CHAPTER 1: AIDS IN SOUTH AFRICA

(1) Introduction

In this chapter I will consider the implications of the AIDS[1] crisis for theology in South Africa. I will begin with a review of the impact that the disease has on South African society and by extension on the Church. This will in turn elicit numerous theological questions which I will consider under the rubrics of systematic, ethical and pastoral. On the basis of criteria to be made clear at that point, only a couple of these questions will be selected for deeper consideration in subsequent chapters.

AIDS is a thoroughly modern disease, and as such modern means of communication are used rapidly to disseminate information and to exchange views. There is consequently an abundance of reliable current information accessible at numerous websites and in many medical and sociological publications. It is not our purpose to review all the medical, social and economic data which are very well documented elsewhere. However, in order to understand the magnitude and all-pervasiveness of the pandemic on the theological context of South Africa, it is necessary to cover some relevant areas.

As new research is constantly being published, I have decided in the writing of this thesis to draw a line at the end of June 2003, beyond which no further developments have been considered. This date might seem rather arbitrary. But it is when I returned to Ottawa from my last research trip to South Africa and Lesotho, to begin writing the thesis. Beyond this date I have access only to what is available in the public forum, in journals and online newspapers and to a few discussion groups to which I belong. From this

1.“AIDS” is an acronym for Acquired Immune Deficiency Syndrome. It is thus written throughout this document in upper case, except where a direct citation requires that it be written in lower case in order to be faithful to the source.

distance, it is not possible to follow the discussions in detail and be accountable for their theological interpretation.

For the sake of setting the context for our theological considerations in the coming chapters, this chapter will consider the following dimensions of the AIDS pandemic: Starting with the early days of the AIDS crisis, we will make the caveat that this study will not focus on homosexual men. We will consider the three principal modes of transmission of the HIV and the associated gender- and age-specific dimensions of the pandemic. Next we will examine particularly African social factors which might contribute to the pandemic. In South Africa, AIDS has flourished in the context of a legacy of neglect of health care for the majority of the population, so we shall consider the association of the pandemic with the already-raging tuberculosis epidemic in the country. Finally we shall consider AIDS as a cause of death, using professional actuarial projections to indicate just how deep and far-reaching the consequences will be.

After considering AIDS in general in South Africa, the chapter will proceed with a survey of the responses from ecclesiastical quarters to the pandemic since the mid-1980's. While the author's principal experience is that of the Roman Catholic Church, he will attempt to bring in the responses of other Christian denominations where the available literature permits.

(2) AIDS in South Africa

(a) Early Days of the Pandemic

Shortly after the worldwide outbreak of the AIDS, the disease was identified and treated among homosexual men in South Africa in the early 1980's. The sources differ on the dates to which they trace back the first cases of AIDS in the country. Whiteside and Sunter say "[t]he first two cases of AIDS were identified in South Africa in 1982."[2] This is

supported by the UN facts sheet of AIDS cases by year of reporting by country, showing that the first two in South Africa were in 1982.[3] Shilts says that on July 8, 1983 "health authorities in Cape Town announced that five gay men in South Africa were suffering from AIDS."[4] For the next eight years, AIDS was considered a disease of (white) homosexual men.

(b) Sexual Orientation Not the Issue

Whiteside and Sunter say "In July 1991, the number of heterosexually transmitted cases equalled the number of homosexual cases. Since then the homosexual epidemic has been completely overshadowed by the heterosexual epidemic."[5] The number of cases of homosexual or bisexual men with AIDS is now minuscule compared with heterosexual people.

One must be careful to avoid distinguishing between a 'homosexual epidemic' and a 'heterosexual epidemic' as Whiteside and Sunter do in the previous quote. There are not two separate epidemics, as it is the same virus that is responsible for the disease among homosexual and heterosexual people. In addition, sexual orientation and identity are not so clearly defined as to delimit two mutually exclusive populations with their separate epidemics. Nor should the impression be given that there might be two different standards of treatment or care according to the circumstances under which a person may have been infected with the virus.[6]

2.Alan Whiteside and Clem Sunter, *AIDS: The Challenge for South Africa* (Cape Town: Human & Rousseau, Tafelberg, 2000), 47.
3.UNAIDS, Unicef, and WHO, *Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections: South Africa: 2002 Update* (2002), 6, Http://www.unaids.org/hivaidsinfo/statistics/fact_sheets/pdfs/Southafrica_en.pdf viewed on 13 August 2003.
4.Randy Shilts, *And the Band Played On: Politics, People, and the AIDS Epidemic* (New York: Penguin, 1987), 343.
5.Whiteside and Sunter, *AIDS*, 47.
6. It is the presumption of this research that AIDS is caused by the the Human Immunodeficiency Virus (HIV). The author concedes that factors such as poor nutrition, poverty, bad sanitation, etc. contribute to the progress of the disease once the virus has been contracted. However, these are

Thus for the purposes of this work, the sexual orientation and practices and the manner in which people contracted the virus will not be considered as an issue. Once people are infected with the virus, or have begun to develop symptoms of AIDS, the progress of the disease does not discriminate on how it was initially contracted.

This is not to deny the following two important points regarding sexual orientation and AIDS:

(i) Different lifestyles expose people living with HIV to different sources of potential infection, and thus to different opportunistic infections which might eventually be fatal. Notoriously, homosexual men are more exposed to enteric diseases like shigellosis, amoebiasis and giardiasis from the practice of oral-anal intercourse.[7]

(ii) The pastoral care offered to heterosexual and homosexual people with AIDS may differ according to their needs, which in turn depend to a large extent on their social, psychological and spiritual integration. In the early stages of the pandemic, in South Africa as elsewhere, the disease was noticed among homosexual men, and early writings on pastoral care of people with AIDS focussed on the pastoral care of this group.[8]

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co-factors for AIDS. He concedes also that there are other medical conditions that deplete a person's immune system, and render him or her vulnerable to opportunistic infections. However, the single prior necessary and sufficient condition for a person to have AIDS, is infection with the HIV. Thus the virus can be said to be 'the cause' of AIDS - which is the opinion of mainstream Western medical science.

The present author does not share the premise of the 'AIDS sceptics' who doubt the existence of the Human Immunodeficiency Virus and its role in the pandemic. Nor is it the intention of this work to dedicate time and space to this debate. The reader may inform him or herself of the arguments of the sceptics which can be found on websites such as http://www.virusmyth.net/aids/ viewed on 8 September 2003.

7.Shilts, *And the Band Played On: Politics, People, and the AIDS Epidemic*, 18f., 39f.

8. For example, in 1990, Daniel Louw, "Ministering and Counselling the Person with AIDS," *Journal of Theology for Southern Africa*, no. 71 (1990): 37–50 concentrates almost exclusively on the pastoral care of homosexual men with AIDS. While acknowledging that at that time the virus was spreading rapidly among the heterosexual population, he writes on page 41 that "AIDS is associated with homosexuality" and in people's minds with promiscuity. However as the pandemic has spread throughout the 1990's, the association of AIDS with homosexuality in South Africa has all but disappeared.

Thus, for example, the Catholic Church's response to people living with HIV/AIDS has been different in South Africa to that in North America. In this latter case, says Kowalewski, it has been a matter of "impression management" or retaining its firm teachings against homosexual activity and for the pastoral obligation to care of people living with HIV/AIDS. See Mark R. Kowalewski, *All Things to All*

(3) Modes of Transmission in South Africa

The three principal modes of transmission of the HIV virus in South Africa are: sexual, perinatal and parenteral. I shall briefly examine each of these.

(a) Sexual Transmission

Sexual transmission is, as I have indicated above, mostly through heterosexual intercourse. It is this mode of transmission that has received the most attention and been most studied during the course of the pandemic - perhaps to the neglect of other possible modes of transmission. Most of the intervention at all levels has focussed on education about the sexual mode of transmission, changing risky sexual behaviour and spreading the use of condoms (this latter, except in the case of many Christian Churches.)

(b) Perinatal Transmission

Perinatal transmission can occur either in utero, during delivery, or through breastfeeding.

Studies conducted in pilot projects around South Africa the late 1990's and early 2000's have shown that the mother receiving a short course of antiretroviral therapy prior to giving birth and the baby being administered a dose shortly after birth, reduces by up to half the chances of mother-to-child transmission (MTCT) of the virus.[9] These studies are supported by articles suggesting that the treatment is so effective and safe, that it should be administered to all mothers of unknown serostatus in high-risk groups, and that it should not be dependent on prior testing and counselling.[10]

People: The Catholic Church Confronts the AIDS Crisis (Albany, N.Y.: State University of New York, 1994).

9.See Whiteside and Sunter, *AIDS*, 147f.

10. See Jeffrey S.A. Stringer, et al., "Nevirapine to Prevent Mother-to-Child Transmission of HIV-1 Among Women of Unknown Serostatus," *Lancet* 362, no. 9398 (29 November 1993): 1850–53.

There is at the time of writing widespread public demand that the government extend the provision of short-term antiretroviral therapy to all maternity facilities in the country. After major initial concerns about the safety of such therapy, the government has undertaken on principle to provide it. However, it maintains this will take time to ‘roll out’ because of the need to train nursing staff to administer the therapy, and of the cost of the drug, nevirapine.[11] The longer the government delays this simple and cost-effective treatment, the greater the number of infants who will be unnecessarily infected.

However, there is not much value in preventing MTCT during birth if the child is later to be infected in another common way. The question of breastfeeding is also fraught with difficulty. It is incontrovertible that many infants have been infected with HIV as a result of vertical transmission from the child being breast fed. As recently as March 2003, the results of a study were published “providing the first quantitative estimates of breast-milk infectivity per liter of breast milk ingested.”[12] This article indicates that the probability of a child contracting HIV-1 from drinking one liter of breast milk from an infected mother is of the same order as a woman being infected with HIV-1 in one unprotected act of vaginal sex.

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11. The cost-argument is becoming weaker as pharmaceutical companies such as Boehringer Ingelheim have offered to make this therapy available free for five years to governments of resource-poor countries. See “World AIDS Day 2003 - Boehringer Ingelheim extends Viramune Donation Programme” at http://www.boehringer-ingelheim.com/hiv/news/ndetail.asp?ID=1514 viewed on 15 January 2004.
The training involved in the administration of the therapy is also minimal, since it involves giving the mother a single tablet prior to delivery, and a single dose of the syrup to the child shortly after birth. Recent studies are showing that the administration of nevirapine alone increases the risk of the HIV developing resistance to the drug. It is being suggested that the single dose of nevirapine be packaged with two to three days’ doses of zidovudine and lamivudine to make a combination therapy that is less likely to result in the virus developing resistance. See Karen Palmore Beckerman, “Long-Term Findings of HIVNET 012: The Next Steps,” *The Lancet* 362, no. 9387 (13 September 2003): 842–43.
12.Barbra. A. Richardson, et al., “Breast-Milk Infectivity in Human Immunodeficiency Virus Type 1-Infected Mothers,” *Journal of Infectious Diseases* 187, no. 5 (1 March 2003): 736–140, Http://www.journals.uchicago.edu/JID/journal/issues/v187n5/30087/30087.html viewed on 11 April 2003.

This raises a dilemma typical to developing countries. Ideally a mother who is tested HIV positive, should be able to nourish her infant on a substitute milk formula. In South Africa, this would mean that the health authorities provide the mother with sufficient milk substitute formula for her child. However, often the quality of the water is parlous and the child risks contracting fatal gastroenteritis from the water used in the formula, if it is not first boiled or chemically treated. In such situations the mother is faced with the dilemma of seeing the child die of AIDS or of waterborne parasitic disease, presuming, of course, she herself does not die first. Thus the need to provide not only milk substitute, but also the means of disinfecting the water with which it is to be mixed.

As an alternative to using a milk substitute formula, mothers who are HIV-positive, wishing to give their child the benefits of breast milk, are encouraged to pasteurize their expressed breast milk. It is believed that micropasteurization kills the HIV. This involves heating the expressed breast milk to 62.5ºC for 30 minutes, and then cooling it as rapidly as possible. This raises the question of resources. If the resources are available for this treatment, it seems to be the best solution to the dilemma of breastfeeding.

It is not obvious that there is much value in preventing MTCT if the child born healthy will not have a mother to care for him or her. So, the ethics of preventing MTCT are questionable if similar efforts are not made to ensure the continued health of the mother. This will usually mean long-term antiretroviral therapy (ART). Thus MTCT prevention is only one part of a much broader strategy for dealing with the AIDS pandemic.

