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**THE CHURCHES' RESPONSE TO
THE HIV/AIDS PANDEMIC:
A CASE STUDY OF CHRISTIAN AGENCIES
IN THE CAPE TOWN AREA**

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ABSTRACT

It is two decades since the start of the HIV/AIDS pandemic. Since then it has caused the death of millions and untold suffering to many more, especially in sub-Saharan Africa. Yet, while some Christian response soon developed, until a few years ago the majority of churches have struggled to recognise in this disaster a challenge to themselves. The last few years have seen a flurry of activity from churches and Christian agencies in this field. New AIDS ministries are springing up, often in a rather haphazard fashion.

This study aims to establish what the response of churches and Christian groups in the Cape Town area is to the HIV/AIDS pandemic. The starting point for the response lies in the perceptions shaping the churches' AIDS discourse, since church activities are to a large degree discourse based. Hence the study starts with an investigation of the relationship between discourse and practice, paying special attention to the common metaphors and discourses used when referring to HIV/AIDS. Since the African context is crucial to the way HIV/AIDS is developing here, questions are posed to these discourses from an African point of view.

The study further considers the type of programmes emerging from this discourse. A survey was conducted by questionnaire in the Cape Town area to collect information from 30 Christian service providers and denominations. The aim is to evaluate whether the response is appropriate to the needs, to our African context and to the churches' mission. It is my hypothesis that while the Christian contribution to AIDS services is valuable, it is in many respects not appropriate. To support this hypothesis the study develops criteria for an appropriate AIDS discourse, and based on that for an appropriate practical response to the HIV/AIDS pandemic. These were derived from relevant literature as well as a series of informal interviews with local AIDS activists.

Finally some pointers are given as to how the Christian response to HIV/AIDS could be developed on a solid theological foundation in order to offer a service that is more appropriate to the needs, to our African context and to the churches' mission.

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LIST OF ABBREVIATIONS

A-B-C	Prevention message based on the advice to Abstain, Be faithful, Condomise.
AICs	African Initiated Churches; also known as African Independent Churches or African Spiritual Churches
AIDS	Acquired Immunodeficiency Syndrome
CPSA	Church of the Province of South Africa (Anglican Church)
FACT	Faith-based AIDS Counselling and Training Group
FBO	Faith-based Organisation
GRID	Gay Related Immune Deficiency
HIV	Human Immunodeficiency Virus
HBC	Home Based Care
MRC	Medical Research Council
MSF	Medicines Sans frontiers (Doctors without Borders)
MTCT(P)	Mother-to-child Transmission (Prevention)
NGO	Non-governmental Organisation
OVC	Orphans and vulnerable children
PWAs	People with AIDS
SABC	South African Broadcasting Service
SACBC	South African Catholic Bishops Conference
SACC	South African Council of Churches
STD / STI	Sexually transmitted disease/infection
TAC	Treatment Action Campaign
WCC	World Council of Churches
WHO	World Health Organisation

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Chapter 1. Introduction

1.1. Motivation

At this stage it is hardly necessary to motivate that HIV/AIDS is an important issue in South Africa. This is the country with the highest number of HIV positive persons globally, currently around 4.7 million.¹ Some regions report that one in three pregnant mothers is HIV positive. The impact of AIDS is becoming more visible and tangible as the number of people dying of AIDS related causes is rising. In Johannesburg the number of persons buried or cremated has risen from 15 000 in 1994 to 70 000 in 1999; the fatality rate of AIDS babies in one Port Elizabeth hospital has increased from 1 per year to two per week within seven years [Whiteside and Sunter 2000: 49]. Statistical evidence shows that this increase is largely a result of AIDS: The Medical Research Council [2001: 37] estimates that 40% of deaths of adults aged 15-49 during 1999/2000 were AIDS related.

Quite simply, AIDS is on track to dwarf every catastrophe in Africa's recorded history. It is stunting development, threatening the economy, and transforming cultural traditions [Schoofs 1999: Part1].

I will not describe the scenario in more detail, as this information is available from numerous sources [see Johnson and Dorrington 2001; Mann and Tarantola 1996 – the sections dealing with Africa; Dorrington et al. 2001; *South African Journal of Science* 2000; Whiteside and Sunter 2000].

The impact AIDS will have on this country will be devastating. The challenge it presents is vast and complex. So it is crucial to mobilise all available resources – in terms of expertise, personnel, infra-structure and funding – and to dedicate them to efforts to stem the tide of infections and care for those already infected and affected² by HIV and AIDS. And it is crucial, I believe, to evaluate these efforts in order to ensure that the resources are used in the most appropriate way.

I will dwell a little on the reasons why I personally have been drawn to this topic.

¹ The ante-natal survey conducted in October 2000 and released by the Department of Health in February 2001 projects that there are approximately 4.68 million (1999 = 4.2 million) people in South Africa living with HIV/AIDS [Meerkotter et al. n.d.: 5].

Two and a half years ago I was part of a Health Systems Trust survey [Schmid et al. 1999] to determine the range and extent of health services provided by religious communities in South Africa. The general lack of services dealing with HIV and AIDS, often linked to the conviction that AIDS did not affect the own membership, was disturbing.³ This raised numerous questions for me: What are the reasons for this non-response? What perceptions give rise to it? How is it possible that so soon after the end of apartheid and the self-recriminations of many churches for not having done enough, not having loved enough [RICSA 1999: 41-43], they develop the same attitude towards the next struggle?

In the course of investigating these issues it became apparent that during the last two years there has been a shift in many churches. The awareness of HIV/AIDS as a challenge to Christian churches has risen. AIDS related issues have moved close to the top of the agenda of numerous church leadership meetings. There is a sense of urgency in many denominations to become part of the response to this pandemic. A variety of programmes has been and is being initiated.

And thus the question for me has shifted: Have perceptions shaping the churches' AIDS discourse changed? What informs the discourse? What programmes emerge from this discourse? And is this emerging response appropriate? It is this latter question that is the focus of this study.

1.2. Scope of the study

It was my aim to establish what the response of churches and Christian groups in the Cape Town area is to the HIV/AIDS pandemic. This includes information on the approach churches have adopted to the pandemic, the type of needs they recognised around it and the range of services with which they responded to these needs. I had initially attempted to also obtain an indication of the scale of the response, the number of people reached with the services, but with a few exceptions the Faith-based

² Infected persons are those who are HIV positive; affected persons refers to all those who are indirectly touched by this, be they sexual partners, family members, children, friends or employers/employees.

³ There were exceptions to this general trend, notably the Catholic Church and individuals in many religious denominations.

Organisations (FBOs) I approached were not in a position to give this information.

The aim in collecting this information is not merely to present an overview of the response, but to evaluate it. The question I attempt to answer is whether the Christian response is appropriate. There are other criteria for evaluating the response to HIV/AIDS or other diseases, commonly used in medical/epidemiological research. They concern the efficacy, effectiveness and efficiency of interventions. While it is valid to raise these questions when planning and evaluating a response to social or medical disasters, especially in a context where a pandemic like this spawns a plethora of responses not necessarily effective or efficient, that is not my concern in this study. I confine myself here to the question whether the response is appropriate, where appropriateness is understood:

- First in terms of the pandemic, its complexity and the areas of need it has created;
- Second, in terms of the specific features of HIV/AIDS in the local context, that is on this southernmost tip of sub-Saharan Africa;
- And third, in terms of the mission of the Christian Church.

It is my hypothesis that while the Christian contribution to AIDS services is valuable, it is in many respects not appropriate.

1.3. Key concepts

Church/churches:

The groups included in the study are Christian churches from different denominations as well as Christian organisations providing AIDS-related services. The inclusive term used for such groupings would be Faith-based Organisations (FBOs), which includes congregations, denominations and non-governmental organisations (NGOs). In the context of this study that term is, however, problematic as it includes groups from non-Christian religions. The accurate, but rather cumbersome, expression would be 'Christian churches and other Christian organisations'. I have in most cases used *churches* as an inclusive term for all types of these groups; where I do refer to FBOs, those would be Christian, except when noted otherwise.

Occasionally, when referring to the whole Body of Believers, rather than to individual groups within it, I use the term *the Church*.

Discourse:

This is a central concept in the study and will be fully defined in Section 2.1. I follow Ricoeur's understanding of discourse as 'language event'.

Response:

What is done in answer to the challenges and needs raised by the HIV/AIDS pandemic.

AIDS:

Acquired Immuno-Deficiency Syndrome, a cluster of diseases commonly occurring in the late stages of HIV infection, due to the impact the virus has on the immune system. While it could be argued that it is technically incorrect to refer to AIDS as a disease or illness, as it presents as any one or more of a syndrome of diseases, the medical symptoms of AIDS do present in a definite way, distinct from that of other diseases. Due to this and also as the acronym includes the S to indicate that this is a syndrome, I have been assured by medical professionals that it is acceptable to refer to AIDS as a disease and I have done so.

HIV/AIDS:

The complete range of stages of infection, sero-conversion and resulting opportunistic infections, associated with this pandemic, as well as the cultural, behavioural, political and spiritual factors impacting on the course of the pandemic.

1.4. Rationale for the focus on churches

The attitudes – be that silence, condemnation, fear, anxiety or helplessness – found in churches around HIV/AIDS reflect the attitudes of society in general. In many instances the reasons for these attitudes are the same and a similar response or lack of response results from them. The question can hence be raised (and has been raised),

why I should focus on this particular sector of society rather than looking at society as a whole. Alternatively, if the intention is to investigate the special dimension of the faith-based response to AIDS, then why not look at faith communities in general? Here are some reasons for my decision.

First, I am a Christian. So for me the Christian realm is the natural place to start. It will be easiest for me to understand the response in a context that I am most familiar with. It is easiest to investigate the community closest to me. It is likely that those in other religious communities (and beyond) will be able to apply some of these findings to their situation.

Second, the Christian churches claim to have a specific calling to reach out to those in need. The WCC study group, for instance, states that the response of churches to the unjust structures, complacency and complicity promoting the AIDS pandemic and to the inhumanity of some against people living with AIDS (PWAs) will determine their relevance for people and society [WCC 1997: 2]. If this is at the heart of what the Church is, it is valid to investigate the response of this particular section of society in terms of its particular self-understanding, the statements it makes about itself and its mission; and to raise critical questions, which do not necessarily apply to other faith communities or secular sections of civil society.

Third, it is undeniable that Christian churches have made a big contribution towards shaping attitudes around sexuality.

Most historians, sexologists, and others who are interested in how sexual practices and attitudes have developed historically seem to agree that in the realm of sexual attitudes, Western history and christian [sic] history are so closely linked as to be in effect indistinguishable. That is to say, the christian church has been the chief architect of an attitude toward sexuality during the last seventeen-hundred years of European and Euroamerican history – an obsessive, proscriptive attitude [Heyward 1994: 12-13].

What Carter Heyward states here for the 'First World', has impacted through Western missionaries and churches on Africa and South Africa as well. Lindegger [1995: 3], for instance, mentions that churches in South Africa together with education departments have opposed moves to address sex and sexuality in a more open way, claiming, for instance, that promotion of condoms would promote promiscuity. Such attitudes are at the centre of much of the ambiguity and judgements in society towards

get involved in AIDS-related work. These interviews were conducted during the first phase of research, when my focus was on understanding the lack of a response, rather than assessing its appropriateness.⁴ So, while only the last interviews included specific questions on the appropriateness of the response, I gained through all of them an insight into the perceptions shaping the response of churches as well as some views on criteria for an appropriate response.

The next phase of the survey consisted of inquiries in *denominations* about their response.⁵ This was done by questionnaire.⁶ Where respondents were willing I followed this up by an interview to establish their views on whether they regarded the response of their church or organisation as appropriate. The 'selection' followed the same pattern as above, resulting in less input from the less accessible denominations, i.e. those with little or no central organisation as well as the wide field of new denominations amongst the charismatic and African Initiated Churches (AICs). Once again I hope to have at least captured the largest part of the response guided by the following criteria:

- 1) To include the denominations which numerically represent the majority of Christians;
- 2) To include the different types of churches: mainline, Pentecostal, charismatic and AIC;
- 3) To include those who although numerically small make an important contribution in terms of a response to HIV/AIDS – e.g. the Salvation Army;
- 4) To include non-denominational projects specifically offering AIDS related services.

Parallel to the fieldwork I conducted a search of relevant *literature*. Focussing initially on the specific area of church involvement in AIDS it soon became apparent that little has been written in this field, especially for the African and Southern African context [Bayley 1996; Byamugisha 1998; Keenan 2000; Nicolson 1995; Paterson 2001; Ruden 2000; Saayman and Kriel 1992 Shelp and Sunderland 1992;

⁴ It was largely due to my findings in this series of interviews that I decided to shift the focus of my study, as it became apparent that the inertia of churches regarding a response to the HIV/AIDS pandemic was finally disappearing.

⁵ For a list of all denominations and organisations approached see Appendix 1.

⁶ For an example, see Appendix 3.

WCC Study Document 1999; WCC Study Document 1997; Whiteside n.d.; Williams since 1989]. As only the last aspect of appropriateness, as I defined it,⁷ is specific to churches, I found relevant material in social science literature. The criteria specific to the mission of churches are not confined to AIDS work, and could be drawn from general literature on the social responsibility of churches.

The criteria for an appropriate response to HIV/AIDS described in Chapter 3, developed out of the literature search as much as out of the interviews.

1.6. Structure of the study

This study is presented in four major steps, corresponding to the four main chapters. Chapter 2 develops a theoretical frame of reference for the study. Since church activities are to a large degree discourse based, I draw some connections between discourse and practice in general and in churches in particular, and outline the major AIDS discourses and their relevance for the South African context.

Chapter 3 offers a detailed definition for an appropriate response to the HIV/AIDS pandemic. It does so by developing criteria first for Christian discourse and hence for the practical response to be appropriate to the reality of AIDS, to the local context and to the calling of churches.

In Chapter 4 I present the findings of my fieldwork into the actual response of churches and Christian NGOs in the Cape Town area, aiming to give as comprehensive as possible a picture of services that are being offered. These are preceded by recent statements of what such a response ought to be and by previous research findings on the response of Southern African churches.

The final chapter offers an evaluation of the existing response, highlighting some areas of concern where it appears to be inappropriate to the challenge. The intention is not to point fingers, but to indicate how the Christian response to HIV/AIDS could be developed and more solidly grounded in its theology in order to offer a service that is more appropriate to the needs, to our African context and to the churches' mission.

⁷ See Section 1.2, p 3.

Chapter 2. The AIDS discourses:

Theoretical framework for understanding the churches' response

The theoretical framework for this dissertation is built around the work of Susan Sontag and Gill Seidel, two authors who have helped me understand the way in which churches (and society in general) are responding to the HIV/AIDS pandemic. Both of them focus on the way we communicate about AIDS and how this discourse shapes attitudes towards PWAs and the response towards the pandemic.

It would be valid to ask why an investigation of the church's response to HIV/AIDS should start with a chapter on the discourse about AIDS. Is what is said really that important? Is it not action that counts? I wish to argue that it is crucial to look at the AIDS discourse; to see what is being said about HIV/AIDS, and to develop criteria for an appropriate discourse, which may frame appropriate actions to counter the pandemic. This is based on my conviction that the discourse strongly constrains the possibilities for any action decided upon, and hence needs to be dealt with first. It is, however, ultimately the practical response that matters and describing and evaluating this remains the final aim of this study.

Before analysing the AIDS discourses, therefore, I will consider the role of discourse within society and within churches, and reflect on some aspects of discourse, which are helpful for my analysis.

2.1. The connection between discourse and practice

Since discourse is a central term in my analysis, let me start by clarifying my usage of the concept. I will be following Ricoeur's [1991: 145] definition of discourse as a 'language-event' or 'linguistic usage'. Discourse then is not language as such, but language that is either spoken or written. Ricoeur identifies four traits of discourse [Ricoeur 1991: 145-150], distinguishing it from language as such:

First, discourse is *temporal*: it is a fleeting event, always realised in time. In the form of speech this fleeting moment of the event is more obvious than in writing, which fixes not speech as such but its meaning. Second, discourse is *subjective*: it has a speaker

whose 'subjective intention' determines the meaning of the discourse. It is not possible to fully understand the meaning of discourse without knowing who is speaking/writing it. Third, discourse is *actualised*: it refers to something, a project, "a world that it claims to describe, to express, or to represent" [Ricoeur 1991: 145]. Fourth, discourse is addressed to someone, it has an *interlocutor* and it is this trait that makes communication possible. Written discourse is addressed potentially to anyone who is able to read and thus breaks out of the narrow confines of face-to-face, momentary communication in the "universality of its address" [Ricoeur 1991: 150].

These traits have some implications for AIDS discourse: Paying attention to *subjectivity* of the different AIDS discourses will be important in their analysis below. For instance, the medical fraternity has for the initial period of the pandemic dominated the discourse and given it a bio-medical face, excluding all other aspects crucial to its understanding. Once this was challenged by other 'speakers', other themes and objectives, other discourses emerged.⁸ Similarly, the presence of the interlocutor is at issue in all claims that a response to HIV/AIDS cannot be developed without involvement of PWAs – a requirement that is overlooked far too often.

Another implication calls for more detailed discussion: Ricoeur says that discourse refers to something that it *claims to describe*. This is of course linked to the subjectivity, the standpoint and worldview of the 'speaker'. Thus discourse 'projects a world', rather than simply describing it as if it was an unmediated given.

It is here that the destructive potential of discourse is located. I want to expand on this by referring to Paul Bové: He insists that it is not possible to say what discourse is; in order to understand it one has to focus on how it functions, where it is found, how it is produced and regulated and what social effects it has [Bové 1995: 54]. Discourse is for him – and for other poststructuralists – a tool with which to describe the linkages between knowledge and power, between those intellectuals and institutions producing knowledge and the institutions of the modern state exercising power to control populations [Bové 1995: 54-55]. He describes this linkage: Truths are relative to a frame of reference; they may be seen even as "a function of these frames" [Bové 1995: 56]. Discourses 'constitute' truths; they 'produce' knowledge rather than merely discovering and transmitting it. In this way they "make possible disciplines and

institutions which, in turn, sustain and distribute these discourses” [Bové 1995: 57]. The institutionalised discourses guarantee the new ‘truths’ with their own legitimacy [Bové 1995: 56].

Chris Kenyon [2001: 6] describes an example of this process where truths about the danger of racism, which were developed in the liberation movement during the struggle period, serve as foundation for the institution of a powerful presidency in the democratic South Africa, a presidency that does not regard any challenges to its policies as justifiable and detects a racist angle in each of them. This powerful institution in turn guarantees the truth of statements President Mbeki makes on AIDS. In the process other claims linking AIDS to HIV and to sexual behaviour, claims based on scientific data and wide experience, claims on which a successful HIV prevention strategy could be built, loose their power to convince and to influence behaviour.

This linkage between discourse and powerful institutions is evident in the way the medical institutions were earlier able to impose their bio-medical understanding of AIDS as the new ‘gay cancer’ as its hegemonic discourse. Gill Seidel highlights this in her article discussed below.⁹ This has implications, for instance, for allocation of the funding that maintains the medical research fraternity [Widdus 1996: 202-204]. Susan Sontag similarly demonstrates how groups with political power impose their views and control populations with their choice of metaphors for AIDS.¹⁰ Her call to challenge these metaphors is a specific example of Bové’s general comment about the political value of discursive analysis:

Since ours is a society which increasingly tries to ensure its political order through discursive systems that discipline our language and culture, any successful resistance to that order would seem to require strong weapons aimed to weaken that discipline [Bové 1995: 63].

Let us return to Ricoeur [1991: 146-47] and his reflections on Austin and Searle’s distinction of “a hierarchy of subordinate acts” of speech on different levels: the level of the locutionary or propositional act, the level of the illocutionary act or force and the level of the perlocutionary act. It is the latter, “that which we do *by* saying” which is of importance for my investigation of the correlation between what is said about AIDS

⁸ See Section 2.3.1, p 20-22 for details.

⁹ See Section 2.3, p 20-26.

¹⁰ See Section 2.2, p 17-20.

and what is done in response to it. Ricoeur says that in the perlocutionary action discourse acts as stimulus on the interlocutor. As it does so without its intentions being recognised, it acts not so much on the cognitive as on the affective domain. Hence it gives rise to action, which is an unreflected response to or result of the discourse. Much of what Susan Sontag says in her book, *AIDS and its Metaphors*, aims to raise these intentions into the cognitive domain, so that it is possible to recognise them for what they are, what they lead to and hence to challenge them.

Turning to the churches and the importance of discourse within this context, there are four points I want to raise:

First, activities of churches are to a large extent discourse based: their leaders preach and teach, celebrate liturgies and offer counselling, their members pray, sing and participate in bible studies. All their other activities mirror the discourse and are reciprocally determined by it.

While churches have lost most of their *political and economic power* in society since the Enlightenment, Cochrane and West [1993: 34] emphasise that their voice has *social force* even in our secular societies. In this voice they express their public identity: “the Church witnesses to what it believes; if this witness has public force, it is because it enters into the discourse by which public life is shaped.”

Averil Cameron [Cochrane and West 1993: 35-39] highlights a number of characteristics of early Christian rhetoric that helped it become the hegemonic discourse after the collapse of the Roman empire: its power to renew society, its capacity to address paradoxes in a way which gave a coherent picture, its ‘celebration of the irrational’, its elasticity as opposed to the rigidity of the Roman rhetoric, and its capacity to join the personal and the public. If Christian language had the power to shape the character and ethos of an empire then, its potential to do something similar in other situations cannot be ignored.

The potential of Christian discourse to “join the personal and the public” has important implications for the AIDS discourse in churches, which directly links the utterly private domain of sexuality and intimate relationships to the highly public realms of the national economy and security and social issues such as poverty and patriarchy. In order to address the HIV/AIDS pandemic in a significant way churches will have to

rediscover this ability to meaningfully join the public and the private.

Second, since narrative is a central element of Christian discourse [Cochrane and West 1993: 38] let us focus on narratives and their potential for impacting on religious groups. Mankowski and Rappaport describe how shared narratives shape the relationship between the group and its members. Stories, whether they are personal stories of individuals' lives or communal stories about important events for groups, are ways of conveying truths both to others and to oneself. As they are told repeatedly and often in situations of special meaning, these narratives "organize experience, give coherence and meaning to life events" [Mankowski and Rappaport 2000: 481], they act as "resources for instilling hope and inspiration, deepening tradition and a sense of history, or coping with and changing negative personal or social conditions" [Mankowski and Rappaport 2000: 490].

Dominant cultural narratives are repeated in central socialising institutions like churches and come to determine general values, beliefs and identities for the majority. This also holds for narratives about marginalised groups, which shape both positive and negative attitudes towards such groups for those outside the group as well as for those within [Mankowski and Rappaport 2000: 482]. People belonging to a group share and repeat their individual, yet similar stories, which together form the *community narrative*. Telling their own stories can help those who do not fit into the mainstream overcome their marginality as they discover that they do belong in a group where others have similar stories, whether this be a personal story or the central narratives of the faith. Discovering such a sense of identity and belonging can be especially powerful for those who are outsiders in society or who are undergoing difficult transitions in their lives [Mankowski and Rappaport 2000: 487]. This has implications for the AIDS discourse: AIDS has its greatest impact in marginalised groups of society; at the same time it creates more marginalisation due to the strong stigma attached to HIV infection. Narratives can be used to help such marginalised individuals and groups to develop a sense of belonging to an alternative community. As a first step this is valuable; it is of course not enough.

The process of "marking collective identity" of the group is also the way in which community narratives demonstrate their exclusive function, as they define the boundary towards those outsiders whose stories do not fit [Mankowski and Rappaport 2000: 488].

Two opportunities can be found within the narrative discourse to overcome this: Mankowski and Rappaport do say that in support groups new members may experience the community narrative as an alternative to their own story, which by way of repetition is adopted as one's own [Mankowski and Rappaport 2000: 489]. This offers one way of opening up the boundaries. Narratives have another function here: they allow us to move beyond statistics to the personal, to present the reality of AIDS not in figures, but in personal stories of those infected and affected. Negative stereotypes and attitudes can be overcome by offering the audience an opportunity to get to know the story of a person living with AIDS [Shelp and Sunderland 1992: 14], to discover the reality of a shared humanity between 'us' and 'them'. Through this process group boundaries can be opened up to include persons previously excluded, like PWAs.

Adopting the common narrative as one's own has another implication relevant to our theme: Mankowski and Rappaport [2000: 489] state that out of such a new story the will to change one's behaviour may emerge. The change of behaviour is an important aim of HIV prevention strategies, and narratives may provide a helpful tool in achieving this. It must be kept in mind however that for marginal groups most vulnerable to HIV infection, alternatives to the dominant narratives will have to be developed which fit their respective contexts. Here too it will be important that the stories of those lacking power are recorded and amplified, for themselves and for others [Mankowski and Rappaport 2000: 490].¹¹

Third, I want to give an example of a specific early discourse on AIDS which made a huge impact on attitudes and even now stands for the church's response to AIDS in many minds, both within and without the church. It is the discourse of judgement. Jerry Falwell from the Moral Majority movement stated that AIDS was God's punishment for sinners and for the immorality of society, specifically for the sin of homosexuality and the immorality not only of homosexual acts but also of a society tolerating this evil in its midst. In my reading for this thesis, the one Christian response to HIV/AIDS that was mentioned most often was Falwell's 'tirade' [Altman 1986: 3, 67; Saayman and Kriel 1992: 9; Seidel 1993: 178; Shelp and Sunderland 1992: 322]. Shelp and Sunderland [1992: 15] mention that in the first years of the epidemic few denominations and Christian leaders spoke out about AIDS in an "enlightened manner"; they left the

¹¹ See section 2.1, p 10 on the importance of the presence of the interlocutor.

floor to some “popular preachers” like Falwell with the result that their theological interpretation was left unchallenged in the mind of the public. It is a discourse still heard quite commonly, if not exclusively, in churches. Falwell’s conclusion, that any expense for research into the causes of AIDS and its possible treatment would be unwarranted waste of public money, even today influences the lack of response of many Christians.

Fourth, in our context there is an additional factor for the importance of the churches’ AIDS discourse: for many in South Africa their church is still the main source of information and education, especially in largely illiterate communities [Saayman 1992: 53]. It remains a crucial agency for interpretation of events and for raising consciousness. Christians – whether those in urban-based fundamentalist Christian groups, who may have access to other sources of information and explanation, but do not accept their validity as they are not ‘biblically-based’, or those in remote areas whose access to information is limited – still largely trust their churches as “honest purveyors of information” [Nicolson 1995: 72]. This offers an opportunity to churches, as part of a body with an infrastructure that extends into even the remotest areas of the country, and makes it all the more important to look critically at the way this opportunity is (ab) used [Nicolson 1995:17].

These examples should suffice to demonstrate that there is a definite correlation between what is said and what is done in churches. Yet the two cannot simply be taken as one and the same. Two factors limit the direct relationship between what is said and what is done.

First, Maluleke’s [2000: 99] distinction between “said things” and “done things” is helpful. “Said things” are those simply said, often in the public realm, even if nothing is done; and “done things” on the other hand are simply done, they merely happen, without much discussion. Churches often do not get beyond “said things”. How many statements have been released on the importance of AIDS, conferences held to discuss its implications? Yet in many cases no actions follow.

On the other hand it is in the realm of “done things” where many of the intensely private “things” relating to sex and to death are found, things that are acted out but never “spoken out”. Sexuality and death play an important role when dealing with

HIV/AIDS. There are reasons for the taboos around these things, and hence around HIV/AIDS. Maluleke [2000: 99] stresses the importance of trying to understand why the taboos have come about and what is behind them, rather than attempting to force people to ignore the taboos and speak about these matters.

In a similar vein Gillian Paterson [2000: 27-28] observes that the real issues behind the pandemic are not mentioned. "We speak about A, while the real issue is B" she says, and we do that because apart from the fact that we may have no language for B, there is nothing we can do about it. In her understanding the real issues are those relating to the cultural identity crisis of Africa, the deeply held beliefs, like the conviction that disease results not from individual behaviour but from a curse or is the punishment of the ancestors for displeasing them; the conviction that the purpose of living is to become an ancestor. While these beliefs have seemingly been given up for a Western way of being, they still shape attitudes, relationships and behaviour.¹² In order to make an impact on the HIV/AIDS pandemic it is necessary to deal with these 'real' issues, according to Paterson, instead of focussing our attention on problems arising out of these, such as resistance to the use of condoms, poverty or gendered power relations.

Another reason for discrepancies between discourse and action is found in the insight that knowledge does not necessarily translate into action; that more talking and better information about the mechanism of HIV transmission does not lead to changed sexual behaviour [Shelp and Sunderland 1992: 184]. Ray et al. [1998: 1431] report studies in Zimbabwe, a country with high rates of infection, where 90% of respondents correctly identified the modes of transmission of HIV, yet individuals perceived themselves as not being at risk of infection. For this perception, and consequently sexual behaviour to change, knowledge has to be more than cerebral, more than 'said things'. This is not to say, however, that knowledge is not important. Clear, complete, unbiased knowledge imparted in an ongoing process remains the precondition for individual empowerment [Van der Vliet 1996: 124].

Here another dilemma arises for the efforts to stem the tide of HIV, as most of the knowledge offered in awareness programmes belongs to the bio-medical and moral

¹² Paterson speaks here of Africa, but the phenomenon she describes is by no means limited to Africa as, for instance, the current resurgence of astrology and pagan religions in the West illustrates.

discourse,¹³ and does neither answer the questions and doubts nor does it challenge the convictions of the African mind.¹⁴ It is another case of talking about A while the real issue is B.

With the dependence of action on discourse established in general, let us now turn our attention to the discourse of HIV/AIDS, before looking in following chapters at the action following from it.

2.2. The metaphors of AIDS

Susan Sontag is known as a author of novels and essays. Her own experience of cancer and of the language used around it started her reflection on the metaphors of disease. Later, with AIDS increasingly becoming an issue in society, she wrote *AIDS and its Metaphors*, reflecting on the origin and impact of the metaphors of HIV/AIDS. She remarks on the significance of metaphor in the context of discourse about illness:

The age-old, seemingly inexorable process whereby diseases acquire meanings (by coming to stand for the deepest fears) and inflict stigma is always worth challenging With this illness, one that elicits so much guilt and shame, the effort to detach it from these meanings, these metaphors, seems particularly liberating, even consoling. But the metaphors cannot be distanced just by abstaining from them. They have to be exposed, criticized, belabored, used up [Sontag 1988: 94].

And that is what Sontag sets out to do in her book. She finds that the most common metaphors for AIDS, as for disease in general, are military: disease invades society; it challenges us to fight the disease, to become part of the struggle against it. In bygone times it was doctors who waged the war against disease; in our time the whole of society is called on to do so [Sontag 1988: 10]. 'War' seems to be an ideal metaphor for mobilising society for an all-out effort – whether this is the war against an enemy nation, against crime, drugs, the scourge of AIDS, or sexual immorality.¹⁵ Another aspect of this metaphor has to be noted:

The metaphor implements the way particularly dreaded diseases are envisaged as an

¹³ See Section 2.3.1, p 21-23 and 2.3.3, p 23-24 regarding these discourses.

¹⁴ This dilemma is dealt with in more detail in Section 2.4, p 27-28.

