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University of Cape Town

# THE RESPONSE OF THE CHRISTIAN CHURCHES TO HIV/AIDS PREVENTION - A DEVELOPMENTAL CHALLENGE

## THE EXAMPLE OF HOUT BAY


BY

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## Abstract

This study is an exploration of Christian Churches' response to challenges posed by HIV/AIDS. The study takes the premise that with seventy nine per cent of the people claiming to be Christian, Christianity is a hegemonic part of South African society. HIV/AIDS has been on the increase in sub-Saharan Africa, with South Africa having the highest prevalence rates. The highest prevalence of HIV/AIDS is among the poor and the young who are mainly black. HIV/AIDS prevention thus presents an important development challenge. Churches have a long history of community involvement, particularly in the fields of welfare and caring for the poor, sick and needy. In recent years this tradition has embraced work in the field of HIV/AIDS.

Although the churches are engaged in efforts of relief, care and welfare their intervention attempts, do not deal with the fundamental causes. According to Korten their interventions are classified as first generation interventions. They help alleviate the symptoms of a problem; however, they do not deal with the causes. HIV/AIDS is spread in the midst of ubiquitous poverty and deepens poverty by depriving poor families of income and redirecting scarce resources to care for the sick. HIV/AIDS prevention is thus an important development agenda. Development, understood as an improvement in the human condition, therefore implies prevention of HIV/AIDS and tackling poverty. This dissertation will argue that, unable to make a significant contribution to behaviour change at an individual level, churches should seek to play a more effective role in poverty eradication at the structural level. This, it is argued, will contribute indirectly to preventing HIV/AIDS.

In support of this argument, the dissertation draws on the experience of Hout Bay. Hout Bay is a small suburb on the coast of Cape Town. Using, the example of the churches in Hout Bay this dissertation highlights the importance of preventing the spread of HIV/AIDS by working on the context of poverty in which it flourishes.

## DECLARATION

I declare that this thesis is my own unaided work. It is submitted for the degree of Masters of Philosophy in Development Studies, University of Cape Town. It has not been submitted before for any other degree or examination in any other university.

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Sazini Mojapelo

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## LIST OF ABBREVIATIONS

| | |
|---|---|
| AIDS | Acquired Immuno Deficiency Syndrome |
| AIC | African Independent Churches |
| ANC | African National Congress |
| HIV | Human Immunodeficiency Virus |
| FBC | Faith Based Communities |
| HBRA | Hout Bay Ratepayers Association |
| HCA | Hangberg Civic Association |
| IY | Imizamo Yethu |
| MP | Mandela Park |
| NMF | Niall Melon Foundation |
| PLWHA | People Living with HIV/ AIDS |
| RPA | Rate Payers Association |
| SANCO | South African National Civic Organisation |
| TB | Tuberculosis |
| WCC | World Council of Churches |

# *INTRODUCTION*

According to the UNAIDS Global AIDS Report (2006), 28% of the South African population has been affected since the beginning of the AIDS epidemic. According to the report, the total number of people living with the virus at the end of 2005 was estimated at 5.5million. The report further estimated that 320 000 people died of AIDS-related illnesses in 2005.

Interventions to curb the spread of the epidemic have emerged in the area of prevention, support, treatment and care (SAHR, 2003). Despite these interventions, the HIV infection rate in South Africa continues to increase with an estimated 18.8% of people between the ages of 15-49 years living with HIV by the end of 2005 (Dorrington *et al.*, 2006). Since HIV is mostly spread sexually, the most effective means of prevention are those that prevent the transmission of sexual body fluids. The most popular of these prevention methods are prophylactics such as the condom. Other means of HIV/AIDS prevention include abstinence from sexual activities and faithfulness to one partner in relationships. All three widely promoted means of prevention – abstinence, faithfulness and the practice of safe sex through use of condoms, have one common thread running through them: individual behaviour. Ultimately, individual behaviour change is the focus of most prevention approaches. However, there are many complex factors that influence the possibility of widespread behaviour change. Among these factors include socio-economic conditions of poverty, lack of services, unequal access to resources and gender roles. Women's financial dependence on men also impacts on their sexual independence (Haddad, 2002). A key influence that has not received much attention is religious beliefs. A practical example is that of Uganda, the only African country that has been able to significantly reduce the spread of HIV/AIDS. Their success is attributed to proactive religious and political leadership (UNAIDS, 1998). However, Uganda is an exception.

The steady increase in HIV/AIDS prevalence in South Africa and the variety of factors influencing behaviour means that it is vital that a multidimensional approach be employed in dealing with HIV/AIDS. Further, this approach will need to be relevant to the dominant societal behavioural influences. In this regard, the role of religion, particularly the Christian religion, which had a 79% (STATSSA, 2001) following in South Africa in 2001 and its associated body, the Church, is critical.

Unravelling the complex influences on behaviour has received much attention. According to Benn (2002), people are influenced to some degree by at least three different paradigms; the scientific, religious and the cultural/traditional beliefs. All these provide different interpretations and responses to the epidemic. They all provide interpretations of its origins, and the most appropriate methods to overcome HIV/AIDS. This implies that there is need to understand individual behaviour within the social, cultural, economic, political, moral and religious context. This dissertation discusses the religious influence, with particular focus on the Christian churches and their responses to HIV/AIDS.

The Christian churches constitute the largest civil society group in South Africa and have influenced public and private responses to HIV/AIDS. The Christian churches have for centuries been, and continue to be, one of the cultural socialization agents in society, shaping peoples attitudes and behaviours from birth. This, according to functionalist theorists, is one of the core functions of religious belief in every society. Religion provides meaning for events that produce uncertainty and powerlessness (O'Dea, 1966). Sociologist Pierre Bourdieu explains that through religious "habituses", people are socialized to think and behave in a certain way (Robbins, 1991). Habitus refers to a process of socialization whereby the dominant modes of thought and experience are integral in the social world. These are social constructs internalized by the people (Robbins, 1991).

In South Africa, interpretations of the HIV/AIDS epidemic by the Christian churches have had an impact on the social reactions to it. The Christian teachings around HIV/AIDS prevention broadly advocate abstinence from sex outside marriage and faithfulness in monogamous marriage (WCC, 1997). This is reflected in the government's campaign. Despite this, there is an increase in the number of HIV/AIDS infections. Since HIV/AIDS is a disease that is spread primarily through sexual intercourse, the churches face a dilemma. The question that arises is that, if people are Christian (79%) and follow Christian values, norms and beliefs of abstinence and fidelity, why, then, does HIV continue to spread? This dilemma calls to question the churches' influence in shaping the behaviour necessary to curb the spread of HIV/AIDS. Further, the question suggests that the churches' influence on behaviour has not been as critical as functionalist theorists contend. Individual behaviour change is not simple. On the contrary, it is complex, as evidenced by the experience of many, not so successful global HIV/AIDS interventions.

The focus on behaviour modification (prevention) as one way of checking the spread of AIDS in South Africa is informed by a number of theoretical orientations of health behaviour. Early intervention models that were used in prevention and awareness campaigns worked on the premise that provision of knowledge was sufficient to change behaviours (Takyi, 2002). They failed to address the individual in the social context. Despite the shortcomings of this approach, which has led to the emergence of a health promotion focus in HIV/AIDS, it has in the past guided most HIV/AIDS intervention attempts. For example, the Health Belief Model (HBM) and Knowledge, Attitudes and Practice (KAP) have guided global HIV/AIDS campaigns in attempting to influence behaviour change (Skinner, 2001). These theories assume that knowledge leads to change in attitudes and behaviour. The Christian churches also largely believe that acceptance of their beliefs is equivalent to shaping attitudes and behaviour. In the time of HIV/AIDS, this means conformity to

Christian interpretations and understandings about HIV/AIDS prevention through abstinence and faithfulness in marriage. The critical limitation to this approach is that like many health campaigns, it does not factor in the individual's environment. This may affect decisions about behaviour change and safe sex practices.

To better understand the complexities involved in shaping attitudes and behaviours towards HIV/AIDS, it is necessary to consider psycho-social theories that explain processes that lead to individual behaviour change. Several theories exist in this regard. The Theory of Reasoned Action by Azjen & Fishbein (1988) and the Theory of Planned Behaviour by Azjen (1988) presupposes that people act in logical ways. In the context of HIV/AIDS, this translates into people making choices about behaviour, based on reasoned logical understanding of the HI virus. They also argue that the intention to change behaviour maybe sabotaged by a whole range of factors in the socio-economic and cultural background.

Other theorists have challenged the assumption that people act logically. One such theory is the Lay Theory. This was advanced by Furnham (1988). According to Furnham, people may hold various beliefs about the same problem whose implications or assumptions are mutually contradictory. They find nothing wrong with this contradiction or simply do not realize it. This theory then acknowledges that people do not always act in logical ways. Furnham (1988) further argues that people are greatly influenced by their surroundings as well as intrinsic motivations which are not consistent and stable, but dynamic and contradictory. Skinner (2001) argues that this theory best explains the complexities involved in negotiating condom use as a means of HIV/AIDS prevention. Skinner (2001) argues that the lay theory is most appropriate in explaining lack of change in attitudes and behaviour towards HIV/AIDS. He explains that lay theories emphasize how people do not always act in logical ways despite the availability of evidence, For example, the knowledge that abstinence and fidelity in

marriage are preventive means of HIV/AIDS infection does not necessarily lead to abstinence and fidelity. This implies that belief in Christian teachings and values does not necessarily mean adherence to them. So what does this mean for Christian churches in the HIV/AIDS epidemic?

Short of abandoning key tenets of its theology, how can the Christian churches' play a more effective role in HIV/AIDS prevention? This is the central question that this dissertation addresses. The aim is to explore the Christian churches' responses in dealing with a growing HIV/AIDS epidemic. It is critically important because preventing the spread of HIV/AIDS is a development issue. The reduction of HIV/AIDS has been identified by the United Nations as one of the eight Millennium Development Goals to be achieved by 2015 (UN, 2007).

The notion of human development incorporates all aspects of an individual's well-being, from their health status to their economic and political freedom (World Bank, 2000). HIV/AIDS is spread in the context of ubiquitous poverty and socio-economic inequalities. However, HIV/AIDS deepens poverty by depriving poor families of income and redirecting scarce resources to care for the sick suffering from the HI virus. Since the advent of AIDS, the Christian church has been engaging with the epidemic. Yet, as noted above, there is an increase in prevalence. The dissertation explores this paradox. It will argue that, unable to make significant contribution to behaviour change at the individual level, Christian churches should seek to play a more effective role in poverty reduction at the structural level. The dissertation suggests that this will contribute indirectly to preventing HIV/AIDS and advancing the human development agenda.

The dissertation argues that the primary focus of the churches has mainly been in the area of relief, care and welfare of people affected by HIV/AIDS. This, according to Korten (1990), in his Four Generations framework on civil society groups, is classified under the first

generation response, whereby, the Church, as a faith-based body, mainly focuses on individual and community "relief" and "welfare". Clifford (2004) argues that very few prevention initiatives by the churches have been successful in dealing with HIV/AIDS. Although the Christian churches have played a major role in alleviating the effects of the epidemic through relief and welfare of people affected by HIV/AIDS, a lot still needs to be done with regards to their activist approaches to prevention and stigma. Parry (2004) accuses the churches of being the "sleeping giant" because of their inability to use their potential influence and power to effectively alleviate the spread of HIV/AIDS. According to King (2004), some of the churches have unwittingly contributed to the growth of stigma and discrimination through silence and pronouncing harsh moral judgments against those infected. Reviewing these responses, Benn (2002) argues that the churches' response to HIV/AIDS has then been a mixture of constructive and divisive engagement with people, groups and issues that surround HIV/AIDS; constructive in the sense that they actively contribute to the relief and welfare of people affected by the epidemic, but divisive in that they have fuelled stigma through their silence and rigid stance on prevention issues. According to Clifford (2004), this conflicted role has raised a lot of debate and controversy around HIV/AIDS interventions by the churches. The following factors are seen by Clifford (2004) as important.

The first factor is the inherent tensions in dealing with issues of sex, sexuality and by extension, sexually transmitted infections and diseases. Throughout the history of the Christian churches, they have had specific views on sexual behaviour, norms, values, mores and sexual morality which have governed 'correct' sexual behaviour. These beliefs are what unite the churches in their response towards the epidemic. These views presented in the second chapter, form part of the moral stance of the churches that approve sex only within heterosexual monogamous marriage. According to the WCC (1997), churches recognize

heterosexual marriage as the only place for the expression of sexuality. As a result, the churches have found it difficult to deal with HIV/AIDS prevention issues, preferring to focus more on Korten's first and second generations of community development, relief and welfare. The churches' relevance is brought to question, as it does not speak to modern realities.

The second factor is the approach of some Christian churches' to HIV/AIDS as a form of sin and punishment for immoral sexual behaviour, which was widespread in the 1980s. Although this stance and perception by the dominant voices in the churches has evolved since then, its fundamental theology has not changed in the church. Through society's identification of some people as high risk groups e.g. injection drug users and prostitutes, society and the churches unwittingly created an artificial hub of people who are perceived to be at little or no risk of contracting HIV/AIDS. According to Kriel (1991), diseases, particularly sexually transmitted illnesses (STIs,) are by extension a sign of dirt and pollution and for most are thus associated with immoral behaviour. Gennrich & Gill, (2004) argue that echoes of this approach remain within some of the churches. Their stance of silent judgment fueling stigma and discrimination.

In making this argument, the thesis draws on the experience of Hout Bay. Hout Bay is a small, geographically self-contained town close to Cape Town. Bordered by mountains and the sea, it is confined to a relatively narrow valley. Although the legal and political structure of apartheid has been dismantled, its economic legacy remains. Hout Bay is still divided into three distinct economic zones that coincide with the former racial divides. Rich, white people occupy the valley floor, living on large detached properties with all amenities. Poor coloured people, traditionally linked to the town's fishing industry, live in solidly built and serviced municipal flats on the right hand slopes of the mountain. Poor Africans, drawn by the hope of

employment, occupy overcrowded self-constructed shacks on the steep slopes of the left hand side of the mountains. Most shacks do not have electricity, running water or hygienic sewage and rubbish disposal.

The prevalence of HIV and AIDS is high in townships in Cape Town, with Khayelitsha recording the highest with 32,5% and Nyanga township recording the second highest with 29,1% (Cape Town City Health Services, 2006). Figures for Hout Bay are not available, but it is reasonable to assume that it approximates to these since the socio-economic situation is very similar. The thesis will argue that the churches are a powerful force in Hout Bay. United, they could act as powerful catalysts in the struggle against poverty. They could engage in what Korten calls third generation interventions or "mobilizers for structural community development."

## Scope of the Study

The first chapter presents the broader socio-economic context within which the churches' response to HIV/AIDS operates, highlighting the diversity of South Africa in terms of religion, values and the impact of the HIV/AIDS epidemic. This chapter also sets out Korten's four generations framework of development agencies/groups. Using Korten's Four Generations Framework, the dissertation analyses the developmental approach of the churches to HIV/AIDS.

