AIDS, Africa, and the Adventist Church

by Andrezj Zeromski

The Acquired Immunodeficiency Syndrome (AIDS) epidemic will have a substantial effect on the Adventist Church in Africa. Adventists must confront the enormity of those changes in relation to the quarter of the denomination's worldwide membership that lives on the African continent. To recognize the certainty and rapidity of these changes, it is also necessary to understand the full dimension of the AIDS crises in Africa. Finally, the Seventh-day Adventist church must explore what it can do to combat the on-slaught of AIDS in Africa.

Impact of AIDS on the Church

The growth of the SDA Church in Africa has been meteoric, with 1.5 million members today and perhaps nearly 5 million by the year 2000.[1] Can this phenomenal growth rate be maintained in the face of the AIDS epidemic? The answer is probably not.

Falling birth rates and loss of young adults due to AIDS will eventually result in decreased membership growth among the 20-to-40-year-olds. This group is vital to the function of the church, since it provides much of the denomination's lay leadership and financial support. Church membership and attendance will become weighted toward the very young, since persons over the age of 40 to 50 in Africa make up a small proportion of the population, especially in rural areas.

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Many young people joining the church now may already be infected with the virus. One reason is the early sexual activity of African young people. A recent unpublished survey in a rural Adventist school found that one out of 10 students was sexually active at age 10. By age 13, one of three children was sexually active. Since life expectancy is shortened, Adventists who are now young will not be sustaining church growth. Perhaps as many as 20 percent of urban adult converts joining the church in 1990 will be dead of AIDS by the beginning of the next century. Early in the 21st century the population growth will probably slow, due to vertical (mother to child) human immunodeficiency virus (HIV) transmission that occurred during the late 1980s and 1990s. This will probably result in decreased accessions to the church.

Women whose spouses are not church members compose a large sector of church membership in many African countries. These women provide continuity to the function and life of the church. Unfortunately, these women are at risk of acquiring HIV infection from their husbands who may have outside sexual contacts. These women provide an Adventist environment for their growing children, many of whom will eventually become church members. Disintegration of these Adventist households and dispersal of children, perhaps to non-Adventist homes, could curtail membership growth.

With time, growth in church membership may slacken, reflecting the effects of AIDS on the general population. If the long-term population decline that some project for Africa becomes a reality, then the church may have to make econo-

mies in its present organizational structure. Paralleling population losses from AIDS, and a decline in African contributions, appropriations from the world church to the church in Africa will probably continue to decrease in real terms. Within the African church, tension could develop between the increasing pastoral needs at the community level and reduced financial resources to maintain the church's central structure.

Several factors that normally might substantially alter projected growth rates will probably not occur. Vaccines or effective treatment, even if they become available, will not substantially change the epidemic's course. Development and production costs are likely to limit their use in the world's poorest regions. The infrastructure necessary for effective delivery may not be present in some countries. Where it once existed, the system may have already disintegrated because of the epidemic. Of course, if there is a decrease in heterosexual promiscuity, both within and without the church, then the effects of the human immunodeficiency virus on population growth and population numbers can be lessened. These circumstances would allow for continued church growth, albeit at a slackened pace. Prevention efforts must be concentrated on effecting sexual behavioral changes among the young. It is uncertain, however, whether a change in sexual mores of the magnitude required can be achieved.

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Although Adventist Church membership in most African countries is predominantly rural, much of the church's income derives from more prosperous urban members. These urban households will become increasingly susceptible to the economic effects of AIDS which will compromise their ability to support the church. Even if AIDS does not infect immediate family members, the household will be expected to assist kin dying with AIDS. Relatives will come from rural areas seeking care in the better medical facilities available in urban centers and will have to be housed and fed. Already many urban households are caring for children orphaned by AIDS.

Church pastors are predictably the least likely to develop AIDS through sexual transmission. However, infection through other routes may still occur. Young clergy probably have a greater chance of having been sexually infected before joining the ministry. The number of young men available to enter the ministry may decrease with time, causing the median age of ministers to rise. A widening age differential in cultures undergoing rapid cultural and economic change may have unsettling effects for both church and national governments.

