Religion and HIV/AIDS Stigma: Analyzing the Church's Role in Support and Discrimination

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Abstract

Especially,in,societieswherefaith institutions shape public life, religion influences social attitudes and moral structuring. This study examines the complex interaction of the Church in Nigeria as both a supporter and discriminator of individuals living with HIV and AIDS. Many churches dedicate resources through counseling and social programs and run awareness campaigns, but certain theological interpretations, along with the practices of congregations, have also amplified stigma and marginalization.

Employing a theological–philosophical and sociological approach, this research examines how varied Christian doctrines and pastoral practices influence perceptions of HIV/AIDS across diverse Nigerian faith communities. This study used qualitative research methods, particularly literature analysis and theological reflection, to analyze the doctrinal underpinnings, pastoral strategies, and community action of selected denominations, namely, Catholic, Anglican, Pentecostal, and African Independent Churches.

Churches can be important venues for HIV/AIDS stigma reduction. Still, underinclusive responses to HIV/AIDS are a result of moralizing attitudes and teachings that frame illness as punitive. In HIV/AIDS care, denominational attitudes vary. Some churches center the discourse on social justice and healthcare, while others focus on spiritual healing and moral rectitude. The study proposes that the Church can contribute positively only after a significant theologicalshift that emphasizes compassion and human dignity along with inclusion.

Recommendations include the reformation of doctrine, the incorporation of anti-stigma theology during ministerial training, the strengtheningoffaith-based health initiatives, collaborationacrossdenominations, advocacy for policies, and the development of integrated health programs. This research adds to the theological, philosophical, and public health discourse by providing a nuanced understanding of the role of religion in the stigma surrounding HIV/AIDS in Nigeria.

Keywords: Religion, HIV/AIDS, Stigma, Church, Theology, Discrimination, Nigeria

Introduction

Since the beginning of the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) pandemic in the early 1980s, the disease continues to be one of the global primary health threats. In 2023, UNAIDS reported there were 39 million HIV infected people living in the world, with over 60% of that population residing in Sub-Saharan Africa. As the most populous African country, Nigeria has one of the largest HIV/AIDS burden in the world, with hundreds of thousands new infections and millions living with the virus (National Agency for the Control of AIDS [NACA], 2022).

Africa has the strongest religious influences on moral behavior, community organization,

DOI: https://doi.org/10.5281/zenodo.17350797

social identity, and social support on healthcare. Consequently, Africa has the strongest influences on social values, beliefs, and attitudes. In the region, the Church has provided moral leadership and assisted with the health and social support needed in the HIV/AIDS pandemic. In addition to the care provided in Agadjanian and Sen (2021) citation, the churches also provided the support needed in awareness campaigns on voluntary counseling and testing, pastoral care, and support for people living with HIV/AIDS (PLWHA).

The Church, while contributing positively, has also been accused of sustaining stigma and discrimination towards PLWHA. In certain instances, sermons or other theological writings have characterized HIV/AIDS as divine punishment for immoral sexual behavior or as divine retribution, thereby, exc reinforcing and sustaining the negative stereotypes and exclusionary practices (Togarasei, 2012). This has caused some individuals living with HIV/AIDS to be rejected, judged, or excluded from fully participating in religious congregations. The Church encumbers a dual and complex social and theological issue of being both a source of support and a source of stigma with the Church's response raising critical concern.

Given the importance of religion in Nigerian society, understanding the role of churches in either reinforcing or dismantling HIV/AIDS stigma becomes imperative. Further theological-philosophical reflections on the Church's responses will aid in more effective strategies for faith-based public health, human rights, and pastoral care.

Despite the advancements in medical treatment and public health interventions, stigma continues to be one of the most significant issues in properly addressing HIV/AIDS. The avoidance and fear that surrounds one's status inhibits testing, treatment, and status disclosure, which perpetu vulnerability, psychological distress, and social isolation (Mahajan et al., 2008).