Chapter two reviews the Christian churches' beliefs about HIV/AIDS. It will look at the function of religion in society, as understood by structural sociologists. It will argue that a more useful approach is taken by post-modernist writers who argue that a defining aspect of modern Christianity is the autonomy of the individual to form her/his own responses to the churches theology and interpretations of the sacred text. This chapter also argues that three broad kinds of Christian churches exist in South Africa. Although ministering to different communities and different in important respects, they all share similar views on sexual behaviour. It will discuss the churches' teachings on sex. It will ask why they are not observed by large numbers of believers and how this has limited their response to HIV/AIDS prevention.

Chapter 3 will focus on Hout Bay. It will discuss why Hout Bay (HB) was chosen for the study. It will describe HB and its demographic, socio-economic and health/HIV/AIDS profile. It will look at the Christian churches in HB; their missions and congregations. Finally, it will discuss the research methodology used.

Chapter 4 will present the findings of the churches' response to HIV/AIDS in Imizamo Yethu (IY), the distinct African squatter settlement that is part of HB, highlighting the difference of intervention between the mainline churches and the African Independent Churches. It will argue that the role of the churches is largely ineffective in the area of HIV/AIDS prevention because their ideas do not resonate with congregants' own ideas. In postmodernist terms, the churches fail to recognise individual autonomy within the understanding and practice of religion. This chapter will suggest that the churches could play a more constructive role in the development of Hout Bay by focusing on poverty alleviation, which it can affect, rather than HIV/AIDS prevention, which it cannot.

Chapter 5 will conclude the dissertation. It will argue that by addressing the problems of poverty, churches will be indirectly addressing problems of HIV/AIDS prevention. It will argue that it should not abandon Korten's first generation interventions (alleviating the symptoms of poverty) or second generation interventions that encourage self-help endeavours, but it should also move towards third generation interventions that encourage sustainable community transformation and development.

# Chapter 1: Development and HIV/AIDS

## 1.1. The Socio-economic Impact of HIV/AIDS

The prevalence and spread of the epidemic is influenced by a complex array of social, economic, cultural, and political factors. An understanding of this environment is critical in the implementation of HIV/AIDS programmes and initiatives by the Church. As already argued, HIV/AIDS is strongly correlated to poverty. According to the UNAIDS Human Development Report (2003);

> "Poverty offers a fertile breeding ground for the epidemic's spread and infection and sets off a cascade of economic and social disintegration and impoverishment. Most households have few financial assets and thus, find themselves unable to seek treatment for sexually transmitted infections. This existence of untreated sexually transmitted diseases increases the risk of contracting HIV/AIDS".

Additionally, poor women and young people may need to resort to 'compensated' unprotected sex to provide for their families. The high TB levels in these impoverished communities exacerbate the untreatable levels of HIV/AIDS. According to the UNAIDS (2002), the links between poverty and HIV/AIDS are 'bi-directional'. On the one hand, poverty contributes to vulnerability to HIV and exacerbates the impact of HIV/AIDS. Yet, on the other hand, the experience of HIV/AIDS by individuals, households and communities that are poor leads to an intensification of poverty. This bi-directional relationship of poverty and HIV/AIDS highlights the importance of the role of the churches in their provision of relief and welfare.

Apart from poverty being a key issue in the discussion around the epidemic, South Africa's history of a highly migrant working population has contributed to the spread of the epidemic. According to Haddad (2002), the migrant labour system and other forms of employment such

as long distance truck driving, where men are away from home for a considerable amount of time, favour the practice of having multiple sexual partners. Studies show that these men engage in high risk sexual behaviour (Haddad, 2002). This propagates the vulnerability of women to infection, including wives with whom they normally have unprotected sexual relations.

Other studies have shown that women are more vulnerable to infection than men owing to a mix of biological and cultural factors. This is especially true for young girls who have little knowledge of their rights and are often deemed powerless. Studies among various African populations indicate that rates of HIV infection in young women aged between 15 and 19 years are higher than among young men (Haddad, 2002). According to the HSRC Prevalence Report (2005), the female to male ratio of HIV infection is highest amongst females between ages of 15-24 years, where the prevalence is almost four times that of males, females- 16.9% compared to males-4.4%. There are manifold reasons for this. Young women often have relations with older men, having their sexual debut at a younger age than boys. They are sometimes forced into prostitution or exchange sex for monetary gain. They are also biologically more vulnerable to infection than boys. These dynamics highlight the complexities involved when dealing with HIV/AIDS intervention programmes in general, and for the churches in particular.

In South Africa, HIV/AIDS is recorded mostly amongst African people. Early writers in South Africa attributed this high prevalence to the sexual practices of African people. According to Head (1992), the association between the African populations and 'unusual' sexual practice is incorrect. The high prevalence levels are not because of sexual practices, but more because of socio-economic conditions within which people live. Those most affected are those most deprived, who live in extreme poverty that increases their

vulnerability to HIV (the bi-directional relationship mentioned above). In an early paper, Judith Head had argued that extreme poverty may weaken people's immune system, thus making them more vulnerable to HIV than people whose immune systems are intact. Similar ideas have been eloquently argued by Stillwaggon (2005) in her recent book, '*AIDS and the Ecology of Poverty*'. Stillwaggon (2005) argues that HIV has many parallels with other infectious diseases. It thrives in areas that have widespread malnutrition and other sanitary and health services deficiencies known to contribute to disease susceptibility. As such, malnutrition and a weakened immune system contribute to greater susceptibility to infectious disease, including those transmitted sexually. Farmer (2003) contends that people who live in poor conditions are more vulnerable to infectious diseases and epidemics like Tuberculosis and HIV/AIDS.

According to the South African Health Review (SAHR, 2003), South Africa has an estimated 4-6million people infected with HIV/AIDS. Although there is evidence of secondary transmission from mother to newborn child and from blood-related products and procedures (e.g. transfusion, the use of syringes, and instruments used in circumcision), an important feature of the AIDS epidemic in South Africa is that it is sustained primarily through heterosexual contact (Takyi, 2002). According to the HSRC (2005), people between the ages of 15-29 years have the highest prevalence rates. This suggests that significant numbers of young South Africans are having unprotected sex. Notwithstanding, according to Parry (2004), it is important to understand that the HIV/AIDS epidemic consists of multiple and overlapping epidemics, each with its own distinctive nature and impact. This is appropriately captured by the late Director of the WHO Global Programme on AIDS, Jonathan Mann, who stated that there were three epidemics.

The first epidemic is HIV that is spread sexually within the community. What makes the HI virus unique is its ability to remain hidden in the body for a long period before detection. This gives it the ability to spread undetected from one person to another, thus impacting on the prevalence levels. According to the HSRC (2005), HIV prevalence amongst persons who are 2 years and older is estimated to be 10.8% with a higher prevalence in females of 13.3% than in males of 8.2%.

The second epidemic is AIDS Acquired Immune Deficiency Syndrome (AIDS). AIDS is the condition in which the HI virus manifests itself. Large numbers of young people are dying from the disease, reducing life expectancy to below 40 years and leaving children orphaned (HST, 2003). According to the HST (2003), individuals infected with HIV will, in the absence of Anti-Retroviral Treatment (ART) develop into AIDS and most will die within one or two years of developing AIDS. However, with the introduction of ART in the public sector hospitals and clinics, there is a hope that the mortality rates will wane. The HSRC (2005), reports that there has been a decline in the number of AIDS deaths due to the introduction of ART. Nevertheless, the waning of death rates will mean that the pool of infected and infections people grows.

The third epidemic is that of stigma and discrimination. HIV/AIDS stigma refers to all unfavourable attitudes, beliefs and policies directed toward PLWHA and their significant others (Brimlow, *et al.*, 2003). Stigma and discrimination against PLWHA has had a negative impact on the spread of the epidemic. As a result, it has been deemed the worst of the three epidemics, as it hinders concerted efforts to reduce the spread of HIV/AIDS (Parker & Aggleton, 2002). The HSRC (2005) agrees that stigma and discrimination against PLWHA has been identified as a primary barrier to HIV/AIDS prevention in South Africa. Stigma

related to HIV/AIDS appears to be more severe than that associated with other life-threatening diseases. Often, HIV/AIDS stigma is expressed in conjunction with other stigmas or discriminatory attitudes and beliefs, particularly those associated with sexual deviance and difference (i.e. "promiscuity", homosexuality) (Brimlow, *et al.,* 2003). According to Brimlow, *et al.*, (2003), people with religious beliefs may be more likely to harbour HIV/AIDS-related stigma than others. This is closely tied to their religious beliefs that HIV/AIDS is a sign of immorality and thus, God's punishment for sexual sin. Parker & Aggleton (2002) argue that some religious leaders have been accused of enhancing stigma and discrimination by maintaining the *status quo* rather than challenging it.

Poverty and marginalization impact on the extent and spread of the epidemic in South Africa. Farmer (2003), drawing on the established corpus of work in the field of public health and social epidemiology, argues that diseases generally affect the poor more than the rich. Surveys conducted across boundaries of time and space show that the poor are sicker than the non-poor. Farmer (2003) further adds that the poor are at an increased risk of dying prematurely, whether from increased exposure to pathogens (including pathogenic situations) or from decreased access to public services. He concludes that environmental and socio-economic conditions have a significant impact on the spread of epidemics. The HSRC (2005) confirms that, where high HIV/AIDS prevalence and poverty coincide, the impact is greatest. Persons aged 15-49 years, living in informal township housing (the most impoverished settlements in South Africa), have by far the highest HIV prevalence rates of 25.8% as compared to the overall percentage of other households of 16.2%, (HSRC 2005). According to Pieterse & Parnell (1999), poverty levels are very high in these areas with approximately 53% of households living below the poverty line and 33% being unemployed.

What have the churches been doing to deal with the epidemic among their parishioners? In answering this question, it is useful to turn back to David Korten's "Four Generations Framework". This is a developmental model which analyses the ability of voluntary and development organisations or civil society groups to begin addressing fundamental causes of social problems, rather than focusing on the symptoms. The potential "generational" roles include:

- First Generation as "doers" focusing mainly on "Relief and Welfare."
- Second Generations as "mobilizers" for Community Development.
- Third Generation as "catalysts" for "Sustainable Systems Development"
- Fourth Generation as "Activists and Educators" for People's Movements

**Table 1: KORTEN FOUR GENERATION FRAMEWORK**

| GENERATION | | | | |
|---|---|---|---|---|
| | FIRST<br>***Relief and Welfare*** | SECOND<br>***Community Development*** | THIRD<br>***Sustainable systems development*** | FOURTH<br>***Peoples movement*** |
| **Problem Definition** | Shortage /Crisis HIV/AIDS | Local inertia | Institutional and policy constraints | Inadequate mobilizing vision |
| **Time Frame** | Immediate | Project life | 10 to 20 years | Indefinite future |
| **Scope** | Individual or Family | Neighbourhood or Community | Region or nation | National or Global |
| **Chief Actors** | **Churches, FBOs, CBOs** | **Church plus community** | All relevant public and private institution | Loosely defined networks of people and organisations |
| **Civil Society Organisations Role** | Doer | Mobilizer | Catalyst | Activist/Educator |
| **Management Orientation** | Logistics Management | Project management | Strategic management | Coalescing and energizing self managing networks |
| **Development Education** | Starving Children, Sick people | Community self help | Constraining policies and institutions | Mindset change |

*Source: Korten, D (1990)*

The *first generation* focuses mainly on meeting the immediate needs of the community. This is what most churches do. Korten (1990) argues that first generation strategies include relief efforts in poor countries where religious groups play a major role. Charitable activities in Africa are often church-related or mission-related.

> "Churches and missionary missions were important in Africa throughout the colonial era, as colonial governments left the provision of basic education and health care largely to the Church and church-related organisations" (Korten, 1990:116).

Baer (1994) states that the work of the faith-based organisations or churches within the health fraternity has been synonymous with relief and welfare work around HIV/AIDS.

According to Korten (1990), *second generation* civil society groups' focus their energies on developing the capacities of the people to meet their own needs. The second generation primarily focuses on sustainability of the development initiative and is developmental in concept. This is often referred to as community development strategies. Korten (1990) argues that this developmental level commonly focuses on imparting knowledge and skills so as to allow the community to take over the project. The key driver to the developmental approach is ownership. In order for the development initiative to succeed, the community has to buy into the vision and own it. This will then lead to sustainability. Evidently, this generation is a step ahead of the first generation that is mostly focused on relief and welfare.

Korten (1990) states that in most instances, second generation civil society groups attempt to 'empower' the community. Organisations within this generation are mainly 'mobilizers', rather than simply 'doers', although some of the organisations that are within the first generation can graduate into the second generation. They attempt to move beyond relief and welfare to sustainable community development. Responses to the epidemic that are within this generation are community-run hospices and support groups. The second generation

strategy of development almost always has a substantial focus on education i.e. human resources development. The proverb "Give a man a fish and you feed him for the day, teach the man to fish and you have fed him for a lifetime" typically describes the second generation.

Korten (1990) argues that the *third generation* goes beyond individual community development and is geared towards changes in policies and institutions at a local, national and international level. Groups operating at this level mainly act as catalysts to change. An example is the Treatment Action Campaign (TAC) in South Africa. Most churches do not normally feature in this front, with the exception of the Anglican Church, that has been vocal about the provision of HIV/AIDS treatment. Churches have little or no autonomy when it comes to the Biblical principals and understandings of HIV/AIDS. Church leaders are forced to maintain the doctrines of their denominations. They are not able to change any of the commandments or teachings in the Bible as interpreted by their denominations. This is contrary to Korten's third generation strategies, where the focus is on creating a policy and institutional setting that facilitates, rather than constrains, just, sustainable and inclusive local development action.

The *fourth generation* is mainly a combination of the second and third generation. The only difference is the scale of the intervention. The focus is on the macro level and global change. These development initiatives can be found in most poor countries. They are often driven by external foundations such as the Kellogg Foundation, the Save the Children Foundation, Care, ActionAid. These types of organisation act as eradicating agents for poverty and HIV/AIDS.

It is within this context of high levels of poverty, social exclusion and the historical legacy of migrancy that the developmental role of the Church towards HIV/AIDS needs to be considered.

## 1.2. Norms, Values, Religion & AIDS in South African Society

AIDS is a disease of society in the most profound sense. It is clearly grounded in the conduct of social life, and its ability to change norms, values, sexual habits, and lifestyles is enormous. All societies, including South Africa, have particular ways of encouraging and enforcing what they view as appropriate behaviour, while discouraging and punishing what they consider to be improper conduct. These are often classified as norms and values to which human society adheres. According to Robertson (1981), norms are established standards of behaviour maintained by society. Schaefer (1986) defines values as collective conceptions of what is considered good, desirable and proper in a culture. Values indicate what people in a given culture find right or wrong and what is important and morally right. Norms are interlinked with the social value system.

According to Schaefer (1986), norms can be formal and informal. The formal norms are documented and are official, that is, they are defined by social institutions such as churches, governments, schools and other official entities. They involve strict rules and regulations which lead to punishment for violators. In the South African society, these are formalized into laws which are precise in defining what proper and improper behaviours are, for example, rape is recorded as a criminal offence as is robbery/theft. The informal, on the other hand, are those reflecting a person's day-to-day behaviour, which may not be consistent with the society's formal cultural system (Schaefer, 1986). According to Parsons (1964), human action is directed and controlled by norms provided by the social system The cultural system provides more general guidelines for action in the form of beliefs, values and systems of

meaning (Parsons, 1964). Religion is part of this cultural system. Most norms in South African society are ultimately derived from religious and cultural beliefs. As such, religious beliefs provide guidelines for human action in private and public behaviour.

