AIDS: GLOBALIZATION AND ITS DISCONTENTS

by Mary E. Hunt

Abstract. HIV/AIDS has changed from a disease of white gay men in the United States to a pandemic that largely involves women and dependent children in developing countries. Many theologies of disease are necessary to cope with the variety of expressions of this pandemic. Christian theo-ethical reflection on HIV/AIDS has been largely focused on sexual ethics, with uneven and mainly unhelpful results. Among the ethical issues that shape future useful conversations are globalized economics and resource sharing, the morality and economics of the pharmaceutical industry, and the need for sex education and access to reproductive choice. Considering such issues in international, interreligious, multiscientific contexts is a concrete next step for the religion-and-science dialogue. It will put the powerful tools of both fields to the service of the common good.

Keywords: globalization; HIV/AIDS; religious pluralism; reproductive health care; sexual ethics; theo-ethical questions; theologies of disease, transgender persons.

AIDS is the most graphic example of globalization that I can imagine. Its current form outlines global injustice: poor women and their dependent children, gay men, and migrants make up the vast majority of its sufferers. I offer a look at the situation from a U.S.–based, white, feminist perspective with the hope that I can encourage religious people, especially people from the Christian tradition to which I belong, to think anew about this common problem.

My approach includes three dimensions. First, I sketch a panoramic view of the HIV/AIDS situation and say why I am intuitively leery of global definitions for *disease*. Second, I look at the HIV/AIDS pandemic

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[*Zygon*, vol. 39, no. 2 (June 2004).]
 ISSN 0591-2385

from a Christian feminist perspective, specifically, how it has changed from a gay men's issue to a mirror of global injustice, and what this implies for changes in theological thinking about it. Third, I offer modest suggestions for moving the religion-science conversation forward toward action so that an interfaith effort can become more than an intellectual exercise.

A Panoramic View of HIV/AIDS—and Why I Am Leery of Global Definitions for *Disease*

I am not an apologist for Freud, but I think he was ahead of his time in predicting what has come to pass in the HIV/AIDS pandemic, namely, that our ability to control much of nature has outstripped our moral ability to seek the common good. Technology, travel, business, communication, and disease have become globalized such that fewer and fewer people make more and more choices that affect all of us. HIV/AIDS is a disease that actually has profoundly different manifestations depending on where and how one lives. For example, when a poor black South African woman is infected she might as well plan on a short life. In contrast, a white gay man in Chicago who has generous health insurance and good nutrition can expect to cope for some years with a chronic disease that may or may not be the cause of his death.

The current contours of the HIV/AIDS situation were outlined at the 14th International AIDS Conference held in Barcelona, Spain, in July 2002. The new approach is to examine AIDS in a globalized economy, not simply as a disease in one country or one group as previous privatized analysis has tended. The face of the disease is changing so quickly that statistics and trends of ten years ago, even five years ago, are outdated.

I am especially concerned to broaden the religious reflection from sexual morality to unjust power dynamics as the epidemic changes from its early presentation as a seemingly white gay male disease in the United States to one that now infects mainly poor women of color and their dependent children in developing countries. I am, of course, concerned about the well-being of gay men, especially young gay men who may not choose safer sex practices. But I want to see them in the larger context so as to have a realistic picture of the problem as it is growing around the world.

The nexus of religion and science can be a cooperative one, with religious people asking useful questions that scientists will factor into their work and scientists sharing data that will help religious people make realistic assessments. We have already seen the disastrous impact of religious prohibitions on condom use, something that no responsible scientist would recommend. It is to prevent such problems that religious and scientific colleagues collaborate.

AIDS in a Globalized Economy. The earliest reported cases of AIDS in gay men more than twenty years ago occurred when the world was far

more compartmentalized than it is today. It is fair to say that globalization has made all the difference in the world! "Globalization is a phenomenon that has remade the economy of virtually every nation, reshaped almost every industry and touched billions of lives, often in surprising and ambiguous ways," states *New York Times* editorial writer Tina Rosenberg (2002). From computers to Coca Cola, nothing has "benefited" more from globalization than the spread of disease. Indeed, 20 million people have died; 40 million are currently living with the HIV infection. But how they live, how long they live, and why they live at all with HIV/AIDS is not a mystery or a case of luck. It is now a predictable phenomenon that can be eradicated in time and managed in the meantime. This is the current medical consensus, despite grim statistics and painful problems for every person who is infected.

