THE ROLE OF THE CHURCH IN THE PREVENTION, EDUCATION, CARE AND SUPPORT OF PEOPLE LIVING WITH HIV/AIDS

BY LUCY AFARI-TWUMASI

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SUPERVISOR: REVEREND K. BOHNEN

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DEDICATION

This dissertation is dedicated to victims of HIV and AIDS patients with the hope that it will make some contribution in educating them about living their life to the fullest despite their HIV/AIDS status.

DECLARATION

I, Lucy Afari-Twumasi, do hereby declare that the work contained in this dissertation is entirely my own work with the exception of such references which have been attributed to their authors or sources and that all sketches are made or drawn by me.

Signature: 

Date: 22 November 2005

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ABSTRACT

HIV is the short form of **Human Immunodeficiency Virus.** It is a virus that attacks the cells of the human immune system and destroys it so that the body is no longer protected against diseases. AIDS has been defined as 'a reliably diagnosed disease that is at least moderately indicative of an underlying cellular immune deficiency or any other causing reduced resistance reported to be associated with the disease' (Moss, 1992:15). In other words, AIDS is the acronym for **Acquired Immune Deficiency Syndrome.**

AIDS is a term that strictly speaking refers only to the last and often fatal stage of an infection by the Human Immune-deficiency virus (HIV). Those at risk of getting HIV viruses are injection drug users, persons with hemophilia, homosexual and heterosexual sex- partners, recipients of transfused blood or blood components, and children born to infected mothers. The vast majority of people infected with the virus throughout the world are heterosexuals. The HIV virus is now present in every continent and almost every country. AIDS remains a condition with an extremely high fatality rate. The individual prognosis varies according to the presenting illnesses.

In the beginning it was thought that all affected people would develop AIDS but it is now known that some appears to remain healthy or develop less severe illness as a consequence of the infection. The weakening of the immune system increases the spread of other infectious diseases, particularly

tuberculosis. Tuberculosis spreads rapidly among people who do not have normal resistance to disease, but goes on to infect those whose resistance is normal. It is always an acquired infection. The majority of HIV-infected people have no symptoms for a long time. They are not aware of the infection unless they have had an HIV anti-body test.

HIV can be viewed as a challenge and as an opportunity for society. It offers us the opportunity to re-evaluate our lives and consider the meaning of life itself, and it challenges our compassion. HIV raises many questions; it challenges our faith and brings us face to face with our insecurities, our own vulnerability and our own fears. How does the Christian gospel relate to the problems and opportunities facing us? How can we best help those faced with a life threatening illness co-creatively? The church can be the family that loves and sustains those who are sick with HIV - related conditions, and their loved ones without barrier, exclusion, hostility or rejection. The church is challenged to integrate them into the wider community to protect against discriminatory policies and practices and to provide practical and spiritual help (Meeting Christ in HIV/AIDS 2001). This is a theological concern because theology is the systematic interpretation of God's self-disclosure to the Christian Church (Barth, 1936:70). Theology, therefore, can be practical if we bring practical concerns into situations.

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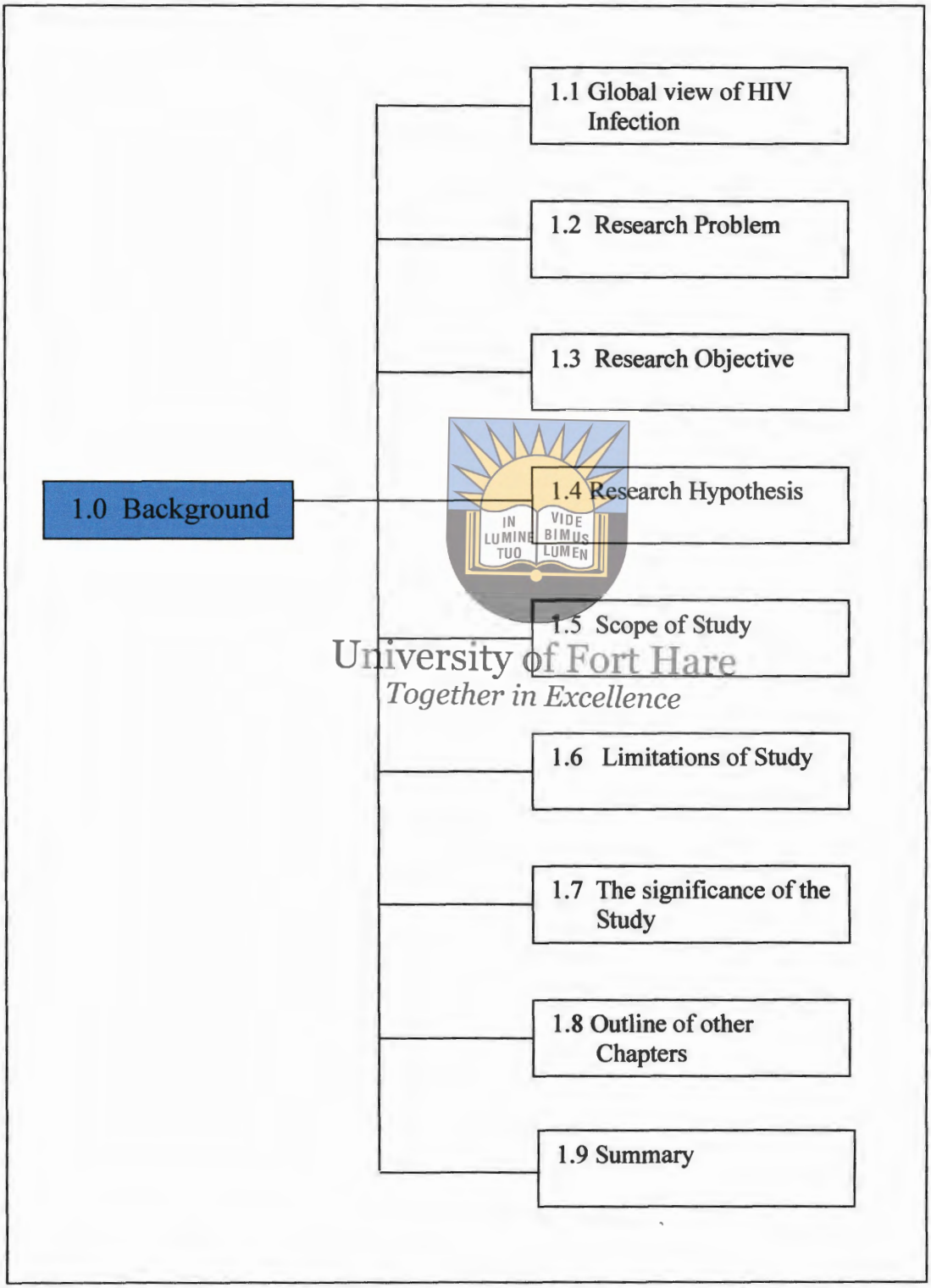
OUTLINE OF CHAPTER 1

