to save himself maybe also the daughter of his host.

(1984:45), the recklessness of the Levite's statement is fundamental, "he acts as though he were in a hurry to get on the road to beat the morning traffic".

The New Testament records a case of violence against women through the engagement of patriarchy. The story is found in the Gospel of John 7:53-8:11. The naming of the story itself as "the woman caught in adultery", stigmatises her. This piece of literature will be dealt with "on its own terms" without making any reference "to its larger literary context" due to the fact that many scholars do not agree on its inclusion in the Johannine literature, particularly in the Gospel of John (O'Day, 1992:297). Violence against this woman can be inferred from the actions of the scribes. Firstly, it is important to note the venue for the accusation. The Pharisees and Scribes chose the Temple to bring their accusation. They did so intentionally to humiliate the woman, because they knew that in the Temple there were areas where women and proselytes were forbidden. Bringing her in the Temple was a reminder that she was insignificant (O'Sullivan, 2015:2). Secondly, the woman's name is not even mentioned. A name carries the personality and integrity of the person. Not mentioning the woman's name demonstrated that she was a non-person; a woman whose charge became her identity (Gench, 2009:398). They reduced her to a sex object. Their main target was Jesus, but the woman was used as bait. Bait has no value. O'Sullivan (2019:4) describes the action of the Scribes and Pharisees as the "craftiness of the male gender" and further asks, "why did Jesus' tempters not use their male folk as the bait?"

Thirdly, the non-inclusion of the male who committed the adultery is another significant piece of evidence of violence against women. It also shows that the Scribes and Pharisees used different modes of judgement for women, most likely stricter than for men.

The Christian faith is not the only religious institution that encourages patriarchy. The Islamic faith is not blameless in this regard.

3.14.3.2 Islamic faith and patriarchy

The Islamic tenets encourage the system of patriarchy. The Sharia Law[44] places emphasis on the paternalistic interpretation of what women should be and how they should behave and dress. This puts many constraints on the fundamental human rights of women. The noticeable recipients and victims of this "political Sharia" are obviously women (Makama, 2013:127). Bako and Syed (2018:10) suggest that the Islamic practice of secluding women at home while

[44] This is the enforcement of strict Islamic law and regulations.

their male counterparts move freely, is a clear indication of religious support for patriarchy. The Sharia Law defines what roles are acceptable for women to play in society, thereby encouraging marginalisation and limiting women's full participation in the community. Aliyu (2020:50), speaking on the impact of Sharia Law on the rights of women, says that the subordination of the rights of women in communities that practice Sharia Law has negatively impacted on their well-being. Women are usually depicted as attachments or servants who are selfish, heartless, wicked, and morally degenerate. Issues faced by women in Islam may be divided into two major categories: financial and marital.

Bawa (2017:153) is of the opinion that in Nigeria and in Islam specifically, men use religion to justify their dominance and rule over women. Women have no right to education and other social activities. Girl-children can be given in marriage at any time and sometimes to whomever the father wishes. Islam reinforces the patriarchal structure that was already in place by its emphasis on women's submission.

From the above discussion, it is glaringly evident that religion is convolutedly intertwined not only with the socio-economic and political existence of the people, but noticeably with its culture too. Men, therefore, use these structures to stigmatise women.

3.15. WOMEN AND THE CHALLENGE OF HIV/AIDS

Women are confronted with many challenges in the context of HIV and AIDS. A few of these challenges will be discussed below.

3.15.1. The culture of silence

Many women who are infected with HIV and AIDS do not go for medical care or seek help because of the stigma attached to the disease. Fear of condemnation and stigmatisation cages them without any forum to freely communicate or reveal their stress and fears. So, they deliberately remain silent to protect their integrity and dignity (Hinga, 2008:40). Ebeniro (2010:128) observes that the culture of silence among women is prevalent in Nigeria. They do not feel free to speak about the humiliation and violation they experience. Mbadugha (2016:13) agrees that among many crises, is the culture of silence in the presence of HIV and AIDS, where women are afraid of losing respect and relationships in society. There is "a deadly code of silence" amidst a plethora of anxieties and uncertainty. A woman knows that the community will simply dismiss her case as "woman's problem".

3.15.2. Widowhood and stigmatisation

Women generally suffer maltreatment at the hands of men. But a particular group of women, widows, face double tragedy. Losing a husband is an experience of pain accompanied with trauma. However, many societies and cultures compound this trauma with expectations that the widow must fulfil. Hendricks (2012:61) observes that the HIV and AIDS rate has led to an increase in the number of widows and many of them are young, infected, and face challenges. Some harmful cultural practices make the widow's life miserable. The research will turn to some of them.

- ***Disempowering the widow***

Upon the death of her husband, a widow is seen as a figurehead with no authority to make any decision in the family. All decisions are made by the in-laws. Her interests are not taken into consideration. Most of these decisions go against her. A story is told of a couple who were travelling and had an accident, in which the husband died. The wife was rushed to the hospital because she sustained injuries. Her in-laws arranged for the burial of her husband, despite serious pleading from the wife. They buried the husband while the wife was still in hospital (Hendricks, 2012:63).

In this story, culture overruled logic and compassion. Akinbi (2015:68) says that in Nigeria, among the Yoruba, the widow is forced to remain in seclusion for a period of seven days during which she may neither bath nor change her attire. She does not have the right to choose what or when to eat. She is forced to cook in broken pots and eat on broken plates. All documents that have to do with the deceased's property and bank transactions, are confiscated. Even though Christianity is beginning to frown on some of these practices, they continue.

- ***Public humiliation***

Akinbi (2015:70) reports that according to one funeral rite the widow is stripped naked and bathed by women in public to demonstrate the severing of her relationship with her deceased husband. This is shameful. Human dignity is a fundamental right of every living being. This cultural practice infringes on the widow's rights. In Igbo State, the widow will tie only a wrapper over the chest and remain silent till her husband's burial (Durojaye, 2013:183).

- ***Widow cleansing***

In various societies in Nigeria, on the death of her husband, the widow is made to undergo rituals. And many of these rituals are unhealthy and may expose her to HIV and AIDS. To prove her innocence, the widow is expected to drink the water that was used to wash the corpse of her late husband. She must also shave her hair with an unsterilised instrument and remain dirty throughout the mourning period (George, 2012:190). Stigma comes in different forms.

3.16. CONCLUSION

This chapter discussed some of the concepts of stigmatisation and why people stigmatise others. It discovered that stigmatisation devalues the dignity of individuals or groups. It discussed that the role of men in HIV and AIDS stigmatisation against women has different dimensions. Cultural, social, and religious structures are some of the means of violence against women. Domestic violence as one of the instruments of stigmatisation, was investigated. The chapter confirmed that violence against women in Nigeria is embedded within cultural stereotyping. Therefore, the issue of patriarchy was discussed. The chapter examined widowhood and stigmatisation within cultural contexts. It also revealed that most of these patriarchal instruments make women vulnerable to HIV and AIDS. The chapter discussed the fact that the patriarchal system has been practiced since the ancient Jewish society. So, the chapter referred to the Scripture to identify instances of violence against women.

The following chapter investigates the relevance of pastoral care as a therapeutic measure against stigmatisation.

CHAPTER FOUR

THE RELEVANCE OF PASTORAL CARE IN ADDRESSING THE PROBLEM OF STIGMATISATION BY MEN

4.1. INTRODUCTION

The theory of stigmatisation was explored in the previous chapter. The functions and effects of stigmatisation were also discussed. It is clear how men use different ways to stigmatise women. Their role in the HIV/AIDS stigmatisation was seen to be embedded in patriarchal stereotyping, and religious and social constructions. This indicates that women experience diverse risks factors within the HIV and AIDS context. How can men be assisted to take responsibility for their actions and change their attitude of stigmatisation towards women?

This chapter considers the normative task of practical theology proposed by Richard Osmer for research work. Therefore, it employs certain concepts from a theological perspective to interpret specific situations. The normative task responds to the question, what ought to be going on? Consequently, the chapter is devoted to establishing a norm for caring and helping PLWHA and all those who are facing difficult situations in life. Hence, the concept of pastoral care and counselling is explored. Various approaches of bringing spiritual help through pastoral care to PLWHA will be discussed. It also focuses on the importance of hope in the healing process. Different models of pastoral care are discussed which could be engaged to help restore the dignity of PLWHA – especially women who are suffering stigmatisation, assist to transform the attitude of men towards women, and provide unconditional acceptance of women living with HIV and AIDS.

4.2. THE CONCEPT OF PASTORAL CARE AND COUNSELLING

Pastoral care is described by Louw (2008) as part of a healing process that takes care of the whole person, not just the patient. If the church is to stay relevant in meeting human need, pastoral care and counselling is an important instrument to employ. The instruments of pastoral care and counselling are methods of connecting the Gospel (Good News) “into the language of relationships” which permits the pastor to send messages of healing to people who are suffering in despair or isolation (Clinebell, 2014:52). Clinebell (2014:31) continues that pastoral care and counselling is, among other things, the utilisation of men and women, and either using one-on-one or group format, to help bring healing to individuals and/or groups.

Authentic spiritual care or wholeness must happen within the real issues of human existence and not imaginary problems. Louw (2010:180) says any Christian spiritual healing must deal with various conditions that threaten the existence of people:

- ***Anxiety***

  People who are stigmatised, live with the fear of rejection and isolation. Their intimate relationships have become distant and sour. What they need, is intimacy.

- ***Guilt***

  People who are stigmatised because of HIV, have a sense of guilt as they reflect on their past. This is especially true for those who contracted the disease by a reckless, immoral lifestyle. Their self-esteem and identity can be destroyed by guilt. Their fundamental need at this stage, is deliverance and freedom.

- ***Despair and doubt***

  Many stigmatised people feel that their existence is void and meaningless, which robs them of hope. The universe does not make sense at all to them, because the structures which gave them hope, are now the source of despair (e.g., family, church, and society). What they need, is "anticipation in hope".

- ***Vulnerability and helplessness***

  HIV and AIDS stigmatisation leads to many infected people becoming "emotionally sick". They see themselves as victims who are helpless in the midst of various structures of human existence and networks. At this point, they need available, functional, and workable support groups or systems.

- ***Disillusionment, unmet needs, and frustration***

  This is a chain reaction. Because of HIV and AIDS stigmatisation, many infected persons do not have access to basic amenities to meet their needs (like employment, etc.). This results in frustration that is expressed through anger and violence. What they need, is an avenue to fulfil their expectations.

Pastoral therapy aims to heal the whole being. It has a different content which is robust and provides spiritual care in a manner that brings healing and change. It influences how a person lives henceforth. Pastoral care is also psychotherapy. It helps to change negative behaviours. According to Streets (2014:4), psychotherapy involves the engagement of two or more people, where one is the helper or healer, whose goal is to aid the other, to bring about change in behaviour or alter attitudes.

4.2.1. Dimensions of pastoral care

Pastoral care should, therefore, promote wholistic growth in the listed six fundamental dimensions of human existence (Clinebell, 2014:31):

- ***To brighten the mind***

  The capacities of the "normal human mind" that are not used, are large. The work of pastoral care is to develop this enormous but partially utilised personality potential for the purpose of experiencing, creating, thinking, and feeling. Enhancing the level of our consciousness, escalating our insight, allowing our creativity to work, and broadening our intellectual understanding, are some of the areas attended to by the wholeness-centred approach to pastoral care.

- ***To reinvigorate the body***

  The body needs some form of exercise and good nutrition in order to function well. This dimension of pastoral care assists people to enjoy their bodies fully, by overcoming the notion of differentiation or alienation within the body. It, therefore, emphasises constant body exercise and eating good food, and engages ways of reducing stress. People must also be taught to try to not only accept but be fond of their "body-mind-spirit wholeness".

- ***To amend relationships***

  The human personality exists in relationships. Whatever happens to the personality, whether it is formed, deformed, or transformed, is still within some sort of relationship. And the quality of this relationship with others determines the rate of healing and growth. Skills of growth and healing that will help to enrich, renew, and repair the complexities of caring and loving relationships are critical in the work of providing wholistic healing.

- ***To restore our fundamental relationship with the environment***

  Wholistic well-being means living in peace with humans and the environment. Pastoral counselling assists people to build and develop an interest in caring for interaction with nature. This helps to make people mentally, physically, and spiritually whole.

- ***To liberate institutions and societies***

  People are buried in individualism and self-centredness. Pastoral care has almost fallen into the trap of individualism and become privatised, bowing to the pressure of the world. Some of the roots of illness are societal. However, no individuals or families can enjoy sustained wholeness in a broken society that has no respect for justice but takes

pleasure in destroying wholeness through its structures of violence, exploitation, poverty, and injustice. Pastoral care has no option but to widen its reach to accommodate healing, liberation, and sustainable growth within its jurisdiction of praxis. This entails:

- Taking responsibility to identify pervasive social vices that are embedded in societal systems.
- Insisting that pastoral care of groups and society be acknowledged as an essential part of relational wholeness and personal growth work.
- Working to overthrow and unsettle any pastoral care or religion that is privatised.
- Conscientising those receiving spiritual care to be aware of the societal root of their predicament and empowering them with potentials to work with other members of community in order to bring change to those social vices within the community.

- ***Engaging spiritual resources***

  Bringing about spiritual growth is the binding bond of the other five dimensions. To realise and achieve any meaningful wholeness in human existence, a trustful, joy-full, and intimate relationship with God, the "Loving Spirit" is inevitable. Because that is the well-spring of all healing and meaningful life and ultimate growth. Pastors are already equipped with training to accomplish this task.

