AIDS in South Africa: Why the churches matter: A "realistic" sexual morality

by Sarah Ruden in the May 17, 2000 issue

South Africa has the world's second largest AIDS epidemic (in gross numbers). Its neighbor, Zimbabwe, ranks first. During the past ten years, while AIDS has come under control in central African countries with far fewer resources, the disease has gone out of control in South Africa, in the richest, most cosmopolitan nation in the whole sub-Saharan region. An estimated 10 million South Africans, out of a population of approximately 40 million, will die of AIDS during the next ten years.

In a recent article in the *New York Times*, author Nadine Gordimer expresses views about the disease that South Africa is eager to promote and that have wide acceptance in America. Gordimer calls for more money to develop a vaccine, for Third World debt relief, and for less military and more public health spending within Africa. She thinks that, given Africa's poverty and social malaise, we cannot condemn the promiscuous sex that is spreading AIDS. And she concludes by warning of the epidemic's economic impact, saying that "the bell tolls for thee, globally."

A critical look at these ideas might help explain why the epidemic continues to rage in the part of Africa with the most resources for fighting it. With a unanimity that invites trust, the scientists working to develop a vaccine have said that the nature of retroviruses itself is the main factor holding up an AIDS vaccine. Third World debt relief would probably not have the intended consequences. The states receiving this relief would be likely to use the public money freed up from social welfare demands to expand their militaries—and military spending is one of the things Gordimer deplores. That donor countries have been the enablers of Africa's arms addiction has certainly been the pattern so far.

That the AIDS crisis threatens Africa's economic development seems unarguable. In central Africa during the early '90s, AIDS threatened to become a disease of the

middle and upper-middle classes, decimating the skilled trades and professions. The higher a man's income, the greater his access to sexual partners, and traditions of polygamy encouraged him to take advantage of all his opportunities. The danger this posed for the region's economic future—a danger reported in the Western press and widely publicized locally—contributed significantly to a rethinking of both public policy and private mores. Most important, this threat motivated the public to move beyond apparently inadequate "safe sex" campaigns to more difficult and effective changes. In Uganda, for example, an HIV test now is required before marriage, and the social pressure in favor of chastity has grown markedly.

South Africa is different. Its white and its thoroughly westernized black middle class are not very vulnerable to the disease. The case of Charlene Smith, one of the few white rape victims, became a media sensation. She was able to obtain the drug AZT as a precaution against the transmission of HIV, and to prosecute her attacker and see him sentenced to 30 years in prison to prevent his carrying out his further threats against her. But destitute rape victims have no such protections. For this and other reasons, in South Africa AIDS remains almost exclusively a disease of the underclass. The prosperous here simply do not share the fate of the poor to the extent common in other African countries. The income gap is wider than in any other nation except Brazil, and the institutional divides left over from apartheid are immense. Consequently, most of the people on the favored side of the prosperity gap do not see AIDS as an eventual or indirect threat to their own well-being.

Almost 35 percent of South Africans are unemployed. These are the AIDS-vulnerable, uneducated black and "colored" (mixed-race) poor. Unemployment is a major reason for the country's very high rate of violent crime. Up to 70 percent of the army is HIV-positive. But the military is being drastically cut back anyway; soldiers of the next generation will be both fewer and better skilled. Gordimer cites a prediction that 270,000 out of 1.1 million public servants will be infected by 2004. But nearly as many, mostly from the lower ranks, may lose their jobs through the privatization and rationalization already under way.

Losses of employees to AIDS are an expense and trauma to American institutions, but not to those in South Africa, where people who are HIV-positive hide their condition as long as possible for fear of persecution and die relatively quickly once they have AIDS, since few interventions are available to them. Private charities and extended families take care of the vast majority of AIDS orphans.

Finally, AIDS has been most common in the predominantly Zulu province of ZwaZulu-Natal. The Zulus supported the apartheid regime and are a thorn in the side of the new government, which is dominated by the Xhosas. Commercial interests covet the fertile ZwaZulu-Natal farmland now kept in small subsistence parcels through tribal allotment. Why would policymakers fear that AIDS would have an economic impact on the country? It can make economically superfluous and burdensome human beings disappear.

The above sketch is the only way I can explain the unusual feebleness of South Africa's attempts to deal with the epidemic. "Sarafina II," the centerpiece of the Nelson Mandela regime's anti-AIDS campaign, was a glitzy traveling musical that, because it charged admission, did not reach most of its target audience—low-income black youth. The Health Department then tried to promote Virodene, an industrial solvent with no medicinal properties, as an AIDS cure, and this led to a vicious fight with and estrangement from medical authorities.

The new president, Thabo Mbeki, has become interested in the widely discredited Duesberg hypothesis that the HIV virus is a fabrication and that AIDS is really a set of symptoms of poverty or drug use. Mbeki has also disputed the safety of the widely esteemed drug AZT. He insists on exploring these issues thoroughly before providing rape victims and HIV-positive pregnant women with AZT treatment to reduce transmission of the virus.