In trying to understand the social norms and values of South African society, it is important to note that these are not homogeneous. South African society is pluralistic. It is a society where individual choices can be made between several competing models and sets of values and beliefs (Jansen, 2001). This is especially the case with sexual norms and values. Nevertheless, a normative sexual behaviour exists. This is defined by mores that are considered necessary for the welfare of society. Many of the norms of the social system are integrated by religious beliefs.

As already indicated, religion is a significant social force in South African society. As Table 2 below shows, 82.7% of South Africans profess to be religious, with 79.8% being Christian.

**Table 2: Number of individuals by religion in South Africa (Census 2001)**

| Religion | Percentage |
|---|---|
| Christianity | 79,8% |
| African traditional | 0,3% |
| Judaism | 0,2% |
| Hinduism | 1,2% |
| Islam | 1,5% |
| Other | 0,6% |
| No religion | 15,1% |
| Undetermined | 1,4% |
| Total | 100% |

Source: Statistics South Africa, Census 2001

According to Schaefer (1986), ideas of what is sexually moral (that is, of what is "right" and not "wrong") are formed in a constant interaction between personal, religious and community values. Through this process, every society has specific norms and values related to sex and

sexuality. These norms are reflected in gender roles, marriage, partnerships, and family. Religious norms often determine sexual practices, marriage customs, punishment for unapproved sexual behaviours, and attitudes toward prostitution, homosexuality, bisexuality, and sexual education. According to Robertson (1981), sexual values and norms in societies influenced by the western traditions have their roots in the Judeo-Christian morality. The Christian faith and the churches have had an important role in influencing the development of personal and community value systems and social norms.

Benn (2002) argues that religious organisations are rooted in local structures and command considerable degree of trust and credibility with most African communities, particularly on moral and social issues. Thus, religious institutions have immense potential in dealing with HIV/AIDS. Christian churches have always sought to regulate sexuality through norms and value systems which classify certain sexual behaviours as socially unacceptable (extra and pre-marital sex, same-sex sex) or through more formal means such as the institution of marriage (Parrinder, 1998). According to the WCC (1997), the expression of human sexuality has been regulated and directed in ways deemed necessary for responsible and safe community life. Churches, in this regard, have particularly affirmed the role of marriage in sexual human relationships. Society determines what sexual information and behaviours are legally permitted or considered appropriate on the basis of tradition, customs, religion, values and history (Parrinder, 1998).

For example, while social norms may frown upon sexual activity outside of marriage, many people may have sex or a sexual relationship with a person to whom they are not married. In some cultures, it may be an informal norm that this is common, while in other cultures, norms make these behaviours acceptable for one sex and not the other. For example, in many Muslim societies, it is acceptable for men to have more than one sexual partner, or sex with a

person who is not their spouse, whereas a woman in the same culture who has sexual relations outside of marriage may be stigmatized, punished, or socially ostracized, even if the woman has been raped (Haddad, 2002). This double standard is especially present in the church community, where women are Biblically considered subordinate to men (Haddad, 2002). Equally, while some societies may have strict taboos on homosexual and lesbian behaviour and may even deny the presence of homosexuality, there is an indication that homosexual orientation exists in nearly all societies and cultures. Under these circumstances, homosexual practices in that society may be suppressed or hidden.

However, as people and societies evolve and change, this has a direct impact on social norms. In contemporary industrial societies, practices such as homosexuality and pre-marital sex have become more accepted, in both formal and informal norms. Postmodern society has become more pluralized and secularized. The term secularization refers to the process through which religious influence in other social institutions diminishes, whilst 'sacred' refers to things related to religious and holy acts of worship (Schaefer, 1986).

Scientific and information technological advances have increasingly affected all aspects of life, including the social institution of religion. Change in South African society has heightened the presence of countervailing norms and informal values in society. However, Benn (2002) argues that religious organisations are firmly rooted in local structures and have a considerable degree of credibility with many African people, particularly on moral and social issues. Churches thus have immense potential in dealing with and influencing the course of HIV/AIDS. They can act as positive social change agents in their communities. Within Korten's (1990) framework, the churches can begin acting as catalysts for behaviour change, they can also go beyond this and become 'activists and educators' (fourth generation) that are relevant to the development challenges that are posed by HIV/AIDS.

### 1.3. Concluding Comments

This chapter has outlined the extent and impact of the epidemic, its characteristics and norms, values and religious beliefs as they impact on the response of the Christian churches to HIV/AIDS. It has also presented Korten's development theory that can be used as an analytical tool to think about how the churches can respond to the development challenge posed by HIV/AIDS.

The next chapter explores the concept of religion, Christian churches and HIV/AIDS. Emphasis is placed on the role of religion in society and the parallel perspectives of sexuality within the Christian churches and increasingly secularised industrialized societies.

# Chapter 2: Religion, Christian Churches & HIV/AIDS

## 2.1 What is religion?

Before we discuss the Christian churches' responses to HIV/AIDS in South Africa, there is need to first conceptualize religion. The first question that needs to be addressed is what religion is. Religion is a cultural universal, meaning that it is a practice present in every human society (Robertson, 1981). It offers answers to such ultimate questions as why we exist, why we succeed or fail and why we die (Schaefer, 1986). Religion takes on various forms; however, most of them involve the idea of the sacred. As such, a definition of religion in its simplest form is belief in the sacred and profane. The sacred can either be viewed as a God, gods or object/objects which have the ability to influence and control human action and behaviour.

Barrets (2001) includes in his concept of religion the collective customs and traditions of people who have formed an organisation or institution to pursue the study of a specific spiritual teaching or belief system, for example, Scientology. Marshall (1998) combines both ideas in his definition; religion is a set of beliefs, symbols and practices, which is based on the idea of the sacred and which unites believers into a socio- religious community (Marshall, 1998).

Religion can also be understood as a philosophy and a way of life. It can define who you are, how you view the world and how you relate to it (Wilson, 1982). Religion is considered the universal tool for explaining phenomena that people do not understand. There are as many different types of religion as there are different types of people and cultures. Today, some people are non-religious or profess to be atheists (Dillion, 2003). This is a result of

secularization, where the influence of the non-religious has taken precedence. This can be a result of the contemporaneity of our societies, where there is a strong influence of media, alternative lifestyles and information. According to some neo-functionalists, religion in contemporary society will lose its momentum and influence (Dillion, 2003). People will change to alternative means of worship and lifestyles which are not governed by religious beliefs. Although this is evident in other parts of the world, in Africa and indeed South Africa, this has not been the case. If anything, religious beliefs have had a significant resurgence (Takyi, 2002). Religion continues to be a significant social force in South Africa society.

Religion is also a cultural influence that plays a significant role in the socialization of an individual. Religious beliefs and values can shape people's lives from birth. According to O'Dea (1966), religion has been characterized as being the bulwark of morality and a source of public order. However, religion and religious organisations are very diverse. According to Popenoe *et al.,* (1998), there are 22 major religions in the world. These include Christianity, Confucianism, Sikhism, Baha'i, Hinduism, Buddhism, Taoism, Rastafarianism, Islam, Judaism and many more. Moreover, within these 22 major world religions, there is a lot of diversity and differences in the form of practice, belief systems and worship. Further, each of the world religions are a classification of multiple distinct movements i.e. sects, divisions and denominations. For example, the Christian religion embraces the Greek Orthodox Church, Catholic Church, African Independent Churches, Evangelical, Pentecostal, Quakers, Charismatic and Christian Scientology, to name but a few (Popenoe *et al.*, 1998).

The sociology of Religion attempts to understand the social aspect of religion and the role it plays in society. It includes the scientific study of religious institutions, beliefs, practices and

the role of religion in society (Wilson, 1982). Its ideology, structures, systems and practices are analyzed in light of its contribution to society.

Within the positivistic tradition, the functionalist perspective is helpful in explaining religion in society. It analyses religion from two perspectives; as a social system and its role in individual function. Emile Durkheim laid the foundations for this approach in his book *Elementary Forms of Religious Life*, first published in 1912. Durkheim (1912) explains that religion is based upon a unified system of beliefs and practices related to sacred things, sacred things being symbols or a representation that are expressed in an entity called the church. Using a small "primitive" community, Durkheim was able to decipher the importance of religion produced from shared values and moral beliefs that form a collective conscience He argued that in order to better understand religion, focus had to be on the religious practices. His focus was on the manifestation of the belief in the sacred. He states that sacred things are symbols that are of value in the people's lives and thus, had immense influence over individual and shared beliefs. As such, one of the core functions of religion is social cohesion and solidarity. Durkheim described religion as a social institution responsible for solidarity that provided meaning for the different experiences confronting people in society. His ideas were later developed by Talcott Parsons. Parsons (1967) writes events that cannot be explained, such as premature death, are best understood within a religious framework.

According to O'Dea (1966), the functionalist perspective argues that in order to maintain social cohesion, value consensus and harmony, different social systems such as religion have a special function in contributing to social solidarity. Religion is understood as a belief system that plays a part in the way people see the social world and their position in that

world. Although the functionalist approach has been criticized and challenged, it is still relevant as it articulates the functional prerequisites needed for shared norms and value consensus. This, however, does not exclude the presence of conflict and divisions in society. One of the limitations of the functionalists is their failure to adequately deal with social conflict and dysfunctions. Marx's theory deals with the question of conflict and competing interests in society. He provides an alternative theory of religion to early functionalist writers such as Durkheim. Marxists see religion as an ideological framework whose purpose is to maintain capitalist system.

Functional theory sees society as equilibrium between social institutions which pattern human activity in terms of shared norms. These are held to be legitimate and binding by the human participants themselves. This complex of institutions, which as a whole constitutes the social system, is such that each part is interdependent on other parts and any changes affect the condition for the system as a whole (Scharf, 1970). The social function is still relevant and it is important in shaping morality and normative ideas.

Postmodernist sociologists have moved beyond the analysis of religion as a social institution to recognize individual differentiation or the role of agency within religion (Dillion, 2003). They recognize that although there are shared religious values, ideas and patterned orientations which affect society, individuals can ultimately inform their own responses. In this sense, the function of religion is seen in light of not only the social structures, but also in that of individual behaviour and beliefs. Within this framework, there is recognition of individual autonomy and of lay theory. There is a dynamic relationship between the individual and religion. Thus, what the religious institution imparts into the individual may not make the desired impact. For example, Christianity teaches against sex outside marriage.

However, each individual has to make the choice whether to adhere or not to the church's teaching. This insight is very important in thinking about HIV/AIDS.

The concerns of the post modernists may partly have been shaped by of Max Weber (1905, 1922). He focuses on the role of religion with regards to the meaning it provides in society. He explains that people not only need emotional adjustment but also mental assurance when facing life problems of death and suffering. Religion provides a powerful tool of reason and explanation (Turner, 1992). Based on Weber's analysis of the 'problem of meaning' in religion, modern functionalists explain that this need for meaning is triggered by two aspects of human existence that transcend beyond human experience and control (Scharf, 1970). These two aspects are uncertainty and powerlessness. Uncertainty is based on the experience of the unknown (O'Dea, 1966). Individuals can plan and create aspects of their lives that give them a sense of security. Yet, there is the element of the unknown, all events are liable to disappointment and life is unpredictable. This uncertainty about the future may create a sense of helplessness, which is linked to the next aspect, 'powerlessness'. Powerlessness is the lack of control over certain events in life like natural disasters, premature death, HIV/AIDS.

Religion provides answers to questions concerning human destiny, the demands of morality and discipline, suffering and death (O'Dea, 1966). Religion is often viewed as the moral guardian in society. When HIV/AIDS first appeared amongst homosexual men in the USA in the early 1980s, the men were considered by most people and most, if not all churches, immoral. The dominant Christian response was judgmental. HIV/AIDS was seen as a 'plague'. Within the Judeo-Christian discourse, plagues are seen as punishments inflicted on those who have sinned. This overtly moralistic stance from Christianity was informed by Biblical interpretations against homosexuality. However, this response facilitated the spread

of the epidemic by creating an artificial hub of people (Christians) who believed they were at less (or no) risk. Today, this stance has been retracted by the dominant voices within Christianity, but elements of judgmental discourse still exist. By only advocating for abstinence and faithfulness in heterosexual monogamous marriage, people who are HIV positive are classified as immoral, engaging in sinful behaviour. The result of this has been widespread stigma and discrimination against people living with HIV/AIDS, while creating a false sense of security among those that consider themselves out of the risk group by virtue of their adherence to the Christian beliefs.

In this view, religion then provides a means for people to adjust to and explain social problems. This is one of the core functions of religion in present society. Its emphasis has moved from being purely social solidarity to one that provides meaning to suffering and premature deaths brought on by the HIV/AIDS epidemic. Parsons (1967), states that religion is able to maintain social stability by allaying the tensions and frustrations which could be disruptive. As stated earlier, the Christian churches' focus on the first and second generation of activities in Korten's framework is evidenced through their comprehensive involvement in care and support of people living with HIV/AIDS. However, the Christian churches have also had a conflicted role in explaining HIV/AIDS. The WCC (2000) states that, "sometimes, churches have hampered the spread of accurate information or created barriers to open discussion and understanding". The dominant responses to the epidemic from Christian churches have evolved over time from judgmental through denial (that practicing Christians could be affected) to compassion and caring for HIV/AIDS 'victims' Throughout People Living With HIV/AIDS (PLWHA) have been stigmatised.

## 2.2. The Christian Church Denominations

Having talked about the churches' responses to HIV/AIDS, the following discussion unpacks what is meant by 'church'. The church is the body commonly associated with the Christian religion. According to the Durkheim (1912), the church is a socio-religious belief system that unites in one single moral community. Thus, a church has a specific value consensus founded on certain religious beliefs. According to Robertson (1981), the term church refers to a formal bureaucratic structure, with a hierarchy of officials. In theory, the church ministers to all members of society. All religions involve communities of believers, but there are many different ways in which such communities are organized. A socio-religious community or institution of the church is defined by regular meetings and the performance of certain rituals that unify the group (Wilson, 1982). In this study, "Church" is used in reference to any Christian denomination that meets in public worship of the Christian God or Jesus Christ. As already mentioned, the church is not a monolith, but is heterogeneous with doctrinal and social differences. It has many different denominations and branches that have different styles of worship, organization, practice and teaching. There is no one body of thought within the broad Christian Church. As evidenced by the different denominations, Christian churches have varying doctrines. However, they are all bound together through their beliefs in Jesus Christ, his resurrection, the virgin birth and a belief in the Bible and the Ten Commandments as the foundational texts governing Christian human behaviour. Based on these shared ideas, the churches can be said to have similar canons that can homogenize certain broad beliefs, even though key doctrinal differences persist. These, as we shall see later, are important.

In South Africa, there are broadly three types of Christian churches with different denominations within each and varying doctrinal differences. The three types are:

i) the "Mainline" Churches, for example, the Anglican, Catholic, Presbyterian, Methodist and the Dutch Reformed Church,

ii) African Independent Churches (AIC) such as the Zionist Church

iii) Pentecostal/Charismatic Churches, for example, the Universal Church.