(c) Parenteral Transmission

Parenteral transmission has been the least studied of the modes of transmission in the country.

The blood supply is deemed to have been rendered relatively safe by screening of

donors and of blood products.[13] I will thus not consider it at any length here.

Shared infected needles by intravenous drug users were identified early on in the pandemic as one of the vectors through which the HIV may be transmitted. There are proportionally fewer intravenous drug users in South Africa than in wealthier countries, because the cost of such drugs places them out of the reach of most users. The drugs of preference are alcohol, mandrax tablets and marijuana, which are readily available and relatively inexpensive. None of these requires needles for their administration. Thus there has been less concern in South Africa about the use of shared needles.

The route of the spread of HIV through medical facilities is referred to only in passing in articles from the 1990's. For example, in his eight-page survey of modes of transmission, Thomas Quinn makes only this mention: "Parenteral transmission includes blood transfusion, and exposure to blood through re-use of needles or syringes among IDU's, or in healthcare facilities where sterilisation of instruments is inadequate."[14]

However three studies published in February 2003 suggest that the use of infected needles has in fact been a major cause of the spread of the epidemic in Africa. Not among drug users, but in the hospitals and medical facilities around the continent. These studies relativise the sexual spread of AIDS and cast an enormous responsibility on healthcare facilities to improve their sanitation.

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13. The 2000 Haemovigilance Report of the South African National Blood Service (SANBS) acknowledged that five confirmed cases of transmission of HIV had occurred in the previous five years, from a total of three million blood transfusions, and that no confirmed cases had been reported in 2000. See "South Africa's Blood is Safe" published on 23 April 2002 by the Department of Health, viewed on 23 April 2003 at Http://www.doh.gov.za/docs/news/2002/nz0423.html. However, in March 2003, the SANBS was warning that the rate of one infection per year may well jump to three per year through the action of "irresponsible donors who expose patients to unnecessary risk when donating blood." See the report in the Dispatch newspaper: "HIV Transfusion Risk Set to Triple" Hhttp://www.dispatch.co.za/2003/03/17/southafrica/BHIV.HTM viewed on 23 April 2003. Three infections through blood products per year remains a minuscule proportion (although no less tragic) of the infections of HIV through other means.

14.Thomas C. Quinn, "Global Burden of the HIV Pandemic," *The Lancet*, no. 348 (13 July 1996): 102.

The first[15] of three articles questions the assumption which became accepted since 1988 that heterosexual intercourse is responsible for 90% of HIV transmission in Africa. Brewer et al. say that this assumption appeared as if out of nowhere and rapidly became the received wisdom. If it were the case that heterosexual transmission was the major vector in Africa, then vaginal intercourse would be three times more efficient than anal intercourse in the spreading of the virus. This has been shown not to be the case in other contexts.

The second[16] article argues that heterosexual intercourse is in fact responsible for about only one third of the cases of HIV transmission on the continent. Through a series of calculations starting from base population infections rates, the authors show that heterosexual intercourse is responsible for 25-29% of HIV incidence among women in Africa and 30-35% among men. They write:

> The third objective has been to present our estimates that roughly one-third of the spread of HIV in Africa can be associated with heterosexual transmission. This estimate is far below those that are usually invoked to explain the AIDS epidemic in Africa, and we suggest that the discrepancies should be addressed.[17]

While the estimation of one-third might be a vast underestimate, the point remains that there is sufficient latitude to warrant the investigation of other modes of transmission.

The third article argues that the majority of the cases of HIV transmission in Africa has happened in medical facilities. "Since early in the African epidemic, when AIDS was demographically associated with sexually active populations, studies of HIV transmission in Africa have generally failed to control for possible parenteral confounding. The importance of this route of infection was well known in the West and in Asia but quickly

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15. Devon D. Brewer, et al., "Mounting Anomalies in the Epidemiology of HIV in Africa: Cry the Beloved Paradigm," *International Journal of STD & AIDS* 14 (March 2003): 144–47, Http://www.rsm.ac.uk/new/std144intro.pdf viewed on 2 April 2003.
16.David Gisselquist and John J. Potterat, "Heterosexual Transmission of HIV in Africa: An Empiric Estimate," *International Journal of STD & AIDS* 14 (March 2003): 162–73.
17.Gisselquist and Potterat, "Heterosexual Transmission of HIV," 171.

dismissed in Africa."[18] Brewer et al. argue that in countries where there is relatively good access to medical care, and where other STI's are generally decreasing in prevalence, HIV infection is increasing. Further, in countries which have high reporting rates of sexual practices regarded as high-risk, but where the people have less access to medical facilities, the rates of infection of HIV are lower. In particular, in receiving health care, people are exposed to contaminated medical injections and other articles carrying infected blood.

A fourth article, a review of medical literature from 2000, published in November 2003, gives the proportion of injections using reused equipment worldwide at 39.3% of some 16 billion injections administered annually. This amounts to some 6.7 billion potentially unsafe injections in which HIV might be transmitted.[19]

The implications of these four studies are enormous.

(i) The most immediate implication is that medical and healthcare facilities must dramatically improve the sterilisation of all needles that are being reused. Greater care must be taken that nobody be exposed to contaminated sharp objects. These steps must be taken even before the results of further and deeper studies are available.

(ii) Better epidemiological studies are needed to research more accurately the routes of transmission of HIV in Africa. It is not good enough to rely on an assumption that became the norm in the late 1980's. More detailed knowledge is required in order to combat more effectively the spread of the virus.

(iii) If it should be demonstrated that sexual transmission is in fact responsible for only a proportion of all HIV transmission, then this seriously undermines programmes premised upon the use of condoms and changing sexual behaviour as the only way to

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18.Brewer, et al., "Mounting Anomalies in the Epidemiology," 146.
19.Yvan J.F. Hutin, Anja M. Hauri, and Gregory L. Armstrong, "Use of Injections in Healthcare Settings Worldwide, 2000: Literature Review and Regional Estimates," *British Medical Journal* 327 (8 November 2003): 5, Http://bmj.bmjjournals.com/cgi/content/full/327/7423/1075 viewed on 10 November 2003.

stop the spread of AIDS. Obviously the avoidance of risky sexual behaviour will always remain a major strategy in the control of the spread of the virus.[20] But de-emphasising the role of sexual transmission will allow space for the introduction of other preventive programmes.

More profoundly, if it is no longer assumed that AIDS is spread solely through sexual interactions, then this could help enormously to de-stigmatise AIDS.[21] The stigma attached to AIDS is based on the following two pillars:

(i) it is associated with death, and thus a limit situation of humanity,

(ii) it is associated with sexuality, and thus an area frequently associated with guilt and shame, in which people find it difficult to express themselves.[22]

20.As more information becomes available, what is regarded as risky sexual behaviour will also evolve. For example, Scott Gottlieb, "Unprotected Oral Sex Can Transmit HIV," *British Medical Journal*, no. 326 (5 April 2003): 730 extends concern for the transmission of HIV to practices that were previously considered quite safe.

21.Janine Pierret, "Everyday Life with AIDS/HIV: Surveys in the Social Sciences," *Social Science and Medicine* 50 (2000): 1589–98 presents a review of the literature concerning people living with HIV/AIDS, or with members of the family living with HIV/AIDS. A major factor is how people organise their lives around the stigma associated with AIDS. The literature reviewed does not cover living with HIV in Africa, where patterns of shame and taboo contribute to the ostracisation of people living with AIDS.

22. While enormous public-education efforts have been made in South Africa, to inform people of the connection between sexual behaviour and AIDS, these have had to work against cultural representations that do not associate disease with sexual behaviour. For example, Carol S. Goldin, "Stigmatization and AIDS: Critical Issues in Public Health," *Social Science and Medicine* 39, no. 9 (1994): 1363 citing B. Ingstad, "The Cultural Construction of AIDS and Its Consequences for Prevention in Botswana," *Med. Anthrop. Q.* 4, no. 28 (1990) and E.C. Green, "Sexually Transmitted Disease, Ethnomedicine and Health Policy in Africa," *Social Science and Medicine* 35, no. 121 (1992) shows how the Tswana and Swazi have different etiologies of disease to each other and to the Western biomedical model, which leads neither group naturally to associate AIDS with sexual transmission. Thus among black South Africans, stigma associating AIDS with sexuality is considerably weaker than in the 'Western mind.'

Writing in 1987, D.J. Louw is dealing with the early days of the pandemic in South Africa, before it spread like wildfire among black people. Louw associates the stigma clearly with a permissive lifestyle: "Die verband tussen VIGS en 'n permissiewe lewenstyl veroorsaak dat so 'n pasiënt onmiddellik 'n etiket ontvang." See Daniel J. Louw, "*VIGS: Die radikale siekte met 'n radikale uitdaging aan die pastorale bediening*," *Ned. Geref. Teologiese Tydskrif* XXIX, no. 1 (January 1988): 71. The label the person receives when he or she has AIDS has to do with the disease's association with sexuality. Louw says that there are often hidden criteria by which people categorise some diseases as 'clean' and others as 'unclean.' People living with AIDS often have the perception that they are being isolated as worthier people distance themselves from the disease. They have the sense of being the 'lepers' of our time who have to live outside the camp, cover their

If it were known that a large number of people with AIDS in South Africa could have contracted it though means other than sexual intercourse, this would help to disassociate the disease from the area of sexuality which people find difficult to discuss. The stigma of the disease would thereby be reduced so that people could talk about it with slightly less difficulty. This would help in programmes to educate people and reduce the spread of HIV. But as we shall see, there are very strong reasons adduced for not reducing the association between sexual intercourse and the transmission of HIV.

Naturally the response to this series of articles has been swift and categorical. However immediate responses did not entirely refute any of the arguments proposed by Gisselquist et al. A joint response from WHO and UNAIDS reads: "Following a review of evidence, which included recent articles suggesting that a majority of HIV infections in sub-Saharan Africa are due to unsafe medical practices, particularly injections, the experts concluded that such suggestions are not supported by the vast majority of evidence and that unsafe sexual practices continue to be responsible for the overwhelming majority of HIV infections."[23] The response says that injections are responsible for only 2.5% (or one in 40) of AIDS transmission in sub-Saharan Africa. However, it acknowledges that of the 16 billion injections administered annually worldwide some 30% (or 4.8 billion) are unsafe. I would suggest that on a continent where health services are often at best rudimentary, there is a probability that a disproportionate number of these 4.8 billion unsafe injections are in Africa, and that they would be responsible for the transmission of HIV. If this conservative estimate of 2.5% of AIDS transmissions in sub-Saharan Africa were applied

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faces and shout 'Unclean! Unclean!' as prescribed in Lev 13:45.
I would note that similar connotations of uncleanness were associated with cancer from the 1950's to 1980's. This cluster of diseases challenged the Western notion of the ability of medical science to overcome disease. Stigma was associated with cancer because it confronted society with mortality in the face of the promise of scientific triumph over death.

23.WHO / UNAIDS, *Expert Group Stresses That Unsafe Sex Is the Primary Mode of HIV Infection in Africa* (Geneva, 2003, 14 March), Http//www:unaids.org/whatsnew/press/eng/hivinfections140303%5Fen.html viewed on 9 April 2003.

to South Africa alone, it would amount to 110 000 people infected by unsafe medical practices. Clearly this warrants further investigation and action.

In terms of programmes for the prevention of the transmission of HIV, the WHO/UNAIDS response says that the promotion of safer sex must remain the mainstay of the response to AIDS in the region. However it also concedes that “More work needs to be done to eliminate unsafe injection practices around the world.” for which the WHO has issued a *Managing an Injection Safety Policy.* Of course, the two programmes must go hand-in-hand. But allowing for an avenue by which one pillar of the stigma, and thus secrecy, associated with AIDS can be reduced, can only be of benefit in communication about the disease.

I foresee two dangers inherent in reducing the publicly perceived significance of the sexual transmission of HIV, and thereby the stigma of the disease, namely;

(i) People may develop a false sense of security, become complacent and disregard completely sexual transmission as a factor, leading to ‘open season’ on risky sexual behaviour.[24]

(ii) There may arise in discourse about AIDS in Africa an unhelpful categorisation of innocent / guilty, with the innocent being those who were infected by needles in a medical situation, and the guilty those who were infected through sexual intercourse. This blame-discourse may drive the people who know they received the virus through sexual transmission into a greater silence and secrecy about their AIDS.

