

“I Can’t Use a Condom, I Am a Christian:” Salvation, Death, and... Naivety in Africa

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The countries of the Southern African Development Community – Angola, Botswana, Democratic Republic of the Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, Swaziland, South Africa, Tanzania, Zambia, and Zimbabwe – continue to be hardest hit by the HIV and AIDS pandemic. There is a whole range of social, biological, economic, and political factors responsible for such a situation. In most of the countries of the Southern African region, HIV infection prevalence estimates among adults are beyond 10%; and even higher in young women, especially pregnant ones. Besides being a consequence of AIDS, malnutrition contributes to HIV vulnerability, further deteriorating HIV infection.

The common mode of HIV spread in Africa is heterosexual intercourse, as opposed to the Americas and Eastern Europe, where injecting drug use and male homosexual intercourse are the common mode.

The extent of the contribution of heterosexual intercourse to the spread of HIV in Africa is not accepted by all medical scientists across the world. Gisselquist et al have suggested that the role of unsafe medical injections in the transmission of HIV within the health sector has been underestimated (1). This observation has been corroborated by other researchers (2,3). Lopman et al, however, have not found sufficient evidence to support the suggestion that medical injections could contribute the HIV infection in Zimbabwe (4).

PREVENTION PRACTICE

As the major mode of HIV transmission in Africa is considered to be heterosexual intercourse, the major mode of prevention has been the ABC approach, ie, sexual abstinence, being faithful (fidelity or mutual monogamy) to one sexual partner, and consistent and correct condom use. Multiple and concurrent partnerships fuel the spread of HIV in Africa.

The Christian church has at times been suggested as an impediment toward the promotion of condoms. At least in Europe, this has caused interesting and bitter discussions, with some people suggesting that the church is insensitive to the real needs of the people it was

supposed to serve. Mukonyora (5) has suggested that “condom use is purely a public health issue and not a spiritual issue” and also described church’s anti-condom message as “mass murder.” Her writing was prompted by a banner at a church building reading – “HIV/AIDS: Using a condom is like walking on a tight rope, one slip could kill you.”

I, however, believe that considering HIV purely as a medical issue with no concerns of the contextual factors such as religion, socio-political, cultural, and economic factors, is at best, naive, and similar to the “denialist” stance that HIV is not the cause of AIDS. I believe that religion, religious beliefs, and affiliation do have a role to play in the stemming, and in some cases, the spread of HIV in much of Southern Africa.

This article is intended to describe the situation in a Christian denomination in Malawi regarding HIV and AIDS. The official position of that church, messages on condoms and sexuality, and the apparent confusion created by various positions of the Church are also discussed.

NUMBER OF CHURCH MEMBERS IN THE SOUTHERN AFRICAN REGION

In the southern African region, there were 1 765 578 members of this Christian denomination in 2004. The full distribution of church members in different countries or geographical regions is shown in Table 1.

Table 2 shows the distribution of new members, members who dropped out, and members who died in 2004 in Malawi. It is noteworthy that Malawi death rates between 1995 and 2004 ranged from 0.57% in 1997 to 1.40% in 1999, with an average of about 0.9%. These death rates are extremely high, ie, the church population in Malawi annually loses about 1% of its members due to death. While the cause of deaths has not been documented, in an environment where adult HIV infection rates are estimated at 14%, AIDS is likely to be one of the main causes of death. It is noteworthy that the distribution follows the distribution of HIV rates in Malawi, ie, lower infection rates in the North and higher rates in the South (6). The church’s response to HIV and AIDS in Malawi ought therefore to consider these statistics.