Even those who at first appear more forthcoming tend to have an "all or nothing" strategy that suggests a basically dismissive attitude toward the disease. In a recent article in the *Cape Argus*, Dr. S. P. Reddy (a "health promotion practitioner and HIV/AIDS researcher") argued that AZT could save 50,000 to 100,000 babies a year from HIV. The virus means death before the age of five for nearly all infected infants. The new drug nevirapine's effectiveness is similar to that of AZT, yet the cost is only a tenth as high, less than $5 per child.

The use of this drug might seem both humane and affordable. However, some children who survived HIV would die later anyway from poverty-induced ailments, Reddy wrote. Why bother with the drug unless South Africa can provide "housing, education, clean water, health clinics, health-worker training, and nutritional supplements" as well? Thus, the "full ramifications [of the drug treatment] must be carefully researched and costed."

Reddy’s rationalization is fairly representative of views popular with the government and the development elite, who strive to keep the international and local media’s attention on South Africa’s AIDS crisis in order to foster foreign aid and grass-roots projects. When I asked a community worker in Cape Town’s squatter camps what ordinary people were saying about AIDS, she replied, “They think it’s a way for people to get jobs.” There is a breath of truth in this version of an AIDS conspiracy theory.

A subcategory of the “all or nothing” approach is purveyed by organizations like Planned Parenthood, which teach “life skills” in the hope that young people will become sexually prudent as part of an integrated improvement in their lives. Participants in programs get information, encouragement in self-esteem and training in social interaction, but no actual prescriptions for behavior. Also, community health workers distribute contraceptives and treat sexually transmitted diseases on the spot. The workers are carefully chosen as ethnically and culturally similar to the people they work with, and trained to communicate within their milieu instead of imposing alien ideas.

The planners seem to have imbibed from the study of population control (especially the notorious coercion used in China) a dogmatic opposition to “targeted” approaches. Their scruples are commendable, but whereas failure to promote contraception means unwanted children and overpopulation, failure to combat AIDS means mass death. Can organizations say with equal conviction in both cases that clients should simply be free to choose, with no pressure of any kind?

AIDS is not causing, nor is it likely to cause, an economic crisis in southern Africa. That is the real reason why the epidemic is not being dealt with effectively there. Perhaps half-consciously, certainly imperceptibly to Western media, a narrowly economic understanding of public welfare is allowing millions of people to die. What’s neeeded is a call to action based on what the epidemic actually is: a humanitarian catastrophe resulting mainly from irresponsible sexual behavior. Against South Africa’s cultural and economic background, the only hopeful efforts to mitigate and control AIDS that I see are coming from the churches.

Churches feel obligated to make spending money on medical care a priority, even if the only outcome is likely to be the temporary relief of suffering. The South African Council of Churches has helped to establish a number of home-based AIDS care groups. These relieve overcrowding in hospitals, allow for the dignified treatment of

patients and help destigmatize the disease. The churches undertake unglamorous charity work such as collecting food for AIDS victims and their families and caring for children with AIDS and AIDS orphans, as in Cape Town's Nazareth House, a Catholic outreach.

Education efforts are mostly in the early stages, but are growing rapidly. Many churches have fitted their traditional teachings about chastity and monogamy into programs to fight the disease. One example is the ZAP AIDS Project, under the auspices of Catholic Welfare and Development. ZAP AIDS does its work in public schools, prisons, churches of many denominations, and shelters for street children.

Denominations are not unanimous in their definitions of sexual morality, but their disagreements are limited to questions that, in Africa, have little to do with AIDS. Homosexuality is a contentious issue within the Council of Churches, but in South Africa homosexuals are a relatively low-risk group for AIDS. (Arguing this, an actively homosexual man recently went to the Human Rights Commission and won the right to donate blood.) Another question is whether condoms should be available to those who do not accept monogamy. Even the liberal churches strongly urge monogamy, though not insisting on legally binding or heterosexual unions.

The "safe sex" controversy is perhaps the most unfortunate distraction in the fight against AIDS, not least because it has restricted cooperation among the churches. The more permissive of the mainline churches staunchly defend condoms, a resource that has been important in combating AIDS in the industrialized world. But the use of condoms is at odds with some aspects of African culture. In many regions of southern Africa, men prefer dry sex, and some women even take pains to dehydrate their vaginal canals. Without natural or artificial lubrication, condoms tear and come off.

Though the Western myth is that the Catholic Church in the Third World is retarding public health measures for the sake of a theological nicety, that is certainly not the case on this continent. African men's resistance to condoms is already considerable. Condoms are imported by the ton and given away by the double handful—and hardly used. In TB eradication campaigns, the overreporting of people's cooperation with medical advice is measurable (chemical tests show whether patients have taken their pills or not) and quite high. If appropriate adjustments were made to the statistics for reported condom use (in the few programs that actually follow up distribution with surveys), the already modest numbers would shrink to practically

nothing.

Reasons for not using condoms vary in Africa, as they do everywhere, but one is particularly strong. African men, the decision-makers with most of the power, tend to believe even more than do African women that sex is for procreation. Activists paddle upriver in working against this belief, and they must work against it in promoting condoms, the most confrontational of modern birth control methods.