According to De Gruchy (1995), Christianity in South Africa was brought about by the first settlers, the Dutch, who entered through the Cape. The first significant church to be established in South Africa was the Dutch Reformed Church. The establishment of Christianity in South Africa is closely aligned to white political domination. Protestantism was the dominant form of Christianity that also established itself in South Africa through missionary work. According to Prozesky (1995), the widespread political influence of Protestantism is evident today when comparing numbers of congregants and churches in comparison to the Catholic Church. The influx of the British people led to the introduction of numerous other Christian denominations, i.e. the Anglican, Methodist, Catholic, Presbyterian and Baptist Church, which are commonly referred to as the "Mainline Churches". According to Garner (2000), these churches are generally characterized by formal liturgical ceremonies and rituals. These churches are bureaucratic with a clear hierarchy of control. The relationship and establishment of these churches is generally from the top downwards. The congregant members have limited involvement in the functions of the church. Indeed, many people who consider themselves members of the mainline churches do not even attend church regularly and they normally have only one service a week.

The gradual conversion of the African population from traditional forms of worship to Christianity saw an increase in the spread of Christianity in its varied denominational forms. This conversion to Christianity also led to the adaptation of the religion leading to the

formation of AICs that incorporated African belief systems into Christianity. De Gruchy (1995) argues that the transformation of Christianity from a white-dominated religion in South Africa, to one that is African-dominated was a significant development in the 20th century. Today, over 75 per cent of the African people in South Africa profess to be Christian.

However, the AIC also originated from the Evangelical Ethiopian churches. These churches are named after Ethiopia from the Old Testament and not the country itself. The Ethiopian Church broke away from the mainline churches in protest against white supremacy in the church. They then formed their own church tailored for the African people, though it maintained the missionary teachings of the Bible. This is the main difference between the AIC and the mainline churches although the AICs are an infusion of Christianity and African religious traditions.

The biggest AIC in South Africa is the Zionist Church. Its primary focus is on spirituality and the ministry of healing. Unlike the mainline churches, Zionism is an expression of community-based religion as opposed to the bureaucratically organised religion like the mainline churches (Kiernan, 1995). It is the refinement of Christianity to relate to African experience. According to De Gruchy (1995), the Zionist Church is an adaptation of the Christian Church to the needs of an impoverished people. Its belief in the ability to heal through spiritual intervention is one of the 'pull' factors in terms of followers. It offers hope to those who have faith and either lack belief in and or the means to seek orthodox bio-medical treatment for serious illness or affliction.

The AICs are spread throughout South Africa and they vary in terms of size. However, their structure and doctrine is generally similar. Central to their belief system is the prophetic healing ministry; the belief that through faith and prayer, an individual can receive healing from God, without the need to seek biomedical help. The healing is channelled through a prophet who then imparts the healing onto the individual. This belief system has led to a rapid growth in the membership of poor people in the lower classes. According to Kiernan (1995), in its healing activities, the congregations' communal prayers are the culmination of the visitation of the Holy Spirit, who then heals people. Healing thus, always presupposes prayer and Christian revelation by the prophet who heads the ministry (Kiernan, 1995). This is central to the belief system of the AICs. As a result, in their healing ministry, AICs draw on this prophetic flair as a means of healing rather than the ministerial faculty of outreach programmes such as establishing hospice centres. This form of Christian church outreach defies Korten's Four Generations framework, as these churches are able to impact on people without being in any of the four generations classified by Korten. In addition to this, the AICs have massive followings and they have the ability to easily mobilize communities and people, with no intention of changing or influencing systems. They simply believe that God can directly heal His followers, rather than taking the sick to hospital. In South Africa, this is the dominant type of AIC. Its main followers are poor people who, not only find spiritual solace, but receive 'healing' without having to spend any money.

The founding of the Apostolic Faith Mission (AFM) and the Assemblies of God led to the dawn of Pentecostalism (or Charismatic Churches) in South Africa in 1914. This form of Christianity is closely linked to the Evangelical Churches. The evangelical churches place a lot of emphasis on a personal relationship between the individual and God. They believe that each follower must spread the faith and bear personal witness by openly declaring the

religion to non-believers (Robertson, 1986). This is similar to the Pentecostal faith which holds most of the same values yet, also believes in the infusion of the Holy Spirit into services and such religious experiences as faith-healing and speaking in tongues. This is the third main type of Christian Church that is dominant in South Africa. This type of church is the most diverse with various denominations falling under the banner of Pentecostalism. The Pentecostal Churches account for between 8 and 10 percent of the national Christian population. This type of church is very proactive and involved to a very high degree in its followers' lives. According to Garner (2000), membership of the Pentecostal Churches is by professing faith and undergoing adult baptism which is perceived as being "born again".

As mentioned earlier, the Christian church plays a key role in explaining social problems. According to Benn (2001), the church monitors the spiritual, religious and moral aspects of society. It identifies with traditional cultural structures that impact on social cohesion and morality. In this regard, the churches have similar canons around sex and sexuality and health and illness that homogenize certain belief systems. Most, if not all, focus on sexual abstinence outside heterosexual monogamous marriage although the degree to which they insist on this varies greatly. The Pentecostal churches, for instance, strictly advocate only abstinence and faithfulness in marriage. Within the Pentecostal churches, there is high level of indoctrination and little tolerance for disobedience. Garner (2000) claims that studies have shown that Pentecostalism has the highest numbers of converts who adhere to HIV/AIDS prevention messages of abstinence and faithfulness. However, Hall (2004) argues that the general response of the churches towards HIV/AIDS over the years has been inadequate and at times, has made the situation of the epidemic worse. The next section pays attention to the churches' views on sex and sexuality.

## 2.4 Christian canons of sexuality & HIV/AIDS

Christianity, by and large, has assumed the characteristics of an anti-sexual religion (Jacob John, 1995). This stems from the historical anti-sexual social environment that informed interpretations of the scriptures, particularly the New Testament (Jacob John, 1995; Parrinder, 1998). It is from this standpoint that early Christian writer's defined sex as a means of procreation and an act to be performed only within the bounds of marriage (Parrinder, 1998). Jacob John (1995) argues that the perceptions of sexuality amongst Christians gained credence, not only in the early writings of Christian Fathers such as St Augustine, but in the New Testament. The writings of Paul in the New Testament seem to be the premise upon which beliefs around sexuality are founded. Paul's writing emphasizes premarital virginity and the blanket prohibition of sex outside marriage (Robertson, 1981). According to Parrinder (1998), Paul largely associated sex and sexuality with its carnal nature and its negative association with women and sin. He tolerated marriage only on the grounds that it is 'better to marry than to burn' (Parrinder, 1998). This view was strongly endorsed by such theologians as St Augustine. Although the writings of Paul on sexuality and marriage were directed to the people of Corinth, who had a reputation of immorality, theologians like St Augustine endorsed Paul's writings into law (Parrinder, 1998). St Augustine's beliefs and interpretations are the source of Catholic Church's requirement of celibacy in its priests. By the early Middle Ages, sex was virtually equated with sin; the doctrines of the Medieval Church were based quite simply upon the conviction that the sexual act was to be avoided, except for the minimum necessary to continue the human race (Parrinder, 1998). The Church during this time restricted the number of days when a married couple could have sexual intercourse (Robertson, 1981). The churches managed to socially construct anti-sexual norms and values in society. As such, the history of Christian sexual norms is largely associated with the history of Western society.

In view of this, sexual norms and values are certainly a social construction. They are a result of years of influence from the period when the churches had a significant influence on the state and society. According to Parrinder (1998), theologians argue that Christian sexual attitudes, norms and values are closely linked to broader societal sexual norms e.g. 'Thou shalt not commit adultery'. Western history of sexuality and Christian norms are interchangeable (Robertson, 1981). Christian sexual norms in South Africa have their origins in this history.

Contemporary society still carries remnants of the anti-sexual theology. According to Jacob John (1995), sex and sexuality continue to be taboo issues in the church. People cannot openly talk about sex. Although this is changing in the western world, there is little change in the African context. This makes it difficult for the Christian churches to deal with issues of sex, let alone sexually transmitted diseases. According to Jacob John (1995), within this negative discourse, it is generally believed that sexuality and spirituality are incompatible, leaving discussion about sexuality out of the church. As a result, churches have not always encouraged open and affirming discussion of issues of human sexuality (WCC, 1997). Yet, if sound moral decisions are required of people to change high risk sexual behaviour, an environment conducive to making such decisions is essential in Christian discourse. Clifford (2004) argues that the silence that engulfs the church around matters of sex and sexuality has facilitated the spread of the epidemic. It is this failure to deal with anything outside the 'divine sexual code' that makes it difficult for the church communities to openly deal with the challenges posed by HIV/AIDS (Benn, 2002, Jacob John, 1995, WCC, 1997). Success in interventions is only possible if the churches begin to address internal stigmas like homosexuality (this is a big debate in the Anglican Church), STIs and extra-marital sex.

Dealing with such issues that are the reality of today's society will contribute to the alleviation of HIV/AIDS stigma and discrimination of PLWHA (Paterson, 2003).

The belief that HIV/AIDS is a product of sin, since it is a sexually transmitted disease associated with deviant and immoral sex, is still present in some churches in Africa (Clifford, 2004). According to Parker & Aggleton (2003), religious doctrines, morals and ethical positions regarding sexuality, sexual behaviour and the denial of HIV/AIDS realties have facilitated the belief that those infected have sinned and are deserving of punishment. The churches are in a predicament: whether to love and care for the people, or to judge and condemn (Parry, 2004). This paradox tends to 'paralyze' some church ministers, drawing them into silence and inactivity around addressing HIV/AIDS issues (Gennrich & Gill, 2004).

Smith (2004) explains that the association of HIV infection with immoral behaviour is part of the negative attitude towards sex and sexuality, characteristic of the churches. This anti-sexual environment extends to society where it is not only normative to not discuss sexual matters, but is entrenched in cultural and traditional beliefs and norms. This creates a difficulty in effectively dealing with complex issues related to sex raised by the AIDS epidemic.

In light of the beliefs around HIV/AIDS how have the Christian churches responded to the epidemic in practice?

## 2.5 Christian Churches response to HIV/AIDS

The South African Council of Churches (SACC, which mostly represents mainline churches) and Treatment Action Campaign (TAC), in a joint press statement in November 2005, stated that with the growth of the epidemic, there was need for the churches to begin addressing the issues that drive the epidemic, i.e. stigma and the lack of safe sex initiatives. According to Clifford (2004), new religious accounts of the epidemic are urging people to love and respect one another, as Christ loved the church, in an effort to counter stigmatizing responses to HIV/AIDS. However, Schmid (2002) found in a study of the churches' response to HIV/AIDS in Cape Town that the discourse of judgment is still common in some Christian churches. Additionally, studies conducted by Gennrich & Gill (2004) found that some church leaders and lay members still held judgmental attitudes and beliefs towards those infected with HIV/AIDS.

With the spread of HIV/AIDS, mostly amongst young people, it has become increasingly evident that the churches have not been too successful in shaping behaviours, but also, that they have been actively teaching an ineffectual and unrealistic HIV/AIDS message. Additionally, Paterson (2002) argues that the messages from the churches have been quite contradictory and confusing. On the one hand, there is a call to love and care for all people who are suffering from the epidemic, yet, on the other hand, there is a call to abstain and practice monogamy in marriage, which excludes 'others' and potentially alienates those who do not adhere.

It is important to recognize that the process by which HIV/AIDS becomes a moral issue is greatly influenced by the responses and interpretations of the religious community (Clifford, 2004). The different responses to the epidemic by the churches are best understood by

looking at the four key challenges posed by HIV/AIDS i.e. stigma and discrimination, prevention, support and treatment.

### *2.5.1. Stigma and Discrimination*

According to Parry (2004), stigma and discrimination of PLWHA remain the biggest hurdles that the churches have in addressing challenges posed by the epidemic. Stigma in the churches revolves around the belief that it is an immoral disease resulting from deviant sexual behaviour. The association of HIV/AIDS with homosexuality in the western world and in African countries with prostitution and promiscuity fuelled stigmatizing and discriminatory attitudes and beliefs. This was made worse by the churches pronouncing harsh moral judgments on people infected with the HI virus. This deepened the silence around the epidemic and fuelled the presence of stigma and discrimination. According to Paterson (2004), the silence around HIV/AIDS is embedded in the inability of the people and religious leaders to openly discuss sex and sexuality. This inability to openly discuss sexuality in the community and churches creates a barrier to openly discuss and deal with challenges posed by HIV/AIDS.

However, with intensified interventions countering stigma and advocacy against discrimination of PLWHA, there has been a shift in some churches. According to Clifford (2004), there are attempts by the churches to move from judgmental attitudes to inclusion and hope. This has not been very successful as the transition is taking place with little input from the people living with HIV/AIDS, hence, these efforts are at times misguided, leaving stigmatizing attitudes unchallenged. According to Gennrich & Gill (2004), in South Africa, HIV/AIDS to most people continues to be about immorality and evidence of sexual deviance. Religious doctrine regarding sexual matters and denial about the realities of HIV/AIDS, have

reinforced the perception that those who are infected deserve it, thus increasing stigma and discrimination (Brimlow, *et al.,* 2003). These beliefs then lead to blame, stigma, denial and discrimination against people living with the infection. Attaching blame to people for HIV facilitates the creation of 'innocent victims' who get infected i.e. children. As a result, the churches have channelled a lot of their HIV/AIDS initiatives to those groups of people (children) whom they apportion no blame for infection (Clifford, 2004).This excuses them from confronting the presence of HIV/AIDS amongst their followers and evidently, the presence of extra and premarital sex in their midst.

However, Paterson (2003) argues that HIV is not only a moral issue. It also has a lot to do with sex, addiction, premature death, human relationships and universal human experiences which are located at the core of family and community life. Hence, in theory, as outlined in the functionalist perspective, the churches are ideally placed to engage with such matters, intimately involved as they are in the lives of people and communities (WCC, 1997).

Parker & Aggleton (2003) explain that stigma associated with HIV/AIDS is reinforced by already existing social discrimination practices. HIV/AIDS stigma is expressed with one or more other stigmas, particularly those associated with marginalized groups (Brimlow *et al.,* 2003). In the churches, women are most affected. According to Haddad (2002), the vulnerability of girls and women to HIV/AIDS and then the silence of the churches on these matters is deadly. Although there is a shift in the right direction of encouraging a discourse of love, compassion and hope, the silence around sex, sexuality and the epidemic still encourages judgmental and stigmatizing attitudes.

### 2.5.2. *Support and Care*

The churches are renowned for their activities in the field of spiritual care, home-based care and assistance to women and children (Paterson, 2003). This dimension of the HIV/AIDS epidemic garners the strongest resources and response from the churches. With an inherent mandate to care and support poor and disadvantaged people, the churches were the first to respond to the challenge of HIV/AIDS in the early 1980s (Paterson, 2003). Some of the earliest home-based care and orphan programs were developed and supported by the churches and faith-based organisations (Paterson, 2002). This remains the most comprehensive response from the churches and faith communities and it is an example of good practice. Schmid (2002) explains that caring for the sick and dying is what the church has done for centuries and it seems to take it on most naturally. This response by the churches as already mentioned, is in line with the Korten's (1990) first generation of relief and welfare.

Interestingly, this care and support from the churches has coexisted with a discourse of 'judgment' of the very people to whom they offer support (Paterson, 2002). This has contributed to the silence around HIV/AIDS which feeds into stigmatisation and denial (Clifford, 2004). The church is also often selective in its assistance. It mostly cares for 'innocent' orphans and women, whom they consider victims. They believe that this group of people is not 'responsible' for the contracting the virus. This sustains the presence of stigma and discrimination of PLWHA.