What was first noticed in 1981 as a strange set of symptoms found in a number of urban-dwelling gay men in the United States is now one of the most complicated and far-reaching pandemics in human history. According to Peter Piot, Director of UNAIDS, the United Nations and World Bank agency with specific concern for the disease, "We are only at the beginning of the AIDS epidemic in historic terms" (Brown 2002). In the African country of Botswana, 45 percent of pregnant women treated in city prenatal clinics and 39 percent of the adults in general are infected. In Zimbabwe and Swaziland, one-third of the adult population is infected. World Council of Churches official Sam Kobia observes that "HIV/AIDS in sub-Saharan Africa is a plague of genocidal proportions. No other calamity since the slave trade has depopulated Africa as AIDS has" (2001).

The Caribbean is not far behind, with Haiti and the Bahamas suffering high infection rates. However, even larger numbers lie ahead, when the huge populations of India, China, and Indonesia begin to feel the impact of their rapidly rising rates of infection. China is a great unknown, because data are hard to come by in rural areas. Current estimates of a million people infected may indeed be five to six times too low. The Chinese government has finally acknowledged the seriousness of the problem and is promising to copy some of the available therapies if prices are not lowered by their Western manufacturers (Rosenthal 2002). Such numbers are almost incomprehensible in that they represent not only those who are likely to become ill but also their children, who will be orphaned, and their jobs, which will need to be filled. A cultural revolution of another kind is happening in a globalized economy that feels the ripple effects.

Despite these numbers, the fastest growing rate of new infections is in parts of the former Soviet Union, especially in the Russian Federation, where the loss of industrial jobs results in poverty. Prostitution and intravenous drug use, breeding grounds for the infection, are poverty's accompaniment. It is not so much a matter of sexual mores but of economic, racial, and gender considerations that determine the ever-changing aspects of HIV/AIDS.

More recent concern has focused on HIV/AIDS as a security threat (Altman 2002). This approach is debatable, since it plays into the hysteria that has been used to rein in certain human rights. But it may prove to be the fastest road to big funding. While the HIV/AIDS situation is different in each country, the National Intelligence Council reports that the cumulative impact will be disastrous (AIDS 2002). Nigeria, Ethiopia, Russia, India, and China, where the disease has not peaked, make up more than 40 percent of world's population. Russia fears the loss of military personnel that will be potentially destabilizing for that country. Nigeria worries about its United Nations peacekeeping force, another cause of insecurity. Migration of peoples and high-risk sexual behavior in these countries contribute to mounting infection rates.

The consensus at the Barcelona meeting was that if prevention and vaccine are not on the horizon soon, more than 68 million people will die of the infection in the next two decades. Earlier projections for southern Africa turned out to be 30 percent lower than what actually happened. Those infected are well beyond the cohort of those first considered at high risk, namely, intravenous drug users and those who have unprotected sexual relations with infected men. The general populations of these countries are at risk. This is a significant change that underscores the need for broad-based education and social change. In addition to prevention strategies and the development of a vaccine, the task is to diminish risk factors such as being illiterate, being a woman in a male-dominated society, being a male who has sex with males in a homophobic culture, and being a person of color in a racially stratified society. These conditions are often exacerbated by religious beliefs and religiously fueled prejudices.

If there is good news out of Barcelona, it is that in some parts of the world the rate of infection is dropping. Piot reports, "Nations with accelerating epidemics must move quickly to adapt proven responses from countries that have succeeded in turning the epidemic around. The essential elements for reversing the disease's spread are frank, widespread HIV prevention, including access to voluntary counseling and testing, leadership at the highest levels of government, and access to care for people infected and affected by AIDS" (Altman 2002a). Countries such as Australia and Poland have done a remarkable job of keeping the problem at bay. The overwhelming factors shaping the pandemic seem to be economic, not moral. Jobs and egalitarian mores, not sexual sanctions and quarantines, work to stem the tide when it comes to prevention and dealing justly with those who are infected.