Introduction to the Study



Chapter 1: INTRODUCTION TO THE STUDY

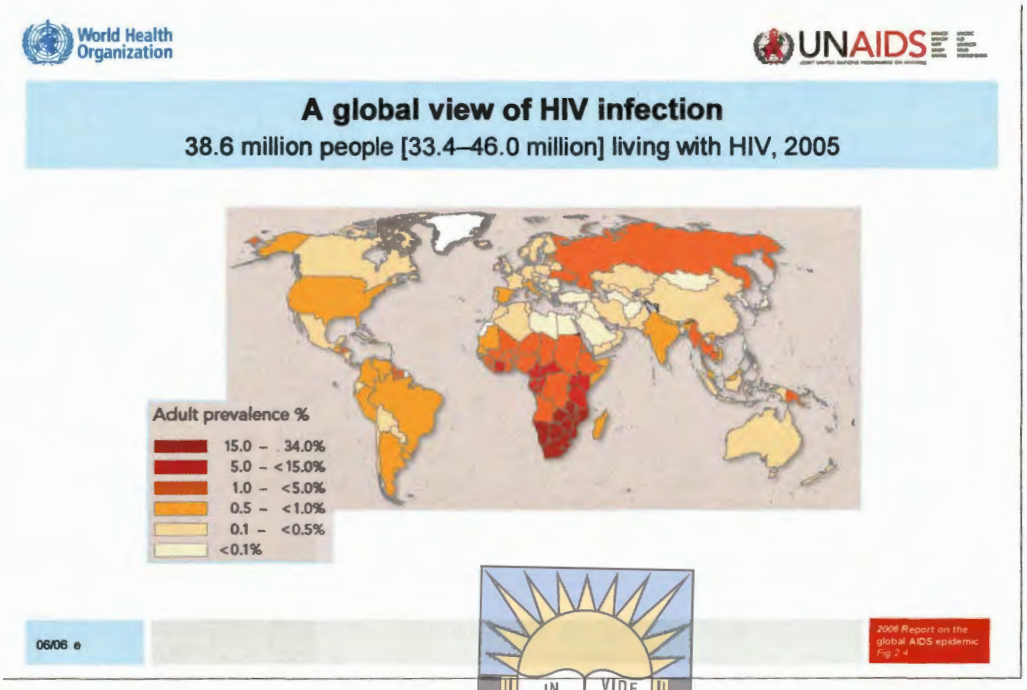
1.0 Background

This study looked at the role of the church in the Bhisho, King Williams Town, Zwelitsha area of the Amathole District Municipality (ADM) in the prevention, education as well as the type of support and care provided for those who suffer from HIV/AIDS.

Chapter 1 provides a general overview of the dissertation. It starts by providing the background information of the study, the aims and objectives of the study, the rationale of the study, significance of the study and lastly the outline of other chapters.

The problem of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) has captured the attention of academics, politicians, social analysts, the business community, the church and the general public. This is due to its social, economic, environmental and to some extent political impacts on countries and communities. The centres for Disease Control and Prevention (CDC) surveillance criteria for the diagnosis of AIDS, as modified in 1987, included a large number of opportunistic infections indicative of a defect in cellular immunity as well as certain neoplasms and other conditions associated with advanced HIV-1 infection (Andreoli, E.T. et al (ed), 4th edition, Cecil Essentials of Medicine, 1997:749). The HIV virus is now present in every continent and almost every country (World Health Organization- UNAIDS 2005). (See Figure 1.1)

Figure 1.1 THE GLOBAL VIEW OF HIV INFECTION



Source: (http://data.unaids.org)

AIDS remains a condition with an extremely high fatality rate (UNAIDS, 2005). The urgency with which attention is directed at this pandemic is justified because HIV/AIDS has massive social, economic political, medical and even environmental impact. HIV/AIDS has also generated a serious public health problem and has employment and human rights implications. For instance, AIDS patients constitute about 40% of medical wards in many state hospitals (Bisseker, 2005:37). The HIV/AIDS pandemic has therefore become a problem that is no longer limited to the medical field. It is also not regarded as an ethical problem anymore. It is on this premise that one sees a positive role of the Church (which hereafter will refer to all the Christian churches) since it is one of the biggest social organizations. It is accepted that there are doctrinal and traditional differences among different churches and that therefore their

approach to HIV/AIDS will equally differ (see Table 1.1 for list of registered churches in South Africa).

Table 1.1 List of registered Churches in South Africa consulted for the research.

1.African Catholic Church
2.African Methodist Episcopal Church
3. Apostolic Faith Mission of South Africa
4. The Baptist Convention
5. Church of the Province of South Africa
6. Coptic Orthodox Church
7. Dutch Reformed Church
8. Ethiopian Episcopal Church
9. Evangelical Lutheran Church of Southern Africa
10. Evangelical Presbyterian Church in South Africa
11. Greek Orthodox Archbishopric of Johannesburg and Pretoria
12. Hervormde Kerk in Suide Afrika
13. Methodist Church of South Africa
14. Moravian Church in South Africa
15. Religious Society of Friends (Quakers)
16. Presbyterian Church in Africa
17. Salvation Army
18. United Congregational Church of South Africa
19. Uniting Presbyterian Church of Southern Africa
20. Uniting Reformed Church in Southern Africa

(South African Council of Churches, 2006)

In terms of practical theology, therefore, the question becomes: Should the Church limit itself only to praying for the sick? The answer to the question, from the viewpoint of this study, should be 'No' because there is the realization that the function of the Church should be widened to encompass, looking at the practical needs of the congregants. For example, the story of the Good Samaritan in Luke chapter 10 verses 30 to 37. A Priest and a certain Levite passed by without helping an injured man. A Good Samaritan had compassion and took care of this injured person while a priest did not. The church should not regard the issue of HIV/AIDS as purely medical. The study therefore attempted to ascertain the role that the Church in Bhisho, King Williams Town, and Zwelitsha area play in the prevention and education on HIV/AIDS, and the care and support for HIV/AIDS sufferers.

1.2 **Research problem**.

HIV/AIDS is widespread and had hitherto been considered mainly a medical issue. Again, because of the moral dilemma which the HIV/AIDS issue embodies, many churches have not been looking at it in terms of practical involvement. The necessary guidelines needed for the church to increase its input with regards to the HIV/AIDS problem have not been adequate. There is lack of sufficient church involvement. It was for such a concern that this study was undertaken. Information obtained from the research, it is felt, will further help narrow what the church knows or should know and the necessary action it must take about HIV/AIDS problem gap.

1.3 **Research Objectives**

The study aimed at achieving the following research objectives. It:

(i). Assesses whether the present response of the Church in the Bhisho, King Williams Town, and Zwelitsha area of the Amathole District Municipality to HIV/AIDS is adequate and appropriate (in the light of the Church's understanding of the epidemic);

(ii). Identifies the practices in the church communities that have made some people living with HIV/AIDS decide to suffer in silence, rather than openly declaring their statuses.

(iii). Evaluates the strengths and weaknesses of the Church's response to the HIV/AIDS problem.

These objectives were guided by the following research questions:

- What are the main HIV/AIDS intervention strategies used by the Church? ;

- What kind of care and support is provided by the Church for HIV/AIDS infected and affected people in the Bhisho, King Williams Town, and Zwelitsha area of the Amathole District Municipality (affected people include family members and relatives etc)

- What has been the impact of the interventions by the church on the lives of people living with HIV/AIDS?

- To what extent have the HIV/AIDS programmes adopted by the church been a success or failure (i.e. to what extent has the church been self-critical of its own actions)?

1.4. **Research hypothesis**

Flowing from the research objectives, the following hypothesis formed the basis of the research:

The Church can play a constructive role in preventing the spread of HIV/AIDS, and educating, giving support and care to those infected and affected by HIV/AIDS.

1.5 **Scope of the study**

The study was limited to the churches in the King Williams Town, Bhisho and Zwelitsha area within the greater ADM. (See Figure 4.2. on page 65 - Amathole District Municipality Map). Table 1.2 shows the population of King William's town, Bhisho, and Zwelitsha.

The decision to restrict the study to these areas in the Amathole District Municipality was influenced by financial and time constraints.

TABLE 1.2

Population by sex

	Male	Female	Total
Bhisho	2711	3765	6476
King William's Town	13091	15027	28118
Zwelitsha	8992	10638	19630

(Statistic South Africa 1993-2006).

1.6 Limitations of the study

The following limitations informed the study:

- It is the belief of this study that HIV causes AIDS but other external factors should not be overlooked;
- From the moral point of view, the writer ascribes to the biblical principles and this is reflected in the work;
- The author relied on available statistical information; and
- Lastly, the author is aware that an expansive study will have yielded much more reliable conclusions but as stated in 1.5 the limited time and the extra financial demands did not make this possible.