¹⁵ For us in South Africa the all-outness of the war against AIDS has not yet become real, as demonstrated by the unwillingness of the government to declare a state of emergency around HIV/AIDS.

alien “other”, as enemies are in modern war; and the move from the demonization of the illness to the attribution of fault to the patient is an inevitable one, no matter if patients are thought of as victims. Victims suggest innocence. And innocence, by the inexorable logic that governs all relational terms, suggests guilt [Sontag 1988: 11].

Society needs to allocate blame; and repeatedly in the course of history found it convenient to declare a disease ‘The Enemy’, identify it with evil, and hold its victims responsible. Syphilis is an example of this.

Sontag believes that this metaphor must be challenged, its implications exposed as it “overmobilises, overdescribes, and is unbelievably excommunicating and stigmatising” [Sontag 1988: 94]. She is adamant: “We are not being invaded. The body is not a battlefield. The ill are neither unavoidable casualties nor the enemy” [Sontag 1988: 95].

Many metaphors for this new scourge, AIDS, are drawn from the diseases with which humankind has been familiar for a long time, mainly cancer and syphilis. Like cancer, AIDS as a micro process is described as an invasion of the body by an “infectious agent” [Sontag 1988: 16-17]. Considering the mode of the transmission of the HI Virus brings up the metaphor of pollution and other metaphors common for describing syphilis in the 15th century: both are repulsive, retributive, and collectively invasive diseases. Syphilis was considered a punishment for individual wrongdoing, but simultaneously for the licentiousness of the community. Similarly AIDS is interpreted in this pre-modern way as a disease that affects people both as individuals and as members of a ‘risk group’ [Sontag 1988: 46]. AIDS is pictured as “a marker of both individual and social vulnerabilities. The virus invades the body; the disease (or, in the newer version, the fear of the disease) is described as invading the whole society” [Sontag 1988: 65-66].

The fear of pollution by contact with HIV positive people is very real for many and avoiding such risk becomes an important matter. In some churches AIDS featured first in discussions about the risk of pollution via the communion cup [Almond 1990: 101]. The essence of life – the wine of communion, blood, and sexual fluid¹⁶ – becomes a threat to life, a source of possible contamination [Sontag 1988: 43].

Like syphilis, AIDS too is considered to be a disease of sexual excess, and in the case

¹⁶ Since Sontag’s writing of this book further research into the modes of transmission of HIV has added breast milk to the list of life-giving fluids, which may impart death.

of AIDS even one of sexual perversity:¹⁷

Getting the disease through a sexual practice is thought to be more wilful, and therefore deserves more blame. ... Those like haemophiliacs and blood-transfusion recipients, who cannot by any stretch of the blaming faculty be considered responsible for their illness,¹⁸ may be ruthlessly ostracized by frightened people, and potentially represent a greater threat because, unlike the already stigmatized, they are not easy to identify [Sontag 1988: 26-27].

Sontag mentions “plague” as another principal metaphor for understanding AIDS. Derived from the Latin *plaga*, meaning stroke or wound, the term is “used metaphorically as the highest standard of collective calamity, evil, scourge” [Sontag 1988: 44]. Consequently it is usually applied to mass incidences of illness, incidences that are understood to be inflicted, rather than merely endured. Such illness is a punishment, a judgement on a community. The most feared diseases – those that transform and hence alienate the body – are most easily promoted to plague [Sontag 1988: 44-45].

After ‘exposing’ these various metaphors of HIV/AIDS and the detrimental effect of their use on those affected by it, Sontag [1988: 93-94] concludes that it is terrible to think of such a disaster as AIDS as belonging to ordinary human experience. But, she insists, it is helpful to think of even such a dreaded disease as ordinary, natural, as just an illness, with no meaning. “It happened with leprosy, now known as Hansen’s disease. It is bound to happen with AIDS, when the illness is much better understood and, above all, treatable.”

One critique of this view is offered by Van der Vliet [1996: 2], when she says that, especially in the case of epidemics, people do not see disease as being without meaning, as mere disease. In the case of HIV/AIDS the epidemic “drew its meaning from the *time* in which it arrived, but also from *those who became infected*” [Van der Vliet 1996: 2; my italics]. Since epidemics only develop when the correct ecology for them is given in society,¹⁹ it is difficult to dismiss the link between the meaning of the epidemic and the meaning of the time. Waves of syphilis and gonorrhoea, for example,

¹⁷ Sontag is here speaking for the USA, where AIDS is still – in spite of all the evidence – considered to be mainly a disease affecting white homosexual males. In Africa, where AIDS is mainly transmitted by heterosexual contact, the idea of perversity and the accompanying judgement is similarly linked to it: those infected by HIV are automatically assumed to be promiscuous.

¹⁸ Even this instance of HIV infection is – in the understanding of the Jehova’s Witnesses – a deserved consequence of the ‘immorality’ of accepting blood transfusions [Nisbet and McQueen 1993: 898].

were concurrent with the social disturbance of the early twentieth century resulting from urbanisation, industrialisation, immigration and changing family patterns. As in other epidemics the time of the beginning of this epidemic and the groups it infected shaped the meanings attached to the disease [Van der Vliet 1996: 3].

Sontag does of course not deny that HIV/AIDS did attract these meanings; she merely maintains that this process is not valid and should be challenged. Yet with her insistence that this is “simply an illness”, nothing more, there is another risk involved. Gill Seidel’s discussion of HIV/AIDS discourses helps us see this.

2.3. The discourses of HIV/AIDS

In this section I draw mainly on Gill Seidel’s article, “The competing Discourses of HIV/AIDS in sub-Saharan Africa: Discourses of Rights and Empowerment vs. Discourses of Control and Exclusion” [Seidel 1993: 175-194]. Her concern is with the way in which the HIV/AIDS discourse functions and how power is exercised through this discourse; how minorities are oppressed by discourses of control and exclusion; and how they resist this oppression by their discourses of rights and empowerment. Seidel shows how discourse impacts on attempts at preventing the further spread of HIV. She identifies a number of distinctive yet overlapping discourses, which compete for hegemony. Dominant among these in terms of determining policies for national interventions and shaping perceptions about PWAs are the medical and medico-moral discourses. Seidel describes six competing discourses in all:

2.3.1. Medical discourse

This is the dominant, authoritative discourse as far as AIDS is concerned, developed and promoted by the World Health Organisation (WHO), Health Ministries and the medical fraternity. Its primary concern is with symptoms and stages of the syndrome. It is a depersonalised discourse about ‘seropositives’ belonging to ‘risk groups’, rather than about human beings whose bodies have been infected by a virus. The identification of ‘risk groups’ has resulted in labelling and consequently the stigmatisation of whole groups. Any contact with persons from these groups was made out to carry the risk of

¹⁹ See Section 3.1.3.1, p 46-48.

becoming infected with HIV. This resulted in harassment, control, and medicalisation, even calls for quarantine. Such discourse caused already vulnerable groups to become even further marginalised.

The so-called 'risk groups' in the USA were initially white homosexual men and intravenous drug users. Further into the epidemic, prostitutes and Haitians were added to the list. In Africa, however, HIV infection followed a different pattern and other risk groups emerged. The differing trends in the development of the pandemic in various parts of the world became a focus of epidemiological investigation. In Europe and North America, the so-called Pattern I countries, HIV is transmitted mainly by homosexual contact; in sub-Saharan Africa transmission occurs mainly via heterosexual contact, unscreened blood supplies and from mother to child. This discourse led to the construction of "African AIDS", which could then be seen as another exotic, tropical ailment, totally different from Western AIDS. Seidel points out that this discourse has implications for allocation of funding and on international solidarity.

Due to its disregard for numerous aspects of the pandemic, this approach has led to ineffective preventive strategies. So for instance the focus on risk groups has resulted in false security amongst many who engage in risky behaviour but are not part of the identified groups.²⁰ Thus it has for instance been found that there was little change in high-risk sexual behaviour amongst heterosexuals as they do not belong to a risk group and hence consider themselves safe from HIV.

Seidel characterises this type of discourse as "a new, authoritative and sophisticated variety of the discourse of control and exclusion, which, because of its medical and scientific stable, passes as neutral and non-ideological" [Seidel 1993: 177]. Sontag's insistence that AIDS is nothing other than merely another illness supports the hegemony of the medical discourse of HIV/AIDS and makes it difficult to come to a full understanding of the disease and the mechanism by which it spreads through societies.

Criticism is levelled against this discourse on various counts. One of the problems resulting from the hegemony of the medical discourse on HIV/AIDS is the

²⁰ Ray et al. [1998: 1431] report that the denial of risk in their study could be linked to the identification of high risk groups as those who were either "promiscuous" or used the services of sex workers.

identification and definition of risk groups. This avoids inter-individual analysis, viewing the individual as indistinguishable from the group [Delor and Hubert 2000: 1568] and leads to stigmatisation of whole groups, resulting in their discrimination [Nisbet and McQueen 1993: 893]. One example is that potential blood donors are turned away exclusively on the grounds that they are homosexual. The reverse side of this, the fact that those not identified with a risk group imagine that they are not at risk, is another factor that contributes to the spread of HIV. The complacency and “false sense of security” in the Muslim community of the Western Cape, on the grounds of the protection offered them by the presumed adherence to the Islamic sexual code, is one example. Ahmed regards it as “extremely dangerous” as this attitude will lead to HIV remaining undetected in his community [Ahmed n.d.: 47].

In Africa the hegemony of the medical discourse is challenged by the conviction that AIDS is a result of witchcraft. When the disease originally made its appearance in Uganda, witchcraft was the immediate explanation. Since then many education drives have spread AIDS information – mainly medical – yet even now the explanations of AIDS given in those areas are still a mixture of medical insights and witchcraft [Caprara et al. 1993: 1232]. A more recent challenge to the hegemony of this discourse is the dissident view, insisting that AIDS is a disease of poverty, independent of HIV, a debate that came to prominence in our context through the support of President Thabo Mbeki for the dissident view.

UNAIDS, and with it the International Prevention Works Symposium held at the World AIDS Conference 2000, identify four strategies of prevention: Prevention of mother to child transmission (MTCT) through drug treatment, treatment of sexually transmitted diseases, life skills training for young people, and lastly – but certainly not least, as this received most of the attention – the development of a vaccine. Adler [2000: 59] points out that these are predominantly medical and public health interventions, with no mention of developmental issues such as human rights or of the cultural practices favouring the spread of HIV. This is an indicator of “the ongoing belief (the silence of which has yet to be broken) that the final answer to the problem will be a medical one” [Adler 2000: 59]. This in spite of the fact that so far medical science has failed in the battle against AIDS as it offers neither a cure nor a vaccine, and the treatment it has developed is out of the reach of the majority of those infected [Adler 2000: 61].

Read

2.3.2. Development discourse

This discourse stresses the developmental link to AIDS and leads to a certain construction of women and gender in development discussions.²¹ It builds on women's experience of men's control over their sexuality, a crucial factor in the spread of the pandemic, yet often defended as being part of 'African culture'. In this discourse socio-economic realities impacting on sexual behaviour are considered crucial in developing any effective AIDS prevention programme.

The understanding of AIDS as a gendered phenomenon is an achievement, which was possible once the purely medical model of HIV/AIDS – developed on the basis of the medical discourse – was challenged. In Africa women were initially seen as the culprits responsible for spreading HIV. As a result prevention models were developed which primarily targeted women and their behaviour. In cases where this leads to the empowering of women to insist on safer sex, for instance when sex-workers are able to insist on the use of condoms, it has a measure of success. Generally however the impact remains limited [Bujra 2000: 7].²²

2.3.3. Medico-moral discourse

This discourse goes along with the social categories of disease developed in the medical discourse. The current upsurge in fundamentalist religious groups on the continent strengthens the view of AIDS as God's punishment for immorality. It stresses the demands on women to be confined to a domestic and reproductive role and develops chastity interventions to prevent HIV infections.

High-profile Christian HIV interventions mobilise sets of meanings primarily around sexuality and the body, such as the value of chastity and fidelity before and within monogamous marriages (predominantly for women – a guarantee of paternity in patrilinear societies where children brought up by women belong to fathers). Christian discourse on the importance of motherhood merges with older, indigenous values [Seidel 1993: 178].

²¹ More recently, as part of the development discourse in agencies such as UNAIDS, AIDS has also been recognised as an issue of human security, impacting on economic, food, health, personal and community security [Piot 2001].

²² This is due to the reality that the pandemic is driven by men. See Section 3.1.3.3, p 51-52 for details.

In this discourse condoms are often opposed as promoting promiscuity. This conviction may be based on religious or cultural arguments.

For some churches AIDS is an opportunity to stress their traditional values about the sexual order. Others, which can be linked to the liberation theology paradigm, do not follow this one-dimensional approach. They realise that calls for faithfulness directed at women in heterosexual relationships with no control over their partner's sexual behaviour are meaningless.

The medico-moral discourse involves blaming others and stigmatisation – as is the case in other sexually transmitted diseases. 'The other' can be variously defined in different times and contexts. In Africa the blame for HIV infection is usually directed at women, particularly young women and sex-workers. This is clearly an example of a discourse used to exert control and exclusion.

2.3.4. Legal discourse and human rights covenants

The AIDS rights discourse is underpinned by the international human rights declarations and has impacted on public health policy in many instances. Two important conferences laid down guidelines for applying accepted human rights in the area of HIV/AIDS. They were the *Global Expert Meeting on AIDS: A Question of Rights and Humanity* in 1991 and the Commonwealth Secretariat's report *Ethical and social aspects of AIDS in Africa*.²³ An important aim in this discourse is the debunking of myths about the transmission of AIDS, for instance by publishing regular health columns in the media. In this way, for instance, the safety of normal contact with infected persons is stressed and any rationale for their quarantine shown to be non-existent. Respect for human dignity and the rights of PWAs are regarded as essential for the development of effective AIDS programmes.²⁴

The balancing of individual and group rights is a central issue in this discourse. It is again an area where the emphasis differs in different parts of the world, with individual rights more in the foreground in the North and group rights more central in the South.

²³ It is an interesting incidence of the silence around AIDS that neither of these reports has been made available through either the indexed AIDS databases or the WHO circulation system.

²⁴ See Section 3.1.1.2, p 38 for some human rights issues relevant to the HIV/AIDS pandemic.

2.3.5. Ethical discourse

The emphasis in this discourse is on balancing various goods and making a judgement on the greatest common good. Issues debated here include compulsory HIV testing and making HIV infection a notifiable condition. This discourse can be one of empowerment or of exclusion; it may be used either to challenge or to support the medico-moral discourse. So for instance the argument for the good of the greatest number can be used exclusively, where the public good will exclude PWAs and other marginalised and stigmatised groups. The challenge is to balance the 'ethic of caring' with the cost of the care.

One such ethical issue that is difficult to resolve is the debate about the ethical imperative to care for PWAs by providing antiretroviral treatment to ease their suffering and prolong their lives. This medication is expensive, even after considerable price reductions as a result of lobbying to make treatment more accessible. The provision of such a costly intervention has to be balanced against the reality that in our context many PWAs die eventually not of opportunistic infections, but of malnutrition. Lisa Cahill [2000: 283] quotes an estimate of US\$35 to 40 billion which would be needed to make "standard AIDS treatment" available worldwide. The same amount would be enough to provide basic health care, nutrition and social services for the poorest people of the world, and thereby remove not only the symptom of HIV but also one of the main factors allowing it to spread. So if there is not enough money to pay both for anti-retroviral medication for PWAs and for the basic needs for the survival of affected families, which one should get the funding?

2.3.6. Activist discourse

This discourse presents a new paradigm, which grew out of the dire need in the South for affordable drugs to treat AIDS related infections. Organised groups of PWAs have initiated a shift in the AIDS discourse away from the medico-moral to focus on human rights and questions of ethics. They address issues such as imbalance in resources between North and South, which result in the bulk of funding going to the North while 90% of the world's PWAs live in the South; or the reality of gender-based power which is one of the factors favouring the rapid spread of HIV in Africa. In Africa such activist groups have brought practices like female genital mutilation and dry sex into the AIDS

debate. This discourse has raised the awareness that knowledge about the disease is power and may prolong life.

By way of conclusion Seidel returns to her original classification, contrasting discourses of control or exclusion with those of rights and empowerment. In the former, such as the medical and medico-moral discourses, meaning is defined by experts; it is closed and immobilised. In the latter meaning is defined in terms of and through participation and self-determination by those affected, based on their access to appropriate information. The discourses of rights and empowerment have gradually been undermining the hegemony of the discourses of exclusion. This is evident for instance in the change in content of the International Conference on AIDS since 1990, where issues such as human rights of PWAs have not only become part of the agenda, but have started impacting on public health policy. There is however still a long way to go in this process of empowerment and participation. AIDS in sub-Saharan Africa, Seidel insists, is not 'only an illness'; it is an issue of human rights, gender, public health, ethics, development and discrimination.

The question whether churches are aware of this distinction, and to what extent they are able to move in their discourse from exclusion to empowerment is an important one for this study

2.4. Conclusions about the language of HIV/AIDS in Africa

A glaring omission in Seidel's framework is the failure to mention the discourse shaped by traditional African culture, which is identified by many working locally in AIDS related services as a powerful influence on the understanding of the pandemic. In their view there are three relevant discourses: medical, religious and traditional.

Laurenti Magesa [2000: 78-80] fills in some details of this traditional discourse relevant to AIDS: In the African worldview the *aetiology of a disease*, especially one which primarily targets people in the prime of their lives, is essentially linked to breach of taboo and to witchcraft. He mentions the common perception that it is a witch or an evil spirit that causes a specific person or community to succumb to HIV infection and AIDS [Magesa 2000: 79]. This is true even amongst nurses and Catholic priests and

nuns, groups one would expect to be furthest removed from this traditional understanding as result of their training. The fact that the biomedical discourse offers neither a proper explanation, merely vague concepts like statistical chance, nor a cure does not help to make it more credible [Magesa 2000: 81]. Nor is it likely that individuals will feel compelled to change *their* behaviour while convinced that HIV infection is due to curses or similar actions of *someone else* [Magesa 2000: 82].

Paterson comes to a similar conclusion about the competition between the three discourses in the African mind:

It is in the context of these powerful beliefs that people receive the public health message of safe sex and reproductive health, the religious messages about choosing abstinence and monogamy: both of which assume that an individual expects to be able to exercise a degree of control over his or her own life, and is free to make choices about behaviour. And yet in reality this 'modern' understanding may be thinly applied to a system of deeply held assumptions, indelibly imprinted on the consciousness of communities, about the power of spirits, the influence of curses, and the inescapable nature of destiny [Paterson 2000: 28].

Paterson emphasises the assumption about "the *inescapable nature of destiny*" [Paterson 2000: 28] as another important aspect of the traditional discourse. She links this to the 'identity crisis' African people find themselves in as they struggle to live in and between two conflicting worlds, the Western and the traditional, between the Christian faith shaped in Europe and the demands of their traditional religions. She quotes Herman Browne, Liberian theologian and anthropologist and chaplain to the Archbishop of Canterbury, who says that many Africans have a sense of having betrayed the ancestors and traditional gods by embracing the Western way of life. Hence when disasters like poverty and AIDS strike communities, they view this is a sign of communal punishment by the ancestors who, instead of protecting them, have now turned against them [Paterson 2000: 27].

Another important aspect of this discourse is the understanding of *sexuality* and sexual activity, which "in Africa ultimately are geared toward marriage and procreation. Procreation preserves the individual's and clan's life force, and therefore their immortality" [Magesa 2000: 79]. This essentially religious view legitimates sexual relationships only in their formation of kinship, in their bonding of the visible and invisible worlds by the birth of children. All those choosing not to fulfil this obligation commit a serious offence against God and the spirits, which could result in danger not

only to themselves but also to the whole community. This risk often weighs much heavier than the risk of contracting HIV/AIDS through the observance of customs, which tradition demands in order to maintain the balance essential for life, even if the biomedical discourse classifies them as 'unsafe sex' [Magesa 2000: 80].

Paterson [2000: 17], for instance, insists that the A-B-C model – advocating Abstinence until marriage, Be faithful in marriage, and if that is not possible: Condomise – is irrelevant for women in Africa, who cannot abstain as “bearing children is the most important thing they do in life”, who even when they are monogamous often know that their partners are not, yet feel powerless to challenge them, and who are not in a position to convince their male partners to use condoms. Studies into resistance to the use of condoms have shown that the desire to have children is one of its primary reasons [Lindegger 1995: 1].²⁵

Quentin Gausset points out another aspect commonly found in the discourse around HIV/AIDS in Africa, which is focussed on cultural barriers to success in the fight against HIV/AIDS, specifically on the 'exotic' aspects of sexuality. He speaks of a '*double discourse*': in the West sexual practices and other risk behaviours like injecting drugs are not regarded as such barriers which need to be changed, rather as practices that have their place in a cultural context and which need only to be made safer. In Africa however sexual practices and behaviours, the taboos around sex are challenged and changed, in attempts to make them more Western. These practices are decontextualised and separated from the cultural identities that they shape. The understandable reaction in African settings is to blame the Western practices and lifestyle for having brought about the HIV/AIDS dilemma, and to offer as the solution to this a return to traditional values and practices [Gausset 2001: 511-12].

Gausset's criticism of an approach that takes the Western bio-medical discourse as the norm and basis for its attack of behaviours that do not fit it is surely valid. This is again an example of a discourse of control or exclusion. Gausset shows how the approach of making practices safer rather than attacking them can be applied to African traditions like polygamy, scarification, inheritance of widows, dry sex, belief in witchcraft and the reluctance to use condoms. Magesa [2000: 82-83] offers a different option, which he

²⁵ See Section 3.1.3.3, p 53 regarding the use of vaginal microbicides, which seem more acceptable to men, are female controlled and offer protection against HIV without preventing pregnancy.

calls a “contextualised approach”. This entails addressing the risk behaviours in a way that make sense in the traditional discourse. So for instance he suggests linking behaviour that can lead to HIV infection to the African understanding that those who commit suicide are considered witches. This identification may offer a culturally acceptable way of convincing people to change such behaviour. Similarly, if it can be shown that certain sexual customs intended to preserve the life force of the clan actually diminish it by causing death, this can be used in challenging communities to change these.

It is interesting to note that the alternatives Gausset offers to the discourse based on criticism of cultural barriers are as much part of the medical discourse as those he criticises. Yet his warning must be heeded that the fight against AIDS may not become an excuse to fight against traditional practices “which are only indirectly responsible for the transmission of the virus” [Gausset 2001: 517].

Certainly the whole debate around ‘African sexuality’ has contributed to discrimination and stigmatisation and has not at all been helpful in stemming the tide of AIDS. Judith Head [1992: 16] comments on this in her search for an alternative explanation of the high rate of HIV infection in South Africa. She locates the origin of this view in a “colonialist/racist view of the world” which found that “Africans are different from Europeans in a variety of ways, including their sexual behaviour.” Such distinctions between the colonisers and the colonised, reinforced by descriptions of anthropologists focussing on exotic aspects of the behaviour of the ‘natives’, were useful for legitimating their exploitation. In the context of AIDS these views developed into a theory of sexual promiscuity amongst Africans, which is responsible for the speed with which the virus is spreading. Head [1992: 16-17] quotes various studies to support her stance that there is no evidence for a view holding Africans in this country more promiscuous either than other groups here or than people in other countries.²⁶

Another aspect of Gausset’s advice is that prevention strategies ought to focus on what is common across cultures and continents rather than on what is different [Gausset 2001: 517]. Various authors contest this, insisting that prevention must be culturally

²⁶ See also the study by Brokensha and White, another by Van Dyk and the Durex Global Sex Survey, quoted by Saayman [1992: 51], Saayman and Kriel [1992: 28] and Whiteside and Sunter [2000: 59] respectively, all of which come to the same conclusion.

specific in order to be effective. Caprara et al. [1993: 1229] suggest this route: Since there is at this stage no cure for AIDS the only way of fighting it is through effective prevention. In order to be able to design effective prevention strategies, they insist, it is essential to understand the cultural context at micro- and at macro-level; that is at the level of the individual, the local village community as well as at the level of urbanisation and of poverty. The local customs and traditions, the patterns of behaviour and ways of seeking treatment, which make up the socio-cultural context, need to be understood to be able to impact on them.

So these authors stress precisely the opposite of Gausset. In their study of two ethnic groups in the Ivory Coast they found, for instance, a widespread belief that witchcraft and sorcery were involved in the spread of HIV. In order to plan an effective strategy this belief has to be addressed, but the differences between the two groups had to be considered, too, and different strategies towards this end devised for each [Caprara et al. 1993: 1234]. I agree with Caprara et al. that in order to achieve Gausset's aim of making local behaviours safer, these behaviours need to be understood. This does of course not imply that in order to stem the tide of HIV infections one has to attempt to destroy these traditions and beliefs, as Gausset correctly points out.

One aspect of the traditional paradigm that neither Gausset nor Magesa address is the gender imbalance in the patriarchal African societies. And it is this – together with poverty – that creates the greatest barrier to success in the attempts to turn the tide of the HIV/AIDS pandemic on this continent. Janet Bujra offers one example of a discourse of empowerment around the issue of gender inequalities. She investigates the effect of discourses of masculinity and their impact on the effectiveness of AIDS campaigns in Africa, that is, in a context where the transmission of AIDS is mainly heterosexual. Common discourse and practice serve to maintain various masculine identities. It will never be easy to change this masculine discourse as it serves a purpose and is supported by the social power of men in society. Bujra suggests that this will only be achieved by “strategies which offer them something in return” for instance “as custodians of family welfare, as fathers secure in the birth of healthy offspring” [Bujra 2000: 20]. For the design of AIDS interventions the discourse emphasising masculine roles such as ‘fatherhood’ or ‘maturity’ rather than ‘conquering hero’, ‘sugar daddy’ or ‘playboy’ can open up new possibilities [Bujra 2000: 20]. Current campaigns under

slogans like “Real men don’t rape” are attempts at redefining masculinity.

2.5. Concluding comments

In this chapter I have constructed a theoretical framework to demonstrate the importance the HIV/AIDS discourse in churches has for the way they respond to the pandemic. Looking at the way discourse functions in society as explained by Ricoeur and Bové, the connections with power became evident. In the church, which is strongly discourse based, the same connections exist. Susan Sontag’s account of AIDS metaphors and Gill Seidel’s classification of AIDS discourses in Africa demonstrated how these relations act in the HIV/AIDS arena. Some of the problematic areas in this debate were then highlighted through referring to the work of Magesa on the traditional African AIDS discourse and to the debate around ‘African sexuality’.

This prepares the reader to face the reality of AIDS in our context, the needs the pandemic creates and the complex set of factors impacting on its course. For these are the facts to keep in mind when attempting to define criteria for an appropriate response to the HIV/AIDS pandemic. The next chapter does this for the AIDS discourse of churches and following from that for their practical response, where the overriding criterion is that any response has to be appropriate to the challenges of the pandemic, to the local context and also to the mission of the Christian church.

Chapter 3.

Criteria for an appropriate response to the HIV/AIDS pandemic

In the previous chapter we have established the importance of the discourse of churches for their actions generally as well as in the specific case of HIV/AIDS. This chapter will develop criteria as a basis for evaluating the response of churches to the pandemic. In order to arrive at criteria for an appropriate response we have to start by spelling out criteria for an appropriate way of speaking about HIV and AIDS.

In the case of both the discourse and the hands-on response there are three major guidelines for these criteria: First, how Christians speak and act has to be appropriate to the pandemic, to what is known and understood about it not only from a medical, but also from the psychological, sociological and political viewpoint. Second, any response has to be appropriate to its specific context. The HIV/AIDS pandemic in Africa follows a pattern differing from that in the US or in Thailand; there are different cultural and societal factors impacting on the course of the pandemic and its effect on individuals. Third, to develop criteria for the response of churches, these have to consider what the Church is, not only as a member of civil society, but as Church, as the Body of Christ in this world. For this we have to turn to the terms in which churches define themselves.

The challenge is, as so often in our being in this world, to keep these criteria in tension to each other. What is done when losing sight of the first may give some moral satisfaction, but it will be largely irrelevant to the course the pandemic is taking and to the majority of those affected by it. Importing a response from elsewhere without ensuring its compatibility with the realities of Africa similarly has in many cases achieved nothing – at great expense. If churches however lose sight of their self-understanding, functioning like any other cluster of AIDS NGOs they will fail to make their special contribution as Christians; and with them society as a whole may lose something of value.

3.1. Some criteria for an appropriate discourse on HIV/AIDS

3.1.1. Breaking the silence

AIDS surfaced in Los Angeles as ‘gay cancer’ or GRID – Gay Related Immune Deficiency – and immediately had a stigma attached to it: this was the disease of promiscuous homosexuals. This stigma provoked either judgement or silence in wide sections of society. While it has since found a place on the public agendas of many groups and meetings, to a large extent it is still a topic that is not really engaged in normal discourse.

Obviously the reality of the stigma attached to HIV/AIDS and the silence around the pandemic are not separate entities. Because the stigma is so powerful we do not speak about it, and because we do not speak about it, the stigma remains unchallenged and grows more absolute. I want to address both issues in some detail. As shown in the previous chapter, discourse is central to what churches are and how they function. For this reason I will start with the silence.

3.1.1.1. *Understanding the silence*

The Church ‘speaks’ a great deal.²⁷ If a topic is excluded from its discourse, this also makes a statement. Hence the silence about AIDS ‘says’ that it is ‘not okay’ to speak about AIDS; which implies that it is ‘not okay’ if someone has AIDS, which then implies that it is ‘not okay’ to have contact with ‘such people’. This message does get across to church members. While the silence in churches is in a sense merely a mirror of what is happening or not happening in society, it is important to be clear on what this silence might mean.

The discourse of churches is directed outward to society at large; and also inward to its own membership. While the means of discourse and its forms will differ for these two audiences, it is important that what is proclaimed publicly, is also made meaningful for the congregation [Cochrane and West 1993: 34-35]. It seems to me that the discrepancy between these two is one of the problems behind the silence in churches: While the leadership is expressing concern about the status quo and ‘groups of experts’ debate the best way forward, the normal church discourse in worship

²⁷ See Section 2.1, p 12.

services, bible studies and church newsletters does only touch on HIV/AIDS rarely and superficially.²⁸

It is also important to note that due to the silence and lack of knowledge the sense that “AIDS affects other people and is not our problem” is still quite common; and this conviction, on the other hand, serves as excuse to avoid the topic and maintain the silence. Often this perception is quite irrational, as demonstrated in a case where a minister told me that AIDS did not affect people in his congregation; this within a few minutes of him having told me of a member who had died of AIDS.

While Maluleke’s warning about *forcing* taboo topics into the open must be heeded,²⁹ it is equally true that in order to stem the tide of the pandemic, ways of speaking openly and honestly about AIDS have to be found.

As a first step let us try to understand this silence. Mary Crewe [2000: 11] gives some reasons for the silence about AIDS at South African universities, which also apply to our society and churches:

- 1) To speak in a meaningful way about AIDS implies having to speak about sexuality and death, both topics from the realm of “done things” that society is uncomfortable broaching. Nicolson [1995: 7] is more specific, when he says that speaking about AIDS involves speaking about the uncomfortable ethical issues of homosexuality and multiple sexual partners. Speaking about sexuality is taboo. Generally not even married partners do so, except by means of erotic body language and by unspoken and often unconscious assumptions [Bayley 1996: 213]. If even those in long-term sexual relationships have hardly any language to verbalise their sexuality, it implies that in spite of the ‘sexual revolution’ there is a deficiency in our sexual language ability, whether this be between sexual partners, between parents and children or in the public realms of churches or universities. If things go wrong in the domain of sexual behaviour – and the way in which HIV is spreading through contemporary society clearly shows that they are – it is difficult to deal with it, because it is so difficult to speak about it. The only language that seems to be readily available is that of blaming and of judgement.