24.This phenomenon has been noticed among homosexual men particularly in North America, for whom AIDS is not associated with an automatic death sentence. With the development of life-prolonging medication, a new generation of homosexual men, who have not had to bury partners and friends, regard AIDS as a treatable chronic disease and do not accord “safe sex” paramount ethical status.

(4) AIDS and Gender

The disease does seem to have a gender bias, in that women are more frequently infected than men. The *2002 Epidemiological Facts Sheet* shows, for example, that male youth (aged 15 to 24) have a prevalence rate of 5.8% and female youth a prevalence rate of 21.6%. Among adult males and females, the figures are much closer, at 23.3% and 23.5% respectively.[25] Using the data on the previous page, this translates into 947 680 female and 263 069 male youths living with HIV/AIDS in July 2002. Thus in South Africa, there are almost 800 000 more women than men living with HIV/AIDS. Death rates are consequently higher among women in their twenties than among those in their sixties. Radhika Sarin explains there are several reasons for this discrepancy:

> Biological, economic and social factors all contribute to women's vulnerability. Women have a large surface area of reproductive tissue that is exposed to their partner's secretions during intercourse, and semen infected with HIV typically contains a higher concentration of the virus than a woman's sexual secretions. Young women are especially at greater risk because their reproductive organs are immature and more likely to tear during intercourse. Women also face a high risk of acquiring other STIs, which multiply ten-fold the risk of contracting HIV when left untreated.[26]

Based on her research in the pseudonymous 'Summertown,' which can be generalised across the country, Catherine Campbell adds two time factors to explain further this discrepancy:

> Second, in unprotected sex, women are exposed to infectious fluids for longer than men. While men are in contact with body fluids containing the virus for the duration of the sex act, women remain in contact with the semen for much longer..... Young women in Summertown tend to have sexual relations with men who are, on average, five years older. Given that HIV levels increase with age, this means that young women are at greater risk from older partners than young men are from their younger partners.[27]

25.UNAIDS, Unicef, and WHO, *Epidemiological Fact Sheet, 2002, South Africa*, 5.
26.Radhika Sarin, "The Feminization of AIDS," in *Correcting Gender Myopia: Gender Equity, Women's Welfare and the Environment*, Danielle Nierenberg (Washington, DC: Worldwatch Institute, 2002), 30.
27.Catherine Campbell, *'Letting Them Die,'* The International African Institute's African Issues (Cape

Tallis extends this line of argumentation to gender inequality. She argues that when the imbalance of power in the relations of male and female are not addressed, then discussion cannot take place that will impact on the spread of the disease. "Gender inequalities affect, amongst other things, the possibilities of prevention, access to appropriate materials, information and resources, the quality of care received, and survival chances. Few people in the HIV/AIDS field would dispute the fact that gender roles and unequal gender relations are fuelling the epidemic by rendering both men and women vulnerable to HIV/AIDS."[28] So, for example, she argues, men are under social pressure to 'perform' sexually and with numerous partners. This exposes them to greater risk of infection. Conversely, women are often unable to negotiate safer sexual practices such as the use of male condoms. Men have a number of reasons for not wanting to use condoms, and having the upper hand in sexual power relations, often do not use them. As the female condom is not widely available in South Africa, women are frequently powerless to prevent their own infection.

In the first such statistical study conducted in South Africa, the research of Dunkle et al. shows conclusively that "women who have experienced partner violence or who are currently involved with controlling male partners are at increased risk of HIV infection, even after their own risk behaviour is taken into account."[29]

Dorrington and Johnson write: "...South Africa remains a fairly patriarchal society, in which women are vulnerable to sexual abuse." They cite statistics indicating that there are almost one million cases of rape per year, including marital rape. Given the violence of these assaults, with accompanying by physical trauma to the victim, as well as the fact that there is a high HIV-infection rate in the population, many women are infected with HIV

Town: Double Storey Books, 2003), 123.
28.Vicci Tallis, "Gendering the Response to HIV/AIDS: Challenging Gender Inequality," *Agenda*, no. 44 (2000): 59.
29.Kristin L. Dunkle, et al., "Gender-Based Violence, Relationship Power and Risk of HIV Infection in Women Attending Antenatal Clinics in South Africa," *The Lancet* 363, no. 9419 (1 May 2004): 1419.

during the rape. Girls, too, are often forced into sexual relationships, often with older men such as their teachers. Dorrington and Johnson conclude: "In many cases, therefore, women have little control over their sexual activity, and are thus more vulnerable to HIV infection."[30]

However, it is an anachronism (if it ever was true in the first place), to think of South African women as completely submissive in gender relations. Women are more and more visible in the workplace, in top managerial positions, in politics and in establishing enterprises. They are certainly not to be universally portrayed as 'victim' of unequal relations. Nor are they to be cast invariably as 'homemaker' or mother. Decades of the policy of labour migrancy have seen men and women separated from their families for up to eleven months of the year. Many households are headed by women, and some of them in the wealthier parts of town, for example in Protea North in Soweto. It is thus evident that women are increasingly assertive, particularly in urban life in South Africa.

But the roles played by men are also changing in the light of changing social circumstances. Janet Bujara says that as societies change (and South Africa is a society undergoing rapid transition), so the representations of masculinity change. She is optimistic that they are changing for the better in South Africa:

> Shire's view is of masculinities continually made and remade within the shifting structures of social and political power. The transformation of such relations in South Africa has created a political climate where the questioning of hegemonic masculinity, framed as rampant heterosexuality and male dominance, is a public issue, unlike elsewhere in Africa.[31]

Bujara concludes the first half of her article:

> The shift to a language of plural 'masculinities', perceived as social constructions, has positive consequences for work on AIDS, for it raises the possibility that men may change their ways in changing social circumstances.

30.Rob Dorrington and Leigh Johnson, "Epidemiological and Demographic," in *Impacts and Interventions: The HIV/AIDS Epidemic and the Children of South Africa*, edited by Jeff Gow, Chris Desmond (Pietermaritzburg: University of Natal Press, UNICEF, 2002), 17.
31.Janet Bujara, "Targeting Men for a Change: AIDS Discourse and Activism in Africa," *Agenda*, no. 44 (2000): 12.

It remains to be seen whether this optimistic possibility is borne out in reality. Clearly, according to the conclusion of Dunkle et al., it is a pressing concern to address gender roles and inequality of power in relationships in South Africa. They conclude that "addressing problems of gender-based violence and HIV will require broad community and societal level transformations that challenge entrenched cultures of violence and male-dominated norms of gender behaviours."[32] This must form part of the education and socialisation agendas of civil society.

(5) Ages Affected

(a) Young Adults

Although AIDS can and does affect people of any age from infancy to old age, it is much more prevalent among young people between the ages of 20 and 40 than among older people.[33] This is principally due to the sexual mode of transmission. Younger people are sexually more active, and during the age of exploration of relationships, have a greater number of sexual partners. Due to pressure from older men, girls are generally sexually active at a younger age than boys, and are exposed to infection earlier than their male counterparts. We have seen in the previous section how more younger women than men are HIV-infected.

Stan Brennan, pastor of Reiger Park, Boksburg, says: "It is sad. Most burials I perform are those of young people. We are losing promising youngsters to violent crime and AIDS."[34] The article in the Saturday Star newspaper reports that he has recently conducted over 100 funerals per year. This comes to an average of two per weekend. The majority of these are of young people.

32.Dunkle, et al., "Gender-Based Violence, Relationship Power and Risk of HIV," 1420.
33.Whiteside and Sunter show how in 1995, for women, the highest prevalence rates of HIV was in the 25 to 29 year age group, and for men the highest prevalence rate was in the 35 to 39 age group. Whiteside and Sunter, *AIDS*, 32.
34.Zondi Mahlangu, "It's Tough Having to Bury Young People," *Saturday Star*, 24 May 2003, 8.

(b) Children

(i) Perinatal Infection

AIDS is not a killer only of young adults. It should be remembered that hundreds of thousands of babies are born with HIV infection, and on average live no more than 2 years. Most of the children with HIV are infected vertically, i.e. HIV is transmitted to them by their mothers, either in utero, during childbirth, or through breastfeeding.

(ii) Child Rape

Rape is another disturbing source of possible HIV infection in infants and young children. It is difficult to ascertain the true dimensions of this potential method of infection through sifting reports in the mass media. Nor are health professionals in agreement about its prevalence.

In the popular press, headlines scream "U.N. Troubled by Rise in Child Rapes in South Africa"[35] attributing the apparent rise in child rapes to the myth that a man can be cured of AIDS by having sexual intercourse with a virgin. Some journalists go further by stating that this myth is spread by traditional healers who encourage their patients to have sex with a virgin.[36] Another says, noting similarities between two cases of infant rape: "Offenders were members of ethnic group[s] where the pervasive myth in the so-called Virgin Cure as a prevention/cure for HIV/Aids is relatively well entrenched within the

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35.Thalif Deen, "U.N. Troubled by Rise in Child Rapes in South Africa," *Inter Press Service*, 4 October 2002, Http://www.aegis.com/news/ips/2002/IPO21006.html viewed on 9 September 2003.
36.See Gavin du Venage, "Rape of Children Surges in South Africa: Minors Account for About 40% of Attack Victims," *San Francisco Chronicle*, 12 February 2002, Http://www.aegis.com/news/sc/2002/SC020203.html viewed on 9 September 2003. Hearsay reports of this nature will do little more than further undermine the minimal collaboration between western-style and African traditional health professionals.

cultural belief system."[37]

This putative myth is evidently a distortion of the reasoning from the knowledge that one cannot be infected with HIV by someone who is himself or herself not infected. To this knowledge is applied the mistaken view that no virgin is HIV-infected. Then there is a major slip in the logic of causality to the belief that having sex with a virgin can actually remove the infection. As more people have AIDS, the logic runs, so more men try to cure themselves by raping infants.

More sober medical journals do not rely on the increasing frequency of reports of child rape in the mass media to base their judgement. Jewkes, Levin, Mbananga and Bradshaw[38] write that prior to 1998 the rape data was not aggregated by age, so it is not possible to discern a trend on the basis of police records. However, in their 1998 study of 11 735 women aged between 15 and 49, the number of women who reported having been raped as a child under the age of 15 decreased with age. This leads Jewkes and her colleagues to suggest: "The negative age trend suggests that child rape is becoming more common in South Africa, although reporting bias cannot be ruled out. Our findings, however, lend support to perceptions of increases in the number of child rapes reported in the media, seen in health facilities, and reported to the police." This does not constitute clear evidence of an increase in the prevalence of child rape.

In the same edition of *The Lancet,* Pitcher and Bowley[39] attribute the perceived increase in the number of child rapes in part to the myth that is said to have its origins in

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37.See Michael Earl-Taylor, "HIV/AIDS, the Stats, the Virgin Cure and Infant Rape," *Science in Africa*, April 2002, Http://www.scienceinafrica.co.za/2002/april/virgin.htm viewed on 9 September 2003. Earl-Taylor does not say, however, how the myth has become "relatively well entrenched" in this South African cultural belief system when HIV/AIDS has only been known for 20 years worldwide, and for even less time in the country. He may be drawing on the work earlier in his report where he looks at Virgin Cure beliefs in general in Africa and Asia, that are not linked to AIDS. But he does not make this connection obvious.
38.Rachel Jewkes, Jonathan Levin, Nolwazi Mbananga, and Debbie Bradshaw, "Rape of Girls in South Africa," *The Lancet* 359 (26 January 2002): 319.
39.Graeme J. Pitcher and Douglas M.G. Bowley, "Infant Rape in South Africa," *The Lancet* 359 (26 January 2002): 274–75.

Central Africa. Pitcher and Bowley do not explain why there is not a commensurate increase of reporting of the number of child rapes in Central Africa, and why this is only a phenomenon in South Africa. Could it be, simply, that isolated incidents of child rape, previously under-reported, are now being reported as part of a trend?