1.7 The significance of the study

The HIV/AIDS pandemic is spreading at a fast rate (UNAIDS, 2006:12-11). The Eastern Cape Province lies second in the whole of South Africa in terms of the incidence and spreading of the disease. Within the Eastern Cape Province itself, the disease is widespread.

The table below is an illustration of sexual experience among respondents between the ages of twelve and fifty.

12-14yr	15-24yrs		25-49yrs		50+ years			
Sex								
Male	768	1.9	2 488	53.9	2 448	96.6	1 269	98.1
Female	836	1.5	3 126	62.3	4 326	97.1	2 477	94.7

(Source: South African National HIV Survey, 2005).

The nature of the disease is such that it is affecting families and individuals who together constitute the membership of the church. It is; therefore, felt that there is an urgent need for those who can reach-out in terms of getting involved. The church is well placed in this regard. The situation has reached such a critical stage which requires massive intervention by public institutions and the church. The church has to be proactive. It is within this context that the study was conducted. If the church is able to reach out to the sufferers and also educate those not infected, it would fulfil its spiritual and moral obligation. The study sought to identify certain areas where the church is perceived to be lacking adequate input in helping those infected and affected by HIV/AIDS. It is the belief in this study that the findings will prove beneficial because they will enable the church to do more than what is presently doing to help HIV/AIDS sufferers in their respective areas of operation. Again, the findings will help the church identify areas where its contribution to the HIV/AIDS intervention has been inadequate and then improve upon it.

1.8 **Outline of other chapters**.

As indicated above, **chapter 1** provides a general overview of the dissertation. It starts by providing the background information of the study, the aims and objectives of the study, the rationale of the study, significance of the study, and lastly the outline of other chapters.

Chapter 2 deals with Literature Review. Here, issues pertinent to HIV/AIDS issues are explored. It looks at the current views on the HIV/AIDS. The chapter touches on how the theoretical knowledge and

actions have shaped the nature of the HIV/AIDS interventions, defining what is regarded as the church's role in HIV/AIDS issues, the impact of the pandemic on the community generally and on the total economy.

Chapter 3 discusses the Research Methodology applied in this study. It concentrates on the research focus and aims, of the research design, case study and selection, sampling method used various methods of data collection and analysis of the data.

Chapter 4 deals with a case study. Various data pertinent to the case study area is provided. These include documentary data, structured and unstructured in-depth qualitative and quantitative data on the case study area to elicit the actions being adopted by the Churches in handling HIV/AIDS pandemic in the study area.

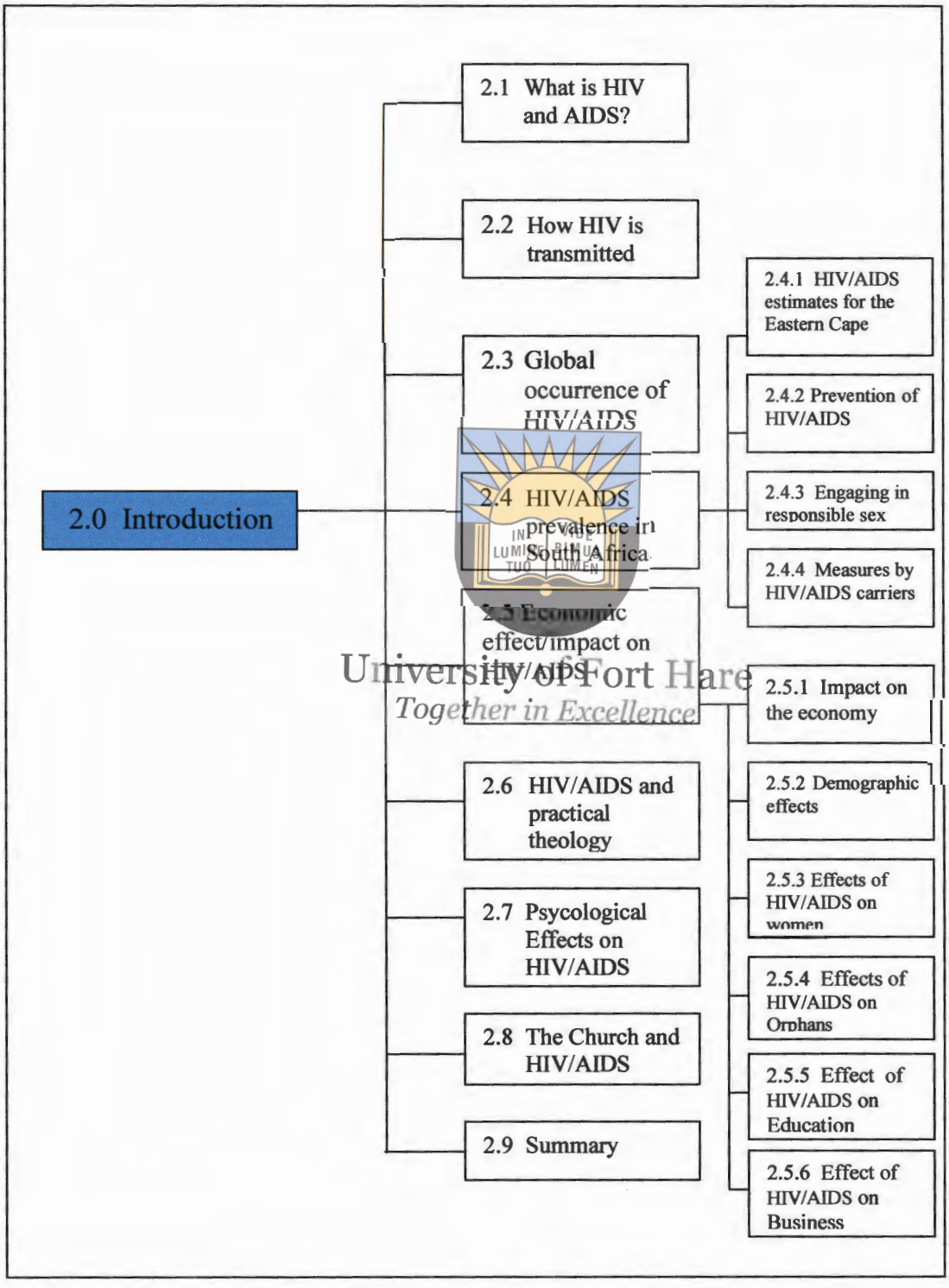
Chapter 5 provides the findings and discussions of the study. It is concerned with data analysis and the interpretation of the surveyed data.

Chapter 6 draws the conclusions from the study and comes out with policy recommendations.

1.9 Summary

This chapter provides the general information of HIV and AIDS. It started by an overview of the dissertation, the aim and objectives of the study and the rationale of the study. It analyses the intentions of the research project.

OUTLINE OF CHAPTER 2
Literature Review



CHAPTER 2 LITERATURE REVIEW

2.0 INTRODUCTION

The objective of this chapter is to explore the literature on what HIV/AIDS is, how it is spread, the global occurrence of HIV/AIDS; the role of the Church; and the social, economic and political impact of HIV/AIDS. This is done within the framework of practical theology.

The HIV/AIDS pandemic has become a perennial problem for individual nations and the international community as a whole. Nations are devoting resources - human and financial– in an attempt to arrest a situation which is spiraling out of control. The reason for the concern is that the illnesses and deaths resulting from HIV/AIDS affect various institutions; for instance, the family, the church and the community to which the deceased belong. It can reasonably be asserted that the HIV/AIDS pandemic affects every individual in every country with a high prevalence of HIV/AIDS.

HIV/AIDS has become the most intensely researched medical problem ever since it was reported in medical journals in 1981 and many governments have committed huge sums of money to help understand the disease and its causes (Muller, 2005: 293-306). This chapter scans the literature which will serve as the background for the case study.