### *2.5.3. Treatment*

In the area of support, the church has contributed immensely. In the case of treatment, the presence of Anti-Retroviral Therapy (ART) presents a new dimension to perceptions of HIV/AIDS. The rollout of ART in South Africa was introduced in late 2004. The Anglican Archbishop of Cape Town has overtly aligned himself with the Treatment Action Campaign's struggle for ART by joining their protests (Gennrich, 2004). Churches should take a leading role in treatment campaigns based on their widespread traditional missionary health care facilities in Africa. By taking on this role, the churches could act as catalysts for change in communities. Gennrich (2004) suggests that the churches should be one of the major partners with government in the ART rollout, as they have access to isolated populations in the rural areas where people rely on church mission hospitals.

Kagimu (2004) argues that in order for the churches to devise an appropriate response to ART, they need to first address the issue of stigma. Due to the stigma, people tend to hide HIV infection and consequently reduce their potential access to ART. This further enhances stigma by hindering open discussion of the epidemic.

### *2.5.4. Prevention*

HIV/AIDS prevention has also been a serious bone of contention in the churches' response. The churches in this regard, have not actively engaged in most prevention messages, like the promotion of prophylactics, which could imply a dilution of their moral standard. The prevention campaigns from the churches have mainly advocated abstinence and faithfulness in monogamous marriage. The use of condoms is seen as a means of promoting promiscuity and reckless sexual behaviour. The concentration on fidelity in marriage fails to take into

consideration that some people within marriage are still vulnerable to contracting the virus. According to Haddad (2002), most HIV-positive women are married women. By denouncing the use of condoms and not teaching safe sex methods, the churches are failing to address a serious problem in HIV/AIDS prevention, and potentially excluding a majority of thier followers.

Clifford (2004) argues that the resistance by some churches to advocate safe sex practices is a result of two factors. Firstly, they associate condom use with promiscuity or sexual deviance and secondly, argue that condoms promote this immoral behaviour. Some churches have become infamous for their position against the use of condoms. For example, in keeping with its doctrinal beliefs, the Catholic Church has refused the use of condoms even within the bounds of marriage. Its theological justification rests on the premise that sexual relations are only ordained in marriage for the procreation of life. It reasons that a person's faith should help them resist sexual temptation, and, therefore, HIV/AIDS (Garner, 2002). This official Catholic Church position is contested by many people and organisations working with PLWHA. The problem with this stance is that it fails to take into consideration the frailty of human beings and the social environment their followers live in, which complicates simple adherence to prevention messages. Recent increases in the prevalence of HIV/AIDS is evidence that very few people are able to adhere to these forms of prevention. Yet, the three dominant Christian denominations in South Africa all continue to advocate abstinence and faithfulness. However, some churches are stricter in keeping with this doctrine. Garner (2002) points out that the Pentecostal churches have been noted as the strictest form of Christianity with regards to religious adherence to sexual norms and values.

A gap in the prevention campaigns of the church is its failure to address safe sex methods. The Catholic Church is perceived officially to maintain a position which cannot plausibly be

adhered to in practice by the body of its followers. Yet, Keenan (2000) argues that the Catholic Church will not change its position on condoms, since this is closely tied to its view on sexuality, which cannot be detached from core values of Christian love, marriage and procreation.

## 2.6 Concluding Comments

After reviewing the literature on religion and the influence behind the churches' developmental response to HIV/AIDS, it is important to summarize the major points. In this chapter, I have constructed a theoretical framework to demonstrate the importance of the Christian churches' interventions in the HIV/AIDS development challenge. The functionalist perspective on religion highlights the important role religion fulfils, both to the individual and the community through social cohesion. Further, it is important to grasp the extent to which the Christian beliefs of sexuality and morality have influenced the society today. This is because, societal responses of stigmatization and classification of HIV/AIDS as an immoral disease is influenced by Christian beliefs. Additionally, this chapter argues that the intersections of the role of the church in society, its perceptions of disease and beliefs around sexuality are paramount to understanding their responses to HIV/AIDS.

Taking into account that this is a vast subject, this work is mainly exploratory. It aims to theorize some of the issues as well as pose questions for further investigation. Using Hout Bay as an example of the Christian Churches' response, the following chapters explore some of the practical responses to HIV/AIDS in a concrete context.

# Chapter 3: The Example of Hout Bay

## 3.1. Overview

This dissertation formed part of a larger research project that was undertaken by the students taking the core course *Critical Issues in the Study of HIV/AIDS and Society,* of the MPhil in HIV/AIDS and Society offered by the Graduate School in Humanities at UCT in 2003. Four students[1] from the course undertook a collective research project focusing on Hout Bay. The aim of the research project was two-fold. Firstly, it was to apply in practice some of the research methodologies and theoretical understandings of HIV/AIDS in a real situation. Linked to this the philosophy of the MPhil was that it would only be useful to the degree that it could be creatively and usefully applied to real challenges posed by the epidemic in South African society.

The motivation for selecting Hout Bay as the area of study was because it is a geographically contained community with the main "racial" groups still living separately from each other. This particular settlement pattern is a result of the history of apartheid, which still holds true for most settlement patterns in South Africa.

The study is based on documentary research and interviews with key informants. The original research was undertaken in 2003. As a result of the lapse of time, further time was spent in Hout Bay 2008 to review the situation since then. This comparative dimension is reflected in the thesis, although it is only a small part of it. A fuller discussion of the research methodology is given in the next section on the research process.

[1] The students were Lillian Mboyi, Dalene Mofokeng and Howard Smith, from the MPhil, Sazini Ndlovu, who is completing a Masters in Development Studies with a thesis on HIV/AIDS, Lauren Templeton and Chao Mulenga participated. Dr Judith Head, Convenor of the Course, led the Study.

The focus of the study is primarily on the Imizamo Yethu (IY) Township. IY is like other very poor communities in Cape Town (urban townships) that experience high rates of infection. There is very dense housing, mainly consisting of self-constructed shacks. Many of these lack piped water and sewage disposal. The population is young and unemployment levels are very high.

Most church interventions on HIV/AIDS in Hout Bay are focused on IY. This is primarily because it is the most impoverished community in Hout Bay and the most vulnerable to HIV.

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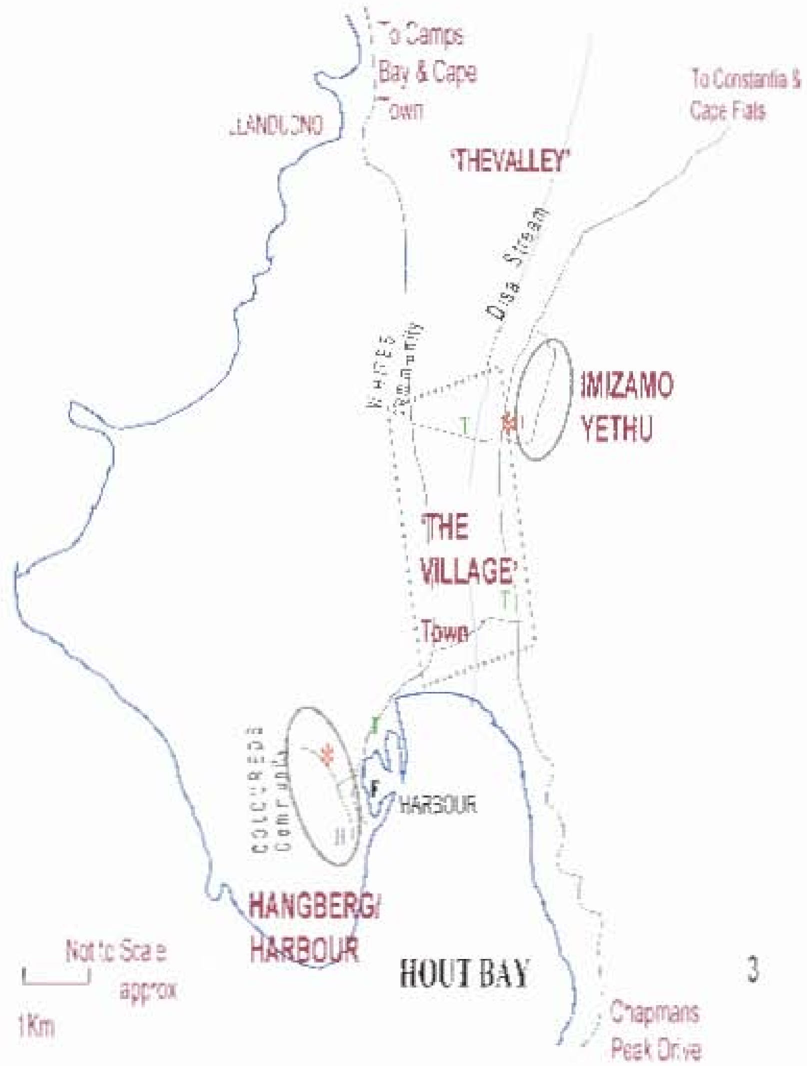


01/06/2008

Source: Howard Smith, Outline of Map adapted from Census 1996

## 3.2 The Research Process

The first step in the research process was the literature review. This involved two phases. The first was collecting data and information on Hout Bay. Reviews of journal articles, books, newspapers and electronic sources were used to gather information on Hout Bay. In addition, presentations from key informants were given to help inform the relevant areas of HIV/AIDS research in Hout Bay. Professor Jim Cochrane is interested in the relationship between poverty and religious health assets. Reverend Renata Cochrane works in outreach programmes in IY through the Moravian church. Each gave a seminar to the research group.

The second phase of the literature review explored how Christian denominations have responded to HIV/AIDS. A literature review was conducted of the official dominant responses from the advent of the epidemic to the present. These two literature reviews informed the interviews in Hout Bay.

Interviews and direct observation were the main elements in gathering information on Hout Bay. Interviews were conducted with various stakeholders in Hout Bay in 2003 and 2008. The church leaders interviewed were either involved in HIV/AIDS work or had a significant following in the target community, Imizamo Yethu. Out of the 19 churches recorded in IY in 2003, we were able to select five, based on the recommendation of the PLWHA. Within the five Christian groups, three were mainline churches (Anglican, Catholic and Moravian Churches) and the other two were from the African Independent Churches (Zionist) and a Pentecostal Church (Universal Church). In 2008, interviews were conducted with three other AICs (Gospel Outreach Ministries, Old Apostolic Church of Africa and the St Johns Apostolic Mission). Iziko Lobomi Centre, an inter-denominational community initiative, was revisited.

Semi-structured in-depth interviews were held with seven women living openly with HIV/AIDS. These conversations were conducted at Yabonga HIV/AIDS Support Centre and at the Main Road Clinic. Interviews with each respondent lasted for approximately 30 to 40 minutes each. A set of broad themes were laid out before the interview as an interview guide and the respondent was encouraged to respond freely. These themes differed from one individual to another, although in most instances, similar leading questions were used to probe the subject. The emphasis was placed on the respondent to impart as much information as possible without feeling restricted. In 2008, discussions were held with the leaders of a support group for PLWHA called Uncedo Lwabantu [Helping People]. This is a new group that is housed in Iziko Lobomi community centre which had not been formed in 2003.

Participant and direct observation was also used in gathering information. The observations were carried out in the Main Road Clinic, in and around Iziko Lobomi Centre and by sitting in support group meetings. The information collected was recorded in note format.

### *3.2.1 Participant selection procedure*

Participants were purposefully chosen. To add richness and an understanding of Hout Bay and Imizamo Yethu, representatives from multiple levels were interviewed. Interviews with people in Hout Bay were, apart from direct observation, the main element of the field research. The selection of people to interview in 2003 was the product of discussion within the group. Twenty four informants were selected for their knowledge of Hout Bay. Of these, three were nursing sisters at two public clinics, who mainly see people from IY, a doctor in private practice who serves the wealthy community, and eight church representatives

The key informants at Hangberg were Timothy Jacobs (TJ), the chairperson of the Hangberg Civic Association (HCA), Fardwa Fardien (FF), an HIV/AIDS activist in the Hangberg, Sister Mathews from the clinic, the School Principal, Mr. Philips, and Ms Smith, a life skills teacher at the Hangberg Secondary school and Imam Abrahams from the Muslim Mosque. In addition, we interviewed the elected ANC MP allocated to the Hout Bay Constituency. This is a non-random manner of selecting people to participate in a study. It is a valid methodology because the respondents, owing to their positions, have important knowledge. Moreover, by drawing on a range of informants, the information can be triangulated.

The selection criterion for the church leaders was also in keeping with the objectives of the study. To this end, key informants were selected from churches involved in HIV/AIDS work in IY. Seeing that a lot of time had elapsed since the last interviews were conducted, as indicated above, more interviews were conducted with four church leaders from the IY community in 2008.

### *3.2.2. Participants*

The participants were chosen on the basis of their knowledge of Hout Bay and involvement in HIV/AIDS development issues. The name and contact details for the first informant, Kenny Tokwe (KT), Secretary of the ANC Branch in Imizamo Yethu, was provided by the Constituency MP's Office at Parliament. He, in turn, provided the name of an HIV/AIDS Counsellor, Buhle Nyathi (BN), in Imizamo Yethu and a contact with Hangberg Residents' Association, who in turn provided names of school principal and the HIV/AIDS counsellor in Hangberg. Thus, some of the study's informants were identified in the course of initial interviews. These included the then ANC MP of HB, James Ngculu, as well as the Principal

### *3.2.4. Ethical Considerations*

At the interviews, the purposes of the research were given to informants and they were informed that the information would be used in the dissertation. Permission to refer by name and to quote the participants was obtained from all people who participated in the research. This is inclusive of the PLWHA. This group of respondents was accessed via Iziko Lobomi and the clinic. The support group is located within the premises of the clinic. The research team had an official introductory letter from the University which it presented to all potential respondents. It was made very clear to respondents that there was no obligation to talk to us; that no consequences would follow if they did not, and that no payment would be offered. Because HIV/AIDS is still a sensitive study as indicated above, pseudonyms have been used for informants living with HIV/AIDS throughout the dissertation.

## 3.3 Description of Hout Bay

***Background***

Hout Bay is a coastal residential suburb and business community of approximately 22,000 people. It is located in the Disa River valley on the west coast of the Cape Peninsula. It is bordered by three mountains and the sea. It is geographically self-contained and quite detached from Cape Town (Oelofse, 1996). The name *Hout* means *wood* in Dutch. The Dutch were the first missionaries in that area.

Hout Bay is a fishing harbour with a vibrant fishing industry. The social composition of Hout Bay, in the past, comprised of a Coloured and White population because the apartheid policies banned African people from working in the Western Cape. Under apartheid, there was no housing and land provision for the African people in Hout Bay. The rise in both the fishing and tourist industry fashioned an increase in the demand for labour. The development of the fishing industry by the white population saw the creation of the Coloured settlement, Hangberg (Oelofse, 1996). The Coloured population was allowed access to work in the fishing industry because of the "Coloured Labour Preference Policy", which only allowed Coloured employment in the Western Cape. This restricted the employability of the black African population into the area.