On the other hand, Jewkes, Martin and Penn-Kekana are emphatic that the myth of virgin cleansing of HIV is not the principal reason for the perceived rise in the number of child rapes. In a reply article in *The Lancet,* they write: "In more than a decade's work as a district surgeon and forensic pathologist, L.M. [Lorna Martin] has seen raped babies periodically, but the numbers have not risen. The perception of a rising rate may be related to the media giving a few cases prominence."[40]

In an effort to dispel the idea that the number of childhood rapes is increasing due to the myth of the virgin cure, they quote the manager of the child sexual abuse referral clinic for the Johannesburg metropolis, The Teddy Bear Clinic. Mr Luke Lamprecht says that he has only come across one case, in 1998, when the perpetrator said he believed the myth. Jewkes, Martin and Penn-Kekana also note that only 1% of children raped in a series of child rapes reported in Cape Town converted from HIV -ve to HIV +ve. Given the physical trauma and injuries associated with child rape, the authors would expect more seroconversion if the men perpetrating the rapes were mostly infected with HIV. They conclude that: "most evidence suggests that this motivation [having sex with a virgin to cure a man of HIV-1 infection] is infrequent." They adduce numerous other reasons for the horrific frequency of rape in South Africa, including poverty, gang initiation rites, "a culture of male sexual entitlement, and the climate of relative impunity for rape",

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40.Rachel Jewkes, Lorna Martin, and Loveday Penn-Kekana, "The Virgin Cleansing Myth: Cases of Child Rape Are Not Exotic," *The Lancet* 359 (23 February 2002): 711 The substance of this article can also be found on the website of the Medical Research Council of South Africa, of which Jewkes is the director of the Gender and Health Research Group. See http://www.mrc.ac.za/mrcnews/april2002/virgin.htm viewed on 9 September 2003.

brutalisation of many South Africans during years of political repression, and high levels of violence in general.

In an attempt to explain the rhetorical usefulness of the myth, Moffett of the African Gender Unit at the University of Cape Town, writes:

> Meanwhile, I suspect that this explanation for the epidemic of sexual violence of children has been eagerly seized upon partly because it fits in neatly with the variation of the "monster" stereotype that paints the rapist as a barbarian or superstitious savage. It also dovetails with the stigma and marginalization that attaches to those who are HIV-positive or have Aids. The rapist can thus be assumed to be a backward peasant, "tainted" by a dread disease, and in thrall to an evil or ignorant witchdoctor.[41]

As more women become assertive of their rights to physical integrity in the advancing democracy in South Africa, it is foreseeable that children might be more frequent victims of sexual violence. Wood et al. show how sexual coercion and violence are already common experiences for young Xhosa women and teenage girls.[42] Moffett writes: "The obvious reasons for singling out children is that they are more vulnerable, more easily bullied or bribed into silence, less likely to report and less likely to be believed when they report."[43]

This clearly has disturbing implications for the possible transmission of HIV to children. But the available evidence does not lead one to the conclusion that the 'virgin cure myth' is a trend that will lead to substantial increases in the number of transmissions of HIV to children and infants. Even Leclerc-Madlala, in her important work among the Zulu in Kwa-Zulu Natal, does not say that this is a major source of new infections.[44]

41.Helen Moffett, "Speaking the Unspeakable: Narratives Surrounding the Rape of Children," unpublished paper forwarded by the author (Cape Town, 2003), 5, Http://www.womankind.org.uk awaiting publication.
42.Katharine Wood, Fidelia Maforah, and Rachel Jewkes, "'He Forced Me to Love Him': Putting Violence on Adolescent Sexual Health Agendas," *Soc. Sci. Med.* 47, no. 2 (1998): 233–42.
43.Helen Moffett, personal communication, e-mail correspondence (Ottawa, Cape Town, 2003)
44. See Suzette Leclerc-Madlala, "On the Virgin Cleansing Myth: Gendered Bodies, AIDS and Ethnomedicine," *African Journal of AIDS Research* 1, no. 2 (2002): 87–95.

On the basis of this conclusion, one might ask why this report has included child rape at all. It has been included because of what it represents for people living with HIV infection or AIDS. A sinister side of the myth is that it is an indication of the kind of misinformation, stigma, demonisation and isolation to which people living with AIDS are subject. An already marginalised group can only be more stigmatised and isolated by myths of this kind. Rumours such as this virgin-cure myth make the disease more pernicious as they contribute to the 'social death' of people with AIDS.

(c) The elderly

Old people are also infected by HIV and succumb more readily than younger adults who generally have a better base health. The Department of Health publishes results from the annual antenatal clinic surveys. However these only record HIV infection among women of child-bearing age attending antenatal clinics, and do not give an indication of the infection rate among elderly men and women. The 2002 Update for the UNAIDS Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections for South Africa does not give data in its fields the AIDS cases by age.[45] The data for this particular field was unavailable in 1996. At the time of writing the most recent data showing the distribution of AIDS cases by age and gender was published in 1995 by the Department of Health.[46] This shows several hundred men and women above the age of 55 who have AIDS. There is no reason to believe that by the time of writing, this number hasn't increased by an order of magnitude.

Elderly people commonly have to care for their orphaned grandchildren. This has a direct effect on the standard of living, as more people are dependent on the old-age pensions of the caregivers. This increased 'pension-burden' has to cover the educational,

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45.UNAIDS, Unicef, and WHO, *Epidemiological Fact Sheet, 2002, South Africa*, 6.
46.Department of Health, *Epidemiological Comments* 22, no. 10 (October 1995).

nutritional and clothing requirements of the young dependents. The consequent increase in poverty makes all the people of that household more susceptible to illness and infection. Although income support grants and child-maintenance grants are available, they are not yet sufficiently effectively administered to provide help to those most in need.

(6) Other Social Factors in the Transmission of AIDS

The reason for the high rates of infection are not only to be explained in biological terms. Social analysts also seek to explain the factors contributing to the high rates of infection in South Africa. Whiteside and Sunter maintain that AIDS is more likely to spread in societies where there is the combination of a relatively high income and low levels of cohesion in civil society.[47] They use the Gini index, a measure of inequality of income, as a predictor of the rates of HIV-infection in a number of sub-Saharan African countries. Those countries with a lower average income, greater equality of income, or a greater degree of social cohesion, the theory goes, are not as hard hit by the pandemic. As South Africa has a high Gini index, and relatively high average income, it is hit by a rapid spread of the disease.

Romero-Daza[48] explains how the migrant labour system has been a major social force in spreading AIDS in Southern Africa. Her work corroborates that of Charles W. Hunt[49] who shows how the patterns of migrant labour in central, eastern and southern Africa have made an epidemiology quite different to that in countries with a settled labour force. Another study, that of Denise Gilgen et. al.,[50] shows how in Carletonville, a mining

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47.Whiteside and Sunter, *AIDS*, 62.
48.Nancy Romero-Daza, “Multiple Sex Partners, Migrant Labour and the Makings of an Epidemic: Knowledge and Beliefs About AIDS Among Women in Highland Lesotho,” *Human Organization* 55, no. 2 (1994): 192–205.
49.Charles W. Hunt, “Migrant Labor and Sexually Transmitted Disease: AIDS in Africa,” *Journal of Health and Social Behaviour* 30 (December 1989): 353–73.
50.Denise Gilgen, et al., *The Natural History of HIV/AIDS in South Africa: A Biomedical and Social Survey in Carletonville* (Johannesburg: CSIR, 2000).

town in the vicinity of Johannesburg, the migrant labourers employed in the gold mines have a greater disposable income, and frequent the services of commercial sex workers. They consequently have a greater incidence of HIV infection than the unemployed men living in the township beside the migrant workers' hostels. Jochelson, Mothibeli and Leger[51] illustrate a "partner network" for migrant labourers in the mines of South Africa, to demonstrate how the system of migrant labour plays a major role in the spreading of disease in South Africa. They conclude with an argument for mining houses to provide housing for stable families at the workplace.

(a) Daniel Hrdy's contribution

Daniel B. Hrdy[52] considers methods of transmission of HIV that are perhaps more particularly African. Particular cultural practices expose some people in various parts of the continent to greater risk of contracting the virus. We shall enumerate these as Hrdy deals with them, but consider only those that are of particular relevance to South Africa.

(i) Female Circumcision and Infibulation

Hrdy begins with a consideration of the practice of female circumcision and infibulation. He says it is inconclusive that these practices contribute to the transmission of HIV, as they do not correspond geographically to the areas of high HIV seropositivity. As this is not a practice in South Africa, and is performed only among refugees from further North in the continent, we shall not dwell on it.

51.Karen Jochelson, Monyaola Mothibeli, and Jean-Patrick Leger, "Human Immunodeficiency Virus and Migrant Labor in South Africa," *International Journal of Health Services* 21, no. 1 (1991): 157–73.
52.Daniel B. Hrdy, "Cultural Practices Contributing to the Transmission of Human Immunodeficiency Virus in Africa," *Reviews of Infectious Diseases* 9, no. 6 (November-December 1987): 1109–19. This is a relatively early study (1987) of the pandemic on the continent. Modes of transmission and details and geographical patterns of infection were still not fully understood.

(ii) Promiscuity

Considering what he calls promiscuity in Africa, Hrdy does not compare with other continents. He postulates that the movements of peoples and armies, refugees, migrant workers, etc. "contribute to the 'sexual mixing' of various African groups and may be related to the spread of AIDS."[53] He also says that matrilineal societies have ways of dealing with questions of inhertiance in the case of uncertain paternity. Finally he observes that women are often forced to supplement their meager income by prostitution in exchange for goods and services essential for survival. This latter phenomenon is frequently registered as a contributing factor to the spread of HIV in Africa.

However, we should bear in mind that 'promiscuity' is a social construct. We must understand what is meant by the term in this context. It is important not to accept uncritically the assertion that Africans are more promiscuous than people of other continents.

Whiteside and Sunter show results of the 1998 Durex Global Sex Survey indicating that "South Africans seem to be no more nor less sexually active than their foreign counterparts."[54] The 1998 survey shows the average age at which South African report having their first sexual experience as 17.3, and the average number of episodes of sexual intercourse per annum as 109, compared with 16.3 and 138 for the United States and 19.6 and 80 for Thailand, respectively. It must be borne in mind that the Durex Sex Survey is based on self-reporting on the internet at the Durex website. So there is the probability that it is not an accurate representative picture of behaviour in the country, because many people do not self-report with complete veracity, and many rural people do not have access to computers or the internet.

53.Hrdy, "Cultural Practices Contributing to the Transmission," 1112.
54.Whiteside and Sunter, *AIDS*, 59.

What I find a matter of concern in the 2002 survey, is that 70% of South Africans said they are likely to have a one-night stand.[55] This is only 2% less than Norwegians, who recorded the highest likelihood of having a 'one-night stand.' If this is taken as a measure of 'promiscuity', then it is undeniable that South Africans reflect a high level thereof.

However, Janet Bujra warns against the danger of racist constructions suggesting that African men are more promiscuous than their European counterparts. She considers that the balance of evidence is that "men on average have more sexual partners than women, whether we do the counting in Britain or Botswana."[56] It is notoriously difficult to obtain data on sexual behaviour, as most surveys rely on the truth of self-reporting. In addition, sexual behaviour is so context-dependent. So one should be cautious to avoid the assumption that AIDS is more likely to spread through Africa on the basis of promiscuity, than in any other context.

(iii) Homosexuality and Anal Intercourse

Hrdy is correct in observing that these practices are said to be very limited in Africa, particularly if one is to believe the protestations of political leaders that homosexuality is "un-African," abhorrent, a Western deviation, etc. The fact that it is illegal in many countries of Africa drives any potential homosexual activity underground and ensures that is not reported or openly practised. However, that it is illegal, means that it is not unknown in Africa.[57] The particularly strong stigma attached to homosexual

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55.Durex, *Global Sex Survey 2002* (2002), Http://www.durex.com/uk/sexsurvey/globalsexsurvey2002/global_sex2002b.htm viewed on 16 September 2002.
56.Bujara, "Targeting Men for a Change," 10.
57.For a case in point, refer to the fate of the former vice-president of Zimbabwe: "Banana Sentenced for Gay Assault," *BBC News Online*, 18 January 1999, Http://news.bbc.co.uk/1/hi/world/africa/257189.stm viewed on 8 September 2003.

behaviour in Africa has to do with the value of fecundity, and the 'cosmological duty' to extend the family lineage. We shall consider this in the following chapter under the heading of 'who becomes an ancestor.'

Hrdy does not consider the prisons and single-sex hostels where there are consistent reports of homosexual activity. While homosexuality in these circumstances can be regarded as situational, rather than as a chosen lifestyle, the rates of HIV infection are not to be ignored as these men eventually return to the general population.[58]

South Africa with its liberal constitution of 1994 forbids the discrimination against people on the basis of sexual orientation *inter alia*. Although homosexuality is legal it is still regularly denounced by some as un-African. There is said to be a thriving 'gay' subculture in the black townships and the significant number of black men openly living a homosexual lifestyle leads one to question just how alien to Africa homosexuality really is. In consequence, as opposed to Hrdy, the possibility of homosexual transmission of HIV is not to be dismissed lightly in South Africa.

