# The Church and AIDS in Africa

## The Politics of Ambiguity

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## Tables

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# 1
# AIDS and Christianity in Africa

Churches in sub-Saharan Africa have been maligned, vilified, praised, and ignored for their role in the fight against the Acquired Immunodeficiency Syndrome (AIDS). Such divergent reactions from scholars, activists, and development officials are unsurprising given the diversity of church responses to the pandemic.[1] Contrast the public statement of Dr. Kwesi Dickson, former general secretary of the All Africa Conference of Churches, with that of Bishop Boniface Setlalekgosi, head of the Catholic Church in Botswana. In a 2003 speech, Dickson placed AIDS in the larger context of poverty, poor governance, and underdevelopment in Africa. He demanded that both governments and churches pay greater attention to the Africans whose lives were being decimated by poverty and disease (*AACC Newsletter*, November 25, 2003). Conversely, Bishop Setlalekgosi took a more narrow approach, portraying AIDS as a question of individual morality. He wrote in a 2004 letter to youth: "Unfortunately, you are ... flooded with wrong messages that give false security, that of 'condomise and stay alive'" (*Mgegi/The Reporter*, August 6, 2004).

Or compare the actions of Prophetess Lucy Nduta of the Nairobi-based Salvation Healing Church with those of congregants in a Cape Town Baptist church. The prophetess insisted that she cured her followers of the Human Immunodeficiency Virus (HIV), the virus that causes AIDS, through prayer and healing services (*Nation*, May 22, 2006). Her actions illustrated her belief in the power of the invisible, spiritual realm to overcome the physical world's problems. In contrast to her spiritual approach, the formation by South African Baptists of the Living Hope Community Centre was rooted in the physical world. The Baptist congregants responded to the immediate physical needs of people living with HIV/AIDS because of their conviction that a combination of physical and spiritual support can improve quality of life.[2]

These four examples illustrate points along the spectrum of church responses to AIDS. While they could be studied as contrasting models of service provision or as the embodiment of theology in practice, my interest in them is in their political nature. Politics is the process of decision-making that shapes resource allocation and acceptance of particular values. Politics occurs in formal arenas, such as legislatures, election campaigns, and bureaucracies, but it also exists in civil society organizations, families, and the workplace. The above-mentioned church actions directly or indirectly challenge power structures in society, and they seek to affect decisions about resource allocation and the acceptance of certain values. When Dickson challenged governments on the relationship between AIDS and poverty, when Bishop Setlalekgosi and Prophetess Nduta used faith to point to powers beyond science, and when the Baptists reached out to marginalized members of society, they all engaged in politics.

At times the AIDS activities that are discussed in this book do not look political. What is political about caring for someone who is dying from AIDS or about urging youth to abstain from sex? I argue that there is something "subversive" about these actions (Miller and Yamamori 2007, 5); they sometimes challenge the established science on AIDS or the donor community's policies; they question the ability of the state to meet its end of the social contract; and they defy global and national-level political and economic structures that often downplay the human rights and dignity of poor Africans. In so doing, many churches are engaging in a form of social activism, or a process by which they challenge the status quo in their churches, communities, countries, and/or the international realm.

The currency of such political activism is power. Power can be rooted in tangible elements, like government authority, material resources, large constituencies, expertise, and tools of physical coercion. Dickson and the All Africa Conference of Churches have some of this tangible power, since the organization counts as members 169 churches, church councils, and theological institutions in forty countries, and it represents more than 120 million African Christians (AACC 2008). But power is also located in intangible sources such as moral authority, symbols, and, for many Africans, the spiritual realm. The Catholic bishop's letter relies on his moral authority, and the prophetess who claims to cure HIV taps into the idea that "spiritual belief offers access to an alternative form of power" (Ellis and ter Haar 1998, 195). Symbolic metaphors rooted in religious imagery or texts may either mobilize or demobilize participation in AIDS efforts (see Vander Meulen 2010). Unlike Western liberalism, African conceptions of

politics and religion do not divide the sacred and the secular. Even if formal constitutions outline a secular state, political life is often "inextricably bound up with religious belief" (Jenkins 2007, 162). The public and private actions of churches themselves influence politics (VonDoepp 1998). While my focus is on Christian majority states, this is also true in countries with large Muslim majorities, as Muslim leaders' long-time involvement in elections in Senegal illustrates (Villalón 1995).