Nonpastoral church employees are more likely to contract HIV infection through sexual contact. Single workers, and wives working for the church whose husbands are not church members, will be particularly vulnerable to HIV infection. Church employees may have to support orphaned relatives. This will add emotional and financial stress in their own households, and impair their effectiveness at work.

Government educational and health units are likely to be particularly hard hit by losses due to AIDS. This will increase competition for trained staff in locations where the church is hard pressed to match salaries offered by government or industry. Replacing losses of trained staff may be difficult for the church. In many countries, governments operate most training courses, and may restrict access to training by non-governmental organizations until its own losses are recovered. Church institutions located in countries where the denomination does not train its own cadres could be hardest hit.

Schools may soon be faced by static or declining enrollment. Where Adventist schools do not receive state support, many parents may no longer be able to afford church school fees. In both government and church schools, female students will be subject to increased sexual pressures by male teachers looking for sexual contacts who are

likely to be uninfected.

Hospitals will be faced with substantial increases in the terminally ill AIDS patients or those with AIDS-related illnesses. These patients have limited ability to pay. Furthermore, the government subsidies, on which many mission hospitals depend, are unlikely to match hospital needs. Many church medical units, already experiencing financial and personnel problems, will be seriously affected. Church hospitals, despite their reputation for compassionate care, may be forced to limit the treatment they can provide those dying from AIDS.

The church's publishing work may have difficulty keeping up sales of expensive books during a protracted AIDS-related economic slump. On the other hand, the market for inexpensive national-language publications may increase where there is heightened spiritual awareness and a climate of searching and uncertainty. As literature evangelism is now conducted in some places, native language Adventist publications, unfortunately, do not carry the profit margin necessary to provide for the economic survival of literature evangelists.

The Impact of AIDS on Society

To appreciate how immediately and pervasively AIDS threatens Adventism in Africa, one must absorb the dramatic scope of the AIDS danger to African societies. AIDS was first recognized during the 1970s in the United States, but today the majority of new cases are occurring in Africa. In Europe and the Americas (excluding parts of the Caribbean), infection with the virus is most common among homosexuals and intravenous drug users, with some spread into the heterosexual community. But in Africa another pattern prevails. Infection is transmitted primarily through heterosexual contact, and to a lesser extent by contaminated blood transfusions, unsterilized needles, and ritual scarification.

In Africa, the AIDS epidemic shows no sign of abating. No African country has accurate data on the extent of the infection. While in some countries HIV infection is rare, in other countries, particularly in East and Central Africa, 25 percent of the urban adults and most prostitutes appear to be infected.[2] In some countries AIDS has become a leading cause of death, even among young children. Groups likely to have higher-than-average infection rates include long distance bus and truck drivers, migrant laborers, teachers (who are transferred frequently), and members of the police and army (usually assigned away from their home area).

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The rapid spread of HIV infection in Africa can be better understood by considering certain patterns of sociocultural behavior and descent. While many African cultures are patrilineal, the Bantu of Central and Southern Africa are matrilineal. In patrilineal cultures, wives command a bride price, cannot inherit property, and have few rights of their own. Women tend to have more rights in matrilineal cultures and children become part of their mother's family rather than their father's family, as in patrilineal societies. Because in matrilineal cultures marriage bonds tend to be weaker, many women are divorced or separated at various times in their lives.[3] Some of the highest HIV prevalence rates are to be found in matrilineal cultures.

The rapid changes affecting many developing countries provide an environment that facilitates HIV transmission. The colonial governments in Africa established agricultural and administrative centers. Men often spent long periods away from their home villages. With the improved transportation brought by the colonial era, women began drifting into urban areas as well. In these urban areas women were at a disadvantage, having neither the education or the job opportunities available to men. Consequently, they often became prostitutes, domestics, or market vendors in the

secondary economy. This pattern has continued from colonial days to the present.

After independence, the pace of urbanization increased, creating further migration of both men and women to urban areas. The hold of traditional authority and the indigenous social controls, governing both the behavior of married and single women, are less strict in urban areas than in rural localities.[4]

Single clerical and professional women need the protection, networks, and gifts which high-status men can provide. What has been in the past their strategy for survival has now become a pathway to disease and death.

