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Markus Patenge

The theological reception of spread factors and preventive measures of the HIV/AIDS epidemic in Africa

A literature study

German Bishops' Conference Research Group on
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Brief notes on the publisher
and the author of the study

The publisher

The German Bishops' Conference Research Group on International Church Affairs is appointed by the Commission for International Church Affairs of the German Bishops' Conference. The Research Group consists of professors from various disciplines. The task of the Group is to investigate issues related to the international responsibilities of the Church in Germany.

The author of the study

This study was drawn up by the Institute for Global Church and Mission (IWM). The IWM is a research institute at the Sankt Georgen Graduate School of Philosophy and Theology, and is devoted to research and teachings concerning the theological reflection on the mission of the Church in the horizon of international church issues. The study project was led by the acting Director of the IWM **Father Dr. Markus Luber SJ**. This literature study was implemented and drawn up by **Dr. Markus Patenge**.

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Background

At the beginning of 2016, the German Bishops' Conference Research Group on International Church Affairs commissioned the Institute for Global Church and Mission (IWM) to study the research literature on the HIV/AIDS epidemic in Africa from a theological and context-sensitive perspective.

This literature study is regarded as a continuation and intensification of the study entitled "Lessons learned from the responses by the Catholic Church to HIV and AIDS in Africa"[1]. In this study, which was presented in 2015, the authors recognised the need to aim for further reflections with regard to HIV/AIDS-sensitive theology in the African context.[2] The literature study presented here takes a first step towards doing justice to this important desideratum in research by systematically discussing the status quo of the current theological reflection of the spread factors and preventive measures of HIV/AIDS in Africa.

The content orientation of this literature study is determined by the following guiding questions:

1. What socio-economic, cultural, religious, etc., factors are identified influencing the HIV/AIDS epidemic in Africa, and what reflections affect them in the theological literature?
2. What preventive measures already exist, and how are they evaluated from a cultural and theological perspective?
3. What elements of an HIV/AIDS-sensitive African theology have already been developed and can be found in the literature studied?

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1 *Fleischer et al.*, Lessons learned from the responses by the Catholic Church to HIV and AIDS in Africa. (Only abridged titles will be quoted in the footnotes. The complete literature list is at the end of the study.)

2 cf. ibd. 43.

In order to be able to answer these questions within a suitable timeframe, it was necessary to limit the mass of literature that is available on HIV and AIDS. The following three criteria were established for this:

1. In the main, literature was considered that had been published over the previous ten years.
2. The literature was to explicitly address the topic of HIV/AIDS in the African context – ideally from an African perspective.
3. The reflection background of the authors was to be of a largely theological nature.

1. An introduction to the topic

Sub-Saharan Africa is the region of the Earth which is worst affected by the HIV/AIDS epidemic. According to the latest UNAIDS statistics[3], there were 36.9 million PLWH (People Living With HIV/AIDS) worldwide in 2014, 25.8 million of whom – that is roughly 70 % – were living in sub-Saharan Africa. Even if one may cautiously speak of hopeful developments – the number of new infections fell by roughly 340,000 in this region between 2006 and 2014, and the number of HIV/AIDS-related deaths dropped by about 710,000 – HIV/AIDS remains one of the greatest existential threats facing people in Africa, and poses a massive challenge to civil society and the Churches.

From a medical point of view, AIDS is the consequence of becoming infected with HIV. The virus is transmitted through coming into contact with specific bodily fluids (such as blood or sperm) of an infected person, albeit the virus must penetrate the recipient's own bloodstream (for instance via an open wound), so that the primary modes of transmission are related to sexual intercourse, but it can also be transmitted from mother to child during pregnancy or in breastfeeding. Infections can also be caused by contaminated medical instruments, as well as through blood, organ and semen donations.[4] According to the state-of-the-art of the research, there is no medical cure for AIDS. Medicines are however now available which considerably extend life expectancy.[5]

This purely medical view cannot however explain why sub-Saharan Africa is particularly affected by the epidemic to the extent described. And the literature is thus dominated by the following broad consensus: "The HI virus causes AIDS. But it does not act alone."[6] Both when it comes to the question of the spread of HIV/AIDS and in the discussion of adequate

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[3] The figures below were obtained from *UNAIDS*, AIDSinfo, http://aidsinfo.unaids.org.

[4] cf. *Fleischer/Ochel*, Schlaglichter einer modernen Seuche, 20.

[5] cf. ibd. 23–24.

[6] *Ackermann*, "Deep in the Flesh", 111.

prevention, it becomes clear that there is a multiplicity of factors which also need to be considered: Voluntary or coerced high-risk behaviour is frequently the result of specific political, economic, social and cultural structures and circumstances.[7] And CZERNY for instance reminds us that the epidemic cannot be successfully overcome if one only regards the biomedical facts:

> Pastoral care, moral formation for responsibility and prevention, spirituality, and indigenous remedies may be less spectacularly successful in reenforcing someone's depleted immune system, but when you admit that basic nutrition, food security, clean water, primary health care, affordable universal education, employment, security are undeniably Africa's top needs, and if you really want to overcome AIDS, it would be reckless to ignore them [...].[8]

The situation is exacerbated by the fact that an anti-Western attitude is prevalent in the debate on HIV/AIDS in parts of African society. AIDS is therefore partly regarded as a non-African disease[9], or as a Western plot[10]. The inability so far to find a cure by classical medical standards may further scepticism vis-à-vis "Western" medicine, leading to denial of the effectiveness of preventive measures such as condom use.[11] Some groups also consider the relevant influence of cultural and social norms and ideas on the spread of HIV and AIDS, which was just touched on, as a Western attack on African culture and values.[12]

This brief overview makes it clear that the fight against HIV/AIDS in Africa cannot be won by medical means alone. Rather, the non-medical factors influencing the spread of this disease also need to be identified and transformed. The concern that was expressed in many cases regarding African culture[13] cannot be countered with "colonialism of culture

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7 cf. *Dilger*, Introduction, 1.

8 *Czerny*, ARVs When Possible, 100.

9 cf. *Ayanga*, Religio-Cultural Challenges, 34.

10 cf. *Behrend*, The Rise of Occult Powers, 36.

11 cf. ibd. 37.

12 cf. *Green/Ruark*, AIDS, behavior, and culture, 73.

13 This term "African culture" naturally gives rise to the question of whether one can speak of *one* African culture in the singular at all, or whether one should not rather

and values", as such colonialism in particular is not culture sensitive, and the values, practices and norms which it introduces are generally rejected as being foreign. Instead, there is a need to initiate an intercultural dialogue on an equal footing which both acknowledges African culture, its values and practices and – where necessary – criticises them and points to alternatives. For this reason, this literature study lends considerable scope to these factors, their anchoring in African culture and their reflection by African theologians.

If we are talking about the various factors influencing the HIV/AIDS epidemic in Africa, then there is naturally also a need to discuss the commitment of the Catholic Church. It is revealed here that perceptions of the Church's activities in this area are ambivalent. It can be observed on the one hand that the Church, along with other religious organisations, is among the main stakeholders in the organisation of prevention campaigns, medical treatment and social guidance.[14] Having said that, we should not keep secret the fact here that the infection rate is highest in "Christian" countries[15]. The literature does not however provide a causal explanation of this phenomenon. On the other hand, various authors complain that the Church's caring pastoral practice is countered by its doctrine: "[C]hurches have been blamed for sabotaging these [...] efforts by their judgmental attitudes, endorsement of patriarchy, and cul-

speak of African cultures in the plural. According to ODOZOR, there are differences in Africa's cultures, but these are founded in shared fundamental convictions justifying to a certain degree also speaking of an African culture. cf. *Odozor*, Morality truly Christian, truly African, 76. Even if this position can certainly be contradicted by lending greater weight to the differences between the cultures in Africa, particularly in No. 2.1.1 – despite all the care that should be given to avoid overgeneralisation – several perspectives of shared cultural convictions in Africa are presented on this basis. There is no denying that this study hence only contains certain ideals of cultural interpretation patterns which remain in the abstract vis-à-vis the extant plurality of living cultures. It should also be noted that the fundamental cultural convictions which have been presented are likely to reflect a more sub-Saharan context.

14 cf. *Burchardt*, Subjects of Counselling, 333.

15 cf. *Chummar*, HIV/AIDS in Africa, 158.

tures of denial."[16] The question therefore also arises of the degree to which HIV/AIDS has come to be reflected in the Church's doctrine with the aim in mind of arming its staff on all levels in the fight against this disease. The answer to this question is controversial: Whilst some are already speaking of the establishment of an HIV/AIDS-sensitive theology within the African Church[17], others are claiming that this has not taken place[18]. This literature study hence also takes up this group of topics as component of a theological reflection, and presents the various elements of such a theology. The focus here is placed on the approach of adopting a culture-sensitive African theology. Such an inculturated theology is not merely a pastoral necessity in the face of the dramatic challenges posed by HIV/AIDS and their contextual influencing factors in Africa, but at the same time constitutes a search for "self-identity and relevance" for the Church(es) in Africa.[19]

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[16] *Paterson*, Who Sinned?, 163.

[17] cf. *Okambawa*, Africa theology of HIV/AIDS, 335; *Orobator*, Catholic Responses to HIV/AIDS in Africa, 182.

[18] cf. *Chummar*, HIV/AIDS in Africa, 158; *Haddad*, Poverty, Gendered Cultural Sexual Practices and HIV, 16.

[19] *Odozor*, Morality truly Christian, truly African, 12.

2. Influencing factors for HIV/AIDS in Africa

The question regarding the factors influencing the HIV/AIDS epidemic goes hand in hand with the question as to how an infection actually occurs. At formal level, two stages can be made out here: exposure to the virus and infection with the HI virus.[20]

Since roughly 80 % of all new infections in Africa are caused by heterosexual intercourse[21], there is a need to ask in the first perspective under what conditions sexual intercourse leads to greater exposure to the virus. If one acknowledges that personal behaviour (e.g. sexual behaviour) is also always influenced by cultural and socio-economic factors, a preventive approach which is solely orientated towards the high-risk behaviour of individuals is simplistic. Individual high-risk behaviour is hence rooted within the prevention debate in terms of its context, so that the vulnerability approach has developed.[22] This approach focuses on the question of what societal, cultural, economic, etc., factors make specific groups of individuals particularly vulnerable with regard to high-risk sexual practices. The specific vulnerability conditions in the African context hence form the focus of the first section of this chapter, in which the specific socio-economic and cultural influencing factors are presented.

2.1. Vulnerability factors

Although African culture is very much influenced by "Western modernism", it is however shown that the thinking patterns of traditional culture in all groups of the population have by no means become insignificant.[23] Through traditional norms and values, these determine not only large numbers of sexual norms and practices[24], but may also increase vulnera-

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[20] This distinction is quoted from Benoît Ferry. cf. *Denis*, Sexualität und HIV/AIDS in Südafrika, 28.

[21] cf. *Fleischer/Ochel*, Schlaglichter einer modernen Seuche, 17.

[22] cf. ibd. 26.

[23] cf. *Bujo*, Im Zentrum steht die Gemeinschaft, 92.