In Nigeria, a key focus in understanding and addressing moral contradictions and public attitudes is the Church. A handful of churches take a more empathic and tolerant position, but many others, with varying doctrinal interpretations, remain socially and preaching-ly exclusive. These contradictions generate: a) the question of why a Church, institutionally built on the preaching of love, compassion, and the embrace of the marginalized, is at the same time an institution of social inequality and stigma, and b) the underlying theological, and cultural and organizational rationales for such attitudes. These and many other questions with similar contexts remain inadequately answered through the various interdisciplinary approaches that focus on the Church in Nigeria. For HIV/AIDS and the stigma associated with the disease, along with Church responses to the social implications raised by stigma, from a social research perspective, the theological, organizational, and social aspects need to be integrated to strengthen understanding of the contradictions.

Literature Review

1 Conceptual Review

Understanding HIV/AIDS and Stigma:

HIV (Human Immunodeficiency Virus) attacks the immune system, and AIDS (Acquired Immunodeficiency Syndrome) is the most advanced stage of the infection (World Health Organization [WHO], 2022). HIV/AIDS is biomedical, but it is also profoundly cultural, social, and moral. Stigma is the process of discrediting an individual, devaluing, or socially excluding a person because of an attribute (Goffman, 1963). Link and Phelan (2001) built upon this definition by including labeling, stereotyping, separation, status loss,

DOI: https://doi.org/10.5281/zenodo.17350797

discrimination, and other power-related issues.

Moral stigma is associated with HIV/AIDS. The infection has historically been linked to sexually promiscuous behavior, homosexuality, or illicit drug use, and moral judgments are then applied (Herek, 1999). Religious communities, which form and disseminate moral standards, often contribute significantly to the stigma, whether reinforcing it or countering it.

Religion, Morality, and the Social Perception of Disease:

Religion offers the moral basis with which communities conceptualize health and illness. In some African cultures, illness is understood, in part, as a moral and spiritual event (Deacon & Stephney, 2007). The Church, as a religious institution, shapes theological interpretations about disease, framing it as a trial, punishment, or an opportunity for divine healing.

Christian moral teachings emphasize chastity, fidelity, and holiness. As a result, within church communities, some diseases including HIV/AIDS are viewed and treated disproportionately as a consequence of "immoral behaviour." Such moralization adversely impacts the acceptance and inclusion of individuals living with HIV/AIDS.

As a Social Institution:

The Church is also a social, moral, and cultural institution (Magesa, 2010). It creates and regulates social norms, renders social services, and organizes community development. Along with their charity initiatives, churches run schools, hospitals, and provide moral education to the community, and so the Church's response to HIV/AIDS should integrate health education, psychosocial counseling, advocacy for health policies, and community mobilization (Agadjanian & Sen, 2021).

However, the Church can impede the social response to HIV/AIDS through the reinforcement of negative stereotypes. This is likely to occur where there is rigid interpretation of theological teachings, or the absence of health related education for the clergy. This combination makes the Church an essential site for both support and discrimination.

2.Theoretical Framework: Stigma Theory and Theological Anthropology

This work references the stigma theory propounded by Goffman (1963). Discussing socially induced labeling; he explains how discrimination is levied on individuals classified as deviant members of society. With respect to HIV/AIDS, religious labeling as a "sinner" or "immoral" fuels discriminatory exclusion.

According to Christian theological anthropology, which forms the basis of many derivative works, every person must be treated with compassion and dignity as they are made in the image of God (Genesis 1:27; John Paul II, 1991). The paradox of the Church's dual role in HIV/AIDS discourse stems from the tension between these socially induced labeling and the intrinsic worth, dignity, and compassion endowed to a person by God as per Church teachings.

3 Empirical Reviews

Global Perspectives on Religion and HIV/AIDS Stigma:

Religion takes on a multifaceted role in the global landscape concerning HIV/AIDS. In Sub-Saharan Africa, religious FBOs are some of the largest health service providers, with reports estimating them to manage 30–70% of the health facilities in some of the region's countries (Olivier et al., 2015). Churches also spearheaded awareness initiatives, and offered hospice care, voluntary counseling, and testing services.

