Shame and Guilt: Some Challenges in the context of HIV Testing and Counselling in Malawi

BY

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Summary

The emergence of HIV and AIDS in Malawi has brought to light unique challenges the health and social systems in Malawi. To be contained the challenge needs a multisectoral approach. The National Strategic Framework on HIV/AIDS, adopted by the National Aids Commission (NAC), recognises the important role Faith Based Organisations would play in the response to HIV/AIDS (Phiri 2004:vi). The area of combating stigma and discrimination was highlighted as an area where the Faith Based Organisations can be of great resource since stigma and discrimination affects the inner man, the part of man which faith groups have been known to be dealing with for generations. For this reason, counselling was mentioned as an area that the church and other faith groups can contribute to.

My interest to focus on this topic is inspired by my participating in the course, "*Praktisk teologi, sjelesorg og formidling*"[1]. I became much occupied with the concepts of shame and guilt as it relates to so many areas of life in people's lives more especially as it relates to HIV and AIDS. The question that I have is what is shame? What is guilt? How is shame and guilt related to each other? What are some of the sources of shame and guilt? Can Christian Theology act as a source of shame and guilt? Finally, I will look at the problem of HIV and AIDS in relation to shame and. This whole scenario aroused my interest to look at the pre-test and post-test HIV counselling session guide called HIV Testing and Counselling (HTC)[2] that is being used in Malawi. The question that I have is whether the counselling process is a tool that can dismantle or exacerbate shame and guilt in people living with HIV and AIDS. Assuming that the tool has some gaps, the next assignment will be to come up with suggestions on how it can be improved by using principles from pastoral counselling.

In this thesis, I have cited some quotations in Norwegian and some expressions in Chichewa in order not to loose the intended original meaning. The translations are under footnotes. The English translation is my own

[1] Practical Theology and Pastoral Care

[2] HIV Testing and Counselling (HTC) is what has been known as Voluntary Counselling and Testing (VCT). For other reasons, the name has changed to HTC but the content of the counselling guide is the same.

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Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CHAM	Christian Health Association of Malawi
FBO	Faith Based Organisation
HIV	Human Immunodeficiency Virus
MCC	Malawi Council of Churches
MIAA	Malawi Interfaith Aids Association
NAC	National Aids Commission
NAF	National Action Framework
HTC	HIV Testing and Counselling
VCT	Voluntary Counselling and Testing

Chapter 1

This chapter is going to tackle what this paper is all about. Introduction will be the first part which will be followed by a definition of diaconia. Diaconia will then be related to the issue of shame and guilt in the context of HIV and AIDS. Counselling will be given as a proposed tool for dismantling shame and guilt. Thereafter, the research question will be presented which will be followed by the research method that will be used to collect data. Finally, the focus and structure of the thesis will be presented.

1.0 Introduction

Diaconia is the gospel in action. It is putting the word of God into practice especially by doing a service to people in need. The emergence of HIV and AIDS has brought with it a variety of problems ranging from material, social, and psychological to spiritual needs. These problems give an opportunity for the diaconal ministry to do what it is there for. The focus of this paper will be the psycho-social and spiritual problems that people living with HIV and AIDS suffer from. To be specific, the problem of shame and guilt in people living with HIV and AIDS will be the focus of this paper. Guilt is a reaction to unacceptable behaviour. It is defined as the bad feeling that one gets after one has broken any of the moral codes of conduct. Shame is the poor self image that a person gets where the person feels worthless and valueless. This paper tries to show how the problem of shame and guilt affects people living with HIV and AIDS. Thereafter, the thesis looks at the pre and post HIV counselling and testing tool called the HIV Testing and Counselling session guide. The interest is to analyse the counselling session guide and determine whether the tool can be an instrument that can dismantle shame and guilt. The principles of pastoral counselling will be assessed to determine whether the HIV Testing and Counselling session guide can be improved by integrating into the process some principles of pastoral counselling. The assumption is that Pastoral Counselling has elements which have the capacity to address issues that relate to the inner man. The approach of David Benner and John Patton to the definition of counselling will be used where David Benner defines pastoral care or care for the souls as, " *the support and restoration of the well-being of a person in his or her depth and totality, with particular concern fro the inner life"* (Benner 2006:14). This means that a helping relationship to man should be holistic. It must address man as body, soul and spirit. . I will come back to the definition of counselling in chapter 5

1.1 Diaconia and the issue of Shame and Guilt in relation to HIV and AIDS

In the new plan for diakon, Diaconia is defined as," *kyrkja si omsorgsteneste. Den er evangeliet i handling og blir uttrykt gjennom nestekjærleik, inkluderande fellesskap, vern om skaparverket og kampen for rettferd"*[3]. (Kirkerådet 2007:6 http://www.kirken.no/?event=doLink&famID=247 date visited 07.01.08). Sub-Sahara Africa, especially Malawi offers its own unique opportunities to the ministry of diaconia in the church. People living with HIV/AIDS suffer from stigma and discrimination which could be linked to shame and guilt. It is this area of shame and guilt that this paper will try to unearth. Thereafter an attempt will be made to find an approach that could be appropriate to handle the problem of shame and guilt in people living with HIV/AIDS so that they can regain their dignity.

Therefore, in this paper, I will endeavour to explore the magnitude of the problem of shame and guilt vis a vis HIV/AIDS in Malawi. Vulnerable groups of the society like women and children will be looked at with special interest. I will also look at the causes of shame and guilt Thereafter, I will analyse the different counselling models, namely, the Classical Model, the Pastoral-Clinical Model and the Classical Model. Thereafter, I will briefly describe the traditional method of counselling in Malawi and also describe the counselling guide that is being used by HIV testing centres in Malawi that is called HIV Testing and Counselling (HTC). According to HIV Testing and Counselling, the client to be tested of the HIV virus is supposed to be counselled before and after the testing to help the client that would be found to be living with the HIV virus live positively after the diagnosis. Those that have been found to be living without the virus are to be encouraged to live consciously so that they do not get infected. My interest is to analyze the process of the HTC counselling guide. The relationship that is there between shame and guilt, and HIV and AIDS will be looked at to determine whether the process of HIV Testing and Counselling is a tool that is able to dismantle the shame and guilt in people living with HIV and AIDS.

1.2 Counselling and HIV and AIDS

HIV Testing and Counselling provides the very first opportunity where communication with a person living with HIV and AIDS begins. If HTC is well handled it can be a tool of

[3] diaconia is the church's care for people in need. It is the gospel in action and deed which is shown through love of the neighbour, inclusive fellowship and a fight for justice

empowerment to people living with HIV and AIDS. If not well handled, it can also be a tool that can make the client to further suffer from shame, guilt, isolation and desertion, forcing the client to remain in a vicious circle of shame and guilt.

My motivation for the research question is that being a Malawian who has lived mostly in Malawi, I can say that I have felt the magnitude of shame and guilt in the case of HIV/AIDS. I know that despite the massive campaigns that have so far been done in Malawi, only a few have gone for testing for the virus, and in the case of the few that have tested and know their status, even fewer go public and declare their status. Does stigma and discrimination have a role in this?

In my study of literature, I have come to note that the problem of HIV and AIDS is a big problem that has left no stone unturned. All sectors are working together to contain the situation. An attempt has been made by the Malawi Council of Churches to come up with positive theology that can address the needs of people living with HIV and AIDS. The contribution of this paper will be to analyse the HIV Testing and Counselling session guide to assess if the positive theology is being put into practice. Where necessary, the HTC tool will be revised.

1.2.1 Research Question

The research question that I will be working with in this paper is:

- *"Is HIV Testing and Counselling (HTC) process a counselling process that can dismantle shame and guilt in people living with HIV and AIDS in Malawi?"*
- "*By using HIV Testing and Counselling (HTC), how can the principles of Pastoral Counselling enrich the HIV Testing and Counselling (HTC) so that the tool can address the issue of shame and guilt in people living with HIV and AIDS in Malawi?*

The literature that I have studied shows that shame and guilt affect people living with HIV and AIDS, which is the possible cause of stigma and discrimination. Most of the people that come for the HIV Testing and Counselling services are aware of the shaming messages that are associated with living with HIV and AIDS, hence it would be true to assume that most of the clients that come for HTC, come with expectations of being equipped with life skills on how to live positively with HIV and AIDS if found to have the virus that causes AIDS. The aim of this paper would be to analyse the counselling process, assess how far it goes in attempting to

dismantle shame and guilt and if necessary, come up with a recommendation on what can be done to improve the process.

1.2.2 Method

HIV Testing and Counselling is a counselling process that is specifically given to people that have made a choice to have their blood screened for HIV virus. In the HTC process, counselling is supposed to be done twice, before and after the testing. In an attempt to answer the research questions, I will first try to give the background information on the different challenges that HIV and AIDS has brought on the people that are related with shame and guilt. Literature and case illustrations from the Malawian media will be reviewed to illustrate how shame works as a barrier to people living with HIV and AIDS to be able to freely fellowship with others that at times includes the church. Different groups of people living with HIV and AIDS will be looked at together, but the issue of women will be analysed with special interest because of the magnitude of the shame that HIV/AIDS brings on this group is also special based on the social and cultural environment that they are in. The two booklets called *"Onebody*" volume 1 and 2 that have been produced by the Nordic-FOCCISA Church Cooperation (this is a collaborative relationship between eleven councils of churches in Southern Africa and five councils of churches in the Nordic countries) will be used to get the information that will help in determining the self image that people living with HIV and AIDS assign themselves. Literature will also be analysed to be able to have an idea of how the general society, including the church looks at people living with HIV and AIDS. That is, is the church able to accept people living with HIV and AIDS without any conditions? If it is found that there are some conditions that are there whether the conditions are practised consciously or unconsciously, how does this attitude affect people that are willing to go for HTC and are in the process of decision making, does the attitude encourage or discourage those that are willing to know their serostatus? The answers to these questions will have a bearing on people who are willing to go for HTC. Therefore, to be able to address the problem of shame and guilt that might be there in the minds of people who have decided to go for HTC, there is need that the HTC process itself should be able to address the shame and guilt that may be in the people. And that is the question that this paper is trying to answer if the HTC process is a tool that can dismantle shame and guilt in people living with HIV and AIDS. The assumption is that after being diagnosed with HIV, people should be able to live a normal life like they used to do before the diagnosis. That is supposed to be the goal of HTC, to equip and empower people

diagnosed with HIV with the right skills and attitude for positive living. But does the tool have the capacity to achieve this? This is the assignment for this paper.

To define the concept of shame and guilt, among several books that I will refer to, I will mainly use Robert H Albers' book titled, *"Shame: A Faith Perspective***".** In addition, I will also be referring to Lewis's B Smedes' book titled "*Grace: Healing the Shame we do not Deserve*". Of course other books on shame and guilt will also be used so that I can come up with a wider definition of shame and guilt which can better be related to the issue of HIV and AIDS.

The concept of counselling will be defined and analysed by using Øyvind Eide's chapter that is titled, "*Three approaches to pastoral care and counselling*" which is in his forthcoming book to be titled, "*Restoring life in Christ : introduction*" I will look at the three counselling Models, that is, The Classical Model, The Pastoral Clinical Model and The Contextual Model. The models will be analysed. Strengths and weaknesses of each model will be pointed out. Thereafter I will discuss the Traditional way of counselling in Malawi by Dixie Maluwa Banda who is a lecture at the University of Malawi, Chancellor College. The Malawian traditional counselling model will also be discussed. Thereafter, I will analyse the HIV Testing and Counselling (HTC) process that is used in Malawi in pre-testing and post-testing of HIV. My interest is that after the HTC process has been analysed, it can be redesigned so that other ideas that are diaconal in nature can be integrated in the process. The assumption is that even with the many strengths that are in the HTC process, the process can be further enriched by the Christian values/ethics so that people living with HIV and AIDS can preserve or regain their human dignity. In analysing the HTC process, I will use the principles of counselling as has been outlined by the Malawi Council of Churches in the "*HIV/AIDS Learners Manual for the Clergy"*. These will be the lenses that I will be looking through in the analysis of the HTC process guide.

It is assumed that the church has a role to play on the issue of people living with HIV and AIDS in Malawi. For this reason, I will briefly describe the theology that has been developed by the Malawi Council of Churches (MCC), which is an umbrella organisation for most of the protestant churches in Malawi. To have their theology, I will use the *"HIV/AIDS Learners' Manual for the Clergy*" that was developed by the same body MCC. The manual was developed for the dissemination of the positive theology that was developed in relation to

HIV and AIDS. My interest will be to analyse if this positive theology that has been developed by the Malawi Council of Churches has been integrated in the HIV Testing and Counselling (HTC) that is being used in the diaconal health institutions of the church.

1.2.3 Focus and Structure of the thesis

I will concentrate my study on Malawi, but will also be using Sub- Saharan Africa literature since Malawi falls in this region. The structure of the thesis is that it will take two parts. The first part will be descriptive, that is I will describe the situation on the ground about the problem of HIV and AIDS in relation to shame and guilt. I will also describe some of the possible theological causes of shame and guilt. Thereafter I will define what shame and guilt is, and relate the two concepts to HIV and AIDS. Counselling will then be defined and discussed to come up with what can be called a good counselling. This will then move the paper to the analytical part where the HIV Testing and Counselling guide will be analysed to determine whether the counselling guide is able to meet the counselling guidelines that were recommended by the MCC. After this part, the paper will take the normative, that is to say, how HTC should be. The final part of the paper will be the presentation of the revised HIV Testing and Counselling, its justification and my recommendation.

1.3 Summary

This chapter is the introduction of the thesis. It has presented what the thesis is going to find out, that is the research question and how the answer to the research question will be found out. The focus and structure of the thesis has also been presented.

Chapter 2

2.0 The Challenge of HIV and AIDS

This chapter is going to explore the challenge of HIV in relation to its transmission. The main mode of transmission for HIV is through sexual contact. The question that will be looked at in this chapter is, "does this have any effect on the identity of people living with HIV and AIDS?" Two illustrations will be presentation that relate to this. This is a challenge because the issue of HIV and AIDS touches on the most sensitive topic of sexuality. Talking on sex used and still is a taboo especially in most parts of Africa and Malawi inclusive. The other question that would be looked at in this chapter is whether shame and guilt affects the different sexes, male and female with a different magnitude.

2.1 Illustrations of the Challenge of HIV and AIDS

To begin with, I will start with a story of a Malawian Pastor of Evangelical Baptist Church which appeared in Nyasa Times of 7th February 2008, which is a Malawian internet News Paper. The pastor is living with HIV. He tells of his story of how difficult was to disclose and share his status with different people including the church that he serves. He says:

> *"I planned to disclose my status at a pastors' conference, but what I heard saddened me. I had asked them what they would do if they saw an HIV-positive person and they answered that they would laugh. I was shocked and did not disclose that I was HIV positive.* (www.nyasatimes.com Date visited 08.02.08).

He continues to narrate his experiences as a person living with HIV that he faced after he had disclosed his serostatus. He specifically points at the shock he experienced after he had finished his studies and was ordained a pastor. He was assigned a congregation to minister to but due to the shame that is attached to the status, some pastors could not imagine that a person living with HIV and AIDS could pastor a child and therefore they protested. In his testimony the pastor living with HIV says, "When I was given a station from where I would be ministering, some pastors protested, saying how could the authorities bother to give me a station when I was going to die soon" (www.nyasatimes.com Date visited 08.02.08). Was the protest of the pastors really based on the fact that the newly ordained pastor is going to die soon? There is need to establish the reason behind the other pastors protest.