4.2.2. Characteristics of pastoral care

Pastoral care and counselling has unique features that differentiates it from psychological counselling. Louw (2000:259) points out the differences as:

- ***Source***

  Pastoral counselling emanates from the Holy Spirit, who conveys the faithfulness of God to humanity.

- ***Content***

  The belief in God who loves a sinful world and sent His son, Jesus Christ, to die for the wholistic salvation of man, is the sole content of spiritual or pastoral counselling.

- ***Anthropology***

  Pastoral counselling takes place within a theological framework that all humanity is created in the image of God but lives in a broken world with many challenges.

- ***Attitude***

  Love is the character of pastoral care. It manifests itself in the compassion of the pastoral caregiver or priest and through the practical concern that is given to the counselee.

- ***Objective***

  Pastoral counselling aims to produce mature faith, living hope, and sustained meaning and significance in the counselee.

- ***Context***

  Christian fellowship (*koinonia*) and the general public environment are the essential context of pastoral care and counselling. Here, healing takes place within a common belief system.

- ***Motivation***

  The motivating factor of pastoral care is to make known in practical terms the compassion and unceasing care of God and the perfect sympathy of the Holy Spirit.

Pastoral care is a widely known field of study. It may include the attitude of caring, administrative work done by pastors, or the healing of the sick (Litchfield, 2013:13). However, Louw (200:258) suggests four distinguishing characteristics of pastoral counselling:

- It is not a dialogue but a trialogue. The Spirit and the Word of God converge to become a third factor of transformation in pastoral care.
- It bears a covenantal disposition. The covenant relationship of God with humanity permeates pastoral counselling. The environment is that of care, restoration, healing, and love – *agape*.
- It is primarily a hermeneutic procedure. The Christian faith is interpreted and understood "within human context". All activities of pastoral care are carefully interpreted within the existential occurrences of the human person, thereby helping people in their very specific needs.
- The pastoral caregiver makes decisions based on real and specific life issues – the interplay of the person's faith development, God's images, and growth. Pastoral care evaluates the strength of faith in the human search for meaning.

The characteristics of pastoral care reveal part of its nature. However, there are other dimensions of pastoral care that are relevant in the healing process.

4.2.3. The nature of pastoral care

Pastoral care is very broad with many dimensions. The definite and basic assumption, however, is that pastoral care is a "conversation" that comes from the Word of God and directs people to the Word of God. The partners who are going to converse with each other are already aware that they will employ the Word of God as their canon (Thurneyson, 2010:115). Pastoral care involves services to humanity.

4.2.3.1. Pastoral care as a ministry for service

The concept of ministry indicates roles that groups or individuals play as they render certain services in a church or community. Doehring (2014:185) opines that, within the contours, ministry refers to the spiritual gifts which God gave to humanity (1 Cor 12: 5). Lyon (2014:17) says ministry may also include prison visitation and acts of hospitality as shown in 2 Corinthians 8:19-20 and Philemon 3. Therefore, believers in the church have diverse gifts which they should use for the growth of the body of Christ. This model of pastoral care puts more emphasis on compassion, availability, presence, and taking care of the vulnerable like PLWHA and the weak. The story of the Good Samaritan in the Gospel of Luke 10:25-37 presents a perfect example of this model, where all people are encouraged to partake in the services of hospitality (Pembroke, 2006:32-40).

Speaking on hospitality in Nigeria, Adedipe (2016:196) says hospitality in Nigeria has metamorphosed over the years from government guest houses and hotels to private and religious organisations' humanitarian services. Aihiokai (2017:10) observes that Africa is the best home of hospitality because of its prominence in the Bible. When Abraham and Jacob were confronted with problems in Canaan, they fled to Egypt in Africa (Gen 12:10-20; Gen 46). When Jesus' life was threatened by Herod, his parents were specifically instructed by God to flee to Egypt in Africa (Matt 2:13).

If this ministry of service is sustained by all, it will give hope to the stigmatised and those in need. This ministry of service can be performed through the various ministry activities of the church. Louw (2008:73) and Lartey (2003:36) list five outstanding activities that may be linked to the ministry of pastoral care in the church:

- ***Proclamation*** (*kerygma*)

  This is the faithful communication of the Word of God. God's Word is responsible for the distinct nature and character of pastoral care and should not be replaced by an "empirical or phenomenological approach".

- ***Teaching*** (*didache)*

  This is the impacting of knowledge which shows how God has revealed Himself in the Scripture. It also reveals authentic traditions of faith, their interpretations, and how the body of believers express this faith in their lives.

- ***Service*** *(diakonia)*

  This is the faithful expression of faith by believers in practical ways like moral and financial support to the needy. It may include providing shelter or visiting prisons and/or hospitals, providing medication or food. This further attests to God's comforting, providing, and caring presence (*paraclesis)*.

- ***Fellowship*** (*koinonia)*

  This is the coming together of the redeemed of God to encounter God and strengthen one another. It also carries the meaning of edifying, encouraging, and supporting each other. This may be demonstrated in different forms such as memorial services, funerals, and marriages. It reveals humanity's social quest for connectedness and community (*Ubuntu*).

- ***Worship*** (*eucharist)*

  This is the response by the human soul to the extravagant love and grace of God. It manifests in many areas of human existence like singing praise to the almighty, and bringing offerings and tithes to the Most High God who is the reason and utmost Source of life. In many churches in Nigeria, most of the first part of Sunday service is given to praise and worship, where congregants are allowed to encounter the divine in a transcendent way in songs of praise.

Apart from worship, hospitality, and fellowship, counselling is also seen as pastoral care in Nigeria.

4.2.3.2. Pastoral care as counselling ministry

Counselling is regarded as part of pastoral care by many scholars. Waruta and Kinoti (2000:2) define counselling as "the art and skill of helping individuals and groups to understand themselves better and relate to fellow human beings in a mature and healthy manner". Lartey (2003:81) suggests that counselling is a relationship that is skilfully used with principles to facilitate growth and emotional acceptance that will help an individual to live resourcefully and satisfyingly. In agreement with Lartey, Rasool (2015:15) says counselling is purely a relationship which utilises "one or more psychological theories" and communication skills that

are recognised to facilitate the process of healthy growth with all its ramifications. The duration of the counselling depends on the nature of the problem and confidentiality is essential.

Counselling is an activity that is engaged by way of a relationship between a practitioner and a client with the aim of enabling change or reducing the state of confusion. It does not encourage providing a "particular course of action". It is non-judgemental and does not engage in exploiting the client but is a mutual communication that is rooted in confidence and confidentiality (Harling, 2010:171). It is evident that the aim of counselling is healing and wholeness through communication. Louw (1998:101) notes that this communication, which includes verbal expression, is embedded in using relationship skilfully to elicit feelings, emotions, and behavioural issues which may result in malfunctioning of the body or soul.

In Nigeria, counselling is practiced both in the secular and religious spheres. Because of violence against women in Nigeria, counselling should be carried out in diverse ways and on different levels ranging from homes, schools, and society. The emphasis should be on "truthfulness in relationship", maintaining self-discipline especially by perpetrators of violence, and developing habits of compassion for the suffering "Other" (Oluwafunmilayo, 2019:38). People who are stigmatised need acceptance and truthfulness in relationships. A person in a hurting condition needs a "fellow human being" who encapsulates love with utmost care and understands (Louw 1994:61).

People who are hurting and suffering need someone to speak on their behalf, to be like an advocate.

4.2.3.3. Pastoral care as advocacy and social work

Ministries that are involved in helping people like social work and pastoral care have a rich and long history. However, a balance must be maintained. The pastoral caregiver must not neglect the spiritual aspects, communicating the Good News, in the process of trying to meet the psychological and social needs of the client. The early church was involved in social action. The apostle Paul emphasised that Christians should make sacrifices for others. Jesus clearly demonstrated this kind of sacrifice in His encounter with the Samaritan woman. Through his actions, he revealed that "godly love and servant-like actions should be extended to" believers and non-believers alike. This is pastoral care in social work (Albertini, 2011:6). Pastoral care for the needy and helpless must go beyond the four corners of the church (Isa 58:3-7; Jer 22:13-19). Jesus said whoever feeds the hungry and stands against injustice to the poor, is doing it for Him (Matt 25:40). Therefore, pastoral care must not only concentrate on evangelism of

repentance but include evangelism of filling the stomachs of the hungry and advocating against injustice to the poor. As the Gospel message proceeds from our mouths, our hands and arms need to touch the lives of those suffering (Albertini, 2011:6).

Albertini (2011:18) echoes that "Jesus was concerned not only with saving humanity from hell in the next world, but with delivering it from the hellishness of this one", such as caring for orphans and widows, visiting prisoners, feeding the poor, nursing the sick, and burying the dead. More than mere hospitality, pastoral care must move into social action, changing political, religious, and social structures like patriarchy in order to increase the well-being of the society (Capps, 2012:7). The victims of HIV and AIDS stigmatisation need a voice, and this voice is pastoral care. Notable African women theologians such as Mercy Odudoye, Tola, Pearce, Musa Dube, and their male peers have done outstanding work in the area of advocacy which includes speaking against HIV and AIDS stigmatisation and violence against women (Baab, 2018:16). In Nigeria, women suffer violence as a result of harmful socio-cultural practices. They need strong pastoral care with the spirit of advocacy to speak against these practices (Capps, 2012:7).

People who are stigmatised, can be strong and cope with any challenge if their capacity is developed.

4.2.3.4. Pastoral care as human development

The essence of pastoral care is to help clients grow to maturity in all aspects of life. Faith development in individuals has been attributed to Christian education, the *didache* of pastoral care (Daniel, 2017:270). Faith formation and growth also occur due to church discipline in order to prevent spiritual decline and boost development. Those in leadership must, therefore, be deliberate in engaging practices that will help in faith formation (Smit, 2015:4). Through pastoral care, people are equipped with practical knowledge to be creative, imaginative, and possess the ability to anticipate the future with all its accompanying hurdles (Louw, 2008:76).

In the context of HIV and AIDS stigmatisation in Nigeria, pastoral care has the capacity to empower women who have suffered violence to cope and understand that they can still live meaningful lives.

In order to understand the significance of social work, we must look at the main functions of pastoral care.

4.2.4. Functions of pastoral care

Pastoral care operates from different angles in human life. The goals are formulated based on the peculiar situation being addressed. Unmasking the functions of pastoral care is imperative for this research because it further reveals the role of pastoral care and its necessity and relevance in the healing of HIV and AIDS stigmatised women in Nigeria. Some essential functions of pastoral care, as suggested by Lartey (2003:60-68), are:

- ***Healing*** connotes the restoration of lost health and the need to regain a former state of wellness and identity. It also refers to acquiring new ideas, concepts, or skills of coping.
- ***Sustaining*** is the mental or physical support system that is engaged to help an individual to survive and continue with normal life in a situation that cannot be changed.
- ***Guiding*** refers to a deliberate placement of some particular philosophy of existence or moral framework by an experienced person that will assist the client to make logical decisions.
- ***Reconciling*** brings two or more people together who were apart or enemies. It tries to close the space of unforgiveness that exists between or within them.
- ***Nurturing*** refers to the creation of an enabling environment through purposeful activities that will eventually climax in maturity.
- ***Liberating*** is the act of setting clients free from mental, social, and physical bondage. It also means freeing people from addiction, slavery, or abusive relationships.
- ***Empowering*** concentrates attention on issues that have to do with "abuse of power". Clients are equipped with knowledge and practical skills which will assist them to courageously respond to the challenges of life.

Louw (2008:75-77) adds another function of pastoral care which he calls "interpreting". This is the hermeneutic burden of pastoral care to bring the existential situations of people together and connect them with biblical account. It is also the responsibility of pastoral care to interpret God's images in connection with people's understanding. The goal of pastoral care is to improve physical, mental, and spiritual maturity (ibid).

For pastoral care to function effectively, it must engage the appropriate approach to problem-solving.

4.2.5. Approaches in pastoral care

Every situation demands a specific approach for effectiveness. Some of the approaches are determined by the situation at hand. Magezi (2016:140-142) lists the following:

- ***Mixed approach***

  This refers to a combination of practices from African traditional religion and Christianity. This occurs when leaders who are pastors perform some rituals and exorcisms to deal with the situation. In the process of healing, they use substances like anointing oil and holy water. These exercises are common among African Independent Churches (AICs) and other new generation churches.[45] The pastoral care approach focuses on trying to find the cause of the ailment and the possibility of restoring the client to complete health.

- ***The encouragement approach***

  This is relevant in a situation where people who are facing crisis in life, quietly derail from the faith. They are obedient Christians when everything is going well, but in life-threatening situations, they consult magicians and diviners, besides prayer and Bible meditation. These clients act without verbally expressing their predicament. Afraid of being exposed and the danger of losing their status in church, they normally patronise the diviners at night. In this situation, the approach of the pastoral caregiver is to encourage people to stand firm in the faith, trusting Jesus in all situations.

- ***Faith development approach***

  This approach may be employed to support, encourage, and empower church members who stand firm in their faith and the ability of Christ to heal them, but face ridicule and mockery from their families and the community. Some of them have been abandoned by their relatives since they refused to avail themselves of divination and other fetish practices. Pastoral care may go beyond presence, prayer, or prophecy to practical acts of charity and help.

- ***Human development approach***

  When people make decisions in life regarding their problems, it may not go down well with everyone. The preceding approaches have indicated that families and communities may exert pressure on people who are suffering. Pastoral care in this approach centres attention on forming coping support systems and structures in the family and

[45] New generation churches here means recently established churches.

community. Church and community administrators and leaders can give power and necessary support to those in the community who are firm in the faith but have been isolated and abandoned, to set up alternative support systems that will supply emotional relief.

