

Comparing the Impact of Religious Discourse on HIV/AIDS in Islam and Christianity in Africa

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In examining the strikingly high prevalence rates of HIV in many parts of Africa, reaching as high as 5% in some areas, how does the discourse promoted by the predominant religions across the continent, Islam and Christianity, affect the outlook of their followers on the epidemic? This question becomes even more intriguing after discovering the dramatic difference in rate of HIV prevalence between Muslims and Christians in Africa, confirmed by studies that have found a negative relationship to exist between HIV prevalence and being Muslim in Africa, even in Sub-Saharan African nations. Why does this gap in prevalence rates exist? Does Islam advocate participating in less risky behavior more so than Christianity? By comparing the social construction, epidemiological understanding and public responses among Muslim populations in Africa with Christian ones, it becomes apparent that many similarities exist between the two regarding discourse and that, rather than religious discourse itself, other social factors, such as circumcision practices, contribute more to the disparity in HIV prevalence than originally thought.

“We are not the healer. God is the healer. Never a sickness God cannot heal. Never a disease God cannot cure. We don’t ask people to stop taking medication. Doctors treat; God heals,” a representative of the Synagogue Church of All Nations (SCOAN) stated in an interview in October 2011.¹ SCOAN is an Evangelical Christian church based in Lagos and operating in several parts of London.² Under the leadership of T.B. Joshua, Nigeria’s thirteenth richest clergyman, the church has come under criticism in recent months for advising their congregations to stop taking lifesaving HIV medication. The church’s website claims to offer special prayer and “HIV-Aids healing” as a service, as well as selling “Anointing Water” to help with healing process. The website also boasts photos and testimonials from members who have been “cured” of HIV. Forty-eight year-old Jane Iwu, a resident of east London, reports that her friend died after her pastor told her to stop taking her HIV medication. “[The pastor] told her...that ‘God is healer and has healed her.’”³ Ms. Iwu, who is HIV-positive herself, is not alone in this story. Three women have recently passed away after ending treatment at the advice of their pastor.

This example, from a church in one of the most developed cities in the world, highlights just how much of an impact religion has on conceptions about disease. This reality is even more prevalent among the developing world, where cultural traditions align closely to religious practices. In looking at the African continent, Christianity and Islam stand out as the two most predominant religions, and they certainly not only shape the

values, beliefs and practices of their followers, but they also impact their conceptions of diseases, such as HIV.

Considering the strikingly high prevalence rates of HIV in many parts of Africa, reaching as high as 5% in some areas, how does the discourse promoted by these religions affect the outlook of their followers on the epidemic?⁴ This question becomes even more intriguing after discovering the dramatic difference in rate of HIV prevalence between Muslims and Christians in Africa. The predominately Christian sub-Saharan Africa possesses the highest adult prevalence rates of HIV in the world. Swaziland, with 82% of its population Christian and a negligent Muslim population, has the highest adult prevalence rate in the world, with an estimated 25.9% of adults infected with HIV in 2009.^{5,6} Amongst the predominately Muslim northern Africa, the adult prevalence HIV rate averages only .15%.⁷ Most studies conclude that a negative relationship exists between HIV prevalence and being Muslim.⁸ In fact, researcher Peter Gray found a decreasing HIV prevalence with an increasing Muslim population in sub-Saharan African nations.⁹ Why does this gap in prevalence rates exist? Does Islam advocate participating in less risky behavior more so than Christianity?

This paper examines these questions by comparing the social construction, epidemiological understanding and public responses among Muslim populations in Africa with Christian ones. Over the course of the analysis, it will become apparent that many similarities exist between the two and that, rather than religious discourse itself, other social factors contribute more to the dispar-

ity in HIV prevalence than originally thought.

