

Differences in Confessional Advice in South Africa

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1. Introduction

In Eastern, Central and Southern Africa the reality of HIV and AIDS is somewhat different to that of the rest of the world. Here it is not something which infects a small minority of people. It affects most people. With infection rates either having passed or approaching 20% of the population, the majority of families either have someone who has died of AIDS or is HIV positive.¹ The rapid rate of HIV infection here can be put down to social and cultural factors.² Ministering in a world of HIV/AIDS must contain a social and cultural response.

2. A Case

Thembinkosi Ngcobo is a truck driver on the N3 highway. This multilane highway is one of the busiest in Africa carrying goods between the port of Durban and the industrial centre of Johannesburg and thence on to most countries of south and central Africa. The highway has created its own culture fulfilling the wants of the truck drivers who ply its route. Petrol stations, food centres, stopover points and tollgates dot the 600 kilometres of concrete and tar. Poor people of the surrounding area are attracted to the highway in search of money. They work in the toll booths. They sell food at the restaurants. Many are "sex workers".³ HIV transmission is part of the culture of the highway.

Thembinkosi is married to Nomusa. Their home is in Durban and they have four children. Nomusa is a devout Catholic whilst Thembinkosi is one of the reliable men of the parish who helps Father when he is in Durban. He was an altar boy as a youth and likes his Catholic faith. It is part of his "Township culture".⁴ Township culture was originally a migrant culture. The apartheid migrant labour laws made it impossible for migrant workers to bring their families to towns and so it became quite common for men to have a "family" at home in the rural area and another "family" in the township.⁵ This too has come to form part of the "Township" culture. Thembinkosi's work means that he spends time at the two ends of his journey: Johannesburg and Durban. It comes as no surprise to find that he also has a "family" in Johannesburg where he supports a younger woman who is the mother of two of his children. He pays for the upkeep of these children and stays with the woman when he is in Johannesburg. His wife suspects something but doesn't ask.

In a routine medical checkup required by the medical insurance programme of the

company he works for, Thembinkosi was found to be HIV+. Initially he was afraid to tell anyone but after some months he told his wife and upon testing it was found that she too was positive. Their HIV counsellor explained to them that it was essential to avoid re-transmission of the disease and that if they were to continue sexual relations they should both wear condoms to prevent re-infection and thus to prolong their lives. As Catholics they were aware that condoms were not something usually acceptable to the Church and so at Nomusa's insistence they went to discuss the issue with their Parish Priest.

The Priest was very disturbed about the case. He was very compassionate to the couple but insisted that the teaching of the Church did not allow them to use condoms. He counselled them to abstain from sexual relations for the rest of their life. He also suggested that they speak to one of the Catholic HIV counsellors employed by the diocese. This they did and during the session it became very clear that Thembinkosi and Nomusa wished to continue their sexual relationship. Nomusa was deeply unhappy with the advice of the Priest as she wanted to continue following the teaching of the Church and to live her faith but thought that the burden of sexual abstinence on top of the tragedy of Thembinkosi's disease would drive him away from her to his "family" in Johannesburg. She was also afraid of what the other members of the Church women's society would think if she did not go to communion.

Margaret, the counsellor went to speak to the Priest and suggested that he leave the counselling of this couple to her as she was more experienced. The Priest was delighted to do so as he too was unhappy with the advice he had given saying that he felt constrained to follow the teaching of the Church but unhappy about how it applied in this case.

During the counselling session several issues arose. Firstly it was clear that every means possible should be taken to prevent re-transmission of the disease since every re-infection increased the viral load and weakened the already struggling immune system. However abstinence was not a viable solution since this would add another burden to their lives besides the ones they already had. The sexual expression of their love was a value to each of them helping bring them close to one another and cementing their marriage relationship. They wished to remain faithful to one another and look for ways to build their bond until death. But they did not want to go to hell when they died for disobeying the teaching of the Church.

As a result of this counselling the couple decided to use both male and female condoms when having sexual relationships. Nomusa said she would go to confession every week but Thembinkosi didn't feel this was necessary. The confession was always a nightmare for Nomusa since their Parish Priest continued to tell her in the confessional that what they were doing was wrong and a sin and so they should abstain from sex. Each week she promised to try but always

failed.