- ***Group therapy approach***

  People face challenges that are numerous and multifaceted. These challenges affect emotional, physical, and spiritual dimensions in life. The pastoral caregiver establishes family, youth, female, and male groups to examine and explore possible solutions. The main focus of this approach is the existential realities in human life.

- ***Healing and exorcism***

  People attribute sickness and other challenges in life to witches, curses, and evil spirits. This approach involves conducting exorcisms and healing sessions. The pastor prays on items that could be used for protection, like oil, arm bands, water, and cloths. This practice is common among charismatic and Pentecostal churches. Some PLWHA believe that witches and wizards can inflict HIV and AIDS on people.

- ***Persuasive approach***

  Some issues and challenges defy prayers and exorcisms. During times of severe difficulty, many people renounce the Christian faith with all its approaches and turn to traditional African ways. The pastoral caregiver should persuade them to come back to Christ and continue trusting Him for a solution.

All these approaches of pastoral care are meant to restore the dignity of the stigmatised and victims of violence.

4.3. THE CONCEPT OF HUMAN DIGNITY

Human dignity is a broad subject matter with many dimensions. No single definition will suffice. In its simplest terms, human dignity refers to the value of an individual. Kateb (2011: preface) argues that no society has ever or will ever fully understand the dignity of a person, “though some societies come closer than others”. However, “a divine entity can provide the right questions and answers”. In describing dignity, Kateb (2011:18) continues that, “I have life to live; it is my life and no one else’s; it is my own life, let me live it; I exist and no one can take my place; I exist and though I do not owe my existence to fate or other superhuman necessity, I am not nothing.” Louw (2013:2) says dignity means different things to different perspectives. Within the human rights discourse, human dignity is seen as “an in-between issue:

between man as beast and man as an angel" (McCrudden, 2008:656). The anthropocentric worldview considers human dignity as "worth of being human". (Moltmann, 1984: ix). So *dignitas* becomes closely related to *humanitas*. To understand dignity, then, would mean to explore the root meaning of being human (Moltmann, 1984: ix). The judicial sector associates human dignity with equality (Ackermann, 2013:58). Erudite philosophers like Plato, Aristotle, and Kant relate dignity with intelligibility, which resides in the human *nous* (mind). Nevertheless, Louw (2013:7) is of the opinion that the point of departure for understanding human dignity in theology should not focus on the creation narrative, but the "re-creation paradigm" of eschatological thinking. Human dignity is a value promised by God's justifying grace to all human beings. Therefore, eschatology sees human beings from a vantage perspective: "who we already are in Christ". Schulman (2018:6) believes that dignity is solely respect of the individual, and violence in whatever form, breaches that dignity. The essence of a person's personhood is inherent in their dignity. Human dignity is rooted in the fact that we are created as *imago Dei* – in the image of God (Soulen, 2006:326). Louw (2013:9), in describing dignity, says:

- Dignity (*dignitas*) in the social model focuses on role, status, function, and authority. In this paradigm, being free from stigmatisation and discrimination plays a significant role. It is mostly hierarchical.
- Dignity in the aesthetic paradigm centres attention on meaning or *telos* and closeness or intimacy. The fundamental desire of people in this category is unconditional acceptance of who they are, which the soul of the humanum is. Dignity within the aesthetic model is connected into reconciliation, empathy, nurture, care, and forgiveness. To a very large degree, it has healing dimensions.
- Dignity in the ethical model points to justice, equality, and rights relating to the desire for freedom and liberation.
- Dignity in the spiritual category is different. Theologically, dignity "refers to the value of human life as determined by the eschatological aesthetics of a suffering God". Christ's suffering in this regard was so cruel that he cried "My God, My God, why hast thou forsaken me?" (Matt 27:46). It points to unconditional acceptance of a person for who the person is. PLWHA live with fear and anxiety. "Anxiety, the fear for rejection, isolation and existential loneliness, is the most basic threat to human dignity and human health. It is even more devastating than guilt and despair" (Malpas, 2007:24).

When the dignity of people is restored, they move with hope. Hopeless situations become hopeful, and they have zest to cope with most life challenges.

4.4. THE CONCEPT OF HOPE IN PASTORAL CARE

It is important to note that the idea of hope is not an easy one for people who are suffering. It is a complicated factor for those nursing the sick (Reder, 2009:637).

Hope has been defined as "the belief that our goals can be secured through our own actions or alternatively, that chance, luck or some universal influence bigger that ourselves will steer us towards something we desire" (Knight, 2013:389). Smith (2010:4) describes hope as "a movement of appetite aroused by the perception of what is agreeable future, ardours, and possible of attainment". The Oxford English Dictionary defines hope as "expectation of something desired, a feeling of expectation and desire combined" (OED, 2010:239). Presently we live in a world that is filled with animosity, sickness, violence, terrorism, sin, and death. Hope, the bedrock of the Christian existence, is bombarded and confronted by "ideologies and global trends" that would refuse to embrace hope and life (Moltmann, 2019:1). It is traditionally believed by adherents of faiths, especially the Christian faith, that there will be a new heaven and a new earth. Everything else, including sickness and all forms of suffering, will pass away. Christianity from beginning to end is full of hope. It is "forward looking and forward moving" and this changes the way people look at the present (Harvie, 2016:13).

Hope in the Christian faith (theology) can be viewed in two dimensions. The first perspective defines the object of hope – Christ Jesus and the implication of the *parousia;* the second defines the standpoint or position on life from which to expectantly gaze at the future activity of God. The rationale of hope is rooted in the activities that God has done in the past through Christ's birth, ministry, death, and resurrection (Purves, 2010:23). Hence, the Christian focuses expectantly on the eschatology, when the believers in Christ will be raised from death as Christ was raised and enter into an eternal Kingdom full of peace and joy, a Kingdom which Jesus inaugurated. The believer, when in worship, expresses that hope by saying "Thy Kingdom come" and partakes in the sacraments of the holy communion (1 Cor 11:26) with great anticipation of the feast at the marriage supper of the Lamb (Rev:19:1-22). In this life, the believer is already sealed with the Holy Spirit as God's property (Eph 1:13) and within the community of faith, experiences Him as a foretaste of the heavenly Kingdom (2 Cor 1:22). By faith, the believer is already seated with Christ in the heavenly realms (Eph 2:6-7). Though the reality on earth is full of challenges, the believer must hold on to faith in Christ (1 Cor 4:8-13).

For Christ, who communicates through the *ecclesia* (church), did not promise His followers a trouble-free world or complete joy of "fulfilment on earth", but promised to be with them in their predicaments (Mittelstadt, 2004:6). In this world, the Christian has "no lasting city" and so is known as "stranger" (Heb 13:14). The believer's real abode is not by human hands (2 Cor 5:1). The Spirit that raised Jesus from the dead, is the same Spirit dwelling in the believer now.

Thus, the believer's mind should be set on things above, not things below (Col 3:1) and they must walk by faith, fixing all attention on Christ, the Author and Finisher of our faith. This hope empowers the believer with the capacity needed to not only endure trials and suffering but lend a helping hand to those suffering (Louw, 2014:7). The quintessence of salvation in the Christian faith is hope. Hope is the most valuable contribution Christianity offers to the universe. Jesus' resurrection is the driving and sustaining force of believers' hope.

4.4.1. Hope grounded in resurrection

Because of the resurrection, people are no longer assessed from the destructive perspective of death, but from a standpoint of life: affirmation (Louw, 2008:432). The main challenger and last enemy of life, which is death, has been conquered through the resurrection of Christ. So, hope grounded in the resurrection has to do with the demise of death. God, in His sovereignty and omnipotence, has finally annihilated all forms of suffering, isolation, stigmatisation, and rejection. Women who are suffering from HIV and AIDS stigmatisation, domestic violence, and sexual assault will consequently be equipped and empowered to live their lives positively and in a constructive manner, notwithstanding their existential realities. Hope becomes the reason for joy; in spite of crisis and endurance, hope is experienced in the midst of suffering. Hope in the Christian faith is never wishful thinking, it has theological underpinnings. According to Louw (2008:154), it is essential and a matter of necessity for any Christian hope to be grounded on:

- Salvation and Christ's work of mediation which pronounces us righteous;
- The victory of Christ's resurrection over death;
- The eternal significance of our existence in the body in view of the resurrected Christ, the fact that this present body will be translated into a celestial one;
- Eschatology and God's promise of a brand-new future.

The resurrection has real implications for hope, since it is not just a new phenomenon but more than that, a historic reality (Louw, 2008:435). The meaning of existence for the entire creation,

including times and seasons, is interpreted in the light of Christ's resurrection, for example, 70 AD (*anno domini* which means "in the year of the Lord"). The resurrection is, therefore, a victorious event with healing implications. This explains why the great apostle Paul desired to "know Christ and the power of his resurrection" and was willing to partake in Christ's suffering "even unto death" (Phil 3:10). Through the resurrection of Christ, death has been defeated and the believer now looks forward with hope to the day of resurrection from the dead (Rev 3:11). This hope that is rooted in the resurrection can mock death by yelling "Where, O death is your victory? Where, O death is your sting?" (Louw, 2014:1). With this hope in mind, PLWHA and women experiencing various kinds of problems can confidently and victoriously acclaim "O HIV/AIDS stigmatisation, domestic and sexual violence, where is your sting?" For a pastoral care theology, the resurrection emanates a series of implications which can guide pastoral caregivers in the process of helping PLWHA deal with stigmatisation. Christ's resurrection (Louw, 2008:156):

- Assures people of triumph over death and inculcates a clear hope in the midst of the worry that accompanies death – including death as a result of HIV and AIDS complications.
- Reinstates trust as a result of the new way of interpreting life events. Every activity is now viewed through the lens of a relationship with God – enjoying a new experience which permeates every fabric of life and society.
- Qualifies believers to be active participants in the power of the resurrection, providing them with the capacity to exist in the midst of life struggles and challenges. Abiding in constant fellowship and relationship with God allows the Holy Spirit to empower the believer for engagement in meaningful human relationships. Sickness, including HIV and AIDS, becomes a way of living in relationships that cut across self, community, and God, and no longer a threat to existence. This relationship promotes acceptance and human dignity, with a feeling of belonging.

The resurrection hope is not "merely escapism" which tries to dismiss the fact of human suffering or a type of "cheap triumphantalism and variant of *theologia gloriae".* It is a practical reality that affects human existential issues (Louw (2014:1). Louw (2014:1) explicitly suggests that this resurrection hope:

is about the reframing of life by means of a radical paradox: "where O death is your victory? Where O death is your sting?" If pastoral caregiving is indeed about change and hope, the resurrection describes an ontology of hope, by which human beings are transformed into a total new being. Beyond the discriminating and stigmatising categories of many social and cultural discourses on our being human, resurrection thereby defines hope as a new state of mind and being. The identity of human being is therefore not determined by descent, gender, race or social status, but by eschatology (new creation). Hope care is primarily about a new courage to be. It opens up different frameworks for meaningful living within the realms of human suffering.

Pastoral care that operates from the resurrection power will help and empower many people, including those suffering from HIV and AIDS and its associated stigmatisation, caregivers, families, and the community with pragmatic hope for survival. Hope does not exist in a vacuum; it is nurtured in an environment. Hope is developed and sustained through a deliberate framework of care.

4.5. CARE IN PASTORAL MINISTRY

Care in pastoral ministry is the renewal of the vitality of the church through making instruments and resources available for renewal and nurturing of individuals, groups, and relationships. People experience wholeness when they come in contact with Jesus. Jesus' healing power, which comes from being open to oneself, others, nature, and God is then experienced. Caring in pastoral ministry can be described as "a refreshing rain to a parched land" (Clinebell, 2011:46).

4.5.1. Caring for the sick

People who are sick need interventions to enable them cope with their situation. Caring can take many routes. In the context of HIV and AIDS, the care concentrates on instilling hope to help the HIV positive person focus less on the restrictions of the sickness and look beyond to fruitful living. The significant dilemma of having HIV and AIDS is mainly fear; fear of opening up and the resultant stigmatisation and rejection (Louw, 2008:445). There are models of interventions that are applicable to all relationships. Van Dyk (2008:223-227) suggests:

- ***Relationship building***

  At this level, the counsellor and counselee establish a relationship of trust that will enhance openness and psychological security.

- ***Assisting the client to open up***

  At this stage, the client reveals the nature of the problem. As the client struggles to open up, this gives the counsellor significant insight into the world of the client.

- ***Building deeper perception of the situation***

  This stage allows both counsellor and client to gain profound knowledge of the situation at hand in order to chart a course of action.

- ***The way forward***

  This stage examines possible intervention measures. The counsellor encourages the client to act in a preferred manner to alleviate the problem. Managing the problem is a joint responsibility of the counsellor and client.

Louw (2008:449), on the other hand, introduces the spiritual dimensions in counselling PLWHA:

- ***The impact stage***

  This is the period of shock, anxiety, helplessness, and denial that follows HIV and AIDS diagnosis. The pastoral caregiver must pay attention to the basic needs of the person, like love and acceptance.

- ***The regression phase***

  This is the stage of emotional withdrawal to face reality. Many people become angry, isolated, and depressed. The counsellor's focus at this time should centre on assisting the person to deal with anger and guilt.

- ***The internalised phase***

  This is the stage when the person accepts and agrees with the reality of the predicament. The counsellor helps the person to see the importance of disclosure.

- ***The reconstruction phase***

  At this point the person is helped to make quality decisions for the future. Counselling here focuses on God's faithfulness.