Secondly, I would like to bring up a story that that came up on a Student Christian Organisation of Malawi (SCOM)[4] yahoo chat group that illustrate shame experienced by the laity. The story happened in one of the congregations in Malawi. The name of the denomination has been withheld; It was the member that contributed this story to the chat group:

> *"I write to share a 'small' story that took place in our church one of the past sundays. I sat on the second row, close to the wall. To my right was a man in his late thirties. Thus, we were practically sitting in front. This man to my right was visibly symptomatic with HIV/AIDS related illnesses. Everyone occupying front rows (there are many front rows in my church as it has four 'arms' or sections) could see that this man was sick and that his condition was related to HIV. As the church service progressed, the convener requested one of the choirs to 'bless' us with one song. Members of the choir, which also occupied some of the front rows in the main arm/section stood up and the choir master took to the front. In no time, the man to my right wished the ground could swallow him up. He held his head in his right hand and looked very tensed up. The church applauded the choir after the song by clapping hands as the man looked more tensed up. It was the song that made this man feel dejected. The song insinuated and in some phrases explicitly stated that the sexually reckless will contract HIV and will die. "Is the church not there to comfort the sick" I asked myself. I was disappointed. Has the church not yet learnt to deliver HIV messages without condemning the sick including those affected by HIV and AIDS?"*

One would ask, why is the situation like that for people living with HIV and AIDS in Malawi? Using the examples above, why could the church not easily accept the pastor living with HIV? In the same vein, why did the church applaud the choir for the song? Despite the applause by the church, how did the man who was visibly symptomatic with HIV and AIDS related illnesses feel? He felt dejected and lonely. He probably came to church to receive answers to his problems. One wonders as to whether the man got the answers that he was looking for. Positive theology that should include people living with HIV and AIDS has been developed, but one wonders in such cases as to whether the positive theology has been

[4] SCOM is a Christian interdenominational youth fellowship that operates in Secondary, Colleges and University schools in Malawi.

translated into practice. Could counselling provide an answer to this dejected person's situation?

2.2 Stigma and Discrimination and HIV and AIDS

From the issues that have been raised above, we can see that HIV and AIDS is not just a health problem. It is also a social, psychological and spiritual problem. It affects the person the way he/she can relate with himself/herself, the way he/she can relate with other people and even the way he/she can relate to God. When tested positive people are aware of the attitudes that the society has towards people living with HIV and AIDS because it could be that even they themselves might have also judged other people living with HIV and AIDS harshly before. They are part and parcel of the same society and they know pretty well the value that is placed on people living with HIV and AIDS. For this reason, a lot of people are scared to go for testing for fear of the psychological torture. This is concurred with Lauw who says:

> *"With this issue of stigma and discrimination, among the many questions that AIDS patients ask themselves, they ask;*
>
> - *Who am I? Am I still the same person? Am I acceptable to my people, my relatives, and my friends? Or they will drop me?*
> - *I am guilty and have made a mess of my life. Could I accept and forgive myself? Could God forgive me? Or What is the meaning of this? Why did it happen to me? Is life fair? And son on (Ibid 1994:131-132)*

For the brave ones who have gone for testing, they are faced with the dilemma of whether to disclose or not. Being found to have HIV in Malawi, it means that first and foremost, they will have to come to terms with the psychological challenges that have been described above. That is the person who has been found with the virus has to come to terms with his/her status. If the person decides to disclose his/her status what it means is that the person has also to gather a lot of courage so as to be able to face the "judgmental cloud" No wonder that the Nordic-FOCCISA in their booklet titled OneBody, vol 1, pointed out that, "For those who are living with HIV or AIDS, stigmatization is the key reason for reluctance to disclose their condition or to come forward for HIV Testing and Counselling, healthcare or medication to prevent transmission to unborn child (Ibid 200 :.5). This is concurred with a testimony from a Zambian Woman living with HIV who says:

"What wears me down is that my role in society has changed. It is no longer easy to meet friends especially in the same way as before. I am aware that they are thinking about me being infected. I often make the situation worse myself. I feel that I can live my leprosy or HIV if you like, by withdrawing. It is not HIV itself that I am suffering from, it's people that make me suffer (One Body vol 1pp.43).

In the same vein, there is yet another person from Zambia who says his experience of how difficult it was to disclose his HIV status:

"This is how my status was disclosed to my children. I know it has not been easy for my daughters who are in highschool having a father who is who is HIV positive – just as it was not easy for me at my work place and in the community. But I just had to face the stigma and the shame and help break the silence by talking about my status publicly (Onebody vol 2: 11)

This stigma and discrimination does not affect only the infected person, but also members of the immediate family, the most hit being children.

Stigma and Discrimination makes the condition of people living with HIV and AIDS to be very awkward and strange. It is normal that when a person is sick from any other kind of disease like in malaria which is very common in Malawi, it is the disease or the disorder that is the problem. The solution comes with handling the disease or disorder like in the case of malaria is to deal with the plasmodia which case the disease in the blood of the patient. But the case of people living with HIV and AIDS seem to be more complex. The solution to the problems being faced with people living with HIV and AIDS is not just in finding solutions to their medical condition. The bigger part of the problem is psycho-social. As the Nordic-FOCCISA Church Cooperation writes:

"It is now common knowledge that in HIV and AIDS, it is not the condition itself that hurts most, but the stigma and the possibility of rejection and discrimination, misunderstanding and loss of trust that HIV positive people have to deal with (One Body vol 1pp.5).

2.3 HIV and AIDS and Women

Much as all people are affected by the impact of HIV and AIDS, the question is; are all people affected equally? According to the Nordic FOCCISA report, it shows that the impact of HIV and AIDS is harder on people who have less power in the society. The next question would be

to look at the power division in the Malawian society. Do men and women have the same power in terms of their sexuality? It shows that most women in Africa do not make decisions on their own sexuality just as Avert (which is an international AIDS charity) reports:

> "*As is the case in many nations, women in Malawi are socially and economically subordinate to men. This inequality fuels HIV infection, as traditional gender roles allow men to sleep with a number of sexual partners and put women in a position where they are powerless to encourage condom use. Many women are brought up to never refuse sex with their husbands, and sexual abuse and coerced sex are common* (http://www.avert.org/aids-malawi.htm date visited 17.04.08)

This relationship between power and HIV that has been brought up by avert has been supported by the Nordic FOCCISA report who says:

> *"HIV and AIDS studies show that a major factor in the spread of HIV and AIDS is the powerlessness of women, especially their inability to make decisions about their lives due to lack of material ownership and decision making powers*" (OneBody vol 1 pp 14)

To emphasise the fact that the challenge of HIV and AIDS has affected women to a greater magnitude that men, avert has actually said that HIV infection is female. That is HIV has a gendered face. Avert says:

> "*HIV infection in Malawi is disproportionately female, and younger women are particularly affected. For instance, AIDS affects more than four times as many women as men amongst the 15-19 age group in Malawi, and about a third more women than men amongst the 20-25 age group* (http://www.avert.org/aids-malawi.htm). date visited 17.04.08)

2.3.1 Women Living with HIV and AIDS and Guilt

HIV and AIDS is viewed as a disease that was gotten from immorality. Even though it was earlier alluded to that women have less control over their own sexuality, the irony is that it is believed that the woman takes responsibility of the "immoral behaviour". Harriet Deacon has this to say on this:

> *"the prejudice of labelling people with HIV and AIDS as prostitutes is worse for women where she says that people believe that the epidemic is the result of women being sexually out control…virginity testing is an attempt to manage the epidemic by*

exerting greater control over women and their sexuality" (Harriet Deacon and HSRC SCI and SAHA 2004; pp 53-54).

This thinking is supported by the well known Malawian proverb which says; *"Chigololo ndi mwini thako"*[5]. The proverb means; for any adultery to take place, responsibility lies in the hands of the women for it is her responsibility to say no. This is supported by the Malawi Interfaith Aids Association report that says, in a number of societies, women are perceived as the main transmitters of sexually transmitted diseases (MIAA report 2006:21). A woman is the one who has the responsibility to weigh and judge as to whether the two can have sex or not. It is assumed that it is only the women who have been given the wisdom to regulate human sexual morality and the needed self control on such matters. Men are excused from taking responsibility of any sexual morality because they are traditionally accepted to be irresponsible. In a Malawian metaphor, men are called *"amuna ndi ana*"[6]. This means that a man is easily excused, understood or forgiven if he is found to be living with HIV and AIDS. But the case is different for a woman. As a woman, it is assumed that she should have been more responsible! These are the issues that a woman living with HIV and AIDS has to address. In this case, when a woman is found to be living with HIV and AIDS, is it possible to maintain her self dignity, self image and self value? It seems that the Malawian society has very high moral expectations from women. HIV and AIDS being transmitted through sexual contact, it is therefore translated as a sign that one has not managed to live up to the societal expectation. The woman being the one who has that responsibility to control immorality is made to bear more painful of not managing to live to expectations.

2.4 Summary

In this chapter, it has been found out that people living with HIV and AIDS have psycho-social problems that need to be addressed. HIV and AIDS changes the way people living with HIV and AIDS look at themselves. It is about their worth, their intrinsic value, and their human dignity that is negatively affected. In this problem, it is the women that are the most affected due to the cultural environment that they are in, in Malawi.

[5] Literary means, "adultery is the owner of the vagina"
[6] Which literary means "men are children"

Chapter 3

3.0 The Church and HIV and AIDS in Malawi

This chapter is generally going to look at the church in Malawi. Since Malawi is a society with a diversity in church denominations, the word church in this paper will be referring to the protestant churches that belong to the Malawi Council of Churches (MCC). The church's teachings on sexuality and stigma and discrimination as it relates to the teachings will be looked at. Thereafter, I will look at the positive theology that has been developed by MCC in an attempt to combat stigma and discrimination and MCC's view on the HTC process that will be analysed in this paper. Finally, I will present the view of the church by the society in Malawi.

3.1 The Church in Malawi

It is true to say that Sub- Saharan African church is predominantly a conservative and moralist. There are diverse views even on the definition of the church. I will not go into details of defining the concept church. But for the purposes of the paper, the term church is referring to all denominations that are members of the Malawi Council of Churches (MCC). Because of the different denominations, there are different doctrinal on behaviour and church discipline. Most of the members of the Malawi Council of Churches are Protestants who follow the teachings of John Calvin, a believer in reformed ecclesiology. Reformed theology teaches that correct faith in Christ must be followed by upright living just as Kärkkäinen comments that:

> "*Whereas for Luther questions of behaviour were mostly left to the judgment of the conscious, Calvin was much more legalist who sought to implement a specific and rather ascetic view of the norms of Christian conduct"* (Kärkkäinen, Veli Matti 2002:51).
>
> It is therefore for this reason that the Malawi Council of Churches is also conservative and legalistic.

3.2 The Teachings of the Church on Sexuality

This issue begins straight form the Decalogue, the Ten Commandments found in the bible and play a very big influence on what is right and wrong especially in the Malawi's Christian context. The eighth commandment says, "Do not commit adultery" (Exodus 20:14). The Malawi Council of Churches has this to say on premarital and extra-marital sexual relations:

"*Premarital and extra-marital relations and prostitution are still as wrong as they were in the ancient days of the Bible (whether they lead to contraction of STIs and HIV, and teenage pregnancies or not). The importance of Christian children, youths and parents avoiding all kinds of sexual immorality is very clear in the New Testament where Jesus condemns it (Mt. 15:19, Mk7:21). It is one of the four basic commands of the Jerusalem council (Acts 15:20,29) (Joda-Mbewe 2004:148). (Joda-Mbewe is a reverend in the Church of Central African Presbyterian* (CCAP), Nkhoma synod in Malawi).

3.3 Teachings on Sexuality vis a vis Stigma and Discrimination

The link with HIV and ADS is that the common transmission of HIV is through sexual contact. For reasons that can not be explained, in the case of HIV transmission, instead of the phrase HIV is transmitted through "sexual contact", the message that is heard in the ears of most Malawians is, "HIV is transmitted through adultery". Being HIV positive is seen as a sign that you or at least someone very close to you like a spouse, or a parent committed adultery and the person living with HIV and AIDS is bearing the consequences of that sin! It is this thinking that has brought stigma to the people living with HIV and AIDS. This thought is supported by Stiebert, Johanna who is an associate professor of Hebrew Bible in the University of Tennessee, USA has this to say:

"*The stigma of being either HIV+ or suffering from AIDS is considerably more profound than the stigma attending many other illnesses or diseases. The reason for this appears to be neither its infectiousness, nor its deadliness per se: influenza, or malaria, or cancer does not suffer comparable shame and stigma. Instead, it seems to be the dominant mode of infection – namely, through sexual contact – that has exacerbated the negative perception of suffers most. Discrimination thus results from perceptions about the infected person's moral fiber and behaviour. Consequently, the second type of stigma, pertaining to blemishes of character, is at issue here* (Ibid 2003:81).

In support of this thinking, Harriet Deacon (who is an independent consultant to the Human Sciences Research Council (HSRC) in South Africa), in her report says:

"because of the acquired nature of HIV infection, the way in which HIV/AIDS stigma has been expressed has often tended to stigmatise people living with HIV/AIDS more for the way it was acquired – being part of a specific community or group that is

already defined negatively – you are HIV positive, therefore you must be a prostitute" (Deacon Hand HSRC SCI and SAHA 2004:13).

The Malawian Pastor concurs with the existence of this attitude by saying:

"*What I have discovered is that there are certain churches (denominations) – the word in brackets is my own- in Malawi that are still unwilling to embrace people like me. They keep preaching that those with AIDS are sinners or got HIV through promiscuity, which is wrong*" (www.nyasatimes.com).

The scenario has led to the thinking that since adultery is sin, the culprits deserve to be punished. HIV and AIDS is the punishment for adultery. Nadar (who is a lecture at the University of KwaZulu-Natal) agrees with this and points out that, "*a lot of people subscribe to the most commonly circulated assumption that HIV/AIDS is a punishment from God*". (Nadar 2004:61). Nadar continue to say that Banda and Moyo(who are both lectures at the University of Malawi, chancellor, College), (2001:51) "*cite similar statements received from the church leadership in Malawi, when posed with the question of how to deal with HIV/AIDS"*. (Nadar 2004: 61). With these sentiments, it shows that the mode of acquisition of the HIV virus has brought a challenge to the church in Malawi.

The Church's teachings on premarital and extra-marital sex that it is wrong and sinful were developed way back in the times of the Old Testament to regulate sexual behaviour among people. The origin of the teachings has nothing to do with the issue of HIV and AIDS, for HIV and AIDS is a pretty new phenomenon. Hence, one wonders as to whether whenever these teachings on sexuality are preached target to shame and condemn people living with HIV and AIDS? Yet, despite the motive of the preachings, it shows that people living with HIV and AIDS get negatively affected, they feel condemned and shamed when messages of sexuality are preached. It is for this reason that a man in the Nordic FOCCISA Church Cooperation booklet speaks of his experience the first time he went to church soon after being tested HIV positive, "*my first encounter with the church and its message, just after I was infected, was to hear a message of condemnation*" Nordic FOCCISA Church Cooperation, Onebody vol 2 2005:7).

3.4 Malawi Council of Churches and Positive theology.

By looking at the above description, it is clear that there is some misinterpretation of the Bible in relation to HIV and AIDS in Malawi. The Malawi Council of Churches acknowledges this

and has come up with a positive theology and has developed a learners manual for the clergy so the positive theology can be disseminated. In short on positive theology developed by MCC, Rev. Joda-Mbewe who says:

> "*It is a mistake therefore to consider those suffering from AIDS as outcasts or sinners. People should give full support to them…..It is possible that in a family one person can suffer innocently from AIDS, just because one partner had contracted it from his or her unfaithfulness. So, it is wrong to sideline those who suffer from AIDS*" (Joda-Mbewe 2004:158)

The Malawi Council of Churches also acknowledges that there is still a gap in the practice of the positive theology because of ignorance on which the body says,

> *"Many pastors are not aware of the biblical approaches fro healing, hope and encouragement for them to develop a biblical basis for dealing with HIV/AIDS stigma and discrimination. This phenomenon led to proclaimation of discriminatory messages that regarded AIDS as a direct punishment from God*" ((Joda-Mbewe 2004:137)

This means that there are still a lot of people including the clergy who preach on the issue of sexual morality at the expense of the dignity of people living with HIV and AIDS.