Their sexual relationship was now becoming a source of anxiety for Nomusa and Thembinkosi and they went back to the AIDS counsellor who suggested that they go to confession to another Priest who was more experienced in this field. The discussion with this Priest seemed much more helpful. He pointed out to them that the primary moral value was the sanctity of their marriage and the maintenance of their bond. Factors supporting the growth of the bond were their support for one another in the face of this crisis, the love they had for one another of which their sexual relationship was an important expression, and their openness to one another in the wish to remain together. Factors militating against the bond were things like the anxiety and stress brought on by the knowledge of the disease, their standing in the Church as “sinners” not going to communion or continually having to confess the use of condoms, and the fact of being unable to live a celibate lifestyle as a married couple. The Priest suggested that whilst in normal cases the use of condoms would not be acceptable there were some mitigating reasons in this case. Clearly unprotected sex would make both open to re- infection and so the sex act rather than being open to life would be detrimental to it. The possibility of bringing children into the world when their parents might soon die was another issue they needed to consider. Abstinence might drive Thembinkosi to look for other outlets thus endangering other people. The Priest asked the couple to take all these factors into account and to use their own conscience in deciding what was in fact sinful. For Thembinkosi it was clear. He did not consider any sin in the condoms and he would go to communion without confessing. Nomusa was less sure but she said she would prefer to come to confession to this Priest who seemed “so understanding” and helpful and showed her that she was not just being a sinner when she had to disobey this law of the Church.

3 Symptom of a Deeper Social Ill

Any theological response to HIV/AIDS must at the same time be a theological response to the underlying social and cultural phenomenon or it will provide pastoral praxis which does not touch the life of people. The Church’s moral theology is sometimes unhelpful in this context since it is often based on Western anthropological categories stressing the individual as the fundamental moral agent. In this part of the world HIV transmission has to be linked with social breakdown and disorganisation leading to fluidity in social mores, cultural values and world view.

We see an increasing acculturation of local belief and ethical systems into some of the Western ones. This often results in people having two or more moral systems to articulate their life style choices: An African Traditional one, a modern Western materialist one and a Christian one. People often dip into these choosing the most convenient to justify and maintain their

lifestyle choices.

Economic forces have led to a struggle for money in a continent of poverty. The result is increasing mobility and openness to whatever means can be used to get it. Migrant labour has reeked havoc on African family life forcing workers into a variety of heterodox sexual practices which would be termed immoral in terms of both African Traditional culture and Christianity. A pastoral moral theology of human sexuality and human sickness needs to take these factors into account or it will fail to respond to the human context within which morality must be lived.

4 An Ignored Teaching

People often ignore the Church's teaching because it seems so far from the reality of their lives and the inhuman value system in which they are trapped. Our society is in need of moral reconstruction but this has to occur in a way that is socially possible. Can the Church continue to maintain a moral position regarding human sexuality which is ignored and disregarded by the vast majority of Catholics as inapplicable? Research shows, for example, that as people become more affluent they have less children and practice birth control whereas poorer people tend to have more partners and are less committed to the stable bonds of marriage. Social facts like these affect behaviour even when people are trying to live a Christian moral life.

People in moral crisis often turn to their Priests. But as in our case study, Clergy is often unequipped to deal with the complexity of the social issues around moral crises. The Parish Priest's advice in terms of the Church's teaching was unhelpful to the couple since whilst it affirmed ideal principles it proposed unworkable solutions. Ultimately his advice was largely ignored by the couple and only served to add to their worries. He too was aware of its inadequacy and was happy to give up his responsibility to the counsellor. The second Priest was more helpful in raising some of the important issues around their situation. He was able to provide a better link between the ideas of the Church's moral teaching and the context of their human life. The ability to make this link would seem to be essential for ministers in our modern world but often it is lacking. What kind of theological approach can help ministers to make these links and thus respond to people in their human context as Jesus did?

5. Some Ways Forward

5.1 *A Holistic Theological Approach*

Theologians are called to develop theological responses to people in need which respond to the reality of their life journey. Otherwise theology loses its power to be a source of decision making for the Christian community. A "Pastoral Moral Theology" should imply the inter-

penetration of authentic teaching and an effective pastoral response.

5.2 *An Authentic Teaching*

Pastorally, authentic teaching implies the effective catechesis of morality. This requires values which are incarnated in an inculturated faith responding to human life in a context. The human sciences, social and cultural analysis have to be part of such a Pastoral Moral Theology. There have been some efforts to do this on the psychological level in recent years but fewer attempts to relate a socio-economic and cultural factors to issues of moral theology.

5.3 *An Effective Pastoral Response: the Mission to Heal*

An effective pastoral response to people in need cannot just be the articulation and application of clear principals and norms. Jesus took account of people in their need and was accused of breaking the law when respond to people in their concrete experience of suffering. He mandated his followers to continue his mission to heal (Mt 10). And it is in the mission to heal that we may find an effective pastoral response.