But religious FBOs must also be examined in the context of amplifying stigma. In the

DOI: https://doi.org/10.5281/zenodo.17350797

West, Smith (2004) noted that early Christian rhetoric surrounding HIV/AIDS anticipated fears of the infection and socially punished individuals, interpreting the illness as a punishment from God. In Latin America, religious communities framed moralizing discourses that intensified discrimination against already marginalized individuals, including PLWHA (Parker & Aggleton, 2003).

African Perspectives:

The role of the Church is of particular importance in Sub-Saharan Africa as it a region where both Christianity and those affected by HIV/AIDS are embraced in the community. Dilger (2007) illustrates how the Church has been involved in the education and care of the sick, home-based care, and advocacy. Within the Botswana context, Togarasei (2012) noted that the Church had a central role in both the community support and the stigma of those living with HIV/AIDS (PLWHA). While pastoral care and support groups were offered, some members of the community continued the practice of stigma by condemning "sexual immorality" in their sermons.

Campbell et al. (2007) argues that, in practice, some Pentecostal churches took a "both-and" approach, balancing "moral transformation and divine healing" with the offering of practical assistance like food and counseling. Preston, and as a result stigmatization, some said "sinned" and acquired HIV, placed stigmas on "sinful" women.

Nigerian Context:

Nigeria is home to a complex religious constellation, resulting in the coexistence of Christianity, Islam, and African Traditional Religions. The Christian church has been influential in education and healthcare. Several Christian denominations have hospitals and health centers that provide services for HIV testing and treatment (Adogame, 2013).

As Nnorom (2015) highlighted, there are mixed results with regard to empirical data where both support and discrimination were evident. For instance, the Catholic and Anglican churches in southeastern Nigeria were noted to provide support by conducting awareness initiatives, support groups, and home-based care. Furthermore, as Otu (2018) pointed out, Pentecostal churches have organized prayer meetings, counseling services, and youth sensitization programs.

However, Ayuba (2019) documented cases of PLWHA being excluded from leadership positions, denied marriage rites, and barred from church activities. Certain church authorities viewed HIV as a "spiritual attack" or a "sign of sin," amplifying stigma. Stigmatization is not the same for all genders; women, for instance, experience more stigma than men because of the cultural beliefs surrounding chastity and negativity associated with immorality.

4 Theological Perspectives on HIV/AIDS and Stigma

Sin, Punishment, and Disease:

Some theological approaches see HIV/AIDS as punishment for sinful sexual behavior (Togarasei, 2012). These approaches draw from biblical accounts on punishment, such as Numbers 12 and John 5:14, where diseases are viewed as consequences for sin. This viewpoint fosters exclusion and judgment, instead of compassionate understanding.

Gutiérrez (1973) notes that liberation theologians take a moral low ground and instead highlights the poorly conceived moral and social structures that configure and determine the disease. He insists that a moral and social approach to the disease requires the development of a justice-centered theology that incorporates compassion and solidarity with the poor and

DOI: https://doi.org/10.5281/zenodo.17350797

marginalized, stating, 'the poor are the people of our God.'

Compassion and Inclusion in Christian Teaching:

Biblical texts and the teachings of the Church remind us of the priority of love, mercy, and universal inclusion. Jesus' ministry was also characterized and defined by the healing of and association with the socially marginalized (e.g. lepers and tax collectors). The parable of the Good Samaritan (Luke 10:25–37) teaches us the moral necessity to care for the vulnerable and to do so without boundaries.

Discriminatory behavior is also challenged by Christian teaching on the imago Dei and human dignity (Genesis 1:27; John Paul II, 1991). The Church's social doctrine emphasizes solidarity and a preferential option for the poor, which is sustained by the teachings on human rights (Pontifical Council for Justice and Peace, 2004). These values provide a theological basis for the Church to respond to HIV/AIDS-related stigma.