[24] cf. *Chiti*, Culture, HIV, and the Church, 147.

bility to HIV and AIDS[25]. The cultural embedding of moral ideas necessitates first of all revealing some of the fundamental perspectives of African culture with regard to HIV/AIDS. It should be taken into account here that culture is an umbrella term for a variety of circumstances:

> Culture describes a people's way of life, both material and spiritual. It consists of technology as well as beliefs, norms and values. It involves prescriptions as well as prohibitions about what people should eat, how to dress, how to deal with disasters and what medicines to use for their sicknesses.[26]

And although it would be a misunderstanding to perceive culture as being static, as it is always also subject to large numbers of adjustments and changes[27], it is possible to identify several stable cultural patterns in today's African context, and these are presented below.

2.1.1. Perspectives of African cultural convictions with regard to HIV/AIDS

African culture – in the sense of a shared system of values and convictions – focuses on a holistic view of the world the genesis of which lies in many traditional African religions. The whole world is for instance subdivided into three areas – "the world of spirits, of human beings and of nature"[28] –, but these areas are not isolated from one another, but form the one world, jointly. The connection between these three areas of the world is to be understood as a hierarchical one:

> Africans believe in a hierarchy of beings, from the ultimate being, God, to lesser ones, divinities, spirits, the living dead, human beings, animals, plants, and inanimate beings.[29]

This hierarchy corresponds to a desired order of the entire world which is also to be reflected in human social order: "This hierarchy is also evident in human society, where there are chiefs, clan heads, family heads,

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[25] cf. *Kamanzi*, Solidarity, a New Categorical Imperative, 22.
[26] *Ayanga*, Religio-Cultural Challenges, 36.
[27] cf. ibd. 37; or also: *Stewart*, Contextualization of HIV prevention initiatives, 386.
[28] *Nyamiti*, An African Theology of Holistic Healing, 20.
[29] *Odozor*, Morality truly Christian, truly African, 87.

older siblings, and so on."[30] This hierarchical view comes to bear not only in social relationships, but also in the gender roles which a culture provides, and which make woman subordinate to man.[31] This order also evokes a set of norms which can cause problems when it comes to HIV and AIDS, such as:

> it is possible to discuss practically any topic with those who have a lower standing, but this is not possible the other way around. Telling one's own mother that she is very probably infected because one's father died of AIDS is regarded as being in breach of appropriate behaviour.[32]

This world view places relationships at the focus of African thinking. A successful human existence is for instance typified by the individual living in good relationships with the living, their ancestors and those who are yet unborn.[33] A strong expression is lent to this relational thinking amongst other things in the African understanding of disease. On the one hand, disease is never interpreted as an individual incident pure and simple, but impacts the entire community in which the sick person lives.[34] Sick persons are therefore as a rule not left alone, even if they are suffering from an infectious disease such as HIV/AIDS.[35] On the other hand, disease is understood as the consequence of disturbed relationships and of behaviour which is in breach of norms:

> Culpable behaviour towards God, people or Nature can cause a disease. It is however not always the sick person who has accrued the guilt, and in fact it may for instance also be the neighbours who have sinned against the patient. A disease is always related to guilt, for which any member of the community can be responsible.[36]

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30 Ibd. 100.

31 cf. *James*, Factors that Render the Girl-Child Vulnerable, 4.

32 *Fiedler*, HIV/AIDS als theologische Herausforderung, 69 (original German; non-official translation).

33 cf. *Bate*, HIV Prevention and the Theology of Sin, 188.

34 cf. *Bujo*, Community Ethics, 69.

35 cf. ibd. 74.

36 *Bujo*, Plädoyer für ein neues Modell von Ehe und Sexualität, 207 (original German; non-official translation).

In African the thinking, therefore, falling foul of AIDS may be connected with the HIV infection, but just as easily with the sick person overstepping specific norms[37].

The connection between this thinking in relationships and networking between the various parts of the world leads to the idea that witchcraft[38] can be responsible for the outbreak of a disease. Belief in witchcraft is so prevalent that it is often said that people as a rule do not simply die, but that they are killed[39]. The "guilt" for one's own disease therefore does not necessarily have to be related to one's own misconduct, but can also be caused by others. One of the most important tasks of traditional healers is therefore to find out who is responsible for a disease.[40] A strong belief in witchcraft can lead to preventive measures against HIV/AIDS not being accepted since the cause of the disease is not regarded as lying solely in the transmission of a virus, but traced back to magical influences.[41] The growing knowledge of medical connections does weaken the idea of a direct causality between witchcraft and disease, but the idea of there being a supernatural cause for the disease nonetheless remains intact:

> Although many people know that AIDS is not caused directly by witchcraft, a witch can influence a man or a woman, for example, to drink too much beer so that he or she leaves all caution aside and has sex with a HIV-positive person and so may contract the virus.[42]

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37 cf. *Steuer*, Krankheit und Ehre, 27.

38 In the European context, the term witchcraft is generally associated with sorcery, partnership with demons, licentiousness and the like; cf. *Laubscher*, Hexen, 79. This contextual image of witchcraft makes it difficult to transfer this term to the African phenomenon. The substance and vitality of belief in witchcraft in Africa is fed above all from the described prevalent relational cosmology, and is not identical with European concepts of witchcraft. It should therefore be noted that the German term "*Hexerei*" (sorcery), which is used as a translation for "witchcraft" is quite problematic.

39 cf. *Khamalwa*, Religion, Traditional Healers, and the AIDS Pandemic, 89.

40 cf. *Essien*, Notions of Healing and Transcendence, 243.

41 cf. *Bujo*, Community Ethics, 72.

42 *Behrend*, The Rise of Occult Powers, 35.

This outline of prevalent African thinking patterns shows that these by themselves have the potential to provoke high-risk behaviour. The Church is called on to take this fundamental relationship between cultural convictions and high-risk behaviour seriously if She wishes to make an effective contribution to HIV/AIDS prevention.[43] Further, this presentation is to provide the cultural background for the following more specific vulnerability factors.

2.1.2. Relationship structures

The literature repeatedly mentions four problematic relationship structures which influence vulnerability to HIV/AIDS: 1. polygamous relationships, 2. the practice of the "bride price", 3. "levirate marriage" and 4. the situation of discordant couples.

1. The risks involved in polygamous relationships are evident: "The infection of the husband or one of the wives brings ill health to all partners."[44] Polygamy remains widespread in Africa – including among African Christians.[45] Because monogamy is frequently associated with the man being poor.[46] Institutionalised polygamy is therefore not practiced among Christians, but long-term relationships outside of marriages which appear to be monogamous are the rule.[47] The intercultural theological debate on polygamy must however not only look at the link between this topic and poverty and riches, but must also take different concepts of monogamy and polygamy into account. Monogamy is also highly valued in the African context, "and it is only the monogamous marriage which also provides a footing for all other po-

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43 cf. *Correll*, HIV/AIDS, 30.

44 *Bujo*, Community Ethics, 73.

45 There are no reliable figures on this, since the spread of polygamy differs greatly from one region to another. FARLEY speaks in this context of a proportion of 20-40 % polygamous marriages in Africa. cf. *Farley*, Verdammter Sex, 105.

46 cf. *Obbo*, Sponsored sexuality, AIDS and tough choices, 33.

47 cf. ibd.

lygamous ties."[48] An inflexible dichotomy of monogamy and polygamy which is anchored in traditional theology cannot be easily transmitted to African ideas.

2. The practice of the bride price is also entrenched within the topics related to monogamy and polygamy.[49] In the European cultural area, the bride price – if only by virtue of its name – is understood as a sale price for the bride, and sometimes as a compensatory payment for the bride's family. The original African meaning however has nothing to do with this association: "The bride price is not a purchase price, but a token and pledge of friendship and harmony between the two families."[50]

   In contradistinction to this traditional view of the bride price, there are now commercialisation developments, so that it is now possible to actually speak of a price being paid for the woman.[51] The consequence of this is that the man makes the woman into an object "with which he does what he wants"[52]. This has major repercussions, particularly with regard to the woman's right to sexual co-determination.

3. Levirate marriage refers to the custom "that should the husband die, his wife is married to one of his brothers or relatives."[53] In

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[48] *Bujo*, Plädoyer für ein neues Modell von Ehe und Sexualität, 136 (original German; non-official translation).

[49] It was not possible to ascertain precise figures on the spread of this practice. It can however be presumed that the bride price is common and accepted. cf. *Knodel*, Für alle Fälle einen Hahn im Kofferraum, 94-95.

[50] *Bujo*, Plädoyer für ein neues Modell von Ehe und Sexualität, 158 (original German; non-official translation).

[51] The change in this practice has for instance shown that cultural practices are not inflexible, but may be subject to many transformation processes – both positive and negative. These dynamics must not be disregarded with context-sensitive methods.

[52] *Bujo*, Plädoyer für ein neues Modell von Ehe und Sexualität, 163 (original German; non-official translation).

[53] Ibd. 124 (original German; non-official translation).

cultural terms, this custom must be placed within the expanded traditional African understanding of marriage, in which marriage is less an institution between two individuals, and more the bringing together of two (large) families. Levirate marriage is therefore also not regarded as constituting a new marriage, but as the continuation of the old one.[54] As well as ensuring that the widow and the children from the first marriage have a livelihood, levirate marriage naturally also has a sexual component, as this marriage is also intended to produce children, if possible.[55] This gives rise to a considerable risk of HIV infection for the new spouses if the widow or the new husband is already infected with HIV. These problems become worse if the levirate marriage is integrated within a polygamous marriage structure.

DENIS sums up these traditional relationship patterns – polygamy, bride price and levirate marriage – with regard to HIV and AIDS as follows:

> The old family structures which made women subordinate to men whilst at the same time giving them a certain degree of security were retained, but lost their protective function. [...] The patriarchal system hence became profoundly dysfunctional.[56]

4. The fundamental problem of many relationships – whatever form they may take – is "discordance", or the discordant couple situation. Discordance means in this context that one partner within the relationship is HIV-positive whilst the other is not. According to KELLY, discordant relationships can be reflected from four points of view:[57]

    - In order to reduce the risk of an HIV infection, discordance in a relationship first of all requires openness when it comes

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[54] cf. ebd. 125.

[55] cf. ibd. 127.

[56] *Denis*, Sexualität und HIV/AIDS in Südafrika, 31–32 (original German; non-official translation).

[57] cf. *Kelly*, Some AIDS Relevant Teachings of Moral Theology, 121–123.

to talking about one's own HIV status and assuring support to one another in the difficult situation.

- In a second step, there is a need to weigh up between living sexuality and protecting the life of the other. KELLY expresses the dilemma as follows:

> Their lovemaking is the channel of God's love for each of them. [...] But their lovemaking could also be the channel for the transmission of the human immunodeficiency virus [...].[58]

This situation calls for a re-evaluation of preventive measures; the latter may not be seen solely from the perspective of contraception, but also from the perspective of the protection of life.[59]

- Since discordant couples frequently would also like to have children, a further weighing up process needs to take place between the protection of life and the desire to reproduce. KELLY recalls that many Bishops' Conferences in this context stress the significance of the personal conscience-based decision, which will point couples in the right direction in their specific situation.[60]
- There is however a need to consider here that the issue of reproduction is not solely a matter of the couple's health, but also of that of the unborn child. The child could be born HIV positive.[61]

2.1.3. Sexual practices

The risk of an HIV infection is exacerbated by various sexual practices, albeit not all sexual intercourse is contagious to the same degree. A particular risk of contagion exists if there are wounds by means of which blood or sperm can penetrate the bloodstream, or in case of sexual prac-

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[58] Ibd. 122.
[59] cf. ibd.
[60] cf. ibd. 123.
[61] cf. ibd.

tices which cause such injuries[62]. Several practices which are exposed to such heightened risks are presented and reflected upon here.