In the United States, the disease is increasing among African American women and their dependent children. Shockingly, 90 percent of African American gay male teens, 70 percent of their Hispanic counterparts, and 60 percent of white gay male teens tested and found to have HIV had no idea that they were infected (Altman 2002c). Moreover, 55 percent of the

new cases from 1994 to 2000 as reported in twenty-four states were African Americans, despite the fact that they made up only 12 percent of the population (Altman 2002c). This means that prevention efforts and access to advanced treatments, which may soon make HIV a chronic but survivable disease for many white gay men, are simply not available now where they are most needed. With so many people in the United States lacking access to adequate health care, and even more without even rudimentary information on the disease, it is time to move beyond gay bars and baths to the street corners, grocery stores, neighborhood houses of worship, and soup kitchens with prevention materials.

A new drug, T-20, helps many patients who have developed resistance to other antiretroviral treatments. However, even those who have access to the best medical care and support systems live with enormous problems. Recent studies indicate that the protease inhibitors, once hailed as wonder drugs for keeping infected people alive and healthier longer, are showing links to increased risk for heart disease.

Theology and Disease. In the face of a situation that seems so uneven and unjust, the matter of a theology of disease leaves me feeling a little queasy. Just the word *theology* seems to have Western Christian and Jewish overtones. In my experience, unnuanced by terms like *feminist, liberation, black, Asian,* and other qualifiers that state up front the perspective of those whose reflections on the divine and whose life situation will be most deeply affected, *theology* tends to reflect and serve the needs of those in power. This is the lesson of the past thirty years of theological work. In the increasingly pluralistic religious framework that is now the reality in the United States, it is even more important.

I do not mean to suggest that colleagues engaged in the work of finding adequate theological expressions have this approach in mind. To the contrary, I would expect that those of us who are white and Western have learned from those who have been marginalized that how we name the divine, the *logos* we use about *theos*, shapes to a great degree the customs and behaviors of a culture. In a globalized culture that harbors an unequal-opportunity disease, I would prefer to look at *theologies of diseases*. Such a formulation suggests a participatory approach in which many experiences, beginning with those who are most marginalized, could be brought to bear. This avoids the risk of further hegemonic discourse aimed at an umbrella category like *theology of disease* that would privilege certain starting points. Instead, we would structure our common listening to hear the varied strains of divine and human suffering as an essential step toward their eradication.

Let me demonstrate how the tendency toward a single theological approach has taken shape in the Christian tradition with negative results, before suggesting ways to move the conversation forward. I limit myself to

the Christian tradition out of a sense of both interreligious politeness and responsibility for transforming my own tradition.

How the Pandemic Has Become a Mirror of Global Injustice, and Theological Implications

I begin with some voices, because I have suggested that listening, rather than pronouncing, is a good first step:

- Bishop Rainy Cheeks, an HIV-positive religious leader from Washington, D.C., put the matter bluntly at an August 2002 conference on Women and AIDS sponsored by CLOUT (Christian Lesbians Out): "The church is responsible for the spread of HIV/AIDS."
- "If the Catholic Church does not change its teaching on the use of condoms to prevent the spread of AIDS, it should be held responsible for the deaths of thousands of AIDS victims," proclaimed Joanna Manning, a Canadian religious writer, at the opening of the Vatican-sponsored World Youth Day in Toronto, in July 2002.
- "I hope that all of you gathered here, and those you represent, want to break the silence barrier, that you are going to be ready—responsibly, urgently and in an engaging way—to speak and teach people about sex, about reproductive health," urged Desmond Tutu, Anglican Archbishop Emeritus of South Africa, addressing religiously affiliated African health organizations in 2000 at the 13th International AIDS Conference held in his country.
- "Unfortunately and shamefully, the church has been somewhat asleep on this issue, and maybe it's because of the social stigma," said the Reverend Franklin Graham, son of evangelical preacher Billy Graham. Despite his tradition's insistence on heterosexual, monogamous married sex, he asked, "How can people who have different opinions at least work together to help the people who are dying? How can we provide hope? That's my heartbeat right now."
- "Some leaders are still afraid of them. They don't want to touch them," said the Reverend Jane Nuthu, a pastor of the Assemblies of God in Kenya who works with street children in Nairobi. "We take any kid that is desperate. And we don't judge them," she claimed as a little girl whose mother had died of AIDS clung to her.
- "A powerful missing ingredient has been the voice of the churches, the mosques, the temples—the entire religious constellation," indicted Stephen Lewis, special advisor on AIDS to Kofi Annan, UN Secretary General. "Dare I say that the voice of religion has been curiously muted?" he asked at an interfaith conference on religion and AIDS organized by the World Conference on Religion and Peace in Kenya in June 2002.