Staying with the example of Zimbabwe, where there is particularly strong denial of the existence of homosexuality, Epprecht concludes his article: "Happily, and for all its over-determined invisibility, knowledge about the history of homosexualities in Zimbabwe is accessible through fairly conventional historical methods including painstaking archival work, linguistics, close and comparative textual analysis, and sensitive interviewing." See Mark Epprecht, "The 'Unsayings' of Indigenous Homosexualities in Zimbabwe: Mapping a Blindspot in an African Masculinity," *Journal of Southern African Studies* 24, no. 2 (December 1998): 651.

58. In 2001, the University of Natal and the Medical Research Council conducted a study of the incidence of HIV in the Durban-Westville Medium B Prison. Based on this study, Washington-based researcher, KC Goyer, consulting for the Institute of Security Studies (ISS), estimates a 42.5% HIV infection rate in the South African prison population. The Department of Correctional Services says that its own estimate of 3% is probably too low, while saying that the estimate of 60% proposed by Judge Johannes Fagan, inspector of prisons is "unrealistic and unreliable." So, whatever the true number is, it is very difficult to make an accurate assessment. However nobody doubts that there is a serious problem in the prisons in South Africa. See: Chantelle Benjamin, "Prisons Cannot Manage AIDS Plight," *Business Day*, 11 March 2003, Http://allafrica.com/stories/200303110099.html viewed on 25 April 2003. The Department of Correctional Services estimates that between 90 and 95% of all natural deaths in the prisons are due to AIDS. See: South African Press Association, "Prison AIDS Deaths Grow by 750 Percent" (2003), Http://allafrica.com/stories/200302190270.html viewed on 25 April 2003.

(iv) Practices Resulting in Exposure to Blood

Next Hrdy considers traditional African incisions, scarifications, blood-letting, blood-brotherhood, assisting at childbirth, administering of enemas, etc. These might all expose the people involved to the blood of another, which may be infected. In South Africa all of these may be considered potential sources of HIV infection, with the exception of blood-brotherhood which is not a traditional practice, and enemas which do not involve any bodily fluids known to transmit HIV.

(v) Practices Involving the Use of Shared Instruments

Hrdy then looks at the danger of HIV infection from contaminated needles and blades. Needles for intravenous drug use and injections by ‘injection doctors’, blades for scarification, tattooing, incisions, ‘witchcraft’, circumcision, etc. are possible vectors in Africa.

In South Africa, both needles and blades are potential sources of infection. Among some tribes, including the Basotho, traditional male circumcision is done with a cohort of young men or adolescents going into isolation in the veld or the mountains, attending an initiation school, the highlight of which is the circumcision ceremony. For a number of reasons parents are nowadays commonly taking their sons to hospitals and clinics for circumcision. This avoids the danger of their son being operated on using the same blade as a number of other initiates. There are also programmes for the ‘circumcision doctors’ to be supplied with sterile blades to perform their function in the initiation schools.

Scarification, when it is performed, is usually done on one child and is not a cohort activity. Thus, even if the blade - possibly a scarce resource in rural areas - is used for a number of other operations, it may have time to dry between uses. So the relatively weak HIV virus, which may have contaminated the blade at one time does not survive between uses of the blade. Hrdy says that the “rarity of AIDS in children argues against

scarification as a significant factor in the transmission of HIV." Clearly he does not have in mind here children who have inherited AIDS from their mothers, as discussed in our section on perinatal transmission.

(vi) Contact with Nonhuman Primates

Finally Hrdy considers - more speculatively than based on any evidence - the possibility of transmission of Immunodeficiency viruses from species to species in Africa. In particular, the Simian Immunodeficiency viruses may have jumped the species barrier between *Cercopithecus aethiops* (commonly called the 'vervet monkey' in South Africa). Early theories about the origin of HIV suggested that it may have been a mutation of a similar virus in monkeys. It is true that there is frequent contact between people and vervet monkeys in Africa, and people are occasionally bitten, or may come into contact with simian blood in the hunting and preparing of these monkeys for the pot, but there is insufficient evidence to support a wariness of HIV transmission from vervet monkeys.

(b) Other Cultural Factors

Other factors in South Africa involved in the transmission of HIV are practices which relate specifically to cultural representations and methods of sexual enjoyment. For example the practices of "dry" or "tight" sex and of male or female circumcision are all cultural practices which relate directly to the transmission of HIV.

(i) 'Dry' Sex

In regard to 'dry' sex, some South African cultural representations regard vaginal secretions as a sign of a woman's infidelity. Thus women attempt to dry up these secretions with absorbent material, or apply astringents to make the vagina tighter.[59]

During sexual intercourse the vagina is dry, without its normal protective mucous layer which:

(i) contains antiseptic lactobacilli, and

(ii) provides a lubricant during intercourse, thereby reducing the risk of abrasive injuries through which infections may be transmitted.

There is a sizeable body of polemics around this practice. Studies have been conducted to see whether there is a relation between the practice of dry sex and greater risk of HIV transmission.[60] Halperin says Beksinska's and several other studies are inconclusive: "Some studies suggest an association between these often mucosally abrasive practices and increased risk of infection by HIV and other sexually transmitted infections, although the evidence is not entirely conclusive."[61]

(ii) Circumcision

Another possible explanation for the close geographical relation between dry sex practices and increased incidence of HIV transmission, lies in the fact that dry sex seems to be practised more frequently in areas where men are generally not circumcised.[62] There is a strong relationship between non-circumcision of men and HIV infection, with many more men who are not circumcised being HIV positive. We will cite here three studies that regard the correlation between HIV infection and non-circumcision.[63]

59.NS Morar and SS Karim, "Vaginal Insertions and Douching Practices Among Sex Workers at Truck Stops in KwaZulu-Natal," *South African Medical Journal* 88 (1988): 470.
60.ME Beksinska, HV Rees, I Kleinschmidt, and et al, "The Practice and Prevalence of Dry Sex Among Men and Women in South Africa: A Risk Factor for Sexually Transmitted Infections?" *Sex. Transm. Inf.*, no. 5 (1999): 178–80.
61.Daniel T Halperin, "Dry Sex Practices and HIV Infection in the Dominican Republic and Haiti," *Sex Transm Inf* 75 (1999): 445.
62.Halperin says: "Dry sex practices appear to be primarily restricted to certain predominantly non-male circumcising regions of eastern and southern Africa, including many of the countries reporting the world's highest HIV seroprevalence.... Presumably, such practices would appear to be less appealing to the drier (non-prepucial secreting) circumcised males of western Africa or other regions." Halperin, "Dry Sex Practices and HIV Infection," 446.
63. There is an abundance of other such studies, and again, no shortage of polemics around the question of male circumcision.

Royce et al. write:

> Male circumcision consistently shows a protective effect against HIV infection. This may be due to the abundance of Langerhans' cells in the foreskin or to a receptive environment for HIV in the sulcus between the foreskin and the glans. The prevalence of HIV infection is 1.7 to 8.2 times as high in men with foreskins as in circumcised men, and the incidence of infection is 8 times as high. A greater proportion of sex partners of uncircumcised men than of circumcised men are infected with HIV, which suggests that the presence of the foreskin may also increase infectiousness.[64]

In support of the same theory, John and Pat Caldwell write:

> The link between lack of circumcision and elevated levels of HIV infection appears robust. In some parts of the AIDS belt,[65] nearly all men are uncircumcised - a situation unlike almost anywhere else in Africa...
> Thus, we concluded that in the AIDS belt, lack of male circumcision in combination with risky sexual behaviour, such as having multiple sexual partners, engaging in sex with prostitutes and leaving chancroid untreated, has led to rampant HIV transmission.[66]

Gilgen, Campbell et al. show how among mine workers in Carletonville, men who are circumcised have a lower rate of HIV infection.[67] Their study, which looks at several factors, and isolates a few, compares migrant workers of different ethnic origins, which have traditions of circumcision and non-circumcision respectively. Their statistics show a significantly lower proportion of men who are circumcised and have HIV than men who are not circumcised and have HIV. Thus, for example, Zulu mineworkers who are not circumcised have a 43.6% HIV prevalence, while Xhosa miners who are circumcised have a 20.5% HIV prevalence.

64.Rachel A Royce, Arlene Sena, Willard Cates, and Myron S Cohen, “Sexual Transmission of HIV,” *N. Eng. J. Med.* 336, no. 15 (10 April 1997): 1072–78.
65. By the ‘AIDS belt’ the Caldwells mean a chain of countries in eastern and southern Africa in which lived about half of the world’s people suffering with AIDS (in 1995).
66.John C. Caldwell and Pat Caldwell, “The African Aids Epidemic,” *Scientific American*, March 1996, 46.
67.Gilgen, et al., *The Natural History of HIV/AIDS*, 57–59.

(iii) Traditional Healers

A final cultural reason that we shall consider that contributes to the transmission of HIV, is the fact that many South Africans still have recourse to traditional healers as their primary health care professionals. Rather than attending hospitals or clinics in which Western-style biomedicine is practised, they will first consult traditional healers who address the diagnosis and treatment in ways that are considered to be culturally appropriate. The delay in seeking Western medical interventions in many cases contributes to the unchecked progress of the disease. We shall return later in this work to the contribution of Edward C. Green on the co-operation between traditional healers and Western-style medical practitioners in stemming the flow of HIV transmission.

It is clear, therefore, that there are cultural co-factors which add to the likelihood of HIV transmission. The evidence is circumstantial in the case of dry sex, but more conclusive in the case of non-circumcision. Recourse to traditional healers delays access to biomedical interventions, which might otherwise retard the onset and progress of AIDS-related diseases. But apart from cultural factors, there are also historical medical conditions that have rendered Africans particularly vulnerable to the spread of HIV infection.[68] We shall examine only one of these, namely, tuberculosis, in relation to the spread of the virus in South Africa.

(7) AIDS and Tuberculosis

Cedric de Beer traces the spread of the tuberculosis (TB) epidemic in South Africa back to the mid-nineteenth Century with the arrival of white people in the interior of the country. The disease spread to black people dramatically with the discovery of gold on

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68. See Susan Hunter, *Black Death: AIDS in Africa* (New York: Palgrave Macmillan, 2003) for a discussion of how colonial exploitation and subsequent dependency has left a legacy of poor base health across the continent, which provided a fertile field for the rapid spread of AIDS.

the Witwatersrand in 1886. Black men were then compelled by the imposition of a 'hut-tax' to begin working in the mines as unskilled labourers. Conditions of damp, dust and overcrowding made for ideal conditions for the disease to spread. TB is a highly infectious disease, which, before the start of the AIDS pandemic, de Beer regarded as the most serious in the country.[69]

AIDS has contributed to the spread of TB. When a person's immune system is weakened by the activity of HIV, he or she can readily be infected by *Mycobacterium tuberculosis*. Overall, TB is the biggest killer of people with AIDS in South Africa. Corbett et al. quote research showing: "[TB] is one of the most frequent serious HIV-1 associated infections, and the commonest cause of death in HIV-1 positive Africans," and further: "Latent tuberculosis infection was already highly prevalent in Africa before the spread of HIV-1, and in consequence, at least a third of HIV-1 infected Africans are co-infected with tuberculosis."[70] This disease, usually attacking the lungs, is often associated with poverty and bad nutrition and spreads rapidly among people living in close proximity to each other. Thus, it spreads rapidly among people confined in prisons, living together in hostels, and in overcrowded houses and shacks.

Although TB treatment is readily available in the country, and many people receive treatment, the disease continues to spread. There are two obvious reasons for this: Firstly, many people who begin treatment do not conclude the four-month course of medication, and stop when they begin to feel better. This has led to multi-drug resistant

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69.Cedric de Beer, *The South African Disease: Apartheid Health and Health Services* (London: CIIR, 1984), 1. De Beer's book is interesting because it was published shortly before the AIDS pandemic took off in South Africa. So it gives a picture of the situation of health in the country as a result of colonialism which had its apogée in the apartheid system. De Beer makes the obvious causal link between poverty, exacerbated by the 'homelands' policy, and falling standards of health. It is evident, from de Beer's work, that political democratisation and economic equalisation are necessary steps for an improvement in health care.