- ***The constructive phase***

  At this stage, the counsellor focuses on helping the person to build a qualitative life despite the present problem. The caregiver must talk less and listen more.

4.5.1.1. Emphatic listening as caring

Due to the plethora of challenges that confront people in life, "many people are looking for an ear that will listen". It is unfortunate that this ear is not found within the Christian community,

for the reason that Christians talk when they should be quiet and listen[46] (Montonye, 2010:70). The activity of listening has been considered as the basis for all types of care. Listening is an important skill and spiritual activity for any Jewish pastoral minister or caregiver. The Shema, which is the central declaration of Jewish faith, reveals that hearing or listening is the classic or quintessential hallowed act for all Jews: "Hear O Israel, YHWH is our God, YHWH is One". From this statement, the Shema declares clearly that listening plays a significant role in caring. This kind of listening involves "both the outer and the inner ear – the ear of the heart" (Breitman, 2005:95). Breitman (2005:95) also points out that paying attention to what other people are saying, either in words or not, is emphatic listening. It helps to listen even to the unspoken words of the speech. It is an intentional act that requires serious commitment.

The importance of all types of listening can never be overemphasised. When critically sick, it is hard for the person to speak. The caregiver listens to the feelings of such a person "including feelings that are between the lines, too painful to trust to words" (Clinebell, 2011:56). Clinebell (2011:56) then suggests some basic functions of listening "in a warm caring way":

- It gives the caregiver opportunity to check the situation at hand. It allows both parties to evaluate and correct any misperception on their sides. The caregiver must be on the same "emotional wave length" with the counselee.
- The period of silence and listening allows the counselee to understand that the pastoral caregiver is working at understanding how they feel and what meanings they give to the crisis.
- Once the counselee understands that the minister is truly concerned and cares, it will inspire trigger confidence/trust and allow the counselling relationship to grow.
- Sometimes the psychic wound is laid bare by silence, allowing space for the venom of strong hidden feelings such as guilt, shame, unforgiveness, and hopelessness to be released in order to give way for normal healing and wholeness to take place.
- As counselling and caring proceeds, the counsellor's responses and listening gives the counselee space and time to scrutinise and appraise whether the actions and feelings of the counsellor are actually real.

Listening is, therefore, an essential ingredient of caring. It is what Tillich calls in Streets (2014:7) "listening Love; an underlying value of caring". Gibson (2018:11) observes that this

[46] See also Clinebell, 2011:47.

key element of listening is often missing in pastoral visits, especially in times of bereavement. Caprello (2015:352) emphasises that during traumatic bereavements through HIV and AIDS related illness, soothing words of comfort are often missing; "a ministry of silent-silence and hospitality" will help greatly. By remaining silent in a situation, the caregiver embarks on the same journey with the sufferer. That is extremely therapeutic for the sufferer. One can make a lot of noise without empathy and one can be silent but empathise much. In listening, the caregiver should not make efforts to control or direct the process but be flexible and see things from the counselee's point of view. Women who have been violated and stigmatised because of HIV and AIDS need someone to just listen to them.

Louw (2011:3) argues that listening is important in caring, but empathise listening is not enough; healing is more than mere listening to a situation, presence is needed equally. Breitman (2005:95) supports the idea that meaningful empathic listening starts with caring presence.

4.5.1.2. Presence as caring

It would be weird and irrational for a caregiver to listen from a far, if loving caring is actually intended. Presence has a healing power that is great and profound. It is among the significant mysteries of caring in pastoral ministry. The maintenance of a pastoral presence must be deliberate to foster a relationship and bring healing. It should be at the centre of caring (Van de Creek, 2014:19). Presence is one of the spiritual interventions used by caregivers and it enhances recovery (Jankowski, 2011:108). Gibson (2018:7), beautifully describes the element of presence in caring thus: "hospitality means primarily the creation of free space where the stranger can enter and become a friend... hospitality is not to change people, but to offer them space where change can take place". Women who are stigmatised because of HIV and AIDS and violated in abusive relationships are seen as strangers by the perpetrators and the community. They will be encouraged if pastoral caregivers employ this method of "there-ness" and become their friends. The ministry of presence in caring is a major feat and giant stride in the process of HIV and AIDS de-stigmatisation; it demonstrates inclusiveness which builds the self-confidence of the stigmatised person to pursue happiness. Louw (2011:4) calls this process "the optimistic approach". Pastoral presence responds through faith language to the negative perceptions of the counselee. A fundamental rule of pastoral care is "to be there. Be present – offer presence as hospitality" (Alexander, 2013:175). The following story demonstrates the practical activity of presence: Rabbi Eleazar fell ill and Rabbi Johanan went to visit him. Rabbi Johanan noticed that Rabbi Eleazar was lying in a dark room, and Rabbi Johanan bared his arm and light radiated from it. Thereupon he noticed that Rabbi Eleazar was weeping

(Breitman, 2011:96). This illustrates the power of presence. Being present must be accompanied by compassion or else it becomes mockery.

Compassion is necessary to add value to listening and presence. For listening and presence are the brainchildren of compassion.

4.5.1.3. Compassion as caring

Compassion is at the heart of pastoral care. This compassion is the character of God (1 John 4:19). This is a hidden but strong passion towards a person in affliction (Lartey, 2003:29). To enter into the suffering state of humanity and identify with humanity's plight, God showed his compassion by coming in human form through the incarnation: in the person of Jesus Christ (Stanssen, 2012:68). The compassion of God in Christ Jesus on the cross to salvage humanity from the "sickness" of sin was a healing activity. God brought healing from sin and suffering (Raj, 2010:79). Herman (2013:217) contends that compassion as revealed in the incarnation and the indwelling of the Holy Spirit in believers indicates the presence of God and his righteous Kingdom among his people. To continue living out the compassion of God on earth, the Holy Spirit endows believers with spiritual gifts to liberate and set people free from bondage, heal the sick, deliver those under demonic attacks, and bring care and acceptance to those marginalised, stigmatised, and rejected. Jesus' earthly ministry included healings and feeding as acts of compassion (Matt 9:36 and Mark 6:34). Compassion was the motivating factor of Jesus' ministry. As his followers, pastoral caregivers must absorb and radiate the culture of compassion towards the sick and initiate ways to inspire hope into their lives (Voorwinde, 2011:24, 28). In the Gospel according to Matthew, Jesus is designated the "compassionate King", in Mark "the Man of sorrows", Luke's gospel calls him "the sympathetic Son", and the Gospel of John "the Loving Lord". In the spirit of neighbourliness as depicted in the story of the Good Samaritan, pastoral carers should not behave as the Levite and the priest who were so religious that they were afraid to defile themselves by showing compassion to this dying man (Cornelius, 2013:3). However, someone to whom he was a total stranger, enemy, and sinner, defied religious, social, and ethnic hostility, antipathy, and antagonism that was prevalent between the Jews and his kinsmen to stop, care, and save the life of an unknown victim (Nagle, 2020:2-3). In the same vein, if pastoral caregivers go against harmful religious, social, and cultural practices that forbid them to care for souls, and move with compassion to put smiles on the faces of victims of HIV stigmatisation and violence, women who are victims of domestic and sexual abuse will experience love and live with hope. Most of these women confess their faith in Jesus.

4.6. CONCLUSION

This chapter attempted to look some theological concepts of pastoral care which can be engaged as tools to establish norms for a healthy relationship between PLWHA and others. The research shows that there are various approaches that can be employed to engage people in meaningful discourse on mitigating HIV/AIDS stigma. An understanding of human beings is critical in fighting the stigma of HIV and AIDS. The concept of hope and its importance in healing was also examined. The resurrection of Christ was seen to be the bedrock of the Christian faith. Therefore, PLWHA can live with eschatology in view, bearing in mind that this life is but a pilgrimage that will soon reach its destination. The functions and goals of pastoral care of PLWHA were explored. The worth of women was discussed and it was confirmed that women are precious in the sight of God as are all human beings. An appropriate pastoral care intervention strategy is needed to help reduce the menace of HIV and AIDS stigmatisation against women by men in Nigeria. That will be the focus of the next chapter.

CHAPTER FIVE

A PASTORAL CARE INTERVENTION STRATEGY FOR HIV AND AIDS STIGMATISATION AGAINST WOMEN IN NIGERIA

5.1. INTRODUCTION

The previous chapter discussed the relevance of pastoral care in addressing the problem of HIV and AIDS stigmatisation in Nigeria, thereby dealing with the normative task of Richard Osmer by answering the question, what ought to be going on? The research topic considered in this research relates to HIV and AIDS and the stigmatisation of women by men in Nigeria. The study is guided by a research question, using the goals of the research, and engaging the four tasks of the practical theological framework as proposed by Richard Osmer.

The main thrust of this chapter is the last task of practical theology – the pragmatic task. The burden of the pragmatic task is to answer the question, how might we respond? If the church in Nigeria wants to demonstrate the holistic nature of the Gospel, it must be involved in HIV de-stigmatisation.

5.2. THE CHURCH AND HIV AND AIDS STIGMATISATION

In simple terms, the church is the assembly of believers. The word church is derived from the Greek *ekklesia,* which is literally translated as "gathering" or "assembly". It was used for both religious and secular gatherings but came to be used for believers' gatherings (Jackson, 2017:1) Meyers (2016:7) defines the church as a universal entity or body that meets often under the authority and leadership of Jesus Christ to fulfil the mandate of the great commission and observe the sacraments of baptism and the Lord's Supper. Pastoral care functions effectively within the church. But the church is also full of members who stigmatise and are stigmatised.

The church in Nigeria is an agent of change in the cosmos (world). Through its diverse ministries, it can affect the world positively and bring healing to hurting minds. The church in Nigeria has the capacity to work for the de-stigmatisation of PLWHA and the healing of domestic and sexual violence victims (Heymans, 2008:93-97). The HIV and AIDS epidemic requires a long-term and enduring response. Chitando (2007:14) contends that the church in Nigeria has the credibility and endurance to develop meaningful programmes that will be sustained in the community, unlike NGOs that pop up and then leave. Therefore, if the church in Nigeria participates in the war against HIV and AIDS with its associated vices, it is likely that its efforts will last. This is a great advantage the church has over secular actors in the HIV

and AIDS response. Furthermore, the church in Nigeria has powerful spiritual resources such as prayer, exorcisms, and spirituality to use in the fight against HIV and AIDS stigma. These resources are in short supply in many NGOs (Chitando, 2007:17). Rice and Richardson (2013:42) insist that the faith community must be positioned well in order to respond to the issues of stigmatisation caused by HIV and AIDS, and this involves sacrifice. Some factors that can motivate church leaders to be involved in eradicating HIV and AIDS stigmatisation are:

- ***Great expectations from church members***

  People living with HIV and AIDS have great expectations of their leaders because they know the kind of influence and authority these leaders have. They expect these leaders to use their positions to influence a significant sector of the community against HIV and AIDS stigmatisation (Religions for Peace, 2008:21).
- ***Powerful resources***

  People living with HIV and AIDS also have confidence in the leaders because they have resources and, therefore, turn to them in times of trouble. The pulpit is a powerful instrument for leaders to utilise for educating their members and creating awareness of HIV and AIDS issues (Ciantia, 2009:67).
- ***Direct contact***

  Because the church is situated in the community, leaders have the privilege of having direct contact with or access to people. During visits leaders can inculcate the message of HIV and AIDS and the need for accepting those infected just as they are (Usadolo, 2019:11). The church in Nigeria has the capacity to partner with local resources such as clinics, hospitals, and NGOs to fight stigma.

Church leaders in Nigeria should stand firm in meeting the expectations of their people as they make efforts to stop discrimination and stigmatisation. Stressing the significant role of churches in fighting HIV stigma, Derose et al (2014:30) argue that churches may engage "informational and contact components" to reduce HIV stigma. Many researchers have suggested a combination of interventions (Brown, Macintyre & Trujillo, 2003; Heinjinders & Van Der Meij, 2006; Mahajan et al, 2008). The informational component will address the various misconceptions relating to the sickness and also educate congregants about the means of transmission and treatment. But since lack of knowledge is not the only reason for HIV stigma, information alone has been found to be ineffective in reducing HIV stigma (Brown et al, 2003).

The church can include a contact component. This component will promote indirect or direct interactions with PLWHA engendering compassion and sympathy for those with stigmatised situations by persuading people to embrace stigmatised people. This will mean a shift in some areas of spirituality.

5.2.1. A shift in ways of thinking and conceptualisation

In order to successfully overcome HIV and AIDS stigma in Nigeria, church leaders must develop appropriate theology and create a good understanding of pastoral anthropology among their members. The church should be proactive and flexible with its theology.

5.2.1.1. Development of appropriate theology

For church leaders to commit their time to combat HIV stigma, they must have a theological foundation for their ministry in place. The point of departure for church leaders is that the church is the Body of Christ which He purchased with his blood (Acts 20:28; 1 Cor 6:19; Eph 5:25; Col 1:20). And as institution it has the will to eventually overcome every challenge, including HIV and AIDS (Matt 16:18; Phil 1:6). It is an avenue for growth, edification, fellowship, acceptance, and healing (Heb 10:22-25; Acts 20:32; Eph 4:11-16). Church leaders are only under-shepherds with Christ as the Great Shepherd. They must model themselves after Christ, who loved the church, his bride, and gave himself for her (Eph 5:25). When church leaders work from this point of view, they lead with compassion and care (MacArthur, 2017: xi).