As HIV/AIDS grows into a global pandemic, these powerful challenges emerge from diverse segments of the Christian tradition and beyond. They stand in stark contrast to the ambivalence and rejection that characterized much of the early reaction from Christian churches to a disease that will soon have taken more lives than all of the armed conflicts of the last century. Perhaps such tremendous loss is necessary to awaken the sleeping giant that organized religions have been in the early decades of the HIV/AIDS pandemic. Such frank talk may even put religious people in the vanguard of those who seek prevention and a vaccine. More to the point, it may catalyze those seeking to restructure the economic, social, and religious frameworks that ground an increasingly globalized world in which HIV/AIDS acts as a mirror reflecting injustice.

As part of the early Christian response to HIV/AIDS, the ethical focus was almost exclusively on sexual morality construed in the most privatized way to the exclusion of globalized, systemic analysis of the conditions that ground the pandemic. One of the best antidotes to that approach was crafted by Jonathan Mann, a medical doctor and World Health Organization AIDS pioneer. In 1994, he gave a prestigious talk at Harvard Divinity School, the Ingersoll Lecture on Immortality, titled "Health, Society and Human Rights." It was a marvelous example of religion and science in collaboration. He wondered why he, a physician, a public health worker, was asked to address so lofty a theme as immortality. He mused that in all his medical and public health training he had never heard the word *immortality*. But he went on to say that in his judgment the old model of chasing after the virus was no longer adequate. Rather, he argued,

> The history of our confrontation with AIDS illustrates that how we define a problem determines what we do about it. . . . The critical discovery was that the spread of HIV is strongly determined by an identifiable societal risk factor . . . in the scope, intensity and nature of discrimination that exists within each community or country. We are not speaking principally about discrimination against already HIV-infected people and people with AIDS, as important as that is; we are considering those forms of discrimination in society which antedated the arrival of human immunodeficiency virus. (Mann 1994, 9)

This was early on in the history of the disease, but his insights set a trajectory for looking usefully at the disease by focusing on the racist, sexist, economically unjust system and calling it the cause of illness. It is this system that is sick and in need of healing. This approach signaled a move away from a privatized analysis of a person who was infected to a social analysis of a disease in a culture that proved a welcome host for the infection for its most vulnerable citizens.

Expanding the Focus to Women and Children. Despite Christian theologies' worries about homosexuality and AIDS, women and children are most at risk in a globalized economy that sanctions sexism and leaves most

childrearing to women. Like gay men, who were among the earliest infected, women and children are considered marginal. Nowhere is this more evident than in the projection from Barcelona that by 2010, more than twenty million children will be orphaned in Africa because of AIDS, five million in other parts of the world (Altman 2000). In some of the hardest-hit African countries, by 2010 one of seven children will have lost one or both parents. The impact of such loss is staggering in terms of children's well-being, economic means to sustain families, and indeed nations' abilities to develop. It bears repeating that the worst is yet to come.

Happily, one new initiative unveiled at Barcelona is MTCT-Plus, a short-course antiretroviral medicine designed to prevent the transfer of the virus from mother to child (MTCT). For the first time in the history of this disease, women will benefit first and not in some derivative way from a new therapy. The effort has received an initial $50 million in funding—a good start, but hardly enough to handle the millions of lives that might potentially be saved. In the United States, African American women comprise the fastest growing cohort of newly infected. In Washington, D.C., for example, one-third of the newly infected are women. Racism and poverty combine to make that the case and to keep their well-being from public scrutiny.