²⁸ See Section 4.2.1, p 86 for one example of this; and also Section 4.3.2, p 90-91.

²⁹ See Section 2.1, p16 for more details.

- 2) AIDS forces us to look at our own lives, our behaviour, our prejudices, and this too can be uncomfortable.
- 3) The way the AIDS message has been presented in “tedious campaigns that have served to alienate rather than inspire, and the dullness of the message underpinned by a false and naïve morality” [Crewe 2000:11] has resulted in boredom with the issue. Adler’s [2000: 57] term “emotional numbness” may be more appropriate to describe our response to predictions of the massive scale of the pandemic [Nicolson 1995: 7]. In my view the emphasis on statistics, and dark predictions for the future linked to these, appear so overwhelming that they stifle many a potential response as any individual attempt to do something appears petty and hopeless. One is then likely to tackle a more manageable problem, which offers the possibility of achieving some success; or to continue with the programmes and topics which are established and familiar. In addition the ‘statisticisation’ of AIDS makes us lose sight of its human face and the very personal tragedies involved, but also the human stories we might identify with and be compelled to respond to.

There are other reasons for the silence. First, other problems like racism, injustice or violence may seem more urgent [Nicolson 1995: 7]. These are of course not really separate matters, but closely related to AIDS.³⁰

Second, church action ought to be based on theology. But theologians have yet to get to grips with AIDS [Nicolson 1995: 7-8]. This is especially true for the situation in South Africa. What is written overseas deals often with pastoral rather than theological issues, and much of it addresses aspects relating to homosexuality. This may be appropriate elsewhere, but is not a central issue in South Africa. In the six years since Nicolson came to this conclusion unfortunately not much has changed. Hardly any local theological reflections on AIDS have been published since, until the recent flurry of articles in theological journals,³¹ and even amongst these the focus is on practical matters rather than a theology of AIDS.

Other ‘uncomfortable’ topics that have to be addressed when speaking of AIDS,

³⁰ See Section 3.1.3.3, p 51.

³¹ In recent months the *Bulletin for Contextual Theology* (March 2000 – but only published in April 2001), the *Journal of Constructive Theology* (July 2001), *Grace and Truth* (Aug 2001) and *New South African Outlook* (Autumn 2001) have all published special issues with a focus on AIDS. In the years prior to this only the odd publication appeared on his topic [Maluleke 2000: 93-94].

include patriarchy – a topic that is not easy to address in either universities or churches with their strongly patriarchal structures – and poverty or socio-economic injustice.

Another factor not mentioned by Crewe or in other literature is that it takes time, energy and money for new issues to get on to the agenda of organisations. Therefore it requires some committed and patient individuals to take up the issue and force it onto the agendas, already crowded with other seemingly more urgent issues. In churches, as elsewhere, officials who are generally poorly-paid, already overstretched by a wide range of duties and demands and not that adept at delegation have difficulty finding time for yet another issue in which they have to take a leadership role.

Apart from such practical reasons for the silence, it is important to consider it theologically. Gerald West [2000: 72-77] explains the significance of such silence in the context of Walter Brueggemann's proposal of the two major theological trajectories found in the Old Testament. One is the "Mosaic liberation" trajectory, which is taken up throughout the biblical period and beyond by "voices that cry out on behalf of the poor and marginalised" [West 2000: 73]. It is a protest movement and speaks on behalf of the marginalised of their faith in a God who intrudes into history "even against seemingly impenetrable institutions and orderings" [Brueggemann quoted in West 2000: 74]. Jesus stands in this tradition when he "embraces the pain of those excluded and exploited" [West 2000: 74]. The second trajectory is that of "royal consolidation" developed during the monarchy of David and Solomon. Its interest is in consolidation of the established order and control, and its representatives are found "among the established and secure" [West 2000: 73-74]. In the New Testament it is represented by those groups intent on preserving the status quo of the temple-state system; and it remains the dominant trajectory in the period of colonialism and mission.

West says that basically the latter trajectory shapes, even now, our churches and theologies. While this royal trajectory reminds us that there is an order, even in the processes of history, and that God is governing, it does however tend to become supportive of the dominant system. And then the voices of "the pained and the pain-bearers" become silenced, as they in their very presence silently refute the legitimacy of the system [West 2000: 76]. It is in this sense too that we need to understand the

silence of churches about AIDS; and also West's urging of the Church to recover the prophetic liberation trajectory, that takes up the cry of pain on behalf of the pain-bearers; which like Jesus restores the visibility and therefore the legitimacy of the poor, the people bearing the pain of HIV/AIDS in their lives, in their families and communities.

The near-silence about AIDS can also be explained by analogy to the "stages of dying" in the response of patients to the diagnosis of a terminal disease:³² First there is denial, i.e. silence – which is still common in South Africa. This ought to be followed by anger. While enough reasons can be found for indignation, for instance at pastors burying unheard of numbers of young people in their congregations without ever raising the issue of AIDS, supporting the concealment through the attribution of some other cause of death, there is not much evidence of it. Heywood [1998: 86] points to this need for anger: "There is not enough outrage about AIDS in Africa. The first world, African governments and African peoples themselves treat African lives as dispensable."³³ Rage and anger are necessary "stages of dying" before acceptance of the condition and constructive engagement with its implications become possible. For that reason a group of churchwomen helped their community arrive at this phase of anger by organising a march to protest against the silence on AIDS in their community and their congregation.³⁴

3.1.1.2. Why it is necessary to break the silence

Let us look briefly at why it is important to break the silence. The silence is widely recognised as one of the reasons for the rapid spread of the virus, as it makes it possible to maintain the myth that AIDS does not exist, or that it is confined to 'risk groups' and hence does not affect the own community. One important way of making it possible to speak about HIV/AIDS is for more of those who are infected to speak

³² This analogy was raised in an interview with Dr Angelika Krug, paediatrician in the Northern Province. It refers to the five common 'stages of dying' in patients who are diagnosed with a terminal illness. The stages are 1) Denial – "No, not me!"; 2) Rage and anger – "Why me?"; 3) Bargaining – "Yes me, but..."; 4) Depression – "Yes, me". This stage includes mourning for past losses, wrongs committed and things not done. 5) Acceptance [K Kübler-Ross 1969].

³³ Since the events of September 11, comparisons have repeatedly been drawn between the worldwide outrage about (possibly) as many as 6000 people having been killed in those attacks; and the relative silence and lack of any similar emotional response to the death of more than that number of people due to AIDS every single day; and on the impact of the preoccupation with the "War against terrorism" on funding commitments to the fight against AIDS and other diseases [Sawyer 2001].

³⁴ Interview with Dr Angelika Krug.

out; and for those who are dying to acknowledge publicly that even though the direct cause of their death may be some infection, the reason that they are unable to overcome this infection is that they have AIDS. Only then will the reality of the pandemic become apparent.

But in order for this to be possible there are two conditions: it has to be safe for people to 'come out'; and there must be some perceived benefit from this, either for themselves or for others who matter to them. This implies that a number of human rights issues have to be addressed.³⁵ Human rights issues that have entered the AIDS discourse include the right to health care and life prolonging medication for all (even the poor) [Van Niekerk 1993]; the right to privacy (i.e. to not disclose one's HIV status if one so chooses) and its possible conflict with the right of others to be protected against the risk of infection (by knowing the HIV status of a partner or family member) [Anrys 1998]; and various issues threatening gender equity [Tallis 2000].³⁶ In order to achieve greater openness of PWAs they must be secure that they will not face rejection and discrimination [Heywood 1998: 76].

One of the core concerns arising from the silence around AIDS and the stigma accompanying the disease is the inability of affected persons to express their painful feelings and fears. There is an inability to recognise these feelings and concerns [Bayley 1996: 246]. Memories, experiences, pain that is repressed, cannot heal. Individually this gives rise to psychological dysfunction. In a case where thousands are affected, the lack of healing results in "social brokenness" with potentially devastating results. Cochrane and West [1993: 25] make this point with regards to the memories about political and social injustices in the apartheid era of South Africa. The enforced silence about AIDS, the massive damage of tens of thousands of PWAs unable to speak out about their infection, their fears, the countless family members unable to speak about the cause of death of a loved one and its implications for themselves is surely analogous. It is crucial to find ways of voicing these realities and experiences to avoid another case of "dangerous memories" [Cochrane and West 1993: 27], dangerous, in this case, because they are false, because a truth that may not be spoken, cannot be remembered.

³⁵ See Section 2.3.4, p 24-25 and 3.1.2.3, p 43.

³⁶ See Section 3.1.3.3, p 50-54 for gender issues impacting on the HIV/AIDS pandemic.

Churches have a responsibility to offer safe spaces where these fears and memories can be expressed, where facilitators can help to uncover what has been repressed.³⁷ It is my conviction that in the church setting the liturgy can act as such a facilitator. It is a powerful resource to overcome the silence, to express the experiences and the pain, the fear and hope around AIDS in a language appropriate to the reality. It may also help people find a language to speak about this through participation in the liturgy.³⁸

3.1.2. AIDS discourse that counters stigmatisation:

A man with AIDS wrote: Whenever I am asked ... by curious healthy people what we talk about in our group I am struck by the intractable gulf that exists between the sick and the well: what we talk about is survival. Mostly we talk about what it feels like to be treated like lepers who are treated as if they are morally, if not literally, contagious [Jantzen 1994: 305].

Apart from it being important *that* we speak about HIV and AIDS, it is also important *how* we speak about it. As much as the stigma of living with HIV remains unchallenged by the silence around AIDS, it may be deepened and reinforced by what is said about AIDS and how it is said,³⁹ in churches as much as in other sectors of society.

3.1.2.1. *The stigma around HIV/AIDS*

Stigma is largely a result of the initial discourse around AIDS, which fitted mostly into the medical and the medico-moral categories. This discourse linked AIDS to promiscuous homosexuals, creating the impression that promiscuity and 'aberrant' sexualities as such were the cause of AIDS, rather than a virus. Not surprisingly this led to the conclusion that whoever had AIDS was promiscuous [Altman 1986: 34]. All the evidence presented since to prove that this perception is inaccurate, has not had a significant impact on either the normal AIDS discourse or on the stigma attached to AIDS.

By stigmatising others, society puts them at a distance, thereby seemingly protecting itself from the risk they pose [Mondragon et al. 1991: 1137]. Misconceptions about the means of transmission of HIV and prejudice about the lifestyles of those infected

³⁷ See Section 3.2.3.5, p 78-79.

³⁸ For a discussion of how the liturgy could be used in this way see Section 5.3.3, p 117-19.

³⁹ This refers to the perlocutionary and illocutionary aspects of discourse – see Section 2.1, p 11-12.

are factors in stigmatisation of PWAs. Mondragon et al. [1991: 1140] report a direct correlation between the level of understanding of the risk to self and the level of hostility and stigmatisation, i.e. those with a correct understanding of which activities pose a high risk tended to be less hostile. What is not clear is which way round the causality functions. Their research indicates that certain pre-existing attitudes in groups limit/filter the amount and type of information which is absorbed. Both fundamentalist religious and conservative political orientation may function as such limiting factors [Mondragon et al. 1991: 1137, 1140]. Other researchers confirm the link between stigmatising attitudes and religion, linking them to certain religious minorities, whose views range “from the moralistic to the retributionist” [Nisbet and McQueen 1993: 900].

Stigma involves both physical revulsion and moral disapproval, regarding HIV infection as punishment for sin, or at least as something people have brought upon themselves. Revulsion and shame are natural as initial response when confronted with people affected by AIDS [Jantzen 1994: 305-07].

Nisbet and McQueen conducted a study of attitudes towards PWAs in the UK and found a definite anti-permissive trend: The view that AIDS was self-inflicted, and that those who had thus “knowingly and almost suicidally” infected themselves with HIV [Nisbet and McQueen 1993: 898] were blameworthy and deserved judgement, was commonly held. This attitude made unsympathetic treatment of PWAs likely, as it was coupled for instance with a sense that it was fair to dismiss employees on the grounds that they were HIV positive or even on the grounds of membership of a risk group, whether they tested positive or not [Nisbet and McQueen 1993: 894, 897]; with use of derogatory names for these groups or their members [Nisbet and McQueen 1993: 896]; and with the conviction that members of such groups were less likely to change risky behaviours than other people [Nisbet and McQueen 1993: 897]. Once victim-blaming of PWAs is accepted, the need to protect their rights is secondary to the protection of society from them and their infection [Nisbet and McQueen 1993: 899], and the argument is raised that public money should be spent on ‘deserving’ patients and illnesses rather than on AIDS [Nisbet and McQueen 1993: 900].

Stigmatisation can become internalised – those affected by it come to identify

themselves with the negative labels society imposes on them [Mann and Tarantola 1996: 401]. Activists working with PWAs report amongst them, for instance, a strong sense of guilt and shame, of being unclean,⁴⁰ a case even of an HIV positive man insisting that he was ‘the devil’.⁴¹

3.1.2.2. *How current AIDS discourses contribute to stigma*

The way we speak about AIDS may contribute to deepening the stigma of those affected by HIV and AIDS. I want to highlight some common instances of this:

The problems resulting from the identification and definition of *risk groups* have been pointed out elsewhere.⁴² This has led to the use of the term *high-risk behaviour* rather than risk group, which indicates that the risk is not confined to a specific group, but is universal. While the ethical reasons for this have to be acknowledged, this term too is problematic, considering that prevention strategies are developed on the basis of it: on the one hand the problem lies in its universality; as prevention strategies have to be specific in order to be effective; on the other the term is exclusively focussed on behaviour and does not give recognition to the fact that social factors influence behaviour [Delor and Hubert 2000: 1568]. Recently the terms *vulnerability* has become more common – both in social science research into AIDS as well as in the development of prevention strategies [Delor and Hubert 2000: 1557]. These terms keep the focus on the individual, hence accommodating differences within groups; they lead to awareness of the “unequal distribution of risk linked to vulnerability; and they address behaviour as well as social relations” [Delor and Hubert 2000: 1568].

Another sensitive matter is the terminology used for those affected by AIDS. The term *AIDS victim* is still used quite commonly in church settings, while these ‘victims’ insist that they are not victims, nor are they dying of AIDS. They regard themselves rather as people *living* with a virus and hence prefer terms like *People living with AIDS* (PWA or PLWA) or more accurately ‘People living with HIV’ (PLWH).⁴³

Saayman [1999: 218] suggest that we reconsider use of the term ‘infection’ as it

⁴⁰ From interviews with Linda Idas, Frances Herbert and Sophia Louw.

⁴¹ Reported by Desire Volkwijn in an interview.

⁴² See Section 2.3.1, p 21-22 and 3.1.1.2, p 37.

carries the meaning of “something dirty, contagious, degrading”, something with which to avoid contact. Unfortunately he does not suggest alternatives that avoid this. He also proposes that the technical terms *open* and *closed sexual relations* be used in this context rather than value laden, “ethically normative” terms like promiscuity. Closed sexual relations are those where, irrespective of the number of partners involved, “partners remain absolutely faithful to one another” and are hence at no risk of HIV infection. Open sexual relations are all relations involving changing partners [Saayman and Kriel 1992: 21].

Lastly, it is important that discourse and actions correspond. Speaking their concern for all affected by HIV/AIDS, but reaching out with caring programmes mainly to the ‘innocent victims’ is not credible.⁴⁴ It perpetuates the stigmatisation, the classification into innocent and guilty.

In order to start undermining the stigma attached to HIV/AIDS churches have to start speaking about the issue, to do so regularly and in an appropriate manner. They have to address sexuality openly, without judgement or prejudice. But even where this is done, the stigma persists if the discourse deals exclusively with individual behaviour. The tenor of presentations is, “If you make the correct choices, you will not be infected.” In this, too, there is inherent judgement involved, because this still suggests that if you are infected *you* are at fault because *you* have made bad choices. In such discourse there is no acknowledgement that AIDS is not merely an infection that individuals bring upon themselves, that social factors beyond the control and choice of individuals play a crucial role in this pandemic.⁴⁵ These factors are discussed below.⁴⁶

3.1.2.3. *Why it is necessary to overcome stigma*

Stigma is a denial that we are created in the image of God. It destroys self-esteem, decimates families, disrupts communities and annihilates hope for future generations. We commit in all our efforts – personal and corporate, programmatic

⁴³ I will be using PWA, most established of these terms, throughout.

⁴⁴ See Sections 4.3.3 (5), p 94; 5.2.1, p 105 and 5.2.2.12, p 114-15 for more details on this bias in programmes offered by churches. Programmes for HIV positive babies and AIDS orphans gain significantly more support than those for adult or gay PWAs. Similarly MTCTP receives more support than prevention of sexual transmission of HIV.

⁴⁵ I do not take issue with the fact that interventions target individual behaviour change [See Footnote 51, p 50.], but with the way this is often done and the discourse that frames such interventions.

⁴⁶ See Section 3.1.3, p 44-55.

and liturgical – to confront it as sin and work for its end [Our Vision, Our Hope 2001: point 4].

Stigmatisation, as well as the resulting discrimination and violence around HIV status, discourages PWAs to disclose their status. It may also prevent them from seeking support [Mann and Tarantola 1996: 401]. *All* efforts directed at reducing the HIV infection rate and caring for those who have become infected can become tools of prevention by raising awareness of AIDS, encouraging empathy with PWAs and fighting the stigma by “driving AIDS out from under the carpet of shame and secrecy that allows it to breed” [Cahill 2000: 293]. Once this is achieved, it will enable PWAs to disclose their status without risk of rejection, exclusion or mob-execution.

In South Africa stigmatisation may have serious consequences for PWAs. It can even lead to death as in the case of Gugu Dlamini: she disclosed her sero positive status in the context of a World AIDS Day meeting and was killed by a mob a few days later for ‘bringing disgrace to the community’ [Associated Press 1998]. For those affected or infected by HIV, stigma has been identified as one of the factors that make it more difficult to cope with the disease and with death:

- It makes people more vulnerable, more likely to engage in risky behaviour, and less likely to seek help or to co-operate with programmes [WCC 1997: 13].
- Negative or at least ambivalent attitudes of family members, society and health professionals impact on those affected.
- Stigmatised workers may lose their jobs.
- For those who stay behind after a loved one has died of AIDS, it complicates the process of grieving [Lindegger 1995: 6-7].
- Women who reveal their HIV status are often abandoned by their partners and have to fend for themselves and their children [Johnson and Dorrington 2001: 15].
- In Africa widows are touched by the stigma of having lost a husband to AIDS and, at a time when they have become sole breadwinners, they often find it difficult to hold on to their means of earning an income. In many instances sex work is the only option left to them [Lindegger 1995: 7]. Apart from the detrimental effect this has on the lives of those making these choices, it is a clear example of the way in which stigma drives the pandemic forward, forcing HIV positive persons into situations where they pass the virus on to others.

Ahmed [n.d.: 21-22, 25-26] reports that the immediate response to enquiries to various Muslim religious organisations to determine their attitudes towards AIDS and to find out what support they could offer an HIV positive member of the community was to ask her 'How did you get infected?'. She turned for support to non-religious AIDS agencies and found it there. Others in a similar position denounced their faith as a result of the prejudices against them from within their own faith communities. The same judgemental attitude prevails in other religious communities, including Christian congregations [Shelp and Sunderland 1992: 43]. Sophia Louw of the Noordelike Stadsgebiede VIGS-Aksiegroep mentioned that 70% of their HIV positive Christian clients were not willing to speak to their pastors about their HIV status as they expected exactly this response of hostility, indifference or condemnation. For support they preferred to go to secular AIDS support organisations. This is of course an indication of perceptions about prejudice and stigma, rather than an indication of the level of actual victimisation, but if Christians in need do not turn to their fellow Christians for support they will usually have good reasons for this.

This brings us to the next criterion.

3.1.3. AIDS discourse stressing not only personal, but also societal aspects

Curbing the spread of AIDS can only be achieved by recognising the role of social factors in the pandemic, not by an exclusive focus on individual behaviours. Before entering into a discussion of such factors impacting on the spread of AIDS, I want to support the basic statement by offering a number of quotations:

Becoming infected with HIV/AIDS is not a random medical event. More perhaps than any other major health threat, it demonstrates the extent to which disease is in fact embedded in the social, political, economic, cultural, behavioural and medical experience of individuals [Van der Vliet 1996: 118].

AIDS is a justice issue, not primarily a sex issue. AIDS as a justice issue concerns the social relationships that help spread HIV and fail to alleviate AIDS, relationships of power and vulnerability that are in violation of Catholic norms of justice and the common good. [A]n exclusive focus on sexual promiscuity obscures the fact that the behaviours that transmit HIV are strongly influenced by social conditions [Cahill 2000: 282].

[P]olitical and ecclesial controversies over AIDS sidetrack identification of the *unjust ultimate social causes* of the spread of HIV by focussing myopically on more volatile proximate causes and deterrents – sex outside marriage and

condoms [Cahill 2000: 283].

Epidemics are never merely biological. Even as HIV changes African society, it spreads by exploiting current cultural and economic conditions. ... Why is AIDS worse in sub-Saharan Africa than anywhere else in the world? Partly because of denial; partly because the virus almost certainly originated here, giving it more time to spread; but largely because Africa was weakened by 500 years of slavery and colonialism. ... Africa, conquered and denigrated, was never allowed to incorporate international innovations on its own terms, as, for example, Japan did [Schoofs 1999: Part 1].

[A]s Christians, are we really content to see 30 million people in the developing world dying from a fatal disease for which treatment is available? This is a moral issue, which calls for moral leadership. But this complicated debate is not just about HIV/AIDS. It is about the whole issue of how the world's resources are divided, and the way we have managed to convince ourselves that there is no alternative [Paterson 2000: 23].

Campbell and Williams analysed the response of the mining industry in Southern Africa to HIV/AIDS in terms of Seidel's typology of discourses. Many of their conclusions are worth heeding by other players in the HIV/AIDS field, including churches. They found that the response was largely limited to the bio-medical/behavioural level or focussed on individualised human rights, and that this was why it had largely failed, as it did not take account of HIV/AIDS as "a broad *social and developmental issue*" [Campbell and Williams 1999: 1631]. According to them the unions try to bring this dimension into the response towards the pandemic, drawing attention to migrancy and poor housing as contributing factors, but management maintains its exclusive focus on HIV as a problem of individuals to be dealt with on the bio-medical and behavioural level. This results in growing despondency amongst those working in HIV prevention as none of the programmes implemented thus far had a detectable impact on the epidemic amongst mineworkers [Campbell and Williams 1999: 1631].

Some prevention programmes offered by Christian groups maintain the same exclusive focus,⁴⁷ and the same critique has to be offered: An AIDS discourse confined to the medical paradigm, and looking for cures in medicine and prevention through change in individual behaviour is too limited. To be effective in HIV prevention, churches like other agencies have to broaden their scope and consider social factors.

⁴⁷See Section 4.3.3 (2), p 92.

Nicolson [1995: 38] takes up this call, insisting that socio-political engagement has to become an essential element in the response of churches to HIV/AIDS. He calls on the legacy of Liberation Theology, which opened the eyes of Christians to the need of addressing structural sin. He insists that churches should be involved in social reconstruction in order to rid society of such sinful structures, which are conducive to the spread of HIV and other ills [Nicolson 1995: 18].⁴⁸

3.1.3.1. *The ecology of AIDS*

Sontag insists that AIDS is merely a disease, a medical condition like many others;⁴⁹ Van der Vliet [1996: 2-3], however, speaks of the *ecology* in which epidemics such as HIV/AIDS develop and shows how our context provides this ecology.

Laurie Garrett has produced a large volume detailing how the ecology of disease has in recent decades given rise to a number of new microbial diseases or has caused known diseases to occur in completely new settings where people have no immunity against them. The crucial ingredients of this ecology are urbanisation and globalisation. Urbanisation forces together huge populations of the poor, vulnerable to microbes due to their crowded and unhygienic living conditions. Globalisation facilitates rapid transmission of viruses and bacteria into all parts of the 'global village'. AIDS is one of these new diseases, but there are others like the various haemorrhagic fevers, the ebola virus and toxic shock syndrome. Garrett states that while humankind may have conquered much of the macro world, the realm of the microbes has not been defeated. AIDS is but one of its ways of taking advantage of this new ecology.

The discovery of HIV/AIDS occurred in a time characterised by the proclamation of sexual freedom. It was the period following the 1970s and 80s when an 'epidemic' of genital herpes, dubbed the 'new sexual leprosy', had become a metaphor for the sickness of society, a sickness preceded in the 60s and 70s by huge insecurity and a sense of loss of control in a time of rapid change.

⁴⁸ I did attempt to find out if there were examples of this Liberation Theology approach to AIDS related issues. I directed my inquiry to Tinyiko Maluleke, Professor of African Theologies at UNISA, who is interested in AIDS-related theological developments. His reply was that unfortunately "the approach of the majority of Christian interventions has been overwhelmingly evangelical with very little space for

Altman draws attention to the political dimension of the ecology of AIDS: while disease is normally viewed as something individual with mainly biological determinants, hitting persons at random, he describes AIDS as a very political disease, due to reasons related to its discovery: It started at a time when modern medicine was believed to have come close to overcoming epidemic diseases “at least in the Western world” [Altman 1986: 11]. It was first seen to affect members of specific groups in society: in the USA that was mainly the group of male homosexuals. This group had become politically organised not long before the onset of AIDS and this enabled them to make an organised response [Altman 1986: 12-13]. With its sexual link, AIDS became viewed as “revenge against the sexual revolution and the modern medical technology that helped to make it possible” [Altman 1986: 14].

The historical setting for the start of the AIDS epidemic in the USA, which deeply affected the way it was dealt with, was provided by the policies of Reaganism, “an ideological syndrome which he epitomised, based on the strengthening of the military while weakening the role of the state in protecting social welfare and civil rights” [Altman 1986: 26]. The emphasis was on individualism, on a return to traditional values. Groups like Moral Majority gained influence in this period of “politicization of religious fundamentalism”, and the age-old explanation of plagues as signs of the wrath of God was pronounced – and believed – once more [Altman 1986: 66].

As is common in epidemics the infected were groups already stigmatised and marginalised – in the US the gay community and the intravenous drug users, in Africa women in general, especially sex workers [Van der Vliet 1996: 3].⁵⁰

In Africa the arrival of HIV/AIDS occurred during a time of massive political upheavals after the end of the period of colonisation. It was a time of rapid urbanisation and modernisation. Urbanisation was mostly not total, as links to rural families were maintained with regular movement between the two worlds. Where men were not allowed to bring their wives to the cities this implied usually the movement between two families and two sets of sexual partners. Modernisation had an impact

liberation issues of gender, class and race”. He does mention that some initiatives have potential of developing in this direction.

⁴⁹ See Section 2.2, p 19-20.

not only on technology, but also on values and norms. In many parts of the continent this was a period of intense instability with wars and huge movements of people – soldiers without their families, refugees without the security and the constraints of their clan. And as always in the wake of war, there was rape and fatalism. These factors resulted, as they do in any place and any time, in distancing great numbers of people from those structures of their society, which exercised a conservative influence on their lives. Persons aged between 15 and 35 were most affected by these movements. As this is the age group that is sexually most active, a significant impact on sexual relationships and behaviour was to be expected [Van der Vliet 1996: 78-83]. Hence the concurrence of a number of events and trends resulted in AIDS becoming the ultimate ‘African disaster’. Whiteside and Sunter [2000: 61-66] list some of the factors particular to a South African ecology that favoured the spread of HIV. Here factors shared with other Africa countries were compounded by the social engineering of the apartheid regime, and the high levels of conflict during the struggle to dismantle it. Both of these factors had a detrimental impact on the social cohesion of society, regarded by the authors as one key variable to determine the rate at which the epidemic spreads; the second variable being poverty [Whiteside and Sunter 2000: 61].

Campbell and Williams [1999:1634] provide a list of social factors impacting on the pandemic: economic factors, working conditions and gender dynamics. These are then mediated by psycho-social factors like low self-efficacy, knowledge and beliefs conflicting with the safe sex messages presented to them (and not addressed by these messages) and masculine identities. Working conditions in mines expose workers to dangerous situations and high risk of contracting diseases; they have little control over their lives and little power to address injustices. This combination of factors decreases the chance that they will change their behaviour in ways that would protect their health. [Campbell and Williams 1999: 1635].

AIDS discourse has to take cognisance of all these factors rather than being limited by narrow paradigms, in order to be able to come to an understanding of the disease. Based on such discourse it is possible to develop successful interventions for the

⁵⁰ Prostitution has complex roots and implications as shown by Brock and Thistlethwaite [1996] in their study, which I cannot dwell on here. Some elements complicating prostitution in Africa are mentioned in Section 3.1.3.3, p 50-51.

prevention of HIV infection, which are not focussed on persuading individuals to change their behaviour, but on “creating circumstances that *enable* behaviour change to occur” [Campbell and Williams 1999: 1636].

3.1.3.2. *Poverty*

“The worst legacy of whites in Africa is poverty,” says Mark Schoofs [1999: Part 1] and this poverty contributes to the spread of HIV in many ways. The debate initiated by President Mbeki about a causal link between AIDS and poverty has confused the issue, turning it into an either/or argument: AIDS is caused either by HIV or by poverty. Virginia van der Vliet [1996: 86] clarifies the situation, saying that AIDS is sexually, not environmentally transmitted; but for those who are poor and forced to live in squalid conditions, the environment contributes to their vulnerability to HIV.

- According to the WHO, 90% of those infected by HIV live in areas where there is poverty, discrimination, and women have subordinate status [WCC 1997: 13].
- Sexually transmitted diseases (STDs) are common but rarely treated, as clinics are expensive or too far away [Schoofs 1999: Part 1].
- People who live in poverty are forced into choosing ‘survival strategies’ that put them at risk of HIV infection such as prostitution [Cahill 2000: 283].
- In conditions where survival for another day is all one can hope for, the threat of a virus that may kill one in a few years time is not perceived to be a real threat [Gupta et al, 1996: 217; Lindegger 1995: 3]. Nicolson [1995: 37-38] highlights the need to understand the meaning of living at risk in the face of so many threats which are much more immediate for many in Africa than the possibility of infection by a virus that will remain hidden for years and only cause death much later on.
- Poor nutrition causes a depleted immune system, and squalid living conditions result in exposure to many potential opportunistic infections. This makes the poor more susceptible to HIV infection and speeds its development into full-blown AIDS [Van der Vliet 1996: 86].
- In addition, for those who are poor, sex is one of the few pleasures available to them [Nicolson 1995: 38; Ruden 2000: 5].
- In South Africa illiteracy, one of the legacies of apartheid and not unrelated to poverty, makes it difficult to spread the prevention message [Schoofs 1999: Part

1].

Conversely, HIV/AIDS also increases the poverty of those individuals and communities it affects, by impairing the ability to earn an income and by necessitating the allocation of funds to the care of the sick [Tallis 2000: 60; Whiteside and Sunter 2000: 91-92].