Area One: Christian Africa

No doubt, Christian practices and religious leaders have had a profound effect on the social construction of the HIV/AIDS epidemic across Africa. On page 5 of Allen Brandt's *No Magic Bullet*, he defines social construction of a disease as determined by five factors: (1) what language is used to describe the disease, (2) how people with the disease are morally judged, (3) what social problems are associated with the disease, (4) societal changes that are linked with the disease, and (5) the ways in which discussions of the disease reveal certain biases.¹⁰ One striking construction among Christians in Africa is that the Christian message often results in the creation of stigma. Like in Islam, the disease is most strongly associated with sexual promiscuity, which, in both religions, is forbidden. Preachers often preach a message of fear, harping on lessons learned from the fall of humankind and its impurity, rather than focusing on a message of compassion.¹¹ This often leads the creation of an unshakeable stigma: to have contracted HIV means to have committed a great sin. This stigma has created a sense of fear, and studies show the sheer fear of being stigmatized aids in fueling the HIV epidemic.¹² Furthermore, the lack of a message of compassion also leads to harsh treatment of HIV patients and the stigmatizing of their family members and caretakers. However, the social construction of HIV and stigma among Christians in Africa has not been shown to impact behavior in any particular way. For some, the sense of disease as a means of "punishment" by God results in a passive attitude about prevention; God will punish those who deserve it. For others, as shown by a study in South Africa, affiliation with a church, a statistic most citizens fall into, has not prevented types of sexual behavior that promote the epidemic, reporting that, in fact, extra- and pre-marital sex, though strictly forbidden in the Christian tradition, is still prevalent.¹³ It is clear that, in spite of rampant stigma and social construction of HIV as a disease that results from sin, having religious affiliation among Christians in Africa does not necessarily correlate with less participation in risk behavior.

Christian religious discourse often also results in misguided epidemiological understandings about HIV/AIDS. Popular religious interpretations of HIV risk are misleading, posing potential dangers to youth underestimating their risk. Jordan Daniel Smith reports in his article focusing on Christian youth in Nigeria that the role of religious morality plays a major part in popular understanding of HIV/AIDS and individual risk assess-

ment.¹⁴ Smith's study documents how Nigerian Christians link HIV/AIDS with sinful behavior. In another study in Tanzania, 80.8% respondents believed that HIV could be cured through prayer.¹⁵ Commenting on these studies, Terrence McDonnell writes, "This connection to sin shapes sexual practices, with the ultimate paradoxical effect of increasing people's HIV risk." McDonnell says that, like in Nigeria, Ghanaians are highly religious, and he reports some of his encounters that highlight the misconceptions of HIV based on religion. He says that one Ghanaian cab driver described how "AIDS is caused by the 'devil entering your body'... A highly educated Ghanaian taking courses on AIDS at the University of Ghana once claimed she had witnessed 'a pastor cure a woman of AIDS.'" ¹⁶ McDonnell attributes much of this to pastors introducing this competing interpretation for AIDS, leading many people to hold on to misconceptions about the disease. Another statistic from the study in Tanzania showed that, though not necessarily directly related to religious belief, 56.2% of people have a fear of HIV transmission through casual contact. As a result, it is clear there exists a real lack of epidemiological understanding among Christians in Africa.

Another factor that impacts the epidemiological understanding of HIV/AIDS, though less directly fueled by religion, is resistance to Western interpretations, prevention methods and treatments of the disease. South African President Thabo Mbeki, for example, has long held a suspicion of antiretroviral drugs and disputes clinically supported research on the premise of anti-colonialism.¹⁷ President Mbeki, in a 2005 letter addressed to President Clinton, accused the West of imposing false scientific knowledge upon them when he called the West's campaign against AIDS in Africa a "campaign of intellectual intimidation and terrorism, which argues that the only freedom we have is to agree with what they decree to be established scientific truth."¹⁸ This historical suspicion is no doubt a contributing factor to the high rates of HIV among Christians in many parts of Africa.

The public and private responses to HIV by Christian religious leaders have had a profound impact on the prevention, treatment, and care of their followers, but it has also further fueled the epidemiological misunderstandings. The responses are both a reaction to these misguided beliefs, being heavily influenced by religious leaders, and a tool for perpetuating the misunderstandings themselves. For one, in shaping policy and responses to HIV in Christian parts of Africa, leaders must consider the existing differences among this large and diverse demographic. Policymakers have to be careful of the difference

between “mainstream” Christian churches and “healing,” more tribally based, churches.¹⁹ Religion in Africa offers a uniquely effective community structure to help mitigate the social impact of the epidemic, and faith-based programs have long been favored in sub-Saharan Africa. The differences among these sects, however, need to be taken into account in order to develop an effective response.