Another recently identified issue is the difficulty faced by transgender persons. One study revealed that one-third of all male-to-female transgender persons in Washington, D.C., are HIV-positive. Of those, two-thirds are African American (Washington 2000). In addition to the usual risks, transgender persons are at risk from prostitution, invasive cosmetic therapy by nonprofessionals, exploitation because of their transgender status, and high incidence of alcohol and drug abuse. This is a community whose needs have never been taken seriously by religious communities but whose reality is now part of our common concern.

Given how most Christian churches have treated gay men, it is no wonder transgender persons are pessimistic. Gay men, especially young gay men of color, face virulent opposition from many Christians with regard to their sexual choices, whether they are infected or not. What began as a personal religious protest against anal receptive sex by men with men is now a condemnation based on the fact that such high-risk practices contribute to the spread of HIV. The result is the same: wholesale dismissal of the goodness of gay men's lives and undue focus on their sexuality.

Some gay men intentionally engage in anal receptive sex without condoms for reasons of closer connection to the other person, internalized homophobia, pleasure, intentional risk-taking, and spirituality (Goss 2002). This is a complicated matter that weighs private choice against communal well-being and personal proclivity against public consensus. If health care were socialized (which it is not in the United States), the decision to put oneself at increased risk would have a growing social component. But

everything in the system says "private," including such choices. Moreover, the homophobic focus some churches have taken on certain sexual practices while passing over the fullness of gay men's lives does not instill confidence that the men's well-being is at the heart of the matter. To the contrary. Listening to gay men on their terms, even if one disagrees, is the first step toward changing the conditions that create alienation, despair, and discrimination. Otherwise, religious groups, especially conservative Christian ones, remain significant barriers to welcome, inclusion, and celebration of gay men in the larger culture, putting them at higher risk.

Economic issues are key to the end of HIV/AIDS, and they are moral matters. Funding remains the most contested aspect of the HIV/AIDS crisis. UN Secretary Annan has emphasized the need for a fund of $7–10 billion *annually* to stem the tide. He has made clear that September 11 and its aftermath have only intensified the call for the world we want, one in which "a child does not die of AIDS every minute," as is now the case (Annan 2001). However, the Bush Administration has thus far steadfastly refused to allocate more than $500 million over a three-year period.

Protestors in Barcelona booed Secretary of Health and Human Services Tommy G. Thompson when, as head of the U.S. delegation, he announced a modest increase in AIDS funding. In the face of the $10 billion needed, it seemed a drop in the bucket from the world's only economic and military superpower. Even staunch conservative Republican Senator Jesse Helms from North Carolina urged $500 million to prevent mother-to-child transmission[1] (Helms 2002). Despite Helms's myopic view of the problem and longtime antipathy toward anything gay, his voice and vote are a help this time, proving that the health as well as moral implications of the pandemic are clear even to the recalcitrant. In the end, however, the Bush White House prevailed, and during the next three years the $500 million pittance is all that the new fund will receive from the richest nation in the world.

Democratic Representative Richard Gephardt led the opposition as a result of his travel to Africa: "AIDS, AIDS, AIDS. I came away knowing and believing that this is the moral issue of our time" (Stolberg 2002b). This remark followed his 1999 visit to southern Africa, where the faces and stories of women and children living—more likely, dying—without medicine or an adequate infrastructure to receive medicine even if available led him to push Congress toward contributing $2 billion a year to this global struggle. In the present climate, one way to persuade his colleagues may be to consider the link between terrorism and political instability, playing the national security card, because AIDS deaths can exacerbate already fragile national infrastructures. As the pandemic spreads, some African countries have already seen the deaths of a whole generation of teachers and engineers, because the ones who die are often the ones with job-related mobility and other circumstances that keep them away from home, where they are more likely to engage in high-risk behavior.

One remarkable federal move, no doubt influenced by the religious right, has been the decline in condom donations by the U.S. government to developing countries from 800 million in 1990 to 360 million in 2000 (McNeil 2002). This decline is the result of complicated economic factors including "buy American" laws when U.S.–manufactured condoms are more expensive than some others. It also is linked to changes in various countries' status with regard to U.S. foreign aid. But the biggest problem is ignorance of condom use and the need for education at very basic levels to dispel the myths and beliefs that discourage condom use. This education is lacking, and at an enormous price. The United Nations estimates that for every $1 million not spent on condoms there are 360,000 unwanted pregnancies and 800 maternal deaths, not to mention 25,000 deaths of children under age 5 (McNeil 2002).