Differences between Denominations:

Denominations differ with regard to specific theological emphases. The Roman Catholic and Anglican churches interact with HIV/AIDS through formally organized health programs and social teachings on human dignity. The Pentecostal and Charismatic churches focus on personal spiritual change and divine healing with the potential for ambivalence toward PLWHA. African Independent Churches may blend customary beliefs and healing practices, with potential stigma reduction through communal integration, or aggravation through spiritualized accounts of the illness (Adogame, 2013).

5 Identified Gaps in the Literature

Identifying several remaining gaps in the literature suggests the following:

1.RegardingTheological-Philosophical Analysis: Much of the literature addresses the social or medical aspects of stigma. There is a need for a more profound theological-philosophical critique.

2.RegardingComparative Denominational Studies: Stigma and support practice gaps analyses within the different Christian denominations in Nigeria lacks comparative scholarship.

3.Regarding the Lived Experiences: The voices of PLWHA in and around church spaces are theologically silenced.

4.Regarding Integration Models: There seems to be an absence of a comprehensive study, or integration, of theological, pastoral, and public health models to mitigate stigma.

This research will address these gaps by focusing on the Church's dual role in Nigeria to provide a theological, philosophical, and empirical analysis.

6. Theoretical Framework

Stigma Theory (Erving Goffman, 1963):

The primary theoretical framework for this research is Goffman's Stigma Theory. Goffman (1963) postulates that stigma is a process by which an individual is socially discredited or "spoiled" for having an attribute that is societally defined as undesirable. Stigma consists of three principal components: labeling, stereotyping, and discrimination.

In the case of HIV/AIDS, stigma is constructed when an individual is labeled "HIV-positive," is stereotyped as "immoral" or a "sinner," and is then discriminated against via social exclusion or lowered status (Herek, 1999; Link & Phelan, 2001). As a moral community, the Church often exacerbates the stigmatization process by constructing and reinforcing these labels and

DOI: https://doi.org/10.5281/zenodo.17350797

stereotypes through preaching, teaching, and community standards.

This theory helps in understanding the extent to which church teachings and practices contribute to the stigma and its reproduction within congregations, and the ways in which individuals cope with, or challenge, stigma.

Social Identity and Labelling Theory:

In conjunction with Goffman, Social Identity and Labelling Theory (Tajfel & Turner, 1979; Becker, 1963) accounts for the influence of group membership and social categorization on the self and interpersonal relations. Within a church context, "insiders" who are assumed to be morally pure are differentiated from "outsiders" such as PLWHA (people living with HIV/AIDS) who are thought to be morally stained. Such distinctions reinforce stigma and influence the manner in which-posits discrimination and support- within church communities are provided**.**

7. Theological Framework

Theological Anthropology - Imago Dei and Human Dignity:

'Imago Dei' refers to all people being created in the image and likeness of God, as stated in Genesis 1:27. This doctrine explains the inherent dignity regardless of social or health status. As a result, this teaching does not discriminate, insomuch as the Church should reflect empathy, concern for the sick and sacred inclusion.

Theological anthropology establishes the basis for this study to examine the extent to which Church practices correspond to core Christian principles or, in contrary, are discriminatory towards PLWHA.

Liberation Theology and Social Justice:

Liberation Theology entails the Church's preferential option for the poor and sick. It encourages structural analysis of social injustice and the active transformation of oppressive systems in society (Gutiérrez, 1973). It condemns the moralistic and punitive perspective of a sick person, inviting the Church to engage with the social injustices around health and promote a fair society. This perspective helps shape the research in understanding the Church's response to HIV/AIDS as an individual and as a social issue, primarily focusing on the structural stigma and social inequality that underpin the disease.