Tony Klouda supports the view that in order to slow down the spread of HIV addressing conditions of poverty is a more promising than targeting individual behaviour.⁵¹ Better general health will develop out of this strategy – without the need for specific AIDS programmes – and the HIV infection rate will decrease. Thus he suggests that those to be targeted for behaviour change should be “the people responsible for general social and economic development” [Klouda 1994: 9].

Women everywhere are more severely affected by poverty than men are [Cahill 2000: 285; Tallis 2000: 60]. Of the world’s 1.3 billion poorest people, 70 percent are women and a study conducted in 19 countries by the International Center for Research on Women found that the lower the status of women in a society, the higher the HIV infection rate [Schoofs 1999: Part 5]. This link between poverty and gender is another social factor determining the HIV/AIDS pandemic and will be discussed next.

But before that, one final comment on poverty, a reminder of the stand I took in the beginning. Undeniably poverty is the major factor making it possible for the HIV/AIDS pandemic to spread at such speed through some communities. Poverty undoubtedly increases vulnerability to HIV and has to be addressed. This does however not imply that poverty causes AIDS. AIDS, like many other diseases, targets marginalised communities. Poverty is a key determinant of marginalisation, but not the only one.⁵²

3.1.3.3. Gender and patriarchy

Where poverty and unemployment are rife, women are poorer and less likely to find

⁵¹ Van der Vliet on the other hand stresses the need of addressing individual behaviour in the short term because addressing social issues can only work in the long term [Van der Vliet 1996: 118-123]. See Section 3.1.3.5, p 55.

⁵² The previous section uses the concept of ecology of disease to describe the interrelatedness of numerous factors. Some specific factors increasing vulnerability to HIV are discussed in the following sections. Section 3.2.1.1, p 61 lists specific vulnerable groups.

employment than men. This places them in a position where the one way to ensure food and a place to stay for them and their children is to find a man who will support them. Women who have lost their partners, often to AIDS, have mostly only two options to ensure survival: to find another permanent partner quickly, or to turn to selling sex to a series of partners. As many of them will have been infected by their former partners this is one more path by which the virus continues spreading [Bayley 1996: 11]. This dependence of poor women in many parts of the world on men for their immediate survival makes it difficult for them to suggest safer sex methods for fear of being abused or abandoned [Gupta et al. 1996: 217-18].

Young women are drawn into 'sugar daddy' arrangements with older, relatively well off men [Gupta et al. 1996: 217]. Ironically as awareness of AIDS grows amongst men, they turn to ever-younger girls in their search for 'safe' partners [Bayley 1996: 11]. The myth that sex with a virgin will 'cure' HIV infection has caused a further increase in already horrific rape statistics [Govender 1999]. Reports indicate that rape of older women has also increased, as they are considered too old to be infected with HIV and hence 'safe'.

In many parts of Africa a high rate of forced first sexual encounter is reported. Jewkes et al. [2001: 740] did a study among pregnant teenagers in the townships around Cape Town and found that less than one third of their subjects had been willing to have sex the first time. Some were 'persuaded' to change their minds, a substantial number were forced or raped. They found that with a more pronounced difference in age between the partners, the already unequal power relations became even more skewed, as evident in the difficulty in confronting boyfriends about other sexual relationships and negotiating for contraception [Jewkes et al. 2001: 741]. The same would be true for negotiating safer sex. Other studies confirm the finding: in Uganda 49% of sexually active schoolgirls were forced into a first sexual encounter [Foreman 1999: 28]. For many women abuse remains part of their sexual relationships: in South Africa 40-60% of women suffer regular physical abuse [Foreman 1999: 31], as do many women in other parts of the world [Gupta et al. 1996: 216].⁵³

⁵³ Abuse of female sexual partners is by no means confined to poor or less-developed communities. But – as has been shown – in such communities it is so much more difficult for women to challenge this abuse or to leave the relationships.

It is widely accepted that the AIDS pandemic worldwide is driven by men, through their sexual and drug-taking behaviour and the choices they make around this. In epidemiological discourse three groups are distinguished in terms of varying risk of HIV infection: The first group consists of those who live in abstinence or within faithful stable relationships and are at no or slight risk of infection. In the second group we find persons at risk of becoming infected but unlikely to pass the virus on, as they are faithful to partners previously infected or having multiple partners. In this group women outnumber men. Lastly there are those both likely to become infected and to infect others. This is the 'core group' that drives the epidemic, and the size of this group will determine the extent of the epidemic. According to World Health Organisation (WHO) statistics men outnumber women in this third group in all societies as men everywhere are more likely than women to have multiple sexual partners – either consecutively or at the same time [Foreman 1999: ix, 4-5].

While it is the behaviour of (some) men that drives the pandemic, in Africa it is women who bear its main impact. Here there are 12 to 13 infected women for every 10 men [Paterson 2000: 24]. In some age groups the discrepancy is much greater: a study amongst youth in Carletonville found infection rates of 14 to 16 year old girls six times as high as those of boys of the same age. In the 17 to 18 age group the ratio was 8:1.⁵⁴ Other studies mention a general trend: in the 15 to 30 age groups women have higher infection rates while in the age groups above 30 men have higher rates. This “may be linked to the strong patriarchal character of traditional African society in which young unmarried women have little defence against sexual advances from older, more powerful men” [Saayman 1992: 51]. In addition women are biologically more vulnerable to infection, the more so the younger they are, and hence statistically twice as likely to become infected with similar exposure to HIV [Foreman 1999: ix, 6-9]. There are some areas in Africa where, due to the greater AIDS-vulnerability of women, the ratio of males to females in the population is approaching a ratio of 3:2 [Bayley 1996: 99].

Some attempts to reduce HIV infections place restrictions on women in the name of strengthening African tradition [Schoofs 1999: Part 5]. A recent example is the 5-year ban on sexual relations imposed on Swaziland's teenage girls, in an attempt to curb

⁵⁴ Methods like abortion, infanticide, and means of contraception like the Pill, injection, or intra-uterine devices.

however, how much impact these methods, once developed, may have in Africa where even condoms provided free of charge are out of reach of so many. In some cases women resort to washing and re-using condoms because they are so difficult to obtain [Star Tribune 2001]. This is especially true in rural areas where even in cases where it is possible – and allowed by those in authority – to distribute condoms at all, it is difficult to collect them anonymously, as communities are so closely-knit. But in all poor communities, whether rural or urban, the additional trip to the clinic to collect condoms, the difficulty of negotiating safer sex with a partner, the crowded living conditions in which sexual relationships are lived out, are all factors inhibiting the use of condoms.

3.1.3.4. Migrant labour

Often economic deprivation is the reason for migration, resulting in uprooted people subject to poverty, malnourishment, discrimination, sexual harassment, fragmentation of families and communities, trade in drugs and illicit sex, child prostitution. All these increase vulnerability to AIDS [WCC 1997: 14-15]. Migrant labourers leave their wives and families for months in order to find work in the cities. Many of them satisfy their sexual urges with women who have no option other than selling their bodies in order to be able to provide for their children, either in shifting liaisons with sex workers or in semi-permanent relations within a 'second family' [Schoofs 1999: Part 1; Saayman and Kriel 1992: 24].

Saayman [1992: 53-54] urges churches to take up anew any means of addressing this structural issue, which contributes not only to HIV infection, but also to countless other social problems by destroying the family. Simply calling for faithfulness within marriage and doing nothing about this cause for unfaithfulness is hypocrisy [Saayman 1992: 54].

Polygamy (like other African traditions) is often blamed for the spread of AIDS in Africa.⁵⁷ Before coming to such a conclusion it has to be considered that modern conditions, primarily job migration and urbanisation, and the social dislocation that accompanies these have distorted the tradition of polygamy and the social constraints

⁵⁶ See Section 2.4, p 28 for problems around the A-B-C prevention formula for women in Africa.

⁵⁷ See Gausset's comments in Section 2.4, p 28-29.

it placed on men, as well as the social guarantees it offered women.⁵⁸ Men no longer have multiple wives for life, but varying successive partners through prostitution or 'sugar daddy' arrangements [Schoofs 1999: Part 1] and very often in the context of migrant labour a 'second family'.

3.1.3.5. Why this is important

Two reasons stand out for insisting that AIDS discourse has to take note of the social causes for the spread of HIV in our region: First, realising that the root cause for AIDS does not lie with individuals who are uninformed, irresponsible or simply bad, but in the social conditions beyond the control of marginalised individuals, emphasises the need to address such conditions. If they are not changed all emphasis on personal behaviour change will not go far. And even where individual behaviour is addressed – as it has to be – it has to be done in a way, which is consistent with this insight.

Second, discourse which keeps in mind that disease is linked to a complex 'ecology' of behavioural, social and bio-medical causes avoids the trap of looking for mono-causal explanations, and employing simplistic 'solutions' based on these. It helps avoid promotion of unrealistic solutions, such as the elimination of poverty or the exploitation of women, and allows the focus to shift to achievable short-term strategies, which can make a difference. And these will invariably be targeting the individual, aiming for behaviour change, because social solutions, essential as they may be in the long run, only work in the long run [Van der Vliet 1996: 118-123]. Hopefully this will be done without completely losing sight of the need for simultaneously working toward real, long-term solutions.

3.1.4. Finding a common Christian discourse

There is a need for churches to come together for joint action to stop the spread of HIV. Since AIDS is a global threat, it can only be effectively confronted by a global response, say Shelp and Sunderland [1992: 188]. Aiming for a truly global response is unrealistic, but certainly the need for joint action, for overcoming differences rather

⁵⁸ In addition, note that a polygamous marriage in which none of the parties has an outside sexual partner constitutes 'safe behaviour' as far as HIV is concerned [Saayman and Kriel 1992: 21-22]. See Section 3.1.2.2, p 41.

than dwelling on them, and for not further confusing the issues by contradictory statements and approaches cannot be stressed enough.

The reality, however, is that responding to AIDS requires difficult choices about complex issues. While religious communities are potentially in an ideal position to give guidance on these matters, this is curtailed because they are unable to agree on the advice to give; and because their lack of “wholehearted commitment to human sexuality education” starting from a young age onwards is limiting the impact they might have on sexual behaviour and hence on the pandemic [Shelp and Sunderland 1992: 185].

As a ‘case study’ let us consider one of the main areas of controversy: condoms as a means of HIV prevention. Some Christian groups are vigorously opposed to the use of condoms in almost all circumstances; others promote them either as a means for those unable to follow the ‘genuinely Christian’ calling of abstinence and faithfulness or as main prevention mechanism. The debate for and against takes up much energy and many words. In Keenan’s recent collection *Catholic ethicists on HIV/AIDS prevention* this appears as the major issue in the case studies and ethical arguments.⁵⁹ Gaining more clarity on the matter of condoms – and hence on one aspect of the ethical basis for Christian work against AIDS – is essential. But an exclusive focus on this matter once more reduces the discourse to the medico-moral realm, disregarding the other central ethical and practical concerns, which need to be included in the discourse.⁶⁰

One of these issues is faithfulness, which is promoted by numerous Christian groups as alternative to condoms, but needs to be problematised. Actually, “being in a close relationship, characterized by commitment” is considered by some as high-risk sexual behaviour. Studies amongst women from the strongly patriarchal Mexican society have shown that these women, even though they had knowledge about HIV transmission, did not consider themselves at risk. The reason for this was that they were faithful to their spouses and assumed the same to be true for them [De Snyder et al. 2000: 107]. Similar findings are reported from African communities.

⁵⁹ Some other issues do feature in the book, e.g. Roger Burggraeve’s discussion of meaningful sexuality and Lisa Sowle Cahill’s focus on AIDS as an issue of social justice.

⁶⁰ See Section 2.3, especially 2.3.3, p 23-24 for the limitations of such discourse; and Section 3.1.3, p 44-55 for other concerns.

what is "this"

Opposition to promoting the use of condoms, and at times to any education on sexuality, is often based on the argument that speaking about this will “promote precisely the sort of promiscuity and irresponsibility in human relationships which has led us to where we are now” [Bate 2000: 220]. The validity of this assumption has to be challenged: at worst it can be said that there is no conclusive research yet about the impact on sexual restraint [WCC 1997: 61], while others claim that it has been shown to be untrue by research [Fuller and Keenan 2000: 34-35]. Another objection to condoms is that they are not really efficient as a means of prevention as they have a high failure rate, another assumption, which according to Fuller and Keenan [2000: 34] is not tenable. There seems to be growing agreement, however, that ‘throwing condoms at AIDS will not make it go away’ and that promotion of condoms needs to be linked to other programmes, promoting change in behaviour and change in social conditions that increase vulnerability [Fuller and Keenan 2000: 35; Saayman and Kriel 1992: 29; WCC 1997: 62].

Amongst faith-based agencies with a value-based approach (as compared to one based on rights) the outright rejection of condoms is loosing ground. More groups are accepting the A-B-C model as an option. That it is not always a heartfelt acceptance is clear from the discourse. I am again quoting Bate [2000: 220] who regards this model as “more acceptable ... for those who choose to be promiscuous: a decision, which some people in our society do make but which can never be a Christian one.” The use of such judgemental language alienates many of those who need to be reached and cannot be helpful to the cause of slowing down HIV infections or of achieving unity. More helpful is the suggestion to link HIV interventions to programmes aiming at cultural reconstruction, which implies moral reconstruction [Bate 2000: 221], especially if morality is not restricted to the personal-sexual realm (as it unfortunately often is!).

Let me suggest some pointers for moving toward a common discourse on this and other areas of controversy.

First, all those working in the HIV/AIDS field have to keep the bigger picture in mind – the many other factors outside of the strictly bio-medical paradigm that impact on the pandemic and that ought to find room in the Christian AIDS discourse: the social, political, economic, religious and cultural dimensions. In the latter domain the African

understanding of illness as disturbance of balance may be helpful [Saayman 1992: 52-53]. Saayman stresses here the need of restoring community by addressing “the idol of death (namely a specific view on sexuality)” including such idolatrous aspects as sexist dominance over women, depersonalisation of sex through pornography and exploitative advertising.

Second, it makes sense to heed the advice of Gideon Byamugisha from Uganda,⁶¹ to let institutions focus on those aspects of AIDS prevention they are comfortable with and successful at, rather than wasting their energies by attacking those with different views.⁶² If one group is able to persuade young people to postpone onset of sexual activity, let them do so; if others are able to convince more couples to use condoms, let them do so. Together all of these small achievements will combine and impact on the HIV infection rate. This sentiment is shared by Whiteside and Sunter [2000:135] when they suggest that the way forward lies in doing “lots of little things”, with the emphasis on *doing*.

Third, let us consider the advice given by Garner. After investigating the possibility of using exclusion from Christian fellowship as a means of ‘enforcing’ compliance to sexual norms he concludes that should we err – as we are bound to – when taking an ethical stand within the tricky field of AIDS interventions, then “let the church err on the side of mercy, not of judgement” [Garner 2000: 17], nor that of doctrinal narrowness.

3.2. Some criteria for an appropriate practical response to HIV/AIDS

Having clarified some criteria for the HIV/AIDS discourse in the churches of southern Africa, we need to consider what criteria these imply for the practical response. :

3.2.1. Response covering the spectrum of needs

A first criterion for a practical response to HIV/AIDS emerging from the discussion

⁶¹ In a radio interview on AM Live, SAFM, on 1 October 2001.

⁶² One problem is overlooked in giving such advice: The reason for criticising ‘the other approach’ is often the conviction that it is counter-productive, rather than just different. Returning to the statements of Bate above this is clear in his understanding; it is also true for my criticism of his approach, which I see as a contributing factor to the stigma around HIV infection. Possibly, in debate with one another, a greater degree of mutual understanding can be achieved in many cases.

above is the necessity to reach out into all areas of need resulting from the many factors impacting on the spread of HIV rather than being selective. This will require networking and co-operation, as no one church (with the possible exception of the Catholic Church) or Christian NGO is able to do this alone. And without networking with the view to inclusivity the emphasis will be on providing a few 'favourite' responses, while other important needs are not met. While I now consider these areas of need separately, it has to be understood that often the one cannot be separated from the others, and that prevention ought specifically to be part of all interventions.

3.2.1.1. Prevention

While medical science is searching for a cure for AIDS, this will not in itself bring an end to the epidemic, as

... the spread of infection might be checked by a vaccine, and the consequences of the disease eased by an effective cure. The epidemic spread of the virus itself, however, will only be checked by a radical change in sexual behaviour patterns – hence the urgent need for sex education [Saayman 1999: 214].

This is evident from the history of other sexually transmitted diseases like syphilis, which have become pandemic in spite of the fact that both prevention information and a cheap cure have been available for some time [Saayman 1992: 52]. The same is true for TB, especially here in the Western Cape.

A first step in prevention is *education*. This should include providing information that is clear, accurate and up-to-date about:⁶³

- 1) The disease itself, the means of transmission for the HI Virus, the effect of the virus on the immune system and the lack of any symptoms for the major part of its duration;
- 2) The procedure, implications and advantages of HIV testing;
- 3) Risk behaviours that may lead to HIV infection, which have to be addressed in a non-judgemental way;
- 4) How one can protect oneself from the risk of becoming infected;⁶⁴

⁶³ Most of this information is taken from Saayman 1992: 52 and Shelp and Sunderland 1992: 146-47. Where other sources have been used they are mentioned.

⁶⁴ Advocating condoms as a means of prevention is still very controversial, although the A-B-C model for prevention is gaining ground. Problems around this model have been raised (see Sections 2.4, p 28

- 5) How HIV is *not* spread and that normal social contact with PWAs is safe [Nicolson 1995: 73];
- 6) The nature of the human condition, being “vulnerable, finite, mortal” and lived in a world full of risks.

Shelp and Sunderland raise the latter point in support of promoting normal social contact with PWAs. It deserves more attention, with special reference to the fact that sexuality is central to AIDS. This implies speaking openly and non-judgementally about sex and sexuality in all age groups. The specific South African “human condition” poses some challenges here: First, it is necessary to keep in mind that most South Africans are uncomfortable with their sexuality, as is apparent in the high incidence of pathological behaviour like rape and incest; second, the lack of balance in power between men and women hinders the “fully mature human relationships” between them on which healthy sexual behaviour depends [Saayman 1999: 214]. This is further bedevilled by the sexual norms promoted by the media [Saayman 1999: 214-15; see also the SACC Resolutions 2001].

AIDS education is also required in order to undermine the stigma attached to the disease. Giving out clear information about HIV/AIDS is necessary to combat hostility and indifference (and fear) about this scourge. There is resistance to such information in society, and hence in churches. Amongst the reasons for this is that AIDS is related to two strong taboos – death and sexuality [Shelp and Sunderland 1992: 145].⁶⁵ One way of addressing this in a manner that overcomes the hostility and opens up a path for an “informed, compassionate response” is by “putting a personal face on the pain and suffering caused by HIV/AIDS” [Shelp and Sunderland 1992: 145]. The overwhelmingly caring response to Nkosi Johnson and his AIDS message proves this point [Beresford 2001]. The fact that so few PWAs are willing to lend their names and faces to the struggle against AIDS due to stigmatisation proves the urgent need for overcoming the hostility. Changing this is a valid aim for AIDS prevention work. A first step in this direction is for those who are infected to find out their status and disclose it at least to their close family, in order to be able to take precautions against infecting others [Paterson 2000: 8].

and 3.1.4, p 57) and have to be borne in mind in order to make an impact on sexual behaviour and hence on the pandemic.

⁶⁵ See Section 5.4.1 and 5.4.2, p 123-25 for the taboos; and Section 3.1.1, p 33-37 for other factors.

It has been shown that merely providing information and calling for a change in behaviour is not enough to achieve this aim [Parker 1996: 137; Saayman 1992: 52]; nor does it enable people who are particularly vulnerable to demand safer sex or to resist unwanted sexual advances [WCC 1997: 13]. Increasingly prevention knowledge is taught in life skills programmes, which empower (mainly young) people to make their own informed choices about their sexual behaviour and develop the attitudes and skills needed to implement these choices. Paterson [2000: 19] cautions against holding up behaviour change as aim in such programmes, as it is predestined to failure because of the absolute standard this sets. Those who have failed once in keeping their commitment to new behaviour will often give up on it completely. Instead programmes should encourage people to aim for risk reduction, e.g. to sometimes wearing a condom. Starting with something they can do is more likely to keep people committed [Paterson 2000: 19].

With HIV prevention special attention has to be directed at those most vulnerable. The following groups need to be considered:

- 1) Women.
- 2) Babies of HIV positive mothers.
- 3) Sex workers: When speaking about prostitution in the African context the lack of access to economic power for women implies a wide range of sex-for-economic-security arrangements. Interventions in this area need to include offering women alternative ways of earning a living as well as addressing the 'culture' of accepting the sexual dominance of men [Saayman 1992: 54].
- 4) Truck drivers and others in occupations that force them to spend much time travelling and being away from permanent partners.
- 5) Soldiers are part of the former group. In addition they live in a context where risk taking is expected and the possibility of death real. This is reflected in STD rates two to five times higher than in the general population at peacetime; in situations of war this factor can rise to as much as 100 [Foreman 1999: 157-59].
- 6) Refugees: They suffer dislocation and live with even greater fear of discovery of their HIV status as it may imply being returned to the situation from which they fled [Bayley 1996: 178].
- 7) Prisoners: Living in conditions of overcrowding, with high incidences of rape,

and totally separated from their normal sexual partners and relationships. This makes them prone to risk-taking behaviour [Bayley 1996: 176-77; Foreman 1999: 46].

3.2.1.2. Care

This is the area of AIDS-related work churches seem to take on most naturally. Caring for the sick and dying is what the Church has done for centuries through its various diaconic institutions. As growing numbers of those infected with HIV need medical care, the established institutions have started taking on this task.

But AIDS is bringing new challenges in providing care. In some areas in Africa up to one third of patients in surgical wards and two thirds of those in medical wards is HIV positive [Bayley 1996: 100]. In the Western Cape, despite relatively low HIV prevalence rates, 60% of medical beds in provincial hospitals are occupied by HIV positive patients.⁶⁶ Hospitals and hospices are unable to cope with the huge number of patients needing care, and this will become increasingly so as the pandemic progresses, so there is a need for churches and other agencies to establish home based care (HBC) programmes offering advice, help with hygiene, some basic medication, and cleaning the house.⁶⁷ As the majority of the HBC volunteers come from the poorest sections of the community and can little afford to work without compensation. Creative ways of supporting them in their work will have to be found. X

Medication in the form of anti-retroviral treatment is now available to alleviate many of the opportunistic infections of PWAs and considerably prolong their lives. While this is an important breakthrough in the battle against AIDS, it also poses a problem as the medication is currently far too expensive for most of the PWAs in South Africa and other developing nations, i.e. for most of the PWAs in the world. The provision of medication to HIV positive persons is an intervention beyond the means of churches, and even beyond the means of many African governments. It does, however, raise the need for another form of intervention: lobbying for access to medication.⁶⁸

⁶⁶ Brenda Smuts, co-ordinator for reproductive health in the province, gave this figure (Oct 2001).

⁶⁷ Often it is neither possible nor desirable to offer care exclusively to AIDS patients. The majority of PWAs do not know their HIV status and those who do, are often not willing to disclose it for fear of stigmatisation.

⁶⁸ See Section 3.2.1.6, p 69.

Another new challenge is to link care to prevention. Gary Adler [2000: 58], in his comments on the AIDS 2000 Conference, stresses the need for prevention strategies to remain a priority so that not all energies and funds go to “the popular and obvious choices of care and support and mitigation of impact” [Adler 2000: 58], as prevention of new infections is the only way of stemming the tide of the pandemic. If this challenge is valid for our society in general, it also needs to be heeded by churches.

Here the link between comprehensive physical, emotional and spiritual care and prevention has to be exploited.⁶⁹ Appropriate care wins the confidence of PWAs and hence their co-operation for finding ways of preventing them spreading the virus. It also helps the family and communities to face the issues around HIV/AIDS [WCC 1997: 12-13]. Reducing discrimination and stigmatisation are also essential ingredients of a comprehensive prevention programme; as are medical means such as MTCT, early treatment of STDs, and provision of sterilised needles [WCC 1997: 13].

3.2.1.3. Counselling and support for those affected by HIV⁷⁰

Providing pre- and post-test counselling is another intervention required. As discovering that one is HIV positive is traumatic, people have to be supported before undergoing a test as well as afterwards. Pastoral care and counselling is needed to provide information to PWAs to help them cope with their situation, to provide support to enable people to cope with its demands and to empower them to make decisions about their own lives [WCC 1997: 85].

Once again this is an intervention that cannot be separated from prevention. The more PWAs are aware of their HIV status, the more targeted support can be provided to keep them healthy as long as possible and to prevent them from infecting others. De Rosa and Marks [1998: 229-230] found that repeated counselling of PWAs at different times from different sources improved the incidence of disclosure of their seropositive status to sexual partners; for those who had only one counselling session immediately post-test the incidence was not high. This finding emphasises the

⁶⁹ For more examples of the link between other interventions and prevention see Sections 3.1.2.3, p 43 (fighting stigma); 3.1.3.3, p 53 (female-controlled protection); 3.2.1.1, p59-61 (AIDS education, disclosure); 3.2.1.2, p 63 (care for PWAs); 3.2.1.3, p 63 (pre-test counselling); 3.2.1.4, p 66 and 3.2.2, p 71 (orphan care); and 3.2.1.6, p 69-70 (addressing social causes, anti-retroviral treatment for PWAs).

⁷⁰ Sources used for this section, unless otherwise indicated, are Nicolson 1995: 74-75 and Shelp and Sunderland 1992: 152-53.

importance for ongoing support, which can be provided through support groups.

Apart from these immediate material needs, there are emotional needs to be seen to. PWAs ought to be encouraged to keep in contact with persons they were close to – family, friends and lovers. They may require advice on how to go about this, as for many the natural response on learning of their status is to withdraw. And the other party may need counselling too in order to come to terms with the reality of being directly affected by AIDS.

After the death of PWAs the emotional needs of their partners and relatives differ from those due to other bereavement due to the secrecy so often associated with AIDS. This makes it more difficult to achieve catharsis. Here too support groups may be helpful. There are various other affected parties for whom such groups ought to be considered, including clergy and the whole support team. And then churches may not forget to give support to their own members in the health care professions who are involved in caring for PWAs as well as those responsible for taking decisions on HIV/AIDS [WCC 1997: 94].

As poverty is one of the components of HIV vulnerability, the response to the pandemic has to include various forms of practical and material support to those infected and their families. HBC programmes offer some help in this regard. Beyond this support groups are needed for moral support and practical help for coping with the demands of living with HIV, like offering meals, skills training, housing or financial help, for instance for transport to be able to get to a clinic.

Churches have experience and credibility when it comes to provision and channelling of funding and ought to use this to support AIDS ministries [Nicolson 1995: 18].

3.2.1.4. Orphans and vulnerable children (OVC)⁷¹

Projects taking care of AIDS orphans are popular AIDS interventions for churches.⁷² While they are costly, they also draw much support. Yet there is wide agreement that

⁷¹ The UN defines orphans as children below 15 years of age who have lost a mother or both parents. The quoted figures do not include those whose parents are already very sick and unable to care for them; or orphaned youths older than 15 years [Whiteside and Sunter 2000: 54]. Nor do they include those who have lost a father – a figure that for South Africa is almost twice that of 'maternal orphans' [Johnson and Dorrington 2001: 15]. The term 'orphans and vulnerable children' (OVC) is more inclusive. See Section 3.2.2, p 73-74 for other aspects of responding to this need.

it will not be possible to institutionalise all children orphaned by AIDS, that alternatives have to be found within the communities of origin of these children. The two main reasons for this are that it is generally of benefit to orphans to stay within the environment they are familiar with, and that the numbers of orphans is already too high to be accommodated in orphanages. Here are some figures for South Africa to support the latter:

- In 1998 there were 180 000 orphans in the country [Whiteside and Sunter 2000: 54]
- By 2000 Kwa-Zulu Natal, the province of SA where the pandemic is most advanced, had 65 000 orphans and this number was expected to reach half a million by 2010 [Whiteside and Sunter 2000: 80].
- The country as a whole currently has just more than half a million orphans [Johnson and Dorrington 2001: 6].
- Should there be no significant changes in sexual behaviour and interventions it is predicted that by 2015, when the orphan population is expected to peak, 15% of all children under 15 will be orphaned, compared to a pre-AIDS average of less than 3% [Johnson and Dorrington 2001: 6, 9].

Stephanie Shutte [2000: 30-33] has developed a four step plan for faith based communities and NGOs to implement community-based care for orphans, pinpointing the aspects of care that have to be provided, which provide the framework for the national OVC response of the Catholic Church. First, orphan programmes will have to create – or re-create – a “child centred, child valuing culture” through emphasis on the sacred value of children. Second, they need to provide widespread education about basic developmental psychology and parenting skills, so that a broad awareness within society of the emotional needs of its children prepares it for opening up homes and families to orphans, and for supporting youths heading households. Third, suitable substitute parents have to be identified in communities and trained to be able to support orphans with no relatives or to “live alongside ... a family of orphaned siblings, giving emotional and material support” [Shutte 2000: 32]. Lastly, access to material support will have to be lobbied for and organised as the impact of caring for the orphans is most severe in the poorest communities and places a great burden on

⁷² See Section 4.3.3 (5), p 94-95.

those already battling for survival. This may include exemption from school funds for orphans, easier access to foster grants, and raising and administering of funds for other support structures like day care centres and job creation projects [Shutte 2000: 30].

Taking adequate care of orphans is essential, not only for the sake of ensuring their immediate well-being, but as this too has a preventative dimension. Young children who grow up without sufficient care, guidance and love are at high risk for getting involved in crime and in sexual behaviour putting them at risk of themselves becoming infected with HIV [Schoofs 1999: Part 1].

3.2.1.5. Gendered nature of AIDS: The need to target men

The recognition that women are more vulnerable to HIV infection than men has resulted in them becoming the focus of the majority of prevention programmes. It is often however the behaviour of (some) men, which drives the epidemic, and in order to have an impact on this, men have to be addressed [Foreman 1999: viii-ix].

Persuading 10 men with several partners to use condoms, sterilise needles or have fewer partners has a far greater impact on the epidemic than enabling 1,000 women to protect themselves from their only partner. The 10 men are at the beginning of a chain of infection; the 1,000 women are its last link [Foreman 1999: ix-x].

While such reasoning makes sense in an epidemiological context, I am unable to accept this argument for three reasons: First, for Christians (and by no means only for them) individual people *do* matter, even if they do not impact on the statistics, because each person is precious in the eyes of God. Second, the argument is based on stereotyping about men and women, which is unfair to the individual. Lastly, it is not true that women are always the “last link”; many of them pass on the virus to their babies at birth (70 000 during 2001 in South Africa [Meerkotter et al. n.d.: 5]); some widows find new partners and may pass the virus on to them; some women are involved in sex work. Neither will it be true that every man is the beginning of a chain of infection.

In spite of these objections I believe that Christians need to take note of the point Foreman makes and to start challenging the position men hold in society and in relationships not merely by empowering women, but also by addressing men directly

[Tallis 2000: 65]. In my enquiries within the Cape Town area I have only come across one AIDS prevention project which focuses on men,⁷³ while there are many who target women, children and youth. If the men are left out, a crucial ingredient in the efforts to turn around the tide of HIV infections is left out.