2.1 **What is HIV/AIDS?**

At this point it is necessary to explain what HIV/AIDS is to put the problem in its proper context.

HIV is the abbreviation of Human Immunodeficiency Virus. It is a virus that attacks the cells of the human immune system and destroys it so that the body is no longer protected against disease. When this happens, opportunistic infectious diseases, growth problems, diarrhea, developmental regression and immune system dysfunction may occur. For instance Churchyard and Grant in their commentary reported in the Southern African Journal of HIV Medicine mention that approximately 2 million South Africans are co-infected with TB and HIV (Churchyard and Grant 2004: 16) The HIV virus attacks two main types of cells. The first is the T-helper lymphocytes which is essential in the control of the immune function. These CD4 cells are vital as they co-ordinate the body's immune system, protecting us from illnesses. The virus lives inside the cells which are meant to destroy and so it actually prevents the body from destroying the virus. As the amount of HIV in the body increases, the number of CD4 cells decrease, weakening the immune system even further. The second are the monocytes and microphages which function as the agent which rids the human body of foreign proteins by ingesting them and also presenting them to the immune system so that the latter can mount a response against them (Schoub, 1994:24). HIV infects mainly the immune system and the central nervous systems.

AIDS is the acronym of for Acquired Immune Deficiency Syndrome which when broken down as follows provides a simple meaning:

A – Acquired (to receive from someone else)

I – Immune (to do with the body's defence system)

D – Deficiency (deficiency of that system)

S – Syndrome (a group of diseases) (Snidle and Welsh, 2001: 27)

Immunodeficiency means that the immune system of the body has broken down and is therefore not able to fight off diseases. A syndrome on the other hand is a group of symptoms which has one cause. AIDS has been defined as 'a reliably diagnosed disease that is at least moderately indicative of an underlying cellular immune deficiency or any other cause reduced resistance reported to be associated with the disease' (Moss, 1992:15). AIDS is the end-stage when the HIV infection manifests itself as a disease at that stage, and the body of a person who is so infected can no longer fight the disease. In medical terms the Centre for Disease Control in the US define an AIDS sufferer as a person with a positive HIV blood test along with either a major opportunistic condition or a CD4 count of less than 200/mm^2 (the normal CD4 count range is 800 to 1 200 cells per cubic millimeter of blood). In the beginning it was thought that all infected people would develop AIDS but it is now known that some HIV carriers can remain healthy or developed less severe illness as a result of the infection.

2.2 HOW HIV IS TRANSMITTED

The HIV virus is transmitted exclusively through human sources. Individuals who are infected with the virus transmit it in various forms as explained further on in this section. HIV is transmitted mainly through the blood, semen and vaginal fluids. A person who has been infected with

the virus can infect others and this potential to infect others continues until he or she dies. For a person to be infected, there should be a sufficient quantities of viremia(i.e virus –infected blood) to enter the blood stream through an entry point which could be the skin or the mucous membranes as found in the genetalia (or through both the semen and the vaginal fluids).

There are several ways for the transmission of HIV. The commonest channel of transmission is sexual intercourse with an infected partner, during sex the virus enters the blood through the mucocosal linings of the vagina, vulva or the rectum. Another source of infection is through contact with infected blood, for instance through sharing of HIV virus–contaminated needles or syringes by drug addicts (Global Change, 2006).

HIV can also be transmitted from mother to child. According to global change.com, this can occur in two ways. Firstly, an infected mother can transfer the HIV when the virus crosses the placenta in the womb or during labour when the baby swallows fluid and blood. Secondly, a lactating mother can transfer the virus through the breast milk to the baby. Another channel of transmission is blood transfusions and blood products. At times tests are not able to pick up recently infected persons who donate blood (especially within the first 6 weeks of being infected).

Some traditional rites in some countries contribute to the spread of the HIV. For initiation rites such as male circumcision using the same knife for a group also contribute to the spread of HIV if there are infected persons in the group (Global Change, 2006).

A word of caution needs to be provided in regards to who get HIV/AIDS and who does not get it. All evidence points to the fact that anyone can

get HIV/AIDS whatever one's social, economic and political status. It does not discriminate against race, colour, rich or poor. Bruce Wilkinson asserts that poverty alone is not the main cause for the spread of HIV/AIDS because both the rich and the poor are at risk (Wilkinson, 2001). However, there are certain categories of people who are referred to as a high risk group:

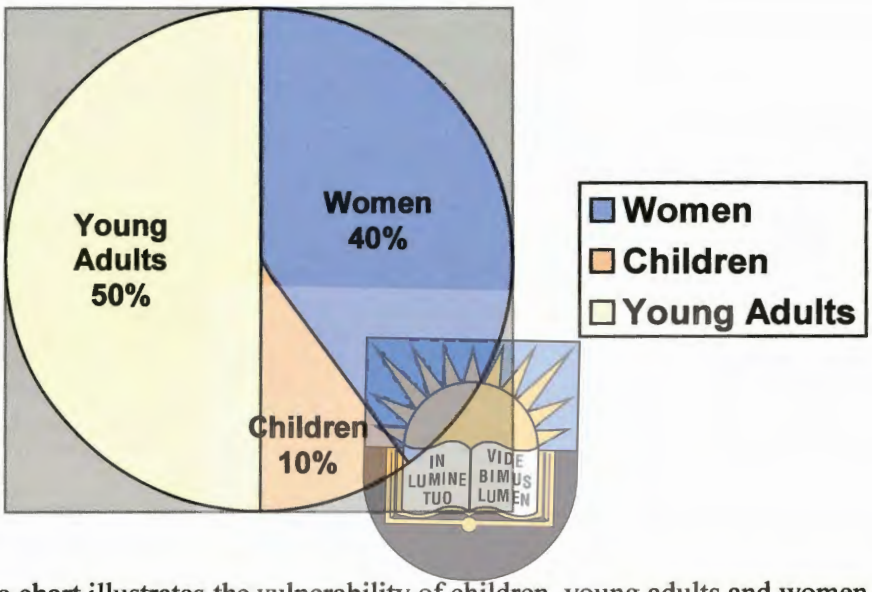
1. Sexually active homosexual and bisexual men
2. Hemophiliacs and those who receive blood transfusions
3. Drug users who use needles
4 Sexual partners of people in 1 to 3 above

(Muller, 2005: 8)

In addition, there are other groups which are also vulnerable to HIV/AIDS. These include sexually abused (particularly children), prostitutes, young adults aged between 15 and 24 years, the transport and mining sectors particularly in South Africa and women. Risky environment such as type of housing settlements, business run from home and exposure to alcohol and drugs all contribute to increasing risk for children because such environments diminish protection and increase exposure to negative consequences (South African National HIV Survey: 115). For instance, The Joint United Nations Programme on HIV/AIDS (UNAIDS) Report on HIV/AIDS (2004:3) which is a very reliable source indicated that women constituted almost 50% of all people living with HIV/AIDS in the world (57% for sub-Saharan Africa). The high level of vulnerability and risk of women is attributed to, among other things, gender and cultural inequalities; ignorance and violence (UNAIDS,

2004:3). The Report also mentioned that young male adults between 15 to 24 years accounted for almost 50% of all HIV infections.

SITUATION ANALYSIS



The above chart illustrates the vulnerability of children, young adults and women at HIV/Aids risk

Fig. 1

http://www.hsrepress.9c.za/freedownload .asp?