Much of the public response among Christian organizations and leaders in Africa has been greatly impacted by American evangelicals and the Bush administration. In 1987, Jerry Falwell stated, “God destroyed Sodom and Gomorrah primarily because of the sin of homosexuality. Today, He is again bringing judgment against this wicked practice through AIDS.”²⁰ After the 2000 election, evangelical figures like Falwell and Senator Jesse Helms, once stalwart opponents of AIDS assistance programs, began to change their attitude. Helms wrote, “We cannot turn away...AIDS has created an evangelism opportunity for the body of Christ unlike any in history.”²¹ Under this influence, and as a result of Bush’s strong religious background, the majority of funding from the President’s Emergency Plan for AIDS Relief (PEPFAR) went to evangelical organizations in Africa, who had little to no experience working in AIDS relief, prevention, or care.²² Many of these male-dominated religious organizations have proscribed the use of condoms.²³ Bitter battles ensued over the place of condoms in sexual education and HIV prevention efforts. For the most part, these evangelical organizations refused to discuss or promote the use of condoms in any way, focusing solely on promoting abstinence and faithfulness, despite the fact that, according to Helen Epstein in *The Invisible Cure*, “to date, every abstinence-only program has failed.”²⁴ In *The Wisdom of Whores*, Elizabeth Pisani criticizes the involvement and influence of evangelical religious organizations, particularly their influence on funding decisions, preventing funds from going to effective programs like the promotion of condoms, as well as channeling funds toward groups that are not considered at risk for HIV, which ultimately excludes groups like injection drug users and sex workers.²⁵ Initiatives like Uganda’s “ABC” program, “Abstain, Be Faithful, or Use Condoms,” though proven successful in lowering HIV infection rates, ignited hot debates among right-wing Republicans. The results of these debates, which most often resulted in higher earmarks for abstinence-and-faithfulness programs, were often most influenced by politics rather than outcomes.

Looking at local, church-based initiatives, the Pentecostal Church, a hugely popular denomination across much of Christian Africa, serves as an example of a highly

involved religious community in combatting HIV. The preachers make a concerted effort to relay a message of abstinence and fidelity through their sermons as a means of education and prevention, and their efforts are paying off.²⁶ A study by Robert Garner found that, while levels of sexual behavior that promote the transmission of HIV and Christians remained high, only members of Pentecostal churches significantly reduced levels of extra- and pre-marital sex among its members.²⁷

Area Two: Islamic Africa

Despite a small body of research on the relationship of religion and HIV, research on the topic with regards to Islamic areas of Africa remains sparse. Most research when discussing the impact of religious discourse on AIDS in Africa focuses on evangelical Christians churches. While there exists speculation about Islam as a reason why HIV has yet to take hold in the Middle East, there has been little study of why Muslims in Africa—sometimes even within the same states as their Christian counterparts—have such significantly lower rates of HIV prevalence. To account for this lack of information, this paper will use data from Middle Eastern and Arab North African countries to draw conclusions about Muslims in Africa.

Religious leaders and rhetoric within Islamic regions of Africa greatly influence the social construction of HIV/AIDS within Muslim populations. Similar to their Christian counterparts, the primary result of this discourse is the creation of stigma. Also similarly, the stigma among Muslim communities is strongly associated with sexual promiscuity. Additionally, rampant homophobia has also contributed to the stigmatizing of the disease. Harsh anti-homosexuality laws instill fear and discourage people from being tested, afraid they would be accused of being homosexual.²⁸ This fear, however, was not limited among the men-who-have-sex-with-men populations. In a survey of university students in the United Arab Emirates (UAE), there appeared to be a real fear, as well as misunderstanding, of the epidemic and its facts.²⁹ This fear leads to people hiding their behaviors, further putting themselves at risk.³⁰ The worst consequence of these social constructions is not, as in 1980s America, the words used to define the disease, but rather the lack of words at all. Much like the “conspiracy of silence” in the Victorian era discussed in Brandt’s *No Magic Bullet*, in which people simply did not discuss venereal diseases openly or at all, the stigma among African Muslims results in a dangerous silence.

As a result of this stigma-driven silence, many are left in the dark regarding the facts of the disease, lead-

ing to high levels of epidemiological misunderstandings of HIV. In the same study mentioned above of university students UAE, 90% knew the main routes of infection, but there were misconceptions about transmission.³¹ Only 31% knew there was no vaccine, and only 34% knew there was no cure.³² When asked why they should be faithful to their partners, 90% cited religious reasons, but only 38% said to reduce the likelihood of contracting an STD.³³ The students claimed their main information sources to be books, media and health professionals.³⁴ Overall, the study found alarming gaps in knowledge about transmission and curability, an alarming fact for a region with roughly half of its population under the age of 25.³⁵

The public response in Muslim communities has been dominated by religious discourse. Early on, many Islamic nations denied the existence of HIV in the Middle East, presenting it instead as a disease brought in from other countries that were sexually promiscuous.³⁶ In these highly conservative societies, they taught obedience to Islam as the best protection. A lot has changed, however, since the early days of HIV in terms of response to the epidemic. While the rates of infections among Muslims are drastically lower than their Christian counterparts, their quickly growing population, high rates of mobility and young population puts this statistic at risk of being changed in the not-too-distant future. Such a young population as the Middle East requires a strong response or the epidemic could grow dramatically. Understanding this, and under great international pressure, fourteen nations in the Middle East have recently begun to develop national plans to tackle HIV, some even agreeing to offer free anti-retroviral drugs.³⁷