Like any behaviour, the risk behaviour of men is to some extent determined by factors beyond their conscious control. Men need a supportive environment, not merely safe sex messages, to enable them to make changes to their sexual behaviour. That implies lengthy, and quite likely costly interventions like group and individual counselling. Strategies that have achieved some success include programmes to develop self-confidence and responsibility, and deal with related issues like intimacy, fears, desires, communication but also substance abuse; social marketing strategies for condoms stressing aspects like masculinity, in conjunction with subsidised prices and effective distribution. In order to achieving changes in norms and hence changes in behaviour, open debate is needed in which there are no taboo topics, in which those who hold positions of power do not monopolise proceedings, and which includes marginalised groups and individuals and where necessary empowers them for such participation [Foreman 1999: 37-45]. Foreman's three conditions are surely unrealistic, but they indicate the areas that need to be considered in setting up programmes targeting the behaviour of men.

While women bear the brunt of the cost of the HIV/AIDS pandemic, it is crucial that men must be targeted because that is where the attitudes and behaviours driving the pandemic are located. Gender roles have to be explored and redefined, but so do "society's constructions of what it means to be a man" [Paterson 2000: 24].⁷⁴ While this may be a difficult area to take on for organisations as patriarchal as the churches in both their structure and their ethic, they have to recognise the contribution they have made (and are still making) to perpetuate this imbalance and take responsibility for addressing it [Nicolson 1995: 21].

3.2.1.6. Lobbying and involvement to counter the social causes of AIDS

I have shown in the first part of this chapter that AIDS cannot be understood as a

⁷³ See Section 4.3.3 (6), p 95.

⁷⁴ See also the work of Bujra discussed in Section 2.4, p 30-31.

purely bio-medical challenge, but is linked to numerous social, economic, political and cultural factors. No agency can expect to make a difference to the pandemic if these matters are not addressed too.

Saayman repeatedly makes the point that churches have to address the social causes rather than only the symptoms of AIDS. He insists, for instance, that churches that simply call for faithfulness within marriage without addressing migrant labour as common cause for unfaithfulness “would be guilty of hypocrisy and would lose any moral right to witness to the good news of Jesus Christ” [Saayman 1992: 54]. The churches in South Africa (or at least a section of them) have a history of addressing contentious issues, of taking a stand with the marginalised, a stand for justice. The prophetic ministry of advocacy and lobbying around these matters will have to become part of their agenda, even where this implies taking a critical stand against institutions and individuals, which have been close allies in the previous struggle. It will be an opportunity to demonstrate social, political and moral leadership [Shelp and Sunderland 1992:155], where morality is understood in its inclusive sense and not in a narrow focus on sexual matters.

The prophetic ministry will have to address a number of conditions on which the quality of life depends for PWAs in Africa – and people in Africa generally. These include [Seidel 1993: 187; WCC 1997: 44]:

- 1) Challenging unjust laws and practices, such as the difficult access to foster grants for orphans in the absence of a birth certificate for the child and a death certificate for the parent, a common occurrence in rural areas, far from Home Affairs offices, and in shack settlements where fires regularly destroy personal belongings and documents;
- 2) Defending basic human rights;
- 3) Access to medication;
- 4) Non-discrimination;
- 5) Empowerment of women;
- 6) Mobilisation of community resources for health education and better medical care and counselling services;
- 7) Working towards a climate of understanding and compassion;
- 8) Absence of war and destabilisation;

9) A new economic order.

Most of these issues have already been addressed; the access to anti-retroviral treatment, however, needs some elucidation. While no treatment at this stage offers a cure for AIDS, anti-retrovirals can reduce suffering considerably and add years to the lives of PWAs. For parents of young children it may give the chance to guide them through a longer part of their childhood. Delaying orphanhood by a number of years can mitigate the potential impact of orphans on society considerably, especially as it is the one intervention which has the potential to significantly reduce the number of orphans in society, possibly by as much as 50% [Johnson and Dorrington 2001: 25]. It will benefit the economy as it prevents premature loss of experienced employees [Bayley 1996: 69]. It is clear that churches are not able to provide such expensive medication to PWAs. This makes it all the more important to support medical intervention by lobbying for greater access to medication. In South Africa the Treatment Action Campaign (TAC) has been formed in 1998 to work toward this goal.

Its main objective is to campaign for greater access to treatment for all South Africans, by raising public awareness and understanding about issues surrounding the availability, affordability and use of HIV treatments [TAC: About us].

It has been instrumental in pressurising pharmaceutical companies to lower prices of AIDS related drugs. Now it is putting pressure on the government to provide treatment to PWAs, specifically to pregnant mothers to prevent MTCT [TAC: About us]. It is a campaign worthy of support. Thus far the only church leaders to support the TAC publicly in this call are those of the Catholic and Anglican Church.

This intervention too is closely linked to prevention: Access to medication is one of the incentives that can make it worthwhile to undergo an HIV test and face the possible consequences. In the Western Cape, where TAC in co-operation with Medicines Sans Frontieres (MSF) has been offering MTCT Prevention (MTCTP) programmes, results clearly show this.

In Gugulethu 89% and in Paarl 95% of clients accept HIV testing after counselling. Clients agree to HIV testing because they get offered a way to prevent their child from contracting a deadly illness [Reuter 2001: 4-5].

The ongoing support they receive enables many to disclose their status and has an

impact on the use of unsafe sexual practices [TAC: FAQ]. These results are advances in overcoming the silence around AIDS and in the fight to prevent further infections.

The prophetic AIDS ministry has to have an additional direction. While it has to be supportive of people in their situations, it will at the same time have to be counter cultural, asking critical questions around accepted cultural behaviours that place persons at risk. The norm of having 'second families' in the city is one such issue mentioned by Bate, who stresses that in raising such challenges the worldview offered must be realistic to have a chance of acceptance [Bate 2000: 217]. The acceptance of the use of violence by men against their partners also needs attention, and so does the "exploitative and obnoxiously ostentatious manner in which funerals are conducted, believing these to be un-African and immoral" [SACC Resolutions 2001].⁷⁵

3.2.1.7. Theological response and worship

Many of those affected by HIV/AIDS, regardless of whether they are Christians, adherents of another faith or atheists, need in addition to all other assistance, spiritual support to help them make sense of their experience within their faith [Sims and Moss 1991: 84]. This has implications for a number of areas to be addressed when churches respond to the AIDS pandemic.

First among these has to be the need to break the silence about AIDS within churches.⁷⁶ The pandemic has to become part of the church agenda, of its worship and the topics discussed in its meetings. Bayley [1996: 280] points out that it is crucial to offer to those who are infected and affected by HIV worship that takes their suffering into account. It is a serious neglect of the pastoral responsibility to keep a topic of such relevance to some of its members out of the churches' discourse. To justify it by stating that none of the own members are known to be infected or affected is not valid either, as those who are affected will only be able to disclose this once they have the experience that AIDS is part of the discourse of their church. And even if it was true that at this stage there are no members affected by AIDS, this was at some stage true for all churches. It does not mean that it will remain so. Furthermore, it has never

⁷⁵ See Section 5.2.7, p 122.

⁷⁶ See Section 3.1.1.2, p 37-39.

been a guideline for Christian discourse that it should be confined to issues (known to be) directly affecting the own membership.

Other spiritual needs of PWAs include sacraments and rituals to express their feelings and fears, reconciliation, guidance in preparing for the possibility of early death, growth [Sims and Moss 1991: 86-88]. Some suggestions follow for churches to take on the challenge of responding to HIV/AIDS in spiritual and sacramental ministries:⁷⁷

- 1) Sermons can be used as opportunities to raise the topic and inform congregations about AIDS.
- 2) Intercessory prayers allow members to participate, to express their concern for PWAs and for themselves.
- 3) Healing rites like confession and the sharing of the peace can form part of the celebration of communion.
- 4) Special prayer services with laying on of hands and anointing can be conducted for all affected by HIV [Nicolson 1995: 76]. Interfaith services for communities affected by AIDS may be advisable because of the reservations many of those who are affected have about their own denominations or about churches generally.
- 5) Finally funeral, burial and memorial services offer comfort and hope to the bereaved.

It is also crucial that a theological response to HIV/AIDS is developed.⁷⁸ To date not much has been done in this regard in South Africa.

3.2.2. Response addressing the scale of need

The scale of the AIDS pandemic, with its overwhelming statistical predictions, is a challenge that goes beyond what societies have had to deal with, possibly throughout history. Yet it is not just the scale of the AIDS pandemic that presents a fundamental challenge to the world, but also its duration as this epidemic shows no sign of abating twenty years after it started [WCC 2001].

In order to indicate the dimensions of the challenge, I provide some figures referring

⁷⁷ Unless indicated otherwise, these suggestions are from Shelp and Sunderland 1992: 150-51. See also Section 5.3.3, p 117-19 on the possibilities of using liturgy in this context.

to the peaks of the various waves [Johnson and Dorrington 2001: 9]:⁷⁹

- The wave of new infections peaked in 1998 at 930 000 infections per year.
- The wave of total number of persons infected will peak in 2006 at 7.7 million.
- AIDS deaths will peak in 2010 at around 800 000 per year.
- AIDS orphans will peak in 2015 at 1.85 million.⁸⁰

Churches may be tempted to continue doing what they have always done, and merely extend the services of their orphanages or hospices to those infected or affected by HIV/AIDS. However, if we bear in mind the scale of this pandemic it becomes clear that all this does, apart from giving us the sense of at least doing something, is to provide symbols of hope that serve a few of those affected by the pandemic. Even opening up some new institutions will not alter that. In a situation that drives so many to despair, there is undeniably a need to offer such symbols as models of the kingdom reality. The question has to be raised whether it is enough for churches to do this; whether the challenge does not go beyond this to find new ways of reaching out to the many in need of not only hope, but also of concrete care and support.

It is clear that no institution can do enough. What institutions can and have to do is to strengthen communities so that they are able to care for those in need and to provide them with support.

AIDS patients need care for a period, from the onset of opportunistic infections until they die. The number of persons requiring counselling and HBC will rise, following the typical pattern of the HIV prevalence curve and eventually flatten. This is true for most services required by PWAs. There is one group affected by HIV/AIDS where this is not true, though. The number of AIDS orphans simply continues growing. Every month of the continuing pandemic produces more orphans.⁸¹

⁷⁸ See Sections 3.2.3.1, p 75-77; 5.3.1, p 115; 5.4.1 and 5.4.2, p 123-25.

⁷⁹ The term 'peaks of waves' refers to the pattern the AIDS statistics follow over time, with a slow increase initially, becoming a steep curve reaching a maximum peak and then gradually decreasing. See the MRC or CARE reports for examples.

⁸⁰ These figures are predictions of expected patterns based on a specific statistical model. The reality may be quite different. Yet they do give an impression of the scale and timeframe we can expect.

⁸¹ Statistical predictions show that the wave of orphans will also eventually peak and flatten, some years after the waves of infections and AIDS deaths [Johnson and Dorrington 2001: 5]. This is due to the fact that orphans are defined as children under the age of 15. They do however not stop being orphans after they stop being counted and the impact they have on society, as teenagers turning to crime, as parents of babies who have no grandparents to care for them should the orphan-parents die.

The challenge this poses to society is enhanced by the fact that orphans seem to not be the responsibility of any ministry – caring for them is not a matter of health, nor of education, although these Departments are involved in providing services to them. Probably it is the responsibility of Welfare and Development – but it is one they never had to deal with before, as in Africa orphans are generally taken care of within the extended family [Paterson 2000: 20].

It is in this area of providing care for orphans where churches need to be most aware of the scale of the need as they plan their response.

Orphans, for example, have always been enfolded into the extended family. But more than 7 million children in sub-Saharan Africa have lost one or both parents, and the virus is also killing their aunts and uncles, depriving them of foster parents and leaving them to live with often feeble grandparents.... But even this fragile safety net won't be there for many of the next generation of orphans [Schoofs 1999: Part 1].

Caring for a few AIDS orphans is not an adequate response in the light of the great numbers. Even caring for many is not enough: One Lutheran Diocese in Uganda provides care for about 10 000 orphans via the community; there are another 40 000 not included in the programme [Nicolson 1995: 46]. It is evident that orphanages cannot be the solution for this challenge.

Extended families are the most important resource for addressing the need of AIDS orphans. Institutionalisation is not an option. It is advisable that children should remain in their communities and ways be found of supporting them within the extended family. The community needs to be involved in this, and the children themselves should be part of decisions about their future [Bayley 1996: 152-53]. At this stage, even in areas with a high AIDS mortality rate it is rare to find orphans with no relatives at all. In the next generation this will be different as the children of orphans will have no grandparents to take care of them should their parents die. It is usually the women, who in this aspect of AIDS, as in most others, bear the major burden and cost [Nicolson 1995: 47]. Even now the burden this places on some is unbearable. Grandmothers, who have nursed many of their adult children until they died of AIDS, then take over the care for the grandchildren, in some cases twenty or more of them [Bayley 1996: 146].

Nicolson [1995: 46] suggests that one of the implications of the scale of the orphan

population is that churches will have to reconsider their stand on abortion. The reality is that without MTCT prevention programmes, babies of HIV positive mothers have a chance of one in three to also be infected. For them this implies a short, miserable life. Without treatment their mothers will die soon and they will be added to the already huge number of orphans. Insisting that abortion is wrong, he says, compels us to care for the orphans. Since the stand taken by churches on this matter (as on many others) does not impact hugely on the behaviour of their followers, much less so on the general population, their stand on abortion will hardly have a significant impact on orphan numbers. What is at stake here, however, is the credibility of the Christian discourse and action and the importance that the two correspond.

Caring appropriately for orphans is, like so many of the AIDS interventions, also a means of preventing a further escalation of infections. Orphans in poor communities are likely to be poor. That implies that they will have limited access to education, and are likely to be abused or neglected. All this adds up to the conclusion that they will be

.... seething with all the needs that make it more likely that a person will have unsafe sex. In a decade's time every fourth South African will be aged between 15 and 24. It is at this age group where people's propensity to commit crime is at its highest. At about the same time there will be a boom in South Africa's orphan population as the Aids epidemic takes its toll [Schoofs 1999: Part1].

Children growing up in these conditions will be easily drawn into dangerous behaviour, whether sexual or criminal. Providing appropriate care for these orphans is essential for preventing another group falling prey to AIDS; and all of us falling prey to another crime boom.

3.2.3. Response appropriate to the Church's self-understanding

Much of what has been said in this chapter and the criteria developed in it apply to any agency involved in responding to the HIV/AIDS pandemic, whether secular, faith-based or Christian. It seems appropriate that before ending the chapter we should consider the specifically Christian challenges, the criteria for how churches and Christian NGOs respond which follow from the fact that they are Christian.

HIV/AIDS is more than a challenge to the church. It sets before the church an opportunity to reflect on its identity and mission. If the church fails to act compassionately, neglects the needs that cluster around people with HIV disease, fails to express itself redemptively, and abandons people who have almost no one to cry out on their behalf for mercy and justice, then the church will abdicate its responsibility and fail in its witness even longer [Shelp and Sunderland 1992: 115].

Maluleke [2000: 93-94] argues that the AIDS pandemic presents a *new Kairos*⁸² to the churches and theologians of Africa, where *Kairos* is understood as a “dangerous time” that offers a “moment of truth”, but also a “moment of grace and opportunity”. The painful truth the HIV/AIDS pandemic shows up is the failure of much of society’s response, whether that relied on technology, medical science, the human spirit, or the institution of marriage; it shows up the human frailty, the sinfulness in many areas of private and public life. But at the same time it offers an opportunity. And for churches this is an opportunity to stand with those affected by AIDS, but also the opportunity for reflecting theologically on the significance of what is happening and on the appropriate ways of responding to it. Maluleke stresses the serious lack of theological reflection on HIV and AIDS in South Africa.

3.2.3.1. *Develop a theological response to HIV/AIDS*

The first response characteristic of a Christian involvement in AIDS ought to be to develop a theological response. Nicolson [1995: 18-42] attempts this in his book.⁸³

A central concern for such a Theology of AIDS would be to address human sexuality.

The religious community does not have a monopoly on either the gift [of sexuality] or its expression, but has an inalienable responsibility to work towards its embodiment in mature human relations [Saayman 1999: 215].

Nicolson raises the need to admit that church teaching on sexuality has been legalistic, rule-based and negative. Since this is such a central concern I want to dwell briefly on the historic reasons for this. Heyward [1994: 14] says that this attitude developed during the early centuries of church history, a time of confusion and chaos when the church leaders had to set down tight rules. It was the only way they were able to stay in control. This was, he says, a way of dealing with a crisis in male identity which was

⁸² The analogy is to the Kairos Document originally published in 1985 in critique of the status quo in the state and much of the Church.

⁸³ Unless otherwise indicated the material in this section is from the relevant chapter in Nicolson.

resolved by defining themselves “not in relation to” women, but “in separation from” them. Historically then, social control of sexuality and social control of women is linked. In most churches (and beyond) sex is still seen as “something pertaining to women and as evil”.

Other themes to be addressed by a Theology of AIDS include the following:⁸⁴

- Looking at sexuality as gift and considering love – not legalism – as context for sexuality;
- Problematising faithfulness;
- AIDS and homosexuality;
- Reassessing an ethic of unrestrained sexuality and replacing it with a sexual ethic, which emphasises love and responsibility. Relationships are a central concern for this topic. Roger Burggraefe [2000: 303-316] deals with this under the title “From responsible to meaningful sexuality”. A first step is to take responsibility for one’s own sexual behaviour. This implies the ‘first do no harm’ principle which is applied to oneself and to the partner. But for a Christian ethics, Burggraefe insists, this “cannot even be our starting point”. It needs to aim for *meaningful* sexuality and this implies sexuality that is relational, appropriate, not based on fear of consequences or instrumentalisation of persons.
- The question of theodicy – how can a loving God allow this to happen?
- Overpopulation;
- Alienation;
- The common cup at communion;
- Ministry to the individual;
- Engagement with the social context of AIDS;
- AIDS in the context of other life-threatening illnesses;
- Proclaiming the Resurrection as real hope for life after death, rather than only in a metaphorical way.

It is interesting to note that the failure of theological reflection on the HIV/AIDS pandemic and related challenges was reflected in the absence of the mention of either Theology or Religious Studies in the Programme for Track D – focussing on the social and behavioural sciences –at the XIII International AIDS Conference in Durban

during 2000.⁸⁵ It is clear that Theology is abdicating a responsibility if it fails to address issues of such concern to society to such a degree that civil society does not even note it.

3.2.3.2. *God's preferential option for the poor*

The poor is a biblical metaphor for those with an inferior position in society who are vulnerable to exploitation, as they have no resources to safeguard their lives. As such they are “subjects of divine concern” [Shelp and Sunderland 1992: 101, 103]. PWAs fit this category of *the poor*. They are often totally dependant on others due to their physical and financial condition. They are unable to advocate their own interest and rights, and are feared and ostracised due to their HIV status [Shelp and Sunderland 1992: 113].

In the Old Testament the call to meet the needs of *the poor* is often repeated. Their needs and rights were not to be regarded as inferior to those of the privileged as both were equal before God. The New Testament, especially in the synoptic gospels, shows the same concern for *the poor*, who are not excluded from God's love and care even though society may exclude them from full participation [Shelp and Sunderland 1992: 104-07]. Lisa Cahill [2000:289] concludes that, “Affirmative action toward those most grievously affected by the AIDS crisis is a duty both of human justice and of Christian love.”

3.2.3.3. *Biblical metaphor of prophecy*

The prophetic Christian ministry on behalf of PWAs is based on the conviction that the Church must “when its values differ from those of society, stand and confront them” [Shelp and Sunderland 1992: 199]. The WCC Study Group insists that taking this stand with *the poor* “is not an option; it is the church's vocation” [WCC 1997: 43-44]. What this will look like in different communities will depend on the needs and possibilities of the communities and of those taking a stand for and with them. It will include challenging structures in society, but also demonstrating alternative ways of being [Shelp and Sunderland 1992: 201f]. A prophetic ministry to the poor consists of active solidarity and compassion with them, calling on those with power to use it to

⁸⁴ See also Section 5.4, p 122-126.

⁸⁵ Pointed out by Nomsa Hani in her reflections on the conference.

the benefit of the poor, and opposing conditions that cause the injustice and suffering [Shelp and Sunderland 1992: 111]. Other possibilities for such intervention are discussed elsewhere.⁸⁶

3.2.3.4. *Community*

De Gruchy [2000: 18-20] says that AIDS raises the question of salvation in a new way, as neither medical science, educational interventions, civilisation nor, sadly, organised religion offer a means that will “save us from this catastrophe”, adding that “it is “all of us“ and not “them“ that must be saved” [De Gruchy 2000: 19]. He suggests covenant community as a solution. Such community is characterised by openness and honesty in matters of money, sexuality and power, by mutual accountability, inclusivity, caring and support. It is important that such community goes beyond a preached vision to something lived out in the public realm [Shelp and Sunderland 1992: 194].

The biblical metaphor of *hospitality* allows further expansion of this idea. In it there are indicators of taking seriously differences, of otherness that separates yet challenges to overcome the differences, of acceptance and affirmation. In offering hospitality Christians follow the example of Jesus, who included ‘sinners’ in the community of his followers. He searched for them, sat with them at table and touched them [Shelp and Sunderland 1992: 192]. For Christians in the HIV/AIDS epidemic this implies an urgency to go out and find the ‘outcasts’ in order to offer them community [Shelp and Sunderland 1992: 195]. The ultimate challenge for such community is to move beyond avoiding judgement, beyond extending hospitality to guests to embrace the other as “rightful member of the family” [WCC 1997: 29].

Saayman [1999: 217] urges churches to consider the relationships between men and women as much as that between ‘sick’ and ‘healthy’ as areas in which community has to be developed.

3.2.3.5. *Providing safe spaces*

The Church as the body of Christ ought to be a place where it is possible to experience the reality of God’s love and his promise of healing and abundance [WCC

⁸⁶ See Sections 3.2.1.6, p 67-70; 4.3.3 (4) and (7), p 94-95 and 5.2.2.6, p 110.

1997: 43]. Here the image is that of the church as *sanctuary*, providing an atmosphere of acceptance and openness [WCC 1997: 79-80].

What does this imply in the age of AIDS? Discovering that one is HIV positive invariably raises spiritual questions such as “Why?”, “Why me?” or “Why like this?” [Cameron 1993: xii]. PWAs need spaces where these questions can be raised in the presence of non-judgemental listeners, where they can mourn the reality and the losses it implies,⁸⁷ where it is safe to disclose not only their sero-status, but also their thoughts and feelings as they try to “make some sense of their suffering and live as well and as long as possible” [Cameron 1993: 151-52]. PWAs require courage and hope in order to live what is left of life with dignity; they need to know that there is some meaning in their suffering; they need the assurance that they will not have to die alone [Shelp and Sunderland 1992: 196]. Churches can become spaces where this is possible.

The challenge is for churches to offer safe spaces where these issues can be explored and these needs be met. AIDS shows up the shortcomings in traditional church structures, as many PWAs leave their original churches to search for safe spaces elsewhere. But then there are also non-Christians who find this safety and acceptance in a church and its ministry [WCC 1997: 81-82].

3.2.3.6. *Overcoming the attitude of judgement*

There is no question that the moral imperative for Christians is to practice agape, selfless love. Moral judgements may not be allowed to interfere with this, as happens when the medico-moral discourse dominates the response to HIV/AIDS [Shelp 1994: 314-15]. Judgement and shaming is not the attitude of God, even if it is the attitude of society and of some who claim to speak on God’s behalf. In Jesus God comes alongside those who are afflicted, thus restoring their dignity [Jantzen 1994: 311]. The other biblical example to follow is that of the *Good Samaritan*, whose only criterion for helping is the need of the victim [Shelp 1994: 320-21].

To be able to move towards a less stigmatising and judgemental response, Jantzen [1994: 306-12] suggests that Christians need to confront and explore their own value

⁸⁷ See stage 4 in the ‘stages of dying’, Footnote 32, p 37.

judgements, feelings and natural responses to PWAs. Common responses are:

- 1) Feelings of revulsion and shame, a tendency to cringe. These are appropriate a initial responses to the horror of AIDS and the way it confronts us with our own mortality and vulnerability as well as the ambiguity around sexuality.
- 2) The tendency to “offer charity at a distance”, which diminishes the humanity of those receiving it.
- 3) The tendency to theorise about suffering, to rationalise it, which almost invariably leads to the conclusion that somehow they must deserve what they have got.

The best way of overcoming these is through spending time with PWAs, experiencing their reality and receiving their love [Jantzen 1994: 312].

Responses of Catholic Case Study

Keenan provides some startling examples of moral judgement overriding love: A married couple, one of whom has been infected by contact with infected blood at work, were advised by a priest who was “genuinely sympathetic” to their case that the use of condoms was “absolutely prohibited” [Keenan 2000: 296]. A Catholic order decided not to make unused space in their facilities available to an AIDS prevention programme, because they would be offering vulnerable young girls the use of condoms amongst other options [Keenan 2000: 200]. Examples of such judgemental attitudes are common in many denominations. I was told of a pastor who publicly stated that if any of his members were found to have AIDS, he would have nothing more to do with them. Some members are denied a Christian burial by their church if they are known to have died of AIDS [Ruden 2000: 6].

Churches are at risk of attributing unsubstantiated ‘truths’ to God and turning them into unchallengeable benchmarks not only of belonging, but also of salvation. In the case of AIDS, as in many others, this can cause unspeakable harm.⁸⁸

3.2.3.7. Taking a stand against superstition

The Church has always had the task of taking a stand against superstition and mythology, yet has not always done so, claims Lovegrove [1990: 152]. In this context the myths of the risk of transmission of HIV through social contact with persons,

⁸⁸ Other examples of this are mentioned in Sections 3.1.2.3, p 43-44.

through sharing of the communion cup have to be addressed as they deepen the stigma and discrimination of PWAs. Some myths are actually created by church representatives such as that AIDS is a result of adultery or promiscuity [Paterson 2000: 26, 29]. These too need to be addressed as they create on the one hand the stigma around PWAs and on the other a false sense of security. Other dangerous myths claim that AIDS is just a fabrication to stop people having children, or having fun.⁸⁹ Similarly the myth that having intercourse with a virgin offers a cure from HIV is causing untold suffering [Govender 1999].

It is crucial that churches add their voice to expose and counter these damaging myths.

3.3. Concluding comments

In this chapter I developed criteria for evaluating the response of churches to the HIV/AIDS pandemic. First criteria for the church discourse on AIDS were developed, and second the criteria for the practical response. Throughout this the reality of the pandemic, the specific context for the pandemic in Southern Africa and the self-understanding of churches were considered as indicators of an appropriate response. In the next chapter we will consider the actual response of Christian groups in the Cape Town area.

⁸⁹ Interview with Labeqa Abrahams and Nontlupiko Ben.

Chapter 4. The current response of churches to HIV/AIDS

In this chapter I will present the findings of my survey into the Christian response to the HIV/AIDS pandemic, including denominational programmes as well as those offered by Christian NGOs. The findings are presented in accordance with the spectrum of needs as stated in the previous chapter.⁹⁰

While my survey was confined to the Cape Town area, I do place its findings in the context of the Christian response to HIV/AIDS in Southern Africa, as far as this could be gauged from the literature. Furthermore I contrast these findings about the practical response with the AIDS discourse as represented by ten statements of Christian individuals or groups on how churches ought to be responding to HIV/AIDS, highlighting agreements and differences between the discourse and the practical response.

4.1. Views of some churches on how they ought to be responding

In Chapter 2 I emphasised the importance of the AIDS discourse for the practical response to the pandemic as well as the connection between the two. As I present information on the actual response, I start off once more with the discourse. In my survey I did not include the collection of relevant examples of such discourse as found in sermons, lessons and bible studies, as my focus was on the practical response.⁹¹ I did however collect some pertinent (public) statements and synod decisions, and list in the table below the views raised in these ten statements by individuals, churches or organisations as to what the Christian response to AIDS ought to be.⁹²

⁹⁰ See Section 3.2.1, p 58-70.

⁹¹ This would have exceeded the scope of this study, but studying the AIDS discourse in churches systematically might well prove a worthwhile undertaking.

⁹² These are in order of the year of publication: Nicolson 1995: 18; "What the churches can do", WCC 1997; Ntsimane 2000: 25; KwaZulu-Natal church leaders 2000: 49-50; SACBC "World AIDS Day Circular", November 2000; WCC submission to United Nations HIV/AIDS special meeting, July 2001; Methodist Church of Southern Africa (MCSA): "Responding to the HIV/AIDS Epidemic in Southern Africa", July 2001; "Our Vision, our hope: The first step", All Africa Anglican AIDS Planning Framework, August 2001; SACC – Resolutions of the Triennial National Conference, August 2001; Uniting Reformed Church of Southern Africa (URCSA) statement on HIV/AIDS, October 2001. While it is a rather haphazard collection – as I requested such statements as a rule, but did not follow up on those not provided – it does give some insight into the perceived challenges and their relative importance.

Figures in the last column indicate how many of the respondents mentioned a specific response, and thereby give an indication of the relative importance accorded a given response in the Christian AIDS discourse.

Response Category	Response	Number
Prevention of new HIV infections	Promote faithfulness or abstinence; responsibility in sexual relationships.	8
	Provide a climate of acceptance; end the stigma by breaking the silence.	4
	Promote sharing of factual information by educating all levels within churches.	4
	Promote full understanding and open discussion of human sexuality and the factors affecting it.	3
	Decrease vulnerability of women and children.	2
	Encourage voluntary testing.	2
	Focus on prevention, not merely on 'ambulance ministry'.	2
	Advocate adopting behaviour that avoids infection.	1
	Address drug use.	1
	Promote avoidance of risk behaviour.	1
Care and treatment of PWAs	Provide basic health care to PWAs.	4
	Increase the capacity of communities to care for PWAs.	3
	Minister to those affected and train them for caring for loved ones.	3
	Make own facilities available for care or establish places of care.	2
	Provide support to health structures.	1
Counselling and support of those affected	Secure the human rights and dignity of PWAs; end stigma and discrimination.	7
	Establish support groups or other counselling services.	4
	Provide pastoral support.	3
	Provide a climate of acceptance.	3
	Ensure sufficient clergy are trained to provide such services.	1
	Accompany the dying and those who mourn.	1
	Provide chaplains for caregivers.	1
Care of orphans and vulnerable children	Provide support to orphans and affected children.	3
	Establish places of care/community networks of support.	3
	Ensure that orphans are able to continue schooling.	1

Lobbying and action to address the social causes of HIV/AIDS	Addressing gender inequality – also in own leadership.	5
	Advocate for increased spending or better utilisation of resources in the health services.	4
	Advocate access to anti-retrovirals, especially for MTCTP.	3
	Poverty relief.	2
	Counter the social causes of AIDS: by participating in public debate on the topic.	2
	Challenge the state and institutional leadership.	2
	Provide/channel funding for such programmes.	1
	Advocate for more justice.	1
	Focus on conditions increasing vulnerability: migrancy, refugees, and sex work.	1
	Promote the right to health.	1
	Working towards social reconstruction.	1
	Encourage research into medical treatment and vaccines.	1
	Engage with business to provide information and access to affordable treatment.	1
	Engage with media to discourage promotion of promiscuity.	1
Networking	Promote ecumenical or faith-based co-operation.	3
	Promote co-operation with government and civil society.	3
Theological response and worship	Develop a theological response and promote constant theological reflection.	4
	Mobilise liturgical responses to confront stigma and to offer spiritual support.	2
	Strive for fuller understanding of sexuality.	1
	Give theological and ethical guidance to both the state and the community.	1
	Confront the experience of death with the reality of resurrection.	1

It is evident from this table that the range of needs recognised in the combined statements is quite comprehensive. While a few responses stand out as having almost unanimous support, the great variety in the number of respondents who considered that specific responses ought to be offered indicates a range of differing emphases.