3.5 The Church and HIV Testing and Counselling in Malawi

The other thing that would be of interest to know is the relationship between the church and HIV Testing and Counselling. HIV Testing and Counselling is mostly the issue for the heath institutions, and the counselling guide was developed by the state machinery.HIV Testing and Counselling takes place in the health facilities owned by the churches that are members of the Malawi Council of Churches. When it comes to the actual HIV Testing and Counselling for the people the Malawi Council of churches (MCC) advises that: "*the clergy should refer all their clients requiring HIV Testing and Counselling (HTC) services to the nearest health facility or AIDS service centres for information*" (Ostiguy, H 2004:109, the author is a counsellor at St John of God Community Counselling Centre). People who have been referred to HIV Testing and Counselling by the clergy would very likely expect that their needs would be met holistically, that is body, soul and spirit. The question is whether the HTC tool has the capacity to address the needs of man holistically and assess how principles of pastoral care can enrich the HTC process guide. This calls for the need to analyse the HIV Testing and Counselling guide. The analysis of the HTC process will be done using the principles for

counselling that Malawi Council of Churches has outlined in its HIV/AIDS learners manual for the Clergy which will be followed by the revised HTC.

3.6 How the Church is viewed by the society in Malawi

The next question to be considered would be, since the designer of the HTC model is the state machinery which is secular, can it be possible for the church to revise the HTC process. To answer this question, let us look at the way the church is viewed in Malawi. The church in Malawi commands a lot of respect. Here is the summary of how the church is viewed by the society according to a research that was conducted by the Malawi Interfaith Aids Association:

- They are respected and trusted and have moral authority
- The church is naturally a value-based institution with direct jurisdiction over issues of behaviour, morality, family life and belief
- The church has regular involvement with its members and followers, including direct contact with people at key life events e.g. birth, coming of age (puberty), marriage and death
- The church has a position as a spiritual home for members and as a source of strength, support and hope for the people who are ill or in need. (MIAA report. 2006:24)

This provides an opportunity for the church to address issues of HIV and AIDS. The church is an influential institution in Malawi and this puts her at an advantageous and powerful position to combat shame and guilt in people living with HIV and AIDS. It is an institution that has moral authority and direct jurisdiction over issues of behaviour and morality. As it has been already discussed in the paper, it was established that the issue of HIV and AIDS is directly related with the issue of morality, especially sexual morality. People living with HIV and AIDS are viewed as prostitutes. This breed shame and guilt as it has already been pointed out. Therefore in this case, where the church has so much respect and authority in the society, it would only take the church to make a move. The Malawi society is waiting just for that move. In fact, the national body that is responsible for coordinating all efforts and activities that are done in Malawi to contain the HIV and AIDS situation had this to say in its national strategic plan, which was called National Action Framework (NAF) for the period of 2005-2009,

> "*The Malawi HIV and AIDS National Action Framework (NAF) 2005-2009 also takes note of the need to improve the need to promote transformation of theological orientations and enhance the involvement of Faith Based Organisations (FBOs) in*

offering spiritual counselling to people living with HIV and AIDS and affected families." (MIAA report 2006:24)

This shows that the ball has been shoot into the hands of the church. The church has the respect and authority that she needs from the Malawian society. Here the government of Malawi has clearly said that the nation need the involvement of Faith Based Organisations in offering spiritual counselling to people living with HIV and AIDS and affected families. Now the ball to break shame and guilt, stigma and discrimination is in the hands of the church. But, does the church have the necessary tools to do the proper job of the said counselling of people living with HIV and AIDS and the affected families? This question moves me more to come up with the revised HTC process.

3.7 Summary

This chapter has defined the church as it is used in this paper. That it refers to the protestant churches that belong to the Malawi Council of Churches (MCC). The church's teachings on sexuality and stigma and discrimination as it relates to the teachings have been looked at. Thereafter, the positive theology that has been developed by MCC in an attempt to combat stigma and discrimination and MCC's view on the HTC process that will be analysed in this paper has been presented. Finally, the view of the church by the society in Malawi has also been presented.

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Chapter 4

4.0 Shame and Guilt

This chapter defines the two concepts of shame and guilt. The concept of shame and guilt will be related to the issue of HIV and AIDS. An attempt will also be made to find out if the shame and guilt in people living with HIV and AIDS has its source also in the teachings of the church apart from the other sources of their shame and guilt.

4.1 Definition of shame and Guilt

The two terms shame and guilt are different but are usually used interchangeably. In trying to differentiate the terms, I will define them.

4.1.1 Guilt:

Guilt is a negative feeling that is basically caused by a wrong doing. Each society has its own moral standards which are used to measure whether an action is morally acceptable or not, that is whether the action is right or wrong. This has been well embodied in people's culture and religion since ancient of days. When a person breaks one or more of these moral codes or standards, the person usually feels bad about it and regrets having done it. This feeling is what is called guilt. Albers illustrates guilt by giving this example; He says in guilt, one hears this command, "*Stop! What you are doing violates the standard or rule. Pay attention to what you did and alter your behaviour*" (Albers 1995: pp.25). In guilt, it is the wrong thing that is done or the right thing that is left undone that gives rise to the bad feeling. A person feels guilty when he/she thinks that he/she has made a mistake or done something that his culture or religion says that it is wrong.

4.1.2 False Guilt

False guilt refers to same negative feeling that a person who has committed something wrongly may feel, yet without doing anything wrong. There are many times when there is something wrong and the blame falls on the person that is not responsible for the wrong action. In this case, instead of defending himself/herself, the wrongly blamed person may suffer from the feelings of guilt even though, he/she is not the one who did the wrong action. This is in agreement with what Berit Okkenhaug says when she writes:

> *"Mange hard et noen kaller 'falsk' skyldfølelse, det vil si at de har en overdriven opplevlse av å væere skyldige, også når de ikke er det. Følelsene deres er ikke 'falske',*

de er ekte nok, men det er sterkere enn det er grunnlag for i møte med reell skyld"[7] (Okkenhaug 2002:207)

The cause of the feelings of false guilt may be unfounded, but the feelings are equally strong and at times stronger that those caused by a wrong action. Many times this experience of false guilt is combined with low or bad self image. People who feel that they are worth low value and are less important are the ones who have a higher likelihood of taking upon themselves the guilt whose wrong actions are done by others, mostly the people taken to be more senior than them. It should be noted that shame involves issues of self-consciousness and self imaging. Therefore, it can be noted that shame and guilt, even though they are two different concepts, the concepts are related. It is for this reason that shame and guilt will be dealt with alongside each other in this paper. The two concepts are also closely related in the context of HIV and AIDS.

4.1.1.1 HIV and AIDS, Guilt and Biblical interpretation in Malawi

To determine guilt, there must be rules and regulations. Malawi just like many other countries is made up of a society that has its own moral rules and regulations. Among many other sources of what is right and what is wrong, religion contributes a greater percentage to the dos and don'ts of the society. Christianity being the biggest religion in Malawi that counts for about 80% of the population has a big influence on this issue of what is right and what is wrong.

4.1.1.1.1 The two case illustrations, and example of guilt and/shame?

Firstly, would refer to the story that has been mentioned earlier where a Malawian Pastor of the Evangelical Baptist Church failed to disclose his serostatus at a pastor's conference because he sensed even before he disclosed that the news was not welcome at all. The people that he talked to at the conference told him right in the face that they would laugh at a person living with HIV and AIDS if they saw one. The question is why would they laugh? And after the pastor had been ordained, fellow pastors protested that he does not deserve to be given station where he can minister the word of God. In the same vein, one would ask, why did the pastor living with HIV and AIDS not deserve to have a duty station? Were the other pastors

[7] Many have what is sometimes called "false" guilt feelings. One can say that the feelings are only an exaggerated experience of to be guilty, but its not like that. The feelings are not false, they are as strong and painful as it is to meet with reel guilt feelings.

really concerned that the man will die soon, so he better stay home and prepare for his death, if at all that is a proper way of preparing to die? The answer to the questions is found in the same article in the Nyasatimes Newspaper. The pastor living with HIV and AIDS gives the answer when he says, "What I have discovered is that there are certain churches in Malawi that are still unwilling to embrace people like me. They keep preaching that those with AIDS are sinners and got HIV through promiscuity, which is wrong" (www.nyasatimes.com Date visited, 08.02.08).

Secondly, I would also want to refer to the incident that happened in a church in Malawi where the church choir sung on how the immoral would be punished with the deadly HIV and AIDS, and that the "righteous" will live and have long and better life without the said disease. This is how the reporter of the story described the response of the person living with HIV and AIDS after the song on sexual immorality, *"the man to my right wished the ground could swallow him up. He held his head in his right hand and looked very tensed up"*. This was in contrast to the response of the other church participants. The other church participants when they heard the message in the song that the sexually immoral and reckless will contract HIV and will die of AIDS had a different response. The writer says that the church applauded the choir after the song by clapping hands. Songs are used as part of lying across massages. In this case, the message was laid, and this message was that sexual recklessness results into the contraction of HIV and AIDS.

4.1.1.1.2 HIV and AIDS and Sexuality's dos and don'ts

It has also been pointed out that HIV is mostly acquired though sexual contact. Even though there are other people that contract the virus though legitimate sexual contact for example from their spouses. Moreover, there is also another group that contracts the virus through other means like blood transfusion and from mother to child like in the case of children. It seems that much as the society is aware of all these exceptional groups that do not get the virus through unacceptable sex, the society temporarily forgets about these groups of people and generalises that all people that have HIV got it from illicit sex. This leads to self condemnation especially to people who got the virus through illicit sex. This condemnation can even blind them so that they may not see any outlet of forgiveness from their situation. On the other hand, the ones who got the virus through other means apart from illicit sex also are found to be in a complex situation in the sense that even though they have not done

anything that is immoral, they still have the feelings of guilt which were defined as "false guilt" above. The people who suffer from feelings of false guilt are the ones that need more consideration when dealing with their feeling because the message on forgiveness may not provide healing to them because these people are not guilty in the real sense. The guilt feelings they have are real and strong yet are not caused by any wrong doing.

4.1.2 Shame:

The concept of shame has two different meanings that need to be clearly understood. The word shame has both a positive connotation and a negative connotation. This means that if the two meanings are confused, the discussion on shame can be confused, misunderstood or derailed. The first type of shame is called discretionary shame and is positive shame and the second type is called disgrace shame which has a negative connotation.

4.1.2.1 Discretionary Shame

Discretionary Shame refers to the functional shame that every person is supposed to possess. It relates to the privacy that every individual is supposed to have. This type of shame helps to preserve appropriate boundaries, standards and relations of people. Just as Albers puts:

> "*it has the positive function of insuring a modicum of modesty, privacy, and prudence. Its function is to establish appropriate boundaries in order to guard against invasive or intrusive actions which can violate the dignity and integrity of another human being* "(Ibid 1995: 8).

A good example of this type of shame is that much as it is not wrong to urinate, it is not acceptable and of course shameful to urinate in public. In this case, a person who is ashamed to urinate in the public is the one that is commended as opposed to the shameless who is able to urinate in the public to the view of everyone else passing by. Using this example, Albers says, "*the concept of shamelessness suggests that the lack of a proper sense of shame is a moral deficiency and that the possession of shame is a moral obligation"* (Albers 1995: 8). This type of shame can be applied to different types of life situations that can only be done in private.

For the purposes of this paper, I will not be referring to discretionary shame when I mention the word shame. My interest is Disgrace shame.

4.1.2.2 Disgrace Shame

As opposed to guilt which is related to someone's behaviour or actions, McNish says that "*shame is connected to the very fact of one's humanness"* (McNish 2004:23). Shame has reference to the needs, desires, situation, or condition of the body. It involves issues of self-consciousness and self imaging than is the case with guilt. That is regardless of what a person has done or left undone the person weighs himself/herself and finds himself/herself wanting, small, worthless and valueless. Albers also quotes Lewis to demonstrate this shame scenario where he said, the shame command is, "*Stop. You are no good*." (Albers 1995:26). Unlike in the case of guilt where the problem is the action, in shame it is about the self that has a problem. Shame becomes more challenging to deal with. In guilt, the solution is to change your actions and do better actions. Moreover, in guilt there are established social and religious rituals which can effect restoration of a guilty person. In the case of shame, just as Lewis puts it that, "*it is about self, not action; thus, rather than resetting the machine toward action, it stops the machine. Any action becomes impossible since the machine itself is wrong"* (Albers 1995:26).

The person feels unworthy and valueless; he/she has a tendency of hiding his devalued identity. Albers says that the very word shame is derived from an Indo-European root (skam or skem) which means "to hide" and from which also we derive our words skin and hide (Albers 1995: pp33). This means that when a counsellor is presented with the person with shame based identity; he/she will have a bigger challenge in order to have a meaningful dialogue with the person unless the issue of shame is addressed. The problem with shame is well summarized by Albers in a paragraph when he says:

> "*The self views the self from the shame perspective and alike a malignancy the shame metastasizes to permeate the entire person, physically, emotionally, socially, and spiritually. Furthermore, shame often has the malignant effect of extending its tentacles to encompass others who are related in a significant fashion to the shame-based person. .....the individual possessed by a shame perspective and perception believes there is no way back to the mainstream of life"* (Ibid 1995:22).

For the purpose of this paper, disgrace shame is the type of shame that I am interested in. It is Disgrace shame that I refer to whenever I say that people living with HIV and AIDS are suffering the pangs of shame.

4.2 Shame and Guilt

It is clear from the definitions that guilt is a result of doing a wrong action while shame is looking at oneself as a wrong thing. Guilt has cultural and religious rituals in form of confession, forgiveness and absolution as a way of dealing with it. The question that I have in this case that shame is clearly different from guilt is, "and can the two be addressed in the same way?" I agree with Albers that shame can not be treated in the same way as guilt as he rightly says:

> *"When shame and guilt are confused or conceptually understood as synonymous, the ritual of confession, forgiveness, and absolution for a person's guilt misses the point and will only exacerbate the sense of shame." (Ibid 1995: 24)*

Therefore, it is imperative to treat shame and guilt separately even though the two concepts can be interrelated most of the times.

4.2.1 Disgrace Shame and People Living with HIV and AIDS

The question that one has is, do people living with HIV and AIDS have shame based identity? This is the question that I am going to try to answer in the following passage. In addressing this question, I will analyze some of the dynamics of how shame manifests itself that Albers has put forward and see if some of these dynamics are manifested by people living with HIV and AIDS. I will only discuss Disgust with self, Deficiency in one's person, Defectiveness as a shame dynamic and Desertion or Abandonment Shame

4.2.1.1 Disgust with Self

Any person has an ideal self image that he/she would want to portray to the public. Most of us want to show the world that we are good people and that we have no problem with following the dos and don'ts of our society, be it cultural, religious or any other social grouping. Unfortunately, there are times when we fail to live up to that image that we would want the public to see. It is this disparity between the image that one wishes to present and the reality that brings shame because it makes someone look silly and foolish. As Albers says, "*No one like to look foolish, silly or stupid, particularly in a public setting where the possibility of being laughed at or ridiculed is a present reality.*(Ibid 1995:36). The case with HIV and AIDS as has already been pointed out is the nature of its main transmission, especially in the case of Malawi where anyone with the virus is supposed to have committed sexual seen. This is image of being a prostitute is obviously not the image that anyone would want to show to

the public. HIV and AIDS puts people living with the virus in an awkward situation. As to Albers:

> *"Any situation that renders a person vulnerable to the possible public humiliation, particularly when the person may feel that the situation was preventable, may result in an experience of shame. The experience is related to loss of masterly and control over the circumstances with the added fear that one will be laughed at, held up to derision, poked fun at, or rejected*". (Ibid 1995:36-37)

This is the situation of people living with HIV and AIDS! This feeling becomes more serious to religious people including Christians because we are supposedly to walk our faith and not only talk. HIV makes one to be vulnerable to public interpretation that one did not practice his/her faith to the letter. Even the people who did not contract the virus through sexual sin, they appear to have no defence to defend their innocence: They suffer the same shame together with the rest.