However, the fishing industry attracted people in search of employment. This led to an influx of "illegal" African immigrants into Hout Bay before 1990. This facilitated the growth of an African squatter population despite apartheid laws not providing housing for the African population (Gawith, 1996). In the late 1980s, with the changing political structure in South Africa, more African people moved into the urban areas that were previously designated as white areas. Their settlement in Hout Bay was illegal until 1990 when they

were finally allocated land on the west of the area of the Valley, now commonly known as Imizamo Yethu (Oelofse, 1996). Of importance here is how IY remains a highly migrant population. To date, a significant number of the people are migrant labourers in search of employment from the Eastern Cape, other townships like Khayelitsha and surrounding African countries like Mozambique and Zimbabwe.

At present, Hout Bay has three main population groups; White, Coloured and African. These population groups are not only *de facto* divided according to race, but are also geographically-contained in separate areas. These areas are differently resourced. The White inhabitants in the valley area live in luxurious, free-hold detached houses or comfortable apartments. The Coloured residents mainly occupy municipal flats and hostels. The African people living in IY live in self-constructed shacks, few of which have running water and safe and piped sanitation. Hout Bay's living standards are still closely correlated with race. Although poverty is not confined to a particular race, it is largely concentrated among the Africans, followed by the Coloured people. There are extremes of wealth and poverty and conflict over land, rights and resources in Hout Bay.

In Hout Bay, contention between the African and white communities has mainly been in the allocation of land for housing in IY. There has been resistance from the white community's Rate Payers Association (RPA) to release more land for the African people, arguing that the previous squatter camp, IY, should be allocated more land elsewhere, whilst the African representatives fight for more land within Hout Bay (Oelofse, 1996). Despite this, there has been housing development in IY in the African community. In the last few years, the Niall Mellon Foundation (NMF) has donated R30 million towards the provision of more houses in the area. There are two public clinics, the Main Road Clinic in IY, the Harbour Clinic and

one day hospital at Hangberg. In the Valley, there is a private medical centre and a group of private doctors. There are nine schools in Hout Bay, but only two cater for the children from Hangberg and Imizamo Yethu.

Tourism is one essential socio-economic attraction in Hout Bay. Hout Bay's natural resources guided the development of the tourist and fishing industry. By the later part of the $20^{th}$ century, Hout Bay became a tourist destination with a growing local industry (Oelofse, 1994). Tourism in Hout Bay has developed immensely over the past decade. This growth in tourism has led to the development of Hout Bay, to accommodate the influx of tourists and immigrant wealthy foreigners who invest in property. This has led to the rapid growth of a business centre and "up market" property development initiatives. The principal beneficiary of this investment and development is the white community. According to Froestad (2001), very little of this property investment and tourism development has actually trickled down to the other two poor communities, although some jobs have been created. This is evident when visiting Hout Bay. Infrastructural and business development is only present in the white area; *The Valley*. The only sign of tourism reaching the poorer communities is through 'township tours' in Imizamo Yethu.

Thus, although Hout Bay's economy is growing because of the influx of capital in property investment and tourism development, there has been little change in Imizamo Yethu and the Hangberg community. The NMF is the only major development donor in the IY area.

### *3.3.1 Development Challenges in Hangberg*

Hangberg, the oldest community in Hout Bay, is primarily a Coloured community situated on the west side of the bay, by the harbour. This community is divided into six sub-divisions, according to type of housing and socio-economic status. According to one of the informants, Ms Smith, 2003 the Lifeskills teacher at the Hangberg secondary school, the sub-communities include the *Heights* which comprise land owners. This group, in the early 1980s, was the middle income Coloured population which was still restricted by the Group Areas Act (Oelofse, 1996). The other areas, according to Ms Smith, include *Hungry Hills.* These are government subsidized houses. Then there are rental housing and flats - the *Zone, Dallas, Texas* - and the C*ompound* which mainly comprises hostels.

There was limited literature on Hangberg. Most information was derived from these interviews. There are very few development initiatives taking place in Hangberg. The whole community is generally casually employed, if at all, and uninvolved in community interventions.

The social and economic challenges facing the Hangberg community were;

1. *Drug and alcohol abuse*. In all the interviews with the respondents in Hangberg, they explained that drug and alcohol abuse was the biggest problem in community. The population group most affected by this problem is mainly the youth in and out of school.
2. *Teenage pregnancy* is also a serious problem in Hangberg. Many girls fall pregnant whilst still in high school. Ms Smith, (2003) explained that it was of serious concern to the school as these girls left without completing school. It is also a sign that they are not

engaging in protected sex. Sister Mathews, (2003) highlighted that there were a number of girls who had serious sexually transmitted infections

3. *Overcrowding* mainly as a result of spill-over housing and the creation of a squatter camp. The spill-over housing was mainly a result of natural population growth. *"Most people they get married they have no where to go, so they build little shacks or houses at the backyard, or rent space in someone's room"* (TJ, 2003). Overcrowding creates conditions conducive to the spread of communicable disease like TB. Little was being done by the council to deal with the problem of overcrowding in 2003. In 2008, nothing had changed.
4. *Crime* is also a serious problem in the Hangberg. According to Timothy Jacobs (2003), dealing drugs, poaching and prostitution are amongst the crimes that affect the area. This is also mainly affecting the young people. *"People use little boys to dive and fish for the endangered fish, this poaching is illegal and affects our tourist prospects and it is risky as the boys can drown"* (TJ, 2003).
5. HIV/AIDS is present. Unlike in IY, there are no visible interventions to deal with HIV/AIDS. According to the clinic sister *"there is a lot HIV in the community but very little work is being done to deal with it*". (SM, 2003). She said that people from IY go to the Hangberg Clinic for treatment instead of their own clinic. This, she attributes to fear of the community learning of their HIV positive status.
6. HIV/AIDS stigma is a serious problem in Hangberg. An interview with Fadwa Fardien, (2003) revealed that there was a lot of stigma and discrimination in the community, resulting in people not getting tested for HIV/AIDS. Imam Abrahams, (2003) from the mosque in Hangberg also explained that there was a lot of ignorance and fear around HIV/AIDS such that people were at times ostracized by their families for being HIV

positive. Other PLWHA interviewed from the clinic stated that they could not reveal their HIV status for fear of being called names and losing their loved ones.

### *3.3.2 Development challenges in Imizamo Yethu*

By 1991, there were six squatter camps in HB (Gawith, 1996). These 'illegal' migrants were mainly from the Eastern Cape, Gugulethu and Khayelitsha, (interview with KT, 2003). The illegal settlers were met with a lot of opposition from the white community, resulting in many attempts to remove them, both legally and illegally (Gawith, 1996). In 1990, a fire believed to be arson, destroyed one squatter camp killing four residents. In 1991, 34ha land was purchased for the Imizamo Yethu community, grouping all squatter camps into one legal settlement area, but with no provision for housing, people continued to stay in shacks (Gawith, 1996). Of the 34ha, it was decided by the Rate Payers Association (mainly white people) that 18ha would be residential and the remaining 16ha, community facilities (interview with KT, 2003). The residents of Imizamo Yethu were not in agreement with this as the allocated residential land was not enough to cater for all the people who needed housing. This disagreement has been the basis of continued tension between the South African National Civic Organisation (SANCO) and the Rate Payers Association (interview with KT, 2003).

Imizamo Yethu is the most impoverished community in Hout Bay. Situated on the steep slopes of the mountain, it is made up of informal shacks constructed from weak building materials like corrugated iron sheets, wood, cardboard, plastic and the like. Unemployment and overcrowded shacks characterise IY. During the day, the streets are crowded. Infrastructural development in the area contributes to an increase of in-migration, thus, an increase in shacks leading to further overcrowding and straining of limited community resources. This was substantiated by the ANC Member of Parliament for HB, James Ngculu

in 2003 who stated that, *"despite there being the housing project in IY, there was still evidently a problem with overcrowding"*. The issue of housing seemed to be at the forefront. Until the Niall Melon Foundation intervened, there were very few formally built houses in IY. Interviews conducted in 2008 show that the Foundation has built over 200 houses towards its target of 450 houses. This housing development has changed the IY landscape considerably since 2003. Access to proper housing facilities is a crucial prerequisite to access other basic amenities like clean tap water and sanitation. However, despite this welcome housing development, interviews conducted in 2008 highlight the ongoing tensions between the white and black African community with regards to land acquisition and rights.

Besides housing, IY has numerous other developmental challenges that could form part of the Christian churches' development agenda at a structural and systematic level. The first of these is closely linked to the housing situation; most of Imizamo Yethu is under-serviced. This means that most houses and dwellings do not have clean running water (taps) toilets. Refuse collection is a problem.

The second challenge, according to observations and interviews conducted in IY, is poor environmental conditions. IY is located on slopes with inadequate drainage systems. The water from this area flows into the Disa River, making it the most polluted river in Cape Town, thus, fertile ground for the transmission of infectious diseases. Froestad (2001) describes these hazardous environmental conditions vividly:

> In Imizamo Yethu, the situation has become increasingly desperate and risky, both for the residents and for the population of Hout Bay at large. On observation, IY has grey water running down the sloping streets, litter pollution, no dirt drains, blocked and leaking sewage, insufficient toilet facilities and piles of rubbish making the ideal habitats for rodents to breed....51% of Imizamo Yethu falls in high risk category

meaning that there is a potential for the infectious diseases to spread in the area in an uncontrollable manner.

Seven years later, the drainage system in IY has not changed. The third challenge is the increase in the prevalence of HIV/AIDS. This is a serious problem. It has been masked by the much more visible problem of lack of housing. With the burden of other communicable diseases like TB, HIV/AIDS has become difficult to contain. The clinic sisters at IY [2] (Sister Thebus & Sister Kholweni) explained the increase in the prevalence of TB and Sexually Transmitted Infection's (STI's). The high prevalence of STI's is an indicator of the high levels of unsafe sexual practices in IY. As shown above, teenage pregnancy was also identified by the Hangberg clinic sisters and the high school teacher as a serious problem in the Coloured community. This also indicates that young people are having unprotected sexual intercourse.

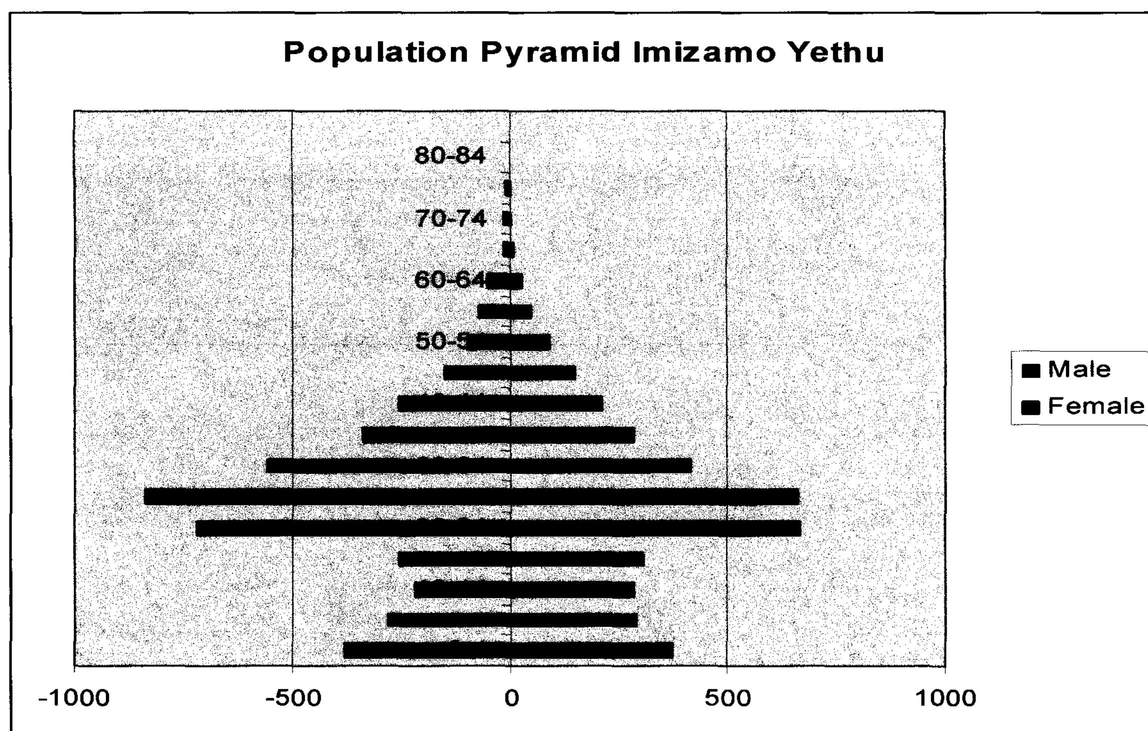


Figure 1: Population pyramid for Imizamo Yethu *South Africa Census Statistics, 2001*

[2] Sisters Kholweni and Thebus are the head sisters at the main road clinic and are responsible for the treatment of all diseases. They complain of being understaffed as there are over 60 people who come to the clinic everyday, making effective individual patient attention limited.

As the population pyramid above shows, the largest group of people residing in IY are between the ages of 20-34years. This abnormal distribution is suggestive of an immigrant community, where young single adults come to seek work. The second striking feature (apart from the almost complete absence of people over 65) is the large number of children under five. This is an indication of three things; the first being the large number of dependents, second, IY has a fast growing population and third, there is a large sexually active group which is not using contraception. It may also not be adhering to the churches' teaching on sexually abstinence outside marriage.

The overall situation in IY highlights the complexities involved in dealing with HIV/AIDS in a poverty-ridden community. The lack of adequate resources and infrastructure in IY weakens the community's own ability to deal with HIV/AIDS. Despite efforts from a small number of church-goers in the white community, it is still difficult to confront the epidemic, as underlying conditions such as poverty, the burden of other diseases, notably TB and STI's, poor nutrition, unemployment, poor living and environmental conditions, make the management of the epidemic more challenging.

### *3.3.3 Hout Bay Religious Profile*

According to the 2001 STATSSA census information, most of the people in Hout Bay are religious. Table 3 is an illustration of the number of people in Hout Bay who are religious and the types of the religious organisations that can be found there. According to the 2001 census, there are 19 different Christian groups in Hout Bay. The Anglican Church has the highest number of believers with a recorded 2,356, followed by the Catholic Church with 2,011. In an interview with the Catholic priest, Father Peters, he stated that the majority of

his congregates were from the Valley and Hangberg. Very few people in IY are Catholics. As a result, the church has not established HIV/AIDS initiatives in IY.

Table 3 gives the actual numbers of the religious following in Hout Bay. The Christian churches in the Valley are primarily the Catholic, Anglican, Methodist, Presbyterian and Pentecostal Churches. Hangberg is mainly Catholic, Presbyterian, Apostolic and there is a small Islamic community. According to the Imam Abrahams, (2003) most of his congregants are from the Hangberg community. He has none from the IY and few from the Valley. The people of IY are divided mainly between the Anglican Church, Pentecostal/ Charismatic churches and Zion churches (African Independent Churches). In the next chapter I shall discuss how these churches deal with HIV/AIDS in HB.