A discussion of this summary follows in Section 4.4 where the ‘Ought’ is compared and contrasted with the actual services provided.

4.2. The response of Southern African churches in general

There is as yet no comprehensive database of Christian or faith-based AIDS services for South Africa from which to draw the data for this section. General databases cannot really be used either, as they do not indicate whether services are faith-based. Information presented in this section is based on the following sources:

- 1) A survey of AIDS-related activities of ecumenical churches in the Western Cape [Williams 1996];
- 2) A national survey of religious health services [Schmid et al. 1999];
- 3) An overview of the church response in sub-Saharan Africa [Paterson 2000];
- 4) An article on some church responses mainly from Johannesburg [Mdhlela and Nolan 2000].

4.2.1. Looking back over the early years of the pandemic

Churches were amongst the first institutions in sub-Saharan Africa to take on the challenge of responding to HIV/AIDS, setting up HBC programmes and admitting HIV patients, who had been turned away from public facilities, to their hospitals and clinics. In all sub-Saharan countries churches make a crucial contribution to the national response to AIDS [Paterson 2000: 6, 16]. The Catholic Church stands out in this regard as one of the largest funders for AIDS related work in South Africa.⁹³

Three years ago a common response to the question: 'What are you doing about AIDS?' was that churches (and other faith based organisations from various religious affiliations) did not feel that AIDS presented a challenge to them, as it did not affect their own membership [Schmid et al. 1999: 124]. Williams [1996: 57, 59] found that such attitudes were common among church members of the ecumenical churches in the Western Cape, whereas the church leadership showed a genuine desire to find an adequate response to the pandemic. The leaders were concerned about causing an alarmist reaction on the one hand, and an 'it won't happen to us' attitude on the other. Pastoral letters, synod recommendations and action plans of the Anglican, Methodist and Presbyterian churches since 1990 have consistently mentioned AIDS, especially the need for education to prevent the spread of HIV and for care of those already

⁹³ The Southern Cross, 11 July 2001, claims that the Catholic Church is the biggest funder of AIDS services in South Africa after the government.

infected [Williams 1996: 39-47, 52-55]. At that time, however, no implementation of such programmes was reported except in the Catholic Church, which developed a programme focussing on AIDS education, training for clergy as counsellors and HIV/AIDS educators and care for AIDS babies [Williams 1996: 48-51].⁹⁴ Individuals from religious communities have long been involved in HIV/AIDS work, but many of these reported feeling quite isolated in this regard within their religious communities [Schmid et al. 1999: 124].

4.2.2. Current trends

During the nearly three years since the HST survey many churches and Christian NGOs have changed their views about the implications of the HIV/AIDS pandemic for their ministry. Halting the spread of HIV and caring for those already infected is regarded as an important challenge, as a test for the credibility of churches [Shelp and Sunderland 1992: 115]. Funds are being raised and used to develop educational material and launch programmes. Often the realisation, 'We need to do something about AIDS!' leaves many at a loss what to do, as the challenges are so diverse, the problem is so huge and the own capabilities so limited. As a result it may take quite long before the intention to initiate an AIDS ministry is transformed into actual programmes.

Currently many new ministries are being developed and existing ones expanded. These ministries include AIDS centres providing nursing care, which are "mushrooming in the Catholic Church", awareness raising programmes, ecumenical bereavement support groups and outreach to sex workers, including skills training to empower them for other work [Mdhlela and Nolan 2000: 2-4]. It is women who initiated most of these ministries and do almost all the practical work; men are only involved with a 1% effort [Mdhlela and Nolan 2000: 2].

In 1999 the most common response to HIV/AIDS was to offer *prevention* programmes, with the youth as the main target group, although some groups did report working with children [Schmid et al. 1999: 125]. There is now a growing awareness of the need to reduce stigmatisation by addressing judgemental attitudes

⁹⁴ The Salvation Army, not included in William's survey, also started working in the AIDS field earlier than most other denominations.

within congregations [Paterson 2000: 7].

A few groups offered *HBC* and relevant training to volunteers.⁹⁵ Other responses included pre- and post-test *counselling* through lay counsellors. Material *support* to PWAs in the form of food parcels and income generation projects was reported by a few respondents [Schmid et al. 1999: 125]. A few Christian hospices have extended their facilities to cater for terminal AIDS patients.

The institutional response offered or in the planning stage includes some existing hospices, which opened their facilities to terminal AIDS patients, a hospital ward dedicated to the treatment of AIDS patients and orphanages for children whose parents had died of AIDS and who might or might not be HIV positive themselves [Schmid et al. 1999: 125]. As the pandemic is taking a growing toll on communities and the number of orphans keeps increasing, many churches across the subcontinent realise that what they need to do is to raise the awareness about OVC in affected communities and build their capacity to care for them, rather than setting up additional NGOs to do so [Paterson 2000: 6-7].

In full realisation that no AIDS programme can really solve the problem of *poverty*, but neither can those helping PWAs and faced with starving families ignore it, churches and AIDS programmes in sub-Saharan Africa offer a range of responses to the interrelatedness of poverty and HIV. These range from the view that addressing the poverty of their clients is not their task, to those who conclude that the poverty of the community is too large to address, but nevertheless run income-generating projects for their workers and/or for PWAs. Others respond by developing small groups of affected persons who care for each other and support each other spiritually and materially, or collect and distribute food aid for affected families [Paterson 2000: 11-13]. Churches have been working to alleviate poverty long before the onset of AIDS, and still do valuable work in this regard.

Williams [1996: 33] reports that Western Cape AIDS activists expressed a concern about the lack of *networking*, while Schmid et al. [1999: 125] found a measure of co-operation and networking between FBOs in parts of the country around AIDS

⁹⁵ At that stage only 6 of 47 groups surveyed countrywide, who were offering some AIDS services, mentioned offering HBC. (This information was collected in the survey, but not published in the report.)

responses. This seems “to have been at least partially motivated by the insistence of government to make funding available to a joint faith-based response to HIV/AIDS”. The need to avoid duplication, to share experiences and existing resources motivates such networks, which are more established in areas where the needs around HIV/AIDS are greatest and the pandemic most advanced. In the Western Cape, where the pandemic has not yet developed as far as elsewhere, there is as yet little networking between Christian groups involved in AIDS work.

In the *charismatic and Pentecostal churches* Paterson [2000: 9] reports a different emphasis. Church is seen as a place where you can get away from your problems and the harsh reality, so problems – like AIDS – are not mentioned there. Some of these churches offer faith healing for people with HIV/AIDS, especially in the early stages; and if that fails “there is always life after death to look forward to” [Paterson 2000: 9].

It is not easy to gauge the response in the *African Independent Churches* (AICs) as each group operates largely independently of others, they have hardly any central structures and it is difficult to include their leadership in decision-making fora as many of them have full-time secular occupations and few have access to modern means of communication. Mdhlela and Nolan [2000: 4] report a concern within AICs about the scourge of HIV/AIDS and an awareness of the need to reach out to PWAs in practical ways and with moral support. Ntsimane [2000: 22-23] did a study in two AIC groups in rural Kwa-Zulu Natal and found that the level of knowledge about the causes of AIDS was quite low, although there was some understanding that this is related to sexual behaviour. A common understanding placed special blame for the spread of AIDS on urban women with loose morals. There was a reluctance to discuss sexual matters, except in groups separated according to age and gender. The leaders had a sense that AIDS was not of great concern to them, and one of them claimed that their leader, Shembe, was able to heal people of AIDS.

4.3. The response of selected denominations in the Cape Town area

4.3.1. Groups included in the survey

I attempted to approach as many of the Christian denominations operating in the Cape

Town area as possible as well as all Christian AIDS programmes.⁹⁶

In most of the mainline denominations a central office could direct me to a person in charge of the denominational AIDS response. Other denominations are not centrally organised and individual congregations do work of which their head office (if this exists) is not aware. In the Pentecostal/charismatic sector with a huge number of denominations and groups, I approached a few of the bigger churches. The AICs were even more difficult to approach. My information in this regard is based on interviews with a few persons with close links to (some) of these groups.

Some of the programmes operating as independent NGOs ^{with} have no formal link to a denomination. In some cases individual church members committed to working in this area started them. At times these projects, once they have become established, are claimed by the denomination as 'their project'. An example of this is the Living Hope Community Centre, Fish Hoek, to which I was directed when enquiring what the Baptist response to AIDS was. The Centre was started by some members of the Fish Hoek Baptist Church, but now operates as an inter-denominational community programme. Other programmes started as church projects and have since become independent NGOs with more or less formal church support. The Wola Nani outreach to People with AIDS, for instance, started as a project of the Anglican St George's Cathedral in Cape Town, but now operates as an NGO no longer regarded as a CPSA project. This means that they can do the work they need to do and take the decisions they need to take without having to consider denominational doctrine, which can be awkward where sexuality is involved.

Much work is being done by groups of individuals committed to AIDS work who run small projects or support bigger ones. The former are not officially church projects, even though some members of one or a number of congregations may support them. Valuable support is given through such projects, but it is difficult to do an exhaustive survey of such informal initiatives. Due to this, I did not include any of them.

Another gap in the survey is that the spokespersons I had contact with might not have been aware of all activities or might not have considered all activities worth

⁹⁶ Limitations to this are discussed in Section 1.5, p 7. See Appendix 1 for a complete list of groups surveyed.

mentioning. So for instance I heard about one group directly targeting men, yet I got this information not from the person responsible for the programme, whom I had interviewed, but from another source. On the other hand it is likely that there was some over-reporting of activities, and it was not possible to check the accuracy of the information given to me in interviews or by questionnaires.

I am aware that I have been unable to achieve my aim of approaching *all* Christian AIDS programmes, and have missed out some projects. Yet, in spite of the low level of active networking between those working in the AIDS field, they are quite aware of each other and I received numerous cross-referrals to projects of other denominations or Christian groups. So while I cannot claim to have made a complete survey of Christian AIDS services provided in this area, I am confident that my survey represents a reasonably accurate profile of the Christian response to HIV/AIDS in the Cape Town area.

4.3.2. HIV/AIDS discourse (See Section 3.1)

As indicated before I did not specifically collect information on the AIDS discourse in the groups surveyed, and can merely report a general impression gained from interviews and reading. Both of these sources draw on the 'informed elite' as far as HIV/AIDS is concerned. Casual conversations with 'normal' church members supplied information on the discourse within.⁹⁷

Another important contribution to the AIDS discourse is made on radio. I have no information on the degree or type of engagement with HIV/AIDS on specifically Christian radio stations. However, Umhlobo Wenene, the Xhosa language service of the South African Broadcasting Service (SABC), with Rev Gideon Nqiwa as director of religious programming, regularly features debates and sermons on this topic. Similarly Radio Zibonele, a local community AIDS radio station, receives strong religious input, amongst others, from the clergy of seven Christian denominations. These fora offer opportunities for discussion and requesting information which are not possible in local congregations as they grant total anonymity to their participants.

In the public discourse of churches AIDS is certainly becoming more prominent. At

⁹⁷ See Section 3.1.1.1, p 33-34; 4.2.1, p 86; 4.3.2, p 90-91 and 5.2.2.2, p 107 on the discrepancy between the discourse at these levels.

church synods and assemblies and in the public statements of church leaders concern is regularly expressed about the AIDS pandemic and its effect on the fabric of society. At this level there is some insight into HIV/AIDS and understanding of it. Yet this has not been sufficiently transmitted to the ordinary membership. In a few congregations HIV/AIDS is mentioned regularly in sermons, prayers and discussions; but this seems to be the exception. The rule is that many regular churchgoers report never having heard AIDS mentioned in their church, or at most quite rarely in general prayers.

The result is that church members generally have a vague idea about AIDS, without really knowing details [Whiteside and Sunter 2000: 138], such as where they are at risk of infection and how they can protect themselves from this risk; and, possibly more importantly, where they are not at risk and where no protection of themselves, and hence no exclusion of others, is needed. A number of denominations are attempting to overcome this lack of knowledge by offering AIDS awareness programmes in their congregations.⁹⁸

Where I had some insight into such programmes, they almost exclusively focussed on biological/medical information, offered guidance and encouragement to persons to make the right choices regarding their sexual behaviour, and often contained some suggestions on showing compassion to those (others!) infected by HIV. Social factors impacting on the pandemic do not as a rule feature in these programmes.

Attitudes towards (anonymous) PWAs are generally quite judgemental, as expressed by the statement: "At least here is one area where I don't have to feel guilty about not giving – they brought it on themselves." This was said with no sense that it is such discourse that strengthens stigma, and hence compounds the pandemic.

4.3.3. HIV/AIDS services offered

This Section describes the general trend in the practical response to HIV/AIDS, following the categories in Section 3.2. Figures in brackets indicate the number of agencies involved. The complete data is presented in Tables 4.1 (denominations) and 4.2 (NGOs) in Appendix 4.

⁹⁸ See Section 4.3.3 (3), p 92.

1) No response at this stage (8 of 18)

The reality of AIDS is still denied in some denominations, if not as a threat 'out there' then certainly as a reality in the own ranks. These denominations have no plans to address the challenge of AIDS, because they consider it to be irrelevant to them. Other denominations have taken decisions to take some action to counter the spread of HIV or alleviate its impact, but have not yet reached the implementation stage. Yet others are involved in AIDS ministries in other provinces.

2) Prevention (See Section 3.2.1.1 and Table 4.4)

Many congregations offer information to increase AIDS awareness for various age groups. Only two groups mention activities specifically aimed at reducing stigma and judgemental attitudes around HIV/AIDS within the own congregation as well as helping members live with PWAs in their midst.

The main focus of awareness/prevention programmes is on youth and young adults. A wealth of material for such programmes with different theological approaches and of varying quality is available. It seems that there is not yet any value-based material for younger children.

Only six of the seventeen churches surveyed have education/awareness activities for youth, and two more for adults. While some of these are intensive life skills programmes, in which sexuality and HIV awareness are a central aspect, offered over up to 30 lessons, others might consist merely of a Sunday service once in a while (a year, even) with an AIDS focus. In churches the latter is more likely, while the more detailed programmes are found in Christian youth organisations that have developed these as their response to HIV/AIDS for their target group – generally for teenagers, and a few also for pre-teens. Most of them offer their programmes wherever they are invited, mostly in schools, but also in churches.

Of the six life skills courses for youth, four specifically mention that they are uncomfortable with advocating condoms and instead place their focus on abstinence. One FBO has the view that, considering the facts around teenage sexual activity, a focus on abstinence and faithfulness is unrealistic; they have regular condom distribution actions. (Churches including such courses/awareness did not specify the

focus of their programmes.)

3) *Care (See Section 3.2.1.2 and Table 4.5)*

Care of those infected with HIV or sick with AIDS related diseases takes various forms. As hospitals and hospices are unable to cope with the huge number of patients needing care, churches and other agencies (8) – often in close consultation with the communities they are operating in and the medical authorities – have established HBC programmes. These programmes offer training, supervision and financial support for volunteer caregivers, who provide basic home care for the sick, such as advice, hygiene, some basic medication, and housekeeping chores.

The majority of the HBC volunteers come from the poorest sections of the community and can little afford to work without compensation and still share the little they have with those they are caring for. Some creative ways of dealing with this include setting up special vegetable gardens for the volunteers, or a fund to pay the school fees for their children [Schoofs 1999: Part 1]. In the Western Cape some of these caregivers are ‘employed’ by the health department and receive a basic stipend; others have contracts with (Christian) NGOs and are reimbursed for their expenses.⁹⁹

4) *Counselling and support for those affected by HIV (See Section 3.2.1.3 and Table 4.5)*

In the area of addressing the need for care for those taking HIV tests or sick with AIDS related diseases, community responses are developing. Medical care is extended through volunteers trained in HBC, as mentioned above. Lay counsellors, many of them from religious communities, are trained and posted in primary health clinics where they offer pre- and post-test counselling. Some denominations have provided training to their clergy to sensitise them to special counselling needs of PWAs. The Moravian Masangane programme is promoting awareness of the special needs in grief counselling for AIDS orphans.

Beyond this support groups are offered in some congregations (10) and FBOs (5). This only becomes feasible once the fear linked to the stigmatisation of PWAs is

⁹⁹ The Catholic HBC agency Caring Network has developed a formula for reimbursement of expenses without the need to offer employment contracts.

overcome sufficiently for them to feel safe to join such groups [WCC 1997: 79-80]. This would require a thorough awareness programme in the congregation. In most instances PWAs are still reluctant to join such groups in their own congregations for fear of stigmatisation. The threshold for joining support groups of other denominations, non-denominational or non-religious groups is lower due to the anonymity they offer.

These groups offer moral support and opportunities to share their experiences, but also practical help for coping with the demands of living with HIV. The poor are most vulnerable to HIV, and once infected HIV exacerbates their poverty. As PWAs are often unable to meet their daily needs for survival, support groups offer, where possible, material support in terms of food parcels, vegetable gardening or income generating projects or at least a nutritious meal at the group meetings. PWAs may also need housing or financial help, for instance for transport fees to enable them to attend clinics. This is one area where efforts are being made to link well resourced and needy congregations through partnerships

5) *Orphans and vulnerable children (See Section 3.2.1.4 and Table 4.3)*

Many programmes offer care for orphans and vulnerable children (8). Programmes for AIDS babies and orphans, like Nazareth House and Beautiful Gate are popular and amongst the best-known AIDS programmes. Between them these two homes care for 80 to 90 HIV positive children who have no relatives capable of caring for them, as they either abandoned the children, have died or are themselves too ill to take on their care. For many congregations supporting one of these institutions materially, financially or with volunteers is a viable way of getting involved in AIDS outreach without overextending their resources. In some cases personal links have been established and families take children into their homes over weekends.

Quite recently the Hope project (supported by a Catholic congregation and secular groups) opened a ward for HIV positive children in Tygerberg hospital. This is linked to community outreach. Another ward for children with AIDS is due to open soon in the Catholic St Josephs home. His People Christian Church is in the process of setting up an AIDS hospice for children under the age of 12.

Realising that institutionalisation cannot be an answer for the majority of HIV

infected and affected children due to the huge numbers, Nazareth House has recently started a day care centre for HIV positive children in Khayelitsha. Here the emphasis is on equipping the community to care for its own AIDS babies. The Anglican Fikelela project offers a similar service.

6) Programmes targeting men (See Section 3.2.1.5)

Very few programmes directly target adult men: The Full Gospel Church of God in Southern Africa congregation in Guguletu has recently started a Men's Fellowship group dealing with HIV/AIDS, family enrichment and other related topics. It is an inter-denominational group of men of different age groups. A special concern is helping ex-prisoners re-integrate and deal with the reality of HIV. Hope Worldwide offers male (and female) support groups. The Salvation Army does not offer specific men's programmes, but makes a special effort to attract men to their awareness programmes for adults, which are normally attended by far more women than men (a ratio of 8:1).

There may be other programmes targeting men, and surely some of the support groups cater for men, too, but they are certainly not a high priority in the church response to AIDS.

7) Involvement to counter the social causes of AIDS (See Section 3.2.1.6)

The leadership of the Anglican and Catholic Churches as well as the South African Council Of Churches (SACC) have given support to TAC in recent efforts calling for the publication of the Medical Research Council (MRC) Report and regarding their court case to force Government into speedy implementation of the MTCTP programme. Locally the Masangane project is organising support among Christian groups and individuals for the work of TAC.

8) Theological response and worship (See Section 3.2.1.7)

The theological response would be expected at denominational (national or diocesan), rather than at local level. There are joint efforts to develop curricula for theological seminaries and colleges for training of clergy (including in-service training) to equip

them to respond theologically and practically to HIV/AIDS [Paterson 2000: 9].¹⁰⁰

Little has been reported in the section on worship in the questionnaire, although I am aware of a number of denominations organising special services, at least around AIDS Day (1 December) and providing special liturgies for these.

9) *Training*

Training is provided in various categories.

- There are programmes for church leaders to raise awareness and sensitise them to the needs around HIV/AIDS.
- Programmes offer training to facilitators for HIV prevention, to clergy and other church workers to equip them as lay counsellors.
- The Faith-based AIDS Counselling and Training Group (FACT) programme offers ongoing training and supervision for leaders of AICs in Guguletu and Khayelitsha to equip them to raise AIDS awareness and offer counselling in their congregations. This programme deserves special mention as an effort where the facilities and staff of well-resourced programmes are used to train and support members of disadvantaged communities.
- Numerous programmes train 'volunteers' to provide HBC.
- There are moves to restructure the syllabi at theological institutions to include AIDS in all aspects of the training of clergy.

10) *Response addressing the scale of the need (See Section 3.2.2)*

Some attempts to *network* Christian or faith-based AIDS services and collect the information about these groups in databases or directories are starting. The aim is to make cross-referrals possible, avoid duplication, co-ordinate activities and promote proven best-practice models. Occasionally different agencies join forces in a network to offer a service jointly, that none of them could offer alone. The FACT programme is one example of this.¹⁰¹

Another way of responding to the scale of the AIDS pandemic is by *building the*

¹⁰⁰ See also *Report on the HIV/AIDS Curriculum Development Consultation for Theological Institutions in Eastern and Southern Africa*. Sadly, I have been told that the recommendations of this consultation have, like so many others, ended up on a shelf and have not yet been implemented.

capacity of communities. The only evidence of this I found in my survey was in the new initiative of Nazareth House and Fikelela to help the Khayelitsha community care for the OVC in their midst; and in the Catholic Church's national strategy for communities to care for orphans. The latter was based on the deliberation of experts in the field of OVC, convened by the Goedgedacht Forum, a Catholic forum for social development, during 2000 and 2001. Since the capacity building of communities is not directly linked to HIV/AIDS, other instances of such work done by churches may not have been reported.

11) Response appropriate to the Church's self-understanding (See Section 3.2.3)

The lack of theological reflection on the HIV/AIDS pandemic has been mentioned repeatedly and the recent spate of articles in local theological journals is hopefully an indication that this is changing.

It is difficult to link the specific institutional response to such criteria as service to the poor, or providing safe spaces, although clearly such motivation must have informed many responses. Certainly the vast majority of Christians involved over the whole spectrum of HIV/AIDS services is motivated to some degree by the factors mentioned in that section.

12) Other responses

The AICs represent about half of the Christians in the Cape Town area. As far as AIDS is concerned they are a crucial group, as they have their base in the disadvantaged communities where HIV and AIDS are most devastating. Generally leaders of these churches lack the skills to deal with social issues. While family and marriage issues are discussed, they shy away from dealing with sexuality, especially in mixed groups. Doubts were raised whether the strict moral codes in many of these churches did also apply to sexual behaviour. Where directly confronted with the reality of AIDS the most common response is to offer prayers and emotional support. Clergy from these groups have responded enthusiastically to the opportunity offered by the FACT training programme.¹⁰²

¹⁰¹ See point 9) on this page.

¹⁰² See point 9) of this Section, p 96.

4.4. Conclusions from comparing the "ought" with the "is"

Overall the type of programmes offered reflects the type of response identified as necessary. Responses mentioned most commonly generally occur more commonly than others, i.e. caring for PWAs, providing factual information about HIV and AIDS, promoting abstinence and faithfulness. However other tasks considered important by many of the institutions are not (yet) addressed in practice. These include addressing the AIDS stigma and related discrimination, promoting gender equality especially in the own group, advocacy for access to health services and treatment (and advocacy/lobbying generally) and developing a theological response.

While all reports mention the need to respond to the pandemic, numerous churches have no programmes in place at this stage.

The type of programmes offered to care for PWAs, emphasising HBC and institutions of care (hospice, orphanage) correspond to the perceived tasks. There is a striking discrepancy, though, in the low rating accorded the care for OVC if compared to the popularity of programmes for AIDS babies both in the 'common discourse' and considering actual programmes offered.

Prevention is seen as an important task, and many FBOs offer education at different levels to further awareness. In some cases this also aims at reducing stigma. The emphasis on abstinence and faithfulness in the statements agrees with the focus of prevention programmes offered. A number of these do however offer condoms as an option, even though this is not directly mentioned at all in the statements.

The perceived need for open discussion about human sexuality has not yet been widely translated into action in churches. As far as I could ascertain FBOs involved in life-skills training, like Scripture Union or Youth for Christ, do this more efficiently and reach a larger audience as they operate in public and private schools.

In agreement with stated objectives training of clergy and other church workers for counselling has been initiated in some groups.

A few support groups for PWAs have been established, but they do not attract many members as fear of stigmatisation still prevents many PWAs from disclosing their

status. Possibly this is linked to the fact that while many mention the need for establishing such groups, only one institution considered the training of clergy for this important.

Networking within the faith-community and with societal structures does not play an important role either in the perceived tasks or in the reality.

Caring for carers is hardly seen as a need. This agrees with the lack of provision of facilities to provide such care. Generally it seems surprising that offering spiritual care to the various groups affected by HIV is hardly mentioned in the statements. Possibly this is so 'natural' to the church that it does not warrant mention. It does however reflect a weakness in the actual response.

4.5. Concluding comments

In this chapter I have given an overview of the response of churches and Christian groups to the HIV/AIDS pandemic, considering both what they say ought to be done and the actual services they offer. The overview is based on recent literature as well as on the survey conducted amongst Christian groups in the Cape Town area. The actual response was then compared with the perceptions on what ought to be done.

In the final chapter I attempt an evaluation of this response by drawing on previous insights about the connection between discourse and practice as well as the critique of the common AIDS discourse raised in Chapter 2, and on the criteria for an appropriate discourse and response developed in Chapter 3.

Chapter 5. Evaluation and conclusions

In this chapter I present my evaluation of the response of Christian groups in the Cape Town area to the HIV/AIDS pandemic, as it is presented in the previous chapter. I do this first, by locating the evaluation in the theoretical framework; second, I briefly comment on the degree to which each of the criteria developed in Chapter 3 is met by the response; third, I point out some areas of concern arising from this; and lastly I suggest some implications for churches and also for future research.

But some disclaimers in advance:

- Evaluating something as complex and diverse as the Christian response to HIV/AIDS is a daring and possibly presumptuous undertaking; especially for one who has herself very little practical experience of involvement in this area. Yet, being a few paces back from the coalface allows an overview that few have who are directly involved in directing or implementing an HIV/AIDS ministry. So I risk it anyway, with the hope that some of the insights I have gained on the way may be helpful to others.
- I hope to be able to offer my concerns without being judgemental and I apologise in advance where I will fail in this.
- If what I say in any way seems to take away the credit due to the many dedicated Christians (and others) who are doing extensive work in HIV/AIDS ministries, let me state here quite emphatically that this is not what I intend. In the face of a still hesitant and ambiguous government response, the compassionate care and solace from religious and secular NGOs is for many of those affected by HIV/AIDS the only help that is available [Van der Vliet 1996: 46]. Christian individuals and groups are making a crucial contribution to this which I respect and honour.

And yet, critical questions have to be asked and concerns have to be raised.

5.1. Locating the evaluation within the theoretical framework

Clearly the last two to three years have seen a turn-about in FBOs regarding HIV/AIDS. Many Christian groups who had until recently not believed that this

pandemic was a challenge to them, have come to a different conviction – often characterised by the slogan “The church has AIDS” – and have initiated some AIDS related response. Many new programmes and projects have been initiated and much valuable work is being done in many areas. AIDS is no longer the concern of a few; it has become an issue of and for the churches.

It seems timely to ask now, a few years into this more concerted drive against HIV and AIDS, whether the way churches and Christian organisations are taking on the challenge of responding is appropriate. In attempting to do so, I am guided by the following insights:

5.1.1. Discourse and practice are inherently connected.¹⁰³ If this is generally true, it is certainly true for churches, where much of the ‘activity’ is discourse based; and many of the convictions undergirded by sacred discourses from the past. What is said and what is kept quiet, how issues are understood and how this understanding is voiced, have a direct impact on what is done (or not done) and how it is done. I will illustrate this theoretical principle by showing the connections between the discourse and practise in each of the ‘areas of concern’.

5.1.2. Susan Sontag’s analysis of the metaphors of AIDS has made clear how easy it is to link HIV/AIDS to previous epidemics and the judgements they raised, through unconscious use of language and metaphors.¹⁰⁴ Specific instances of this will be pointed out.

5.1.3. Gill Seidel showed how the different AIDS discourses in Africa can be classified – and more importantly used – as instruments of empowerment or of control.¹⁰⁵ I will draw attention to instances of the latter and opportunities for the former.

5.1.4. While much of the AIDS discourse, along with the emotional and practical response it generated, was shaped in the West, authors like Magesa and Gausset

¹⁰³ See Section 2.1, p 9-17.

¹⁰⁴ See Section 2.2, p 17-20.

¹⁰⁵ See Section 2.3, p 20-26.

have pleaded for the traditional African discourse to be taken seriously.¹⁰⁶ In South Africa, where white rule – with all it entailed – was entrenched for longer than elsewhere in Africa, and more effort was invested in discrediting African values and their way of life, it is all the more important to take seriously the challenge these authors pose.

5.1.5. The criteria for the AIDS discourse and response draw on this theoretical foundation.¹⁰⁷ They spell out some of the implications of these insights in response to three concerns:

- Is the response appropriate to the reality of the HIV/AIDS pandemic?
- Is it appropriate to its local context: being located in sub-Saharan Africa, in South Africa with the highest number of infected persons worldwide, and again in the Cape Town area with its specific opportunities and challenges?
- Is the response appropriate to the self-understanding of the church?

I refer back to the criteria, in the form they were spelt out in Chapter 3, for a first round of my evaluation, checking the response against each of them. Following that I highlight twelve more general areas of concern arising from this, and point out some connections between discourse and response in these.

5.2. Evaluation of the response

5.2.1. The degree to which the response satisfies the criteria of appropriateness

(1) Breaking the silence/Countering stigmatisation (See Section 3.1.1 & 3.1.2)

The nature of AIDS is such that it is absolutely essential that the silence about it needs to be broken. This has been discussed in detail elsewhere.¹⁰⁸ At this point I merely point this out as one area where the churches' response is not appropriate: First, ^{Schmidt's opinion} HIV/AIDS has not yet become part of the common Christian discourse. Second, when it is raised it is not done in a way that ^{does not} promotes understanding of this complex pandemic, that dismantles stigma and promotes a committed response.

¹⁰⁶ See Section 2.4, p 26-31.

(2) AIDS discourse addressing societal aspects (See Section 3.1.3)

For the discourse to be appropriate to both the reality of the disease and the specific context, it has to consider the causality in terms of an ecology of AIDS, including various factors. In our context the crucial ones, apart from the historical era in which HIV entered the country are poverty, the impact of gender on power in society and in relationships, and migrant labour. In the common discourse I found very little indication of awareness that social factors impact on individual choices or lack of choice; nor of the degree to which such a moral discourse contributes to stigma – issues which are increasingly receiving attention in the public and academic Christian AIDS discourse.