4.2.1.2 Deficiency in one's Person

This is also called inferiority complex. It is shame which is felt when one compares oneself with another person and finds himself/herself wanting as Albers says, "*When we begin to measure ourselves against others, we come up deficient and label ourselves as inferior*" (Albers 1995:40). If we realise that we do not measure up, we know that the price we pay for not measuring up is being laughed at, that is being shamed. In the case of HIV and AIDS as has been pointed out that it is mostly a social disease that hinges on a persons morality, it becomes very easy for a person living with the virus to compare herself with friends and other people around whom are believed to be not living with HIV and AIDS, and the question that can be asked in most of the cases is, "why me?" In the Malawian context where HIV and AIDS prevention campaigns are in the media each and everyday, despite their well meaning intended purpose of prevention, the create a sense of deficiency in people living with HIV and AIDS. An example of such messages is, *"its all about "individual's choice and vigilance*" (MIAA report 2006:19). This may imply that if found to have the virus, one did not choose properly, or that one was not smart enough to be to avoid the virus, like the others who do not have the virus. This situation makes people living with HIV and AIDS feel to be vulnerable to the "better others" who might be laughing at poking fun at them. As Albers says:

> *Any situation that renders a person vulnerable to the possible public humiliation, particularly when the person may feel that the situation was preventable, may result in an experience of shame. The experience is related to loss of masterly and control over*

the circumstances with the added fear that one will be laughed at, held up to derision, poked fun at, or rejected. (Albers 1995: 36-37).

Thereafter they may just believe it that they are not good enough and put on the shame –based identity! Counsellors have a challenge to address this issue in their counselling process of people living with HIV and AIDS.

4.2.1.3 Defectiveness as a Shame Dynamic

Health is regarded as a normal state of man as opposed to illness. So is any form of defectiveness be it deformity, scars etc is regarded as abnormal. Physical illness is also equated with physical defectiveness and hence shame (Albers 1995:51). Albers continues to illustrate how much illness can be a source of shame by giving this example, *"Friends and parishioners of mine have asked me to keep their illness confidential because they did not want others to know they were ill"* (Ibid1995:51). This is also true in the context of Malawi with any illness. But the illness with AIDS brings shame to a greater degree as is evidenced by the Malawi Interfaith Aids Association report. In their research, it was found that peopleliving with HIV and AIDS suffer a lot from such derogatory language:

> "*mahang'ala (looking skinny like a wire-hanger referring to severe loss of weight);...anayamba kudaya (referring to a symptom of hair which looks pale, as if it has been treated with hair chemicals); government disease (meaning a common type of disease) battery loyendera kutchajidwa (which literally means translate rechargeable batteries – referring to those who are now on anti retroviral therapy (ARVs)"* (MIAA report 2006: 30-31)

These are some of the derogatory language that people living with HIV and AIDS endure. Hence a call for quality counselling that would meet the need of a person living with HIV and AIDS in Malawi.

4.2.2.4 Desertion or Abandonment Shame

Human beings are social beings. We derive a lot of our identity from what we belong to, that is the community we live in especially family members. To be deserted and abandoned as it is presented in Otto Rank's theory can be a source of shame. Desertion or abandonment may also send a message to the person that she/he is not good enough to warrant the attention or concern of other people (Albers 1995:43). This kind of abandonment can refer to being deserted by parents, loved ones and even God. In the case of people living with HIV and

AIDS, this becomes a real issue and question that they struggle with as is presented by Lauw on the questions that these people ask themselves, *"Who am I? Am I still the same person? Am I acceptable to my people, my relatives, and my friends? Or they will drop me?"* (Lauw 1994: 131). To be deserted makes one feel that she/he is not loved anymore. This is more painful if the ones that has deserted the person are members of the family because we are introduced to the world through parents who give us a family and sense of belonging. In this case, the family is our source of our very life.

This is the case of people living with HIV and AIDS in Malawi. From the attitude of the society towards the disease:

> "*Living with HIV can lead an individual to internalise the self-image created by others, and then to turn it into a truth about himself or herself. Thus, the virus becomes the defining truth about ones identity*" (Onebody vol 2:12).

Are these not some of the feelings that the church need to address?

4.3 Relationship between Shame and Guilt

It should be noted that even though shame and guilt have different definitions and generally refer to different state, that is, shame refers to the person who is wrong and that the person is wrong it reduces his/her value. On the other hand guilt basically refers to the action that is wrong, or wrong behaviour produces guilt. It should be noted that the two concepts are closely related to the other in as much as guilt can be a cause of shame and shame can also be a cause of guilt which can also be termed as "false guilt". As it has been alluded to in this chapter that in the context of HIV and AIDS that there are some people who may suffer from guilt because they might have gotten the virus through illicit sexual contact. Yet, there are some people that got the virus in ways that are morally wrong, for example, from the spouse, blood contact or from their mothers. As the false guilt has been described by Berit Okkenhaug, the false guilt can be unfounded, but its feelings are too strong to be ignored. False guilt affects the self image of the person suffering from it. This means that the situation of people who suffer from 'false guilt' is more complex because many times 'false guilt' goes together with shame whose feelings also too strong and real to be ignored. It is for this reason that shame and guilt will be handled together in this paper.

4.4 Is there a Theology behind the Shame and Guilt in people living with HIV and AIDS?

This question does not require just a yes or no answer. It is complex in the sense that the core message of the gospel is love. According to the gospels, Jesus sadi:"H*ear oh Israel the Lord your God, the Lord is one. Love the Lord your God with all your heart and with all your soul and with all your strength….Love your neighbour as yourself*." (Mark 12:29-31) By just looking at this core message, it is easy to answer, "No, there is no theology behind the shame and guilt that people living with HIV and suffer because Christianity teaches love and love is against shaming other people. Therefore it can be easy to say that the source of the shame in people living with HIV and AIDS is from elsewhere and not in the Christian teachings." Yet when one looks at the church's teachings on sexuality, the main mode of transmission of HIV which is through sexual contact and the concepts of shame and guilt in relation to HIV and AIDS, then the complexity can be sin. Sexuality is generally a sensitive area to be discussed. There is moral code of conduct around the issue and breaking the code of conduct has the capacity to induce shame and guilt in the affected people. The answer to the question will be answered by looking at the teachings of the Christian faith that relate to sexuality.

As it has been discussed in the previous chapter on the role of the church, it was noted that the church teaches on the accepted behaviour on sexuality. Adultery, fornication and other forms of sexual immorality are forbidden and are preached against in the ceremonies as it has been shown in the statement by the Malawi Council of Churches:

> "*Premarital and extra-marital relations and prostitution are still as wrong as they were in the ancient days of the Bible (whether they lead to contraction of STIs and HIV, and teenage pregnancies or not). The importance of Christian children, youths and parents avoiding all kinds of sexual immorality is very clear in the New Testament where Jesus condemns it (Mt. 15:19, Mk7:21). It is one of the four basic commands of the Jerusalem council (Acts 15:20,29) (Joda-Mbewe 2004:148). (Joda-Mbewe is a reverend in the Church of Central African Presbyterian* (CCAP), Nkhoma synod in Malawi).

The spirit behind this teaching is good in the sense that the teaching promotes sexual morality. This message against sexual immorality has been preached on the pulpits in Malawi since the coming of Christianity. In its true sense, the message against sexual immorality does not target people living with HIV and AIDS. The goal of the message is to control behaviour

among Christians. But the challenge in the context of HIV and AIDS is: "how does the church continue to propagate its messages on issues of sexual morality?" It has been noted that the mode of transmission for HIV is through sexual contact, which is thereafter unconsciously or consciously translated as, "HIV is transmitted through sexual immorality". It is for this reason that the Nordic FOCCISA Church Cooperation says:

> *"In this era of HIV and AIDS, the church has been accused of promoting stigmatizing and discriminating attitudes based on fear and prejudice; of pronouncing harsh moral judgements on those infected...churches have not been recognised as places of refuge and solace, but places of exclusion for all those 'out there' who are simply suffering the consequences of their own moral debauchery and sin."* (Nordic FOCCISA Church Cooperation, Onebody vol 1 2005:28)

The complexity of the teachings on sexuality is that the motive of the teachings is to let people have good sexual morals. In the context of HIV and AIDS, teaching on this subject has become a little complex because the one speaking on the pulpit has to consider saying the truth that sexual immorality is wrong without pronouncing judgement on people living with HIV and AIDS. The scenario that has been created in this era of HIV and AIDS is as it was described in the two scenarios of the pastor and the man in a church earlier on. The messages on sexual immorality though unintended bring both guilt and 'false guilt' to people living with HIV and AIDS. With these observations, it can be said that though not intended, there is a theology behind the guilt and the shame that people living with HIV and AIDS are struggling with.

4.5 Summary

Shame and guilt have been defined and differentiated. It has been found that there is what is called guilt and what is also called 'false guilt'. It has also been noted that there are two types of shame namely, discretionary shame and disgrace shame. Mostly people living with HIV and AIDS are affected with the disgrace shame especially in relation to disgust with self, deficiency in one's person, defectiveness and desertion or abandonment. The concept of guilt has also been discussed and it has been noted that there is and element of guilt and "false guilt" in people living with HIV and AIDS. These are some of the issues that any type of counselling that is given to people living with HIV and AIDS needs to address. The question that needs to be answered in this paper is; is HIV Testing and Counselling a tool that can

address the shame and guilt in people living with HIV and AIDS? Is there something that the HIV Testing and Counselling can learn from the pastoral counselling principles that can make the process richer and more able to dismantle shame and guilt in people living with HIV and AIDS?

Chapter 5

5.0 Counselling

This chapter is going define what counselling is as defined by Berit Okkenhaug and David Benner. Thereafter, I will describe the different counselling models that are in use namely, the Classical Model, the Pastoral-Clinical Model, the Contextual Model and the way how traditionally counselling is done in Malawi, though not necessarily a model. I will finally present the HIV Testing and Counselling guide.

5.1 Definition of Counselling

The English word counselling has its root in the Latin phrase 'cura animarum' which can be translated as care or cure. Care refers to actions designed to support the wellbeing of something or someone while cure refers to actions designed to restore well-being that has been lost (Benner 2006:14). The Norwegian word sjelesorg is translated from the german word '*seelensorege*' which means" *omsorg for sjelen* " (Okkenhaug 2002:14). O*msorg for sjelen* means care of souls. David Benner continues to say, "*Care for souls can thus be understood as the support and restoration of the well-being of a person in his or her depth and totality, with particular concern fro the inner life"* (Benner 2006:14). The goal of counselling is to help the individual who is going through a tough and difficult situation find a solution to his/her situation, just as Okkehaug says, '*sjelesorgen handler mye om å gi støtte og help til mennesker som lever i vanskelige livssituasjoner"*[8]. (Ibid 2002:18). For the purpose of this paper, the client is the person living with HIV and AIDS, who among many of the other challenges that they face, shame and guilt is one of them that need to be addressed for the client to be able to be reintegrated in the society. People living with HIV and AIDS should be able to regain their human dignity and self worth that was endowed in them during creation, but due to wrong attitudes it has been marred. The goal of counselling in this paper will be to let people living with HIV and AIDS regain their dignity. This will be a key to unlock even other potentials in them that can be used to solve other problems that might arise from their status so as to be able to live positively and contribute to their persoanl welfare, the welfare of the family, the society and even the development of the nation. Benner, the Canadian psychologian, who quotes Clebsh Jackle, points out four primary elements of counselling that has always taken a central part in the life of the church namely; healing,

[8] Counselling is to give support and help to people who are living in difficult life situations

sustaining, reconciliation and guiding. Healing involves curative actions with the aim of helping someone overcome impairment and move towards wholeness, which is both physical and spiritual. Sustaining refers to acts of caring that are designed to help a hurting person endure and transcend a circumstance in which restoration or recuperation is either impossible or improbable. Reconciliation refers to efforts to re-establish broken relationships and then guiding refers to helping a person make wise choices and thereby grow in spiritual maturity (Benner 2006:15). All the four elements put forward by Benner are important elements in counselling a person that has been diagnosed HIV positive. To come up with the HIV Testing and Counselling that I would want the church to promote among the Christian Health Association of Malawi, that are diaconal institutions, I will firstly describe the three counselling models namely, the Classical Model, the Pastoral-Clinical Model and the Contextual Counselling from Eide Øyvind who together with other scholars refer to John Patton in his book, Pastoral Care in Context which was published 1993. In addition to the counselling models, I will also describe the traditional way of counselling in Malawi as it has been described by Dixie Maluwa-Banda, a Lecture at the University of Malawi, Chancellor College. Thereafter I will present the process of counselling that is used for pre and post HIV test, called HIV Testing and Counselling (HTC) in Malawi that has been designed by the Ministry of Health in Malawi and is being used by all hospitals, including those that are used by Christian churches in Malawi and are diaconal institutions and other HIV testing centres. My interest will be to look at the HIV Testing and Counselling process for pre and post HIV test counselling, identify the gaps if there are any in the said process and using the rich diaconal resources of our Christian faith, and if necessary, redesign the HTC process for pre and post HIV test counselling in a way that can address the problem of shame and guilt in people living with HIV and AIDS. The goal of counselling people with shame and guilt can be only achieved by a model and a process of counselling that is sensitive to the needs of people living with HIV and AIDS.

The understanding of pastoral counselling is also another question that needs to be made clear for the purposes of this paper. The question is should it only be done by the ordained ministers, the clergy? There are diverse views to this question. But for the purposes of this paper, pastoral counselling will be looked at from the view of John Patton who says that his understanding of pastoral care is, "*the caring community, inclusive of both the laity and the clergy, that provides pastoral care"* (Ibid 1993:3). For this reason, the understanding of

pastoral care/counselling in this paper is not only that which is done by the clergy, but is inclusive of the counselling that is done by the laity, the health professionals who are involved in counselling people who are ready to go for HIV testing and counselling in the health facilities that are owned by the different churches in Malawi.

5.2 The Classical Model

This approach also called the Kerygma Model. Kerygma means good news or gospel**.** This approach to counselling was inspired by Carl Barth whose thought was taken up by Eduard Thurneysen who was a friend to Barth and was a reformed theologian and a professor at Basel until 1959. According to this approach, counselling is defined as "*Guds ord til den enkelt*"[9] (Okkenhaug 2002 pp. 24). The counsellor thinks from the general to the specific which means that the process is deductive. The word of God and theology is the norm. This norm has to be applied to the specific problem that the client is facing. Since it is the counsellor who has the knowledge on the norm, which is the word of God; it is therefore the responsibility of the counsellor to take leadership. Counselling is to show the right way which is found in the Bible which is Gods word. In support of this Engedal says, "*Sjelesorg er knyttet til at konfidenten får møte Guds ord – åpenbaring av seg selv og sin vilje slik det lyder i Den Hellige Skrift"*[10] (Engedal 2004:40.)

In this model, the Bible plays a very central role. The basis for using this model is that man is fallen and that on his own man does not have the capacity to rise up and therefore depends on the grace of God to rise up and solve his problems. Since man is fallen, it is therefore imperative that "*in the light of one's sin, at some time during counselling a break must come about, leading to change or conversion*.(Louw 1994:68). This implies that the behaviour pattern of the client is supposed to change and be in line with the word of God. The counsellor should proclaim the central elements of the gospel which is, sin and forgiveness. The classical model is in line with Plato's philosophy on solving the psychosocial problems of man who says that for these problems to be properly sorted out, curing the soul is basic and should be the first thing. Plato says:

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[9] Gods word to the individual

[10] Pastoral care is linked to the clients encounter with the word of God, the revelation of him self and his will as it is written in the Holy Scripture

> "*As you ought not to attempt to cure the eyes without the head, or the head without the body, so neither ought you to attempt to cure the body without the soul….for the part can never be well unless the whole is well……And therefore, if the head and the body are to be well, you must begin by curing the soul*" (Clinebell 1984:103)

This means that according to the Classical Model, any meaningful counselling should have an understanding of human's fundamental need which is the spiritual needs. The model acknowledges the finite nature of man, that even though man has been endowed with a vast potential of capabilities, man is still limited and should therefore depend on the word of God. The challenge with this approach according to H Tacke is "*that the concepts of diakonia and charity mean that the church will reach out and assist people in distress, despite their not being Christians"* (Louw 1994:69). That is the call of diakonia, to reach out to all people regardless of their faith orientation. Does it imply that diakonia will shift from this thinking if the classical model has to be followed so that all clients that use diaconal counselling facilities should become Christians? And those who are not willing to be converted to Christianity do not deserve the diaconal services? These questions are real in the context of Malawi because it is not only Christians that use Christian Health Association of Malawi (CHAM) health facilities. People of other faiths also use these health facilities. These are the questions that need to be taken into consideration when using this model.