The churches would do better to forget about condoms and put their energies into what they do have to offer, which they themselves fail to appreciate fully. Their stance for chastity and monogamy, often labeled as “unrealistic,” is actually much better suited to African culture, especially in its present troubled condition, than are modern Western teachings about sexuality emphasizing personal freedom and individual development.

For many women in southern Africa today, heterosexual intercourse is either coercive or deceitful in some way. Either a woman is actually raped (South Africa has the highest rate of rape in the world; the rumor of the “virgin cure” has sent male AIDS patients on the hunt for younger and younger girls to rape), or she is pressured socially and economically. Women do not believe they have the right to disobey men, and wives and girlfriends are desperately dependent on their men. Extreme poverty may force women to become prostitutes in order to survive. And many women do not know and are afraid to ask whether a man has other partners.

A nurse and midwife who routinely deals with AIDS in families lamented the effect of anarchic sexual practices on the spread of the epidemic. She was especially concerned about the attitude of young men. Xolisa, 15, said that she and her friends were regularly harassed, chased and grabbed, sometimes in public. “They try to drag you inside—you have to get away,” she said. As a veteran of Planned Parenthood education, she was fully aware of and articulate about the danger of AIDS, but she was facing that danger alone. The police were “useless,” she said, as the media also assert.

Xolisa and other young people I spoke to confirmed that parents typically retain the traditional notion of choosing spouses for their children, but put it into practice only to the extent of refusing to meet boyfriends and girlfriends or even acknowledge that there could be any. (An alarming custom is for the parents of a teenage boy to build him a small, private hut behind the family home; girlfriends can meet him

there, unseen by his family.)

Young people are thus left to negotiate their relationships without guidance from the people most interested in their welfare. Peer pressure, heavy-handed seduction and rape are the outcome, with predictable victimization of young girls by older boys and grown men. AIDS spreads more easily from men to women than in the opposite direction, and traumatic sex, with the tearing of tissues, is the easiest route to sexual transmission.

The most reassuring message to a typical African girl is that her community will protect her from early, chaotic sex and that she will be able to marry a man indoctrinated against adultery and raise her children in safety. Trying to get someone so powerless to “take responsibility for her sexuality” is a cruel joke. With family and tribal structures pathetically weakened by colonialism and apartheid, and the government inept and indifferent, the only institution even seeking to make these all-important promises is the church. Though these promises cannot always be kept, they are far more practical than projects to “foster every individual’s right to his or her own unique development”—projects that make no sense in the African context.

A return to chastity would be a return to a workable African society. Gordimer states that “promiscuity is difficult to condemn when sex is the cheapest or only available satisfaction.” That is an obstacle only insofar as human activity is a laissez-faire marketplace. That marketplace begins to turn into a community when people insist that all its members have a future to protect, so that it is unacceptable for any to behave irresponsibly.

Muslims as well as Christians have strict views on sexual conduct, and even animists are expressing their desire to restore older mores. (Credo Mutwa, a leader of traditional healers, appeared in the *Cape Argus* recently speaking of ancient practices involving voluntary quarantine, which he claimed defeated earlier waves of venereal disease introduced by colonial forces.) But the Christian churches are strongest and best positioned, and therefore bear the greatest responsibility for demonstrating what can be done.

What the churches are doing is not enough to contain the epidemic, but they are ensuring that many of their members survive it. Keith Benjamin of the South African Council of Churches reports that in a group of 25 clergymen interviewed, not a single

one had had to deal with a congregant who was an AIDS patient. He sees the clergy's distance from the disease as unfortunate, but I think that he has missed the good news. Among those who feel bound by it, what the churches say about sex is life-saving.

Ironically, a disproportionate amount of the credit goes to conservative black churches with no AIDS programs and no specific AIDS message—the churches regularly accused of having their heads in the sand. Most black churchgoers belong to these denominations. (The Zionist Church alone has 3.9 million members; this single institution keeps nearly one out of ten South Africans relatively safe from the new plague.) Lucy is a 26-year-old who attends the Gospel Church of Power in Guguletu, a squatter settlement near Cape Town. She said her church had nothing to say about AIDS. No one in the church had AIDS. All its members were very strict about marriage.

Some churches do go too far, and ostracize the few AIDS sufferers they have to deal with. In the mainline churches, certain parishes have refused pastoral care to victims and their families. Some of the conservative black churches have an actual policy of exclusion, which extends to a ban on church burial. This is, of course, inexcusable for any people professing to follow the teachings of Jesus—but it is somewhat understandable, given the churches' own weakness and exclusion in South Africa. The apartheid government shut down mission institutions and defamed religious proponents of racial equality. Churches' commitment to nonviolence (and in some cases refusal even to take sides) diminished their influence with the liberation movement, and consequently with the new government, if not the whole new polity.

But the absence of economic incentives to fight AIDS might make an observer feel, apart from any moral, sectarian or theological considerations, that a religious revival alone can save South Africa from eventually consigning perhaps a third of its population to death. This is my own conclusion, although I am a Quaker, a member of a sect that is liberal and tolerant almost to the point of being secular and that frowns on proselytizing. I simply see in this part of the world the greatest practical need for churches to do what they ordinarily do, and to do more of it.