(3) Response covering the spectrum of needs (See Section 3.2.1)

In order to be appropriate to the pandemic the response ought to cover the wide spectrum of needs related to HIV and AIDS, such as prevention of new infections, care for the sick, counselling and support for those affected in any way by HIV, special measures to provide suitable care to orphans and vulnerable children. In all of these areas numerous ways of responding to the needs are being offered. Ministries for children, especially babies, are the most ‘popular’, both in terms of the number of FBOs offering such services and in the support they garner from the (Christian) public.¹⁰⁹ While prevention education is quite widely offered by the FBOs surveyed, some of the awareness raising, especially by churches (as opposed to NGOs), is quite superficial.

Other areas of need are not addressed appropriately: Targeting men, which ought to be a special concern due to the role men play in driving the pandemic, is not yet being widely addressed. Too few FBOs have initiated responses specifically for men or make a concerted effort to involve men in the programmes they offer. Lobbying around HIV/AIDS concerns has until very recently been avoided by most churches. A growing number of FBOs are adding their voices to calls for justice towards PWAs. While uplifting poor communities, addressing unjust structures, and working for empowerment of women have long been on the agenda of many FBOs, their

¹⁰⁷ See the whole of Chapter 3, p 32- 81

¹⁰⁸ See Sections 3.1.1, p 32-39 and 5.2.3, p 117.

¹⁰⁹ See Section 4.3.3 (5), p 94-95 and 5.2.2.12, p 114.

involvement to counter the social causes of AIDS is difficult to evaluate, as it is not specific to the pandemic and is a very long-term effort.

Christian leaders response to spiritual needs of P.W.A.
The spiritual needs of those infected or affected seem to be often left to the general counselling duties of clergy. It seems that there is not yet a sufficient realisation of the specific spiritual needs of those affected by HIV and the barriers facing PWAs who would want to turn to their congregations for support, but a few FBOs have risen to the call and are offering special forms of worship and spiritual support.

(4) Response addressing the scale of need (See Section 3.2.2)

First, the degree to which volunteers are both trained to provide AIDS services – mainly HBC and lay counselling – and supported in this work by FBOs, demonstrates their acknowledgment that the pandemic far exceeds the capacity of existing institutions. It is an area where churches soon realised the need and responded in an appropriate way, for which they were well equipped with their tradition of service. Yet even here the dilemma of expecting volunteer service from people themselves desperately poor, whose possible employment poses difficulties, as it has to comply with liberal labour laws, shows that the traditional mould has to be adapted.

Second, the response to the needs raised by the many children orphaned or made vulnerable by AIDS has its prime focus in the provision of institutional care for babies and small children. Orphanages may be necessary in some instances as there are children in need of shelter who have no adult relatives left, or at least none well enough to take care of them. As main response to AIDS they are not appropriate to the need as they are costly interventions that only benefit a few. Without in any way discrediting the value of such work, it has to be noted that it does not address one of the urgent needs arising from the orphaning of great numbers of children: The reality that tens of thousands of young children and teenagers are growing up without parental guidance and a sense of belonging, many of them having to take on the care of dying parents and the responsibility for younger siblings. An appropriate OVC response needs to address the serious implications this will have for the South African society.

In both areas mentioned here an appropriate response has to involve strengthening

communities to offer care for the sick and support to those affected.¹¹⁰ Some moves are being made in this direction, notably within the Catholic domain.

Another concern that needs to be addressed is the lack of networking.¹¹¹ The scale of the pandemic is such that a common response to it is essential. Yet Christian groups around Cape Town seem largely content to develop their own response, often without first enquiring what is already being done and what can be learned from the experience of others.

(5) Response appropriate to the Church's self-understanding (See Section 3.2.3)

The theological response to the pandemic has until a year ago been poor. Recent publications seem to indicate that this lack is being recognised and a response is developing.¹¹² At this stage it is difficult to assess how appropriate this is in terms of countering stigma or developing a comprehensive understanding of the pandemic.

It has been said that churches have been slow in recognising in the HIV/AIDS pandemic a special and urgent call to demonstrate their participation in God's preferential option for the poor by reaching out to those affected by HIV; to take on the call for prophetic ministry; to open up their communities to become safe spaces for those afflicted by AIDS; or to take a definite stand against hurtful and damaging superstitions around HIV and AIDS. All of this is related to the difficulty in overcoming the attitude of judgement in their own midst. But it is slowly progressing.

5.2.2. Areas of concern regarding the response of churches to HIV/AIDS

5.2.2.1. Ambiguity

From the beginning of the pandemic some Christians, churches and church-related institutions have been active in education and prevention programmes, and in caring for people living with HIV/AIDS. But it is the judgement of the [consultative] group that by and large the response of the churches has been inadequate and has, in some cases, even made the problem worse [WCC 1997: 4].

While some churches have been faithful in their witness towards PWAs, others have contributed to the stigmatisation and discrimination against them [WCC

¹¹⁰ See Section 3.2.2, p 71-74 and 4.3.3 (10), p 96-97.

¹¹¹ See Section 3.2.1, p 58-59; 4.2.2, p 87; 4.3.3 (10), p 96-97 and 5.2.2.5, p 109.

¹¹² See Section 3.2.1.7, p 70-71 and 3.2.3.1, p 75-76.

1997: 44].¹¹³

The ambiguity expressed here regarding the response of churches and FBOs worldwide to HIV/AIDS is common to many evaluations of their response. Some examples of this follow.

Churches have the infrastructure and the credibility to offer information and care and have in numerous instances used it to lessen the impact of the pandemic; but their ^{However} often moralistic attitude to sex, ^{words} when it is mentioned at all, makes it difficult for those affected to disclose their status and this causes many of them to feel "that their churches are the last place they would go for help" [Paterson 2000: 6]. In churches they experience (or fear) being labelled 'sinners' and 'fornicators' [Paterson 2000: 8]. And they continue to seek help elsewhere.

The judgement is based in a discourse that fails to see the bigger picture and is still ^{Church} ^{see} determined by the early claims of "AIDS is God's wrath on the sinner"; it seeks solutions exclusively in medical technology and changes of individual behaviour. This can go so far as to advocate exclusion from churches as a measure to enforce compliance with norms for sexual behaviour [Garner 2000: 13-17]; a clear example of what Seidel calls a discourse of control. ^{Churches exercise a}

The message of chastity and monogamy can be a powerful one for protection in communities where the religious beliefs are dominant in forming values and influencing behaviour. In view of the limited impact of AIDS prevention programmes on changing behaviour such contributions, even if small, are important. The great risk is that churches will use those who are infected as 'object lessons' for what happens when you leave the narrow path prescribed by their teaching, thereby increasing the stigmatisation of PWAs and those close to them [Van der Vliet 1996: 46-7] – another instance of using discourse for control rather than empowerment.

As the WCC executive committee noted in 1987,

¹¹³ The WCC study group provide no detail of this either here or elsewhere in this document. While this is understandable as there is not much to be gained from pinpointing culprits, it would have been helpful to pinpoint behaviours, actions and words that stigmatise and discriminate, as often those who are 'guilty' of this are not aware of the effect of their words and actions. It is in this sense that I am pointing out such attitudes in this study.

¹¹⁴ See section 2.3, p 26.

through their silence, many churches share responsibility for the fear that has swept our world more quickly than the virus itself. Sometimes churches have hampered the spread of accurate information, or created barriers to open discussion and understanding. Sometimes they have reinforced racist attitudes by neglecting HIV/AIDS, because it occurs predominantly among certain ethnic or racial groups, who may be unjustly stigmatized as the most likely carriers of the infection [WCC 1997: 4-5].

For the South African context Lindegger [1995: 3] states that churches together with education departments have opposed moves to address sex and sexuality in a more open way, claiming that this would promote promiscuity. All of these are examples of a discourse that seeks to exercise control.

The role of women and their position in society is another area of ambiguity. This is dealt with separately.¹¹⁵

Ambiguity is apparent, too, where church groups offer help, yet shy away from getting personally involved. Joy Wilson tells that she is often invited into churches as speaker on AIDS.¹¹⁶ There are always big audiences, as people want to know and want to help. But when she specifies what help is required – befriending PWAs, assisting them in daily tasks, inviting them into homes – none is offered.

5.2.2.2. Speaking in public vs. Speaking inside

To a large extent churches are still silent about HIV/AIDS. While their public discourse does focus increasingly more on this burning issue, the discrepancy between such discourse and what is being said and heard within churches has been pointed out before.¹¹⁷ The type of discourse is almost exclusively medico-moral; some voices are raising human rights issues related to HIV, but that is largely confined to the circle of the 'expert elite', and hardly filters down. The use of terminology linked to the 'fighting AIDS' metaphor – complete with enemy images, us and them – is predominant. Where churches, due to a lack of 'AIDS experts' in their own ranks, invite persons like directors of AIDS services or TAC activists to address them, this presents an opportunity for opening up church discourse beyond the narrow medico-moral. But perceptions don't usually change on the basis of one talk. It will take a

¹¹⁵ See Section 5.2.2.8, p 111-12.

¹¹⁶ Interview with Joy Wilson, founder of the "Joy for Life" drop-in centre for people affected by AIDS.

¹¹⁷ See Section 3.1.1.1, p 33-34; 4.2.1, p 86; and 4.3.2, p 90-91.

concerted effort to turn around the judgemental discourses, bent on control, that are deeply entrenched and also easier to hear.

5.2.2.3. Traditional care vs. Prevention

Care for the sick is the traditional domain of the Church. Hence the increase in Christian involvement in AIDS services once the pandemic had reached the stage where more PWAs had progressed beyond the asymptomatic stage and needed medical care. The value of the contribution made by churches in providing HBC to many, and specialised hospice care to some AIDS patients, cannot be stressed enough.

In order to make an impact on the pandemic, however, new infections have to be prevented. To do this effectively comprehensive programmes are needed and this in turn implies that a number of uncomfortable topics have to be addressed openly: sexuality and sexual behaviour, patriarchy and the lack of power this implies for women and girls to make choices regarding their bodies, poverty and socio-economic injustice. As long as the effort of FBOs to provide care for those infected is not matched by their commitment to such prevention programmes, their response will be avoiding major causes of HIV infection and cannot be judged appropriate.¹¹⁸

Of course, it is not really a matter of providing either care or prevention, as the two are linked. Largely the connection between care, treatment and prevention has not been realised and the potential of work done in caring for AIDS patients is not sufficiently used to motivate prevention.

5.2.2.4. Institutional response vs. Building community capacity

The response to HIV/AIDS has to bear in mind the scale of the pandemic.¹¹⁹ Current predictions speak of close to 2 million orphans by 2010 in South Africa. 20% of all deaths will soon be AIDS related. Two direct concerns arise from these figures:

The response to care for those dying of AIDS related infections quickly moved towards non-institutional, community-based interventions, with hospice interventions far outnumbered by HBC programmes. The response in the area of care for OVC,

¹¹⁸ As shown in Section 4.3.3, p 92 numerous FBOs *do* offer prevention programmes; the issue, however, is whether these are conducted in a way that can and will bring about change in perceptions and in behaviour – issues related to the degree of commitment to such messages and their content.

however, has remained largely in the institutional realm. Attempts to consider these issues and plan a national OVC programme have been undertaken by the Catholic Church. Their planning of a response was closely linked to two rounds of debates between various experts in the field, organised by the Goedgedacht Forum for Social Reflection. It is an instance of informed discourse preparing the way for an appropriate response. Most of the OVC responses are not based on such deliberations, causing AIDS workers from Uganda to call for less rushing into a response with 'bleeding hearts', and more reasoning and thinking about what is needed [Paterson 2000: 2].

A question I want to merely raise – and not pursue – in the context of the tendency towards an institutional response, is how this relates to the desire to hold onto control, rather than work for empowerment,¹²⁰ a question linked in our context to the reality that this control is mostly in the hands of white, western directors of AIDS services.¹²¹

5.2.2.5. Doing our own thing vs. Joining hands

I have pointed out elsewhere the lack of networking,¹²² as well as the failure to develop a *common* Christian AIDS discourse.¹²³ The scale of the pandemic is such that a common response to it is essential. Yet Christian groups seem content to develop their own response, often without first enquiring what is already being done and what can be learned from the experience of others. Where some groups are willing to share their experiences and findings with others, this is not matched by an awareness that they themselves might benefit from the experience or insight of others. The inability to listen to one another and find opportunities where this can happen is reflected in the inability to work together in practice. This results in duplication of material and mistakes, wasting energy and limited resources. It is another way in which discourse and practical response are linked.

Another result of this lack of networking is that a response is planned without a clear overview of the needs and the existing services. Hence some types of popular

¹¹⁹ See Section 3.2.2, p 71-74.

¹²⁰ See again Section 2.3, p 26.

¹²¹ See Section 5.2.2.9, p 112-13.

¹²² See Section 3.2.1, p 58-59; 4.2.2, p 87; 4.3.3 (10), p 96-97 and 5.2.1 (4), p 105.

¹²³ See Section 3.1.4, p 55-58.

programmes proliferate while other areas of need are not addressed.¹²⁴

5.2.2.6. *Charity vs. Activism*

Charitable responses to immediate needs are part of the traditional repertoire of Christian interventions. In a pandemic presenting so many desperate needs, these measures are needed to relieve suffering. Yet charity will not address the root causes of many of the problems raised by the HIV/AIDS pandemic. Even as churches need to add their voices to the call on government to make available medication to those infected (and on rich governments elsewhere to support funds set up to finance such medication for poor nations), they need to keep in mind that while medical treatment may alleviate the suffering for many, it will not solve the problem. That will only be achieved at a different level, where societies “address the inequalities and injustices facing people, the issues around gender and culture, around poverty and lack of access to resources” [Munro 2001: 4], and thus make changes in behaviour feasible. Issues like migrant labour, poverty, gender inequality and the lack of access to available medication have to be addressed, through lobbying of those in power in governments and industry and through advocacy work.

This is a challenge that few FBOs have taken up thus far. Even those with a tradition of supporting the struggle against apartheid, like the SACC and its provincial offices, have not yet taken on this new struggle.

As second point that has to be raised in the face of a charity-response is that charity is a way of keeping the HIV/AIDS at a distance, as charity is something we do for others. This is related to the one reasonably common occurrence of AIDS in the church discourse, as I have experienced it: as one item in the list of ‘poor’ – that is them, not us – included in the prayers of intercession.

5.2.2.7. *The poor vs. The rich*

Some initiatives aim to link the resources of well-off congregations to needy groups in disadvantaged areas, who bear the brunt of the pandemic [Nicolson 2000: 12]. The AIDS pandemic has, however, not merely highlighted the existing inequalities in our society, but to some extent exacerbated them. For some PWAs anti-retroviral

¹²⁴ See Section 5.2.1 (3), p 103-04.

treatment is financed by medical aid schemes or high salaries; balanced nutrition and food supplements sustain the body's immune system; and hospital and hospice care are within reach in times of medical need. For the great majority of those affected by HIV/AIDS there is no means of obtaining any of these. Many congregations reflect the race and class profile of the residential areas in which they are located and few bridges have been established to link the resources from the well-off denominations and congregations to the needs of the poor. It is interesting to note in this regard the inordinately high number of AIDS services, as well as head quarters of national and international AIDS service agencies based in Cape Town; whereas other areas with much higher HIV infection rates, and much greater need, but fewer 'attractions', are severely under-serviced.

AIDS offers here, as in many other areas, an opportunity that the majority of churches have yet to grasp [Nicolson 2000: 11]. The challenge for them is to become 'development brokers', linking those with resources to those in need of them. Even churches pleading poverty are in a favourable position to raise funds locally and internationally, with potential donors waiting for someone through whom to channel their funds towards the most needy [Loudon 2000: 6].

5.2.2.8. *Men vs. Women*

In the understanding of many believers religious conventions require women to be subservient to men. Thus they remain silent and comply with their partners' sexual demands, even when they suspect that they have been unfaithful. Anane [1999: 86] quotes the opinion of an AIDS worker that "religion is the biggest problem" in fighting the spread of HIV, as it encourages subservience where it should be promoting "spousal communication". Both claims constitute a huge challenge to assess, and where needed, to adjust the discourse around relationships and gender in churches.¹²⁵ Numerous Christian groups do proclaim equality of men and women and some actively advocate against such abuse, supporting the empowerment of women.

Yet the reality of an overwhelmingly patriarchal structure remains the norm for most churches. 'Women's issues' as a result stay mostly at the bottom of the agenda; but at least they have made it onto the agenda, have become part of the discourse, which is

¹²⁵ The marriage vows are a case in point.

primarily shaped by men. This is also true for the churches discourse on HIV/AIDS; and is reflected in the planning of programmes and allocation of funds, even in this area where overwhelmingly the work is done by women.

A similar concern arises with another group largely excluded from decisions about the AIDS response:

5.2.2.9. *Western solutions vs. African solutions*¹²⁶

Most NGOs dealing with Aids are run by white people, often expatriates. Undoubtedly, all of them have the best of intentions but they lack rooted-ness in the local culture, a prerequisite for effective prevention programs. Aids prevention will become effective, only when South Africans find their own solutions [Viljoen 2001: 7].

African and Western understandings of illness and wellness and the implications this has for HIV/AIDS differ widely [Saayman and Kriel 1992: 34-44]. Medical missions have traditionally over-identified with the medical paradigm. "Historically, churches do not have a good record in their respect for African culture," says Nicolson [2000: 12]. They have, with few exceptions, demonstrated an inability to include African discourse, and instead follow Western models, resulting in interventions that do not fit the context [Munro 2001: 3; Viljoen 2001: 6-7]. In our context such a one-sided approach is inappropriate as it marginalises the traditional African worldview and those adhering to it, thereby making it impossible to build a joint response against a common threat [Paterson 2000: 27].

Munro suggests a way forward:

.... it is only when we grapple with that [African] worldview, and come to terms with it, and challenge it where it needs challenging, that we will begin to make significant inroads into the problem we face [Munro 2001: 3].

Why, I am compelled to ask, does she not add "... and be challenged by it"? Why is the richness of the African traditional discourse with its holistic view of being and its emphasis on relations so rarely seen as opportunity, and so often merely as something needing correction, as Gausset pointed out so forcefully?¹²⁷ What needs to happen is a dialogue between two equal partners making it possible for the technical

¹²⁶ Refer to Section 2.4, 26-31.

¹²⁷ See Section 2.4, p 28-30.

understanding of the HI Virus to be complimented by the African emphasis on community and holistic well-being.

If it was possible to a large extent to overcome the artificial polarisation between either advocating condoms or abstinence and faithfulness, which dominated the AIDS discourse for some time, so that now many 'religious' and 'medical' interventions emphasise both the importance of responsible relationships and the use of condoms; surely it should be possible to overcome the polarisation between Western and African understandings and ways of responding to AIDS and find common ground.

The existing disparity in the current discourse is reflected by the reality in the practical response, where attempts to placate the ancestors clash with keeping a commitment to treatment; where it is difficult to resolve whether the little money that is available should be allocated to immune boosting food supplements or saved towards a 'decent funeral'. The reality is that the two discourses and the responses they give rise to, are at times in conflict. It does happen that patients consulting a traditional healer are advised to discontinue treatment, and die soon after. Conversely, those in Western treatment are often discouraged to honour their traditional responsibilities, with detrimental consequences for their spiritual and relational well-being.

5.2.2.10. Dealing with sin vs. Dealing with a virus

The way in which churches define the challenge of HIV/AIDS impacts on the way specific theological issues arising from it are dealt with, which in turn will influence the type of response that will be developed [Paterson 2000: 4]. One of the dichotomies at issue here is that between the world of development and the world of the churches. Is the response planned in terms of concepts like empowerment, capacity building and structural change or in terms of sin, salvation and unconditional love? Finding an answer and an unambiguous way forward implies raising and answering questions like:

Which is the problem: the virus or the sin? What is the goal? Is it prevention of disease or salvation? Has the women with HIV been unwise, or powerless to help herself, or wicked? Should responses be interventionist (condoms, pharmaceuticals) or moral (abstinence, faithfulness) [Paterson 2000: 3]?

5.2.2.11. AIDS services vs. AIDS ministries (The specific Christian contribution to a response to HIV/AIDS)

One fundamental weakness in the Christian response is the failure to consider the implications of HIV/AIDS theologically. The attempts at formulating joint curricula for institutions preparing church workers for their ministry are steps in this direction.¹²⁸ But generally, beyond developing material for awareness and prevention work (often based on that of secular programmes), there is an overwhelming silence of theology with regards to AIDS. As a result too much of the Christian response consists of either falling back on what churches have always done or duplicating what secular agencies are doing, rather than developing a response with a specific Christian ethos [Munro 2001: 4].¹²⁹ Allowing secular interventions to determine the response is one more way in which copying what is done in the West simply does not fit our context.

In interviews with AIDS activists many of them emphasised the spiritual questions raised for those who discover that they are infected.¹³⁰ As yet, apart from counselling support to individuals courageous enough to approach their clergy, little help is offered to PWAs to accompany them on this path and help them find ways of dealing with issues of guilt and shame, with their inability to believe in a loving, caring God or to find meaning in their lives.¹³¹ Churches have to recover the resources enabling them to offer healing, compassionate community. It is clear from the choices PWAs make, that in many cases their congregation is not the place where they (expect to) find this.¹³²

5.2.2.12. Guilt vs. Innocence

Sadly, some Christians have only compounded the sense of isolation by their attitude and their pre-occupation with judgement and the logical discussion about innocence and guilt, right and wrong [Sims and Moss 1991: 85].

Christians speak of support for all PWAs, yet their programmes offer such support

¹²⁸ See Section 4.3.3 (8), p 95.

¹²⁹ In many regards there may be no need to work in a specifically Christian way, but without a clear understanding of where the challenge to churches lies, it will be difficult to know which those are. And it will be likely that the specific contribution Christians are able to make to the overall response to HIV/AIDS is not developed.

¹³⁰ See Section 3.2.1.7, p 70-71 and 5.3.4, p 119.

¹³¹ See Section 5.3.3, p 117-19 for ways in which liturgies can be used for this purpose.

mainly to children (AIDS babies and orphans) and women, rarely to men, especially not to those who are homosexual. Only one FBO offers an AIDS related service to prisoners. When referring to children born with HIV some speak of 'these most innocent victims'. Does this imply that some PWAs are totally innocent, some slightly innocent and others not at all, in other words guilty? Does it furthermore imply that it is valid, moral and Christian to help those most innocent, but not those who must be 'guilty'? This harks back to the issues raised by Sontag about metaphors of AIDS, especially those of war, which create categories of us and them, of innocent victims and others, of enemies and insiders.

This use of language, the choices and the possibly unintended judgement inherent in it, is prevalent in churches. It shows up in other areas, for instance in sexuality education teaching young people to make the 'right' choices – as opposed to 'wrong' ones.¹³³ It is fear of such judgement, whether direct or hidden, which causes a majority of HIV positive Christians to go to secular organisations for support rather than to their own clergy or congregations.

5.3. Some Implications for churches

5.3.1. Developing a theological framework for the response

The lack of theological reflection on HIV/AIDS has been mentioned above.¹³⁴ Some specific suggestions for moving forward in this area are given below.¹³⁵ At this point I merely stress once more the urgency for churches and theologians to develop a theological basis for their response to the pandemic; especially the need to do so within the tradition of liberation theology.¹³⁶ A special challenge in adopting this paradigm lies in the fact that in the AIDS pandemic there is no identifiable group to claim liberation. 'The poor' or 'the promiscuous' – often regarded as such groups –

¹³² See Section 3.1.2.3, p 44 and 5.2.2 (1), p 106-07.

¹³³ See Section 4.3.3 (2), p 92.

¹³⁴ See Section 3.2.3.1, p 75-77.

¹³⁵ See Section 5.3. 1, p 115-16 and 5.4, p 122-26.

¹³⁶ See relevant comments by West in Section 3.1.1.1, p 36-37; by Nicolson in Section 3.1.3, p 45-46; and by Maluleke regarding the new Kairos in Section 3.2.3, p 75.

would hardly be keen to identify themselves under such a label.¹³⁷

5.3.2. Leadership

Paterson [2000: 7] mentions “lack of leadership in churches” as a reason for the failure of some churches to respond to the AIDS pandemic. Speaking to those involved in AIDS work it is evident that many of the programmes in churches and Christian organisations resulted from the conviction and efforts of individuals who saw the need and responded to it. A number of these activists express frustration at the lack of support they receive from their church leadership, and the resentment they experience from colleagues for continuing to mention this ‘unsavoury topic’.

There is a general need for leaders to be sensitised for the challenge HIV/AIDS presents and to own up to this.¹³⁸ While it is unlikely that many in leadership positions are able to take on the added burden of AIDS related work, it is they who have the power to ‘open the doors’ and make it possible for others to become involved.¹³⁹ It is the leadership that is able to designate people and resources in the churches for a response. This is true on denominational as well as congregational level. It is also those in power who are challenged to “construct a bridge of tolerance” to those who are unable to live up to the high standards set for sexual behaviour, for instance by admitting that condoms can save lives [Anane 1999: 94].

The discrepancy between public and internal church discourse has been mentioned.¹⁴⁰ It must be stated categorically that the public pronouncements of leaders are crucial. It is such leadership of those in high profile public positions that has contributed to the success in slowing down HIV infection rates in countries like Thailand and Uganda [Whiteside and Sunter 2000: 135]. If in South Africa most political leaders are not yet taking this lead, it is all the more important to have leaders in all sectors of civil society “... the village headman or councillor, from the preacher in the pulpit to the captain of industry, ... from sports heroes to soap opera stars” [Whiteside and Sunter 2000: 138] take on this responsibility.

¹³⁷ The exception to this is in the gay community in the West, which had formed a visible, political identity, adept at lobbying for gay causes, not long before AIDS was identified as a ‘gay disease’.

¹³⁸ Informal interview with Christo Greyling. See Section 5.2.2, p 116-17.

¹³⁹ This point is strongly made by Rev Christo Greyling of Old Mutual’s “I have Hope” AIDS prevention programme.

¹⁴⁰ See Section 3.1.1.1, p 33-34; 4.2.1, p 86; 4.3.2, p 90-91 and 5.2.2.2, p 107.

The majority of AIDS related work is done by women. One of the problems is that the majority of clergy, i.e. the majority of the decision makers around church-based programmes, are men, while the burden of infection and care is mostly borne by women [Paterson 2000: 8].¹⁴¹ Conflict between the female AIDS workers and the male authorities can cause tension in programmes. This emphasises the need for women to be more involved in planning and leading the response, and to take up leadership positions, not only in AIDS agencies, but in all churches structures.

5.3.3. Breaking the silence/Addressing the stigma

Due to the primary importance of discourse to the way churches function this is an area that needs serious attention. While AIDS has become a common topic in the deliberations of church leaders and their resolutions, at congregational level the silence is still almost absolute.

Churches will have to become creative in finding ways of breaking the silence. Taboo subjects can be broached in age and gender specific groups, already existing in many churches. This may be the way to deal with the taboos around AIDS, as in the view of some these are not really taboos in African society, but sensitive topics, which have always been addressed only in gender- and age-specific groups.¹⁴²

Such peer groups can provide the support needed to translate knowledge into changed behaviour as they offer 'alternative peer-group pressure'. Bayley [1996: 205] emphasises this for youth AIDS clubs, but it may be as relevant for groups of men or women, who individually may find it all but impossible to break out of traditional roles. Youth clubs deserve special mention here, as a tested and proven way of giving mutual support in making choices for safe behaviour. They provide information through magazines and fora for answering questions and promote anti-AIDS messages by various means, thereby giving youths a way of taking charge of their future [Bayley 1996: 205].

It is my conviction, that in the Church the liturgy is a powerful resource to overcome the silence around AIDS, to express the experiences and the pain, the fear and hope around AIDS in a language appropriate to the reality. Participation in the liturgy may

¹⁴¹ See Section 5.2.2.8, p 111-12.

¹⁴² Comment by Rev Sam Silungwe from Zambia in an interview.

also help people find a language to express their feelings and fears about this, offering a way to:

... help these people – the multitude of homeless, roofless, shelterless, family-less, energy-less, future-less people – to recover and to re-encounter, from within their pain and their suffering body, the responses and arguments, the inexhaustible spring that helps to make radical changes. Only confrontation with the Mystery, with the always-open revelation of God, can break down the faith in well-prepared speeches which for that very reason no longer “convince” many people. Now is when symbols, gestures, indirectness, silence, are fundamental: learning to do liturgy with people who suffer, learning to discover the signs of the Sacred in the midst of garbage and dregs [Ernesto Barros Cardoso quoted in WCC 1997: 41].

The World Council of Churches [WCC 1997: 78-79] urges its members to offer a liturgical response; to conduct worship services focusing on HIV/AIDS and those affected by it, addressing the special needs of those living with AIDS; and to do so with the involvement of people affected by HIV/AIDS and those working in the field. Christian liturgy centres on the life, death and resurrection of Jesus Christ. In this “resurrection perspective” it offers a way of dealing with premature death – one’s own or that of loved ones [Bayley 1996: 280-81], and it offers hope in the context of death [Paterson 2000: 14].

Andrea Bieler has explored the possibilities of liturgical services for helping rape survivors. Many of her findings are applicable to a wider field, especially to that of AIDS, which is often the result of rape and which is surrounded by a similar silence. Bieler [2000: 117] finds that liturgies centred on the psalms of lament offer a possibility to state the unspeakable in language, gestures and song. The psalms of lament express many of the fears and feelings, the loss of faith, even the anger and hate, the desire for revenge common to those suffering, yet not given space to voice these in the theology and normal worship services. Own laments can be added to the ancient ones of the psalms [Bieler 2000: 122-25]. The safe space of one-on-one counselling is complimented by such public safe spaces, created in worship services where the words of the psalms offer a way of jointly uttering own experiences before God [Bieler 2000: 121-22].

Looking back at the 14th century plagues in Europe shows the need for such a creative liturgical response to plagues, whether the Black Death or AIDS. The crisis of the plague had disrupted normal routines and ‘customary restraints’ until eventually new

rituals developed “to discharge anxiety in socially acceptable ways”. The normal established church rituals of the Catholics as much as the Protestant focus on following the Bible, which “had little to say about how to cope with massive outbreaks of infectious disease...” [McNeill 1975: 174], were insufficient in dealing with the plague and its impact. “Because sacred rituals remained vigorously conservative, it took centuries for the Roman Church to adjust to the recurrent crises created by outbreaks of the plague” [McNeill 1975: 173].

X It is evident that liturgy is one of the resources churches have to offer to strengthen aspects of AIDS ministries like awareness, care for PWAs, bereavement support and care for carers. It is one of the opportunities not yet exploited to a significant degree.

5.3.4. Dealing with spiritual challenges brought about by AIDS

In the South African context the massive death from AIDS follows a period where communities had to deal with death in the violence of the struggle, which almost made “violent and untimely death” a normal and permanent feature of life [Paterson 2000: 14]. It is no co-incidence that Kwa-Zulu Natal, the area that had experienced the worst violence during the eighties, is the province with the highest infection rate in the country. The challenge here, says Bishop Rubin Phillip, the co-ordinating bishop for the HIV/AIDS response in the Anglican church, is to offer hope in a context that is “crowded with images of death”, and offer reconciliation where violation seems to be the norm [Paterson 2000: 14]. The need is also there to offer a means of overcoming the ‘dangerous silence’ around the massive incidence of death.