When using this model in the context of people living with HIV and AIDS, how does the counsellor take into consideration all the elements of the gospel without overemphasising on one and underestimating the other? It has been noted earlier that the main mode of transmission for HIV is through sexual contact and that in the Malawi context, this is easily implied to mean sexual immorality as it has been earlier discussed in chapter 4, how does the counsellor, for example in the case of using HIV Testing and Counselling, handle this issue of sexuality so that the process would lead to the intended salvation and not to shame and guilt? If this model could be used in the process of counselling people living with HIV and AIDS, the danger is that it might arouse feeling of guilt in people who got the virus through sexual immorality, at times false guilt in people who got the virus through other means than through sexual immorality. More also is the fact that the model has the capacity to exacerbate shame in both people who got the virus who got the virus through sexual immorality or through other means.

The question is, does the HIV Testing and Counselling process fall under the classical model? It is important to note the HTC does not fall under the Classical model. Yet, there are some strengths in the classical model of which an example is the acknowledgement that man's capabilities are limited. Man still remains a created being and therefore should rely on the creator for solutions to most of his problems.

5.3 The Pastoral-Clinical Model

This model is one of the 20the centaury paradigms that have been developed from liberal theological thinking. The pastoral model has traditionally used the therapeutic- counselling by Carl Rogers. According to this approach, the counsellor puts the client at the centre of the counselling process. The counsellor's duty is to encourage the client to express their feelings, thoughts and ideas. The counsellor is there only to guide the way. He/she does not suggest how the client might wish to change, but by listening and then mirroring back what the client reveals to him/her, he/she is supposed to help the clients to explore and understand their feelings, thoughts and ideas for themselves. The client is then able to decide what kind of changes he/she would like to make and thereafter can achieve personal growth. In this model Okkenhaug says:

> "*I en aksepterende, ikke dømmende atmosfære, der relasjonen kan oppleves trygd, kan konfidenten våge å utlevere vanskelige følelser. Sammen kan de utforske underliggende material, og gjennom en speilingsmetode, der sjelesorgen ved empatisk innlevelse viderefører det materiale som kommer fram, vil en legende forandring skje*."[11] (Ibid 2002: 26).

For the counselling process to be effective Carl Rogers suggests that the counsellor should have the following qualities: empathy with the patient's emotions and perspective, genuineness, and unconditional positive regard for the patient. In this counselling process, the centre is the client. Counselling must start the client. The process must try to find ways of how to deal with the problem at hand. The goal is to have the problem sorted out which might lead the client to either embracing the gospel or not. If the client embraces the gospel, it is commended but the most important thing according to this model is that the client should find

[11] In an accepting, non-judgmental atmosphere, where the relations can be experienced as safe, the client can share difficult and hidden feelings. Together they can dig into the underlying material and through a mirroring method where the counsellor uses empathy to bring up the hidden material, a healing change will happen

his/her own solution to the problem. This approach takes its starting point on the assumption that:

> "*humans have the inherent (almost magical) capacity to grow in a positive direction and to realise their full potential if they are (lucky enough to be) nourished by the unconditional love and understanding of the significant others"* (http://www.springerpub.com/samples/23848_chapter.pdf "Person-Centred Counselling in Rehabilitation Professionals. date visited 27.04.08)

This means that the responsibility of counselling is to "*latch onto the innermost potential of man"* (Louw 1994:69). This means that as opposed to the classical model where the norm is theology, the word and the Bible to be specific, in this model, the norm is the inherent inner potential of man. This potential is the one that is believed to be imprisoned in man by other factors that causes man to judge himself so harshly and mercilessly. Going through this therapy will help man free himself from that. This is why Carl Rodgers says:

> "*The goal of Rogerian psychotherapy is to help the individual 'become that self he truly is' by offering a relationship characterised by empathy, openness and acceptance. Of these three, acceptance is the most potent in overcoming guilt, since it communicates 'a warm regard for (the client) as a person of unconditional self-worth – of value no matter what his condition, his behaviour, his feelings*" (Campbell 1986:68-69).

The duty of the counsellor is to help the client rediscover his/her inherent inner potential that is positive. This most important positive feature of this approach is that it acknowledges the positive potential that is inherent in man. Man has enormous capabilities that if well utilised, a whole lot of mans problems can be reduced.

Much as the approach has its advantages, it has not been spared of criticisms. The first point that critics put forward against this approach is its identity. The approach is identified with the liberal and humanistic thought which says that "*the solution to man's problems lies in the man himself" (*Adams1975:81). Critics of this pastoral-clinical model like Jay Adams argue that for pastoral care to be what it is meant to be, "*sjelesorgen må frigjøre seg fra psykologien, fordi denne ikke legger Bibelen til grunn for sin praksis. Adams legger mye vekt*

på å bruke Bibelen og se alle problemer ut fra et åndelig perspektiv"[12] (Okkenhaug 2002:25). The problem with this approach is that it starts with man and ends with man. There is no place for God. Could this imply that the Rogerian approach is liberal and humanistic and therefore does not qualify to be a diaconal counselling tool?

The other reason that critics for this approach put forward is that this approach does not acknowledge the spiritual part of man. Man as a whole being is made up of body, soul and spirit. Berit Okkehagen says, "*vi er både kropp, sjel og ånd som ikke kan splittes*"[13] (Okkenhaug 2002:51). This implies that for any counselling to be effective, it must address man as such, as body, soul and spirit that can not be split. This means that there are some problems that are spiritual in nature and therefore can only be solved by spiritual solution and not by psychology. Adams and Howard Clinebell goes further to say that even the psychological problems that man has, has its roots in the spiritual questions that man has. To show this Clinebell says:

> *"Though often not so obvious and in some cases completely hidden, there is an existential-spiritual dimension in every problem with which the pastor and parishioner struggle in counselling. This is true because awareness of our morality is inherent in every human experience, most often on a subconscious level*" (Clinebell 1984:107)

This thinking gives the diaconal ministry a challenge to take in implementing its diaconal services because the diaconal services, being born out of the Christian faith which acknowledges that man is body, soul and spirit, aims at serving the man as a whole and not just the body and soul. Diaconia is meant to address even the spiritual problems of man.. The church can not expect the psychologists to solve problems that have roots in spiritual questions. The church should take lead on addressing the spiritual problems of man. If the church do not take the challenge the result will be idolatry as pointed out by Clinebell, "*whatever one uses to cope with existential anxiety is, psychologically speaking, one's religion"* (Ibid 1984:108). Letting psychologists answer existential questions is promoting idolatry. Clinebell continues to give suggestions on the way forward on this problem that, "*the only constructive means of handling existential anxiety is an authentic religious life, enabling the actualization of the image of God within the person."* (Clinebell 1984:109). And the

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[12] Pastoral care must free itself from psychology because pastoral care puts much emphasis on the use of the Bible in its work. Adams puts a lot of value on the use of the Bible and sees all problems from a spiritual perspective.

[13] We are body, soul and spirit which is one and can not be divided

authentic religious life is the Christian gospel which is found in the Bible and the Christian tradition. This gives a challenge to the diaconal ministry that mans spirituality should not be substituted by psychology. Therefore adopting Rogerian approach to counselling wholesome may not contribute to achieving the goal of diaconia which is also to minister to man holistically, body, soul and spirit.

Analysing the HIV Testing and Counselling shows that the process, falls more into this Rogerian approach. It is therefore imperative that a way must be found to make sure that HIV Testing and Counselling meets the needs of man holistically, especially the needs related to shame and guilt in the context of HIV and AIDS.

5.4 The Contextual Model

This approach says that man lives in a society which has its own culture, values and norms. Man is not dependent from the society he lives inThis fellowship can not be seen outside the Christian fellowship, *". Sjelesorgen hører hjemme i den kirkelige kontekst."* [14](Okkenhaug: 2002: 28). In the context of the contextual model, it is very important for a counsellor to know the social context of his/her client for the counselling to be effective. This would be important in the African context as Lutahoire a Tanzanian master student of Øyvind Eide, puts it:

> "*One characteristic which is emphasized is the essentially non-individualistic communal nature of all African life. The individual identity is derived from and nurtured throughout the life cycle by the social network of the extended family, clan and tribe, with all the rich traditions and practices associated with this vital network. Another important characteristic is the fact that religion is inseparable from the total life and identity of persons and families and tribes in Africa*" (Eide: accessible to the author)

This stresses on the communal context, both the counsellor and the client are members of a community and are operating in a particular religious and social context. The approach acknowledges the religious part, and psychological part, and the social part of a human being. Therefore the model is a hybrid of the classical model, the pastoral clinical model, which has also taken into consideration the community together with its culture, in which the client lives. All these factors are to be integrated into one counselling model. The model looks to be

[14] Counselling/Pastotral care is at home in the context of the church

very good, but how can it be translated into action? How can the Classical Model be used together with the Pastoral-Clinical Model together with taking into account the community without contradicting each other?

5.5 Traditional Way of Counselling in Malawi

Counselling in Malawi is mostly done in the way of advice giving. Traditionally, Malawi is a structured society. That is, there are people who know and others who do not know and those who do not know must therefore learn from those who know and have the expertise. We have elders and the young. The elders are the ones who know, and the young must listen to the wisdom and knowledge of the elders that has been derived from their life long experience and has been passed down from generation to generation. In this case, it is assumed that the experience of the elders has been tried and tested by time and therefore can be trusted. As life has so many critical stages, those who are older and have the expertise are expected to advise the young ones when they are passing though different life stages like childbirth, puberty, marriage and birth. The clients are expected to humbly listen to everything and most of times without questions. Just like in the Classical Model, where the aim of counselling is to have the client know the Word of God after he has heard the word, and thereafter that the client must develop a relationship with God, in the Malawian traditional way of counselling, the client is expected to know the treasures of wisdom that has been passed on from generation to generation|. This has been echoed by Dixie Maluwa-Banda, who is a lecture at the University of Malawi, Chancellor College who said that, "*Advice giving has been one common feature of providing help to other people for a long time in almost all cultures in Malawi"* (Ibid 2006 :68).

The approach is good that it gives direction on how the client can conduct himself/herself to be able to fit in the African society which is very cultural. But it greatly ignores the client. While the Rogarian psychotherapy overemphasises the significance of the client, the traditional way of counselling in Malawi is the opposite. It does not recognise that an individual has the capacity to solve his/her own problems. It is assumed that when an individual has come into problems, the likely cause is that he/she went astray from the wisdom of the elders and for that person's problem to be sorted out, he/she must be assisted to be brought back to the same wisdom of the elders that he/she ignored. This is also true in the context of people living with HIV and AIDS. The wisdom of the elders says no to sexual

immorality. Since HIV is transmitted through sexual contact, it is therefore assumed that the client disobeyed the wisdom of the elders that he/she should not have involved himself/herself in sexual immorality. With this counselling approach to HIV and AIDS in the context of shame and guilt, the question is, how can people living with HIV and AIDS feel after going through this process of counselling knowing what the community thinks about the disease, that it is caused by disobedience to dos and don'ts of the society?

5.6 The HIV Testing and Counselling

HIV Testing and Counselling (HTC) combines HIV testing with counselling, information and support (http://www.avert.org/aids-malawi.htm date visited 17 April 2008). HIV Testing and Counselling is a skilled and confidential communication between a counsellor and a client that uses the general principle of counselling to enable clients make personal decisions and adopt skills relating to prevention of contracting HIV and living positively with HIV and AIDS within an atmosphere of trust and acceptance. In short, HIV Testing and Counselling is a process through which an individual is confidentially counselled and tested for HIV. The given guide is the national counselling guideline that has been developed by the Malawi government. It is being used by all HIV Testing and Counselling centres in Malawi. This implies that the tool is ideally made to reach the about 12 million people which is the population of Malawi. This means that heath institutions that are under the Christian Health Association of Malawi (CHAM) are also included. The health institutions which are under CHAM are diaconal health institutions. CHAM is an ecumenical body, that is, it has a membership of different Christian churches. The aim of the health facilities is not for profit making. CHAM is an umbrella organisation of Christian owned health facilities. According it its website,

> "*CHAM has a membership of 171 health facilities spread across the country. Out of these facilities 20 are main hospitals, 19 community hospitals, 1 mental hospital and 131 health centres. 90% of these health facilities are located in the rural settings of the country. This is 37 percent of all health facilities in Malawi*" (www.cham.org.mw.http://www.coldfusionwebhostings.be/ICCO/www/index.cfm?type=workprocedure&id=34&menu=Secretariat. Date visited 17.04.08)

5.6.1 Ministry of Health (Malawi) Counselling Session Guide

Introduction and Orientation

Welcome client, introductions, explain counsellor role/session content

Explain confidentiality and anonymous test

Informs the client about counselling and rapid test process including clinic flow and time

Address immediate concerns and questions

Risk Assessment

Assess recent risk pattern (who, when, where)

Identify risk triggers/vulnerabilities/circumstances

Assess communication with partners

U Summarize and reflect back client's story/risk

Explore Options for Reducing Risk

Review previous risk-reduction experiences

Identify obstacles to risk-reduction

Assess and enhance condom use skills

Identify range of options for reducing risk

Role play, skill build and problem solve

HIV Test preparation

Assess client's reason for CT, previous tests

Identify with whom client has shared test decision

Discuss understanding of a positive/negative test

Discuss benefits of testing/positive living

Determine client's test readiness/decision

Obtain informed consent for HIV testing

Test Results Counselling

Provide and explain results clearly and simply

Explore client's understanding/response to results

If positive, provide support, address positive living

Negotiate_Risk-Reduction_Plan

Identify priority risk-reduction behaviour

Develop incremental steps toward behaviour change

Sources of Support and Referrals

Negotiate Disclosure and Partner Referral

Identify whom client may disclose for support, and care

Anticipate potential reactions

Discuss approach to disclosure/referral — role play

5.7 Summary

In summary then, this chapter has defined how counselling can be understood and has also discussed the different ways of how counselling is done or should be done. The Classical Model, the Pastoral- Clinical Model, the Contextual model and the Traditional way of counselling in Malawi have been discussed with their strengths and weaknesses. Finally, the HIV Testing and Counselling has been presented. The HIV Testing and Counselling will be discussed and analysed in the next chapter.

Chapter 6

6.0 Analysis of HIV Testing and Counselling process

This chapter is going to analyse the HIV Testing and Counselling process. Special Interest will be on whether the process has the capacity to dismantle shame and guilt in people living with HIV and AIDS. The main criteria that will be used for the analysis is the principles of counselling that have been compiled by the Malawi Council of Churches and the list that was compiled by Howard Clinebell of the goal of any counselling. Reference will also be made to the other resources and values of the Christian faith that has been mentioned in the previous chapter on the normative especially the theology of Grace and Creation Theology that can be used as tools to dismantle shame and guilt. First, I will present The Goal of Counselling as presented by Howard Clinebell and thereafter the principles of counselling by the Malawi Council of Churches (MCC). Above all, the assumption is that man is a totality as Berit Okkenhaug puts it, "*vi er bade kropp, og sjel og ånd somm ikke kan splittes*"[15] (Ibid 2002:51). Therefore, HIV Testing and Counselling will be analysed to the effect as to whether it is a process that can address the problem of man as a totality, body, soul and spirit. Man being body, soul and spirit, the aim of counselling is that he/she should be able to live in harmony with God, other people, nature and himself/herself. In doing so, the following some of the basic spiritual needs that must be satisfied in any counselling process:

6.1 Principles for Counselling (By MCC)

The Malawi Council of Churches in its Training Manual for the clergy on HIV and AIDS has outlined principles for Counselling from which I have picked some that I will use in analysing the HIV Testing and Counselling (HTC) process. The outline which I have slightly paraphrased is as follows:

a) The Value of the 'Umunthu', the human being

The human being is created in the image of God, and so each person, without exception, is worthy of respect and care. Whatever circumstances or reality, a human being always deserve full recognition of the basic dignity that each individual is endowed with by the simple fact that he/she exists. Therefore, the counsellor needs to respect this value.

b) The right to healing, growth and full life

[15] We are body, soul and spirit which is one and can not be divided.