Recent difficulties borne by much of Africa include declining per capita food production, widening income disparities, migration to cities already crowded with the unemployed, and increasing hunger in both urban and rural areas. Recent "feminization" of poverty means that poor women and children fare worst under these circumstances. While disrupting traditional and family relationships, these events have also contributed to the rapid spread of AIDS in Africa.

In many African cultures, sexual contact outside marriage is common behavior, even in the Christian community. This is particularly true for men who travel in the course of their work. The more prosperous men in a community may have several families living in different locations, and also maintain loose relationships with other sexual partners. Many cultures forbid sexual relations during the wife's pregnancy and for varying periods of time after delivery. During these times husbands often seek other partners.

Although prostitution has been incorporated into African systems of capitalism and industrial production,[5] many other types of multipartner relationships exist, particularly in urban areas.[6] These transient alliances often carry little or no social stigma.[7] Men contracting HIV infection from multipartner sources transmit it to girlfriends and wives (who are, traditionally, monogamous). Poor urban women, often heads of the household, find these sexual and domestic liaisons vital to financial survival. Single clerical and professional women need the protection, networks, and gifts which high-status men can provide.[8] What has been in the past, their strategy for survival has now become a pathway to disease and death.

Well-educated men with high salaried managerial positions constitute an elite urban strata. They often are able to maintain several households as well as various impromptu liaisons. The multiple partners of the elite from Christian backgrounds may consist of an "inside," or legitimately betrothed wife, and an "outside" mistress.[9] Recently, a new class of urban elite professional women has emerged, who, while remaining single, often maintain a wide range of sexual contacts.

Sexual activity among children appears to begin at younger ages than it did in previous generations.[10,11] As it becomes known that prostitutes are usually infected with HIV, men turn to younger women and girls in the hope of avoiding infection. In many male-dominated African cultures, young or unmarried women have little prerogative to resist sexual advances from older men.[12] This places adolescent girls at increased risk of infection.

What will be the future impact of AIDS on the African continent? While hard data are virtually unobtainable, it is certain that AIDS will produce major economic and demographic changes in Africa.[13] As AIDS strikes particularly hard at the educated and managerial sectors of society, a general economic and bureaucratic slow-down is likely. This is likely to be a critical factor in countries already experiencing negative economic growth.

AIDS may, of itself, have lesser consequences than malaria, malnutrition, and the continent's steadily declining per capita food production, when these are considered individually. However, in the face of existing high morbidity, short life expectancy, and declining national resources, the additional burden imposed by AIDS is likely to wipe out many gains African countries have achieved.

The human immunodeficiency virus will have a profound effect on the future population of Africa. Development of a mathematical model to predict population changes is hampered by many unknowns. Despite this uncertainty, some projections have been published.[14,15,16] Although these forecasts do not entirely agree, it is clear that the annual population growth, which is now 3 to 4 percent in most African countries, will drop substantially over the next 10 to 15 years in those countries with high HIV prevalence, perhaps even reaching zero percent in some. In heavily infected countries, a negative population growth may possibly begin during the next 20 to 50 years.

The direct and indirect costs of AIDS are substantial even in poor African countries. In Zaire it is estimated that an urban child dying from AIDS represents a loss equivalent to 14 months of family income.[17] The direct and indirect costs associated with the death of a young adult are likely to be considerably greater.

African industries tend to be very labor-intensive. Economies often rely on a handful of industries to earn the foreign exchange necessary to support the nation. AIDS is likely to produce high employee morbidity and turnover, while at the same time increasing the employer's health-related expenses. The cumulative loss of product–ivity resulting from AIDS is likely to produce major damage to some national economies.[18] Losses of key managerial personnel, often trained abroad at considerable expense, are already beginning to affect industry in some countries. Training for their replacements may not be readily available, especially if grant funds from the developed world are redirected to the reconstruction of Eastern Europe.