Just as has been the case with secular efforts to address AIDS, religiously based responses involve contentious processes of identity formation and frame alignment. Religious adherents have struggled both among themselves and in relation to secular activists to define a common identity that drives their involvement on AIDS. While some religious actors involved with AIDS are HIV-positive, this is not the case for all participants. What identity then facilitates action? The development of a unifying identity to propel activities is a process shaped by power, representation, and constructs of ideas (Melucci 1996). Similarly, the process of framing the AIDS issue may include some, while excluding others. For example, when AIDS is framed as an issue that primarily affects innocent women and children, then HIV-positive men are excluded from potential policy outcomes or mobilization efforts. The way the issue is understood affects who gets access to resources and power (Snow et al. 1986); such processes occur in religious institutions just as they do in secular groups.

In this book, I use the word *church* broadly, to mean both an institution and a community of individual believers. Institutionally, church congregations and denominations have rules, formal and informal norms, officials, material resources, and histories (North 1990, 3). My institutional definition includes church-related organizations like health care facilities, advocacy wings, ecumenical networks, and centers of theological education. The process of church institutionalization occurs over time, with newer churches often lacking the formal bodies, rules, well-defined liturgy, and specialized leadership training of the churches established by the colonial missionaries. The church is also a fluid and diverse community of individuals who identify themselves as Christian and who believe the biblical messages of Christianity. Newer churches may lack well-defined institutions, but they do not lack the fervor of belief among their members (Jenkins 2007, 157-158). While I do examine church leaders as instigators of AIDS programs, my general focus is on churches as institutions, not on individual Christian believers.

In the pages that follow, I analyze the interactions between churches—as institutions and as communities of believers—and politics on the AIDS issue. These interactions take on various forms, and these forms often are not mutually exclusive. To be clear, I do not argue for more or less church involvement in the political questions surrounding AIDS. The church's role on AIDS is controversial, both within Christian circles and between Christians and non-Christians. In the Western experience, particularly during the first years of the AIDS epidemic, the church was viewed as an obstacle to AIDS efforts. Many AIDS organizations were secular, often organized by HIV-positive gay men and their HIV-negative friends or partners. The regular protests of ACT UP–New York in front of St. Patrick's Cathedral demonstrate this tension. But the situation in Africa has been different, because many members of AIDS groups (both the majority who are HIV-positive and their HIV-negative supporters) are religious believers; they may be church members who regularly attend services, pray daily, and read the Bible. This African reality complicates church mobilization against AIDS and challenges assumptions that religion and activism cannot coexist (Siplon 2010; Dilger 2010).

This book is not intended to be a theological treatise or a defense of or challenge to Christian belief. Rather, I acknowledge that religion is important for a large number of Africans, and as such, cannot be ignored in any analysis of social, political, or economic issues. What I seek to do is to move beyond the tendency to portray churches as either stigmatizing obstacles or charity do-gooders (Dilger 2007, 59). Churches play a complicated role in the AIDS pandemic because of their diverse historical experiences, resources, leadership styles, and theological perspectives. This variation leads to different forms of mobilization and ways to frame the AIDS issue. My assumptions about churches' responses to AIDS were sometimes challenged during the course of the research: churches that I did not think would respond to AIDS had well-developed programs; churches that I thought would be progressive in dealing with AIDS-related issues (such as gender equality or condom distribution) were not. Church interviewees I least expected to be compassionate in the struggle with AIDS told compelling stories of church efforts, while those I most expected to care about the issue dismissed my questions.

What became clear through the research was that making blanket statements about churches and AIDS responses, as both church critics and advocates tend to do, does not contribute to an analysis of church mobilization on the AIDS issue. On the other hand, because social scientists recognize that some generalizations are helpful for examining

patterns of behavior or institutional structures, I set up a five-fold typology of church responses based on the timing and breadth of church AIDS actions: (1) no response; (2) the early, narrow response; (3) the early, broad response; (4) the late, narrow response; and (5) the late, broad response. This model may not initially be intuitive, particularly for readers with strong views on specific AIDS policies, such as condom distribution, abstinence-only education, or HIV prevention efforts to men who have sex with men. As I explain in Chapter 2, rather than narrow my analysis to the substance of one or two policies to classify mobilization patterns, I analyze a wide variety of church responses and the complex reasons for those actions. Given the often dynamic and multi-faceted AIDS activities of many churches, the model provides a more accurate picture of church actions on the ground. Chapter 2 fully defines the model and gives examples. The rest of the book uses explanations based on resources, organizational structures, relations with the state, and global networks to elucidate why churches have fallen into one of the five patterns.