The use or non-use of condoms exerts a considerable influence on the risk of infection during sexual intercourse. It is shown that condoms are primarily regarded as a contraceptive and less as protecting against the transmission of the virus. Accordingly, the condom is frequently left out if the contraceptive function is not relevant to a sexual practice, such as in anal sex.[63] It must also be borne in mind when it comes to the use of condoms that men frequently refuse to use them. In a highly patriarchal society – see No. 2.1.4 – women are frequently unable to insist on men/husbands using a condom, even if they know that they engage in high-risk sexual intercourse elsewhere.[64] This dominant role played by men relates not only to the power to decide on condom use, but also to other high-risk practices which are known in Africa such as "dry sex". In "dry sex" "the vagina is dried out by using certain substances [...] in order to increase the man's pleasure."[65] This practice entails increased inflammation of the vaginal mucous membranes, and an increased risk of injury, which favour infection. Just as "dry sex", anal sex also entails a greater risk of injury to the mucous membranes. As has already been stated, anal sex is practiced to avoid pregnancies, but also to preserve women's vaginal virginity. Anal sex is hence frequently widespread where the tradition of a pre-marital virginity test is practiced.[66] What is more, anal sex is also commonly practiced where women are circumcised. Anal sex is used as a replacement during the period when vaginal sex is not possible because of the circumcision.[67]

With regard to vulnerability to HIV/AIDS, the conviction must be broached that sexual intercourse with a female virgin can cure an HIV

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62 cf. *Denis*, Sexualität und HIV/AIDS in Südafrika, 33.

63 cf. *Abdool Karim*, Heterosexual transmission of HIV, 299.

64 cf. *Haddad*, Poverty, Gendered Cultural Sexual Practices and HIV, 10.

65 *Denis*, Sexualität und HIV/AIDS in Südafrika, 33 (original German; non-official translation).

66 cf. *Haddad*, Poverty, Gendered Cultural Sexual Practices and HIV, 15.

67 cf.. *Abdool Karim*, Heterosexual transmission of HIV, 299.

infection. This myth plays a major role in infecting girls and young women.[68] Apart from the fatal consequences of this mistaken conviction of "virgin cleansing", it frequently entails raping virgins[69], including children[70]. Sexual violence is highly significant to the vulnerability of women with regard to an HIV infection, since forced sexual intercourse entails injuring the female genital organs, and hence maximises the risk of an infection.[71]

In conclusion of this section, there is a further need to discuss prostitution. Changing sexual partners places sex workers at heightened risk of infection, but they are also the main carriers of the HI virus[72]. It should be borne in mind here that, in the African context, prostitution is not only widespread in the classical understanding (sex for money), but that it takes on a wide range of forms. Sexual services are also offered amongst other things for "transport, school uniforms and fees, food, accommodation"[73]. In whatever form prostitution occurs, it is frequently motivated by poverty. The prices that are paid therefore also determine the practices that are offered, which leads to additional high-risk behaviour. Higher prices are paid for particularly high-risk practices, such as sex without a condom, anal sex or "dry sex", and this makes these forms of sex particularly interesting for the prostitutes in economic terms.[74] Prostitutes who insist on safe practices must expect to lose income, or are forced to serve more customers. The economic lucrativeness of these high-risk practices means that prostitutes have a higher risk of infection. Their economic constraints however also cause sex workers to be common carriers of the HI virus. Since they rely on income from prostitution, they do not cease working, even when they know that they them-

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68 cf. *Mathews*, Reducing sexual risk behaviours, 163.
69 cf. *Haddad*, Poverty, Gendered Cultural Sexual Practices and HIV, 15.
70 cf. *Mathews*, Reducing sexual risk behaviours, 163.
71 *Denis*, Sexualität und HIV/AIDS in Südafrika, 34.
72 cf. *Ramjee*, Female sex workers, 339.
73 Ibd. 330.
74 cf. *Mulligan*, Confronting the challenge, 31.

selves have an HIV infection.[75] In conjunction with the high-risk sexual practices described, customers are put at a high risk of infection.

The Church's response to these practices as a rule consists of abstinence. This certainly brings Her into agreement with some ideas within traditional African culture.[76] Abstinence will be re-examined separately in the chapter on preventive measures. It can only be stated at this point that the scope and effectiveness of this proclamation in Africa are disputed:

> A major question is whether the proclamation of the ideal of sexual abstinence outside of marriage really leads to less risky behaviour among Christians. After this presumption had been long presumed to be highly unrealistic and even counter-productive, the indications are now growing that particularly in African countries the influence exerted by religious communities has had a positive impact on behaviour changes, especially among the young.[77]

2.1.4. Gender roles

As is shown by the above, a variety of factors lead to greater vulnerability to HIV/AIDS. It has already become clear that these factors are not simply "there", but that they are in turn an expression of certain pre-existing cultural or economic circumstances. The most influential of these contextual conditions includes the cultural construction of gender roles in Africa. Such studies show that women are not only infected twice as frequently as men, but that they are infected with HIV an average of between five and ten years earlier than men.[78]

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[75] cf. *Ramjee*, Female sex workers, 336.

[76] cf. *Gichure*, AIDS Stories as a Process of Healing, 104.

[77] *Benn*, Der Einfluss von Weltanschauung und Kultur, 19 (original German; non-official translation). BENN refers here to studies carried out in Senegal and Uganda on the efficiency of Christian and Muslim prevention methods. This article however does not provide any concrete figures. These study results may however indicate that abstinence is accepted when it is entrenched in a (religious) value system which is communicated interculturally with abstinence.

[78] cf. *Abdool Karim*, Heterosexual transmission of HIV, 287.

The African gender role construction starts with the patriarchate which is dominant there.[79] This fundamental patriarchal construction of African society leads to a pronounced dominance of the male over the female, and women are therefore frequently regarded as second-class citizens[80], as weak[81] or as incomplete individuals[82]. It is evident that this perspective leads to glaring inequalities between the genders. African women are suppressed from a very early age[83], even if the consequences of the cultural gender role construction does not fully develop until adolescence:

> Adolescence may thus be a time when boys gain autonomy, mobility, opportunity and power, including in the sexual und reproductive realm, while girls are deprived of the same privileges.[84]

This list makes it clear that women are fundamentally denied self-determination of their lives. The loss of self-determination includes here also all aspects relating to ensuring a livelihood, so that women are economically dependent on men.[85] In content terms, the African role understanding of women is exclusively based on the two terms: marriage and offspring.

This gender role construction makes women much more vulnerable to HIV/AIDS on several levels[86]. This fact is however revealed particularly clearly in the basic African norms of sexuality, which define different standards for women than for men. Women are fundamentally expected not to concern themselves with the subject of sexuality and to take a more passive role.[87] This denies them the right to determine their sexuality, or the sexuality that is practiced in their relationship: "Their sexuality

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79 cf. *Mwaura*, Violation of Human Rights of Kenyan Women, 127.
80 cf. ebd. 129.
81 cf. *Vandi*, The Church's Role in Empowering Women, 75.
82 cf. ebd. 76.
83 cf. *Wakhusama*, Abused and Infected with HIV, 171.
84 *Harrison*, Young people and HIV/AIDS in South Africa, 308.
85 cf. *Mwaura*, Violation of Human Rights of Kenyan Women, 128.
86 cf. *Orobator*, Ethics of HIV/AIDS Prevention, 151–152.
87 cf. *Abdool Karim*, Heterosexual transmission of HIV, 295.

is objectified and seen in terms of pleasing men. Women do not have the right to own their bodies and to sexuality."[88] This fundamental perspective in terms of sexual ethics is developed in a variety of individual norms and practices, such as:

1. Women have neither the right to refuse sex, nor to insist on specific practices or protective measures.[89]
2. Women are expected to be monogamous and faithful, whilst men are allowed to have many relationships and sexual contacts.[90]
3. Women are forced to marry older men at an early age[91], so that they have sexual contacts earlier than men do[92].

Even if women do not share these cultural precepts in individual cases, they have virtually no opportunity to emancipate themselves from them. The widespread nature of these gender roles leads to attempts to break out of such perceived roles leading of necessity to social isolation.[93] Men furthermore frequently enforce their claim to dominance by force[94]; specifically by means of physical, sexual and emotional violence[95]. This leads women into a perilous entanglement in unjust structures transmitted by their culture, as violence against women in turn is also culturally legitimised and accepted.[96] It seems to be evident that the violent enforcement of male-dominated gender roles constitutes an additional vulnerability factor for women in view of HIV and AIDS. In the same vein, the academic debate on these gender roles and their injustices is difficult

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88 *Mwaura*, Violation of Human Rights of Kenyan Women, 129.
89 cf. *Abdool Karim*, Heterosexual transmission of HIV, 296.
90 cf. *Machyo*, Gender Issues, 61.
91 cf. *Doma*, Educational Response to HIV Prevention, 4.
92 *Ayanga*, Religio-Cultural Challenges, 40. This is one of the reasons why women are previously infected with HIV compared to men.
93 cf. ibd. 38.
94 cf. *Kelly*, HIV and AIDS, 124.
95 cf. *James*, Factors that Render the Girl-Child Vulnerable, 4.
96 cf. *Patrick*, Violence against Women, 109.

since most Africans are convinced "that gender issues are not African issues; [...] they are western, feminist [...]."[97]

In the context of gender inequality, the topic of education must also be touched upon. The patriarchal structures do not provide women with equal access to educational facilities and services.[98] If one focuses this lack of educational equality on the HIV/AIDS problems, a further factor emerges for gender-specific vulnerability to HIV/AIDS:

> This imbalance in knowledge is a major obstacle to women's ability to assess their risk and take steps to reduce it; ignorance fosters myths and fears about both risk and prevention options and makes it very difficult for women to be pro-active in negotiating safer sex.[99]

With regard to the cultural role models and the inequalities which they entail, the Church has done little to liberate women from these role categories. On the contrary: The Church in Africa teaches the subordination of women, which is also understood in many places to mean that the Church accepts male violence towards women.[100] There is disagreement in the literature available with regard to the influence exerted by the Church's proclamation on violent attacks on women. Whilst for instance MACHYO stresses that the Church's proclamation condemns violence towards women[101], MWAURA and KIMANI claim that the Church is silent on this issue, so that the Church shares guilt as to the violence experienced by African women[102]. (Female) voices are also heard on this issue, criticising past attempts to develop or establish inculturated theology in Africa:

> African women theologians point out that here culture is approached rather uncritically. Seeking to reclaim and affirm African culture, inculturation theologians would overlook cultural traditions of patriarchy that marginalise and oppress women. African women theologians employ a

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97 *Njoroge*, Resisting Gender Inequality and Injustice in the Name of Jesus, 55.
98 cf. *Ayanga*, Religio-Cultural Challenges, 42.
99 *Abdool Karim*, Heterosexual transmission of HIV, 295.
100 cf. *Ayanga*, Religio-Cultural Challenges, 41.
101 cf. *Machyo*, Gender Issues, 67.
102 cf. *Mwaura/Kimani*, Gender Based Violence, 33.

gender-sensitive hermeneutics and a call for a ‚critical solidarity' with African cultural traditions.[103]

This summary overview of the cultural gender construction has revealed that the African idea of the Patriarchate leads to discrimination against women en masse. Even if the opinion is prevalent in Africa that the norms and practices put forward here are as a rule "natural and unchangeable"[104], according to KELLY there is no doubt that there is a need to change this gender construction in order to be able to stem the HIV/AIDS epidemic[105].