Pastoral care and Counselling is totally committed to assisting individuals, families and groups of people in their needs to find healing from pain and suffering, to develop fully as human beings through the life stages, to enjoy positive relationships with self, with others and with their God, and so to enjoy fully the gift of life.

c) Confidentiality

All the secret information must be kept private unless permitted to use it in a professional way

d) Truthfulness

The counsellor must give truthful information and not false reassurances.

e) Informed choice/consent

The client has the right to make informed decisions after being offered with clear, adequate and unbiased information.

f) Non-judgemental Process

The attitude and behaviour of the client should be assessed objectively with no pre-conceived ideas.

g) Privacy

There must be auditory and visual privacy

h) Friendly atmosphere

The atmosphere must be receptive with the counsellor showing interest and attentiveness to the client

i) Emotional Involvement

The counsellor must be responsive to the client's feelings but not emotionally involved

j) Record Keeping: The right to the client's file

Counsellors are obliged to keep record of the counselling process, interactions with the clients and any important information related to counselling. The client has the right to know that a file is being kept and to have access to the file if one wishes to do so. (Adapted from Ostiguy, H 2004:109-110)

6.2 The Voluntary Counselling Process Analysed:

This is a process for HIV Testing and Counselling will be analysed by using the principles that have been outlined by the Malawi Council of Churches. In the analysis, it is assumed that

counsellors for the HIV Testing and Counselling are required to follow all the steps in the guide, hence all the steps will be considered in the analysis. The analysis will first consider the strengths of the HTC process and thereafter bring out its weaknesses.

6.2.1 The Strengths of the HIV Testing and Counselling (HTC)

The strengths of the HTC process is that it meets the following points that are in the criteria, namely, confidentiality, truthfulness, informed consent, privacy, friendly atmosphere, emotional involvement and record keeping. The mentioned points sill be described below:

6.2.1.1Confidentiality

According to the criteria of a good counselling process, the client must be assured that all the secret information would be kept private unless permitted to use it in a professional way. The HTC process passes very well on this criteria in the sense that right at the beginning as the client and the counsellor are introducing themselves to each other, the counsellor makes it clear that all the things to be discussed will be confidential and the test is anonymous, that is, the HTC process does not keep files of the clients because in any case, the results should only be known by the counsellor, that is the one taking the test and the client. Thereafter, the records are kept for the purpose of statistics but no name is assigned to any result. This is good because with the stigma attached to HIV and AIDS, most people would not like their results to be shared to a third person anyhow. In this case, confidentiality is important and it is good that the HTC process makes to clear to the client that it is confidential.

6.2.1.2 Truthfulness

The counsellor must give truthful information and not false reassurances. This is well captured in the HTC process especially after the test. The counsellor is required to provide and explain results clearly and simply. This means that the counsellor will be very honest. The counsellor is not expected to give any false reassurances to underestimate the effects of HIV and AIDS especially if the test results if positive. The client is expected to give the necessary support and response so that the person who has been diagnosed with the HIV virus will be able to live positively afterwards. This is every important and it is a strength that the HTC process has incorporated it.

6.2.1.3 Informed choice/consent

The client has the right to make informed decisions after being offered with clear, adequate and unbiased information. Firstly, HTC process gives the client the freedom to choose what she/he want to do. Before the test, informed consent is obtained for HIV testing. HIV test is

never forced on any client even after entering the testing room, the client is given a choice on either to have the test or not. Secondly, the client is encouraged to identify priority risk-reduction behaviour and develop incremental steps toward behaviour change himself/herself. It is the responsibility of the client to decide what type of behaviour he/she would like to lead after the test. This is not forced on the client. The choice is his/hers. This is also the strength for the HTC process.

6.2.1.4 Privacy

There must be auditory and visual privacy. HTC is done in a private environment where the counsellor and the client could not be seen or heard.

6.2.1.5 Friendly atmosphere

The atmosphere must be receptive with the counsellor showing interest and attentiveness to the client. In the HTC process, the counsellor welcomes client, initiates introductions, and explain the counsellor's role. Immediate concerns and questions are also addressed. All this is done to make sure that the client feels welcome and accepted. Hence the chances that the process will be more successful are greatly increased.

6.2.1.6 Emotional Involvement

The counsellor must be responsive to the client's feelings but not emotionally involved. This is also done in HTC especially after the client has been diagnosed to be HIV positive. The client is expected to explore client's understanding and response of results. The counsellor is also expected to provide support and not to get crushed with the results together with the client.

6.2.1.7 Record Keeping: The right to the client's file

There is no mention that the records kept in the HTC process have a name assigned with. This of course makes it impossible for the client to come back for reference. But this is taken care of in the process by the negotiation of disclosure and partner referral. The client is encouraged to at least disclose his/her status to someone that she/he trusts who can give him/her the necessary support and care. The client is prepared for any negative reactions that he/she might face by disclosing his/her status by discussing the potential reactions so that the client will be psychologically ready especially where the reactions are not as positive that are mostly influenced by the stigma, shame and guilt that surround HIV and AIDS. Referral is also discussed so that the client can also be able to get the other physiological, sociological, psychological and spiritual needs from elsewhere.

6.2.1.8 The Communal Man is addressed.

Does the process take care of the society around the client? This is also a question that has been answered on the referral point. In the African context, the community is very important as it has been alluded to by Howard S. Clinebell, the most read author within the clinical model, in which the HIV Testing and Counselling falls, gives a most interesting characteristic of the thesis of his student Sebastian K. Lutahoire, the first Tanzanian scholar of pastoral care, as it has been presented by Øyvind Eide:

> *"One characteristic which is emphasized is the essentially non-individualistic communal nature of all African life. The individual identity is derived from and nurtured throughout the life cycle by the social network of the extended family, clan and tribe, with all the rich traditions and practices associated with this vital network. Another important characteristic is the fact that religion is inseparable from the total life and identity of persons and families and tribes in Africa"* (Eide Øyvind*)*

The process has tried to let the client be in a position to receive the social support that he/she may need, even though the final responsibility of making that decision has been left in the hands of the client alone. Before the client goes into the community, he/she is encouraged to identify the one whom he/she can confide in concerning his/her serostatus. The anticipated reactions are discussed before hand so that the client should not be taken unawares. The aim is that much as there is stigma and discrimination that is caused by among other reasons, by shame and guilt, it is to the benefit of the client to have the social support. This is a way of providing him/her an entrance into the community. The entrance will be this trusted person. Of course, more can be done to improve the way the client can be reintegrated into the community say by referring the client to other groups like the church, and other groups of people living with HIV and AIDS.

In conclusion then, it shows that the HTC process has a lot of strengths that must be cherished, among which is confidentiality, truthfulness, making informed choices, privacy, friendliness, emotional involvement and even the way records are kept.

6.2.2 Weaknesses of the HTC process.

In my analysis of the HTC process, I have come to notice that the process has a list of very positive elements. No wonder that it is the process that is being used nationally. That is by the State/Government, CHAM, and Private HTC facilities. Yet, it has weaknesses that I am going

to present below. The weakness has to do with consideration to the dignity of man, and the nature of counselling in the Malawi traditional counselling context.

6.2.2.1 HIV Testing and Counselling vis a vis the Malawian Traditional Counselling way

As it has been pointed out in the last chapter, traditionally counselling entails that the giving of the pieces of advice. Those who know, who in the case of Malawi, the elders tell the ones that are seen to be in need of advice. The client's duty is just to listen to the advice of the counsellors without questioning. In the context of HTC, the counsellor stands in the place of the elders of the traditional community. HTC process falls under the Pastoral-Clinical Model where the process is client-centred and the counsellor's duty is to encourage the client to express their feelings, thoughts and ideas. Compared to the traditional way of counselling to which people in Malawi are culturally used to, it is completely the opposite. People who are vulnerable and are in need are culturally expected to be quiet and listen to those who have the wisdom and ideas on what they can do to get out of their problems. The challenge is that in the HTC process, they are expected to speak out there feelings, thoughts and ideas. The question is, "How can the client who has been cultured and is used to be silent, be expected to express himself/herself meaningfully in this counselling process?" It would not be easy for the counselling session to be meaningful unless there is an icebreaker to let the client manage to speak.

6.2.2.2 The Value of 'Umunthu'[16]

The human being is created in the image of God, and so each person, without exception, is worthy of respect and care. Whatever circumstances or reality, a human being always deserve full recognition of the basic dignity that each individual is endowed with by the simple fact that he/she exists. Therefore, the counsellor needs to respect this value. The question that could be of interest is, "Does the Voluntary Counselling process help to uphold the human dignity (umunthu) that is the criteria for counselling by the Malawi Council of Churches? If we look at the way the second stage where the counsellor and the client have to assess the risk factors, we would notice that the counsellor and the client are supposed to assess together any risks that the client might have put himself or herself in. That is the client has to remember and narrate if he/she has been involved in careless and immoral behaviour that he/she suspects

[16] Human Dignity

that it could be the source of infection. Here the client is expected to be very honest and should be able to say with whom he/she had sex? When was it? Where was it? (That is, was it at home with your spouse, or was it at a drinking place with a prostitute or a womanizer?). At the end of the risk assessment, the counsellor is supposed to summarise the client's risk story. My question is, how does the client feel at the end of this stage narrating his story in terms of, "with who, when, and where" considering the sensitiveness of the area of sexuality. Looking at this stage, can we say that the client's shame is reduced or enhanced? Albers in his book, "Shame: A Faith Perspective" rightly points out that

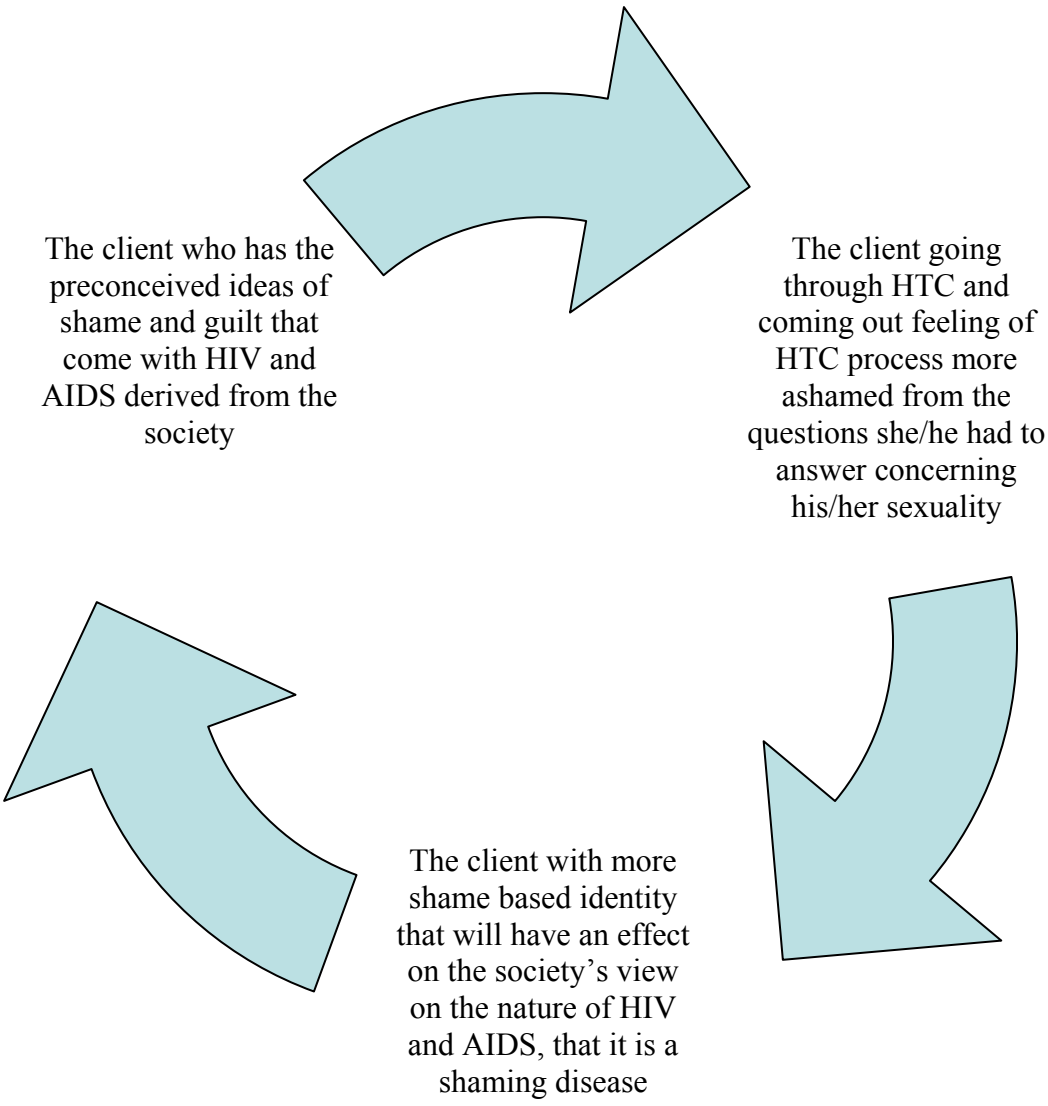
> *"Shame is inextricably linked with exposure…. The fear of exposure implies that something has been hidden which if revealed would result in some form of rejection. It signals the fact that the person would feel diminished in the eyes of others, and certainly in her or his own eyes. Even the anticipation of possible shaming pushes people to extraordinary lengths to keep something secret or hidden*" (Albers 1995:33).

We see that at this stage of the counselling process, the counsellor is made or encouraged to speak on the risk triggers, risk behaviour that he/she has been recently involved in. This behaviour refers his/her sexuality. The client is made to speak his recent sexual behaviour. Yet, sexuality is something very private, and is a very sensitive subject. It is dignifying to keep it to oneself unless one is discussing the subject with someone that he/she trusts very much. Otherwise, talking about ones sexuality to someone that you are not very familiar with can be a cause of shame. Yet, this is exactly what the HIV Testing and Counselling does in its second stage. Can this HTC then dismantle shame in a person that is already shamed? The second stage where the client is expected to narrate his/her sexual adventures leaves a lot to be appreciated. This agrees with Albers who said, "*much shaming is fixated on that which is associated with the body and sexuality*" (Albers 1995:88).

In this case, it is observed that in the process of counselling people ant the Voluntary Counselling centre, the process may lead people living with HIV and AIDS to come out of it more ashamed and feeling more stigmatised. The possible result of this is that the client may withdraw completely from the society after testing HIV positive. This can be so because Albers argues that,

> "*Withdrawal and isolation create a world of presumed safety wherein the person can hide behind seemingly impenetrable barriers erected as a fortress of defence to ward off all situations which may occasion shame.* (Albers 1995: 81)

The client will find safety in isolation. The question that one would ask is; "could this be the cause that most of the people that go for HIV testing do not disclose their results?" This scenario of getting shaming ideas of living with HIV and AIDS from the society someone lives in, then the person who has decided to go through HTC but instead of being freed from shame and guilt comes out with more shame leads to what I would call the vicious circle of shame which will be illustrated as follows:



(The Vicious Circle of Shame and Guilt and HIV and AIDS)

The challenge is of breaking the vicious circle. The possible point of breaking the circle of shame that breeds stigma and discrimination is when the client goes for HTC. For the arrow to point the other direction, the client must come out of the HTC process feeling more

dignified. This feeling of self-worth and value will very likely have a positive effect on the society. This gap that has been identified in the HIV Testing and Counselling process moves me to sit down and revise the process so that it can be more useful to the people of Malawi. It is the aim of this paper that we should be able to come up with the counselling process that can be able to address shame.