Africa is a religiously plural continent. Even though an estimated 57 percent of people in sub-Saharan Africa are Christian, 29 percent are Muslims and 13 percent practice African traditional religions. When one compares Islam and Christianity across all of Africa, the numbers are much closer, but because North Africa has unique historical experiences, political and socioeconomic linkages to the Middle East, and a predominantly Arab culture, I only focus on sub-Saharan Africa. Surveys and ethnographies further illustrate that adherence to Christianity or Islam south of the Sahara does not necessarily exclude individual involvement in African traditional religious practices, such as the use of diviners or healers. While I acknowledge this complexity, the book limits its scope to focus on Christian responses to AIDS. In Chapters 3 and 5, however, I incorporate analysis of how those church responses have shaped church relations with Muslim and African traditional religious institutions and leaders. This analysis is situated in a context where Muslim-Christian tensions have increased over the last decade, particularly in light of religiously based violence (Pew Forum 2010).

Church AIDS activities occur on a continent where Christianity is growing, many civil society groups play a political and economic role, and bilateral and multilateral donors have given large amounts of funding to faith-based organizations to fight AIDS. To explicate this context, I first provide background on Africa's AIDS pandemic. Next, in order to comprehend how churches differ in their AIDS approaches, I describe the growth of Christianity in Africa and distinguish various

types of churches. Because churches are often defined as civil society organizations, the chapter investigates how adequately the civil society paradigm applies to religious organizations in African politics. Finally, I highlight recent bilateral and multilateral donor attention to churches and AIDS. Increased funding and recognition give these religious bodies a greater stake in AIDS and necessitate that political scientists, donors, and activists more thoroughly investigate their role in AIDS politics.

## African Churches Confront AIDS

Churches have numerous reasons to be concerned about AIDS. The first, and most obvious, is the magnitude of the pandemic. In 2005, the Joint United Nations Program on HIV/AIDS (UNAIDS), the agency that coordinates all United Nations activities on AIDS, predicted that without continued large-scale commitment to fight AIDS, eighty million Africans would die from the disease by 2025 (UNAIDS 2005a, 110). While AIDS is a global problem, sub-Saharan Africa has been particularly hard hit. The region has over two-thirds of the world's thirty-three million people infected with HIV. In 2008, 1.4 million Africans died from AIDS (UNAIDS 2009a).

In reality, AIDS affects African countries differently, with each experiencing its own unique epidemic. HIV epidemics are classified into four types: (1) low-level epidemic; (2) concentrated epidemic; (3) generalized low-level epidemic; and (4) generalized high-level epidemic. In low-level epidemics, HIV prevalence is below 1 percent in the general population and less than 5 percent in key populations with greater HIV infection risks. These most-at-risk groups include commercial sex workers, men who have sex with men, and intravenous drug users. Because HIV tends to be transmitted heterosexually or from mother-to-child during pregnancy, delivery, or breastfeeding in Africa, epidemiologists often rely on HIV prevalence in the general population to classify a country's epidemic. Also, it is difficult to get accurate data on HIV in key populations such as sex workers or men who have sex with men because of the often illegal and stigmatized nature of their activities. For these reasons, I classify epidemics based on prevalence levels in the general population in Tables 1.1 and 1.2.

In the concentrated, generalized low-level, and generalized high-level epidemics, HIV prevalence in key populations is more than 5 percent, although prevalence in the general population differs. In a concentrated epidemic, as found in Senegal and Somalia, less than 1 percent of the general population is HIV positive. In a generalized, low-level epidemic such as in Ghana, Eritrea, and Kenya, HIV prevalence in

the general population is between 1 and 10 percent. Countries with generalized high-level epidemics, such as Zambia, South Africa, and Namibia, have general prevalence rates that are 10 percent or more. Some of the most extreme generalized, high-level epidemics are in the southern African countries of Botswana, Lesotho, Swaziland, and Zimbabwe, where prevalence rates are above 20 percent (UNAIDS 2009a; UCSF 2008).