2.1.5. Stigmatisation and discrimination

Becoming infected with HIV or being affected by AIDS is frequently linked for those concerned with stigmatisation and the resulting discrimination – not only in Africa. The causes of such stigmatisation vary widely. They result in some cases from the nature of the disease itself: HIV/AIDS is incurable and potentially fatal, which naturally leads to considerable fear of infection.[106] The connection of the disease with the sensitive topic of sexuality also provokes a potential stigmatisation of those who are infected with HIV.[107] BANGERT speaks in this contest of a moral AIDS dilemma.[108] This consists of the demand for ethically-responsible sexuality, in order to minimise the risk of infection, thus leading to an infection rapidly becoming associated with personal immorality. As it was just shown, however, this general suspicion frequently affects women, and wrongly so.

The stigmatisation processes in relation with HIV/AIDS should however not be looked at in isolation from the cultural context[109], given that the disease tends to amplify existing prejudices rather than creating new

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[103] *Klinken*, Transforming masculinities in African Christianity, 27.
[104] *Mwaura/Kimani*, Gender Based Violence, 30.
[105] Vgl. *Kelly*, HIV and AIDS, 127.
[106] cf. *Tombi*, Stigmatisation and discrimination against persons living with HIV, 232.
[107] cf. *Czerny*, Working for Healing, 50.
[108] cf. *Bangert*, HIV und AIDS als theologisches Problem der Kirche, 87.
[109] cf. *Paterson*, Who Sinned?, 164.

ones.[110] The stigmatisation therefore particularly affects infected women, who are quickly accused of promiscuity[111], including by medical personnel[112].

If one approaches the phenomenon of stigmatisation at societal level, it can be found that it aims to strictly distinguish between different groups.[113] The negative labelling of the behaviour of infected people constitutes a moral judgment, excluding those concerned from the group of those who conduct themselves "correctly". This exclusion naturally impacts people with HIV themselves:

> [T]he stigmatised individual becomes laden with intense disabling feelings of fear, anguish, shame, dejection, self-doubt, guilt, self-blame and inferiority [...].[114]

Even though stigmatisation per se already has a serious impact on those concerned, this is amplified further by the fact that it is accompanied by discrimination in most cases.[115] At societal level, discrimination is expressed above all in violations of the elementary rights of HIV/AIDS sufferers:

> Violations of the right to work and to employment, of the right to medical treatment and maintenance of medical confidentiality, non-compliance with bioethical principles in research projects, rights violations within the family such as inheritance rights or family assistance, exclusion from religious communities, denial of bank loans and insurance policies, restriction of freedom of travel and movement.[116]

It is obvious that stigmatisation and discrimination lead to social exclusion[117], which appear to provide the non-infected with a justification to

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[110] cf. *Frohlich*, The impact of AIDS on the community, 376.
[111] *cf. Machyo,* Gender Issues*, 65.*
[112] cf. *Ayanga*, Religio-Cultural Challenges, 40.
[113] cf. *Kelly*, HIV and AIDS, 130.
[114] Ibd.
[115] cf. *Frohlich*, The impact of AIDS on the community, 376.
[116] *Fleischer/Ochel*, Schlaglichter einer modernen Seuche, 26 (original German; non-official translation).
[117] cf. *Kamanzi*, Solidarity, a New Categorical Imperative, 26.

treat people with HIV "badly, cruelly, inhumanely"[118]. This means one thing above all for the sufferers: "AIDS creates fear"[119]. This fear manifests itself not only in fear of the disease itself, but above all in fear of sharing HIV status with other people.[120] As a result, stigmatisation and discrimination actually increase vulnerability to HIV infection, as they evoke "a culture of silence and denial"[121] in which people are no longer able to know whether they are engaging in high-risk contact. KHAMALWA concludes for this reason that the stigma linked to HIV/AIDS is the most dangerous aspect of this disease.[122]

Stigmatisation and discrimination can be found in Africa not only in civil society, but according to the findings of the literature studied here also in the Church's proclamation and practice. At the level of proclamation, the opinion is still put forward that HIV/AIDS is God's punishment for sinful behaviour.[123] BATE uses this link as a reason to point out that, whilst there is a connection between behaviour and the disease, this is however frequently wrongly interpreted.[124] Once again, this misinterpretation affects women above all:

> In the face of such stigmatisation, many women living with HIV/AIDS feel unwelcome and condemned when they listen to sermons by clergy who pronounce with seeming authority that HIV/AIDS is God's punishment for sin. Yet this position is not credible, given that many married women, although living faithfully and monogamously, have been infected with HIV/AIDS through their husbands' irresponsible sexual behaviour. Such condemnation makes many HIV+ women stay away from churches thereby cutting themselves off from much-needed union with God at such a needful time.[125]

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[118] *Czerny*, Working for Healing, 51.

[119] *Denis*, Sexualität und HIV/AIDS in Südafrika, 26 (original German; non-official translation).

[120] cf. *Frohlich*, The impact of AIDS on the community, 377.

[121] *Kelly*, HIV and AIDS, 133.

[122] cf. *Khamalwa*, Religion, Traditional Healers, and the AIDS Pandemic, 89.

[123] cf. *Bangert*, HIV und AIDS als theologisches Problem der Kirche, 78.

[124] cf. *Bate*, HIV Prevention and the Theology of Sin, 195–197.

[125] *Shisanya*, Today's Lepers, 150.

This doctrine, in conjunction with mistaken presumptions on the part of the clergy that HIV can for instance be transmitted through the air or by other normal physical contact[126], is also reflected in a certain marginalising practice on the part of the Church. This ranges from different chalices for HIV-infected and non-infected people, to refusing to shake their hands.[127] The stigmatisation within the Church however relates not only to the relationship between clergy and laity, but is also felt among the clergy. Since the relationship with sinful behaviour is effective here too, infected clergy are under pressure to maintain secrecy, which is made easier by the fact that there is little commitment within the church community to speak openly about the HIV status of its members.[128] KELLY considers this to reflect a problematic attitude on the part of the Church vis-à-vis HIV/AIDS:

> Not being open about HIV in the life of a priest, pastor or other person professionally dedicated to the religious life, effectively denies solidarity with infected lay people.[129]

Having said that, we should also not forget that a change is taking place within the Church(es), which includes a loving, helping approach being taken towards people who are infected with HIV.[130]

Stigmatisation and fear of stigmatisation, both in civil society and in the Church, therefore create a climate of silence aiming to hide one's own HIV+ status. For the infected, this also means that they are unable to seek medical assistance without risking revealing their status.[131] By contrast, this climate places the non-infected in the dangerous situation of being unable to know whether their (sexual) partner is providing truthful information on an infection, so that the potential risk of contagion is increased.

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[126] cf. *Vitillo*, The Human and Pastoral Challenges of HIV and AIDS, 38.
[127] cf. *Shisanya*, Today's Lepers, 161.
[128] cf. *Kelly*, HIV and AIDS, 242.
[129] Ibd.
[130] cf. *Shisanya*, Today's Lepers, 161.
[131] cf. *Machyo*, Gender Issues, 65.

2.1.6. Poverty

"AIDS is a disease of the poor and underprivileged."[132] These few words bring up a further major vulnerability factor with regard to HIV/AIDS. According to ACKERMANN, 90 % of all HIV-infected people live in developing countries.[133] Within the literature that was investigated, the connection between poverty and HIV/AIDS is reflected at two levels. At societal and structural level, poverty leads to a lack of medical infrastructure[134], and little money can be invested in educational campaigns[135]. The problem can also be found at structural level that poverty in Africa affects women to a disproportionate extent[136], thus further exacerbating the position for women, which is already generally difficult. At individual level, poverty first of all results in a lack of economic resources "to pay for tests, diseases accompanying the HIV virus, transport to the clinic, food, school fees (for instance for sick children) and the like".[137] Poverty is so prevalent in some cases that there is no money even for condoms.[138] Being exposed to such extreme poverty however also means that life is a constant battle to satisfy elementary needs, which makes a mockery of the idea of longer-term life planning.[139] These reasons generally lead to behaviour on the part of the poor which increases their vulnerability with regard to HIV/AIDS, but which they hope will help them to survive on a day-by-day basis. The literature repeatedly cites prostitution and labour migration in this connection. Since prostitution has already been discussed in No. 2.1.3, we will now only briefly discuss labour migration:

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[132] *Nubuasah*, Salvation and Liberation in Africa, 123.
[133] cf. *Ackermann*, "Deep in the Flesh", 110.
[134] cf. *Bujo*, Plädoyer für ein neues Modell von Ehe und Sexualität, 206.
[135] cf. *Bujo*, Community Ethics, 70.
[136] cf. *Hinga*, Becoming Better Samaritans, 93.
[137] *Bujo*, Plädoyer für ein neues Modell von Ehe und Sexualität, 205 (original German; non-official translation).
[138] cf. *Doma*, Educational Response to HIV Prevention, 3.
[139] cf. *Kelly*, HIV and AIDS, 115.

The phenomenon of labour migration primarily affects men from rural areas who try to find better-paid work around the major cities.[140] Given that they are separated from their families for prolonged periods and are no longer subject to local social controls[141], extra-marital sexual intercourse is common among such labour migrants – particularly since marital faithfulness is not a strict moral principle for men in Africa.[142] This behaviour increases not only the infection risk of the men, but also that of their wives when the men return home and have unprotected sexual intercourse with them.

If the person who is responsible for ensuring the economic security of the family is infected with HIV, the family's poverty situation worsens further:

> The combination of losing that person's income or contribution in terms of daily household chores and the financial burden of expensive medical treatment, leads to problems of food security and other material needs in the household.[143]

Poverty therefore leads not only to increased vulnerability to HIV/AIDS, but HIV/AIDS also leads to an increased poverty risk.[144] This poverty risk once more particularly affects the children of HIV-infected parents. On one hand, the disease of the parents, or of one parent, requires children to take responsibility for looking after the sick family members at an early age.[145] It may often adversely affect the children's schooling.[146] On the other hand, children of parents suffering from AIDS are subject to a latent risk of becoming orphans. Given that this places them in an even more precarious situation[147], orphans are in turn forced to develop dangerous survival strategies.

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[140] cf. *Kamanzi*, Solidarity, a New Categorical Imperative, 22.
[141] cf. ibd. 23.
[142] cf. *Ayanga*, Religio-Cultural Challenges, 43.
[143] *James*, Factors that Render the Girl-Child Vulnerable, 7.
[144] cf. *Kamanzi*, Solidarity, a New Categorical Imperative, 22.
[145] cf. *Fleischer/Ochel*, Schlaglichter einer modernen Seuche, 27.
[146] cf. *James*, Factors that Render the Girl-Child Vulnerable, 7.
[147] cf. ibd. 6.