**Table 3: Religious affiliation in Hout Bay Census 2001**

| NAME OF CHURCH | No. of believers |
|---|---|
| Dutch Reformed Church | 830 |
| Zion Christian Church | 781 |
| Catholic Church | 2011 |
| Methodist Church | 1750 |
| Pentecostal/Charismatic Churches | 1602 |
| Anglican Church | 2356 |
| Apostolic Faith Mission of SA | 81 |
| Lutheran Church | 255 |
| Presbyterian Church | 422 |
| Bandla Lama Nazaretha | 30 |
| Baptist Church | 274 |
| Congregational Church | 51 |
| Orthodox Church | 57 |
| Other Apostolic Church | 1713 |
| Other Zionist Church | 379 |
| Ethiopian type Church | 190 |
| Other Reformed Church | 12 |
| Other African Independent Church | 210 |
| Other Christian Church | 2484 |
| African Traditional Belief | - |
| Judaism | 200 |
| Hinduism | 42 |
| Other faiths | 164 |
| Islam | 465 |
| No religion | 4511 |
| Refused, not stated | 449 |
| **Total** | **21319** |

*South Africa Census Statistics, 2001*

# Chapter 4: Hout Bay Churches and HIV/AIDS

## 4.1. HIV/AIDS in Hout Bay

In 2003 when the levels of infection were still relatively low, HIV interventions took the form of prevention activities. At that time, HIV was still highly stigmatized and seldom discussed openly. It was also perceived as an illness that mainly infected women. Most HIV/AIDS initiatives were managed by women from the community. In the support group meetings, the researcher observed that most of the people were women. There was only one man who was living openly with the infection. Interviews conducted with female patients in the Main Road Clinic revealed that most of the men they knew did not consider themselves at risk of getting infected. This was confirmed by Dr Haile, in 2004, who stated that *"most of the men did not come to get tested; they mainly came for TB treatment. It is the women who are carrying the burden of the disease".* However, Buhle Nyathi, in 2003, an HIV/AIDS activist in charge of the Yabonga Support Group also stated that the infection was a serious problem in the community and that most men did not want to get tested nor disclose their status.

Returning in 2008, this picture has not changed significantly. Most HIV/AIDS initiatives are still run by women with most men taking a back seat. There is, however, a new support group that is headed by a man although it still has more women than men.

The response to HIV/AIDS in IY has primarily been public responses from government through the clinics and schools, and the church community. PLWHA rely on donations and charity initiatives. In an interview, Sister Mathews, explained how containing the spread of

HIV/AIDS was a concern in IY because it is a high migration area. This makes it difficult to keep track of PLWHA and TB patients who need monitoring.

In Hangberg, the HIV/AIDS situation in 2003 was not as visible as in IY. Regardless of the challenges facing the community, making them vulnerable and at high risk to infection, there were limited interventions. HIV/AIDS is still largely perceived as a health risk that only impacts on a few. The clinic is only one of two places where there are any active strategies towards the epidemic (interview with Sister Mathews, 2003). The high school is the only other area that has also engaged in issues around HIV/AIDS. The interventions at the high school have mainly been from outsiders and outside organizations such as Lovelife (Interview with Ms Smith, 2003).

In the Valley community, responses to the epidemic are predominantly private. Gennrich & Gill (2004) argue that the churches in the affluent areas have tended to bury their heads in the sand, denying the presence of HIV/AIDS in their communities. Hout Bay Valley community is no exception. A doctor practicing at the Valley clinic, Dr S Brouckaert, (2003) stated in an interview that,

> *"HIV is present in the community but there are confidentiality clauses that do not allow me to disclose statistics or to say anything......the only two people I know who are positive are white gay men".*

In all the interviews conducted with informants from the Valley community in 2003, their concerns about HIV/AIDS were expressed towards Imizamo Yethu. There was little acceptance that HIV was present in their own community. This feeling was also reflected in the interviews with the Catholic priest and the Anglican father. When referring to HIV/AIDS and initiatives, they only referred to IY. Most programs around HIV/AIDS in 2003 were

targeted at IY. This was where there was a perceived problem. The assumption seemed to be that whites were not affected by HIV and AIDS.

An overall picture of Hout Bay shows that HIV/AIDS is present, but inadequately managed in all three communities. The Anglican Church appears to be the only church that is actively engaging in HIV/AIDS initiatives in IY although the Moravian church has also been active. Hout Bay as a whole has very few HIV/AIDS initiatives. As stated above, besides the work being done by the clinics, Lifeskills teachers in the high schools and support groups, there is minimal work in the three communities.

In Hout Bay, HIV/AIDS advocacy and intervention strategies have mainly been spearheaded by the mainline Christian churches whose congregations primarily reside in the Valley (white) community. However, interviews also highlight the presence of a number of partnerships that have been formed between the white and black African church communities as a result of the suffering brought by HIV/AIDS. An example of this integration has been the development of Iziko Lobomi, a community hall which houses many projects in IY. Amongst others is an income-generating beading project, a soup kitchen, computer courses and a hospice center. Despite the presence of this centre, in 2003, HIV/AIDS was still not really spoken about and it was feared and stigmatized. When the researcher mentioned the presence of PLWHA in an interview in 2003 with Marian Franke from the Anglican Church, she responded, *"...we do not say that word here"*. Her failure to talk about the epidemic at the time was telling of the inability of the church community to address HIV/AIDS and thus, unwittingly contributing to the stigma associated with it. However, an interview with the same lady in 2008 was very different. She indicated that they had started a support group

called "*Uncedo Lwabantu*" [Helping People] in the centre and there appears to be more openness about the infection and the epidemic and the assistance to those affected.

## 4.2 Christian Churches response to HIV/AIDS in Imizamo Yethu

As already stated, of the 19 Christian denominations present in Hout Bay, only two were working directly in HIV/AIDS issues. The two groups that were directly engaged in HIV/AIDS issues were the Moravian Church and the Anglican Church. The other churches focus on other development initiatives that border on charity work. These initiatives mainly involve the donation of blankets and food to the poor in IY. This is one form of intervening indirectly to ameliorating the impact of HIV/AIDS. However, a more concerted and sustainable effort to alleviate poverty could be a powerful contributory factor to the fight against HIV/AIDS. Through providing better access to health services, basic amenities, employment opportunities and food security, the churches could have a significant impact in addressing the effects of HIV/AIDS at an individual, household and systemic level. According to Korten (1990), this would be a third generation strategy, that is, engaging with social problems at a structural and systemic level. Such development initiatives are more sustainable and lead to individual change by reducing poverty levels within a community (Korten, 1990).

Notwithstanding, most of the poverty alleviation initiatives and development efforts have been in the area of relief and welfare. Most of the churches focus on helping poor children, women and youth. Hence, most HIV/AIDS outreach programmes are in line with the ministry to the poor and previously disadvantaged groups from the mainline churches. This is the case with the Anglican Church; HIV/AIDS is one of the areas of focus that fall under their poverty alleviation outreach programs to IY. The Anglican Church has facilitated the building of a community hall. This was a joint initiative involving over 19 denominations

and is a powerful illustration of the importance of churches uniting under the banner of ecumenicalism to assist the disadvantaged community. The Iziko Lobomi Community Centre is a significant development initiative within the IY community. It is a beacon of hope for the community and has provided a base for other development initiatives within IY.

### 4.1.1 Mainline Churches' Responses

Mainline churches have been involved in different types of first and second generation interventions i.e. charity and welfare work to support those who are infected or affected by the virus. This first generation approach mainly deals with alleviating the symptoms of a problem and pays little attention to the causes of the problem. Second generation interventions focus on empowerment through education so that people can begin to find solutions to their own problems. Typically, this role is played by organisations that try to affect behaviour change. For example, the Moravian Church has tried to spearhead awareness education campaigns. These campaigns were met with little success and with a lot of resistance within the IY community.

The Anglican Church has also been one of the leading HIV/AIDS faith-based activist groups in South Africa. This is evidently the second generation of Korten's framework (1990): mass mobilization in addition to the traditional role of relief and welfare. This is also evident in IY, as the St Peters Anglican Church is actively involved in creating a framework of assistance for the PLWHA.

> *"People from the Valley community, mainly the St Peters Anglican Church and another church, spearheaded the mission to build this place. It was meant to be a community hall that the people could meet and pray or hold a church service once or twice a week... After this the Hout Bay Christian Churches Association (HBCCA) was formed it helped to address needs of the Imizamo Yethu community" (MF, 2003).*

In addition to this, one of the PLWHA informants, Buhle Nyathi stated

> *"When I found out that I was positive, the only people who helped me where the Church, but that is only because I worked for them".*

Interestingly, the first impression of IY is one where the churches are doing a lot of work in the area of HIV/AIDS. Further investigations reveal that the situation on the ground is more complex. The HIV/AIDS initiatives from the mainline churches are haphazard and underpinned by high levels of stigma, discrimination and paternalism; paternalism in that most initiatives are taken from the 'outside- in' and very few are internally generated, with no programs coming from the beneficiaries. An example is how all the initiatives were run by the white people from the Valley and not members from the IY community. The most obvious reason is the lack of resources in IY and the abundance of resources in the white community. Yet, in the midst of this 'framework of assistance', very little of it deals with the 'actual' problems and challenges faced by people living with the HIV/AIDS according to our respondents. Korten (1990) classifies this type of development approach as 'crisis-oriented' in that it deals with the symptoms of the community problems and does not penetrate into the root causes. As a consequence, these initiatives are short-lived and do not have a lasting impact on the affected community. This is evident when specifically analyzing the HIV/AIDS work of the Churches in IY.

In one support group meeting in IY, which is an initiative from a lay member from the Anglican Church and comprises mostly woman who are not openly living with the infection, the researcher recorded the following observations:

*The 'manager' of that group, a white lady, gave out four sets of pills, enough for seven days. This undisclosed group of women was not aware what the pills were for but took them regardless. The 'manager' did little to explain what the pills were for. Speaking to one of the ladies, she expressed how she was not concerned with the pills but attended for the sake of the food parcels at the end. The whole session did not have any 'support' structure; it was introductions, distribution of pills, choir discussions and then food parcels. Towards the end, the manager questioned the group leader about new PLWHA joining this support group, stating that she has to look for more people because she had found more funding, but only if more people came. The group leader complained in Xhosa how it was difficult to force people to attend a support group especially if they had not disclosed.*

The above observation is not meant to undermine the work that is being done in Imizamo Yethu. However, it highlights the importance of developing a systematic, well-researched and planned approach to HIV/AIDS initiatives by the churches. For example, this support group could also focus on educating the people about healthy HIV lifestyles and what their rights are as PLWHA. This would graduate the response of the Anglican Church from merely being charity and welfare-based towards lasting community development. This, according to Korten (1990) would be a third generation intervention.

In 2003, most HIV/AIDS initiatives from the church leaders in HB were handed down from their national church's mandate and not tailored towards meeting the needs of the specific community. For example, the Catholic Priest explained;

*"It is very important for us to sort of educate the people about the illness, and this is done especially in the Catholicism classes. We bring in someone who will talk to them about HIV and AIDS prevention and whatever else. That's in every parish" (FP, 2003)*

In 2008, there were still very few planned initiatives spearheaded by the church ministers/leaders. Of all the church informants, only one church leader from the Moravian Church (Reverend R. Cochrane) in 2003 stated that she was once involved in personally spearheading HIV/AIDS projects. However, she was pessimistic, stating *"all the HIV/AIDS prevention initiatives I tried in the past to help the IY community have failed"*

Reverend R. Cochrane (2003) explained how she had tried awareness campaigns and condom distribution, but they had not been a success because the people she worked with did not adhere or lead by example. In this instance, failure of the initiatives was the 'fault' of the beneficiaries. Reverend Cochrane's campaigns could have failed because of intolerance from the community and fear of stigmatization. Interviews from IY with people who had been involved in these failed initiatives revealed that there was no understanding of or appreciation for the HIV/AIDS awareness campaigns. This suggests that the campaigns may have been poorly designed and executed or that people had more immediate and pressing concerns.

In 2003, three other pastors (Universal, Zionist and Catholic Churches) admitted to having little or no involvement in HIV/AIDS work. The bulk of the work is initiated and managed by lay members of the church. For example, Iziko Lobomi was an initiative by women from the Anglican Church; the church minister/leader did not take the initiative. This is an interesting dynamic that could possibly impact on HIV/AIDS initiatives. The church leaders interviewed in 2008 also explained that they were not really involved directly in HIV/AIDS work. Instead, they focused on the development work e.g. educare centers. Pastor Eddie, (2008) from the Gospel Outreach Ministries stated as part of their vision that their *"intention*

*is to try and impact on the community by starting crèches, to get those children to get a grounded education because that is one of the reasons why we started this educare".*

### 4.1.2 African Independent Churches' responses

The AIC's response to HIV/AIDS has mainly been in line with their liturgy. The AIC believes that the healing ministry of the church comes directly from God, hence, the need to preach faith messages of salvation and healing. The issue of divine healing plays a dominant role among the reasons, that is why people join AIC's (Jansen, 2001). This was portrayed by the Zionist pastor in 2003 who explained:

> *"In our church, we use water to heal the sick people. We use plain water from the tap. We fill up a bucket and we pray for that water, and as we pray for each one, we give them a cup, a cup, a cup, a cup of water, we believe that water has got God 's power." (PZ, 2003).*

This was also a sentiment shared by Pastor Jonathan from the Universal Church, who stated that he had seen people being healed from all diseases including HIV/AIDS. Their belief system stipulates that faith and prayer are the keys to healing.

> *"Yes there are a number of people, who are living with the AIDS, but we preach the message of healing and they know that they can get healed if they believe and have faith that God will heal them."(Ps J, 2003).*

The AIC church groups within IY are not actively engaging in HIV/AIDS issues. Members of the Yabonga Support Centre complained that *"they did not receive any support from their IY church communities".* Interviews with the community members reflected low interest levels in issues around HIV/AIDS. Most of the people interviewed did not make mention of HIV/AIDS and the challenges facing the community in this regard. Despite its obvious presence, as there were two support groups and people openly living with HIV/AIDS, the primary concerns in IY were issues like poverty, housing, overcrowding and lack of

recreational facilities. This was the general reaction in Hout Bay as a whole. This view is summed up in an interview with the Catholic priest, who stated;

> *"Within the Catholic community here in Hout Bay, it is not a significant issue, there are other more significant issues like poverty, unemployment things like that. At this stage that is the situation". (FP, 2003)*

HIV/AIDS continues to pose multi-faceted challenges to the Christian community. Gennrich (2004) argues that the church can only begin to be effective in its response if it recognizes that AIDS is not confined to only those outside the faith. In IY, although a tiny number of churches have been involved in HIV/AIDS issues and have in the past implemented a number of awareness initiatives, most of the work done by the church is in the area of relief and welfare, the principal beneficiaries being women. The HIV/AIDS initiatives are mainly from the white community and there are no initiatives from within the African community. This could be due to a number of factors. Firstly, the AICs which dominate African communities believe in the healing ministry of Jesus Christ, hence, do not engage in outreach programs. Secondly, lack of resources inhibits outreach programs. Thirdly, stigma and denial of the presence of HIV/AIDS are impediments and finally, the overwhelming material poverty of people's lives present much more immediate and compelling challenges..