Beyond the magnitude of the pandemic, churches are interested in AIDS because the Bible commands believers to care for the sick. In Matthew 25:31-46, Christ tells his followers that caring for the sick, lonely, imprisoned, and naked is the same as caring for him. One cannot love Christ and ignore the "least of these" in society. Christ himself heals those with physical ailments (the paralyzed, the bleeding woman, the leper, and the blind), demonstrating the importance of both physical and spiritual health and illustrating that the two are linked.[3] Other biblical passages urge believers to care for widows and orphans, and to love and accept society's most vulnerable members, such as children.[4] While not all churches emphasize these messages, they are key Christian teachings. In Chapter 3, I examine divergent biblical understandings of AIDS as one explanation for why churches have adopted different patterns in their AIDS responses.

Churches also are concerned about AIDS because African citizens are increasingly prioritizing the disease as a public issue. The Kaiser Foundation and Pew Forum found that in seven of ten countries surveyed in 2007, citizens ranked "AIDS and other diseases" as the biggest problem their country faces.[5] In South Africa, 88 percent of respondents ranked AIDS and other diseases as a big problem, second only to crime. Even in Nigeria and Mali where the issue was ranked as the third biggest problem, over 60 percent of respondents mentioned it (Kaiser Family Foundation and Pew Forum 2007). While the survey does not give information on the intensity of these opinions, it does demonstrate public concern about health, including AIDS.

The magnitude of AIDS, biblical messages, and growing concern in society about health are compelling reasons for churches to react to AIDS. Church leaders often add to this list when they assert that as an institution rooted in society, the church cannot ignore the various impacts of AIDS (Interviews 9, 10).[6] For example, life expectancy has fallen by almost five years in Africa, both because of AIDS and because HIV infections make individuals more vulnerable to death from other diseases such as malaria and tuberculosis (*Business Day*, June 20, 2006). Churches are aware of the negative effects of AIDS on education, health care, and businesses. In Mozambique, for example, one-sixth of the

country's teachers die annually of AIDS-related causes (*Reuters*, March 25, 2008). Similarly, Gold Fields, one of the world's largest gold producers, estimates that the total cost of HIV infections is around $5 per ounce of gold mined in South Africa (*Reuters*, July 11, 2007). And churches have had to directly confront the fact that twelve million African children have lost one or both parents to AIDS (AVERT 2008). Churches recognize that not only do many of these children lose material support, but they also lose love, guidance, and nurturing.

Beyond these social, theological, and economic reasons, churches have found it increasingly difficult to ignore AIDS because, as one church official remarked, "The church has AIDS" (Interview 2). Pastors, lay leaders, and congregants are HIV positive, and millions of African Christians have died from AIDS. The church has not been spared the personal, family, and societal effects of the disease; one South African pastor remarked, "We are overwhelmed."[7] Yet, it would be simplistic and cynical to view church concern over AIDS as purely instrumental. One Zambian church official explained, "We care for people because they are hurting and dying, not because of their religion" (Interview 17). Another religious leader said that even in countries with low-level epidemics and small Christian populations, the church is concerned about all people's health (Interview 53).

While the church proclaims concern for all people living with HIV/AIDS, one cannot deny that the disease has greatly affected countries with large Christian populations. Table 1.1 provides data on religious percentages and HIV prevalence rates for most of the forty-eight countries in sub-Saharan Africa. The table relies on the *World Christian Encyclopedia*, which is compiled for 238 countries by 450 global experts. However, getting reliable data on religion is problematic. One challenge is definitions: Are "Christians" people who attend church or individuals who profess belief? Here I follow Philip Jenkins' model (2007, 102) and define Christians as professing believers, not church attendees. Governments also may have an interest in shaping religious data, and religious groups may dispute census results (Jenkins 2007, 100-105; 190-192).[8] While I acknowledge these (and other) data challenges, I use the statistics to demonstrate general trends, not to give exact numbers of religious adherents.

Table 1.1 indicates that Christianity is the majority religion in twenty-six countries; Islam, in eleven; and ethno-religions (or traditional religions), in two. There is no majority religion in nine countries, although Christians compose at least one-third (33 percent) of the population in four of those nine. Muslim-majority countries are