Available funding goes a long way. Contemporary studies indicate that HIV/AIDS prevention is not as difficult as it might seem. In fact, the know-how is at hand even when the money is lacking. Steps include what experts have been saying from the beginning: that improving women's social and economic well-being, making condoms available and their use normative, offering counseling and frequent testing, and improving educational offerings, especially sex education, for young people and workers will go a long way toward reversing the trends (Altman 2002b). Although the consensus is less solid on needle exchange, it, too, appears to be a significant factor in lessening transmission. In the absence of a vaccine, and knowing how difficult developing a vaccine will be, this public health approach seems the wisest course in the short run (Thomas 2002). However, gearing programs to specific populations and getting access to women and children in settings where men dominate can be next to impossible. This is where religious groups can be helpful—though many choose not to be.

Religious Issues. In light of the many factors that make up the current HIV/AIDS situation, I suggest that issues of sexual morality, specifically gay male sex, be considered only when all other issues have been aired. I urge this because of the disproportionate amount of religious energy that has gone into debating gay adult consensual behavior, which in my view needs no more scrutiny than any other form of consensual sex. To do so is to distract from the myriad issues for which religious insights, in my case from the Christian tradition, may be very useful.

Among the many possibilities for Christians in the United States are theo-ethical concerns in the following areas, which could have far-reaching implications and constitute the broadest rubric for understanding and eradicating the HIV/AIDS pandemic.

1. Economic globalization and the need for resource sharing
2. The morality and economics of the pharmaceutical industry
3. Sex education and access to reproductive choice as basic human rights

First is economic globalization. As Rosenberg argues, this is at best a mixed blessing. Trade is essential to growth, and growth is key to raising living standards. Treaties such as the North American Free Trade Agreement (NAFTA) and other World Bank/International Monetary Fund (IMF) solutions systematically privilege the rich and use the labor and resources of those from poor countries to fund it. The sex trafficking of women and children in prostitution that in many countries accounts in large measure for the spread of HIV/AIDS is a logical by-product of such a system. Likewise, the collapse of the Soviet economy and the now astronomical numbers of persons in that region who are HIV-infected seem to have a cause-and-effect relationship.

I urge religious people, especially Christians who claim gospel-based values such as love and justice, to forsake their worries about homosexuality and focus their attention and resources on the economic system that grants their privilege. A critical analysis of the racist, sexist, and colonialist dimensions of contemporary capitalism and of its transnational caretakers, such as the IMF, would keep Christians busy for years to come. Such an exercise would, I believe, take us much closer to the root causes of HIV/AIDS in the social sphere than any comparable expenditure of energy on sexuality.

The results of many previous efforts to deal with sexuality have been disastrous. Methodists, Presbyterians, Episcopalians, and other mainline Protestant churches have come scandalously close to schism on this matter. Gay men and lesbian women have been subject to shockingly uncharitable discourse that has had tragic consequences including hate crimes, job losses, and custody battles. My strong recommendation in the absence of any consensus is a moratorium on such discussions until capitalism as a system and as a theory is thoroughly and critically deconstructed and rethought.

Second on my list is a related religious issue, the morality of pharmaceutical companies that keep a lock on so many of the HIV/AIDS drugs. Great strides have been made in the development of drugs that prolong and enhance the quality of life for those living with HIV/AIDS, but when it comes to equitable distribution, the picture is dismal. Routine treatments in developed countries are still out of reach for those in the poorest countries. Encouragingly, some countries, including Zimbabwe, have moved to sidestep patent requirements in order to import substitute generic compounds (Cauvin 2002). This move, in the spirit of Act-Up[2] and other activist groups, shows an ethical way for a country with an acute problem, with more than a quarter of its adults infected, to take action.