Still, as a result of stigma and a history of silence, some resistance and prejudice persist. In the same survey of UAE university students, a group that will serve as the future leaders, 97% felt all people in the UAE should be tested.³⁸ 53% believed that people with HIV should be segregated, while only 27% thought children with HIV should be allowed to attend school.³⁹ As far as public efforts for education and prevention, 96% wanted more education about protection among young people, and 57% said that just teaching it in schools was insufficient.⁴⁰

Though much stands to be improved in terms of public response, some measures are being taken. As our knowledge about HIV has improved over the last several decades, the globalized effort to tackle HIV has put pressure on political leaders in the Middle East to be more proactive. There exists a strong need to improve surveillance, prevention and care in order to maintain their currently low levels of infection. Egypt, Morocco

and Iran serve as models for these efforts. In Iran, the Islamic nation with the largest number of people living with HIV, the government has begun to “distribute free needles through its pharmacies in its effort to reduce HIV transmission through needle sharing among injection drug users, its most common mode of transmission.”⁴¹ Additionally, Iran has instituted services for voluntary counseling and testing (VCT) throughout the country. The Iranian Ministry of Health promotes condom usage within schools and the public, as well as in mandatory premarital family planning classes. Egypt has implemented a program focused on VCT, outreach to high-risk groups, and care for patients living with HIV.⁴² Egypt has also published a series of Arabic-language manuals, VCT guidelines, and a national monitoring system, as well as providing training and technical assistance for establishing VCT centers in other Arab states. In their progressive and comprehensive plan, Morocco established its National AIDS Action Plan in 2001 and was the first Islamic country to receive a grant from the Global Fund. Its National Plan created a coordinating committee, made up of diverse local and international organizations, charged with three major objectives: “to reduce the vulnerability of groups most exposed to HIV infection; to increase awareness and change attitudes and behavior through a communications program targeting young people and women; and to increase access to diagnostic services and treatment for people living with HIV/AIDS.”⁴³ Additionally, HIV/AIDS patients in Morocco are treated for free.

Ultimately, though much progress has been made since the disease first became prevalent in the region, most public and religious leaders fear tackling the issue of HIV/AIDS in an effort to avoid being seen as “condoning” such behaviors that put people at risk. Many leaders are afraid that if they tackle these issues on a national scale, they will be seen as tolerating these behaviors, which are considered culturally and religiously unacceptable. The legitimacy of these rulers—both political and religious—rely on their ability to maintain their authority as religious leaders, chosen by God. There are, of course, other social and structural factors, such as the enormous lack of gender equality found in the Muslim world that may also contribute to the disease’s spread, aside from simply promiscuity. Unless these leaders are able to recognize HIV as a legitimate threat to the livelihoods of their nations, economies and lifestyles, the HIV rates among Muslims could increase.

Analysis and Conclusion

Though differences in beliefs and practice exist, there appears to be many similarities between Muslims and Christians in Africa in their approach to HIV. In comparing the social constructions of the disease, there seems to be a lot resemblance between the two groups, primarily in stigma. The teachings of both religions have resulted in the stigmatization of HIV patients, their families and caretakers. The disease is most often associated with sexual promiscuity, a habit forbidden in both religions. This stigma and judgment placed on HIV patients also coincides with a real sense of fear for both.

Many similarities are also found in comparing the epidemiological knowledge between both groups. It has been argued that both possess a gender bias that affects this knowledge. However, in the poll among Muslim university students in Dubai, for example, both men and women were included, yet it was found the majority of students lacked an overall epidemiological understanding, particularly regarding transmission. Ultimately, an overall lack of epidemiological understanding seemed apparent among both Christian and Muslim populations, particularly among youth.

Among the public responses between Islamic and Christian groups, some differences were found to exist. In the early years of the epidemic, responses were similar. They possessed a “not-in-this-region” mentality that often led to leaders ignoring the problem. In Muslim areas, the disease was framed as a disease of non-believers, brought in by foreigners. Christians, like in South Africa, believed the disease and its threat were exaggerated and were suspicious of their medicines and treatment recommendations, further leading to inaction. Today, many Christian leaders in Africa are still reluctant to respond. They are heavily dependent on non-profits and foreign aid workers to address the disease, organizations that are often evangelical, while Muslim leaders and government have recently began considering policy action more seriously. Places like Egypt, Morocco and Iran have taken huge leaps to tackling HIV/AIDS within their borders. It is important to understand that both groups face very different epidemics: Christian leaders’ initial lack of response had led to increase in HIV prevalence, resulting in a generalized epidemic; Muslim leaders, though also initially offering a lackluster response, are not faced with a threat of such proportions. Though they need to act to maintain their currently low rates, this fact could impede their willingness to act in the near future.