This information regarding the close connection between poverty and vulnerability to HIV/AIDS reflects the common sense that is expressed in the literature taken as a basis here. KELLY breaks ranks from this commonly-held conviction by stating that high-risk behaviour cannot be found solely among poor people, but also among the non-poor, so that people with higher incomes have a higher HIV prevalence than those with lower incomes.[148] This is because

> Being better-off makes it possible to adopt certain lifestyles and behaviours. Wealth [...] has been found to be associated with earlier male sexual debut, less likelihood of being faithful to one's partner and a greater likelihood of having multiple partners. Wealth also provides more opportunities for travel and casual sex, and more resources to pay for transactional and intergenerational sex. All of this implies that individuals who are relatively more affluent, be they women or men are more likely to be infected with HIV than the poorest people.[149]

KELLY therefore criticises a one-sided focus on the poor when it comes to HIV/AIDS prevention. The non-poor too need to be observed, for instance with campaigns which are tailored to this target group.[150]

This broader view of the economic background to the HIV/AIDS epidemic is certainly helpful. However, it also makes it clear that – although both income groups show high-risk behaviour – the starting situations are however quite different. The fundamental difference, which also justifies giving preferential treatment to the poor, is their lack of freedom of action. Whilst their situation frequently offers them, or appears to offer them, no alternative to ensuring their survival and that of their families with high-risk behaviour, the non-poor do not face such existential pressure.[151] According to KELLY, they are therefore free to opt either for or against high-risk behaviour.

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[148] cf. *Kelly*, HIV and AIDS, 111.
[149] Ibd. 112.
[150] cf. ebd.
[151] cf. ebd. 116.

All in all, therefore, CHUMMAR is likely to be right to say that poverty is a central element of the HIV/AIDS epidemic in Africa[152] if we consider that the non-poor also constitute a group with increased vulnerability.

2.1.7. Interim conclusion

This summary overview of the spread and vulnerability factors has shown how complex the HIV/AIDS epidemic in Africa is and in what complicated manner the individual aspects are linked. There is no need to mention here that it has not been possible to cite all the influencing factors. Other factors include female genital mutilation[153], other sexually-transmitted diseases[154], mother-child transmission[155] and certain healing theologies[156].

It also becomes clear without developing these other phenomena in detail that HIV/AIDS is not simply a disease which can be countered by medical means pure and simple, but above all cultural, economic and religious aspects need to be looked at. Against this background, the Church in Africa also needs to face the question as to the extent to which She is promoting attitudes and actions in Her doctrines and pastoral

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[152] cf. *Chummar*, HIV/AIDS in Africa, 155.

[153] cf. *James*, Factors that Render the Girl-Child Vulnerable, 5: "This practice poses a great danger to the initiates if any are HIV positive. This is because some women surgeons use the same blade to initiate each of the girls. Furthermore, the external genital mutilation of circumcised girls tends to leave scar tissue, which easily tears during sexual intercourse making it easier for women to become infected."

[154] cf. *Denis*, Sexualität und HIV/AIDS in Südafrika, 33: "The incidence of such infections […] considerably increases the probability of infection. Sexually-transmitted diseases are however very rarely treated in Africa." (original German; non-official translation).

[155] cf. *Fleischer/Ochel*, Schlaglichter einer modernen Seuche, 27.

[156] cf. *Mboya*, A local Church's holistic response to HIV/AIDS, 133: "The danger of this teaching is that it creates room for the person for whom prayer has been offered to live in denial of his or her status and to refrain from seeking medical help in an effort not to interfere with the healing or faith. This may mean that the person would view HIV/AIDS testing as unnecessary, as undergoing it would indicate a lack of faith, which would then frustrate the healing."

practice which do more to support the spread of HIV and AIDS than to stem it.

2.2. Preventive measures

The distinction that has been introduced between exposure to the virus and contagion makes it clear that not all high-risk contact must also lead to an infection since suitable preventive measures can reduce the risk of the virus being transmitted. Those preventive measures will therefore now be explored which according to the literature, firstly, can minimise the individual risk of an HIV infection with high-risk contact and, secondly, are to stem the phenomenon at societal level.

2.2.1. Changing behaviour

The be all and end all of many preventive measures is the call to change (sexual) high-risk behaviour.[157] Something which at first sight appears to be highly plausible and simple is a somewhat complex topic when looked at more closely. It has already been revealed here that HIV/AIDS-relevant behaviour in Africa is predominantly determined by cultural convictions or economic constraints. The idea that individuals who are either already infected, or indeed not, would alter their behaviour in order to protect others or themselves although the socio-economic conditions remain the same appears to be utopian wishful thinking. When it comes to those who are already infected, BANGERT points out that the structure of the disease itself makes it difficult to change behaviour. Since a considerable period of time passes between the time of the infection and the first symptoms occurring, infected people are not immediately forced to change their behaviour.[158]

In spite of these obstacles, it is nonetheless evident that effective HIV/AIDS prevention must be accompanied by a change of behaviour on the part of those concerned. MATHEWS sums up as follows the conditions that need to apply in order to do so:

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[157] cf. *Ayanga*, Religio-Cultural Challenges, 44.
[158] cf. *Bangert*, HIV und AIDS als theologisches Problem der Kirche, 81.

[T]he individual:

(a) has a strong positive intention to perform it;
(b) is not impeded by constraints, either external or internal to the person, that make the behaviour difficult to achieve;
(c) perceives more social or normative pressure from relevant referents to perform the behaviour than not to perform the behaviour;
(d) has the necessary skills to perform the behaviour;
(e) believes that the perceived advantages outweigh the perceived costs, i.e. the person has a positive attitude toward performing the behaviour;
(f) perceives the performance of the behaviour to be consistent with his/her self-image;
(g) has an emotional reaction to performing the behaviour that is more positive than negative and
(h) perceives that he/she has the capabilities to perform the behaviour under a number of different circumstances.[159]

2.2.2. The ABC method

The call to change behaviour is detailed as a rule using the "ABC method" (abstinence, be faithful, use condoms), which is the prevention strategy that receives the greatest amount of publicity[160], and which clearly targets individual high-risk behaviour. The order of the three individual prevention methods can also be understood such that they are not a contingent result of the play on words, but constitute a sequence. This would then primarily call for sexual abstinence until a stable partnership (ideally marriage) is established, in which mutual faithfulness is required. If it is not possible to remain faithful to one's partner, the use of condoms is strongly recommended.

The literature does not question the benefit ensuing from abstinence and faithfulness when it comes to fighting the HIV/AIDS epidemic – although gender inequality leads to women being denied their right to sexual self-determination; by contrast, the contribution made by condom use is disputed. As will be shown below, the authors however do not take up

[159] *Mathews*, Reducing sexual risk behaviours, 165.
[160] cf. *Abdool Karim*, Heterosexual transmission of HIV, 292.

the fundamental doctrinal ban on condoms as a contraceptive, but advance other arguments.

However, it must first be noted that, according to various studies, the continuous, and correct, use of condoms reduces the risk of infection by roughly 80 %.[161] It can further be shown that the willingness to use condoms rises if people already have experience of using them.[162] Nevertheless the level of acceptance of condoms tends to be low in Africa, as they are generally associated with "infidelity, lack of trust and the possibility of infection"[163].

Condoms however only offer maximum protection against HIV infection if they are actually used on each instance of sexual intercourse and are not badly manufactured or used wrongly.[164] This leads to the first point of criticism, since a certain level of quality in the manufacturing process of condoms cannot always be guaranteed in Africa.[165] Even if the manufacturers were able to ensure the necessary quality, the problem would remain that condoms are not available in all places in Africa.[166] As serious as these problems may be, they would be relatively easy to solve in technical terms. What would however remain would be the only relative protection which condoms provide. "Even if it is only a small percentage, no one can be certain that they are not among them."[167] Critics hence accuse the proponents of condoms of pretending to offer a safety which condoms simply cannot provide, and hence inciting people to engage in high-risk behaviour. KEENAN replies on this that, even if it does not pro-

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[161] cf. ibd. 293.
[162] cf. *Myer*, Barrier methods, 193.
[163] Ibd.
[164] cf. *Keenan*, Vier Aufgaben der theologischen Ethik, 307.
[165] cf. *Bujo*, Community Ethics, 75.
[166] cf. *Myer*, Barrier methods, 194.
[167] *Bujo*, Plädoyer für ein neues Modell von Ehe und Sexualität, 203 (original German; non-official translation).

vide 100 % protection, "this method offers a significant level of protection"[168] for sexual contacts.

A further criticism addresses not the protective potential of condoms, but targets a more general level. OROBATOR for instance stresses that condoms while providing protection only treat "symptoms" of the HIV/AIDS epidemic: "[T]hey do not address the root causes of the disease."[169] And BUJO goes on to state:

> Many people, and the young in particular, feel that condom use is equivalent to a victory over the deadly virus, and they no longer make efforts to change their sexual behaviour, which is however what could actually effectively combat the real cause of the disease.[170]

CHUMMAR adopts a culture-sensitive perspective on condoms. He feels that condoms cannot be the solution to HIV/AIDS in Africa. As they are a Western solution, "it can never be an inculturated solution for the people of Africa."[171] The solution to the problem in Africa would however have to be one that took the cultural convictions and values of African people into consideration.[172]

A final evaluation of the entire ABC strategy is ambiguous. Since the main cause of the epidemic in Africa is unprotected sexual intercourse, the triad of abstinence, faithfulness and using condoms does actually constitute a set of tools providing protection. Since however the strategy remains static at the individual ethical level, it is blind to cultural and structural influencing factors:

> This strategy can however not be applied to most women: It ignores the deep-seated patriarchal norms giving men the right to decide under what conditions sexual intercourse takes place, that is whether force is used or condoms may be used. […] Effective HIV prevention must therefore go

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[168] *Keenan*, Vier Aufgaben der theologischen Ethik, 307 (original German; non-official translation).
[169] *Orobator*, Ethics of HIV/AIDS Prevention, 153.
[170] *Bujo*, Plädoyer für ein neues Modell von Ehe und Sexualität, 205 (original German; non-official translation).
[171] *Chummar*, Inculturated Theological Ethics in Africa, 37.
[172] cf. ibd.

> beyond ABC. It must appropriately enable women and girls to implement what they have learned in their lives. It must also change the structures making women vulnerable, meaning changing property rights and promoting the economic independence of women and girls.[173]

2.2.3. Antiretroviral therapy (ARV/ART)

It is also possible to entrench antiretroviral therapy in the context of the preventive measures to prevent the spread of the epidemic. The priority goal of this therapy is to use the antiretroviral medicines to reduce the viral load in the body to below the detection limit.[174] This therapy, which entails conscientiously taking drugs for the rest of one's life, does not cure the disease, but it can delay the development of the infection until the outbreak of AIDS long enough to make normal life expectancy possible. ART opens up new prospects for people infected with HIV, and thus the Church too is committing Herself to an above-average degree to the implementation of ART programmes in Africa.[175] Recent studies have shown that ARTs can not only delay the outbreak of AIDS, but can also reduce the risk of transmission:

> Results announced today by the United States National Institutes of Health show that if an HIV-positive person adheres to an effective antiretroviral therapy regimen, the risk of transmitting the virus to their uninfected sexual partner can be reduced by 96 %.[176]

Effective ARTs therefore protect the non-infected partner with a higher success rate than for instance condoms can.

This success story of ARTs can however not deny the fact that this therapy has come up against certain obstacles in Africa: The medicines administered themselves constitute a considerable strain on the body, and often have major side-effects. The therapy also requires the medicines to be taken continuously and consistently in order both to be successful

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[173] *Weinreich*, HIV und AIDS aus Sicht einer christlichen Frau, 143–144 (original German; non-official translation).
[174] cf. *Mboya*, A local Church's holistic response to HIV/AIDS, 133.
[175] cf. *Czerny*, ARVs When Possible, 98.
[176] *UNAIDS/WHO*, Press Release.

and also to prevent the virus becoming resistant.[177] But even if they are taken correctly, the effectiveness of the medicines has been shown to fall off over time, thus making it necessary to re-adjust the dosage. All of this requires a medical infrastructure in the environments in which the patients live, something which can rarely be guaranteed in Africa[178]:

> [P]roper medical and social infrastructure must first be in place; medical staff need to be trained in ARV therapy, testing facilities for blood products must be available, counselling services are required, as are other technical and support structures.[179]

The medicines are also very expensive[180], and many infected people have little or no chance of being able to pay for them.