As discussed earlier in this research, in the Old Testament, people with leprosy, which may be compared to HIV and AIDS today, were regarded as unclean and stigmatised. But in the New Testament, when Jesus came, he graciously and unconditionally accepted them all. When Jesus touched the leper in Matthew 8:3, he made it clear that stigmatisation and discrimination are not God's will. For Jesus always obeyed his Father's will; it was his food (John 4:34; John 6:38; Luke 22:42). He left a legacy for the church to use in addressing social and cultural perspectives (M'bwangi, 2021:8). The church in Nigeria must model Christ by accommodating and accepting PLWHA, involving them in church activities (Adogame, 2007:480). The church leaders in Nigeria need to reject theological rigidity and adopt a theology concerning HIV which affirms life and, by so doing, leave "the Egypt of theological rigidity and firmness into Canaan of theological creativity as it speaks to respond to HIV" (Chitando, 2007:25). Jesus took the shame and disgrace of PLWHA on the cross of Calvary and removed their stigma when he received the piercings and beatings that left scars on his body. Not only must the

church develop an appropriate and functional theology against stigma, it must have a clear understanding of human beings.

5.2.1.2. The importance of understanding pastoral anthropology

The success of reducing HIV and AIDS related stigma hangs on the understanding of human nature as revealed in the Scripture. The Bible makes it clear that all humans are created in the image and likeness of God (Gen 1:26-27). So PLWHA are created in the image of God. The church is the living representative of Christ on earth to minister to people. The understanding of what and who a person really is, will to a great extent determine the kind of intervention needed for healing (Louw, 1998:123). Long ago, Guthrie (1979:130) postulated that the distinguishing mark of pastoral care and counselling is an anthropology that is rooted in "faith in the triune God who is Creator, Redeemer" and the giver of life. It means all life emanates from God. Therefore, PLWHA are creatures made by God and they are His delight (Gen 1:31). Louw (1999:157) states that our knowledge of pastoral anthropology comes "from our understanding of our relationship with God and human beings in relation to God". This understanding is crucial for the development of a strong faith. Therefore, the church must look beyond HIV and AIDS and acknowledge the image of God in PLWHA. This should be done by church leaders through affirming and defending the dignity and right of victims whose *imago Dei* has been tarnished by stigma (Son, 2017:125). Consequently, whether healthy or sick, rich or poor, man or woman, child or adult, educated or illiterate, everyone deserves respect and care (Kim, 2010:7). This is why Cimperman (2005:15) contends that in the midst of HIV and AIDS today, "there is need to explore theological anthropology for it determines our response to the pandemic". The church in Nigeria must, therefore, deal with the problem of gender inequality or imbalance within the framework of pastoral anthropology. This will create space for PLWHA and victims of violence to express their humanity to the fullest. The church by nature is a healing community.

5.3. THE CHURCH AS A HEALING COMMUNITY

Churches have diverse ways of seeking healing in their worshipping activities. In Pentecostal churches the gift of the Holy Spirit and baptism are the paramount focus; mainline churches emphasise social action; and the evangelicals emphasise faithfulness to Scripture and personal devotion or commitment to God (Musgrave et al, 2002:559). Lay members understand healing as miraculous power which defies the effectiveness of modern medicine. The counsellor or pastor sees healing as the restoration of psychological, emotional, spiritual, and physical

harmony through the grace of God. The church has been commissioned by Christ as a healing place through proclamation (Thesnaar, 2010:270; Luke 9:1-2). The mission of Jesus was to give life and give it more abundantly (John 10:10). HIV and AIDS stigma is an illness which confronts PLWHA (Bradley, 2018:731). Healing can take place in the church, home, hospital, or community (Musgrave et al, 2002:559). Therefore, healing should begin with the church in the form of harmony and *shalom* which means harmony between people and harmony between people and creation (Wang, 2021:726).

5.4. STRATEGIC PLAN FOR CHURCH LEADERS IN NIGERIA: 2023 – 2026

5.4.1. Introduction

The previous sections of this research set out the framework and background underpinning the significance and necessity of a pastoral care intervention strategy as it relates to HIV and AIDS stigmatisation against women in Nigeria. These sections examined the nature and extent of HIV and AIDS in Nigeria and also explored the prevalence of the pandemic. HIV and AIDS stigmatisation was discovered to be a major barrier to HIV and AIDS testing, care, and treatment (see section 2:11). The research also discussed examples of HIV and AIDS stigmatisation against women (see section 2:9). Chapter Four addressed the normative task of practical theology by Richard Osmer, setting pastoral care as the appropriate response to the problem of HIV and AIDS stigmatisation against women by men in Nigeria.

Scholars have provided interventions in the area of HIV and AIDS stigmatisation, but they have concentrated on using Social Marketing Principle (Rimal and Creed, 2008), engaging home-based HIV testing (Morin et al, 2006), or providing home-based HIV testing and counselling (Macpherson et al, 2011). Their interventions have helped to a certain degree, but are mostly secular. Hence the need for an intervention that is predicated on and saturated with the Word of God.

5.4.2. PASTORAL CARE RESPONSE

This section of the research carves out practical ways in which the church leaders[47] in Nigeria will respond to the challenge of HIV and AIDS stigmatisation against women in Nigeria over a period of four years, from 2023 to 2026.

[47] Church leaders here refers to the leaders of the Christian Association of Nigeria (CAN), which is the umbrella body that controls all church denominations in Nigeria. They will ideally drive the intervention strategy, as they have the human capacity and power to implement the strategy.

This pastoral care intervention strategy is holistic in nature and all-inclusive, targeting both men as perpetrators and women as victims of HIV and AIDS stigmatisation. It includes programmes specifically addressed to men as perpetrators and others specifically addressed to women as victims of HIV stigmatisation. There are also programmes directed at the general populace because most stigmatisers will not admit and intentionally attend the programmes; there are potential stigmatisers and HIV and AIDS stigmatised victims out in the society. Hence, the all-inclusive nature of the strategy. This intervention strategy will be implemented by the Christian Association of Nigeria (CAN). This research views theological education and Theological Education by Extension (TEE) as the main bodies to transmit the pastoral care intervention strategy through mainstreaming of HIV, as education is where leaders are developed, and those who receive theological education include men and women, stigmatisers and stigmatised. For everything rises and falls on leadership (Maxwell, 2013:1). So, besides the quarterly seminars and conferences for men, women, and church leaders which are suggested, a sample of a curriculum mainstreaming HIV and AIDS into theological education and TEE was designed. The church in Nigeria must read the Bible through the lens of HIV and AIDS (Dube and Kanyaro, 2004:65). This will help to mainstream HIV and AIDS into all aspects of church life in Nigeria, thereby achieving one of the objectives of *Africa praying* (Chitando, 2008:90). The challenge of HIV and AIDS requires that theology students and faith communities collaborate with God in creating "a new heaven and a new earth" (Rev 21:1).

This section will set out principal strategic priorities and strategic objectives for church leaders in Nigeria in a time frame of four years from 2023 to 2026, structured according to the following headings:

- Guiding principles that will inform and guide the work of CAN;
- Vision statement and mission statement;
- Strategic objective No 1 – To work towards the reduction of HIV and AIDS and its related stigma in Nigeria through effective pastoral care prevention strategies;
- Strategic objective No 2 – To increase public understanding and awareness as it relates to HIV and AIDS stigmatisation through vigorous announcements from the pulpit
- Strategic objective No 3 – To improve the quality of life of PLWHA through pastoral counselling, advocacy services, and quality evidence-based support;
- Strategic objective No 4 – To raise the promotion of wider sexual health objectives through theological education and training.

5.4.3. BELIEFS, VALUES AND GUIDING PRINCIPLES FOR CHURCH LEADERS IN NIGERIA WHILE IMPLEMENTING THE STRATEGY

CAN in Nigeria is very much aware of the economic and cultural hurdles that can affect life choices, thereby rendering both women and men more vulnerable to HIV. Therefore, the implementation of this strategic plan by CAN in Nigeria from 2023 to 2026 should be informed and guided by the following principles and beliefs:

- CAN should be non-judgemental in its interactions with the people concerned;
- CAN must believe in the rights of and respect the desire of PLWHA to be treated with dignity, equality, and respect and to be consulted on issues concerning them;
- It should work within the legal framework of the country in providing support and services (legal and advocacy) to PLWHA;
- CAN should understand that PLWHA and people at risk of contracting HIV can play a significant role in reducing HIV and AIDS transmission and stigmatisation.

5.4.4. VISION STATEMENT AND MISSION STATEMENT

5.4.4.1. Vision statement

To contribute positively towards reducing incidences and prevalence of HIV and AIDS stigmatisation against women in Nigeria, thereby realising a HIV stigmatisation-free Nigeria.

5.4.4.2. Mission statement

Advocating for individuals living with HIV and AIDS, preventing new HIV and AIDS infections, and combating HIV-related stigma and discrimination.

5.5. STRATEGIC OBJECTIVE NO 1: TO WORK TOWARDS THE REDUCTON OF HIV AND AIDS IN NIGERIA THROUGH EFFECTIVE PASTORAL CARE PREVENTION STRATEGIES (January to December 2023)

5.5.1. RATIONALE AND EVIDENCE BASE

This research (2.3.3) revealed the prevalence of HIV and AIDS in Nigeria by states, geographical zones, marital status, and age. Annual reports of HIV and AIDS with detailed information about prevalence provided by the Centre for Disease Control (CDC) in Nigeria is insightful and valuable. In 2020 there were 1.9 million Nigerians living with HIV and AIDS (Olusola, 2021:1). CAN will work with relevant authorities, agencies, and non-governmental organisations to reduce HIV and AIDS in Nigeria.

5.5.2. STRATEGIC GOALS AND ACTIONS

5.5.2.1. Develop and expand church-based HIV testing services targeting population groups at risk (January to April 2023)

Key Actor/Driver = General Secretary of CAN

Actions:

- Expand existing church-based HIV testing services everywhere in Nigeria to meet the growing need.
- Establish and develop outreach HIV testing services in three locations in the South-South geographical zone of Nigeria, which this research (2.3.3.2 and 2.3.3.3) shows has the highest percentage prevalence. This should be done in collaboration with the relevant community-based projects.
- Employ Christian medical staff who have knowledge of HIV and AIDS and related stigma. Pastoral counsellors should also be recruited to meet the spiritual needs of clients.

5.5.2.2. Work with immigrant communities in Nigeria to reduce the prevalence of HIV infections and stigmatisation in this population group (May to August 2023)

Key Actor/Driver = Assistant General Secretary of CAN

Actions:

- Identify places for expansion of targeted outreach work among migrant groups and communities and deliver appropriate support services in these areas.
- Ensure that relevant spiritual and educational materials are made available in different languages for easy assimilation.
- Partner and strategically target relevant organisations such as AIDS Prevention Initiative in Nigeria (APIN) which works among population groups at risk of HIV to motivate and encourage these groups to participate consistently in HIV prevention, training, and education programmes.

5.5.2.3. Develop and deliver targeted HIV stigma prevention training, education workshops, and seminars[48] (September to December 2023)

Key Actor/Driver = Director of Education of CAN

Actions:

- Organise seminars and workshops for spiritual leaders and PLWHA to interact. The paper "The pastoral church as a space for healing and reconciliation" (Thesnaar, 2010) and the book *Africa praying: A handbook on HIV and AIDS sensitive sermon guidelines and liturgy 2* (Dube, 2003) could be of great help. Church leaders should be empowered to understand that they can use their pulpits, sermons, and worship to counteract myths about HIV and AIDS, to speak against HIV and AIDS stigma and to talk about prevention and care.
- Organise quarterly seminars and workshops specifically for men's fellowship leaders at national level to sensitise them to the issues relating to HIV and AIDS stigma. Materials such as the book *Grant me justice! HIV and AIDS and gender readings of the Bible* (Dube & Kanyaro, 2004), the paper "Engaging stigma: An embodied theological response to HIV and AIDS" *(*Ackermann, 2005), and other relevant material will be useful tools.
- The leaders of the men's fellowship at national level should facilitate the training of leaders at regional or parish levels.
- Likewise, regional or parish leaders of the men's fellowship should facilitate the training of leaders at local levels.
- Organise quarterly seminars and workshops specifically for women's fellowship leaders at national level to sensitise them to the issues relating to HIV and AIDS stigma. The Circle of Concerned African Women Theologians can be of help in terms of consulting, and human and material resources.
- The leaders of the women's fellowship at national level should facilitate the training of leaders at regional or parish levels.
- Likewise, regional or parish leaders of the women's fellowship should facilitate training of leaders at local levels.

[48] Studies such as the UNAIDS policy position papers demonstrate that sustained education and prevention programmes are a significant variable in reducing the incidences of HIV transmission and stigmatisation. Stover (2002) estimates that 63% of new HIV infections could be reduced through prevention initiatives.

- Organise seminars and workshops for women living with HIV and AIDS. Again, Dube & Kanyaro (2004), especially the chapter "Talitha Cumi" should be used to encourage women to have hope in spite of their situation. The Circle of Concerned African Women Theologians can again assist through consulting, and human and material resources.

5.5.2.4. Develop and deliver targeted HIV stigma prevention training and education workshops and seminars; mainstream HIV and AIDS in theological education (January to August 2023)

Key Actor/Driver = Deputy Director of Education of CAN

- Organise quarterly seminars and workshops specifically for youth fellowship leaders at national level to sensitise them to the issues relating to HIV and AIDS stigma. Materials like Dube & Kanyaro (2004) and Ackermann (2005) and other relevant materials will be useful tools.
- The leaders of the youth fellowship at the national level should facilitate training of the leaders at regional or parish levels.
- Likewise, regional or parish leaders of the youth fellowship should facilitate training of the leaders at local levels.
- Work in conjunction with communities to deliver a faith-based training workshop for traditional rulers and stakeholders of selected communities. A potential training manual is shown below.