70.Elizabeth L. Corbett, et al., "HIV-1 AIDS and the Control of Other Infectious Diseases in Africa," *The Lancet* 359 (22 June 2002): 2182.

strains of TB, which are then more difficult and more expensive to treat.[71] Secondly, as the immunity of people living with HIV is lowered, they are more susceptible to infection by TB, and the TB is able to spread.

In sub-Saharan Africa, Harries et al. state: “The numbers of patients acquiring tuberculosis has increased 300%-400% in high HIV-prevalent countries in the past decade.”[72] There has not been a commensurate increase in the resources made available for the treatment of TB.

(8) AIDS and Death, AIDS and Life

In South Africa, when a person is diagnosed as being HIV-infected, this is frequently perceived as the pronouncement of a death sentence. It is notoriously difficult to estimate how long a person might live with the virus. Dabis and Ekpini say baldly: “Survival with AIDS tends to be short in Africa,” and further: “.... [African women with AIDS] median survival without care is 9 years (range 8-11).”[73] An individual’s survival depends on his or her background health, nutrition, living conditions, stress, etc. For children with HIV-1, “[m]ortality is estimated at 26-45% by the first birthday, and 35-59% at 2 years.”[74]

Studies in Uganda and Ivory Coast have shown that between 40 and 79% of adults remain symptom-free for three years of being infected with HIV.[75] This so-called ‘incubation period’ is believed to last up to ten years in otherwise healthy people in

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71.United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA), *SOUTH AFRICA: Feature: Tackling the World’s Worst TB Epidemic* (Johannesburg: Integrated Regional Information Network (IRIN) News, 2003), Http://www.irinnews.org/report.asp?ReportID=33082&SelectRegion=Southern_Africa&SelectCountry=SOUTH_AFRICA viewed on 9 April 2003.
72.Anthony D. Harries, et al., “Deaths from Tuberculosis in Sub-Saharan African Countries with a High Prevalence of HIV-1,” *The Lancet* 357 (12 May 2001): 1520.
73.François Dabis and Ehounou René Ekpini, “HIV-1 AIDS and Maternal and Child Health in Africa,” *The Lancet* 359 (15 June 2002): 2097 f.
74.Dabis and Ekpini, “HIV-1 AIDS and Maternal and Child Health,” 2100.
75.Dabis and Ekpini, “HIV-1 AIDS and Maternal and Child Health,” 2097.

developed countries. During this period, HIV is reproducing itself and infecting T4+ white blood or CD4 cells, which are responsible for fighting infections. The HIV-infected person is consequently less and less able to resist infections, and eventually the capacity of the immune system to overcome these infections is depleted. A person is said to have AIDS when he or she is unable to overcome opportunistic infections, or when neurological diseases or tumours show.

An indication of the fact that South Africa is a country in development, is that there is a vast gap between those who have and those who do not have access to quality health care. Rural areas, for example, have very poor health infrastructure and resources. Some people have medical insurance or belong to medical aid schemes which afford them medical treatment of first world standards. Thus some people with AIDS are able effectively to medicate themselves, and live a long, productive and relatively healthy life. But at the time of writing, medication for the majority of people with AIDS is simply beyond their financial means, and as a result they succumb to AIDS-related infections.

At the time of writing, numerous nongovernmental organisations and, more famously, activist groups such as the Treatment Action Campaign (TAC) are importing and making less expensive generic antiretroviral drugs available in defiance of international and national commercial law. These help to prolong the lives of people who then have access to them. But this can only be regarded as an interim solution, because the nongovernmental groups do not have the finances to sustain the distribution of the medications.

With medication, AIDS has become a chronic manageable disease. There are debates about the morality and legality of provision of generic life-saving drugs, about the Doha agreements on TRIPS of the World Trade Organisation, about access to some of the trade deals in President George W. Bush's March 2003 budget of US$15 billion for combating AIDS worldwide, etc. It is not the purpose of this paper to navigate these complicated issues.

On this issue, I would say only that it is the responsibility of governments to provide, to the very best of their ability, for the health of their citizens. More and more pharmaceutical companies are making their drugs available to the South African and governments of other developing countries at costs much lower than can be commanded on the international market.[76] Those governments thus have less and less reason not to make such life-saving medication available to their citizens.

Actuarial Projections of Mortality

While there have been many scare-stories on the effects of AIDS on South African mortality,[77] there are also numerous more sober actuarial projections for the effect of AIDS on the South African population. While these may differ substantially in detail, they are all in agreement that the effect will be devastating. Millions of people will die of the disease, and it is mostly younger, potentially economically active, people who will succumb.

We will consider here only two of the many projections, namely the September 2001 projection of the Medical Research Council[78] (MRC) in conjunction with the November 2002 projection of the Centre for Actuarial Research (CAR) at the University of Cape Town.[79] This collaborative work was the most recent at the time of writing, considers sources of its own possible inaccuracy, and gives an idea of what the effect of AIDS will be up to the year 2010.

76.See GlaxoSmithKline, *GlaxoSmithKline Again Reduces Its Not-for-Profit Price of HIV/AIDS Medicines for the Developing World*, press release (GlaxoSmithKline, 2003, 28 April), Http://www.gsk.com/media/pressreleases.htm viewed on 29 April 2003.
77.Piet Meiring, "*Laaste woord oor VIGS is nog nie gespreek*," *Die Kerkbode* 149 (26 June 1992): 6.
78. Rob Dorrington, et al., *The Impact of HIV/AIDS on Adult Mortality in South Africa* (Tygerberg: Burden of Disease Research Unit, Medical Research Council of South Africa, 2001 September), Www.mrc.ac.za/bod/complete.pdf viewed on 28 September 2001.
79.Rob Dorrington, Debbie Bradshaw, and Debbie Budlender, *HIV/AIDS Profile in the Provinces of South Africa: Indicators for 2002* (Cape Town: University of Cape Town Centre for Actuarial Research, Medical Research Council, Actuarial Society of South Africa, 2002 November), Www.mrc.ac.za/bod/AIDSindicators2002.pdf viewed on 15 April 2003.

On page 21, figure 6, the MRC model indicates that by the year 2010 "Premature adult mortality, indicated by the probability of a 15 year old dying before the age of 60 (45q15) will more than double, rising to as high as 800 out of 1000, i.e. 80%." In other words 80% of South Africans will not reach 60 years of age.

Page 25, table 5 shows that life expectancy in 2000 was 55 years. By 2010, this will drop to 40. So AIDS is responsible for a drop in life expectancy of 15 years. This means that the average South African will not reach old age. This is in marked contrast with the situation in 1990, of which the projection says on page 40: "...the age distribution of the deaths of Africans in 1990 shows the mode for the adult deaths is still in old age for both men and women." Thus the country is changing from one in which the majority of the population die in old age to one in which the majority of the population die before they are forty.

On page 22, figure 7 shows: "...by the year 2010 the cumulative number of HIV/AIDS deaths is expected to exceed 6 million, while the number of AIDS sick people will be well over 1 million." In 2000, AIDS accounted for 25% of all deaths in South Africa, and was the single biggest cause of death. By mid-2002, the CAR model estimated that AIDS was responsible for 40% of the deaths in the country.[80] In the future it will be even more significant a cause of death, as more and more people succumb to opportunistic infections.

The MRC projection used an actuarial model called ASSA600, published early in 1996. The results of the application of this model were compared with three others (- the US Bureau of the Census, the United Nations and the Metropolitan-Doyle model) all of which gave results of a similar order of magnitude. As more data became available about the effects of the pandemic, and as more understanding was gained, the model has been

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80.Dorrington, Bradshaw, and Budlender, *HIV/AIDS Profile in the Provinces*, 6.

modified, and the CAR based their 2002 calculations on the ASSA2000 model, using antenatal data from 2000. Whichever actuarial projection is used, consensus exists around the fact that AIDS is responsible for and will continue to account for the deaths of millions of people in South Africa.

The AIDS pandemic in South Africa will have previously unseen social and economic effects. As parents die, the number of orphans will increase, many of whom, themselves will be infected with HIV. Those children who are fortunate enough to have living relatives who are able to take them in and care for them will often be perceived as a burden on their new families. Many children are being cared for by their grandparents. Those who do not have relatives to care for them may end up in foster homes or institutional care, of which there is woefully inadequate provision in South Africa. Many more children will end up as 'street children,' relying on their wits to survive with no fixed shelter or source of income. The phenomenon of child-headed families is growing, in which a child is caring for younger siblings, and often for ill relatives. Children will be increasingly vulnerable to exploitation.[81]

Households will be increasingly poor as money is spent on medication and ultimately funerals. The presence of greater numbers of ill people in a household will mean a reduction in household income, as members are unable to go out to do regular remunerative work.

In the field of education, declining numbers of educators will be healthy enough to continue teaching. Those who are ill or who die will have to be replaced. Badcock-Walters predicts a corresponding reduction in the age and experience of the professional

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81.For the texts of a workshop on Christian responses to the orphan crisis, held at the Goedgedacht Trust in Cape Town, on 28 September 2000, the reader is referred to Http://www.goedgedacht.org.za/new/reports_pub/divine.doc viewed on 23 September 2003.

educational corps.[82] Learners are likely to drop out of the system with lower levels of education as members of their family require care, or as there is no money available in the home for education. Badcock-Walters sees the AIDS crisis as an opportunity for creative thinking to review and restructure the provision and way of education in the country.

(9) Conclusion

We have seen that AIDS is an all-pervasive reality in South African society. People of all ages are afflicted by the pandemic. The HIV is transmitted through a number of different means, of which we considered sexual, parenteral and perinatal vectors. Some cultural and social features, among which the migrant labour system features prominently, exacerbate the spread of the disease.

The disease has taken root in South Africa in the context of a legacy of imbalance in the provision of health care for black people by the previous government, and of the denial of the gravity of the situation by the present government. In a subsequent chapter we will consider the contribution of the traditional (non-Western) health care givers to the treatment of the pandemic.

HIV-infection invariably leads to death for the majority of South Africans who have no access to antiretroviral treatment, and who are often poor and under-nourished. It is not entirely clear what effects this high rate of mortality will have on the county as a whole, but there are foreseeable problems in the provision of education, care for orphans, maintaining a skilled workforce, and even in the provision of sufficient ground to bury so many people. This is to say nothing of the effects on morale and optimism that the

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82.Peter Badcock-Walters, “Education,” in *Impacts and Interventions: The HIV/AIDS Epidemic and the Children of South Africa*, edited by Jeff Gow and Chris Desmond (Pietermaritzburg: University of Natal Press / UNICEF, 2002), 109.

pandemic will wreak. It is to these more spiritual dimensions that we now turn our attention.

(10) AIDS Raises Context-Specific Questions for Theologies - A Brief Survey

It is the purpose of these few pages to give an impression of where the theological discussions and reflection around the AIDS pandemic has taken place, with particular reference to work in South Africa. We propose neither to cover all the ground, nor to offer full consideration of each topic raised. Rather, it is to situate the systematic work which we will do in the coming chapters. We will look here at some systematic, ethical and pastoral questions that have arisen in publications in South Africa, and where necessary, relate them to international material. But it is two of the systematic questions that we will investigate further in subsequent chapters.

(a) "Systematic" Questions

The major theological implication of the crisis is surely a consequence of the fact that AIDS is responsible for the deaths of millions of young people. They have not lived what would under normal circumstances be considered a full life, leading to old age and handing on of wisdom and the transmission of the faith to their own children. The very act of transmitting life has become a source of death. Thus the questions of the meaning and purpose of life and its fulfillment are raised.

For a society in which the attaining of the status of ancestor is regarded as fulfillment of life, the very meaning of life comes under scrutiny. AIDS prevents the attainment of ancestor-status, since most people who succumb so some AIDS-related illness die young, certainly prematurely in most ways of considering the normal lifespan.

Akin to this question is: what, if anything, awaits us after this temporal experience. This is where the question of the ancestor cult in South Africa is of relevance. Does the

cult of the ancestors hold a more optimistic eschatological outlook than traditional Christian eschatology? This will be studied in depth in a subsequent chapter of this work.

Christianity, being a religion of salvation, should have something to say about the soteriological implications of a crisis in which hundreds of people are dying daily. How can talk of salvation not ring hollow in the face of probable premature death? In what way can Christ be considered to be universal saviour when there is a situation crying out for divine remedy? Is the multivocality of the term "salvation" not a potential source of false expectation? Does salvation amount to avoidance of infection and its accompanying death sentence? Clearly the meaning of salvation should be clarified.