As well as these structural difficulties related to ARTs, other reservations remain against this form of therapy. ARTs are regarded as a Western form of therapy which does insufficient justice to the cultural background in Africa.[181] In conjunction with a strong anti-Western interpretation of HIV and AIDS – HIV as a Western "invention" to weaken Africa – there is also major prejudices against ARTs, which are regarded as just another way of earning money in Africa.[182] Added to this are reservations against ARTs, which are primarily put forward by the Pentecostal/Evangelical Churches. They fear that these medical developments will undermine their HIV/AIDS method, which primarily consists of sexual abstinence.[183]

Even though ARTs therefore have a positive impact on the life expectancy and quality of life of infected people, as well as drastically minimising the risk of disease transmission, this form of therapy is contingent on a developed medical and social infrastructure, and it entails reservations

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[177] cf. *Czerny*, ARVs When Possible, 99.
[178] cf. *Bujo*, Plädoyer für ein neues Modell von Ehe und Sexualität, 206.
[179] *Mulligan*, Confronting the challenge, 65.
[180] cf. *Czerny*, ARVs When Possible, 99. No concrete figures are provided here.
[181] cf. ibd. 100.
[182] cf. *Chummar*, HIV/AIDS in Africa, 159.
[183] cf. *Burchardt*, The logic of therapeutic habitus, 53–54.

and risks, thus making it difficult to adequately supply the population in Africa.

2.2.4. Cultural development

This literature study documents the fact that, in the unanimous opinion of the various authors, neither an effective fight against HIV/AIDS in Africa, nor an African theology of HIV and AIDS, can do without the cultural convictions. As has been shown, inculturated methods and solutions are repeatedly and rightly called for which are to link to positive aspects of African culture. The presentation of the vulnerability factors in this study has however also made it clear that there are equally problematic cultural convictions, norms and practices which increase the risk of infection instead of reducing it. A comprehensive prevention strategy must therefore also attempt to trigger a cultural development in order to minimise the vulnerability and high-risk behaviour of women and men within this cultural group.[184]

This perspective is naturally contingent on culture not being an inflexible concept, but dynamic and adaptable. Many authors – albeit not all of them – presume the existence of such an adaptable understanding of culture.[185] It is interesting at this point to see how cultural norms can be changed. Here too, the method of an "inculturated method" appears to be the most promising, that is cultural changes should not be primarily forced from the outside, but should take place from within one's own culture.[186] BENN reports of a successful example of such a process of change:

> One example is the widespread tradition of the sexual cleansing of widows who are 'inherited' by male relatives of the deceased man. Case studies from Zambia show that there is an increasing understanding of the risks of HIV and AIDS that are connected with these practices. This has led to village elders and chiefs, who exert a major influence on cultural

[184] cf. *Green/Ruark*, AIDS, behavior, and culture, 48.
[185] cf. for instance *Ayanga*, Religio-Cultural Challenges, 37; *Benn*, Der Einfluss von Weltanschauung und Kultur, 26; *Odozor*, Morality truly Christian, truly African, 171.
[186] cf. *Bujo*, Plädoyer für ein neues Modell von Ehe und Sexualität, 156.

> practices, handing down local laws to abolish these traditions. The tradition of social assistance and of the symbolic cleansing of widows has not been abolished, but replaced by alternative rituals which were of a more symbolic nature and avoid the risk of HIV transmission.[187]

This example not only shows how the separate development of the culture can take place, but also reveals what fundamental evaluation criterion can be taken as a basis when it comes to re-orientating cultural ideas: It is vital here to distinguish between promoting life and endangering it.[188] True, this distinction requires to be made more concrete, but it permits an initial assessment to be made with regard to the value attaching to cultural norms and practices. It is important here that this fundamental criterion is in turn in harmony with African culture. If one concurs with BUJO, this evaluation standard is deeply anchored in African thinking:

> It should therefore be repeated once more, as we have done for other areas, that the ancestors, were they alive today, would no longer hold on to their traditions if they did not promote life, but in fact brought death.[189]

The role played by the Church and other religious groups within this process of cultural self-renewal should not be underestimated. They are rooted in the local structures in most instances[190], and hold considerable authority within the population[191], which however turns into hubris in some cases:

> Only Christian faith can impact the worldview of those who exercise the sexual practices which are primarily responsible for the spread of HIV and AIDS.[192]

This notwithstanding, it is a major task of the Church in Africa and of African theology to take a critical view of African culture.[193] Apart from

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[187] *Benn*, Der Einfluss von Weltanschauung und Kultur, 21 (original German; non-official translation).
[188] cf. *Odozor*, Morality truly Christian, truly African, 84.
[189] *Bujo*, Plädoyer für ein neues Modell von Ehe und Sexualität, 183 (original German; non-official translation).
[190] cf. *Benn*, Der Einfluss von Weltanschauung und Kultur, 24.
[191] cf. *Mboya*, A local Church's holistic response to HIV/AIDS, 125.
[192] *Correll*, HIV/AIDS, 34 (original German; non-official translation).

the general distinguishing principle of "promoting life vs. endangering life", which is compatible with liberation theological and feminist theological methods from Africa[194], the literature does not offer many normative methods from which the cultural reflection of the Church could depart. Only recourse to Holy Scriptures appears to be common, which is generally regarded in the theological literature as an important normative foundation. Thus, for instance NKANSAH-OBREMPONG calls as follows:

> We must challenge cultural practices and values, social hierarchy, unhealthy relationship between husband (man) and wife (woman), relationships between parents and children, unfair or unjust cultural practices that have moral implications for the community's members that are incompatible with biblical ethics. We must repudiate such cultural practices. Throughout the Scriptures, we are exhorted to disengage ourselves from the things and practices that characterized our former ways of life that did not please God. These values should not determine our behavior any longer because the triune God has given us a higher cultural value that He has modeled for us.[195]

What these and similar methods however overlook is the fact that Biblical ethics too – whatever form their content may take – are only accessible to us in the shape of cultural conditionalities. A direct transfer of Biblical norms from their original cultural context to another context is only possible in most cases if the Biblical norm itself remains general, which in turn requires concretisation in the respective context and circumstances.

The question as to the normative sources of an intercultural theology which approaches cultures in a sensitive, critical manner in general and – in our case – the cultural patterns of Africa, hence does not yet appear to be adequately answered. This circumstance can be exemplified once more using a concrete example: "virgin testing", that is the requirement that a woman be a virgin when marrying and this also being tested. Whilst for instance BUJO considers this practice to constitute a contribu-

[193] cf. *Thawale*, African Anthropology and Holistic Pastoral Approach to HIV/AIDS, 35.
[194] cf. *Lindorfer*, Skizzen zur Prävention von HIV, 119–120.
[195] cf. *Nkansah-Obrempong*, Foundations for African Theological Ethics, 309.

tion towards HIV prevention[196], other authors vehemently reject it. The responsibility for safe sexuality is said to lie solely with women in this case, which further cements gender inequalities.[197] Furthermore, "virgin testing" is said to promote anal sex to maintain virginity[198], which in turn entails a heightened risk of infection (see No. 2.1.3). Depending on the point of view, therefore, one and the same cultural practice is assessed as either positive or normative. In order to be able to resolve this conflict, it is vital to reveal the normative background of such an evaluation and to reflect on it as to its consistency and coherence.

These difficulties must naturally not lead to a situation in which attempts are terminated to respectfully integrate life-promoting elements of African culture into an HIV/AIDS strategy and theology and to transform or abolish life-endangering aspects. Cultural development is a cornerstone for getting the epidemic in Africa under control.

2.2.5. Education

A further important preventive measure is education action regarding HIV and AIDS. Even if there are voices which stress that education alone does not lead to changes in behaviour[199], education is nonetheless regarded as an important element in the fight against HIV/AIDS[200]. High-risk behaviour can only be avoided by knowing which acts are risky and what alternatives exist. Although this is primarily concerned with communicating knowledge on sexuality, symptoms, infection paths, etc., it is also about education in a more comprehensive sense. Poverty and economic dependence are also induced by education in Africa[201], so that a lack of education leads to a heightened vulnerability to HIV/AIDS.

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[196] cf. *Bujo*, Community Ethics, 75.
[197] cf. *Abdool Karim*, Heterosexual transmission of HIV, 300.
[198] cf. *Haddad*, Poverty, Gendered Cultural Sexual Practices and HIV, 15.
[199] cf. *Kamaara*, The Impact of HIV and AIDS on Vulnerable Groups, 82.
[200] cf. *Nduku*, The Impact of Poverty, Illiteracy and Ignorance, 53.
[201] cf. *Ayanga*, Religio-Cultural Challenges, 42.

The demand for education efforts in the (expanded) field of HIV/AIDS, which the Church must also face[202], is voiced above all with regard to three "target groups":

1. Since women are much more vulnerable than men in Africa, it is primarily mentioned that there is an urgent need to offer education for women.[203]

2. Traditional healers and other authorities constitute another important target group:

> Traditional healers and opinion-leaders should be enabled to receive qualified training and attend HIV/AIDS prevention activities from the outset. Then they can also be expected to change dangerous myths or practices. Neglecting them and what they say about the HIV/AIDS phenomenon would be counterproductive, and would neglect important options in prevention.[204]

3. And finally, clergy, Religious and pastoral workers need a sound HIV/AIDS education. They are frequently confronted with infected people or the diseased, and are asked for advice, but: "[t]heir knowledge of the pandemic is rudimentary."[205] This disqualifies them from offering appropriate assistance to those who need it.

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[202] cf. *Nduku*, The Impact of Poverty, Illiteracy and Ignorance, 54.

[203] cf. ibd.

[204] *Benn*, Der Einfluss von Weltanschauung und Kultur, 26 (original German; non-official translation).

[205] *Nubuasah*, Salvation and Liberation in Africa, 125.

3. African-theological reflections on the HIV/AIDS epidemic

The analysis of the HIV/AIDS epidemic by the theologians listed here shows that HIV and AIDS constitute a medical, cultural and economic challenge. However, this approach to the epidemic would remain lacking were one to disregard its religious dimension: "HIV and AIDS demand answers to existential questions"[206] Many people in Africa expect the Church to provide assistance and helpful answers to their concerns, needs and questions with regard to HIV and AIDS. If one takes a look at Her practical actions, it is however revealed that the African Church and Her workers do not speak with one voice; the attempts to provide answers vary from condemnation and exclusion on the one hand to sympathy and support on the other.[207]

This tension is certainly also based in the complex topics which are concerned by the HIV/AIDS problem in Africa. All the aspects of the epidemic that have been put forward here need to be considered in a theological response, so that a theology in the face of HIV and AIDS needs to be holistic in terms of its basic concept:

> The methodology of HIV/AIDS theology must be holistic because of the diversity of ways this issue is being addressed. As well, because of its very complex nature that involves natural sciences, human sciences, education, philosophy, and theology, it should be addressed in a holistic way.[208]

Although this expectation as to the Church's response and theological reactions is justified, it might however lead to a misinterpretation of the Church's position: The Church would be outside the HIV/AIDS problem, and could nonetheless provide answers from outside. HIV and AIDS are however also Church realities, and by no means only a problem affecting "others": faithful, priests and bishops are "infected with the HI virus, have

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[206] *Bangert*, HIV und AIDS als theologisches Problem der Kirche, 83 (original German; non-official translation).