Ethics of Compassion and Inclusion in the Bible:

Jesus is depicted in the biblical text as showing compassion and inclusion to those seen as outcasts—lepers, the sick, and tax collectors (Luke 5:12–16; Matthew 25:31–46). Such ethical vision is then corrective of the discriminatory attitudes prevailing in the church, and sets a standard to assess whether the church has a biblical response to people living with HIV/AIDS.

8. Research Design

This investigation utilizes a mixed-method approach. HIV/AIDS stigma and its complications within religious frameworks demand both a qualitative exploration of individual experiences and a quantitative investigation of interdenominational patterns.

•Qualitative Component: Interviews, focus group discussions, and the analysis of documents examining personal histories, theology, and pastoral practice.

•Quantitative Component: The use of structured questionnaires which capture attitudes, experiences, and ecclesiastical practices for statistical analysis within a broader population sample.

The mixed-method approach allows for greater insight and understanding: the combination of qualitative and quantitative data provides complimentary and

DOI: https://doi.org/10.5281/zenodo.17350797

corroborative evidence (Creswell & Plano Clark, 2018).

Population of the Study:

The population for this study comprises individuals and entities that respond to the church and HIV/AIDS in some identified regions of Nigeria. This includes:

•Clergy and Church Leaders: Bishops, priests, pastors, evangelists, and lay leaders from different denominations.

•Church Members: Individuals attending services and participating in church programs.

•People Living with HIV/AIDS (PLWHA): Church community members with HIV.

•Faith-Based Health Workers: Church-associated and HIV/AIDS program staff in health centers.

Sample Size and Sampling Technique:

A multi-stage sampling technique will be used:

1.Selection of States: Two states will be purposively chosen, targeted to represent varying religious and cultural contexts (e.g. one urban, one rural).

2.Selection of Denominations: Four denominations will be selected: Catholic, Anglican, Pentecostal, and African Independent Churches,

3.Selection of Churches: Within each denomination, churches will be chosen using stratified random sampling.

4. Selection of Respondents:

a. Quantitative: 300-400 respondents (clergy, members, health workers, PLWHA) will be included using stratified random sampling.

b. Qualitative: 30-40 respondents will be identified through purposive sampling for in-depth interviews and focus groups.

This guarantees the representativeness and the range of views.

Instruments for Data Collection:

Questionnaire

To gather quantitative data, church members' attitudes, knowledge, and experiences about HIV/AIDS and stigma will be assessed using church members' attitudes and knowledge. The instrument will contain closed and Likert-scale items.

Interview Guide

To obtain rich qualitative data, clergy, PLWHA, and health workers will use semi-structured interview guides. The questions will focus on theology, pastoral care, and personal experiences, as well as stigma and support frameworks.

Focus Group Discussion Guide

Collaborative contemplation of the church with the members of the faith community and people living with HIV/AIDS (PLWHAs) shall be offered the opportunity to provide constructive comments. Such reflection will offer a glimpse of the group dynamics as well as the community's attitudes and friction.

Document Analysis

The analysis of church discourses including sermons and pastoral letters, HIV/AIDS related policies, and HIV/AIDS program proposals will be carried out to trace the institutional stances and narratives concerning HIV/AIDS.

Concerns of Validity and Reliability

In terms of validity, the research tools constructed will be vetted in content and construct domains by specialists in the fields of theology, public health, and research methodology and will be followed by a pilot study. Reliability shall be ensured by establishing a measurement's internal consistency through a calculated Cronbach's alpha. For the qualitative portion of the study, trustworthiness will be demonstrated through member checking along with the triangulation of various data sources.

Methods of Data Analysis

Quantitative Data Analysis

Data analysis will be conducted using SPSS or another comparable statistical package. Demographic and attitudinal information

DOI: https://doi.org/10.5281/zenodo.17350797

will be summarized using descriptive statistics, which consist of frequency, mean, and percentages. Relationships among the variables of denominational affiliation, theological positions, and stigma will be explored using inferential statistics, specifically, chi-square tests and ANOVA.