The effect of AIDS on food production is also likely to be substantial. Between 1960 and 1980, per capita food production in Africa fell by 20 percent.[19] There is little evidence to suggest this trend has reversed. The majority of African food is produced by subsistence farming. This requires a large rural population to maintain production. AIDS will decrease production in the subsistence sector and may seriously damage social structure in rural areas.

Declining tax revenues will decease financial support for school systems, which will also be affected by a drop in population growth and the number of children starting school. Church school systems may have a particularly difficult time financially.

The health-care system, like education, will suffer from decreased manpower and financial resources. It is already proving difficult for the system to cope with patients requiring care for AIDS and AIDS-related illnesses. The diagnosis and treatment of these persons will require sizable quantities of imported medical supplies, a serious problem in the context of weak national economies and depleted reserves. Already HIV infection is producing a rapid upswing in patients hospitalized for opportunistic infections.

The pattern of AIDS in Africa means that young adults in their prime working years, as well as their children, will represent the largest number of victims.

Because it will create losses in key personnel, AIDS may well increase political instability. Governments could be unable to maintain many services because of a shrinking tax base and loss of trained staff from their infrastructure. Accordingly, local and multinational organizations will have difficulty operating. Increasing numbers of nationals may leave for Europe or North America to seek professional fulfillment in more stable environments.

Perhaps the biggest impact of AIDS will be on the families of the victims themselves.[20] The pattern of AIDS in Africa means that young adults in their prime working years, as well as their children, will represent the largest number of victims. In some matrilineal societies, perhaps a third of households are headed by a single parent, almost always the mother. Loss of the family head in these circumstances could be catastrophic—especially in an urban nuclear family.

AIDS is likely to further loosen marital bonds and increase social instability. As a wife becomes ill from AIDS or one of its complications, the

husband may take another wife, or desert the family to marry someone in good health. Even if the family remains together, an incapacitated mother may enfeeble the family, since on the African continent 50 to 90 percent of food is grown by women.[21]

In urban areas the nuclear family is becoming the norm. These families may not have the emotional or economic resources to care for a member with AIDS. Where there is an extended family, the person most likely to assume responsibility for surviving children would be the grandmother, who often lives in a rural area. Taking on survivors from several households could cause her considerable stress, since she may herself be a widow. These new wards of the grandmothers will be locked into subsistence activities in order to maintain this extended family. In many countries such children would be unlikely to attend school, even if money were available. This may cause a drop in literacy rates, especially among females.

What Can the Church Do About AIDS?

In the face of this epidemic and its social consequences, what can the church do? Some religious bodies have concluded that AIDS is outside their province of responsibility. However, if the Adventist Church wishes to maintain its current momentum, it must consider vigorous intervention. Since change in sexual behaviors offers the only option available to combat the spread of AIDS in the short or medium term, this needs to become a church priority. Such an initiative must receive whole-hearted commitment from church leadership and clergy. To succeed, AIDS education must be based in such local groups as local church elders, youth leaders, and the Dorcas society. The church must select target groups within its membership for concentrated AIDS education. School children who have not yet become sexually active are a prime target group. Young adults, especially those about to be married and those deferring marriage for educational reasons, are another important target group. Adolescent and young adult women should be encouraged how to resist illicit sexual pressures.

AIDS education is not an easy task since, there is widespread skepticism among youth. The acronym SIDA (AIDS in French) is popularly known as *Syndrome Imaginaire pour Decourager les Amoureaux*. Events that might occur in the future are of little concern in most African cultures.[22] Thus, visualizing the future consequences of present acts is an important but difficult part of AIDS education. This is especially true of a disease like AIDS, since many years may pass between infection and the eventual consequence. Knowing this gives rise to the expectation that medical discoveries will soon provide a vaccine or treatment. In Kenya, extensive press coverage of AIDS stressed medical research rather than behavioral change as hope for control.[23]

The key to AIDS awareness and behavioral modification ultimately rests with the family.[24] Whatever form or function the family takes in Africa, it remains the basic social unit.

Most national AIDS programs are built around the concept of "safer sex." The church needs to stress a message based on Christian morality, with a particular emphasis on reaching its youth. The Adventist Church in Africa has traditionally taken a strong stand against adultery among its members, but it has had a rather lax attitude toward promiscuity among its youth and single members. This attitude needs to be reevaluated.