On an individual level AIDS also raises spiritual challenges as is clear from the comments of numerous AIDS activists I interviewed. They highlighted the needs in this area of caring for PWAs and mentioned their need to deal with their anger, the feelings of guilt with special mention of the guilt mothers feel towards their babies born with HIV, their sense of ‘being dirty’ and their embarrassment.¹⁴³ AIDS patients bear the burden – in addition to their physical diseases – of having to deal with hostility, allocation of guilt, family ruptures and avoidance. They have to find ways to deal with a tendency for self-destruction (‘I brought it on myself’) and to forgive

¹⁴³ Comments from interviews with Linda Idas, Frances Herbert and Sophia Louw.

themselves.¹⁴⁴ For many PWAs the discovery that they are HIV positive has brought greater depth to their lives, and they have come closer to God.¹⁴⁵ This affords churches an important opportunity to accompany PWAs on this path, to offer them healing, spiritual care and community. This too, is a call they are not yet heeding well.

Pastoral challenges also arise in the area of grief counselling. Churches have a long tradition of aiding people in a time of the loss of a loved one, but the silence around AIDS complicates the process of grieving. In addition the unprecedented rate at which young adults are dying, especially young women, implies that many young children are orphaned. Apart from all the practical ways of care already pointed out, the spiritual care of these orphans, helping them find appropriate ways to grieve, to remember the parents they lost so soon present new challenges to clergy for which they must be prepared.

Another challenge in this area, especially for faith communities, is the 'dilemma of trust': Trust is the basis of relationships, of faith. Yet what people have to learn and to teach in the context of HIV is that it is not safe to trust anyone.¹⁴⁶ Faithfulness as safe-sex behaviour has a high 'failure rate' and is actually regarded by some as high-risk behaviour.¹⁴⁷ Many women – and surely some men as well – have been infected by their only partner, whom they trusted. This is complicated even more by the reality that infidelity of a partner is more likely to happen later in a relationship, when mutual trust has been established. Many young girls are raped and infected with HIV by close relatives or teachers. It has disturbing implications for trust, if children, young people, married women and men have to be taught, for the sake of their own survival, not to trust those closest to them. Yet, this is not the way to build community – an essential ingredient of any attempt to stem the tide of HIV and deal with its toll – as community is based on being trustworthy and trusting those near you. I have no solutions to offer to this dilemma, but it is certainly something that churches will have to deal with.

¹⁴⁴ Comments from the interview with Peter Fox, hospice chaplain at St Luke's, Cape Town.

¹⁴⁵ Interviews with Sophia Louw and Bishop Cawcutt.

¹⁴⁶ Stated thus by Pat Francis of Wola Nani.

¹⁴⁷ See Section 2.4, p 28 and 3.1.4. p 56.

5.3.5. Addressing the cultural divide

People are forced to choose between Western and traditional treatments for AIDS.¹⁴⁸ Since Western medicine admits that it has no cure for AIDS and its institutions send countless patients home saying: “There is nothing more we can do for you!”, traditional healers are for many an obvious choice. The challenge to churches is to help bridge this divide, a divide they helped to entrench in times gone by, to bring traditional healers into the mainstream of caring for PWAs so that choosing to appease the ancestors does not have to imply giving up anti-retroviral treatment.

Further it is essential to win over the traditional healers for joint efforts against AIDS. Their support is essential for instance to challenge the damaging myth of a virgin cure, which is apparently advocated by some of them; to adopt hygiene measures needed to prevent transmission of HIV during circumcision rituals; their support to help AIDS patients deal with the socio-religious impact of the disease.

If B is the real issue, rather than A, then we need to find ways of talking about B.¹⁴⁹ A prerequisite for this is a genuine willingness to listen and learn and change on the side of those within the Western (both medical and Christian) paradigm.

5.3.6. Networking and cooperation

In order to make an impact on the pandemic churches will have to find ways of networking with each other, with other faith-based responses and with all agencies offering AIDS-related services. I have made this point repeatedly.¹⁵⁰ The challenges are too great, the needs too many and varied, to allow individual responses, designed to satisfy the private agendas of separate groups. In order for churches to have a meaningful impact on the pandemic they have to analyse it together and plan a joint response. This does not have to imply that there is no space for individual convictions and preferences; simply that in making such choices the bigger picture is considered. Where success has been achieved in responding to AIDS, it came through finding the broadest possible common purpose between diverse agencies, without impeding the diversity.

¹⁴⁸ See Section 5.2.2.9, 112-13 and 5.3.5, p 121..

¹⁴⁹ See Section 2.1, p 16.

¹⁵⁰ See Sections 3.2.1, p 59; 4.2.2, p 89; 5.2.2.5, p 110-111.

5.3.7. Some practical challenges

AS more people die of AIDS related diseases, often a number of members from the same family within a short period of time, the cost of funerals add another burden to those who stay behind. Churches can contribute to change by challenging funeral traditions, which are too expensive and have many relatives travelling long distances [Bayley 1996: 13]. The SACC has recently made a strong statement, calling churches to challenge these 'traditions' and the funeral parlours exploiting them [SACC Resolutions].

Tensions are caused in communities where support is readily available to those affected by HIV/AIDS, but excluding those destitute for other reasons. Should agencies supporting AIDS orphans be exclusive or should they also reach out to those orphaned by other causes or those 'social orphans' who have parents both of whom are without an income? Is it morally tenable to open employment projects and day care centres that cater exclusively for PWAs in communities where many others are desperately poor? AIDS ministries have to be planned in ways sensitive to other needs within the communities.

Where good material has been developed, its use is often limited as it is only available in one language. Until recently most material was only available in English,¹⁵¹ making it useless for those who most need it in the poorest, least educated sectors of the population.

5.4. Implications for future research

In this last section I will briefly highlight some areas for future research emerging from my conclusions. The topics I am suggesting here were mentioned in the interviews with AIDS activists as reasons for the reluctance of churches to become involved in AIDS-related work. The same factors influence the response that is eventually planned and implemented and explain why this response is in some regards inappropriate. While I am unable within the scope of this paper to deal with these potential obstacles for Christian AIDS work, it is important that they be attended to if

¹⁵¹ Interview with Nomsa Hani, Renate Cochrane.

churches are to arrive at a more appropriate response to the HIV/AIDS pandemic.

5.4.1. Theology of sexuality¹⁵²

The silence around AIDS and the resulting lack of involvement in AIDS work within churches is most often explained in terms of the dis-ease with sexuality, and the resulting silence around sexuality in Christian theology. It is important to note that this trend was not confined to theology, and that all the behavioural sciences marginalised the study of human sexuality during the 50 years before the onset of AIDS [Parker 1996: 137].

Apart from setting boundaries for sexual activity, and placing harsh penalties on transgression of these, little reflection on sexuality as part of human nature has taken place within the Christian realm for centuries. The one exception is the area of homosexuality, which has generated some interest and debate in recent decades. It is then largely around same-sex relationships that sexuality and the theological implications of AIDS are addressed – if at all – in churches [Bayley 1996: 111].

It is deeply ironic that a religion named after one who was incarnate love should have so total a vacuum in its theology of embodied desire, and be so frightened of public discourse about sexuality [Jantzen 1994: 308].

“The churches’s teaching on sexuality is being trashed by the reality of AIDS,” says Peter Fox.¹⁵³ Foreman [1999: 79] agrees that human sexuality is the aspect of human behaviour that conflicts most with the teaching of the monotheistic religions. Their ideal of celibacy until marriage and faithfulness within it has never been achieved in any society. Both the religious leaders and their followers fall short [Foreman 1999: 79]. The reality and wide spread of AIDS even within the membership of churches has shown this up clearly [Van der Vliet 1996: 44] and makes it imperative that this area of church teaching is revisited.

Some areas that need consideration in a theology of sexuality follow:

- 1) Sexuality makes people vulnerable – to each other, to the abuse of this gift, to sexually transmitted infections like HIV. This is why communities and churches have always provided guidelines for the protection of individuals and society.

¹⁵² See Section 3.2.3.1, p 75-76.

They have upheld marriage as the ideal relationship in which the sexual relationship is expressed [WCC 1997: 31]. Such guidelines serve a purpose, even in this time.

- 2) When these guidelines are taught in a legalistic and rule-based way, when in their application sexual transgressions are judged more harshly than others, a negative teaching about sexuality emerges. This results in a simplistic, legalistic morality that is out of touch with how people are living and is largely ignored by them, hence not serving its purpose [Nicolson 1995: 20].
- 3) The Old and New Testament both view sexuality as part of the goodness of the creation, but also as being under the influence of sin. A theology of sexuality has to hold these two aspects in tension.
- 4) But more than that: Lisa Sowle Cahill [1994: 22-23] suggests that there are four complementary, mutually correcting reference points to be considered when developing Christian sexual ethics. The Bible is but one of these; the others being the traditions of faith, theology and practice; philosophical accounts of human nature; and experience. She states that while it is often difficult to balance these four, all of them have to be considered for each ethical decision.
In the case of South Africa two of these reference points are themselves complex. The fundamentally differing Western and African traditions exist side by side in communities, even in individuals, and interfere with each other. Regarding the last factor, a pathology of sexual behaviour is part of the South African experience, where rape is common, even that of babies and old women.
- 5) Lastly there is the age-old link between sexuality and death to consider, more specifically sexual sin which leads to death. The conviction that AIDS is 'the wages of sin' brings this connection to the fore again.

This brings us to the next factor.

5.4.2. Theology of death

Two apparently conflicting attitudes to death need to be dealt with in a theology of AIDS. The first is fatalism, which accepts massive untimely death of youth and people in the prime of their lives as inevitable. Bishop Rubin Phillip expressed the challenge this poses to the theology and praxis of the Church:

¹⁵³ Informal interview.

Perhaps what we need ... is some serious thinking about a theology of death, some work on liturgies to bring hope in the context of death, a concerted effort to find spiritual responses to the fatalism that prevents people from looking to their own futures with hope, and stops them seeing the value of looking after themselves [Paterson 2000: 14].

A second aspect is the fear of dealing with death, whether one's own imminent death or that of a loved one. While a period of disease causes loss in many aspects of life, impending death implies the ultimate loss, the loss of a future. It raises questions about the nature of death, and of what will happen after death and how to prepare for that. For those accompanying a loved one towards death there are questions about how to go about this [Cameron 1993: 79]. In the case of the long period of suffering and dying from AIDS-related infections the financial, emotional and spiritual resources of families become depleted.¹⁵⁴ For all concerned this is a time where they ought not to be left alone.

Paula Coeey [1999: 96-97] speaks of "the messiness of dying", the ambiguity and complexity in moral and spiritual terms, the uncontrollable suffering accompanying the process of dying which "the architects of this culture", whether religious, social, ethical or medical, do not address. In the process society loses the opportunity of preparing for death as an "occasion for spiritual or moral transformation".

Churches need to investigate means of preparing people for the experience of death, accompanying them through it and supporting those who stay behind through their time of mourning. This is not a new topic for Christian theology. Yet it seems that there are gaps in what has been done so far. And certainly the massive scale of death from AIDS, the fact that young people are dying at greater rates than old ones and the restrictions stigma imposes on grieving pose new challenges, not least for the clergy who have to deal with it so directly.

5.4.3. "Othering"

Another crucial reason for avoiding engagement with AIDS is the tendency of *othering*: "AIDS is a disease that affects them, not us." Myths around AIDS such as stereotyped risk groups and 'African sexuality' have been touched on in this paper.¹⁵⁵ The reasons behind such *othering*, its implications and especially ways in which

¹⁵⁴ Peter Fox in an interview.

AIDS can be 'brought home' need further study.

5.4.4. AIDS is a secular issue

AIDS, like all illness, is often considered a medical, and hence a secular issue and as such not truly part of the domain of the Church. It seems that churches feel unease at dealing with this, and other secular matters.¹⁵⁶ A similar reasoning, denoting politics as secular and hence not belonging to the domain of the Church, was often used by churches for their lacking engagement in the struggle against apartheid. Parallels can be drawn, and hopefully lessons learnt, by studying the submissions of church leaders before the Truth and Reconciliation Commission [RICSA 1999: 15 ff].

5.5. Conclusion

Is the response of the Christian community to the challenges posed by HIV/AIDS appropriate? This is the question I set out to answer. I have done so by considering the importance of discourse for churches; developing some criteria for the Christian AIDS discourse and from these criteria for the response to AIDS; and by showing what ministries churches and Christian AIDS organisations are providing in Southern Africa and specifically in the Cape Town area. While acknowledging the huge, dedicated contribution of FBOs in the AIDS field, I have highlighted twelve areas of concern, which show that the response of Christians to the HIV/AIDS pandemic is not as appropriate as it might be. These are followed by specific suggestions for churches to consider and some areas for future research to provide a better foundation for an ongoing Christian response, which will surely, as time goes on, become more appropriate.

¹⁵⁵ See Sections 2.3.1, p 21-22; 2.4, p 29-30 and 3.1.1.2, p 37.

¹⁵⁶ Peter Fox in an interview.

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Appendix . 4)List of Denominations and Organisations surveyed

Denominations

Apostolic Faith Mission
Baptist Union
Church of England
Church of God in Christ
Church of the Province of SA
Congregational
Dutch Reformed
 Northern Areas AIDS Action Group
Full Gospel Church of God in Southern Africa
His Glory Church
His People Christian Church
 Thembacare
Lighthouse Rhema Ministries
Touch Community Services
Lutheran
Methodist
Moravian Church
 Masangane
Roman Catholic Church:
 Caring Netw: HBC training and carers
 Women in Need: street people AIDS work
 Nazareth House
 Liso Nobantu;
 St Gabriels AIDS orphans
 Missionaries of Charity
 AIDS children wards: St Joseph's + Hope Project
Salvation Army
Uniting Presbyterian Church of SA
 J L Zwane Training & Dev Centre
Uniting Reformed Church

Organisations

Campus Crusade for Christ
 Youth at the Crossroads
Christian AIDS Bureau at Huguenot College
FACT: Faith Based AIDS Counselling and Training Group
Hope Worldwide
Joan Cousin HIV/AIDS Mission
Living Hope Community Centre
Scripture Union
SIM
 Community AIDS Network
YMCA
Youth for Christ
Youth with a Mission
 Beautiful Gate - Francis Herbert
Wola Nani - Pat Francis

Appendix 2: List of persons interviewed

Labeqa Abrahams, Zikhulule AIDS Project
Nontlupiko Ben, Zikhulule AIDS Project
Rev Keith Benjamin, Western Cape Provincial Council of Churches
Bish Reginald Cawcutt, SACBC AIDS Committee
Rev Renate Cochrane, Moravian Church
Rev Peter Fox, hospice chaplain at St Luke's, Cape Town
Pat Francis, Wola Nani
Rev Christo Greyling, Old Mutual's "I have Hope" AIDS prevention programme
Nomisa Hani, UCT student doing related research.
Prof Judith Head, UCT, Dept of Sociology
Francis Herbert, Youth with a Mission - Beautiful Gate Home for AIDS babies
Rev Linda Idas, Red Cross Hospital Chaplain
Dr Angelika Krug, paediatrician in the Northern Province.
Sophia Louw, Northern Areas AIDS Action Group
Rev Rachel Mash, Church of the Province of SA and Fikelela AIDS Programme
Past John Miller, His People Christian Church
Logy Murray, Christian AIDS Bureau at Huguenot College
Rev Gideon Nqiwa, Full Gospel Church of God in Southern Africa and SABC religious programmes.
Thandi Nqiwa, Full Gospel Church of God in Southern Africa
Rev Sam Silungwe, Zambia
Rosemary Smuts, Roman Catholic, Caring Network
Desire Volkwijn, Presbyterian Church
Linda Walters, Salvation Army
Rev David Wanless, Congregational Church
Joy Wilson, "Joy for Life" drop-in centre for people affected by AIDS
Rev Spiwo Xapile, Uniting Presbyterian Church of SA and J. L. Zwane Training & Development Centre

Appendix 3

From: Barbara Schmid
Return to: Fax 021- 689 7575
Contact me at Tel: 686 2703
Or E-mail: jtsa@humanities.uct.ac.za

To:
Fax:
E-mail:
Telephone numbers:

The church's response to AIDS: Western Cape

Thank you for taking time to complete this questionnaire.

1. Contact details for yourself: please fill in gaps / correct the section above.
2. Denomination
 - 2.1. Name of denomination
 - 2.2. Approximate membership in the Western Cape
3. Contact person for information on *National* AIDS programmes in your denomination:
 - 3.1. Name
 - 3.2. Telephone numbers
 - 3.3. E-mail
4. If there have been public statements and / or synod decisions about AIDS, please let me have copies or information where to get hold of them.
5. If there are any persons I should still contact in order to get a complete picture, please specify:

Name	Specific programme / information to ask about	Contact info
------	---	--------------
6. Other comments

Explanation:

In the table on the next page we are trying to get an overview of what is being done by whom. For each area in which you are currently providing / have in the past provided / are planning to provide services, please

- Give the name of the programme (if none, simply indicate "yes");
- Indicate whether the programme was offered only once or is / was ongoing;
- State the year in which the programme was offered (once-off) or initiated;
- Give an approximate number of the persons who have been / are being reached by the programme.

PWAs stands for People living with AIDS.

Programmes offered by your denomination in the Western Cape

Programme	Name of programme	Once-off/ Ongoing	Year started	Numbers reached
1. Education 1.1. Awareness / prevention for youth (age 12 – 25) 1.2. Awareness / prevention for children (age less than 12) 1.3. Awareness / prevention for adults 1.4. Other: Please specify				
2. Training: 2.1. Clergy 2.2. Home based care 2.3. Counselling / spiritual support 2.4. Other: Please specify				
3. Counselling 3.1. Pre-test / Post-test counselling 3.2. Bereavement counselling 3.3. Other: Please specify 3.4. Other spiritual support: Please specify				
4. Care 4.1. Homes for PWAs (Specify Babies and/ Adults) 4.2. Home based care 4.3. Hospice care (Specify Babies and/Adults) 4.4. Nursing wards for PWAs (Spec: Babies / Adults) 4.5. Other: Please specify				
5. Support: 5.1. Support groups for PWAs 5.2. Support for AIDS orphans 5.3. Material / financial support 5.4. Employment / training for PWAs 5.5. Other: Please specify				
6. Lobbying: Please specify				
7. Other: Please specify				

Church denom	Project name	Edu chil	Edu yth	Edu adlt	Edu gen	Trn clerg	Trn HB	Trn couns	Trn gen	Coun s test	Coun s gen	Support PWA	Chil dre	Ho mc	H B	Hos picc	Other supp	Lobby /advoc	Other
Apostolic Faith Mission		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input checked="" type="checkbox"/>	
Baptist Union	None, link to Living Hope	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Church supports Living Hope	<input type="checkbox"/>	
Church of England	None yet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes - unspecified	<input type="checkbox"/>	No denominational work in WC.
Church of God in Christ	None yet (Living Word Ministries)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Church of the Province of SA	Various	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Provide facilities to Joan Cousins	<input checked="" type="checkbox"/>	Special awareness efforts around St George's Cathedral
Congregational	None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Dutch Reformed	Northern Areas AIDS Action Group	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input checked="" type="checkbox"/>	
Full Gospel Church of God in Southern	None; Only 1 Congregation;	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input checked="" type="checkbox"/>	
His Glory Church	None; had a project	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
His People Christian Church	Thembacare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	support PWA acceptance in own church	<input checked="" type="checkbox"/>	

Appendix 4.1

Church denom	Project name	Edu chil	Edu yth	Edu adlt	Edu gen	Trn clerg	Trn HB	Trn couns	Trn gen	Coun s test	Coun s gen	Support PWA	Chil dre	Ho me	H B	Hos picc	Other supp	Lobby /advoc	Other
Lighthouse Rhema Ministries	Touch Community Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Lutheran	None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Methodist	None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	No formal projects, some members involved in AIDS services; support
Moravian Church	Masangane	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input checked="" type="checkbox"/>	
Roman Catholic	various	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	AIDS children wards: St	<input checked="" type="checkbox"/>	Had counselling for PWAs in prison - discontinued.
Salvation Army	Various	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input checked="" type="checkbox"/>	
United Presbyterian Church of SA	J L Zwane Training & Dev Centre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input checked="" type="checkbox"/>	
Uniting Reformed Church		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Involved with Northern Areas AIDS	<input checked="" type="checkbox"/>	Support CAB; liturgies; 2 Regional conferences for leaders.

AIDS Services by Christian NGOs

Organisation	Project name	Educ child	Educ youth	Educ adult	Educ gen	Train clergy	Train HBC	Train counsel	Train n	Coun sel	Couns el gen	Support PWA	Chil dren	Ho mes	HB C	Hos pice	Info other	Lobby/ advoc	Other
Campus Crusade for	Youth at the Crossroads	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Christian AIDS Bureau		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input checked="" type="checkbox"/>	networking, resource centre
FACT		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input checked="" type="checkbox"/>	
Hope Worldwide		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Distribute food and clothes to	<input type="checkbox"/>	
Joan Cousin HIV/AIDS		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input checked="" type="checkbox"/>	
Living Hope Community		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Work with comm health forum.	<input checked="" type="checkbox"/>	
Scripture Union		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
SIM	Community AIDS Network	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Wola Nani		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input checked="" type="checkbox"/>	
YMCA		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Youth for Christ		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	Spec target: homeless children
Youth with a Mission	Beautiful Gate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input checked="" type="checkbox"/>	

Appendix 4.2

AIDS services for Children

Denomination	Organization	Project name	Educate children	Educate youth	Children	Children Info	Homes	Hospice	Other	Comments
	Campus Crusade for Christ	Youth at the Crossroads	<input checked="" type="checkbox"/> Life skills	<input checked="" type="checkbox"/> Life skills	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		A,B. Focus on right values based on Jesus=role model.
	Joan Cousin HIV/AIDS Mission		<input checked="" type="checkbox"/> awareness, lifestyle	<input checked="" type="checkbox"/> awareness, lifestyles	<input checked="" type="checkbox"/> Children 2 yrs up are target group		<input type="checkbox"/>	<input type="checkbox"/>		Target children, youth, women, adults.
	Living Hope Community Centre		<input checked="" type="checkbox"/> awareness / prevention via schools	<input checked="" type="checkbox"/> awareness / prevention via sport, coffee bar	<input type="checkbox"/>		<input checked="" type="checkbox"/>	<input type="checkbox"/>		Focus in prevention: A
	Scripture Union		<input checked="" type="checkbox"/> Gr 6+: Lifeskills - responsible sexuality, A	<input checked="" type="checkbox"/> -15yr: Lifeskills - responsible sex - choice	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		Offer lifeskills programme in schools/churches for 10-15 yrs; focus: abstinence. Not exclusive for AIDS.
	SIM	Community AIDS Network	<input checked="" type="checkbox"/> Gr 6+: awareness - Big B	<input checked="" type="checkbox"/> awareness: Big B	<input type="checkbox"/>		<input checked="" type="checkbox"/> Planning orphanage	<input type="checkbox"/>		Not comfortable with condoms, focus A, B (Big B)
	Wola Nani		<input type="checkbox"/>	<input checked="" type="checkbox"/> condom distribution + info in public places	<input checked="" type="checkbox"/> day care; meals for children of PWAs		<input type="checkbox"/>	<input type="checkbox"/>		
	Apostolic Faith Mission		<input checked="" type="checkbox"/> Awareness in congregations	<input checked="" type="checkbox"/> Awareness in congregations	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		
	Church of the Province of SA	Various	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> Fikelela day centre and orphan care(day & home)		<input type="checkbox"/>	<input type="checkbox"/>		Special awareness efforts around St George's Cathedral

Appendix 4.3

AIDS Prevention Services

Church denom	Organisation	Project name	Educate children	Educate youth	Educate adults	General AIDS Educ	Comments
	Campus Crusade for Christ	Youth at the Crossroads	<input checked="" type="checkbox"/> Life skills	<input checked="" type="checkbox"/> Life skills	<input type="checkbox"/>	<input type="checkbox"/>	A,B. Focus on right values based on Jesus=role model.
	Hope Worldwide		<input type="checkbox"/>	<input checked="" type="checkbox"/> Awareness in schools, university	<input checked="" type="checkbox"/> Awareness	<input checked="" type="checkbox"/> Awareness in business, prison	Only group targeting prisons
	Joan Cousin HIV/AIDS Mission		<input checked="" type="checkbox"/> awareness, lifestyle	<input checked="" type="checkbox"/> awareness, lifestyles	<input checked="" type="checkbox"/> awareness, lifestyle	<input type="checkbox"/>	Target children, youth, women, adults.
	Living Hope Community Centre		<input checked="" type="checkbox"/> awareness / prevention via schools	<input checked="" type="checkbox"/> awareness / prevention via sport, coffee bar	<input checked="" type="checkbox"/> awareness / prevention via life skills	<input type="checkbox"/>	Focus in prevention: A
	Scripture Union		<input checked="" type="checkbox"/> Gr 6+: Lifeskills - responsible sexuality,	<input checked="" type="checkbox"/> -15yr: Lifeskills - responsible sex - choice	<input type="checkbox"/>	<input type="checkbox"/>	Offer lifeskills programme in schools/churches for 10-15 yrs; focus: abstinence. Not exclusive for AIDS.
	SIM	Community AIDS Network	<input checked="" type="checkbox"/> Gr 6+: awareness - Big B	<input checked="" type="checkbox"/> awareness: Big B	<input checked="" type="checkbox"/> awareness- Big B	<input type="checkbox"/>	Not comfortable with condoms, focus A, B (Big B)
	Wola Nani		<input type="checkbox"/>	<input checked="" type="checkbox"/> condom distribution + info in public places	<input type="checkbox"/>	<input checked="" type="checkbox"/> media campaign	
	YMCA		<input type="checkbox"/>	<input checked="" type="checkbox"/> awareness	<input checked="" type="checkbox"/> awareness	<input type="checkbox"/>	
	Youth for Christ		<input type="checkbox"/>	<input checked="" type="checkbox"/> Life skills	<input type="checkbox"/>	<input type="checkbox"/>	
	Youth with a Mission	Beautiful Gate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> AIDS awareness to community	
	Apostolic Faith Mission		<input checked="" type="checkbox"/> Awareness in congregations	<input checked="" type="checkbox"/> Awareness in congregations	<input checked="" type="checkbox"/> Awareness in congregations	<input type="checkbox"/>	
	Church of the Province of SA	Various	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> AIDS awareness Sundays in most	
	Dutch Reformed	Northern Areas AIDS Action	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> Life skills(NAAG)	<input type="checkbox"/>	Condom distribution

Appendix 4-4

<i>Church denom</i>	<i>Organisation</i>	<i>Project name</i>	<i>Educate children</i>	<i>Educate youth</i>	<i>Educate adults</i>	<i>General AIDS Educ</i>	<i>Comments</i>
His People Christian		Thembacare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> AIDS awareness in congregation	Hospice opening March 2002.
Lighthouse Rhema		Touch Community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> AIDS awareness	
Moravian Church		Masangane	<input checked="" type="checkbox"/> Responsible sexuality	<input checked="" type="checkbox"/> Lifeskills + sexuality	<input type="checkbox"/>	<input type="checkbox"/>	
Roman Catholic		various	<input type="checkbox"/>	<input checked="" type="checkbox"/> Education for life	<input type="checkbox"/>	<input type="checkbox"/>	
Salvation Army		Various	<input checked="" type="checkbox"/> Awareness	<input checked="" type="checkbox"/> Awareness	<input checked="" type="checkbox"/> Awareness, spec target men	<input type="checkbox"/>	
Uniting Presbyterian		J L Zwane Training & Dev	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> AIDS awareness in every service	
Uniting Reformed			<input checked="" type="checkbox"/> since '97	<input checked="" type="checkbox"/> since '97	<input checked="" type="checkbox"/> since '97	<input type="checkbox"/>	

Care and/or Support for PWAs

Denomination	Organisation	Project name	Training: HBC	Train: counsel	Counselling: pre- / post test	Counselling: general	Support PWA	Homes	HBC	Hospice	Support other
	Campus Crusade for Christ	Youth at the Crossroads	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Christian AIDS Bureau		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Hope Worldwide		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> psychosocial support to PWAs	<input checked="" type="checkbox"/> Supp groups (F&M), income gen,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Supp groups (F&M),
	Joan Cousin HIV/AIDS Mission		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> 12 counsellors lifestyle counselling	<input checked="" type="checkbox"/> empowerment supp group; food bank;	<input type="checkbox"/>	<input checked="" type="checkbox"/> 60 carers	<input type="checkbox"/>	<input type="checkbox"/> empowerment supp group; food
	Living Hope Community Centre		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	Scripture Union		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	SIM	Community AIDS Network	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> post test	<input checked="" type="checkbox"/> family	<input checked="" type="checkbox"/> nutrition for PWA + family	<input checked="" type="checkbox"/> Planning orphanage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> nutrition for PWA + family
	Wola Nani		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> individual, family, bereavement	<input checked="" type="checkbox"/> income gen;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> income gen;
	YMCA		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Youth for Christ		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix 4.5

Denomination	Organisation	Project name	Training: HBC	Train: counsel	Counselling: pre/post test	Counselling: general	Support PWA	Homes	HBC	Hospice	Support other
	Youth with a Mission	Beautiful Gate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> 21 AIDS orphans (increasing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Church of the Province of		Various	<input checked="" type="checkbox"/> 18 carers on Red Cross course	<input type="checkbox"/>	<input checked="" type="checkbox"/> pre/post	<input checked="" type="checkbox"/> >10 parishes: lifestyle, bereavement,	<input checked="" type="checkbox"/> supp. groups (6parish): food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> supp. groups (6parish):
Dutch Reformed		Northern Areas AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> NAAG - pre/post + testing	<input type="checkbox"/>	<input checked="" type="checkbox"/> NAAG: advice, support groups,	<input type="checkbox"/>	<input checked="" type="checkbox"/> 3 carers (NAAG)	<input type="checkbox"/>	<input type="checkbox"/> NAAG: advice, support groups,
Full Gospel Church of		None; Only 1 Congregation;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> 1 Support group, nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 1 Support group, nutrition
His People Christian Church		Thembacare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> spiritual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> for 20 children <12 yrs;	<input checked="" type="checkbox"/>
Lighthouse Rhema Ministries		Touch Community Services	<input checked="" type="checkbox"/> own course for volunteers	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> Mobile clinic, food, shelter	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mobile clinic, food, shelter
Moravian Church		Masangane	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> Memory book; Grief counselling	<input checked="" type="checkbox"/> wellness info + support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> wellness info + support
Roman Catholic		various	<input checked="" type="checkbox"/> Caring Netw: 5 day course for township.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> part of priestly work	<input checked="" type="checkbox"/> Women in Need: street people AIDS	<input checked="" type="checkbox"/> Naz Hs: home for 50 HIV	<input checked="" type="checkbox"/> Caring Netw: 70 carers, 10	<input checked="" type="checkbox"/> Miss./Charity: acc/destitut	<input checked="" type="checkbox"/> Women in Need: street
Salvation Army		Various	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> community	<input checked="" type="checkbox"/> Spiritual supp: congregations and teams into	<input checked="" type="checkbox"/> 3groups+1 for affected, material , 1	<input type="checkbox"/>	<input checked="" type="checkbox"/> 27 carers	<input type="checkbox"/>	<input type="checkbox"/> 3groups+1 for affected, material , 1
Uniting Presbyterian Church		J L Zwane Training & Dev Centre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> to affected and infected	<input checked="" type="checkbox"/> Support group, food, job creation	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Support group, food, job creation