2.3 GLOBAL OCCURRENCE OF HIV/AIDS

The HIV virus is now found in every continent and in almost every country. (South African National Survey, 2005:37)

According to Fact Sheets on HIV/AIDS document over two-thirds of all the people living with HIV in the world are located in sub-Saharan Africa, and this region also accounts for 83% of the world's AIDS deaths. The UNAIDS (2004) Executive Summary provides the following statistics on the pandemic:

- The rate of infection in sub-Saharan Africa is increasing. In 2003 alone 3 million people became newly infected. As many as 25 million people are living with HIV/AIDS. Nearly 2.2 million deaths from AIDS were reported in sub-Saharan Africa in 2003 which represented about 75% of global deaths;
- Eastern Europe and Asia are experiencing the fastest-growing epidemic in the world;
- There have been about 20 million deaths globally from AIDS since it was first reported in1981 and there were about 3 million deaths in 2003 alone;
- A total of about 38 million people were infected with HIV in 2003 alone as against 35 million in 2001. This is an increase of 8.6%;
- Asia had a total of about 7.4 infected people in the region (5.1 million in India alone). There were also 1.1 million new infections in the region in 2003;
- Women are more at risk. In sub-Saharan Africa for instance, the ratio of young women infected with HIV/AIDS is higher than young men living with HIV/AIDS ranging from 20 women for every 10 men in South Africa to 45 women to 10 men in Kenya (UNAIDS, 2004:6);
- Eastern and Central Asia have about 1.3 million people living with HIV/AIDS;
- Latin America has 1.6 million infected people; and
- The developed countries altogether have 1.6 million infected people.

2.4 HIV/AIDS PREVALENCE IN SOUTH AFRICA

The aim of this section is to gradually narrow the focus of the HIV/AIDS problem to the study area in order to situate it in its proper context.

The prevalence of HIV is high in South Africa. All the seven countries in Southern Africa have a prevalence rate over 17% with South Africa having the largest number of people living with AIDS in the whole world (UNAIDS, 2004: 6).

The international labour organization projects that the labour force in 38 countries (all but four countries in Africa) will be between 5% and 35% smaller by 2020 because of AIDS. In a recent research by UNAIDS, the pandemic had claimed over 17 million African lives. Taking an average of the figure provided by UNAIDS and those in a recent South African research project (Nelson Mandela HSRC study document) it would appear that HIV prevalence among people in South Africa between the ages of 15 to 49 years is about 20 percent of our total population. Women have a higher HIV prevalence than men of about 4 percent. The Medical Research Council of South Africa calculates that 25 percent of last year's adult deaths were due to AIDS-related diseases in South Africa and life expectancy is now at an average of 37 years and will drop even more before the pandemic peaks. At present 600 people are dying daily from AIDS related causes (Nelson Mandela HSRC study document).

The following data on HIV/AIDS compiled from The Joint United Nations Programme on HIV/AIDS (UNAIDS) 2006 Report on Global Aids Epidemic May 2006 and the CIA World Fact book was reported on the Global Health website.

(All estimates are for the end of 2005)

- The South African Population was estimated at 44 344 136 (July 2005).
- Estimated number of people living with HIV/AIDS was 5 500 000
- Estimated percentage of adults (ages 15 - 49) living with HIV/AIDS was 18.8%.
- Estimated number of women (ages 15 -49) living with HIV/AAIDS was 3 100 000.
- Estimated number of children (ages 0 -14) infected with HIV/AIDS was 2 600 000.
- Estimated number of deaths resulting from AIDS during 2005 was 320 000 (Global Health Reporting, 2006).

The following is also reported in 'The Executive Summary' of the 2005 South African National HIV Prevalence, and HIV Incidence Behavior and Communication Survey 2006.

- Prevalence of 5.7% at national level, with females at 13.3% (higher) as against 8.2% among males.
- The prevalence in females is most pronounced in the 24 – 25 age groups where the ratio is almost 4 times that of males (16.9% as against 4.4%).

The Centre for AIDS Development, Research and Evaluation reports from 2 National Surveys that the HIV/AIDS antenatal prevalence in was 30.2% while the National population prevalence was 10.8% (HIV and AIDS Scenarios for South Africa, 2005:28).

2.4.1 HIV/AIDS ESTIMATES FOR THE EASTERN CAPE

Deaths resulting from AIDS have increased considerably. The South African National Burden of Disease Study Estimates for the Eastern Province Mortality reported that AIDS was the leading cause of death in both males and females - 20% (Joubert, J. 2000:83).

2.4.2 PREVENTION OF HIV

HIV is preventable only if people will abstain totally from sex before marriage and married couples remain faithful to each other. Abstinence is the best solution to prevent the spread of HIV. AIDS is still a condition with an extremely high fatality rate. Unfortunately, no cure has been found for AIDS (Wilkinson, 2001: 5). This fact makes it an urgent goal for every country, especially South Africa which has the largest number of people infected, to put in place very effective measures to prevent the spread of HIV/AIDS.

The prevention of HIV/AIDS is most beneficial to any country down to the local community because apart from the socio-economic and political effects discussed further on, it causes a great deal of physical and mental pain and trauma for both the infected and the affected. The basic assumption for the prevention is that each role player should take responsibility for his or her action. The following sections identify ways that can be used to prevent the spread.

2.4.3 **Engaging in responsible sex**

Sexual intercourse is the commonest way of transmitting HIV virus. According to Roth (1989: 120), vaginal intercourse is the biggest cause of new HIV infections in the whole world, that is, 60-70%. Several options have been proposed in the prevention of HIV/AIDS originating from vaginal sex. These can be described as safer sex measures. The use of condoms has become a major aspect of these options. It is claimed that the use of condoms does not provide an absolute prevention because of user failure or product failure (Snidle and Welsh, 2001:40). However, it is equally accepted that the condom provides a highly effective protection against all sexually transmitted diseases including HIV if it is used in the correct way.

The issue of condoms has become a contentious one. Some churches like the Roman Catholic opposes it.

Safer sex also requires that sexually active persons reduce the number of sexual partners most preferably to one. People must also avoid any sexual activity which causes bleeding. Some writers even insist on avoidance of oral or anal sex (Snidle and Welsh, 2001: 39) which is a reasonable suggestion because transmission through these activities can not be prevented by using condoms.

2.4.4 **Measures by HIV/AIDS carriers**

It should also be the responsibility of HIV/AIDS carriers to prevent further spread. For instance HIV/AIDS carriers:

- should not donate blood
- should not donate organs

- should tell their doctor or dentist if they are HIV positive
- should not share syringes; and finally ,
- should remove spilled blood with detergent and antiseptic fluids.

Prevention strategies

a. abstain

b. have one mutual partner

c. have safer sex

d. treat all sexually transmitted infections (STIs)

e. know your status

f. never share needles

g. take precautions when handling blood

h. do not share toothbrushes and razor blades (Khomanani 2005:7-8)

HIV/AIDS awareness programmes and campaigns through television media (in South Africa) include:

1 Soul City

2 Soul Buddyz

3 Khomanani

5 Lovelife

6 Gazlam

7 Tsha Tsha

8 Takalani Sesame

These television media programmes provide an overview of overall awareness, and are an indicator of the efficiency at which the campaigns have been able to reach into various audiences. Soul Buddyz and Takalani Sesame achieve higher awareness in the 12 – 14 year age group,

and awareness of Soul City is the highest in all age groups. Although Takalani Sesame is primarily a children's programme, it achieves high awareness across all age groups (www.hsrcpress.ac.za)

Education for sex workers.

Sex workers belong to the highly vulnerable group which has less opportunity to practice safer sex. One reason is that they have different working styles and also there are new entrants and those who leave on frequent basis. A very useful method is through constant HIV/AIDS prevention education.

2.5 The economic effects/impact of HIV/AIDS

HIV/AIDS has social, economic and even political impact on an economy.

It is necessary to briefly discuss the impact of HIV/AIDS because it will reinforce the earlier statement that HIV/AIDS is not only a health issue. It will bring to the fore the magnitude of the problem and through that provides a rationale for the Church's urgent intervention. The Church's unique role as an organization or institution of influence puts it in a good position to play a significant role in the prevention and spread of the pandemic.