[207] cf. *Nubuasah*, Salvation and Liberation in Africa, 125.

[208] *Okambawa*, African HIV/AIDS theology, 337.

already fallen foul of AIDS or have even died [...]."[209] HIV and AIDS surround the Church in Africa, and form part of Her; this requires a reflection of the Church's understanding of Herself and of Her mission.[210] A theology of HIV/AIDS must hence both reflect the situation of infected and sick people, and the theological position of the Church in Africa against the background of the epidemic. This intertwining of HIV/AIDS with the Church is incorporated in theological terms with the image of the body of Christ: "When all baptised are parts of the body of Christ, the infection of one single member has consequences for all other parts."[211] The infection or illness of one individual hence means – figuratively – the infection and illness of all parts.

MAJAWA formulates two questions in the face of this challenge, which a theology of HIV/AIDS should work out:

> How can we build a living, vibrant, self reliant and transformative African Church in the face of HIV/AIDS? How can the Church preach and witness to the Gospel of hope and values of development while confronting imminent death?[212]

In this sense, elements of an African theology will be presented below in the face of HIV/AIDS.

3.1. The foundation of a theology of HIV/AIDS: Inculturation

The theologians cited here agree that only an inculturated theology "can answer the real issues [...] and give real guidance and hope in Africa."[213] The call for such an inculturated and contextual theology is based here amongst other things on the circumstance that questions and problems occur in the various cultures which are not adequately answered and

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[209] *Bangert*, HIV und AIDS als theologisches Problem der Kirche, 79 (original German; non-official translation).
[210] cf. *Orobator*, When AIDS Comes to Church, 120.
[211] *Bujo*, Plädoyer für ein neues Modell von Ehe und Sexualität, 228 (original German; non-official translation); cf. also *Mwaura*, Violation of Human Rights of Kenyan Women, 140.
[212] *Majawa*, Concluding Remarks, 125.
[213] Ibd. 134.

solved by traditional (European) theology.[214] An African theology hence always has inherent in it a momentum of "rebellion" against a negative qualification of African culture and history.[215] Conversely, a truly inculturated theology which appreciates African culture would remove from theology the aftertaste of cultural colonialism and make it more acceptable to Africans.[216]

This sparks an existential demand for an African theology and an African understanding of the Church, which SANTEDI expresses as follows:

> The Churches in Africa cannot be imitations or officially-certified duplicates of the Churches in Europe. They are called upon to determine their own authentic manifestation. […] This […] perspective of inculturation impacts both the Churches in Africa and the Universal Church. It means that the life and thinking of the Church can no longer be understood monolithically, but in terms of the diversity of the cultures. This includes in highly practical terms the assertion of cultural identities within the Universal Church, as well as the possibility for these peoples to interpret and express Christianity in a different way in their lives.[217]

African theology naturally does not come from nowhere, but can and must play a critical role in the theological tradition of the past. ODOZOR sees four pillars here on which an inculturated African theology should be based:[218] the Holy Scriptures, God's unique revelation in Jesus Christ, African tradition and Christian tradition.

The desire for an African theology of HIV/AIDS is given concrete form in the literature by virtue of diverse elements of such a theology being named and their position being reflected in the African context.

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[214] cf. *Odozor*, Morality truly Christian, truly African, 10.
[215] cf. ibd. 12.
[216] cf. *Bujo*, Plädoyer für ein neues Modell von Ehe und Sexualität, 234.
[217] *Santedi Kinkupu*, Für die Inkulturation der Glaubenslehre, 435 (original German; non-official translation).
[218] cf. *Odozor*, Morality truly Christian, truly African, 21–22.

3.2. Components of an African theology of HIV/AIDS

An African theology of HIV/AIDS focuses on theological ethics, ecclesiology, the doctrine on the sacraments and the Church's pastoral practice. Other topics, such as the liturgy[219], are also touched upon in individual cases, but the vast majority of publications are focussed on these topical areas.

3.2.1. Theological ethics

The HIV/AIDS epidemic poses a challenge to theological ethics at both individual ethical and at social ethical levels. Here, above all the individual ethical and moral theological discussion shows that traditional European moral theology tends to start with the individual, whilst the African reflection on values and norms is based more firmly on communal thinking.[220] BUJO criticises in this context a misunderstood universality of norms which serves solely to "silence other cultures without engaging in any dialogue whatever."[221]

CHUMMAR is less radical in his identification of four principles of inculturated ethics in Africa:

1. First and foremost, is the ‚Principle of Life', which is the highest good and God's most precious gift for us in African culture and belief.
2. The ‚Principle of Liberation', which serves to liberate the people and their life from all possible ways of new slaveries and sufferings – poverty, illness, faith in an evil spirit and its power, economic and political oppression and exploitation – based on the liberation paradigm of Jesus of Nazareth.
3. The ‚Principle of Inclusion' by which not only the ‚oppressed' is liberated, but also the ‚Oppressor' from his/her oppressive methods, so that a holistic salvation can take place and the liberation become a permanent reality.

[219] cf. *Njoroge*, A body of knowledge for HIV research, 133.
[220] cf. *Bujo*, Plädoyer für ein neues Modell von Ehe und Sexualität, 229.
[221] Ibd. 236–237 (original German; non-official translation).

4. The Principle of Faith and Moral Relevance‘ in line with the official Church, which establishes the universal characteristics to ensure its standing in union with the Catholic and Apostolic Church.[222]

These principles and the concrete problems posed by HIV/AIDS lead to certain topics of theological ethics which require a more intensive discussion and greater commitment on the part of the Church:

- There is a need for an African-theological reflection on the understanding of sin and sinful behaviour with regard to HIV/AIDS which has both a Biblical and an African-anthropological foundation.[223]
- A further topic is the Church's understanding of sexuality. The African experience with HIV/AIDS confronts the Church's doctrines with the fact that sexuality "is a social reality which is characterised by social, economic and cultural factors."[224] This experience has received inadequate attention to date.
- In terms of lending concrete form to the understanding of sexuality, the Church in Africa is called upon to implement the Catholic teaching on marriage in Africa in such a way that the essence of marriage is not swallowed up in fertility: "A human-African, Christian life is certainly also possible if there are no offspring."[225] Such an implementation with regard to marriages between discordant couples could promote the acceptance of condoms and prevent the transmission of the infection to the offspring.
- Another topic within the Church's sexual morals which requires profound reflection is condom use. Even if they certainly do not

[222] *Chummar*, Inculturated Theological Ethics in Africa, 45.
[223] cf. *Bate*, HIV Prevention and the Theology of Sin, 189.
[224] *Denis*, Sexualität und HIV/AIDS in Südafrika, 41 (original German; non-official translation).
[225] *Bujo*, Plädoyer für ein neues Modell von Ehe und Sexualität, 154 (original German; non-official translation).

constitute a final solution to the HIV/AIDS epidemic in Africa[226], they are nonetheless one of the most effective technical aids to prevent infection[227]. In terms of the Universal Church, there is hence a need to consider whether the prevalent guiding ethical perspective – condoms as an artificial contraception method – does justice to the situation in Africa with regard to the epidemic, or in fact should be expanded to include the aspect of infection prevention. The (cultural) reservations which were presented at No. 2.2.2 should also be dealt with at the intercultural level.

- Finally, the Church in Africa is called upon – starting with the fact of all people being created in God's image[228] – to point to structural and individual poverty, uncover social injustices and name their cultural backgrounds:

> Dismantling the unjust structures in which gross income inequality, the low status of women, stigma and discrimination, and exploitative global economic practices are embedded, and establishing just structures and practices in their place, will create a terrain in which the human immuno-deficiency virus can no longer flourish.[229]

This means in the context of HIV/AIDS in Africa that it is a central challenge for theological ethics to specify an option for the poor as a "preferential option for women and children"[230]. Such an option might express itself for instance in theology and Churches in Africa enhancing women's right to sexual self-determination so that they can play an active, equal role in shaping sexuality within partnerships.

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[226] cf. *Orobator*, Ethics of HIV/AIDS Prevention, 153.
[227] cf. *Keenan*, Vier Aufgaben der theologischen Ethik, 307.
[228] cf. *Majawa*, Concluding Remarks, 131.
[229] *Kelly*, HIV and AIDS, 252.
[230] *Lebouché et al.*, Religion in the AIDS Crisis, 173.

3.2.2. Ecclesiology

The problem of HIV and AIDS also challenges the Church to think about the "nature, identity and mission of the Church Herself"[231]. The self-understanding of the Church in Africa is all the more on the test-bed as it initially adopted, without reflection, a European ecclesiology from the missionaries, which some authors also consider to be responsible for the heightened vulnerability to HIV and AIDS:

> The prevailing ecclesiastical models existing within Africa were inherited from European missionary Christianity. As such, they are hierarchical, thriving on the centralisation of power and a corresponding disempowerment, particularly of the laity. Such a top-down ecclesiology has not only troubled women, but all who are concerned about the rights and well-being of those at the bottom of such hierarchies.[232]

Against this background, theologians are called upon to develop an African ecclesiology focussing on the terms inclusion, justice and the protection of life.[233]

3.2.3. Sacramental theology

It is above all BUJO who on the basis of a need to develop an African ecclesiology is in favour of subjecting European sacramental theology – particularly with regard to a "renewed theology of the minister"[234] – to a culturally-characterised re-reading in order to make the "healing dimension of the Church"[235] more visible to the outside. He proceeds here from the observation that many laity, and women in particular, assume the "ecclesial task"[236] of caring for the sick.

> This finding is significant not only with regard to African ecclesiology, but specifically in relation to the ministering of the sacraments, namely the

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[231] *Majawa*, Concluding Remarks, 130.
[232] *Hinga*, AIDS, Religion and Women in Africa, 87.
[233] cf. *Haddad*, Poverty, Gendered Cultural Sexual Practices and HIV, 17. More on this in No. 3.3.3.
[234] *Bujo*, Plädoyer für ein neues Modell von Ehe und Sexualität, 217 (original German; non-official translation).
[235] Ibd. (original German; non-official translation).
[236] Ibd. 211 (original German; non-official translation).

> Eucharist, confession and the anointing of the sick. It therefore needs to be stressed that we are dealing in Africa with many women who are in the service of those who are infected with HIV/AIDS, such that one may speak here of a feminisation of the Church which could lend a new dynamism to our ecclesiology. The predominant presence of women in the service of the sick makes the question of the ministering of the sacraments more complex still.[237]

BUJO considers a renewed practice of the ministering of the sacraments to be centred on the African institution of the communal "palaver", which constitutes a place in which to discuss problems and solutions, and finally reconciliation.[238] With a view, for instance, to the anointing of the sick, he therefore writes:

> From the point of view of the therapeutic palaver, apart from the inner liberation of the patient, physical healing is also clearly stressed. People who accompany those suffering from AIDS regard their service as constituting healing in the holistic sense. They cannot separate the spiritual dimension from physical care. It is hence worthwhile discussing the problem of the anointing of the sick differently than previously. The burning question [...] is whether they cannot give the anointing of the sick to the dying in their function as helping those infected with HIV/AIDS, although the traditional teaching of the Church reserves this ministration to priests and bishops alone.[239]

3.2.4. The Church's pastoral practice

The elements discussed in the literature of an African theology of HIV/AIDS refer furthermore to a change in the everyday pastoral practice of the Church in Africa. In this regard, SANTEDI points out that inculturation is not only a task for the Church's teaching, but also relates to Christian orthopraxy.[240] VITILLO also points in the same direction by indicating that the Church's response to HIV and AIDS cannot consist of words only, but must prove itself in the everyday service of all faithful for the sick and in the fight against the epidemic.[241]

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[237] Ibd. (original German; non-official translation).
[238] cf. ebd. 133–134.
[239] Ibd. 215 (original German; non-official translation).
[240] cf. *Santedi Kinkupu*, Für die Inkulturation der Glaubenslehre, 438.
[241] cf. *Vitillo*, A witness to truth and solidarity, 368.