Table 3: A faith-based training framework for communities

S/NO	Module topic	Main objective	Intervention adaptations	Approach
1	HIV facts, and social context	To increase knowledge of HIV and AIDS transmission and national/state and local area statistics To explain how social issues, affect HIV and AIDS	Provide information and on HIV and AIDS testing, common myths, and social drivers of HIV and AIDS from NACA or other relevant non-governmental organisations	Information

		To stress the importance of HIV testing		
2	Name the problem	To define stigma To identify forms, causes, and effects of HIV stigma To develop empathy for PLWHA	Non-HIV-related stigma (homelessness and incarceration) may be added with relevant pastoral magazines	Contact, information, and skill-building
3	More understanding, less fear	To help religious and traditional leaders articulate fears about HIV and AIDS To establish the connection between fear and stigma and discriminatory behaviours towards PLWHA To explain modes of HIV transmission	Revise and update list of vulnerable or high-risk (e.g., breastfeeding) and low-risk (e.g., blood transfusion) activities	Information
4	Impact of HIV and AIDS infection on families	To facilitate open discussion of how HIV and AIDS impact families To identify crucial issues related to living with and caring for PLWHA without stigmatising	Create culturally relevant scenarios, vignettes, or role-play CDC's or NACA's Act Against HIV and AIDS video clips showing support for	Contact, information, and skill-building

			PLWHA will be helpful	
5	Sex, morality, shame, and blame	To discuss the power and influence of these words To develop empathy for PLWHA	Prevalence rate of HIV and AIDS should be used to better reflect the Nigerian epidemic	Information
6	Stigma and religion	To explore some religious and cultural beliefs that may undergird stigma To identify relevant biblical texts that demonstrate compassion for PLWHA To promote and encourage HIV testing	Relevant handouts and sermons for addressing HIV and AIDS stigma may be used	Advocacy, skill-building, and information
7	Coping with stigma	To discuss the significance of the emotional well-being of PLWHA To identify channels of promoting emotional health of PLWHA To identify ways to confront stigma and help PLWHA to cope with the effects of stigmatisation	Relevant materials and pastoral briefs may be adapted	Contact, advocacy, skill-building, and information

8	Using advocacy to confront and challenge stigma and promote social justice	To identify practical steps that religious and traditional leaders can take to advocate for PLWHA To identify meaningful and constructive ways to counter challenges to HIV and AIDS activism and social justice	Stages of advocacy based on NACA's activity manual may be added	Advocacy

- Collaborate with theological institutions and TEE to mainstream HIV and AIDS into their curricula. The rationale for a HIV sensitive curriculum is very strong. It is high time for theological institutions in Africa in general and Nigeria in particular to focus on existential realities. Desmond Tutu (1983:107) contends that non-Western Christians try to answer questions that nobody in their home context is asking or apt to ask and calls for contextual theologies. The impact of HIV and AIDS in Nigeria necessitates the emergence of theologies which speak to this reality. The mainstreaming may take the approach shown below.

Table 4: A sample of mainstreaming HIV and AIDS in theological education

Course title	**Course objectives**	**Course outline**
Bible, Theology, and HIV and AIDS	To equip new and old pastors with basic information on HIV and AIDS To enable students to gain skills in developing HIV and AIDS ministries in their parishes and training home-based caregivers	Basic information on HIV and AIDS Theological understanding of HIV and AIDS Churches' role in the pandemic Developing home-based care

		HIV and AIDS and gender-related issues
Ministry in HIV and AIDS context	To equip students with knowledge and skills to minister in an HIV and AIDS context To enable students to gain deeper insights on HIV and AIDS To help students become partners in prevention and mitigation of, and in the fight against HIV and AIDS	The Bible and disease, healing, compassion, and hope Basic information on HIV and AIDS Social factors promoting HIV and AIDS Care and counselling of both the infected and affected Role of Christians and the church
Pastoral Counselling	To equip leaders with information on HIV and AIDS To provide hope to PLWHA so that they see God's love as the answer	Who is God? God-human relationship Humanity's fall and suffering God's intervention in our lives The resurrection hope
Human Sexuality, Culture, HIV and AIDS, and the Church	To equip students with basic information on HIV and AIDS and contemporary issues	Defining human sexuality Biblical perspective on human sexuality Conceptualising different cultural beliefs and practices Christianity and other world religions Transmission of HIV and its medical diagnosis
Theology, HIV and AIDS, and Human Development	To enable students to understand the biblical basis for social intervention To equip students to effectively reach out to the community	Theology of development Defining development Development from below Working with the poor and vulnerable

		The role of the church in decolonising development Advocacy and the Bible Be your neighbour's keeper

5.6. STRATEGIC OBJECTIVE NO 2: TO INCREASE PUBLIC UNDERSTANDING AND AWARENESS AS IT RELATES TO HIV AND AIDS STIGMA (January to December 2024)

5.6.1. RATIONALE AND EVIDENCE BASE

Ignorance and misinformation about HIV and AIDS are fundamental issues in Nigeria. It is both surprising and frustrating that 35 years after the presence of HIV and AIDS was first officially reported, lack of understanding and general lack of awareness on HIV continues to prevail (see section 2.3.3). Misinformation and ignorance feed into all sorts of negative feelings, attitudes, and stigmas about PLWHA. There is an urgent need for creating awareness on the issues of HIV and AIDS.

5.6.2. STRATEGIC GOALS AND ACTIONS

5.6.2.1. Develop a concentrated and sustained public awareness campaign about HIV and AIDS in collaboration with other relevant agencies and organisations (January to August 2024)

Key Actor/Driver = Coordinator of AIDS Awareness and Care Programme of CAN

Actions:

- Obtain funding and identify crucial partnerships to develop and implement a HIV and AIDS anti-stigma awareness campaign nationwide.
- Develop and implement targeted HIV and AIDS anti-stigma awareness campaigns using evangelistic outreaches.
- Develop and ensure enhancement of the church's relationship with the media to engage new social media techniques in HIV and AIDS anti-stigma awareness and secure national coverage of crucial issues relating to HIV and AIDS stigma. This should be done in collaboration with the Department of Information and Communication Technology of CAN.

- Commission a survey to ascertain the level of public awareness about HIV and AIDS and also attitudes towards PLWHA.

5.6.2.2. Develop considerable understanding and awareness of HIV and AIDS stigmatisation among pertinent professional groups who are in constant contact with population groups at risk of HIV and AIDS (August to December 2024)

Key Actor/Driver = Coordinators of denominational AIDS Awareness and Care Programmes (organisations like COCIN[49] AIDS Awareness and Care Programme (CAACP) and ECWA[50] AIDS Unit)

Actions:

- Increase participation and inputs at seminars and conferences organised by relevant professional associations.
- Identify HIV and AIDS related issues for debates/topical discussions and organise workshops for relevant professional associations. This can be done during Nigerian AIDS day, Zero Discrimination Day, and World AIDS Day.
- Sustain free pastoral counselling in church clinics and hospitals.
- Develop of digital media strategy for CAN (which will include stories of hope from the Bible) to be used in training, prevention, and education programmes.

5.7. STRATEGIC OBJECTIVE NO 3: TO IMPROVE THE QUALITY OF LIFE OF PLWHA THROUGH PASTORAL CARE, ADVOCACY SERVICES, AND QUALITY EVIDENCE-BASED SUPPORT (January to December 2025)

5.7.1. RATIONALE AND EVIDENCE BASE

As revealed in this research (2.3.3), the total number of people living with HIV and AIDS in Nigeria was estimated at about 1.9 million in 2020. Given the circumstances of people diagnosed with HIV and AIDS, national and international evidence indicates that many people find it very difficult, if not impossible, to come to terms with the diagnosis. People have to face the healthcare consequences of the HIV and AIDS diagnosis as well as crucial decisions on what type of treatment to take, and issues around stigma associated with HIV and AIDS and how to reveal one's HIV status; social consequences, alienation, and isolation experienced by most PLWHA abound.

[49] COCIN: Church of Christ In Nations.
[50] ECWA: Evangelical Church Winning All.

In helping people to overcome these challenges, it is clear that CAN has a significant role to play in supporting people diagnosed with HIV.

5.7.2. STRATEGIC GOALS AND ACTIONS

5.7.2.1. Promote good quality, evidence-based support and advocacy services to PLWHA (January to August 2025)

Key Actor/Driver = Director of Social Services Department of CAN

Actions:

- Improve partnerships and relationships with appropriate organisations to ensure efficient referral mechanisms and information flow to and from CAN.
- Advocacy on behalf of women living with HIV in relation to issues of stigmatisation, discrimination, rights, and legal matters relating to HIV, engaging Christian advocates.
- Provision of pastoral care and support services which relate to the secondary prevention, disclosure, leading a healthier life, and other issues that PLWHA encounter.

5.7.2.2. Help and support the development of self-advocacy and peer support amongst PLWHA (August to December 2025)

Key Actor/Driver = Deputy Director of Department of Social Services of CAN

Actions:

- Establish CAN network of People Living with HIV and AIDS.
- Set in place a peer support group for newly HIV infected people.
- Initiate a faith-based HIV and AIDS stigma reduction intervention.

The programme may follow the framework of the table below.

Table 5: A community-based HIV and AIDS stigma reduction intervention

Two days with only PLWHA	Two days with PLWHA and spiritual leaders	One-month community HIV stigma project	One day report back and evaluation
Facilitated by a non-infected person and an infected person from the team of facilitators:	Facilitated by a non-infected person and an infected person from the team of facilitators:	Participants include spiritual leaders; Support and monitoring provided by a non-infected person and an	Evaluation by relevant community and stakeholders: Report back on community project

Understanding HIV stigma Identifying personal strengths Responsible disclosure	Increase HIV stigma knowledge and coping Emphasise relationship between PLWHA and people living close (PLC) Empower PLWHA and PLC to reduce HIV stigma Plan a HIV reduction project	infected person in the research team: Implementation of project within their community	

5.8. STRATEGIC OBJECTIVE NO 4: TO INCREASE THE PROMOTION OF WIDER SEXUAL HEALTH OBJECTIVES THROUGH EDUCATION AND TRAINING (January to December 2026).

5.8.1. RATIONALE AND EVIDENCE BASE

There is a clear connection between HIV and sexual practices; the majority of HIV infections result from sexual activity between a person infected with HIV and AIDS and a person not infected with HIV and AIDS. There are other sexually transmitted diseases (STIs). Hence, there is a need to discourage people from involving themselves in sexual activity that will put them at risk of contracting HIV or other STIs. CAN will complement the efforts of the government and other relevant organisations in providing sex education and training.

5.8.2. STRATEGIC GOALS AND ACTIONS

5.8.2.1. Develop and implement targeted HIV and sexual health training and education programmes

Key actor/Driver = Director for Health of CAN

Actions:

- Improve the delivery of training for trainers' programmes within health sectors of churches working with population groups at risk of poorer sexual health outcomes.
- Identify opportunities (especially with the Federal Ministry of Health) for establishment of strategic partnerships for organising trainers' training programmes.

- Support the delivery of education and training in church clinics and hospitals through provision of up-to-date education and training of personnel, who will in turn transmit that knowledge to their clients.
- Collaborate with chaplains to establish sustained visitation and counselling sessions with patients in the HIV and AIDS wards of selected hospitals.

5.8.2.2. Develop partnerships and participate in relevant networks and committees involved in sexual health promotion and education

Key Actor/Driver – Deputy Director for Health of CAN

Actions:

- Participate actively in the development of the National Health Strategy implementation plan and incorporate relevant pastoral actions within this strategic plan through local churches.
- Ensure the inclusion of biblical principles in the content of the National Health Strategic Plan.

5.9. CONCLUSION

This chapter focused on pastoral care intervention strategies for dealing with the issue of HIV and AIDS stigmatisation. The church and its role in HIV and AIDS de-stigmatisation were examined. It was discovered that pastoral care functions effectively in the church to provide positive change in the lives of its members. The chapter also looked at some factors that will motivate the church to engage in eradicating HIV and AIDS stigma.

The church must develop appropriate theology and have a good understanding of pastoral anthropology if it hopes to successfully intervene in HIV and AIDS stigmatisation. The church is a healing community and it was seen that members naturally frequent churches or places of worship where their problems are cared for and solved. The chapter also revealed that members have great expectations of church leaders because church leaders have the capacity to engage different legal and God-centred mechanisms to support their members.

The chapter then drafted a four-year pastoral care intervention strategy for the Christian Association of Nigeria to effectively pursue the course of reducing HIV and AIDS stigma (especially against women). The last chapter will offer a conclusion of all the research.

CHAPTER SIX

CONCLUSION

6.1. INTRODUCTION

The aim of this research was to explore HIV/AIDS and stigmatisation and its consequences for Nigerian women. The research was carried out under the guidance of the research question and directed by the goals of the study, using the qualitative research method and the practical theological framework of Richard Osmer (2008). HIV and AIDS continues to escalate throughout the globe with its attendant devastation and high death toll (WHO, 2020:1), and this research identified stigma as a fundamental barrier in the war against HIV and AIDS.

This chapter, which is the conclusion of the research, will be divided into two sections. The first section of the chapter looks at the problem statement, the research question, the objectives of qualitative research method, and the research in order to extract the study findings and draw a final conclusion. The second part considers the contribution of this research to the problem under investigation, makes recommendations, and suggests direction for further study.