2.5.1 Impact on the economy and increasing the level of poverty

Health is very important for human production and activity. When one is deprived of one's health there is no strength. When there is no strength to work, the economy is affected. Workers in the public sector with a high

degree of absenteeism affect the economy. When there is no work, there is no pay and this therefore leads to poverty. If the AIDS sufferer is the bread-winner, then the rest of the family is also affected. The impact of HIV/AIDS on household income can be devastating. Household income may have to be diverted towards buying medication.

2.5.2 **Demographic effects**

Death is the end result of any HIV or AIDS sufferers. This can also have an effect on economic growth. This reduces membership in church growth and future leadership positions.

2.5.3 **Effects of HIV/AIDS on Women**

Women's vulnerability comes from the lack of power and control over their sex life (especially married African women) which increases their risk of HIV. One important remedy is to create opportunities to foster empowerment, combat ignorance and improve education for women, including education about their bodies, STDs and AIDS, and the skills to say no to unwanted or unsafe sex (Fact Sheet, 2000:10). The socio-economic status of women places them at a higher risk of HIV infection due to the fact that:

a. Many women cannot choose to abstain, use a condom, or insist on other forms of safer sex, because this may result in violence or abandonment by their male partners.

b. Rape contributes greatly to the spread of HIV because of the risk of trauma to the vagina. This risk obviously increases in the event of gang rape.

c. Poverty forces many women into sex-work in order to survive and support their children.

d. Some men are reluctant to visit hospitals and clinics when they have sexually-transmitted infections. Many also blame their woman partner for having a sexual transmitted disease (STI). The violence that may follow also discourages women from telling their partners they have STI. This can result in a recurrence of the STI (Khomanani Red Ribbon Resource, 2005:15).

2.5.4 **Effects of HIV/AIDS on Orphans**

UNAIDS (2004) shows the estimates of orphans as follows: the overall orphan-hood prevalence rate of 14.4% of children aged 2-18 years, 2.6% are maternal orphans, 10.0% paternal orphans and 2% double orphans. This means that overall there are a total of 2 531 810 orphans in South Africa in 2005, with 455 970 of them being maternal orphans, 1 745 715 paternal orphans and 330 125 double orphans. When the data was broken down by age, 13.3% of children between 2-14 years and 21.0% of respondents between 15-18 years were orphans. A further breakdown of the 2-14 years age group shows that 2.5% had lost a mother, 9.1% a father and 1.7% both parents (South African National HIV Survey, 2005).

There are a number of grants available to support orphans and vulnerable children. Social workers employed directly by provinces deliver some of the welfare services currently provided to vulnerable individuals including children and families affected by HIV and AIDS. The department of social welfare and the department of health also fund a number of not-for-profit organizations (NGOs) which play a critical role

in delivery of social development service delivery to vulnerable children (RSA Strategic Planning 2000-2005:103).

2.5.5 **Effects of HIV/AIDS on education**

Education has a strong impact on children and young adults who suffer from HIV and AIDS negatively. Another important indication of how it affects them is loss of hope and concentration. The myth has led to children living with or affected by HIV being prohibited from attending school due to fears that they will pass on HIV to the other children. Another effect is when they are asked by a parent to look after the sick, it affects the education. Therefore, knowledge, perception, and attitudes of HIV/AIDS are important precursors for behavioral responses to the disease.

2.5.6 **Effect of HIV/AIDS on businesses**

HIV/AIDS has become an obstacle to so many things in life. There are so many instances whereby one decides to sell his or her business thinking that he or she will die soon. To some they have to prepare for the worst. Much absenteeism due to sickness can have an effect on businesses. Some employers believe that people with HIV are sick and unproductive. Some HIV sufferers lose their jobs due to those perceptions of their employers even when they are still fit to work (Airhihenbuwa, 1989: 1(1), 57-69).

2.5.7 **Economic development and HIV/AIDS**

The fight against HIV in the most affected developing countries has largely benefited from improved access to treatment. However, that progress is far from sufficient. The human resources needed to provide access to healthcare are lacking in number and the shortage continues to deepen. Faced with this challenge, a response is urgently needed for economic development (Conseil National du Sida, 2005:4)

2. 6 **HIV/AIDS and practical theology**

From the point of view of practical theology it offers us the opportunity to re-evaluate our lives and consider the meaning of life itself, and it challenges our compassion. HIV raises many questions; it challenges our faith and brings us face to face with our insecurities, our own vulnerability and our own fears.

There are some people who doubt that theology can be practical (Browning, 1991:4) while others assert that it can be practical. For instance, Barth (1936 cited by Browning 1991:5) asserted that theology becomes practical when God's self-revelation is applied to the concrete situations of life. There are practical obligations of Christian life. The story of the 'Good Samaritan' (Luke 10:30-37) is an example. From the foregoing, one can conclude that theology can be practical and that the Church's role vis-a vis the HIV/AIDS position taken in the study is an example of practical theology. One of the five dimensions of practical action according to Browning (1991) is the Obligation dimension which insists that we love our neighbour as ourselves (Leviticus 19:18, 34; Matthew 22:39), and the 'golden rule', which tells us to do to others what

we want others to do to us Luke 6:31 (The New Open Bible, study edition).

2.7 **Psychological Effects of HIV/AIDS**

The impact of HIV on an individual who has realized that he/she is HIV positive is possible psychological shock, anger toward individual(s) who might have transmitted the virus, fear of abandonment, rejection by others, social isolation, emotional numbing (depression, anxiety, or panic), possible disfigurement or pain, drain of family savings and resources etc.

The pandemic also affects business in many ways, including increasing costs because of absenteeism, sick[illegible] recruitment organizational disruption and loss of skills and increasing health expenses and funeral cost (UNAIDS Report, 2004:24). HIV/AIDS does not only affect workers on the job, it also causes a major drain on family savings and resources. In the same way this will affect the future leadership positions of the church and reduction of membership. It will therefore be wise for the church to rise up and do something to stop the spread of this dreadful epidemic disease.

The church cannot just pray for the victims of HIV/AIDS but needs to support them financially, spiritually and emotionally. What one church does may differ from another church because the Charismatic and Pentecostal churches may play a different role towards the HIV and AIDS pandemic from the Orthodox churches (traditional churches).

These churches may play their roles towards the HIV/AIDS pandemic differently as churches have different teachings, so this would impact their approaches in educating youth on the HIV/AIDS issue.

The HIV virus attacks and slowly destroys the immune system. Many Africans have their own theories about the origins of the disease, depending on where they live. On a global basis, some people believe that it was man-made and was created to control homosexual populations, prostitutes and intravenous drug users in the United States of America and Europe. Others in Africa believe it was spread by colonialists to do damage to the indigenous population of Africa and therefore bring about their demise (Bodibe, 1992:18).

Scientific theory, however, believes HIV originated in the Central and Western parts of Africa as a cross-over (zoonosis) between primates and human beings, the original virus being the monkey form of the disease (Simian Immune Deficiency Virus – SIV) which managed to infect human beings and found a willing host (Kaisernetwork, Haart: 2005:9-10).

HIV belongs to a group of viruses called retroviruses which are only found in animals. HIV is currently the only retrovirus found in men. Retroviruses have unique enzymes called reverse transcriptase, which converts viral RNA to DNA as part of the infection and multiplication process (Kaisernetwork, Haart: 2005: 11).