The promotion of condoms to prevent transmission of AIDS has created conflicts between church groups and national AIDS organizations in several African countries. The Adventist Church needs to seriously consider its position on this subject. Some Adventist organizations in Africa have taken the position that no activity within their jurisdiction may in any way promote the distribution of condoms aimed at preventing AIDS transmission. Under this policy medical personnel can not give condoms to sexually active HIV patients, provide condoms to couples where one spouse is infected and the other is not, or supply them to medical personnel exposed to AIDS in order to protect their own spouses. This policy also ignores the common situation where the wife knows her husband to be unfaithful and wishes to

protect herself against possible infection.

In many African cultures, circumcision and male sexual initiation rites take place at puberty. Sexual initiation of pubescent females is also common. Initiates are often expected to prove their acquisition of adult status. The church might hold its own equivalent rites, stressing Christian morality, and in the case of males, arrange for circumcision under hygienic circumstances. If held in cooperation with other Christian bodies with similar concerns, these rites could help break down prejudice against Adventists.

Few families will be left untouched by AIDS. The church and its medical personnel can also help to prepare family members for the return of terminally ill AIDS patients from the hospital. Denominations that feel a special call or mission often have difficulty showing tolerance to others.[25] Dealing with AIDS among its members, clergy, and employees may pose a special challenge to the church. It is easy for Christians to make "judgment of God" pronouncements against those with AIDS, regardless of how the infection might have been contracted. This destroys communication and creates long-term tensions within the church. Condemnation of AIDS and its victims may be an unconscious conduit for anxiety and preoccupation about the deterioration of society in general and its morals in particular.[26]

An AIDS awareness program within the church must promote understanding and compassion while foregoing judgment. Because an Adventist pastor may have responsibility for dozens of churches and companies, local members must be trained to comfort the dying and console family of victims suffering from a disease that carries a stigma among Christians. This is an opportunity for the church to demonstrate the compassion of Christ, and to build strong emotional bonds both within itself and within the community.

The church needs to introduce its own curriculum for AIDS education at all levels in all its schools. These materials should inculcate principles of Christian moral conduct and stress the integrity of the family. Behavior modification is most likely to be effective among school-age youth.

Church health units can play an active role in promoting AIDS awareness, alone or in joint undertakings with health units of other denominations. Funding for well-designed projects is available through ADRA International. Finding or sparing the qualified personnel to implement such projects is more difficult. Health personnel have ready entry to most primary and secondary schools for health education. Ready access is also usually available when approaching community leaders. In many places clergy and churches of other denominations would welcome AIDS information provided by the Adventist health workers. Counselling is a key part of AIDS education programs, and one that already over-stretched medical personnel cannot take on alone. Other groups in the community must be trained to assume this role. Women's associations, where they exist, are excellent resource groups for the church to use to establish ongoing AIDS educational programs. These would also provide important access to single parent households.

The AIDS epidemic provides an opportunity for the church's publishing work to address a contemporary social issue within a Christian context. Since many who understand the AIDS crisis are educated, publications on AIDS could be prepared first in French and English, thus cutting down on lead time. Subsequent local translations could be made from these sources. This witness would spread rapidly anywhere there is an active colporteur system. This is a subject that, if presented attractively, would probably do very well in the secular bookstores of African cities.

Few events have given the church greater opportunities to address contemporary issues from a Christian context than has the AIDS epidemic. The church is being challenged to live the principles of Christian morality, and to proclaim these as more socially relevant than ever before. This epidemic is also a call for the church to display the concern and compassion of Christ for the welfare of fellow human beings.

NOTES AND REFERENCES

1. _____, "Annual Council in Nairobi: What Is Its True Meaning?" *Adventist Review* (October 27, 1988), p. 1156.

2. James Chin and Jonathan M. Mann, "AIDS: A Global Perspective." *The New England Journal of Medicine*, 319 (August 4, 1988), pp. 302-303.