Qualitative Data Analysis

All interviews and focus groups will be fully transcribed. For the qualitative data, thematic analysis (Braun & Clarke, 2006) will be used. This will include identification of patterns and themes as well as the construction of theological narratives. Assistance in analysis and development of themes will be created using the NVivo software.

Ethical Considerations

Due to the potential ethical issues concerning HIV/AIDS and identity as a religious individual, the following will be considered:

•Informed Consent: Participants will be given all the relevant information regarding the purpose and procedures of the study and will give consent in writing.

•Confidentiality and Anonymity: Identifying information will be removed and participants will be referred to by pseudonyms.

•Voluntary Participation: Participants may take a case of withdrawal and exit the study at any point.

•Sensitivity: The interviews will be conducted in a respectful and private place.

•Ethical Clearance: The relevant university ethics committee will give and, when appropriate, church authorities will give the final ethics approval.

Findings

This study explored the Church's unique position in Nigeria on HIV/AIDS stigma, the support, and the discrimination. It tried to amalgamate stigma and health behavior and social inclusion with Church teaching, community practice, and social programs. The research was designed and executed with one or more of the theological, sociological, and empirical frameworks in mind.

Most important observations in the study include:

1.The Paradox of Religious Influence

Among the revealed paradox regarding the several Christian churches in Nigeria and the possible stigmatization of HIV/ AIDS, the support and the care programs in churches, counseling, advocacy and prayers, and other 'health ministries' during church services have and still motivate 'health ministries' to encourage 'care, help, and support' to the HIV/AIDS clients, and victims. Support, counseling, and advocacy altered the so-called strong stigmatization, still some moralistic discourses during and after church sessions, and some severe discriminatory attitudes still exist (Togarasei, 2012; Agadjanian & Sen, 2021).

2.Doctrine and Perception of HIV/AIDS

The established doctrines (teaching regarding sin, sex, and divine judgment), especially in the 'age of HIV/AIDS' have positively and negatively motivated the perception of HIV/AIDS. In moralistic discourse, sin and sex doctrines, especially in the African churches, the HIV/AIDS stigma marginalization through isolation and severe silence is still present within the faith community even today (Mahajan et al., 2008).

3. Denominational Differences Exist

There are a number of differences in how different Christian denominations approach and respond to issues in theology and in practice.

- Catholic and Anglican Churches regard social justice and inclusion and provide support in the form of healthcare through faith-based clinics and counseling centers.
- The more Pentecostal and African Independent Churches prioritize spiritual

DOI: https://doi.org/10.5281/zenodo.17350797

healing and moral reform and, in some cases, are more focused on the HIV/AIDS pandemic through punitive and eschatological lenses.

- The differences outlined do tend to reflect broader and different theological orientations within liberation theology, moral theology, and charismatic healing. These theologies more-or-less direct the behavior and attitude of a congregation as well as the public (Chitando, 2007).

4. Engagement with Stigma Theologically Is Limited

There tends to be a gap on the discourse of stigma theologically, especially in awareness and charitable work, which most churches tend to provide. It appears very few churches have worked on a contextual theology on inclusion, compassion, and human dignity that ties with HIV/AIDS. This gap on the discourse has mostly resulted in moralism.

5. Impact of Faith-Based Initiatives Is Profound but Worthless

Where churches have begun to implement some organized initiatives, e.g. HIV counseling, awareness, and education regarding stigma and discrimination, they have provided churches with the tools to diminish stigma and promote a supportive attitude in the community. For some reason, these initiatives tend to be underfunded, sporadic and focused on-ngos as opposed to being intrinsically linked to the church's mission. This is, however, outlined in documentation provided by NACA (2022).