In analyzing these comparisons, and their revealing similarities, it raises the question: why has the disease

not spread in Islamic regions as it has in Christian areas? At first glance, it would seem behavioral: that Muslims must participate in less risky behavior than Christians, despite similar religious rhetoric condemning such habits. This case could certainly be argued in areas where Muslims represent a religious minority, as it has been suspected that minorities may adhere more strictly to their religious practices, either as a defense mechanism in response to a perceived threat or in an effort to cling to their identity.⁴⁴ However, a recent study shows that religious participation and attendance correlates with reduced participation in risk behaviors—regardless of the particular religion or denomination.⁴⁵ According to this analysis, these initial assumptions are incorrect.

In fact, this gap has less to do with religion, but with other social factors practiced by each group. Most studies show a negative relationship between HIV prevalence and being Muslim; however, risk factors have given mixed evidence with respect to following Islamic sexual codes, such as not having extramarital affairs. Instead, evidence shows benefits arising from other social practices may be to blame, such as the use of alcohol and circumcision in particular. While Christianity condemns drunkenness, casual drinking is widely considered to be acceptable, which in social settings could lead to engaging in risk behaviors. Alcohol in Islamic communities is harshly condemned. This is, of course, not to say that no Muslim consumes alcohol, but rather that many local leaders’ bans on alcohol make it less readily available than in comparable Christian areas.

The practice of circumcision among Muslims may be the most significant factor accounting for the difference in HIV prevalence rates. Multiple studies have reported that circumcision cuts a man’s risk of contracting HIV by roughly fifty percent and cuts a woman’s risk by 30% when sleeping with an HIV-positive man.⁴⁶ Helen Epstein, in *The Invisible Cure*, says, “male circumcision offers more effective protection against HIV than any of the experimental vaccines currently undergoing clinical trials around the world. It is also cheaper, carries few side effects, requires no booster shots, and is available now.”⁴⁷ Epstein adds that many thought the drastically different rates of HIV between East and sub-Saharan Africa, where Christianity is predominant, and West Africa, where Islam is widely practiced, should be attributed to the Muslim religion, “which imposes restrictions on women’s sexual freedom. However, male circumcision, which is ritually practiced by Muslims... turns out to be highly protective against HIV.”⁴⁸ In Islam, circumcision is mentioned in some *hadith*, which serve as supplemental teaching to the

Qur'an itself, and there is some debate over whether it is mandatory or simply highly recommended.⁴⁹ Either way, this results in circumcision becoming a widely practiced ritual among Muslim populations. In the Christian tradition, however, the story is quite different. The Roman Catholic Church had, at one point, formally condemned circumcision, but has since taken a neutral stance on the custom as a medical practice.^{50,51} Circumcision in Christian communities in Africa outside of the Catholic Church experiences mixed reviews. Coptic Christians and Christians in Ethiopia and Eritrea customarily practice circumcision. Others, like some churches in South Africa, entirely oppose it as a pagan practice.^{52,53} This debate among African Christians outside Catholicism stem from the belief that circumcision need not be a religious requirement, since the circumcision of Christ replaces the humanly need for the practice.^{54,55}

In looking forward, it is important to consider how this will impact the way we do HIV prevention, education and treatment in the future. The original assumption of the significance of the impact of religious discourse and attitudes proved to less significant than originally thought. The impact of religious discourse cannot be denied, particularly on policy, as we have seen in the United States. However, cultural assumptions about how religion impacts behavior, such as the belief that Islam promotes less risky behavior, can be a dangerous supposition. In the end, it appeared that other behaviors, such as the decision to be circumcised, had a greater effect on people's HIV-status than their religious affiliation. About 70% of the world's people identify as a member of faith community, giving religious groups and organizations huge potential to influence HIV/AIDS efforts.⁵⁶ Through this influence, religion has the unique forum to continually construct and reconstruct their followers' views on HIV/AIDS. The important question is whether this influence will ultimately be positive or negative in the long-term. As the Synagogue Church of All Nations in London showed, however, there is still a long way to go.

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