The spread of HIV/AIDS needs to be arrested because of its serious implications in the social, economic and political spheres. In recognition of this fact, in the year 2002, the Office of the Premier according to Education Sector Policy on HIV and AIDS, began a drive towards developing and implementing provincial level policies on HIV and AIDS

for all government departments with an emphasis on workplace issues. As a department responsible for 6,314 schools, 65 000 educators and almost 1.9 million learners at different levels, the Eastern Cape Department of Education (ECDOE) acknowledges the seriousness of the epidemic and recognizes the important role that it can play in mounting a comprehensive response to HIV/AIDS. In education, the ECDOE has taken the initiative to develop a policy for the sector that covers all aspects of HIV and AIDS in the education context. If other organizations like the ECDOE are making efforts to stem the spread of HIV/AIDS then the church's role needs to be defined as well as.

According to Fact Sheets on HIV/AIDS document, over two-thirds of all the people living with HIV in the world live in sub-Saharan Africa, accounting for 83% of the world's AIDS deaths. There are no simple explanations as to why some countries are more affected by HIV than others. Poverty, illiteracy and engaging in identified risk behaviors account for much of the epidemic. People who are infected with HIV often have no symptoms of disease for many years and can infect others without realizing that they themselves are infected. Much needs to be done to ensure better tracking of the epidemic and to find better prevention strategies and care for people living with HIV/AIDS.

Bruce Wilkinson (2001:8) asserts that poverty alone is not the main cause for the spread of HIV/AIDS because both the rich and the poor are at risk. Therefore the solution to the problem is to educate people.

2.8 The Church and HIV/AIDS

Some may ask if religion is part of the problem or part of the solution. A part of the problem of HIV/AIDS control may be silence, indifference, stigmatization and discrimination, lack of pro-active programmes, not addressing injustice, lack of faith in the future, reducing HIV to individual immorality, and lack of language to speak about human sexuality.

The churches have heard the urgent plea from people living with HIV and AIDS (Kaisernetwork, Haart:2005). Therefore, many churches have engaged with HIV/AIDS programmes and have excellent care, education and counseling.

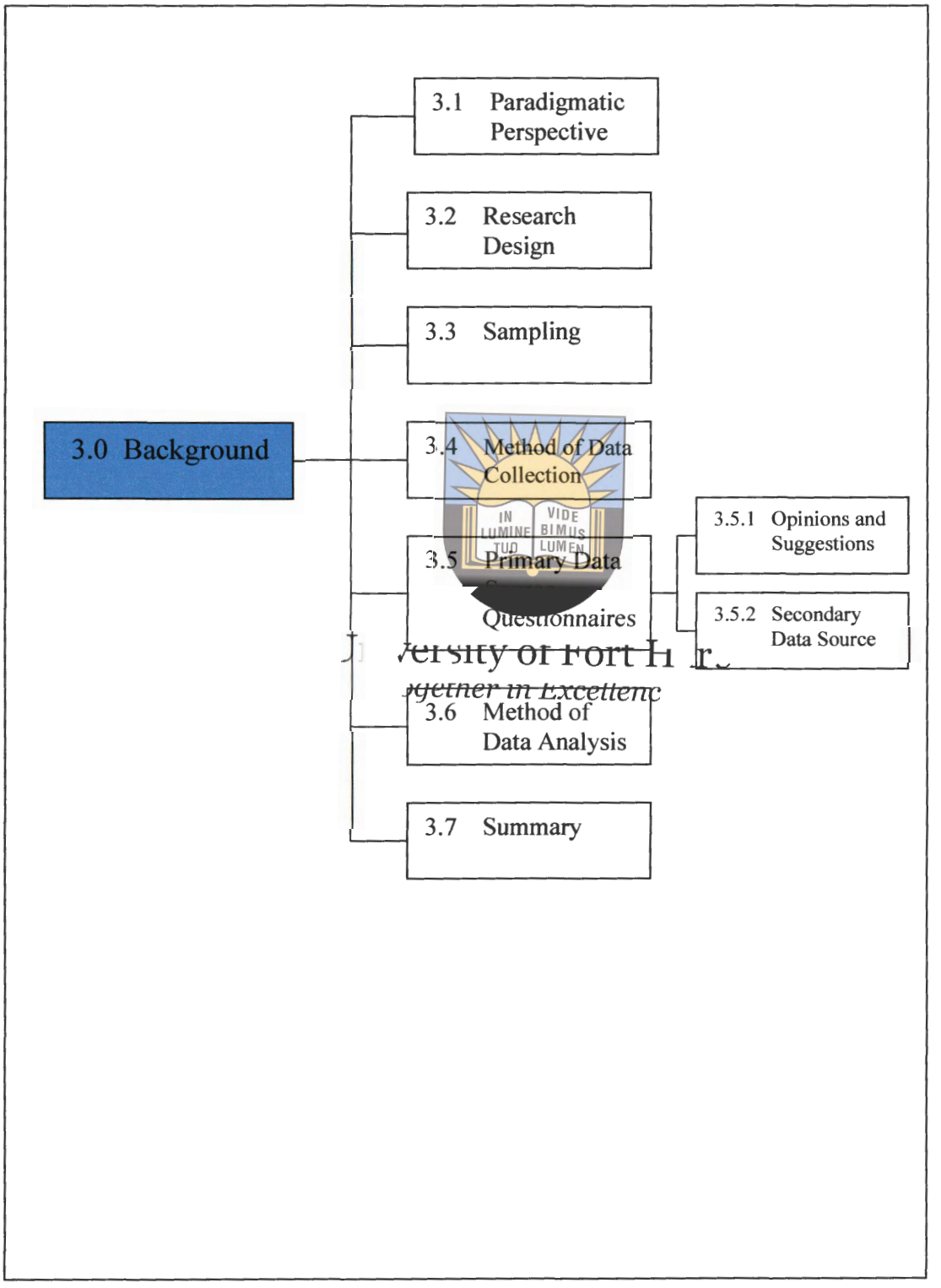
The church is regarded as an influential and powerful institution, with the potential to bring about change. The intention is that its activities become more effective, efficient and sustainable as a result of greater co-ordination, better networking, and strengthened communication and also improved mechanisms for working together, building on each other's experiences and success and avoiding unnecessary duplication of effort. As the church enters into solidarity with the person living with HIV/AIDS, its hope in God's promise of abundant life comes alive and becomes visible to the world (Kaisernetwork, Haart:2005).

2.9 Summary

The study has established the review of literature on what HIV and AIDS are and its effects, the findings of how HIV is transmitted, and the precautionary measures. This chapter was done within the framework of

practical theology, the role of the Church and social, economic and political impact of HIV/AIDS. The literature review is centered mostly on the global context. This chapter indicates what others have studied or said about the HIV/AIDS viruses.

OUTLINE OF CHAPTER 3
Research Methodology



CHAPTER 3

RESEARCH METHODOLOGY

3.0 **Introduction**

This chapter provides the research methodology that was used in the study. The aim of this is to make the reader aware of how the research was carried out. The methodology includes the subject, the research instrument, the research design, focus group discussion, the procedure and findings.

The study was conducted from September to November 2006.

3.1 **Paradigmatic perspective**

The study followed an interpretive-positive paradigm. This paradigm uses both the qualitative and quantitative approaches. There are certain epistemological assumptions in the search for knowledge. Newman (2000:66) states: "Positivism sees social science as an organized method from combining deductive logic with precise empirical observations of individual behaviour in order to discover and confirm a set of probabilistic causal laws that can be used to predict general patterns of human activity'.

The positivist takes the stance of an observer, aims at observing the social world 'objectively' and predicts human behaviour, and uses the method of science, (Cohen et al, 2000: 3-4; Newman, 2000: 12) and such a researcher relies on accurate quantitative data.

The interpretive paradigm, on the other hand, regards knowledge as 'of a softer, more subjective, spiritual or even transcendental kind, based on

experience and insight of a unique and essentially personal nature and humanly created' cited in (Cohen, Manion and Morrison, 2000:6).
The subjectivist, and the interpretivist on the other hand, gets involved with the subjects and rejects the way of the natural science (Cohen, et al, 2000:6-7). The interpretivist can select from a range of techniques like personal constructs and participant observation, and interviews.