Nürnberger[83] relates the suffering caused by AIDS to salvation wrought by the suffering of Christ on the Cross:

> Here a terrible human catastrophe is proclaimed to be God's act of salvation. If he can turn such a disaster into his prime tool of redemption, then he can also turn our own disasters into tools of redemption. Looking at the cross, Christians believe that, in spite of all the evil encountered in this world, God is for us, and with us, and not against us. In Christ he leads us through suffering to glory, through death to life.

The circulated but unpublished Lutheran / Moravian document[84] to which Nürnberger is offering a critical introduction, chooses to speak of redemption, rather, in terms of God's suffering acceptance. The parable of the Lost Son is cited as an example of God accepting the unacceptable person into fellowship with God. "It is the fellowship of God itself out of which redeeming power flows.... Transformation is not the condition of acceptance, but it is indeed the consequence. God expects us to get healed in his fellowship."

83.Klaus Nürnberger, *Theology of AIDS - A Lutheran/Moravian Case Study*, Critical Introduction to the Lutheran/Moravian Proposed Programme (2002), 3, Http://www.cpsajoburg.org.za/hivaids/theology_of_aids.htm viewed on 16 April 2003.
84.Lutheran and Moravian Churches in Southern Africa, *Proposed Programme for the Lutheran and Moravian Churches in Southern Africa to Respond to the HIV/AIDS Crisis* (2000), 6f.

It appears that here is the nexus of salvation for the Lutheran / Moravian study in the context of AIDS. It takes place within the Christian community. Christians are called upon to accept people suffering with HIV/AIDS and in their suffering acceptance of the unacceptable, to be transformed themselves, and to assist in the redemption of the person with AIDS:

> Not only the infected persons themselves, but, together with them, the affected families, the congregation, and the community as a whole enter into a process in which they are transformed into a responsible, accepting, coping, caring, supporting community.

This introduces the equally systematic questions of christology and ecclesiology. Susan Rakoczy IHM advances the argument that the AIDS pandemic presents a new *kairos* for South African society, in which "[t]he future of the country and the credibility of the Christian community is (sic.) at stake."[85] In the tradition of liberation theology, Rakoczy proposes three images on which the Christian community might model its transformative praxis: the compassionate Christ, "voice of the voiceless" and iconoclastic prophet.

In the ecclesiological vein, Kevin Dowling notes: "The body of Christ has AIDS. The Church has AIDS. It is our people who are living, suffering and dying because of this virus."[86] One cannot separate the Church and AIDS. Bishop of Rustenburg, a diocese which is the temporary home of many migrant mine workers, Dowling is also responsible for the AIDS Desk of the SACBC and is confronted daily with the pandemic.

The AIDS crisis raises the question of theodicy. The pandemic brings enormous personal emotional, physical, familial and social suffering. How do Christians explain such suffering? Casimir Ruzindaza says: "Due to the acute sorrow involved in most cases of

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85.Susan Rakoczy, "Christology in the Context of the HIV/AIDS Pandemic," *Grace and Truth* 18, no. 2 (2001): 15.
86.Kevin Dowling, "Africa's Aids Heroines," *The Tablet*, 30 November 2002, 6.

AIDS-caused premature deaths, there is always a temptation of looking at this kind of calamity as a punishment from God."[87]

On the question of suffering, Dowling writes:

> It is vital that we do not make an instinctively defensive response to those who criticise our positions. A theology of Aids must reflect how people live. When, for example, the child whose parents have died of Aids tearfully looks up at one of our sisters and asks "Why does God hate us so much that he takes away our parents?", we must be careful not to take refuge in doctrines. There are times when, in the face of the great suffering of the infected and affected, we can only be speechless. In the face of Aids, we need a trustful willingness to rest in uncertainty, without grasping at reason.[88]

Writing from a Calvinist perspective, J.H. van Wyk,[89] relates the theodectic question to that of eschatology. He makes the connection between AIDS, sin and the judgement of God. While the Scriptures present an undeniable relationship between sin and God's judgement, the nature of this relationship is neither transparent nor of a simplistic causality. Because this relationship is not completely transparent, one must not think that AIDS is outside of the sovereign reign of God and the lordship of Christ. Suffering, says van Wyk, is one way in which God prepares the new order, and is thus a call to repentance in preparation for the coming judgement, forgiveness and fulfillment.

In an even more moralistic manner, Andrew White[90] also links the AIDS pandemic with eschatology and divine judgement. The suffering of people with AIDS is a manifestation of God's revelatory, retributive, purificatory and corrective judgement. This judgement is both present and future, particularly for homosexual men and intravenous drug users. These were the two core groups of AIDS sufferers in the USA when White wrote. On p.81, White regards the AIDS pandemic and associated judgement as events

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87.Casimir Ruzindaza, *Living Positively with AIDS: An African Experience* (Nairobi: Paulines Publications Africa, 2001), 86.
88.Dowling, "Africa's Aids Heroines."
89.J.H. van Wyk, "*VIGS in visier: 'n teologies-etiese besinning*," *Koers* 56, no. 3 (1991): 409–23.
90.Andrew A. White, "AIDS as Divine Judgement," *Journal of Biblical Ethics in Medicine* 2, no. 3; 4 (1988): 60–67; 79–82.

of significance for the modern world: "Further, the failure to recognize God's disposition of judgement in this major event in the history of the world is to fail to recognize a significant aspect of its meaning." They are signs of a realised eschatology.

(b) "Ethical" Questions

In a more ethical vein, are the questions of human relationships and the place of sexuality in the context of these relationships. Dowling says:

> Catholic moral theologians can no longer assess human actions in the abstract regardless of context, but as choices arising out of a "fundamental option" about the way to live. They also highlight the sinfulness of structures which make individual choice all but impossible.[91]

For the first time, the Catholic Church is articulating a more comprehensive sociologically-informed understanding of sexual behaviour. Beyond the unitive and procreative dimensions of the sexual act acknowledged in *Humanae Vitae*, it is indisputable that sexual intercourse is a means of economic exchange in situations of grinding poverty. This reality falls short of the Christian ideal, but the hierarchy is careful not to characterise the behaviour as 'sinful.'

Dowling is perhaps best known for his lone stand in the SACBC that would permit the less restricted use of condoms as a means of preventing transmission of death. He sees this stance as consistent with the tradition of Catholic moral teaching of promoting life. In more general terms, Dowling would condone the use of condoms to prevent the transmission of the HI Virus when there is the possibility that either of the partners has the virus.[92]

The SACBC's "Message of Hope"[93] encourages sexual abstinence before

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91.Dowling, "Africa's Aids Heroines."
92.Kevin Dowling, "An Explanation of What Has Been Published About Bishop Dowling and AIDS/condoms: Statement Issued Before the Plenary Meeting of the SACBC," *Sunday Times*, 9 July 2001, Http://www.sundaytimes.co.za/health/aids/dowling.asp viewed on 30 July 2003.
93.SACBC, *A Message of Hope from the Catholic Bishops to the People of God in South Africa, Botswana and Swaziland*, Message from the July Plenary Session (Pretoria: SACBC, 2001),

marriage and faithful monogamous relationships. It has a call to conversion, prayer and action. The Message, however, is unequivocally against the use of condoms. The bishops argue that the promotion of condoms contributes to a message undermining the moral fiber of the nations. However they concede the permissibility of the use of condoms as a means of preventing the transmission of HIV between serodiscordant *spouses*.

This Message has not been without its critics within and outside the Catholic Church. For example, Philippe Denis OP considers that while the bishops' call for abstinence and conjugal fidelity as the answer, and their condemnation of the use of the condom, make sense, they are also unjust and dangerous. They are unjust because they do not consider the real lives of broken families in South Africa, and are not within the grasp of ordinary men and women. They are dangerous because they contribute to the conspiracy of silence surrounding sexuality in South Africa.[94] Denis believes it is important to re-examine sexuality, particularly in the case of sexually active youth.

A group of Dominican theologians have published a similar view, maintaining that the Church should consider more compassionately the debate in favour of the use of condoms. While the condom is not an entirely reliable means of defence, it does prevent the transmission of the virus in the majority of cases. If even one life is saved from infection, it is a victory. The Conference is urged also to bear in mind that many people are unable to live up to the Christian ideal of marital fidelity, due to circumstances of poverty, isolation, and exploitation often entirely beyond their control. The Dominicans say that: "HIV/Aids is a social problem, not only a problem of personal morality. It is not only the individual who is called to conversion. Industry, advertising, corrupt officials who leave people in poverty and despair through their selfish acts, persons who regard HIV as God's

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Http://www.sacbc.org.za/hope.htm viewed on 21 September 2001.
94.Philippe Denis, "Sexuality and AIDS in South Africa," *Journal of Theology for Southern Africa*, no. 115 (March 2003): 73f.

curse, all of us, in fact, are called to conversion."[95]

A notable characteristic of the Catholic debate over condom use in South Africa has been the shortage of reference to the same question in similar conditions outside of the country. For example, the debate between Jon Fuller, James Keenan and Jacques Suaudeau (of the Pontifical Council for the Family) was widely reported in the Catholic media. But this debate has not been used to enlighten either side of the discussion in South Africa. In essence, Fuller and Keenan[96] see in Suaudeau's article[97] a signal tolerant of the use of condom as prophylaxis for the containment of HIV. They read in the article an acceptance of the 'lesser evil' of the use of condoms after establishing the primary principles of sexual abstinence and marital fidelity. The riposte by Suaudeau[98] maintains this is an erroneous interpretation of a particular passage citing the use of condoms among prostitutes in Thailand. The term 'lesser evil' is used in an epidemiological and not a moral sense.

In June 2001, Fuller and Keenan argued in a lecture tour of six European cities, that:

> ... an effective response to the need for immediate prevention through condoms and needle exchange need not threaten Catholic orthodoxy. The Church's teaching in *Casti Connubii* and *Humanae Vitae* is directed against contraceptive acts, not just against condoms or birth control pills as such..... [C]ondoms can be used for purposes other than contraception.

It is this aspect of the use of condoms that must be borne in mind when couples are being advised to use them as protection against the transmission of AIDS. The

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95.Martin Badenhorst, Philippe Denis, Kees Keijsper, and Munyaradzi Murove, "A Catholic Opinion on Condoms and AIDS," *Sunday Times* (2001), Http://www.suntimes.co.za/health/aids/dominican.asp viewed on 30 July 2003.
96.Jon Fuller and James F. Keenan, "Tolerant Signals: The Vatican's New Insights on Condoms for HIV Prevention," *America* 183 (23 September 2000): 6–7.
97.Jacques Suaudeau, "Prophylactics or Family Values? Stopping the Spread of HIV/AIDS," *L'Osservatore Romano Weekly Edition*, 19 April 2000, 9–10.
98.Jacques Suaudeau, "Prophylactics or Family Values? Stopping the Spread of HIV/AIDS," *L'Osservatore Romano*, 27 September 2000, 2.

technology, while originally designed to prevent the transmission of life, is now being used in the battle against death.

Other ethical issues centre around the provision of medical treatment, of drugs, and the uneven distribution of life-enhancing medications across the world. These issues are raised by Noël Simard[99] and are also addressed by Marliese Smurthwaite.[100] The worldwide AIDS crisis has led governments to re-evaluate TRIPS and allow that generic copies of life-saving drugs be manufactured and distributed in the circumstances of pending disaster.

J.H. van Wyk makes a very clear connection between the pandemic and political ethics in South Africa. He asks whether the high rate of HIV infection among black people in South Africa 'goes together with poverty and squatting, job-reservation and unemployment, migrant labour and political discrimination, in short, with the total political framework in which the black population lives.'[101] He says that government policies hold consequences for sexual and marriage ethics, and that an immoral structuring of society brings damaging moral consequences, and that these will last a long time. Acknowledging that the country is in a situation of transition, van Wyk does not make specific recommendations for radical political change.