3. M. G. Marwick, *Sorcery in Its Social Setting* (Manchester: Manchester University Press, 1965), pp. 111-198.

4. Monica Udvardy, "Social and Cultural Dimensions for Research on Sexual Behavior Related to HIV Transmission: Anthropological Perspectives From Africa." *Society and HIV/AIDS*. G. Sterky and I. Krantz, eds. (Stockholm: Karolinska Institute, 1988), pp. 55-96.

5. Laketch Dirasse, *The Socioeconomic Position of Women in Addis Ababa: The Case of Prostitution*. Ph.D. dissertation, Boston University, 1978.

6. B. G. Schoepf, "AIDS and Society in Central Africa: A View from Zaire." *AIDS in Africa: the Social and Policy Impact*. N. Miller and R. C. Rockwell, eds. (Lewiston, NY: Edwin Mellen Press, 1988), pp. 211-235.

7. Aylward Shorter, WF. *African Culture and the Christian Church* (London: Geoffre Chapman, 1973), pp. 14-43.

8. Ilsa Schuster, *The New Women of Lusaka*, (Palo Alto: CA.: Mayfield Press, 1978).

9. W. Karanja, "Outside Wives and Inside Wives in Nigeria: A Study of Changing Perceptions in Marriage." *Transformation of the African Marriage*. D. Parkin, D. Nyamwaya, eds. (Manchester University Press, 1987), pp. 247-263.

10. C. Obbo, "The Old and the New in East African Elite Marriages." Ibid.

11. D. O. Owuamanam, "Sexual Activities of School-going Adolescents in Nigeria." *Adolescence* 17:65 (1982), pp. 81-87.

12. Edward C. Green, "An Agenda for Behavioral Scientists." *AIDS in Africa: the Social and Policy Impact*, pp. 175-195.

13. A. Griffiths, "Implications of the Medical and Scientific Aspects of HIV and AIDS for Economic Resourcing." *The Global Impact of AIDS*. A. Fleming et al eds. (New York: Alan Liss, 1988), pp. 111-117.

14. R. M. Anderson, R. M. May, and A. R. McLean, "The Possible Demographic Consequence of AIDS in Developing Countries." *Nature*, 332 (March 17, 1988), pp. 228-234.

15. J. Chinn, J. Mann, "Global Surveillance and Forecasting of AIDS." *Bulletin of the World Health Organization*, 67 (Jan. 1989), pp. 1-7.

16. J. Bongaarts, "Modeling the Spread of HIV and the Demographic Impact of AIDS in Africa." Working paper No. 140, Center for Policy Study (New York: The Population Council, 1988).

17. F. Davachi, P. Baudoux, K. Ndoko, B. N'Galy, and J. Mann, "The Economic Impact on Families of Children with AIDS in Kinshasa, Zaire." *The Global Impact of AIDS*, pp. 167-169.

18. Edward C. Green, "An Agenda for Behavioral Scientists." *AIDS in Africa: The Social and Policy Impact*, pp. 175-195

19. United States Department of Agriculture, Economics and Statistics and Cooperative Services, International Economics Division, Africa and Middle East Branch. *Food Problems and Prospects in Sub-Saharan Africa—The Decade of the 1980s*. (Washington: USDA)

20. Gary A. Lloyd, "HIV-Infection, AIDS, and Family Disruption." *The Global Impact of AIDS*, pp. 183-190.

21. J. Goody, and J. Buckley, "Inheritance and Women's Labor in Africa." *Africa*, 23 (1973), pp. 108-121

22. J. S. Mbiti, *African Religions and Philosophy* (London: Heinemann, 1969), pp. 15-27.

23. _____, "AIDS in Kenya," *The Weekly Review* (Nairobi), (September 8, 1989), pp. 5-17.

24. Philista Onyango, and Pervin Walji, "The Family as a Resource." *The Global Impact of AIDS*, pp. 301-306.

25. Roger L. Dudley, "The Christian and Prejudice," *Ministry* (Vol. 61, 1988), pp. 4-7.

26. S. Wallman and L. Sachs, "AIDS in Context." *Society and HIV/AIDS*. pp. 25-54.