6.2. REVISITING THE STUDY PROBLEM, QUESTION AND OBJECTIVES.

Stigmatisation is a fundamental burden in the HIV and AIDS discourse. Gender inequality and imbalance have contributed to the problem of HIV stigmatisation against women. Men employ different systemic structures to inflict pain on women. In an effort to address the problem, the study attempted to answer the question:

How can pastoral care assist in de-stigmatisation of women in Nigeria?

To further probe the nature of the problem, the following sub-questions were raised:

- What is the nature and the extent of the HIV and AIDS pandemic in Nigeria?
- What steps do men need to take in order to reduce or prevent the stigmatisation of women living with HIV and AIDS?
- What role could pastoral care play in addressing the stigmatisation of women living with HIV and AIDS by men?

To help answer the research question, the objectives of the study were to:

- Examine the nature and extent of the HIV and AIDS epidemic in Nigeria and the presence of HIV and AIDS stigmatisation.

- Enumerate the steps men need to take in order to prevent the stigmatisation of women living with HIV and AIDS.
- Discuss the role pastoral care could play in addressing the stigmatisation of women living with HIV and AIDS by men.

6.2.1. RESEARCH FINDINGS

The first objective or goal of the research was to examine the nature and extent of the HIV/AIDS epidemic in Nigeria and ascertain the presence of HIV and AIDS stigmatisation. This was discussed in Chapter Two and the findings are shocking.

In looking at the understanding of sickness in the Bible, it was discovered that the Old Testament concept of illness is very broad and its terminologies differ from modern medical semantics. Archaeologists played a key role in unveiling the Old Testament notion of illness (Arnold & Williamson, 2005:895). Sickness may come from God as punishment for disobedience (Louw, 2008:109). The study discovered that not all sicknesses are a result of personal sin. Therefore, PLWHA are not necessarily the cause of their condition, as many tend to believe. In a cross-disciplinary study, it was discovered that sickness has a psychological dimension. It is a crisis that engulfs the whole person and initiates conflict in the psyche of the individual. The study also discovered that in Africa, sickness is considered to be a communal phenomenon that affects not only the individual, but also the family and community. It affects relationships and disrupts intrinsic harmony between the individual, community and the "living dead" – ancestors (Omonzejele, 2008:120). Therefore, healing means restoration of broken relationships with all affected relational dimensions. The concept of *Ubuntu* is mostly experienced in the context of illness. Sickness in an African context is seen to be attributed to witches and wizards when it is idiopathic.

The first case of HIV and AIDS in Nigeria was diagnosed in Lagos State in 1985 but officially reported in 1986. Since then, the virus has steadily spread, reaching its peak in 2001, when Nigeria recorded a new HIV infection every minute (Folayan, 2005:85). The effect of HIV and AIDS on the nation's economy, education, agriculture, women, and children was discussed. It was discovered that most women who were infected, lost their means of livelihood and were seen as liabilities to their families, which also triggered stigmatisation. However, the Federal Government of Nigeria responded to the challenge, establishing many intervention bodies such as NEACA, NACA, and HEAP in an attempt to contain the epidemic. NGOs participated in

the war against HIV and AIDS. The modes or means of HIV transmission were discussed and it was discovered that HIV and AIDS can be transmitted through heterosexual or homosexual activity, blood transfusion, and from mother to child (MTCT) through either the placenta or breastfeeding.

The study found that poverty and ignorance are some of the factors standing on the way of HIV and AIDS control and care (Agbaji, & Akanmu, 2018:159). The effect of COVID-19 on the treatment of HIV and AIDS was explored. The lockdown restrictions imposed due to the corona-virus impacted negatively on the treatment and funding of HIV and AIDS. PLWHA have no access to health facilities for care. And money meant for the control of HIV and AIDS is being used to ameliorate the sting of COVID-19 (Oladele, 2020:2).

The research discovered that the lockdown also provided an enabling environment for domestic violence. It created an atmosphere conducive for transmission of HIV and AIDS. In many countries the rate of domestic violence increased because of the lockdown.

The second objective of this research was to discuss the concept of stigmatisation and enumerate the steps men need to take in order to prevent stigmatisation of women living with HIV and AIDS. The point of departure for this research, as stated earlier, was that any thought or activity that attempts to or actually inflicts pain or injury either physically, psychologically, spiritually, or emotionally on women, is an act of stigma. The research discovered that men use several ways to stigmatise women. First, men use gender construction. The construction of gender was seen to be patriarchal in Nigeria. Male-children are seen as precious assets of the family while girl-children are regarded as “passengers” that will soon drop out of the vehicle of the family to their husbands’ homes. This mentality nurtures other principles of stereotyping that aims to keep the female gender permanently male possessed. So, the study found that girl-children become vulnerable to HIV and AIDS at an early age due to poverty, child labour, child marriage, and gender constructions that do not allow them to grow with a positive mind-set to reach their full potential in life. Secondly, men use violence against women. The study discovered that women experience various types of violence ranging from sexual harassment and rape to female genital mutilation (WHO, 2020). The concept of violence against women was explored and the result shows that domestic violence is usually perpetrated by intimate partners. Some examples of domestic violence against women were laid bare. It was discovered that causes of domestic violence may include: (1) Cultural stereotyping: culturally, men are placed above women in terms of authority, freedom, and respect. Women are regarded as the

property of their husbands (Abayomi, 2013:57). This indoctrination is passed from generation to generation. (2) Financial dependence is another cause of domestic violence. Because women are already crippled economically due to the cultural underpinnings, they depend on their husbands for almost everything in life. And when the husband has nothing to give, he resorts to violence and abuse. (3) Childlessness and the male-children syndrome in African families were seen as other causes of domestic violence.

Thirdly, the research discovered that men use patriarchy to justify venting violence on women. The research confirmed that Nigeria is a patriarchal society where men have dominated almost every facet of the nation. For example, in the educational sector, men have taken all key positions in both government and private tertiary institutions. It was seen that this is happening because girl-children are not given equal educational opportunities given to male children right from childhood. The belief that women's education is a waste of resources, exacerbates this practice. Furthermore, the colonial system of education did not allow girls to enrol in school since they were mainly scouting for manpower and they felt educating women was not justified. The same "poison" infiltrated the political space. The study found that women are the majority of the population in Nigeria, but not one has ever occupied the seat of either president or vice-president of the nation. It was, sadly, discovered that women who struggled to attain high positions were humiliated out of office (Makama, 2013:124).

It is not only secular organisations that exert patriarchal power over women. It was found that religious organisations also support patriarchy in their places of worship (Oduyoye, 2001:81). Women are not allowed to perform sacraments or speak with authority. Men allude to 1 Timothy 2:12 to justify this. The Anglican and Lutheran churches in Nigeria still believe that equality of women and men is not biblical. This may not be unconnected with the statement of the late Pope John Paul II, who said Jesus did not make a mistake by choosing only males as his disciples, because women are unsuitable. To further explore violence through the instrument of patriarchy, the research discussed the stories of the Levite and his concubine in Judges 19:1-30 and the woman arraigned for adultery in John 7:53-8:11. The research found that patriarchy played a significant role in both narratives. The practice of brutality against women is not foreign to Nigeria as recorded in section 3.5.1 of this research. It determined that the Islamic faith also encourages patriarchy through its doctrines and *Hadith*.[51] The Sharia Law

[51] *Hadith* refers to the teachings of Prophet Mohammed (PBUH).

is infused with paternalistic interpretations that are geared towards the control of women's social and sexual lives.

The research also examined some challenges of women in the HIV context. Stigma was discovered to be a major challenge for PLWHA. Though both men and women who are HIV positive suffer stigma, the research found that women suffer more than men (Odimegwu, 2017:24). The research literature defines stigma as "a construction of deviations from some ideal or expectation". Stigma disconnects, excludes, and marginalises individuals from common groups due to their HIV status (Odimegwu, 2013:2). Stigma linked to HIV and AIDS is still deeply rooted in many institutions, families, and individuals in Nigeria. It is another global pandemic. The research revealed that, over the years, many PLWHA have suffered stigmatisation in one way or the other. Wives have been divorced by their husbands because of their HIV positive diagnosis. Widows suffer the double tragedy of losing a spouse and experiencing stigma. A widow's plight has many forms. First, the widow is disempowered by the in-laws, she is not respected nor are her opinions accepted. Almost everything that belonged to her late husband, is taken by the in-laws. The widow is left with nothing to feed her and her children. Secondly, she is made to endure the public humiliation of bathing in public (Durojaye, 2013:183). Thirdly, the widow is forced to undergo ritual cleansing, which usually involves drinking the water that was used to bath the corpse of her late husband.

In the course of the study, different types of stigma were identified and most of them are practiced in Nigeria. One major effect of HIV and AIDS stigmatisation as disclosed by the study is that some infected individuals commit suicide. Stigma is still prevalent because of factors which include connecting HIV and AIDS with immorality so it is the bearers' burden to bear, and lack of public awareness, especially in churches and communities. In Nigeria, as any other African culture, the subject of sex is never discussed publicly. Families, churches, and societies lock away the issue of sexuality in the abyss of mystery. Consequently, HIV and AIDS makes Nigerian people uncomfortable because the issue of sex is involved. Patriarchal structures undergird the practice of HIV stigma. "The virus of patriarchy which views women as inferior to men is perhaps more dangerous than the HI virus. This is the virus that causes men to stigmatise women" (Ackermann, 2003:83). The research enumerated in Chapter One, the steps men need to take in order to prevent stigmatisation of women living with HIV and AIDS.

The third objective of this study, which was explored in Chapter Four, was to discuss how pastoral care can help to address the problem of the role of men in the HIV and AIDS stigmatisation against women. It was concluded that the church can engage its various ministries to help mitigate the menace of stigma against women. In discussing the dimensions of pastoral care, the study noted that counselling can be used to brighten the mind, reinvigorate the body, and amend relationships. And because of its divine Source – the Holy Spirit – pastoral care can go beyond natural care. The study found that pastoral care, through prayer and exorcism, can deal with idiopathic malfunctioning where medical science proves deficient (Louw, 2000:259). Pastoral care was seen to be a ministry for service where believers use their spiritual gifts to encourage, teach, and bring healing to hurting souls. It is a voice of the voiceless. It speaks against injustice in society and defends the poor. The church should help men to take responsibility for their violent actions against women.

The research also examined the concept of human dignity. It found that being human in its simplest form refers to the inherent value of a person and can be viewed from social, aesthetic, ethical, or spiritual paradigms. But in theology, human dignity is intertwined in a paradox, because it is determined by an eschatological aesthetic that has already been realised in Christ. Human dignity can never be separated from the suffering of Christ. To understand human dignity, a person must use the lens of the cross (Louw, 2013:9).

In examining the concept of hope, this research discovered that hope is significant for PLWHA. The Christian hope is viewed from the resurrection of Christ. Believers, therefore, move with hope. Hope in the resurrection was seen to be an antidote against fear and the anxieties of life. This hope also builds the capacity of believers to render help to those in need (Louw, 2014:7).

The research found that in pastoral caring, listening and presence are essential. For there are times that words may not be enough to console a person because of the gravity of the event, but presence can signify care.

In discussing the value of women, the study discovered that Jesus placed great value on women. He interacted with them freely without any signs of a patriarchal mentality or discrimination. He accepted a Samaritan and a prostitute as friends but corrected their lifestyle with love and care.

The implication of all this for the church is that it should rise to the challenge and fight stigma from the pulpit or through deliberate programmes. The church could also help destigmatise

women through developing a flexible but relevant theology for PLWHA – a theology of acceptance, edification, and healing (MacArthur, 2017: xi). The church, as the representative of Christ in the universe, could model Christ, who accepted women unconditionally, rescued, and redeemed them from patriarchal tyranny. The research found that if the church in Nigeria was to accept PLWHA, it must truly understand the nature of humanity from God's perspective. The research thereafter designed a pastoral care intervention strategy in chapter five.

6.3. MAIN CONCLUSION

Based on Chapter Three, stigma manifests in many dimensions and women are the frequent victims. Men use patriarchy, domestic violence, and rape among others to inflict pain on women. Husbands who discover that their wives are HIV positive, maltreat or divorce them, consequently making them vulnerable to social vices.

The method I employed to confront the problem of the role of men in HIV and AIDS stigmatisation, is a pastoral care approach. From the research, it is clear that the church in Nigeria has not done enough in the area of restraining patriarchal mechanisms that empower men to dominate and stigmatise women. But church leaders still have the opportunity to correct their mistakes and make the church a safe place for all. Women who are stigmatised and suffer violence need to understand that their Master, Jesus, suffered stigmatisation on the cross to identify with them and there is hope for them.

6.4. THE RESEARCH CONTRIBUTION

This study contributes to the body of research by suggesting that a theology of unconditional acceptance be developed by the church. It revealed that every human being needs acceptance and respect. The fundamental motivation is embedded in the reality that the church, society, and individuals desire wholeness and peace. No organisation or individual cherishes catastrophe. If the church engages pastoral care ministries in shepherding the flock of God, it will create a serene environment for physical, emotional, and spiritual development. I agree with Louw (2014:1) that pastoral care has the capacity to empower church leaders, caregivers, and PLWHA with hope to cope with existential challenges. I am convinced that if all the dimensions of pastoral care are set in motion within the church, it will confront and address the role of men in stigmatising women.

Below are recommendations that support this contribution.