The theo-ethical question is how such inequity has developed so that the same disease can be a quick death sentence for one and a treatable chronic illness for another. Religion and science could focus on no more relevant a concern with the common goal of doing something to change

this. I urge religious people to take on the pharmaceutical industry in all of its moral and scientific complexity. This means not vilifying those who work in it but assuming that they are partners in the provision of health care who want to act ethically. This applies both to treatment drugs and to any potential vaccine yet to be created.

Fundamental to this discussion is ethical reflection on how much profit is acceptable in the face of death. Much of the argument on the part of pharmaceutical companies is the need to keep profits for research and development of future drugs (not to mention for their stockholders). But there is no consensus on what this means, what numbers are morally acceptable—how to balance profit with lives that could be saved now.

Another important matter to consider is why racial disparity is found in so many AIDS clinical trials (Stolberg 2002a). For a disease that is increasingly prevalent in racial minority communities, it seems extraordinary that African American and Hispanic people living with HIV are only half as likely as their white counterparts to be part of trials involving treatment drugs and only half as likely to be among those who receive experimental drugs. Who knows about this pernicious form of racism, and why is it countenanced in the medical/scientific community? These are the theoethical questions of the day, the ones for which science as well as religion has wisdom to share.

None of these questions is easy to answer, and fruitful discussion will require massive doses of good will on all sides. Nevertheless, I predict that there will be more productive questions to wrestle with in terms of human life than the now tired, polarized, and divisive discourse on homosexuality. For a change, religious people will sink their ethical teeth into a topic worthy of their best theological considerations.

The third issue is the highly polarized matter of reproductive health care, both for people living in the United States and for those whose care is compromised because of governmental decisions to de-fund programs that include abortion services. In fact, sex education is one of the most effective means of preventing sexually transmitted infections (STIs), including HIV. Family planning courses and radio, television, and print media, which shape public consciousness about the needs and rights of women and are communicated in language and images appropriate to the target population, are crucial—especially for young people who are at the heart of this pandemic. Yet, such educational tools, and the issue of easy availability of condoms, remain beyond the scope of most religious communities' concern. I submit that conservative religious efforts to couch reproductive health matters in moral terms are a major contributing factor in the rise of HIV/AIDS, because they pass over the life-threatening aspect of unprotected sex.

Catholics for a Free Choice is one group that makes a strong case in its global effort to get out the message "Banning Condoms Kills" using bill-

boards and subway ads as well as newspaper and Internet outlets. Its president, Frances Kissling, states forthrightly, "The Vatican and the world's bishops bear significant responsibility for the death of thousands of people who have died from AIDS. For individuals who follow the Vatican policy and Catholic health care providers who are forced to deny condoms, the bishops' ban is a disaster. Real people are dying from AIDS. Real bishops are silently acquiescent. We can no longer stand by and allow the ban to go unchallenged" (Kissling 2001). Her words take on even more vigor in light of the Catholic Church's pedophilia and coverup scandal.

Roman Catholics are not the only ones who have work to do on reproductive health policies as they relate to HIV/AIDS. The Religious Coalition for Reproductive Choice launched a solidarity effort in South Africa, sharing its "Keeping It Real!" sex education dialogue model in an effort to prevent the spread of HIV/AIDS. Material of this kind needs to be distributed in the United States as well, where sex education is considered largely a private, family matter and where church and school discussion is dictated by the use of abstinence-only curricula. It is obvious that such a head-in-the-sand approach must end.

I have purposely limited my religious reflections to the Christian tradition, hopeful that those from other traditions will do the same from different starting points. I conclude with some modest suggestions for how this strategy might be broadened.

Moving the Religion-Science Conversation Forward toward Action

A clear-eyed reading of the "signs of the times" indicates that the tip of the HIV/AIDS iceberg is all we have seen. As the populations of China, India, and Indonesia begin to cope with the impact of a devastating public health disaster, it is obvious that the face of the disease—and, therefore, of the world—will change. Unfortunately, those who will bear the brunt of its fury will be women and children of color, the "throwaways" whose lives can be expended in the service of globalized economic privilege for others. Even in the United States, the most deeply affected population is African American women whose place in the pecking order is low. In my religious view, this is an abomination. Creation belongs to everyone equally; anything less is a perversion.