TABLE 1. Distribution of church members in different countries or geographical regions*

Country	Churches	Companies	Members	Population
Angola	873	1015	253 410	13 459 000
Botswana	71	114	24 349	1 684 000
Indian Ocean	424	822	89 325	20 416 000
Malawi	1205	1471	233 300	11 938 000
Mozambique	937	2614	186 724	19 182 000
Zimbabwe	824	2014	427 762	12 672 000
Total	6608	11861	1 765 578	141 986 000

*Source: Seventh Day Adventist Church. World Church statistics; available from: http://www.adventiststatistics.org/view_Summary.asp?FieldID=D_SID&Year=2004&submit=Change

TABLE 2. Membership status of one denomination in Malawi, 2004*

Region of the country	Beginning membership	Accession (%)	Death (%)	Dropped/missing (%)
Central	37 552	6363 (17.0)	299 (0.8)	2008 (5.4)
North	30 190	2765 (9.2)	138 (0.5)	1273 (4.2)
South	166 118	11 647 (7.0)	2327 (1.4)	4032 (2.4)
Total	233 860	20 775 (8.9)	2764 (1.2)	7313 (3.1)

*Source: Seventh Day Adventist Church. World Church statistics; available from: http://www.adventiststatistics.org/view_Summary.asp?FieldID=D_SID&Year=2004&submit=Change

If we exclude HIV deaths, it is estimated that the total number of adult deaths in Malawi would be around 22 000, ie, 0.18% of the current 80 000 deaths (7).

Absolute annual increase in Church membership ranged from 7255 in 2004 to 17 722 in 1992. However, there was a net membership loss of 39 591 in 1998.

CONDOMS AND HIV PREVENTION

Consistent and correct condom use in penetrative vaginal and anal sex has been demonstrated as an effective way of preventing HIV transmission (7). Condoms also prevent the transmission of other sexually transmitted infections such as syphilis and gonorrhoea. These other sexually transmitted infections also facilitate the efficiency of transmission and acquisition of HIV.

Users of male latex condoms have reported discomfort, vaginal or penile irritation, and lack of sensation as some of the impediments toward consistent use (8). Also, condoms have especially been promoted out of primary relationship and in commercial sex (9). Kaler (10) has described condom use in rural Malawi in regard to "the symbolic nexus in which they are fused with disease, population control, and malevolence will be an ongoing challenge in the struggle to prevent the spread of HIV/AIDS..." They suggest that the relationship be-

tween the community and the agent that has promoted condom use, first for family planning and later for diseases prevention, shapes the acceptability of the device. The female condom is yet to become acceptable to the majority of women and their partners (11). Zachariah et al (12) in their study of commercial sex workers in Thyolo, southern Malawi, reported that too much lubrication, too great size, and noise during sex were some of the technical problems experienced with use of the female condom. Jivasak-Apimas et al (13) from Thailand reported pain, difficulties with insertion, and itching as the most frequent problems. Despite the shortfalls associated with condom use, some reports have suggested that condom use is an effective and presently vital aspect of HIV and other sexually transmitted infections prevention globally (14,15).

CHURCH AND CONDOM CONTROVERSY

The role of the church in the prevention and control of HIV and AIDS in Africa has been fraught with controversy, especially in regard to condom use (16). Bernadette Mukonyora (5) suggests that churches, "instead of advocating for the preservation of human 'life' and exercising 'love' for mankind, are slowly but surely becoming public enemies by discouraging the use of condom." Mukonyora argues that "The Zimbabwean youth of today are growing up in a world where they are exposed to sex, violence, nudity, and vulgar language at a tender age. Youths lose their virginity at a very young age;" that "Gone are the days when only one discourse ruled the day and dictated how people should live their lives, what they should believe and who they should love;" and that "The Church should not confuse issues. Condom use is purely a public health issue and not a spiritual issue." Mukonyora also quotes Lois Lunga of SAFAIDS, "By calling against condom use, the churches are encroaching in a domain that is not theirs...out of curiosity why haven't the churches spoken against treatment of sexually transmitted infections."