The consequence of this is that the state of pastoral workers' knowledge on HIV/AIDS and their behaviour towards infected and sick people must change. Many can only be said to have rudimentary knowledge of the disease and its infection paths, which leads to considerable fear and consequently to the exclusion of people who are infected with HIV.[242] It is only on the basis of such sound knowledge that the Church is able to wholeheartedly devote Herself to the infected and sick, which naturally also includes offering them spiritual guidance.[243] The Church's efforts may however not be reduced to guiding those who are already sick. Her responsibility explicitly entails Her actively attempting to reduce vulnerability to HIV/AIDS in Africa. CZERNY has put together a concrete list of tasks to this end, albeit this is certainly not to be understood exhaustively:

> The Church's AIDS ministries need close links with every effort to eradicate poverty, fight disease and sustain human development:
>
> a) Making sure that every man, woman and child can meet their essential nutritional requirements;
> b) Providing adequate and truly accessible primary health care with proper infrastructure;
> c) Staffing clinics and health centres and stocking them adequately with essential drugs;
> d) Offering quality basic education for every child and every adolescent;
> e) Assuring safe water and hygienic sanitation for all;
> f) Expanding employment.[244]

3.3. Potential guiding theological perspectives

It is noticeable that specific individual elements are frequently named in the literature, which however are rarely placed into a broader theological context. Only in isolated cases are possible guiding theological perspectives discussed – in greater or lesser detail – which could act as a yardstick for an African theology on HIV and AIDS. The common path of

[242] cf. *Mwaura*, Violation of Human Rights of Kenyan Women, 368.
[243] cf. *Thawale*, HIV/AIDS as a Spiritual Challenge, 146.
[244] *Czerny*, Working for Healing, 60–61.

these various methods is a respective reading of the Holy Scriptures. Even if these methods – prophetic theology, theology of hope and healing – are presented here in isolation from one another, overlaps nonetheless exist between these theological perspectives.

A first possible guiding perspective could be a "prophetic theology". Inspired by the Old Testament's prophetic tradition, the Church is also to unmistakably stand at the side of those who are suppressed in society and whose voices are not heard.[245] This includes proclaiming God, who is present in the world as a "God of liberation and life, bringing healing to all"[246]. A prophetic theology thus understood can also be anchored in the New Testament – in particular in the Jesuanic talk of a compassionate, merciful God.[247] For the Church and Her workers, such a theology leads to radical solidarity with those concerned, but also with those who are resisting the epidemic.[248]

A "theology of hope" points in a similar direction. Having said that, this theological method is directed more – albeit not exclusively – towards the connection that is frequently established in Africa between the epidemic and sin.[249] The theology of hope in Africa counters the image of a punishing God, and calls on all Christians to be "agents of hope"[250] in order to combat a certain fatalism in Africa vis-à-vis HIV and AIDS.

The best-developed model appears to be an African "theology of healing" which is also able to integrate the core elements of the other guiding theological perspectives. It tackles the fundamental conviction that healing is a task for the Church.[251] Fuelled by African convictions of healing and the Biblical tradition of healing, African theologians expect the Church to develop "a holistic vision of well-being and flourishing, which

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[245] cf. *Mboya*, A local Church's holistic response to HIV/AIDS, 138.
[246] *Haddad*, Poverty, Gendered Cultural Sexual Practices and HIV, 18.
[247] cf. *Simiyu*, The catholic church's response to the HIV/AIDS pandemic, 389.
[248] cf. *Hinga*, AIDS, Religion and Women in Africa, 99.
[249] cf. *Grzelak*, Collaboration between the Catholic Church and the Religions, 225.
[250] *Mombé*, Compassion of Christ, 47.
[251] cf. *Orobator*, When AIDS Comes to Church, 123.

[…] is God's shalom"[252] and to make it become effective in practice. By doing so, the Church realises its mandate in the world to be there for the sick and weak and to offer them help.[253] In Biblical terms, this understanding of healing links to the image of Jesus as a healer whose physical contact with the outcast[254] could be quite paradigmatic for the Church's approach to people who are infected with HIV. According to STINTON, this understanding of Jesus implies four dimensions of healing in particular:

> First, the image of Jesus as healer essentially means that Jesus restores life where it has been diminished, that he repairs life where it has been broken. […] The second major affirmation is closely related to the first, in that the African theologians, church leaders and laypeople alike emphasize Jesus' healing as the re-creation of wholeness in all aspects of life. […] So the third main point regarding the meaning of Jesus as healer is that it conveys Jesus' supremacy over every form of evil operating in the universe, whether manifested in the physical, mental, emotional, spiritual, social, or any other sphere of life. […] A fourth and final affirmation regarding the meaning of Jesus as healer is that the image is intrinsically related to other significant roles such as saviour, liberator and redeemer.[255]

This perception of healing fits in many aspects with the African idea of healing: It goes beyond an individual perception of healing to become healing in the community; it takes life seriously, in all its facets; it offers a space for the influence of "evil" on the well-being of the human. The service of healing which the Church in Africa, following this model, can offer people with HIV is hence also not reduced to the physical dimension of healing:

> People living with AIDS experience healing because they have been welcomed, accepted and integrated into the worshipping community of faith, especially in situations where they have been abandoned and ostracised by family, community and society out of fear and stigma.[256]

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[252] *Katongole*, "An Age of Miraculous Medicines", 111.
[253] cf. *Mwaura*, Violation of Human Rights of Kenyan Women, 137.
[254] cf. amongst others Luke 5:12-13.
[255] *Stinton*, Jesus as Healer, 31–33.
[256] *Orobator*, When AIDS Comes to Church, 123.

According to KATONGOLE, the potential is intrinsic to an African theology of holistic healing to firstly make it possible to experience God in the epidemic, and secondly to carry on a discussion on the various aspects causing the spread of HIV/AIDS in Africa, and to re-invigorate it via the preventive measures:

> Doing so will not only reconnect discussions about HIV and AIDS in Africa with the story of God; it will also re-invigorate discussions about the meaning and value of human life, friendship, marriage, sexuality, fidelity and chastity within the Church and its vision for the New Creation.[257]

It has been noted at various junctures that an African theology of healing is already being enacted, primarily where small Christian communities are at work.[258] These communities are practicing a new way of "being a Church" combining the holistic-healing dimension of the Church with traditional African values.

3.4. Interim conclusion

There is no doubt that the HIV/AIDS epidemic is a "sign of the times" for the African Church.[259] Particularly the evils constituted by this disease call on the Church in this time and in this place to proclaim and live out the Gospel under these conditions – "the kerygma of salvation"[260]: "The crisis of these people is also a call to kairos, to the revelation of God's salvific grace through the dedication and generosity of human beings."[261] In the Church's solidarity with the poor, weak and sick, She testifies to Her mission in the world. However it manifests itself in concrete individual questions, this commitment must be borne by the conviction that people with HIV are rejected neither by the Church nor by God.[262]

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[257] *Katongole*, „An Age of Miraculous Medicines", 111.
[258] cf. *Bujo*, Plädoyer für ein neues Modell von Ehe und Sexualität, 210–211; *Thawale*, African Anthropology and Holistic Pastoral Approach to HIV/AIDS, 36–37.
[259] cf. *Orobator*, When AIDS Comes to Church, 128.
[260] *Okambawa*, African theology of HIV/AIDS, 343.
[261] Ibd.
[262] cf. *Thawale*, HIV/AIDS as a Spiritual Challenge, 149.

4. Conclusion

The task of the literature study was to present the HIV/AIDS epidemic in Africa in its facets – spread factors, preventive measures and theological reflection. This compilation made it clear, first and foremost, that HIV and AIDS is not a medical disease pure and simple: "The AIDS epidemic reveals who we are as people [...]. Our reactions reveal what truths, convictions and values really apply in our society."[263]

As true as it is at medical level that the transmission of the HI virus leads to the outbreak of AIDS, it is also true that the transmission risk and vulnerability to HIV/AIDS are influenced by cultural, socio-economic and religious factors. It will not be possible to understand and stem the extent of the epidemic in Africa if these factors are ignored.[264]

It is against this background that the call for an inculturated solution – and consequently for an inculturated HIV/AIDS theology – is comprehensible and necessary. This study has nonetheless also shown that inculturation may never be based on the foundation of an uncritical cultural understanding. The process of inculturation always includes a critical dialogue with the extant culture, and is particularly not compatible with radical cultural traditionalism. A fundamental precondition for inculturation is also a dynamic understanding of culture which comprises both the aspect of conserving a culture and that of changing it. Even if most authors agree on this point, the question of the normative foundation for this critical standpoint is unresolved, and marks an important research issue urgently requiring theological revision. There is a need to recall at this juncture the briefly-outlined discussion of "virgin testing", which revealed that there is a variety of normative methods for tackling the evaluation of cultural practices. It is certain that critical inculturation can only be successful if it leads to the creation of a more profound under-

[263] *Bate*, Verantwortliches Heilen in einer Welt mit HIV/AIDS, 77 (original German; non-official translation).
[264] cf. *Chummar*, HIV/AIDS in Africa, 159.

standing of genuinely African values and practices.[265] It should be recalled in this context that this study generalised some elements of African culture, thus doing inadequate justice to the plurality of African lifestyles.[266] Practical attempts at inculturation, by contrast, must take account of the concrete contexts, and these may differ from the "African culture" outlined here.

If one considers the Church and theology, one notices first of all "that religion is not only central to how people understand an epidemic, such as HIV; but also how they respond to it."[267] It is important in this regard that the Church in Africa develop a responsible inculturated theology vis-à-vis HIV/AIDS, particularly if one takes into account the fact that previous aspects of the doctrine and practice of the Church have heightened the vulnerability to HIV/AIDS of specific groups of individuals. And although there are methods and individual elements of such a theology, Bishop NUBUASAH stresses: "Very little of the theology of the church deals with the pandemic we are faced with. We are not prepared to face AIDS at all." [268] And thus he urgently calls:

> Those of us in the pastoral field in the frontlines of the pandemic are waiting and calling on theologians to develop a theology of AIDS. It is a matter of urgency, it is not a luxury.[269]

This study has shown that African theologians have already started developing a theology of HIV/AIDS. What appears to be missing is a synthesis of the different individual voices to form a coherent inculturated theology which locates its normative basis theologically and – critically – in a culture-sensitive manner. This would enable theologians to do justice to the challenges of the epidemic that "it is possible for an African to be both African and comfortably Christian."[270]

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[265] cf. *Chummar*, Inculturated Theological Ethics in Africa, 45.
[266] cf. footnote 13.
[267] *Nguyen*, Therapeutic Evangelism, 359.
[268] *Nubuasah*, Salvation and Liberation in Africa, 127.
[269] Ibd.
[270] *Odozor*, Morality truly Christian, truly African, 111.

5. Literature

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