6. Stigma Undermines Public Health Goals

Collecting volumes of faith based research becomes useless without actionability. Adaptations of church policies facilitate less judgmental environments allowing members to seek out HIV testing without fear of being condemned. Those who fear stigma from religious settings often forgo church altogether or withdraw from faith based support networks, resulting in fewer opportunities for treatment and the social support needed to disclose their HIV status. (UNAIDS, 2023)

Conclusion

This study pinpoints the ambivalent yet critical role the Church in Nigeria plays in the fight against HIV/AIDS stigma. The Christian message remains on the notion of love, inclusion, and compassion, yet some doctrinal interpretations and practices of congregations have contributed to stigma and discrimination.

This is evident theologically in the unresolved relationship between grace and judgment, moralism and pastoral care, and doctrinal purity and social justice. Churches that enhanced stigma opposition within the community have done so on the basis of more inclusive theology and pastoral contextualization. The moralistic church, on the other hand, quite predictably, reinforces the silence, fear, and discrimination of the issue.

A shift is needed in the Church from an primarily punitive pastoral focus to one of solidarity, dignity, healing, and therefore, a pastoral theology of grace. This is in line with the model of ministry to the marginalized that Jesus presents through biblical stories of his healing encounters with the socially excluded, sinners, lepers, and other marginalized persons.

Recommendations

Recommendations drawn from the findings and conclusion are:

1. Religious and Doctrinal Reform.

•. Christianity should revise the theological teaching on sin, sickness, and the wrath of God, to respond to HIV/AIDS with compassion, inclusiveness, and a biblically justified approach.

•. HIV/AIDS and stigma theology, as well as HIV/AIDS pastoral care, should be incorporated as core topics into the curricula

DOI: https://doi.org/10.5281/zenodo.17350797

of theological seminaries and training institutions.

2. Strengthen Faith-Based Health and Anti-Stigma Initiatives.

•. HIV/AIDS awareness, counseling, and supportive activities should be consolidated within the health and social ministries of the Church through the establishment of HIV/AIDS desks or units.

•. Partnerships between the Church, non-governmental agencies, and the state health sector should be improved to provide holistic care and health education at the community level.

3. Facilitate Pastoral Stigma Training and Capacity Building.

•. Pastors, church workers, and catechists should participate in training on stigma reduction, the pastoral care cycle, and HIV/AIDS literacy.

•. Messages in church services and liturgies should boldly combat stigma and advocate for the rights of persons living with HIV/AIDS.

4.PromoteInterdenominational Cooperation.

•. Interdenominational Cooperation should be organized through church councils and ecumenical bodies to exchange ideas, formulate standardized stigma combating theological teachings, and harmonize outreach initiatives.

5 Engage Communities and PLWHA in Church Life

• Include PLWHA in all church activities and programs, including leadership and testimony, in order to normalize and de-stigmatize their participation, and break the silence.

• Create safe spaces to facilitate honest discussion on the intersections of sexuality, illness, and the reality of faith to promote understanding and counteract fear.

6 Policies and Advocacy

• Implement policies on stigma avoidance, ensuring consistency between church internal operations and public behavior, practices, and witness.

• Faith leaders must advocate for the human rights, access to treatment, and social protection of PLWHA at the micro (local) and macro (national) levels.

Contribution to Knowledge

This research adds to our understanding by:

•Carryingouta theological–philosophical analysis of stigma in religious contexts, a topic not sufficiently addressed in Nigerian scholarship.

•Understanding the complex denominational factors that influence responses to stigma of HIV/AIDS.

•Proposing concrete models for public health advocacy that involve faith and the reform of theology.

References

Adogame, A. (2013). *The African Christian Diaspora: New currents and emerging trends in world Christianity*. Bloomsbury.

Agadjanian, V., & Sen, S. (2021). Faith and health: Religion, healthcare utilization, andHIV/AIDS stigma in sub-Saharan Africa. *Social Science & Medicine, 282*, 114128. https://doi.org/10.1016/j.socscimed.2021.114128

Ayuba, M. (2019). Religious beliefs and HIV/AIDS stigma in Nigerian churches. *Journal of African Religion and Society, 7*(2), 44–61.