6.2.2.3 The Spiritual Man is not addressed

As has been pointed out by Berit Okkenhaug that man as a totality is body spirit and soul, HIV Testing and Counselling has taken purely the Rogarian therapeutic approach. Therefore, the approach as a psychotherapeutic tool has the capacity to address the problem of the soul but one wonders if it has the capacity of addressing the problem of shame and guilt as the issue of shame and guilt is closely linked to the spiritual problems of man. It would be necessary then to consider integrating the spiritual element into the HIV Testing and Counselling. That is when the tool can be able to achieve the goal of counselling according to Clinebell:

> *"Having a growing relationship with and commitment to a loving God that integrates and energizes their lives, and developing ways and to move from the alienation of guilt to the reconciliation of forgiveness*." (Clinebell 1984:110)

It was already pointed out in the previous chapter that there are hidden spiritual issues underlying most problems of man as it was stated by clinebell who said:

> *"Though often not so obvious and in some cases completely hidden, there is an exixtential-spiritual dimension in every problem with which the pastor and parishioner struggle in counselling. This is true because awareness of our morality is inherent in every human experience, most often on a subconscious level*" (Clinebell 1984:107)

For this reason, it would be proper to revise the HIV Testing and Counselling to meet the spiritual needs of man in totality. Diaconia is a service that has grown out from the Christian faith. The zeal and motivation of diaconal work does not stem from the will of man but of God. Much as the diaconal services on the ground may not be very different from the services that are being offered by other charitable organisations, diaconia springs from the heart of the Christian faith. It is therefore imperative to maintain that identity if the church would like to qualify any of her service as diaconia.

6.3 Summary

Therefore it would be proper and advisable that the HTC that is to be used in the health facilities owned by the Churches in Malawi should have the capacity to address man in his/her totality, as body soul and spirit. This can not be done by the current HTC tool that is in use because it is largely Rogerian and does not acknowledge the spiritual part of man. Of course, the strengths of the HTC model is that it has the capacity to meet the psychosocial problems of man, that is problems of the body and the soul, are acknowledged. What is needed is to build on the strengths so that the tool can also address the needs of the spiritual man. This will be the next assignment of this paper. In the following chapter, the normative according to the Christian faith will be looked at. The approach will be to look at Jesus as an example and also look at Creation Theology and the theology of Grace and Justification.

Chapter 7

7.0 HIV and AIDS and Theology of Hope.

This chapter is going to be different with the previous chapters in the sense that it is going to be normative. After looking at the description and the analysis of the HTC, the purpose of this chapter is to answer the question, "what should be done to people living with HIV and AIDS so that they should feel that they are valuable?" Firstly, the chapter is going to look at the example of Jesus life and teachings. This will be related to how the church can embrace with people living with HIV and AIDS especially through counselling. Creation theology and the doctrine of Grace and Justification will be used as theological resources that can dismantle shame and guilt in people living with HIV and AIDS.

7.1 The Teachings and Life of Jesus

7.1.1 The Greatest Commandment.

In Matthew 22:36, Jesus was asked, "Teacher, which is the greatest commandment in the Law?" To this question, Jesus replied, *"Love the Lord your God with all your heart and with all your soul and with your entire min"* (Matthew 22:37), and in verse 39 he said, "*Love your neighbour as yourself*". Love is the cornerstone of the Christian teachings. And love is the heart of the diaconal ministry. The question is who is this neighbour? Can someone living with HIV and AIDS, someone who is labelled as a prostitute be a neighbour of a Christian?

7.1.2 Jesus and Women

It has been noted that HIV and AIDS has brought a bigger burden of shame and guilt more especially on the women in Malawi. They have been taken as the scapegoats for the spread of HIV. The result of this type thinking is that when a woman has been tested to have HIV, it is much harder for her to deal with the situation. It might be easier for the man who is tested HIV positive for he can push the blame on the wife or at least be excused for his "natural" weakness to manage his sexuality. This provides a bigger challenge to the counsellors that would counsel women. Women need counsellors who can respect them and take them seriously. Just as Ndossi puts it:

> *"For women to tell their stories they must feel safe. A safe place can only be created with men and women having a correct knowledge and attitude towards women i.e. counsellor who respects and takes women seriously. A woman is worth of dignity like men because she is created in Gods' image*" (Ndossi 2006: 9)

To be able to address the cause of women in the context of shame and guilt in the face of HIV and AIDS, we need to have a look at how Jesus treated women. Jesus treated women

with the dignity that they have ever experienced. The woman who was caught in adultery is an example. Jesus also interacted with women of different social backgrounds, for example prostitutes and outcasts. Jesus never demeaned any woman for the reason of her low social status. Hence the comment of Dorothy Pape:

> "Perhaps *it was no wonder that women were…the last at the cross and (and the first to the grave on Easter day). They had never known a man like this; there never has been such another. A prophet , a teacher who never nagged at them, never flattered, patronized, who never made such jokes about them….Who took their questions and arguments seriously….who never mapped out their sphere, never urged them to be feminine or jeered at them fro being female…. Who had no un easy male dignity to defend, who took them as he found them and was completely, unselfconscious. There is no act, no sermon, no parable in the whole Gospel that borrows its pungency from female perversity, nobody would possibly guess from the words and deeds of Jesus that there was anything funny or we might add inferior about womens nature*" (Ndossi 2006:9)

If the church is to take the example of Jesus, women living with HIV and AIDS will be heard, respected and will be given a place in the church.

7.1.3 Jesus and People Living with HIV and AIDS

There was no HIV and AIDS in the time of Jesus, yet the issue of HIV and AIDS can be compared to many contexts in the time of Jesus. Jesus has a message for people living with HIV and AIDS. In the time of Jesus, there were different groups of vulnerable people like tax collectors, sinners, lepers and others who were despised by the society. The question is, how did Jesus relate with such people? The Nordic FOCCISA church cooperation says:

> "*Jesus identified himself with those whose lives were most broken, sitting at the table with tax collectors, sinners and the sick, we as the church are also called to identify with people who are despised. The church has to start with those whom Jesus identified himself – the outcasts, the rejected ones, the marginalised and people in need."*(Onebody vol 1:28)
>
> In the same way, the church has a responsibility to identify herself with people living with HIV and AIDS

The church need to make one more step, a step in identifying a way on how to promote messages of acceptance of people living with HIV and AIDS without condoning sexual immorality and yet without scandalising people living with HIV and AIDS

7.2 Addressing Shame and Guilt

Shame and guilt are very complex concepts that need to be handled with great care. Much as they hang together, they need to be treated differently for confusion of the two could probably destroy the whole process. The church has always been very good with addressing guilt. The church has put forward measures of what a person can do if he/she is guilty of any sin. Most church denominations in Malawi have very clear rituals of confession, forgiveness and absolution. Yet, the gap is in addressing false guilt and shame. This makes the probability of confusing shame and guilt higher. Albers warns against this intentional or unintentional confusion of shame and guilt. He says:

> *"When shame and guilt are confused or conceptually understood as synonymous, the ritual of confession, forgiveness, and absolution for a person's guilt misses the point and will only exacerbate the sense of shame*". (Albers 1995:24).

I have looked at the process of HIV Testing and Counselling. The process does not address the shame and guilt that surround people living with HIV and AIDS. The HIV and AIDS is a good starting point that need to be improved so that it can be able to address the issue of shame and guilt in people living with HIV and AIDS.

7.3 Theological Resources that can help Dismantle Shame and Guilt

It has been established that the church need to be careful in dealing with people whose lives are characterised by shame and guilt because as Albers puts it,

> "*By its attitudes and actions, the church may exacerbate the sense of disgrace shame ensnaring its members in the web of bondage, rather than serving as a vehicle for freedom and liberation from the paralyzing and debilitating effects of shame*" (Albers 1995: 85)

In this case, it is imperative for the church to use its resources in the right way so that the required result could be achieved. By saying this, I mean that the real problem that needs to be addressed in the people living with shame and guilt in the context HIV and AIDS should be identified. After identification, proper measures should be taken; otherwise, the intended purpose may not be achieved. For people with shame based identity, it is the self that has a

problem. The person with shame based identity looks at himself/herself as inferior and not worth anything of value. To address the problem, there are so many teachings in the Christian faith that can be utilised to help people with shame regain their human dignity. Among which are: Grace and justification by faith in Jesus and Creation theology.

7.3.1 Grace and Justification

To begin with on how grace works in healing shame, I will quote Johann Goethe who says,

> "*When we treat a man as he is, we make him worse than he is. When we treat him as if he is already what he potentially could be, we make him what he should be*" (Smedes 1993:105)

How would people living with HIV and AIDS be treated? To use the wisdom of Johann Goete, it would mean that there is need that something positive should be done to them even if their present situation may seem not to be as positive. People with HIV and AIDS feel inferior and not accepted in the Malawian society. According to the earlier findings of this paper, they feel as if everyone thinks that they are prostitutes or womanisers. The callenge for the HIV Testing and Counselling is to let people living with HIV and AIDS feel accepted. In connection to this challenge Smedes poses this question that he also tries to give the answer;

> *"Are we stuck with our merciless illusion that we need to be acceptable before we can feel accepted? Is there an Alternative to the shame producing ideals of secular culture, graceless religion, and unaccepting parents? There is. It is called grace. Grace is the beginning of our healing because it offers the one thing we need most: to be accepted without regard to whether we are acceptable. Grace stands for gift; it is the gift of being accepted before we become acceptable."* (Smedes 1993:107-108)

Grace is what Paul talks on in Ephesians 2:8-9 which says: *"for it is by grace you have been saved through faith – and this not from yourselves, it is the gift of God – not by works, so that no one can boast"*. This means that according to Paul's teaching of salvation, man is saved in his sinful state. It is after man has already been saved and justified by faith and has received the righteousness of God, that he is expected to produce good works. The grace of God comes on man whist man is still in his desperate shameful situation, even that of living with HIV and AIDS. Smedes puts this picture more clearly when he says:

> "*Grace gives us courage to look at the messy mixture of shadow and light inside our lives, be ashamed of some of what we see, and then accept the good news that God*

accepts us with our shadows and all the ogres who live inside of them". (Smedes 1993:115)

The same author continues to say how important it is for man to start the journey towards grace, being valued and acknowledging ones inherent worth from the same point man is regardless. That is even if man is in a state of shame and guilt, he/she can receive grace in that same state, for it is grace that will help the man move to human dignity and freedom from guilt. For this reason, Smedes saya:

"*Mind you, we do not have to feel good about the shabby things that go on there, but we have to acknowledge them, own them, respect them as part of the selves we are. Grace gives us permission: is God accepts us whole, light, dark and shadowed, he gives us permission to accepts ourselves whole*". (Smedes 1993:147).

Grace will let people living with HIV and AIDS accept themselves in their state, and look at themselves the same way as God looks at them, that they are valuable and respectful.

7.3.2 Creation Theology

According to the teachings of the church, the whole cosmos was created by God. The cosmos was intentionally designed and created by its maker who is God. After God created the whole world, he looked at what was created and said" *Behold, it is very good*" (Gen 1:25). God is satisfied with His creation. The creation of man was even more special. After God had created man, He saw what He had created and said, "*it was very good"* (Gen 1:31). When God said that it was good, He was referring to both the material and the spiritual entities that He had created. According to Christian teaching, the body and all the other material things are good. If we look at the doctrine of incarnation, it would be noticed that the material is also very important. The body of any human being is good and valuable. Albers points out this truth as he says,

"God is not only linked with materiality and corporeality, but is also incarnated in human fresh. This reality has important consequences for the people of God as they deal with shame issues (Albers 1995:88).

The point here is that the body of a human being is inherently good and valuable. This is goodness is not conditional on the state of the body. The goodness also applies even to the body that has been infected by HIV and AIDS. In the New Testament, Paul says that the body is the temple of the Holy Spirit. To this fact, Albers has this to say:

> "The *Pauline metaphor of the body as the "temple of the Holy Spirit" (1 Corinthians 3:16-17) is a helpful image for the shame based person. It emphasises not only the sacredness of embodied life, but also the value that God places upon the creatures whom God has created. There is intrinsic value in "being" because each person has been created in love. To quote an old adage, "God does not make Junk*!"(Albers 1995:89-90)

In Christianity, the body is valued with no any other qualification. To show how the early church valued the body, the church catholic, in its ancient creeds, speaks of the "*resurrection of the body" rather than the immortality of the soul"* (Albers 1995:87-88). In Christianity, the body is so valuable that it will partake in the after life, which is after resurrection. That includes the bodies that have been infected with HIV. This is in contrast to other beliefs that look down upon the body and the material things of the world.

Creation Theology provides an opportunity for dismantling shame in people, including those living with HIV and AIDS. It affirms that all the created order is good without giving any conditions. It is the intrinsic value of man that counts and not what he/she has done. Albers affirms this approach of beginning to dismantle shame and guilt with creation theology when he says,

> *"For the shame-based person, beginning with an anthropology informed by creation theology, which affirms the fundamental goodness and intrinsic worth of the creature and the whole created order, is a more effective theological posture from which to operate* (Albers 1995:87).

This means that God values the bodies of people living with HIV and AIDS no matter how the disease can disfigure their bodies. Even if the mode through which they contracted the disease was prostitution, it does not change their status, they are valuable before God. HIV and AIDs does not robe people living the virus and the disease the intrinsic value that God has endowed in them at the time of creation and the same God, the Holy Spirit lives in the bodies of human beings. We are temples of the Holy Spirit, whether living with HIV and AIDS or not.

7.4 Summary

In addressing the problem of shame and guilt, the theologies of Grace and Justification and Creation Theology can prove to be very useful. People living with HIV and AIDS need to be

reminded that just by being created in the image of God, they are valuable without any conditions attached. This unconditional worth is well supported in the theology of grace and justification. Hence, this principle of inherent human dignity needs to be included and highlighted in the HIV Testing and Counselling process.

Chapter 8

8.0 HIV Testing and Counselling Process Revised

This chapter will answer then question, "What do we do now after describing what is happening on the ground, identifying the gap in the HTC process, and looking at the normative,?" To answer this question I will provide the suggested revised HTC process. The revised HTC session guide has the goal of addressing the inner man also, the spirit. The process will largely remain psychotherapeutic but will integrate the spiritual element of man.

8.1 Justification for a Revised Counselling Process

The HIV Testing and Counselling (HTC) fits very well under the Pastoral-Clinical Model. It is a psychotherapy and has its roots in psychology. For this reason, I can say that the model has the capacity to minister to the soul or mind of man but not the spirit. Yet if as Berit Okkenhaug put it, "*vi er både kropp, sjel og ånd som ikke kan splittes*"[17] (Okkenhaug 2002:51). We therefore need a counselling process that can address the need of man holistically, as body, soul, and spirit. For the HIV Testing and Counselling to qualify to be a good diaconal tool, we therefore need to integrate an element in the process that will be able to meet the spiritual needs of man. Since the diaconal ministry does not only offer its services to Christians only, that is, the services are offered to all people that belong to different faith communities that surround the diaconal institution. For this reason, consideration must be put in place when integrating the spiritual element so that the people of other faiths should not be scared away but should be able to identify with it. Because I think that despite the different faith affiliations, there are so many religious values that Christianity share with other religions. Hence, it is possible to find an element that is spiritual and Christian, yet it does not offend any other person that does not belong to the Christian community. That is, the spiritual element should have the capacity to dismantle shame and guilt in people living with HIV and AIDS who belong to other faiths without necessarily forcing them to be converted to Christianity.