6.4.1. Recommendations

To achieve maximum success in dealing with HIV and AIDS stigmatisation, leaders of the church in Nigeria should try to:

- Unmask the primary causes and impact of HIV stigmatisation in families and society. This will give the church solid ground to ameliorate them.
- Create avenues for awareness campaigns and information dissemination. The church should make sure people receive accurate and relevant information on HIV and AIDS prevention, treatment, and transmission. It can achieve this through developing Bible studies materials with a deliberate focus on HIV and AIDS. This knowledge will counteract the myths about HIV and AIDS.
- Stand against any form of violence against members of the community, especially women and children. The church can employ the African *palaver* (meeting together to discuss issues) for this.
- Encourage PLWHA to have hope despite their condition by building their self-esteem and developing social support systems for PLWHA so they can access care with ease. This can be done through providing home-based care and distribution of relief for PLWHA.
- Defend the cause of widows and orphans whose spouses or parents died of HIV related sickness. For example, the church can initiate scholarships for these orphans; protect and safeguard the dignity and respect of PLWHA who have disclosed their HIV diagnosis results; encourage members of the church to handle sensitive information about PLWHA with complete confidentiality; and teach their congregations to desist from malign language towards PLWHA. This will give to other people with HIV and AIDS the confidence to disclose their status.
- Work on harmful cultural stereotypes that see women as inferior or view them as less than human and help church members to understand the equality of women and men before God.
- Become agents of hope and wholistic healing through educating church members to unconditionally accept PLWHA. If the contemporary church can emulate the early church in this regard, it would be extremely helpful.
- Work with traditional leaders who are Christians to begin eradicating societal norms that promote divisiveness and dichotomy among people.

6.4.2. Suggestions for further research

As stated earlier, this research, which was done during the COVID-19 pandemic, which severely restricted movement, depended on a literature review for its results. It could not involve the empirical feature, which is significant for gathering up-to-the-minute information using primary sources resident in Nigeria. Therefore, the study recommends that any subsequent research on this subject matter should involve meeting with the people in Nigeria to collect first-hand information on the role of men in HIV and AIDS stigmatisation.

I close this research with the words of Billy Graham, "… the most eloquent prayer is the prayer through hands that heal and bless. The highest form of worship is the worship of unselfish Christian service. The greatest form of praise is the sound of consecrated feet seeking out the lost and helpless" (NIV Prayer Devotional Bible, 2004:1065).

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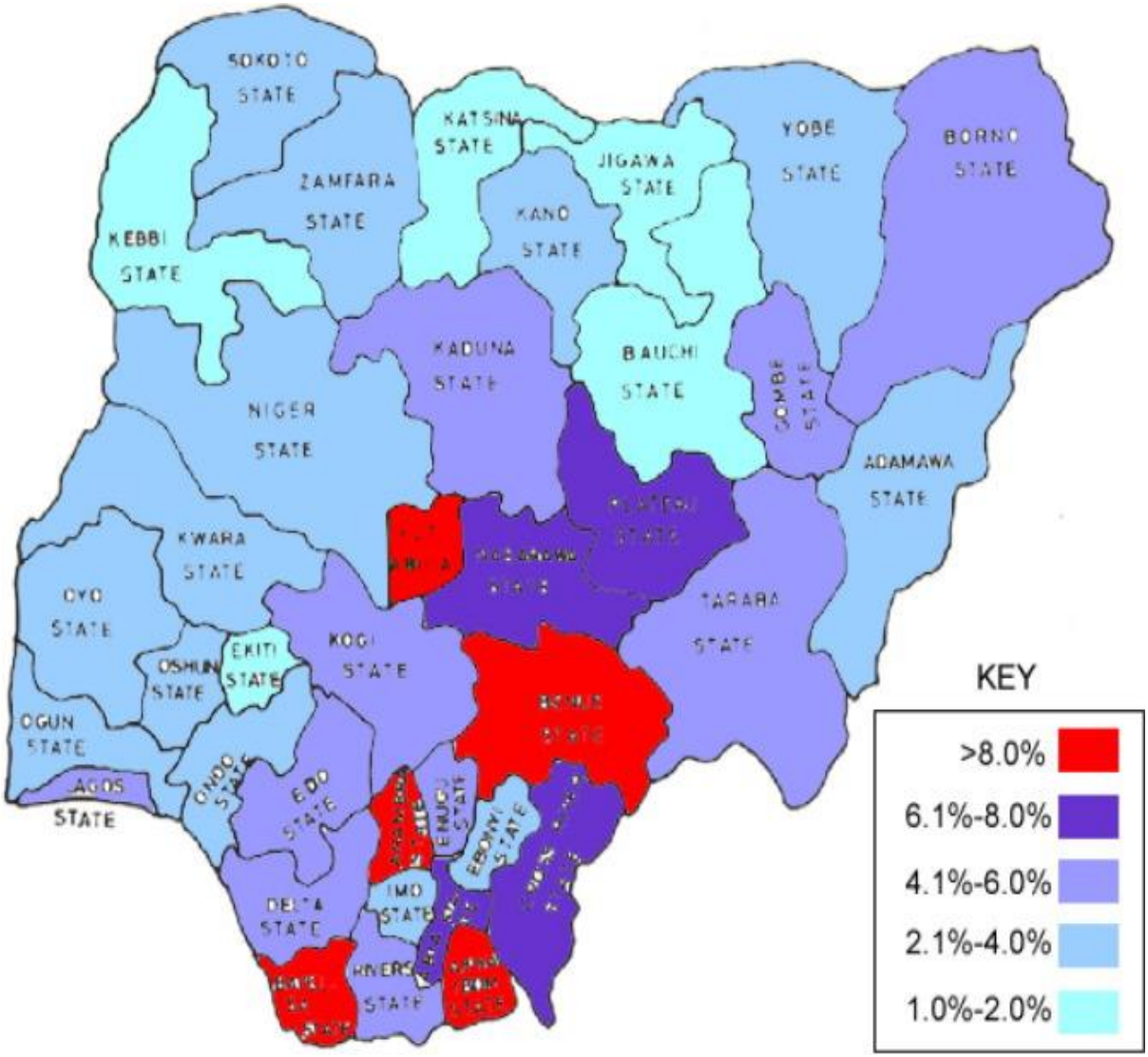
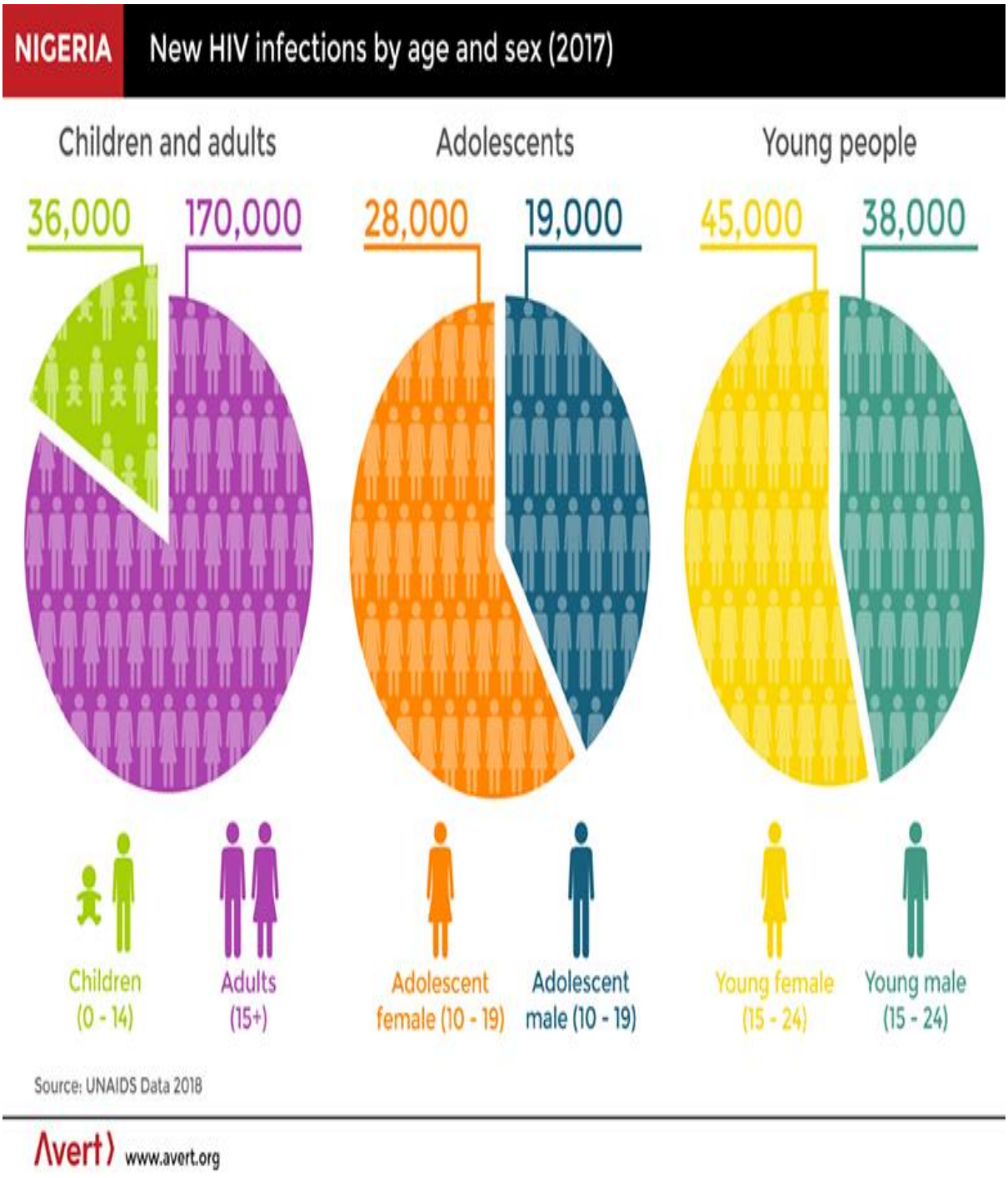
APPENDIX I



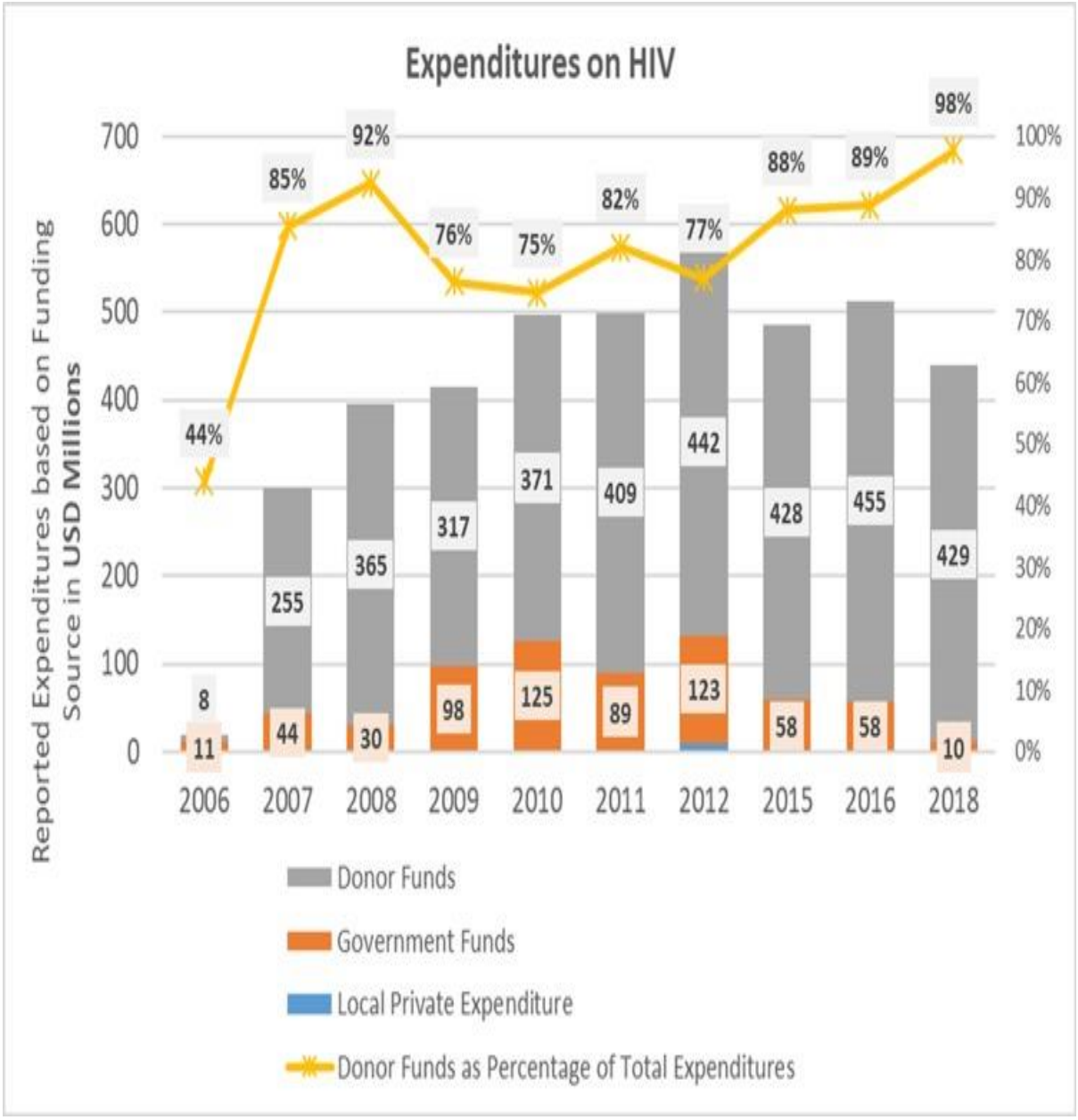
APPENDIX II

APPENDIX III



APPENDIX IV

APPENDI XV



APPENDIX-XX