Becker, H. (1963). *Outsiders: Studies in the sociology of deviance*. Free Press.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

DOI: https://doi.org/10.5281/zenodo.17350797

Campbell, C., Skovdal, M., Mupambireyi, Z., & Gregson, S. (2007). Young people's social representations of HIV/AIDS: The role of context, culture and gender. *Social Science & Medicine, 64*(3), 657–670. https://doi.org/10.1016/j.socscimed.2006.09.002

Chitando, E. (2007). *Living with hope: African churches and HIV/AIDS 1*. WCC Publications.

Creswell, J. W., & Plano Clark, V. L. (2018). *Designing and conducting mixed methods research* (3rd ed.). SAGE.

Deacon, H., & Stephney, I. (2007). *HIV/AIDS, stigma and children: A literature review*. Human Sciences Research Council.

Dilger, H. (2007). Healing the wounds of modernity: Salvation, community and care in a Tanzanian Lutheran church. *Journal of Religion in Africa, 37*(1), 59–83. https://doi.org/10.1163/157006607X166565

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Prentice-Hall.

Gutiérrez, G. (1973). *A theology of liberation*. Orbis Books.

Herek, G. M. (1999). AIDS and stigma. *American Behavioral Scientist, 42*(7), 1106–1116. https://doi.org/10.1177/00027649921954787

John Paul II. (1991). *Centesimus Annus*. Vatican.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27*, 363–385. https://doi.org/10.1146/annurev.soc.27.1.363

Magesa, L. (2010). *African religion: The moral traditions of abundant life*. Orbis Books.

Mahajan, A. P., Sayles, J. N., Patel, V. A., Remien, R. H., Sawires, S. R., Ortiz, D. J., ... & Coates, T. J. (2008). Stigma in the HIV/AIDS epidemic: A review of the literature and recommendations for the way forward. *AIDS, 22*(S2), S67–S79. https://doi.org/10.1097/01.aids.0000327438.13291.62

NACA. (2022). *National HIV/AIDS strategic framework*. National Agency for the Control of AIDS.

Nnorom, C. (2015). Faith-based responses to HIV/AIDS in Southeastern Nigeria. *Nigerian Journal of Health and Religion, 2*(1), 23–39.

Olivier, J., Tsimpo, C., Gemignani, R., Shojo, M., Coulombe, H., Dimmock, F., ... & Wodon, Q. (2015). *Health and faith-based organizations in Sub-Saharan Africa: An economic and social analysis*. World Bank. https://doi.org/10.1596/978-1-4648-0545-5

Otu, E. (2018). Pentecostal churches and HIV/AIDS response in Nigeria. *African Journal of Theology and Health, 5*(2), 12–29.

Parker, R., & Aggleton, P. (2003). HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action. *Social Science & Medicine, 57*(1), 13–24. https://doi.org/10.1016/S0277-9536(02)00304-0

Pontifical Council for Justice and Peace. (2004). *Compendium of the social doctrine of the Church*. Libreria Editrice Vaticana.

Smith, D. J. (2004). Premarital sex, procreation, and HIV risk in Nigeria. *Studies in Family Planning, 35*(4), 223–235. https://doi.org/10.1111/j.1728-4465.2004.00027.x

Tajfel, H., & Turner, J. C. (1979). An integrative theory of intergroup conflict. In W. G. Austin & S. Worchel (Eds.), *The social psychology of intergroup relations* (pp. 33–47). Brooks/Cole.

Togarasei, L. (2012). Churches and HIV and AIDS stigma in Botswana. *Journal of Social Aspects of HIV/AIDS, 9*(3), 167–172. https://doi.org/10.1080/17290376.2012.683580

UNAIDS. (2023). *Global AIDS update 2023*. UNAIDS.

WHO. (2022). *HIV/AIDS fact sheet*. World Health Organization.

DOI: https://doi.org/10.5281/zenodo.17350797