The second element that needs to be considered is that a human being is relational. Man is not an island and it is therefore necessary to treat man as such. This is mostly true in the Malawian society where the community plays a very important role culturally. Berit

[17] We are body, soul and spirit which is one and can not be divided

Okkenhaug says, *"vi verken kan tenke teologi eller sjelesorg uavhengig av den kultur vi er en del av"*[18] (Okkenhaug 2002:126). The added advantage of the ritual of the pearl is that in the process of explain the significance of the ritual of the pearl is that it is in line with traditional Malawian counselling process. It is the counsellor who does most of the speaking at this stage of the ritual of the pearl. This is in line with the traditional way of counselling which Malawians are used to. The counsellor does the speaking and the client listens. It is assumed that at the end of this ritual, the client would realise the value that is instilled in him. This worth and value that has been rekindled in the client is expected to raise his/her self image and self confidence which will enable the client to participate more fully and effectively in the remaining counselling process.

To address the issue of shame and guilt in the context of HIV and AIDS, we need a counselling process that can address the needs of people living with shame and guilt. We need a process that will not make them feel more ashamed and scandalised at the end of it. In my opinion, it is scandalising to be asked to remember and narrate all the recent risk patterns. The HTC process has been analysed and it was shown that the process has a lot of strengths that qualifies it to be a good tool for counselling. Moreover, the Malawi Council of Churches recommends it and encourages its members and their clients of pastoral counselling to go through the process HTC. But the step where clients are made to narrate their sexual adventures, I find it problematic and I think it is the stage that need revision and can be replaced by something that is spiritual and will remind the clients of their human dignity.

For the reason stated in the above paragraph, I would suggest that the second stage in the HIV Testing and Counselling should be dropped. Instead, I would suggest that soon after the counsellor and the client has introduced themselves to each other, the ritual of the pearl can come in. The ritual will remind the client that he/she is valuable despite of the status if he/she will be diagnosed to be HIV positive. The client who has been already stigmatised in every other way possible before he had come to the decision of meeting the counsellor need to be reminded of his/her inbuilt human dignity his intrinsic value, the "*umuthnu*"[19] in the Malawian Chichewa language that the Malawi Council of Churches referred to in its

[18] We can neither think theology nor pastoral care independent of the culture we are part of.
[19] Human Dignity

"*HIV/AIDS learners Manual for the clergy*". Because man has been created in the image of God, He/she deserves respect. Benner has this to say on respect:

> "*Respect is having and showing a deep valuing of the other. That is the client is not judged and is accepted unconditionally. It is the seeing of a fellow human being as God does – as an image bearer of God and therefore a person of extreme worth, even if this image is marred by brokenness and distorted by sin"* (Benner 2006 :75).

If we look at what Paul said regarding the body as the temple of the Holy Spirit, then it would be difficult to answer the question above in the negative. The Holy Spirit continues to live in the body of any person that is living with HIV and AIDS. People living with HIV and AIDS are valuable, very good and a habitation for the Holy Spirit. Shame and guilt has robbed people living with HIV and AIDS of realising this truth. I would propose that a ritual that symbolises who they are before God should be done. I suggest the ritual of a pearl to show that they are valuable before God.

8.2 Dismantling Shame and Guilt in People living with HIV and AIDS.

As it has been discussed in this paper, it has been seen that the issue of shame and gilt is real among people living with HIV and AIDS. Shame and guilt has contributed to the problem of stigma and discrimination. This calls for the need even to revise the very first counselling process that people living with HIV and ADS go through in Malawi which is HIV Testing and Counselling. In revising the HTC process, I would want to take the suggestion that was put forward by Robert Albers who said:

> *"when it comes to the issue of dismantling the shame, creativity is called for in each instance. Each person, group, or community must draw upon the recourses, symbols, rituals, and activities which best suit the situation"* (Albers 1995: 139).

I would want to borrow a ritual that is being used by the Church's Resource Centre in Norway in the context of shame among people that have been sexually abused. I think that the ritual can also be helpful to people living with HIV and AIDS in relation to their human dignity self-esteem, and self worth. People living with HIV and AIDS need to be reminded that even though their bodies have been infected by the virus, their bodies have not stopped to be the images of God. HIV does not change their status in terms of which they are, that is their identity. People living with HIV and AIDS are still the image of God and their bodies are temples of the Holy Spirit. The Holy Spirit does not depart from them because they have been

infected by HIV. The reason I have chosen to borrow the ritual is as Albers has put it when he said:

> *"Valuable information and insights are provided for in the social sciences. But in order to be holistic in our approach to human beings, the faith dynamic needs to be factored into the whole scenario*" (Albers 1995:138).

Here is the ritual that I would like to be integrated in the HIV Testing and Counselling process in Malawi Malawian diaconal health facilities in addressing the issue of shame among people living with HIV and AIDS.

8.2.1 The ritual of the Pearl

The ritual of the pearl is being used by the Church's Resource Centre in Norway. The ritual is used for people that have been sexually abused and consequently suffer from shame and sometimes guilt because of what they went through. The pearl is something that is good and valuable. It is a symbol of the intrinsic value that man is endowed with right from creation. The Church's Resource center has this to say on the meaning of the pearl,

> "*Perlen som symbol på verdighet har gitt oss mening. Perlen er historien om forvandling… Perlen kan minne om den verdigheten som alle eier*"[20] (http://www.kirkens-ressurssenter.no/jubileum.shtml 02.03.08).

To people living with HIV and AIDS, the pearl would be a reminder of their intrinsic value. That no matter what challenges that they have gone through, and even those that lie ahead of them, just like a pearl, they are still valuable. They are not worthless as the society may loudly communicate to them verbally or non-verbally.

The ritual of the pearl is in line with the church's creation based theological anthropology that emphasises that God created a good and valuable human being. All that is material is good and is treasured by God. More especially the body of the human being is so treasured that it is the temple of the Holy Spirit and this is true whether the person has HIV or not. No wonder then that the apostolic creed talks about the resurrection of the body; this includes even bodies of people that have been infected by HIV and AIDS. Moreover, whether the people living with HIV and AIDS got the virus through sexual immorality or not, Jesus still speaks to them, "neither do I condemn you, go and leave your life of sin". That is, people living with HIV and

[20] The pearl can be seen as a symbol of dignity. It is the history of transformation……. The pearl can be a reminder of the dignity that everyone owns.

AIDS are accepted before God unconditionally. This is the theology that when put into practice, can help the people living with shame and guilt accept themselves and develop a better self image. In integrating the ritual of the pearl into the HTC process, which has a theological background, it is hoped that the process of the HTC will be able to serve the spiritual part of man, thereby serving man in totality, body spirit and soul as it was argued by Berit Okkenhaug.

8.2.2 The Haslum Experience with the Pearl

In the month of October 2007, I was attached to Haslum Parish where I did my attachments. Whilst there at Haslum, I was exposed to the use of the pearl as a symbol of human dignity that has been endowed in each and every human being regardless of gender, age, social status, health, race or any difference that can there be among people. Every human being is special and valuable, priceless, and worthy of love and recognition before God regardless of their past experiences. It was at a special church service called, Tomas messe[21]. This service is mainly targeted at people who feel that they have faith in Christ but because of various reasons, their faith in Christ waves between what I would call weak and strong faith. There are times that they would believe, and there are other times when they would doubt. Each of the participants was given a pearl to have and have a feel of it, take it home and let the pearl be a reminder that he/she is valuable before God. It could be seen from the participants' faces that they were encouraged by the whole process. The message and the ritual of the pearl made them feel valuable. This made them feel accepted before God and one would guess that their faith in God and in themselves was strengthened. I personally was tempted to think that if there was anybody who was suffering under the weight of shame; it might have been dismantled by the process of the ritual. One participant told me the following day that the ritual made her feel more confident of herself. It was encouraging to her to hear that God accepts her the way she is which she treasured.

8.3 The Proposed HIV Testing and Counselling process

1. **Introduction and establishing rapport.**

   Welcome client, introductions, explain counsellor role/session content

   Explain confidentiality and anonymous test

[21] Thomas Mass

Informs the client about counselling and rapid test process including clinic flow and time

Address immediate concerns and questions

2. **A ritual with the pearl**

   Explain to the client the figurative meaning of the pearl, that is, it represents their value and worth regardless of the results of the HIV test, whether positive or negative results, the client remains to be the image of God and valuable.

3. **HIV Test preparation**

   Assess client's reason for Counselling and Testing, previous tests

   Identify with whom client has shared test decision

   Discuss understanding of a positive/negative test

   Discuss benefits of testing/positive living

   Determine client's test readiness/decision

   Obtain informed consent for HIV testing

4. **Test Results Counselling**

   Provide and explain results clearly and simply

   Explore client's understanding/response to results

   If positive, provide support, address positive living

5. **Negotiate_Risk-Reduction_Plan**

   Identify priority risk-reduction behaviour

   Develop incremental steps toward behaviour change

   Sources of Support and Referrals

6. **Negotiate Disclosure and Partner Referral**

   Identify whom client may disclose for support, care,

   Anticipate potential reactions

   Discuss approach to disclosure/referral — role play

8.4 Conclusion

In conclusion then, I think that shame and guilt are challenges that can be to pastoral counselling. Among the reasons for the challenge of shame and guilt is caused by some theologies that are intended to regulate the morality of the church but unfortunately end up in closing people outside from the same church. The church in Malawi has noted this problem and has come up with positive theology to integrate people living with HIV and AIDS in the

church. What is needed now is to make sure that the positive theology is implemented on the ground. People living with HIV and AIDS need to realise and be reminded of their intrinsic value even just before their new status of living with HIV and AIDS is announced to them. That is where HIV Testing and Counselling stands at a strategic point where people living with HIV and AIDS can be psychologically empowered by the knowledge that they are valuable. This would give them strength and ability to be able to manage the possible stigma and guilt that might come their way because of living with HIV and AIDS.

Robert Albers has summarised well on the role that the church can play on the issue of shame and guilt where he says,

> "*By its **attitudes and actions**, the church may exacerbate the sense of disgrace shame ensnaring its members in the web of bondage, rather than serving as a vehicle for freedom and liberation from the paralyzing and debilitating effects of shame (emphasis mine)*." (Albers 1995:87).

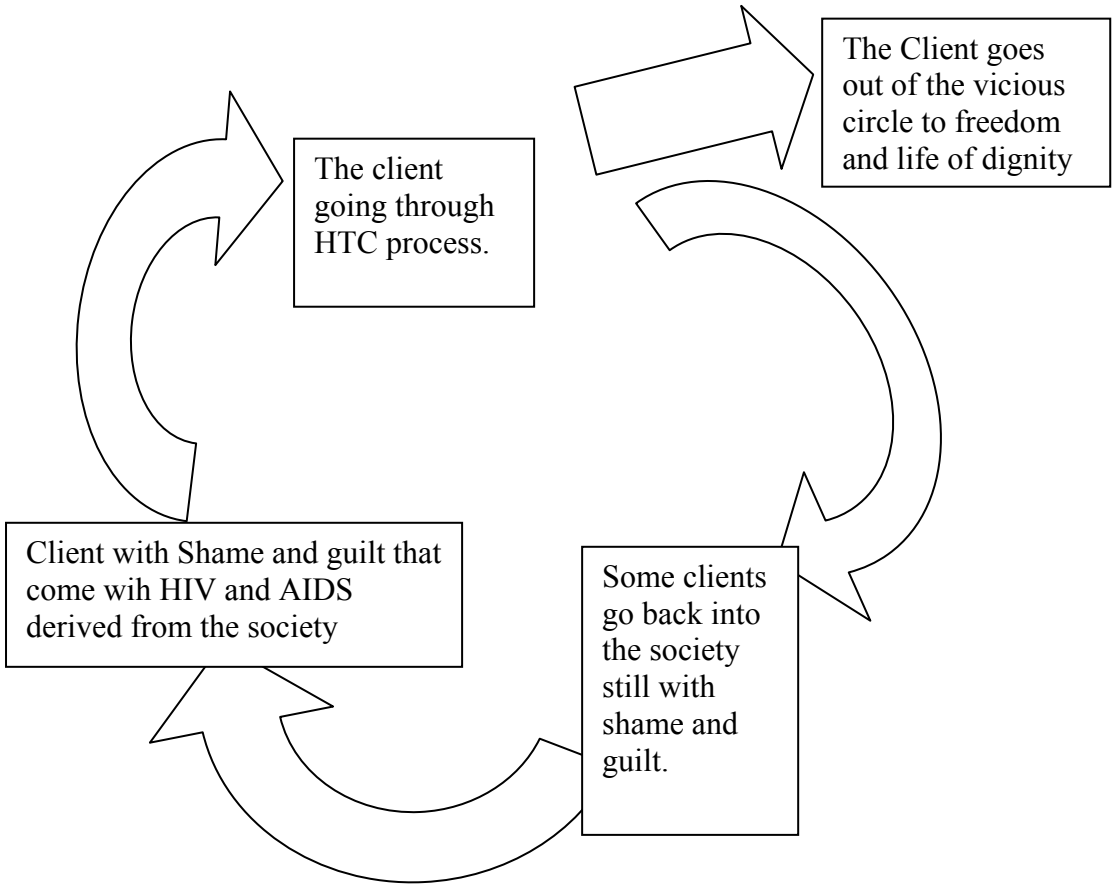
The positive theology that has been developed by the church, especially the model "*HIV/AIDS Learners' Manual for the Clergy"* by the Malawi Council of Churches is the tool that has the capacity to change the "attitudes" of people that may bring shame and guilt in people living with HIV and AIDS. The gap that was identified was the "actions". The HIV Testing and Counselling process gives the church an opportunity where the positive theology that has been developed can be put into action. Even though the HIV Testing and Counselling was developed by the government and is therefore secular in nature, the government has declared in its National Action Framework (NAF) for the period of 2005-2009, which says,

> "*The Malawi HIV and AIDS National Action Framework (NAF) 2005-2009 also takes note of the need to improve the need to promote transformation of theological orientations and enhance the involvement of Faith Based Organisations (FBOs) in offering spiritual counselling to people living with HIV and AIDS and affected families."* (MIAA report 2006:24)

For this reason, I think that the church can start implementing the positive practice (actions) that are based on the positive theology that was developed in the CHAM health facilities because actually, almost all CHAM health facilities has Voluntary Counselling centres. The vicious circle of shame and guilt that was earlier given can be broken and take a new direction after the HIV Testing and Counselling. Here is the new progression that is expected:

1. The client with some preconceived ideas that brings shame and guilt that is related to people living with HIV and AIDS.
2. The client going through HIV Testing and Counselling that is able to break all the preconceived ideas on shame and guilt that were derived from the society. The client comes back from the counselling session feeling more valuable and having a better self-image even after testing HIV positive
3. The client goes back into the community empowered with the right psycho-social skills to and starts living positively with HIV and AIDS. The client will have a positive effect on the information that will be circulating in the society. The positive information will lead to positive effects in reducing shame and guilt in people living with HIV and AIDS.

The following is the diagram of the anticipated results of the revised HTC:



TheVicious Circle of Shame and Guilt and HIV and AIDS with an Outlet

This progression is based on the assumption that is put forward by Robert Albers, who says,

"*A whole tone of attitude is established if the individual is viewed and begins to view her or himself as a priceless person in the eyes of God and others who is endowed with unique and special gifts and talents*" (Albers 1995:87).

This is what the revised HTC session guide intends to do. The revised model seeks to instil the feeling of value and worth in individuals seeking counselling help. It should be noted that individuals who manage to go out of the vicious circle will influence the community in a positive way. They will be the ambassadors of the revised counselling process which can have an effect on the number of people that would go for HIV testing and counselling. In the long term, the stigma and discrimination problem can be addressed.

8.5 Recommendation

My recommendation is that after analysing the HTC process that is now in use in all HIV testing facilities in Malawi, it has been found out that there is a gap in the current HTC session that need to be improved if the tool is to break the vicious circle of shame and guilt that was earlier given in chapter 6. The proposed revised model has been given in this chapter with the anticipated results. My recommendation from this point is to test and try the proposed HTC session guide. I propose doing it with the HIV testing facilities for CHAM institutions in Malawi. The reason is that if the tool is to be sold nationally for national use, it should be something that has been tested and tried and has proved to show that it is a workable tool. The Malawi government has already appealed to the faith community to assist in spiritual counselling in people living with HIV and AIDS to reduce the problem of stigma and discrimination that is there. The onus now is with the church to move.

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