In Medical Anthropology “disease” is used to refer to organic malfunction whereas “illness” “refers to the psycho social experience and meaning of perceived disease”.⁶ The construction of illness out of disease is always a cultural process following cultural categories of sickness and health. Consequently the healing process is also always a cultural process.

It is worth noting the healing refers to two related but distinguishable clinical tasks: the establishment of effective control of disordered biological and psychological processes, which I shall refer to as the “curing of disease” and the provision of personal and social meaning for life problems created by sickness which I shall refer to as the “healing of illness”⁷

HIV/AIDS exhibits aspects of being an illness and a disease. Because of the way society has stigmatised this sickness and because it is a sickness unto death, people who contract HIV go through a process of cultural and social isolation which is in many ways much more “sickening” than the clinical symptoms themselves. Often testing is avoided since this will construct the illness out of the disease and moves people into the socially ostracised group of HIV/AIDS victims.

Now the mission to heal may concern itself with the curing of disease but it should not focus there for a number of reasons

- X AIDS is an illness and needs healing as much if not more than curing
- X Healing is concerned with the human person whereas curing is concerned with scientific processes which require scientific expertise
- X curing is often “out of our hands” as missionaries and Christians. Whereas healing

is our vocation

X Care, affirmation, hope and acceptance are not provided by the curing model which is concerned with organic processes not human processes

Clearly those involved in any form of work with the victims of HIV/AIDS need to see themselves as healers doing the Churches healing ministry and following the theological categories appropriate to that ministry.

6. HIV/AIDS: A Symptom of a Deeper Sickness which Calls for Healing

Healing is an essential ministry today especially in a world beset by cultural, social and psychological sickness. We need to actively search for the means of human healing in our ministry. In our case the second Priest was more of a healer whereas the first, even whilst trying to do good, actually contributed to the illness by increasing the stress of Thembinkosi and especially Nomusa. Cultural and religious healing is fundamentally a question of care and prayer in an accepting human environment. So we need to look for ways to set up “caring structures” which help people to cope and live human and Christian lives. Counselling, group therapy for HIV+ people, family based care of people with AIDS would be examples of effective healing. We can contribute to healing the illness even when the disease may be incurable by removing the sickness which is culture of silence and fear around this disease. Here healing demands a move to a healthier world view from the sicker one of the past. This is evangelisation and here the teaching of the Church needs to come in. Clearly Thembinkosi’s cultural value of two families needs to be challenged. His township culture is in need of evangelisation here. But what is the world view that we offer as Christians? It needs to be realistic or it will not be taken seriously. There is no doubt that healing occurs through living a moral and coherent human life and so our theology and ministry needs to search for realistic ways to do that.

The breakdown of coherent cultural value systems has led to chaotic societal behaviour on this continent. AIDS is but one symptom of this fact. Functionalist solutions to these problems such as condoms, pills and injections together with structural solutions such as National campaigns and legislation are important but the underlying problem is a cultural one and so the long term effective remedy needs to operate on this level. Cultural reconstruction is vital at this period of African history and cultural reconstruction implies moral reconstruction. In helping in moral reconstruction of our society the Church plays a vital pastoral role in the healing of our communities.

Endnotes

1. Around one in four adults is HIV positive in countries like Zimbabwe and Botswana. See Marian Westley and Erika Check, "Is AIDS Forever," *Newsweek US Edition* (6 July 1998):60-61, at 60. In the KwaZulu-Natal province of South Africa, the incidence of HIV+ pregnant mothers rose from 1.6% to 25% between 1990 and 1996; See Diakonia, *An AIDS Kairos for Durban Churches*, May 1997, p. 5.

2. For the influence of Social and Cultural factors on HIV infection rates see Willem Saayman and Jacques Kriel, "Towards a Christian response to AIDS," *Missionalia* 19, no.2 (1991): 154-167 and Willem Saayman, "AIDS" in *Doing Ethics in Context*, ed. Charles VillaVicencio and John De Gruchy (Cape Town: David Philip, 1994), pp.174-175.

3. The government's current politically correct term for those who sell sex for money or food. For the role of commercial sex workers in HIV spread see Lorenzo Togni, *Aids in South Africa and on the African Continent* (Pretoria: Kagiso, 1997), pp. 20-24.

4. Township was the name given to urban areas for black South Africans in the Apartheid era. A "Township culture" emerged as an amalgam of Traditional African culture, Secular Western culture and Christianity as people from different backgrounds became urbanised.

5. See Philip Mayer, *Townsmen or Tribesmen* (Capetown: Oxford University, 1971) pp. 263ff

6. Arthur Kleinman, *Patients and Healers in the Context of Culture* (Berkeley: University of California, 1980), p. 72.

7. Kleinman, *Patients and Healers*, p. 82