## 4.2 Silence and Stigma- a development challenge

According to Talcott Parsons (1967), on of the core functions of religion is to provide meaning and understanding of social problems that leave individuals powerless. In the presence of HIV/AIDS, most people are rendered powerless. Faced with an incurable disease like HIV/AIDS, people turn to the churches to understand better their illness. According to the WCC, the Christian churches have too often failed to fulfill this function. They have ostracized, discriminated against and stigmatized PLWHA. This is partly because they have failed to recognize individual autonomy within the understanding and practice of religion. To

date, silence is major challenge facing the churches in responding effectively to HIV/AIDS in IY. As one Church leader stated;

> *"There is one kid at the moment that has.... you know......... the AIDS hmm what is it HIV, given the stigma attached to it, one is not very keen to talk about it" (FP, 2003).*

Interviews with PLWHA in IY revealed that there were high levels of silence about the epidemic in the community. People did not talk about the epidemic and where there was mention of HIV/AIDS, it was in a negative and reproachful light. One respondent who is HIV-positive stated;

> *"There is a lot of ignorance in Mandela Park (IY). The people here are not yet ready to deal with the disease they still think that you are a prostitute if you have AIDS, which is wrong. Many women from here complain about the way people treat them. I once had an argument with this old man who was shaming me for having HIV". (BN, 2003)*

Similar sentiments were expressed by other PLWHA, who had not disclosed their statuses to their friends and families. In an interview with one undisclosed lady, she stated that the stigma attached to people infected with HIV was too much for her to bear, hence she would not disclose her status:

> *"Once you begin to lose weight, even before disclosure, friends become difficult. They do not want to go with you anywhere, they leave you and start avoiding you. It is very upsetting and painful you become angry and at times you cry..." (AM, 2003)*

The HIV/AIDS epidemic places an enormous emotional burden on people who are living with the virus. The possibility of death and uncertainty for the future increases the burden. The functionalist theory of religion, explains that, it is at this point that one of the core functions of religion is fulfilled. The churches, at this point, are expected to step in and provide meaningful explanations about the epidemic. Yet, the Christian churches are not positively disseminating a message of love and inclusion; their response has been at times

judgmental and tentative. According to Stein (2002), one of the major causes of HIV/AIDS stigma is due to religious teachings and the association made between sex, sin, immorality and punishment.

In 1997, the WCC executive committee noted how through silence, many churches have shared responsibility for the fear that has swept the world. This was evidenced by one of the interviewees from the faith community in 2003 who, when asked about stigma in the community, responded,

> *''we are battling with stigma here it is very serious in the community. People here do not want to be associated with the illness so we just do not say it around here."*

This was a sentiment echoed by another informant,

> *"HIV/AIDS; we do not want people to point fingers, so we don't talk about that stuff here, we also do not say that the people in the respite center are positive, we just say it is a respite center open to everyone" (MF, 2003).*

Since 1997, the WCC has transformed its approach to HIV/AIDS. It launched an 'Ecumenical HIV/AIDS Initiative in Africa' (EHAIA) in 2002 that will assist the churches in designing and implementing action plans to tackle HIV/AIDS issues. These plans are all-encompassing. They focus on developing programmes that not only tackle HIV but also other development issues. For example, by tackling the problems of poverty, indirectly the churches will be addressing problems of HIV/AIDS prevention. This was echoed by Marian Franke from Iziko Lobomi in 2008, in a follow-up interview;

> *"The ideal would be for people to learn skills and then apply them. What happens here is that some people sometimes come to us and say that they would like to run a project and can they use our facility and then people from the community come and they learn a skill. Some of the things being sold outside were a result of training programmes and the mosaic you saw as you enter and now that group is doing work*

*even outside the community. They are selling to visitors and tourists who come here" (MF, 2008).*

In addition to engaging in second generation strategies of community development, the churches can begin working with other social forces, encouraging open dialogue, identifying social and economic challenges and finding ways of collectively addressing them. The churches can act as catalysts of change in the community. This third generation development strategy will lead to the sustainability of development initiatives. This is not to say that the churches should abandon their community development and support and care of PLWHA. These interventions are crucial. However, there is also need for the churches to employ a robust approach to poverty alleviation and HIV/AIDS. If successful, this process of mobilisation around a challenge that affects everyone (rich white residents of Hout Bay are frightened of crime, the poverty in their midst affects property values, and the high levels of pollution may potentially lead to an epidemic which would also affect them) would both help to break down the racial barriers that still exist and indirectly help prevent HIV/AIDS by working on the context of poverty in which it flourishes.

## 4.3 Concluding comments

HIV/AIDS is present in all three communities in Hout Bay. Private and public responses to the epidemic have influenced the nature of interventions by the churches. Since IY is a poverty-ridden area where the AIC, which does not believe in outreach work, has a large following, most of the HIV/AIDS work is conducted by two of the mainline churches: the Moravians and Anglicans. These mainline churches do not have many followers from IY, but as part of their ministry to help the poor and disadvantaged, they actively engage in HIV/AIDS support work. Their focus is on relief and welfare, Korten's first generation intervention. Yet, opportunities exist for collaboration between the churches around other

development issues. A concerted focus on identifying these development challenges, lobbying, advocating and fund-raising to address them, would have an indirect but important impact of HIV.

# Chapter 5: Conclusions

This dissertation set out to explore the Christian churches' response to HIV/AIDS using the example of the small community of Hout Bay in Cape Town. Broadly, Christian teachings around HIV/AIDS prevention advocate abstinence and fidelity in monogamous marriage. In South Africa, where approximately 79% of the population are Christian, interpretations of the HIV/AIDS epidemic by the Christian churches should have an impact on both the individual perceptions of the epidemic and the reactions to it. Yet, there is an increase in the number of HIV/AIDS infections despite the Christian churches' teachings. Given that HIV/AIDS in South Africa is an illness that is spread mainly through heterosexual intercourse; this presents a dilemma for the churches. If people are Christian and follow Christian values, norms and beliefs of abstinence and fidelity, why does HIV continue to spread?

In answering this question, this study has shown that behaviour change is complex. A number of factors contribute to this complexity. These include competing values and norms, socio-economic characteristics and cultural factors. This is further compounded by the difficulties of discussing sex and sexuality in the churches. All Christian churches exhort abstinence until marriage and fidelity thereafter, yet, the high prevalence rate of HIV/AIDS amongst the youth is evidence of the inadequacy of the churches' prevention campaigns. This disconnect between the ideal and reality forces them to focus mainly on their traditional areas of community intervention: care and support/relief and welfare.

Based on the example of Hout Bay, this study is able to extrapolate parallels from the literature which could be investigated in future research.

Firstly, HIV/AIDS has forced the Christian community to confront the possibility of dealing with issues considered taboo in the churches, issues of sex and sexuality, death and disease. Since HIV/AIDS is sexually transmitted, it has become associated with sexual immorality. This parallel has crippled the ability of the churches to respond meaningfully to the challenges posed by HIV/AIDS without confronting their discomfort in addressing sexuality. Nicholson (1995) argues that if we continue to see AIDS as God's punishment for sexual immorality, we shall fundamentally miss the real point as to where Christians should be involved. Gennrich & Gill (2004) suggest that in keeping with its moral integrity, the churches need to accommodate the social conditions that may influence an individual's sexual choices and decisions. As a result, the churches need to understand that the causes of HIV/AIDS infection are complex and should not be seen in isolation but should be contextualized within the socio-economic environment.

Secondly, HIV/AIDS prevention has presented a serious challenge to the churches' intervention attempts. This is because the main official (government-supported) prevention campaign message includes the need for safe sex practices through the use of condoms. Yet, churches are not involved in safe sex issues in IY because of the doctrinal barriers they have to confront before they can adequately address safe sex practices. As a result, most of the mainstream churches' efforts target support at women who are perceived to be 'innocent victims' of infection. The inability to deal with the prevention of HIV/AIDS creates an opportunity for the churches to engage in other forms of development that can indirectly impact on the spread of the epidemic such as poverty alleviation and health promotion initiatives.

Third, stigma in the Christian churches is fuelled by silence. In 2003, the churches present in HB did not openly discuss the epidemic. In the AIC, HIV/AIDS was only addressed in connection with divine faith healing. The mainline churches also did not openly discuss HIV/AIDS with their followers. This is partly because mainline churches are established in the white community where HIV/AIDS is not seen as a problem and if it is, then it is dealt with privately. Yet, silence is one of the factors amongst Christians that has fuelled the spread of the epidemic. In order to openly address HIV/AIDS prevention, the churches need to first break the silence that surrounds sexuality. In doing this, the churches will be better placed to deal with the disconnect between what is preached and what is practiced. Clifford (2004) argues that in place of a theology of punishment and judgment, the churches must offer a theology of acceptance, hope and life.

Fourth, HIV/AIDS responses are greatly influenced by socio-economic and cultural factors. Imizamo Yethu is a community with socio-economic and structural problems. In order for the churches to effectively deal with HIV/AIDS epidemic, the developmental approach used needs to be contextualized. Instead of only dealing with HIV/AIDS as a medical, moral phenomenon, other community development challenges need to be taken into account. A health promotion approach needs to be employed. This approach argues that a healthy community is only possible if the social and the environmental conditions in which it lives are themselves salubrious. As such, in dealing with the HIV/AIDS epidemic, churches should view problems posed by the epidemic in light of other development challenges. By employing a holistic integrated development approach to HIV/AIDS, the churches could have a positive impact on curbing the spread of the epidemic. According to Korten (1990), this is the level where the civil society group becomes a catalyst for change (third generation intervention).

Fifth, the study in Hout Bay revealed that HIV/AIDS seems to have a more adverse affect on women. As such, they were on the forefront of most HIV/AIDS initiatives and support groups in the community. Women carry a 'double burden' of HIV/AIDS i.e. poverty and increased vulnerability to HIV infection. In addition, they also bear the brunt of caring for people infected and affected with HIV/AIDS. Women are arguably then those who most need support and who would most benefit from changes in living conditions. Recognizing this, the churches could focus their developmental strategy around an investigation of women's needs and then put their collective weight behind campaigns for them to be met.

One of the major challenges facing churches' initiatives in Hout Bay has been the issue of integration. This dissertation was researched in 2003 and was submitted for examination in 2008. In 2003, people were more concerned about development than they were about HIV/AIDS. In 2008, this still seems to be the case. However, as one respondent put it, *"the community is disconnected"*. This has made dealing with broader development challenges, and HIV/AIDS within them, a fractured, unplanned process with few sustainable initiatives. There is need for a systematic, well-planned development program for socio-economic development and HIV/AIDS. According to the South African HIV/AIDS Strategic Planning Framework (2002), the success of any program lies in adequate planning and preparation. Success lies in a united, concerted effort tailored for the people by the people. The traditional missionary style in development programmes by the mainline churches needs to be abandoned. Equal partnerships between the wealthier white churches and poor African churches are vital for effective sustainable HIV/AIDS initiatives.

In combating HIV/AIDS, the churches must take cognizance of the fact that relief and welfare alone are not enough to change the course of the epidemic. There is need for the

churches to graduate from Korten's first generation approach of 'relief and welfare' and the second generation of 'community development,' to that of third generation that focuses on 'sustainable systems development' wherein they act as catalysts to change. The fourth generation focuses on the ability of the churches to become change agents, activists and educators. In this fourth generation, the churches can begin to facilitate the formation of integrated development strategies that can lead to policy change as Archbishops Desmond Tutu and Njongonkulu Ndugane have attempted to do in the Anglican Church.

HIV/AIDS must be understood within its social, economic, political and religious context. It cannot be viewed in isolation as a purely medical/moral phenomenon. The churches' interventions must begin to take into account every aspect of a person's daily life and start to address effectively the challenges the lived context pose in an integrated way.

# LIST OF INTERVIEWS[3]

"AM", 2003 From Notes of Interview with "Avril Mpofu" (*pseudonym*) HIV positive respondent from Main Road Clinic. Held in Yabonga Office, Imizamo Yethu, 17 September 2004.

"BN", 2003. From Notes of Group Interview with "Buhle Nyathi" (*pseudonym*),HIV positive Counselor with Yabonga HIV/AIDS Support Centre. Held in Yabonga Office, Imizamo Yethu. 21st May 2003.

DH, 2004. From Notes of Interview with Dr Haile, A doctor working part time at the Main Road Clinic. Held in Main Road Clinic, Imizamo Yethu, 17 September 2004

FF, 2003. From Notes of Group Interview with Fadwa Fardien, HIV positive counselor with Leadership South, HIV/AIDS Education NGO. Held in Hangberg Clinic, Hout Bay. 4th June 2003.

FP, 2004 From Notes of Interview with Father Peters, Catholic Priest in the Valley Community in Hout Bay. Held at the Catholic Church, Hout Bay, 20 September 2004.

IA, 2004 From Notes of Interview with Imam Abrahams, Imam of the Mosque in Hangberg. Held at the Mosque offices, Hangberg, Hout Bay 31 August 2004

JN, 2003. From Notes of Group Interview with the Hon. James Ncgulu, MP. Member of Parliament allocated to Hout Bay Constituency by ANC and Chair, Parliamentary Health Portfolio Committee, Parliament of South Africa. Held in his Office, Parliament, Cape Town. 19th June 2003.

KT, 2003. From Notes of Group Interview with Kenny Tokwe, Secretary, ANC Ward 74 Branch. Held in ANC Office, Imizamo Yethu, Hout Bay. 7th May 2003.

MF 2003, Group Interview with Marian Franke. Social Welfare Coordinator for the Iziko Lobomi centre. Held at Iziko Lobomi, Imizamo Yethu, 7th May 2003

MF 2008, Interview discussion with Marian Franke and two other HIV/AIDS coordinators and the Social Welfare Coordinator for the Iziko Lobomi Centre. Held at Iziko Lobomi, Imizamo Yethu, 18th March 2003

MS, 2008. From Notes of Interview with Mr. Sigli, St Johns Apostolic Mission. Held at his home in Imizamo Yethu, Hout Bay, 18th March 2008

MsS, 2003. From Notes of Group Interview with Ms Smith, Member of Teaching Staff at Hout Bay High School. Held in Office at Hout Bay High School, Hangberg, Hout Bay. 11th June 2003.

[3] For interview notes please email request to sazini.mojapelo@gmail.com

"NT" Interview with "Nomhle Tsiba" (*pseudonym*), Member of the Yabonga HIV/AIDS Support Centre. Held at the Yabonga office, Imizamo Yethu. Hout Bay, 21st May 2003

PE, Interview with Pastor Eddie. Leader of the Gospel Outreach Ministries. Held at his house, Imizamo Yethu, Hout Bay, 17 March 2008

PJ, Interview with Pastor Jonathan, Leader of the Universal Church in Wynberg. His church encompasses the people from Imizamo Yethu. Held at his offices. Wynberg, 25th August 2004

PZ, Interview with Pastor Zion, Leader of the biggest Zionist Church in Imizamo Yethu. Held at his place of work in Hout Bay Valley area. Hout Bay, 25th August 2004.

RC, 2003. From Notes of Group Interview with the Reverend Renata Cochrane, Member, Hout Bay Community Health Forum. Held in Private Home, Hout Bay. 28th May 2003.

SB, 2003. From Notes of Group Interview with Dr Sophie Brouckaert, Medical Practitioner with Practice in Hout Bay. In Private Home, Hout Bay. 11th June 2003.

SM, 2003. From Notes of Group Interview with Sister Matthews, Nursing Sister at Hangberg Clinic (City of Cape Town Health Department). Held at Hangberg Clinic, Hout Bay. 4th June 2003.

"SN", 2003 From Notes of Interview with Selina Ndove, (*pseudonym*) an HIV positive mother who has not disclosed her status to her boyfriend and family. Held at the Main Road Clinic, Imizamo Yethu, Hout Bay. 28th October 2003.

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