Arie's (17) claim in the *British Medical Journal* that "the condom corrupts and weakens people... destroys families and individuals... and spreads promiscuity" provoked an interesting discussion. Estraviz (18) commented: "I am Catholic. I know what is a condom and how to use it. I am free and I can use it or not. I choose not to do it. Why can't the Catholic Church explain its doctrine in this or any other field?" Baschetti (19) quoting Good (20) wrote: "Men never do evil so completely and cheerfully as when they do it from religious conviction," implying that the prohibition of condom use was evil and opponents of condom use were not any different from religious fanatics. How-

ever there were some defenders of Church's position on condoms. One example is Kahn (21) who suggested that marital fidelity as church policy was more likely to reduce HIV spread rather than condom use, since condoms were not 100% effective. That condoms are not 100% effective has also been reported in a Cochrane review, which concluded that condoms are only 80% effective (22). Individual studies have reported condom effectiveness of 69% and a range of 60%-96% (23,24). Another Cochrane review on population-based interventions showed 2 studies that had no impact and one with a 38% reduction in infectivity rates (25). Kahn (20) also states that "To argue that the ... Church's stance on condoms is causing deaths is illogical. The Church is saying do not be promiscuous. Where one partner has become infected, due to extra-marital sex or a blood transfusion, I have not come across any priest recommending that the couple ignore medical advice and not use condoms."

Xavier (26), on the other hand wrote, wrote: "First of all, the stance of the ... Church with regard to contraception is based on age old spiritual percepts. The ...Church that prohibits condoms also prohibits sex out of the institution of marriage. Those who obey the church and not wear condoms when having sex out of marriage are being twice stupid for exposing themselves and their partners to disease."

"CONDOMS ARE NOT 100% EFFECTIVE"

Condoms, just like any other public health interventions, from water treatment, vaccines, to insecticide treated bed nets used in the prevention of malaria, are not 100% effective. Although many health interventions are fallible, this attribute of the condom is taken as reason why they should not be used. The effectiveness of condoms depends on how they are used. At the same time, other aspects of the sexual intercourse are ignored and emphasis is made on the less than 2% failure rate. It is also not unusual to hear opponents of condoms saying condoms are laden with holes, laced with pathogens, liable to become stuck in women, and cause promiscuity. There is no doubt that due to manufacturing defects, tears arising during sexual intercourse, or material porosity, there may be some risk of transmitting HIV through the condom (27). Voeller et al (28) have demonstrated in a 1994 study that certain brands of condoms can allow small amounts of viruses to leak through. Whether these amounts of viruses were adequate to cause infection is another matter altogether, although it is an important consideration in a discussion about the importance of the leaks. What also needs to be put in perspective in the Voeller study is that the condoms

used were old, a much smaller virus than HIV was used, the concentration of virus was high, and the condoms were subjected to stresses as would occur during sexual intercourse for 30 minutes. These conditions may not be operable in real life situations.

THE CHURCH AND SEXUAL BEHAVIOR

The Church often suggests that it is committed to: i) providing education that teaches prevention of HIV; ii) fighting against the circulation, sale, and use of drugs; iii) supporting sex education teaching that human sexuality belongs only within the marital relationship of a man and a woman; iv) promoting the biblical concept that sexuality intimacy excludes promiscuous and all other sexual relationships that may increase exposure to HIV.

WHERE IS THE CHURCH'S POSITION RIGHT?

Among the major risk factors for sexual HIV transmission are high number of sexual partners (the church would call this promiscuity, infidelity, fornication, and adultery, depending on the context), rape, and unprotected sex. As early as 1995 there was evidence to suggest that HIV control efforts with minimal condom promotion could bear fruit in rural Uganda (29).

On condom failure, the church stated: "The commonest failure is because the condom is incorrectly applied. Failure to leave a loose portion at the tip can result in rupture and its consequences. Another failure is failure to apply the condom at the beginning of sexual interaction, with resultant potential for failure. Condoms should also not be lubricated with Vaseline, as this weakens them; neither should old condoms (past expiration date) or those that have been exposed to heat or cold extremes to be used. Use of condoms with spermicidal gel or foam is recommended by some professionals. A couple should disengage following coitus, lest a condom be lost intravaginally."

CONCLUSION

The Malawian Christian church has contributed immensely to the care of HIV-infected persons. The church, however, is limited in the way it may become more pragmatic in preventing HIV acquisition among persons perceived to be "in sin."

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