Obviously the possibility of contracting a deadly virus from one's sexual partner has a profound effect on the way people regard each other. Emmanuel Katongole[102] argues that suspicion is becoming "a cultural pattern of life." This will be a lasting legacy of AIDS on African life, resulting in cynicism and nihilism. Promoting condoms as the

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99.Noël Simard, *AIDS: Ethical and Spiritual Considerations*, translated by Marie Evans Bouclin (Sherbrooke, Québec: Médiaspaul, 1997), 207–11.
100.M.E. Smurthwaite, "The Moral Responsibilities of the Pharmaceutical Companies, Government Leaders in South Africa and the World Health Organisation and NGOs as Regards the Issue of AIDS in Africa," *St Augustine Papers*, March 2001.
101.van Wyk, "*VIGS in visier," 418.*
102.Emmanuel M. Katongole, "Christian Ethics and AIDS in Africa Today: Exploring the Limits of a Culture of Suspicion and Despair," *Missionalia* 29, no. 2 (August 2001): 146.

solution to the crisis will make people see their partner in terms of a potential 'danger' from whom they must protect themselves. They will consequently lack any serious commitment and attachments to the other. This profound philosophical change will undermine the interdependence which is the fabric of African social life. People living with the virus will move to despair and nihilism and want to take others "down" with them.

Katongole concludes[103] that it is the theological and ethical challenge to "provide alternative symbols, images and practices" to prevent this cultural change. The death and resurrection of Christ should become the primary hermeneutical grid through which Christians narrate their existence. The Church must provide a vision which values rather than deflates individuals living with AIDS. A powerful cultural regeneration is necessary, which does not simply retrieve or reaffirm African traditions, but which displaces the power of the pandemic. The paschal mystery should be celebrated in the Eucharist in a way that replaces despair with hope, cynicism with love, nihilism with commitment.

Last but not least among the ethical questions to be considered is how patriarchal theological assumptions and practice of some churches have contributed to the situation that women are in a position of weakness when it comes to negotiating relationships. An urgent return to the sources of Christian life is necessary to redress this situation. Christian witness should be a prophetic voice in this wilderness.

(c) "Pastoral" Questions

The AIDS pandemic raises the question of pastoral care of people living and dying with HIV and AIDS. "Christians have to develop a pastoral theology that measures up, based on a deep appreciation of the value of human life and a holistic understanding of the human person."[104] Should there be a special pastoral outreach to people dying of this

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103.Katongole, "Christian Ethics and AIDS in Africa Today," 158f.
104.Dowling, "Africa's Aids Heroines," 7.

particular disease? Or should people with AIDS form part of the ordinary pastoral care of the Church? The particularly tragic circumstances clearly require a greater pastoral sensitivity, given the relative youth and the family circumstances of the people receiving care.

Certainly every effort must be made by the pastoral care-givers to abandon any prejudice they might associate with the disease. The hint of any negative judgement of the patient suffering from AIDS will be counterproductive in the caring relationship. In a (relatively) early article on AIDS and pastoral care in South Africa, Saayman and Kriel write of the necessity to dispel the stereotypes that associate AIDS with homosexuality and with race, respectively. "[B]ecause both are a tremendous hindrance in pastoral and educational work. AIDS has nothing to do with homosexuality as such, nor has it any specific relationship with Africa or African culture."[105]

In a subsequent article, Saayman feels that the Christian community is still not doing enough to confront the pandemic. The biomedical interventions aimed at spreading the use of condoms are not geared towards "altering the pattern of sexual relations underlying the spread of HIV/Aids, but simply at preventing or retarding the spread of the 'harmful agent'."[106] He states that we "have to move outside the dominant biomedical "philosophy," into the realm of cultural, sexual and moral norms."

Saayman, professor emeritus in the Department of Missiology at the University of South Africa (UNISA), probably does not have the Catholic Church in mind here, when he speaks of the necessity to move into the realm of sexual and moral norms. Both of the statements of the SACBC before 1999 are firmly in the realm of sexual and moral norms.

105.Willem Saayman and Jacques Kriel, "Towards a Christian Response to AIDS," *Missionalia* 19, no. 2 (1991): 155.
106.Willem Saayman, "AIDS - Still Posing an Unanswered Question," *Missionalia* 27, no. 2 (August 1999): 212, footnote 3.

The first,[107] proposes "premarital chastity and marital fidelity as the best protection against Aids." The bishops state the "Conference regards *equally abhorrent* the scourge of Aids, so destructive of human life, and the response of the South African government making provision for so-called safe sex, however indiscriminate, by the use of condoms." (emphasis mine.) After emphasising the Christian pastoral response to the pandemic, the second statement,[108] dwells on the need for a change in sexual responsibility and it makes the link with the need for radical changes in structures of social injustice which promote the spread of AIDS. With remarkable prescience the statement begins to spell out some of the future effects of AIDS on South African society. It also calls on those responsible for the general welfare to ensure that no incidence of AIDS might be used as an opportunity for exploitation.

Sam Pick[109] considers the pastoral responsibility of the Church under a number of rubrics: The Church is a healing community and should approach the pandemic in a hands-on way. He advises members to give pastoral accompaniment to patients, their families and the broader community. The book, written in Afrikaans, for a mainly Dutch Reformed readership, is clearly written with the ordinary lay person in mind. The Calvinist churches in South Africa do not have as large a corps of professional religious workers who are involved in full-time ministry as does the Roman Catholic church for example. So the book is timely in encouraging the non-professional lay person to become involved in hands-on ministry.

Stephen Lewis, Special Envoy of the UN Secretary General for HIV/AIDS in Africa, acknowledges the pastoral work that religious organisations do in the realm of AIDS. In

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107.Southern African Catholic Bishops' Conference (SACBC), "Statement on AIDS," in *The Bishops Speak*, Volume V (Pretoria: SACBC, 1988, 5 May), 30.
108.Southern African Catholic Bishops' Conference (SACBC), "Pastoral Statement of the Southern African Catholic Bishops' Conference on AIDS," in *The Bishops Speak*, Volume V (Pretoria: SACBC, 1990 January), 129–36.
109.Sam Pick, *MIV/VIGS - ons grootste uitdaging nog! Die pad vorentoe vir die kerk in Suid Afrika* (Wellington (Cape): Lux Verbi B.M., 2002).

his address to the Assembly of African Religious Leaders on Children and HIV/AIDS, he says that

"[r]eligous communities provide vital care to the ill and the dying at village level."[110] However he challenges the religious leaders of Africa to be proactive in denouncing the stigma attached to AIDS, in abolishing school fees in order to enable orphans and vulnerable children to attend school, in influencing political leaders in the North and the South to make good their promises of assistance. His vision has religious leaders co-operating not only among themselves, but also with secular powers in order for death not to be the final victor.

This raises the question of ecumenical and inter-religious dialogue. These were important factors in the struggle against apartheid from the 1970s to the 1990s. The experience of many people involved in this struggle was that dialogue itself did not prove very useful, but that it was in joint action that people of different faiths and of none came together with a common task and vision. It is evident that such common action should be a feature of the struggle against AIDS. It is likely that there will be different agendas and visions, but that should not detract from the active demonstration of love and commitment to overcome the scourge and to deal with its effects.

(11) Afterword

In August 2003, after years of resistance, the President of South Africa announced that he would instruct his cabinet to make provisions for the nationwide deployment of

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110.Stephen Lewis, "Address by Stephen Lewis, Special Envoy of the UN Secretary-General for HIV/AIDS in Africa to the African Religious Leaders Assembly on Children and HIV/AIDS, Nairobi, Kenya" (2002, 10 June), 3, Http://www.uoguelph.ca/~citizen/doc/African_Religious_Leaders_Assembly.pdf viewed on 21 August 2003.

antiretroviral therapy (ART) within a month. Thus, by September 2003, ART was supposed to be available across the country. This major policy change was greeted with enthusiasm and considerable justifiable self-congratulation by many lobby groups and activists who had been advocating the universal provision of affordable ART.

However, this is more of a symbolic than a definitive victory. The rapid deployment of ART is not going to mean the 'salvation' of the situation. It is imperative not to overestimate the immediate significance of this decision. As the Chief Director: HIV/AIDS and TB of the Department of Health explains, the health care system is not ready to rise to the task. If suitable health care professionals can be found, it will take some time till they are sufficiently trained to implement the programme. "It is therefore important to ensure that health workers are trained in this component of AIDS care, especially on issues such as drug interactions, adherence, and managing adverse events."[111] To provide this training, Silemela proposes the establishment of centres of excellence in AIDS care in the existing medical schools. This is clearly a long-term goal and does not reflect the urgency with which the ART is needed in order to begin saving lives immediately.

This is not unnecessary foot-dragging on behalf of the government, but is in line with current best practice. ART is relatively complicated therapy that requires frequent monitoring, and has side-effects and long-term complications. If the therapy is not administered consistently, drug-resistant strains of HIV may develop, which will be more difficult to treat in the future.[112] For these reasons, the Canadian Public Health Association (CPHA) is opposed to the rapid deployment of ART in resource-poor settings. Besides redirecting scarce resources from prevention programmes, ART may be

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111.Nono Silemela, "Achieving Excellence," *Perspective: African Journal on HIV/AIDS*, no. 5 (2003): 83.
112. It is important that the drugs be taken according to a strict schedule. Hence the concern of articles such as Ivan Oransky, "African Patients Adhere Well to Anti-HIV Regimens," *The Lancet* 362, no. 9387 (13 September 2003): 882, which allay fears that the precision required in the ART is beyond the ability of African patients.

perceived as the panacea that leads people no longer to be as vigilant in prevention of HIV transmission.

> The central issue is the capacity of the country to deliver ART rather than the cost of the drugs themselves. The Association, while recognizing that there will be obvious benefit for some who have access to ART, believes that the long-term solution lies only in developing a safe, effective and equitable delivery system, which cannot be achieved by merely flooding the market with drugs.[113]

Karim, of the Medical School of the University of Natal writes of the enormous task to introduce HAART (Highly Active Antiretroviral Therapy) in 27 pilot sites in four of the nine provinces:

> Efforts to overcome operational constraints to national coverage of AIDS treatment include: urgent procurement of medicines; speedy accreditation of treatment sites; resource allocation to underdeveloped sites to build capacity for site accreditation and treatment roll out; clear, accurate, and appropriate advice on testing, treatment, nutrition, and prevention; and training and support of health-care personnel.[114]

Hence, while it is a step in the right direction, the decision of the South African government to provide ART is not going to salvage the situation overnight. The drugs are one major strategy in the battle against HIV/AIDS but can only be effective in the context of a comprehensive improved health and nutritional infrastructure.

The question of the treatment of people with AIDS directs the further work of this thesis. The Prime Minister and Minister of Health, Manto Tshabalala-Msimang maintain that as a disease affecting Africans, AIDS should be treated with African remedies. Making the point that good nutrition is an essential dimension of preventing the onset of AIDS, Tshabalala-Msimang has said repeatedly that African potatoes, olive oil, lemon and garlic are essential ingredients of a balanced diet that can help to boost the immune

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113.CPHA, "2002 Position Paper on the Opportunities and Challenges of Introducing Anti-Retroviral Therapy (ART) in Resource-Poor Settings," paper presented at Annual General Meeting of Canadian Public Health Association (CPHA) (2002), 4.
114.Quarraisha Abdool Karim, "HIV Treatment in South Africa: Overcoming Impediments to Get Started," *The Lancet* 263, no. 9418 (24 April 2004): 1394.

systems.[115]

I do not share the ideological stance of the ministers. But I do recognise that it is appropriate to use what tools are available to Africans in dealing with a crisis that is affecting millions of Africans. While the ministers seek African nutritional and medicinal ways to assist people with AIDS, other Christians wishing to offer "spiritual" support to people with AIDS might look among African spiritual resources.

The primary resource to which many Africans turn is the cult of the ancestors. This ancient part of life in Southern Africa belongs within a worldview with its own eschatological dimension. It is used to explain suffering and misfortune, as well as to offer ritual healing and social integration. It connects individuals with their forebears as well as rooting them to the earth from which they spring up and to which they return upon death.

In the following chapter I will examine the cult of the ancestors in the context of present South Africa. I will try to show as clearly as possible the way it is lived in the modern situation, with reference to current and historical anthropological and religious writing. The subsequent chapter will take a more diachronic approach, to show the way in which the cult was initially persecuted by Christian missionaries and later cautiously allowed into mainstream Christian life and practice. This will allow us to address the question, in the fifth chapter, of what "salvation" might be hoped for in the context of the AIDS pandemic.

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115. See, for example, Kalay-Vani Nair, "Manto Again Prescribes Garlic," *Mail and Guardian*, 9 February 2004, Http://www.mg.co.za/Content/l3.asp?ao=30905&t=1 viewed on 5 July 2004.