We live in a religiously pluralistic world (see Eck 2001). Efforts to deal with HIV/AIDS need to reflect this pluralism. As I indicated, I am leery of developing a theology of disease that results in a least common denominator. I find Hans Küng's efforts to develop a global ethic as problematic as they are promising for just this reason.[3] "Theologies of diseases" is closer to the mark. My suggestions are meant to move us in that direction.

First, I suggest that we keep the wide-angle lens on our ethical cameras and frame all of our analyses and proposed solutions in a global context.

Note my effort to do so in this essay by couching all U.S. concerns in terms of what is happening elsewhere. Otherwise, we persist in the pattern that puts our well-being first. Our issues, no matter how urgent locally, take on disproportionate importance in the global arena without this corrective.

Second, we need to declare a moratorium on sexual ethical debate, especially on homosexuality, until we have made good-faith efforts on other major concerns, especially economic and racial matters. This is not to say that sexual ethics are unimportant. Rather, it is an acknowledgment of their ability to eclipse other issues and distract from a broader analysis, serving the purposes of those who would uphold the status quo. Religious conservatives seduce religious progressives (and perhaps vice versa) into debates that lead nowhere, because we do not share the same worldview on such fundamental matters as how many sexes there are, much less how they should behave. The same might be said for those in science. Debates that skirt those basic issues are pointless and can be destructive, especially of the lives of those gay, lesbian, bisexual, and transgender persons who are objectified in the process, and of those who live with HIV/AIDS but will live shorter lives if we waste our time. I suggest that we at least temporarily halt such ineffective discussions and covenant instead to stop the deaths with concrete actions like condom distribution. Perhaps after a decent interval we can return to those controversial matters. But for now I strongly urge action to prevent infection and to seek a vaccine.

Third, I urge a systematic rethinking of the relationship between church and state—or, better, religion and politics. When it comes to lobbying, the institutional religious expressions are simply not the only voices. For example, I am a Catholic who favors use of condoms, a view that U.S. Roman Catholic bishops do not share. Decisions are often made on funding overseas population programs or distributing condoms without adequate reference to the pluralism of beliefs within religious groups as well as among them. Such fair play is the only way I know to break the political logjam that keeps funding for HIV/AIDS low and political capital for those who oppose it high. If the likes of Jesse Helms and Franklin Graham can see their way to support some funding for HIV/AIDS even with their conservative religious convictions, perhaps there is hope after all.

The religion-science conversation will live up to its potential when it becomes a forum for diverse and even competing voices to air views on crucial topics. On the religion side I see hope in a variety of efforts, from that of Ma Jaya Sati Bhagavati, founder of the River Fund and leader of a community in Melbourne, Florida, that works with people with HIV/AIDS, to the Salvation Army, which, while anti-gay, still extends its services to all persons with AIDS. I assume that the same diversity can be cultivated among scientists.

I expect that such a renewed religion-science conversation emanating from a range of religious sources will focus its attention on twin goals: to eradicate the disease and its underlying social, economic, and political causes, and to turn this dastardly disease into a vehicle for globalized interreligious (and indeed multiscientific) dialogue on what it means to share the planet creatively with people from a variety of starting points. Accomplishing the first is obviously my priority. But accomplishing the second might be one of the few good things HIV/AIDS will ever produce.

NOTES

1. In a fervent conclusion to his opinion piece, Senator Helms wrote, "But not all laws are of this earth. We also have a higher calling, and in the end our conscience is answerable to God. Perhaps in my 81st year, I am too mindful of soon meeting Him, but I know that, like the Samaritan traveling from Jerusalem to Jericho, we cannot turn away when we see our fellow man in need."
2. Act-Up is short for AIDS Coalition to Unleash Power. It is a group of individuals who use nonviolent direct action to stop AIDS.
3. Hans Küng has been working on a global ethic for some years. He was recently part of a UN–sponsored "Group of Eminent Persons" that drafted the document "Crossing the Divide: Dialogue among Civilizations," which calls for compromise and cooperation with religious differences understood as a resource, not a barrier. This is similar to Daniel C. Maguire's notion of "renewable moral energies" (2000, 10). Such moves have real merit but are also subject to scrutiny with regard to their tendency to imperialize, however unconsciously, certain content.

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