3.2 **Research Design**

Christensen (2004) defines research design as the outline, plan, or strategy specifying the procedure to be used in seeking an answer to the research question. Bless and Higson-Smith (1995:46) sees research design as 'The plan of how to proceed in determining the nature of the relationship between variables'. It specifies such things as the kind of data required, from whom it be acquired (that is the sampling), and how to collect and analyze the data (Cohen, et al (ed) 2000: 15)

The research paradigms explained in the preceding section informed the research methodology and hence the research design. The positivist-interpretivist paradigm was chosen because it benefits from the complementary nature of the research process (Leedy and Ormond, 2001:107). The approach also enabled the researcher to apply qualitative aspects to the results from the questionnaire for a better understanding and interpretation of the results. A mixed methods approach is usually utilized when a researcher intends to base knowledge on practical foundations as was done in the study (Cresswell, 2003:11).

The quantitative, descriptive survey design involved administering a questionnaire and a qualitative method using semi-structured interviews and focus group discussions. A descriptive survey according to (Cronbach, 1990:45), attempts to describe existing behaviour, opinions or attitudes of the group under study. The descriptive component of the study describes education, prevention, care and support of people living with HIV and AIDS. The advantage of the descriptive study is that a large amount of information can be gathered.

It was also felt that the exploratory questionnaire-based survey was ideal for collecting large scale data in order to make generalizations especially when the focus is on opinions, scores, outcomes and conditions (Cohen, et al, 2000: 18). Other reasons were that the research sought to question people about themselves concerning their attitudes and behaviours and so it is felt that the method is appropriate.

Survey researcher may make use of either a questionnaire or interviews. Generally, the questionnaire approach is more cost-effective than the interview approach as questionnaires can be administered to groups of at a time. Questionnaires also allow for anonymity of the subject. This is especially pertinent in HIV/AIDS research where most people do no want to speak-out their statuses. A personally-administered questionnaire survey was utilized in cases where respondents were not comfortable with the English which was used as the language in the questionnaire. Thus, no individual respondent was handicapped by the language barrier and also the boredom and lack of motivation to respond was reduced.

3.3 **Sampling**

There are two types of sampling techniques, namely probability and non-probability sampling. In the probability sampling, each subject of the total population has the equal chance of being selected for the sample. In the non-probability sampling however, each subject of the population does not have an equal chance of being selected as sample subjects (Grein et al, 2004:18; Trochim, 2006:12). Probability sample designs are used where representatives of the sample is of importance for purpose of wider generalization (Sekaran, 1992: 2(3):2-4). The non-probability sampling is used when generalization is not the primary purpose (Kerlinger, 1992:92). In this study a non-probability techniques called convenience sampling was also used. This method involved collecting information from people suffering from HIV/AIDS who were conveniently available at the time of the survey. The main reason for choosing the convenience sampling method was that there was no intention to generalize the results to the entire population, but to gain more insight into the subject of inquiry.

In line with the choice of the mixed methods approach used in the study, the probability and non-probability sampling which combines purposeful and simple random sampling was used in the selection of participants. The simple random sampling method which used the random table was selected to enable every member of the population to have an equal chance of being included in the study (Cresswell, 2003:48).

In this case, data collected focused on pastors, church elders, and youth of selected churches of different denominations.

This will mean a count of all orthodox churches and non- orthodox churches in the study area. A total number of 20 churches were involved from where data was collected.

3.4 **Method of data collection.**

This study aimed at obtaining and assessing the role of the church in the educating for preventing HIV/AIDS as well as the type of support provided for and care given to the infected and the affected. Consequently, the collection of data was done using different sources which allowed 'triangulation'. Such a strategy is supported by most writers on research.

Statements like: 'multiple sources of evidence that entails a variety of data collection techniques, which are highly complementary in nature, will result in a good research study' (Cohen, et al, 2000:98, Jick, 1979:17 as cited by Aramantunga and Baldry, 2001:32 Flowerdew and Martin, 1997:84, Stake, 2000:44, Babbie, 1992:16)). Such an approach promotes the 'development of converging lines of inquiry' (Yin 1994:78) and reduces the threats to validity and reliability of research findings (Denzin 1997, cited by Cohen et al 2000) and consequently make for accurate and convincing findings.

For this study, therefore, the data collection methods included data which was obtained from both primary and secondary sources.
The following instruments were used to gather data required:

3.5 **Primary data sources Questionnaires.**

The main primary source was the questionnaire. Questionnaires were administered to the churches, the elders and sampled congregants. The questionnaire had open-ended questions (See appendix 1 i.e. questionnaire). Questionnaires were variously administered. Some of these were personally administered (where the language used to write the questionnaire posed a problem) while others were left filled in by the respondents at their own convenience. The response rate was very high because out of 23 questionnaires given, 20 responses were obtained.

The questionnaire covered five critical areas which were pertinent to the outcome of the study. These were:

1. **The precautionary measures applied by the church to educate and prevent the spread of HIV/AIDS and the type of support and care provided.**

This section was made up of three questions which asked respondents to mention the preventive methods, and the educational programmes which the church has in place as well as the care and support mechanisms. It also aimed at finding out how the church identifies sufferers in order to design support and care programmes for them.

2. The impact of interventions

This section helped assess how those infected and affected by HIV/AIDS have benefited from the interventions put in place by the church.

3. The success or failure of programmes adopted by the church

This part of the questionnaire served to elicit information on the self-criticism of the church's approach as well as gauge the degree of inadequacy or sufficiency of the interventions.

4. **The relationship between the church, the community, government and other role players.**

This section of the questionnaire tested the relationship between the community, the government, the Non-Governmental Organizations (NGOs) and any other role players. This was done because it was felt that the nature of the HIV/AIDS problem required a multi-disciplinary and multi-organizational solution.

3.5.1 **Opinions and suggestions**

This section of the questionnaire elicited answers for four very pertinent issues which are required for policy formulation and policy adjustments in terms of the church's research goals. Specifically, it elicited respondents'' opinion about the necessity of the church's involvement in HIV/AIDS issue; whether the church is playing a major role in this area; the level of satisfaction in the church's performance in this case as gauged by respondents; and the areas of necessary improvement.

Interviews:

Face-to-face and semi-structured interviews (Qualitative technique) were conducted. Babbie, (1992:18) points out that the interview as a data gathering strategy allows the researcher to obtain more elucidation on issues and correct misunderstandings which crop up later (Leedy and Ormond, 2001:103) An interview schedule with predetermined open-ended questions was used to give direction to the interview so that there was minimum deviation from the focus of the research.

Focus groups

Focus group interviews were used to assess if the congregation plays a major role towards HIV/AIDS pandemic. Those involved in the discussion were pastors, church leaders, youth and the congregation

Focus group discussions were also used to gather information on the attitudes and perceptions of group of people on HIV and AIDS. This approach, like informal interviews, provided an excellent way of getting good response information. The focus groups interviewed, provided a first-hand, close-up picture of what is happening in the church and the support that are provided. A question which kept cropping up was: 'What must faith communities do to make the fight against the spread of the virus effective?' The focus group approach also assessed whether the present response of the church to HIV/AIDS is appropriate, especially in the light of the church's understanding of itself. This enabled the researcher to evaluate the strengths and weaknesses of the church in rendering the task of responding to HIV/AIDS.

Direct observation

Direct observation occurred when field visits were conducted during the study period. In fact, observation is inevitable where human interaction occurs.

3.5.2 **Secondary Data sources**/Documentation (including material for the literature review) included:

- Accredited books;
- Accredited journal articles;
- Statistical data, e.g. from Statistics South Africa
- Government reports;
- Policy documents; and
- Internet sources.

These sources provided additional information as well as understanding of the context of the study.

3.6 **Method of data analysis**

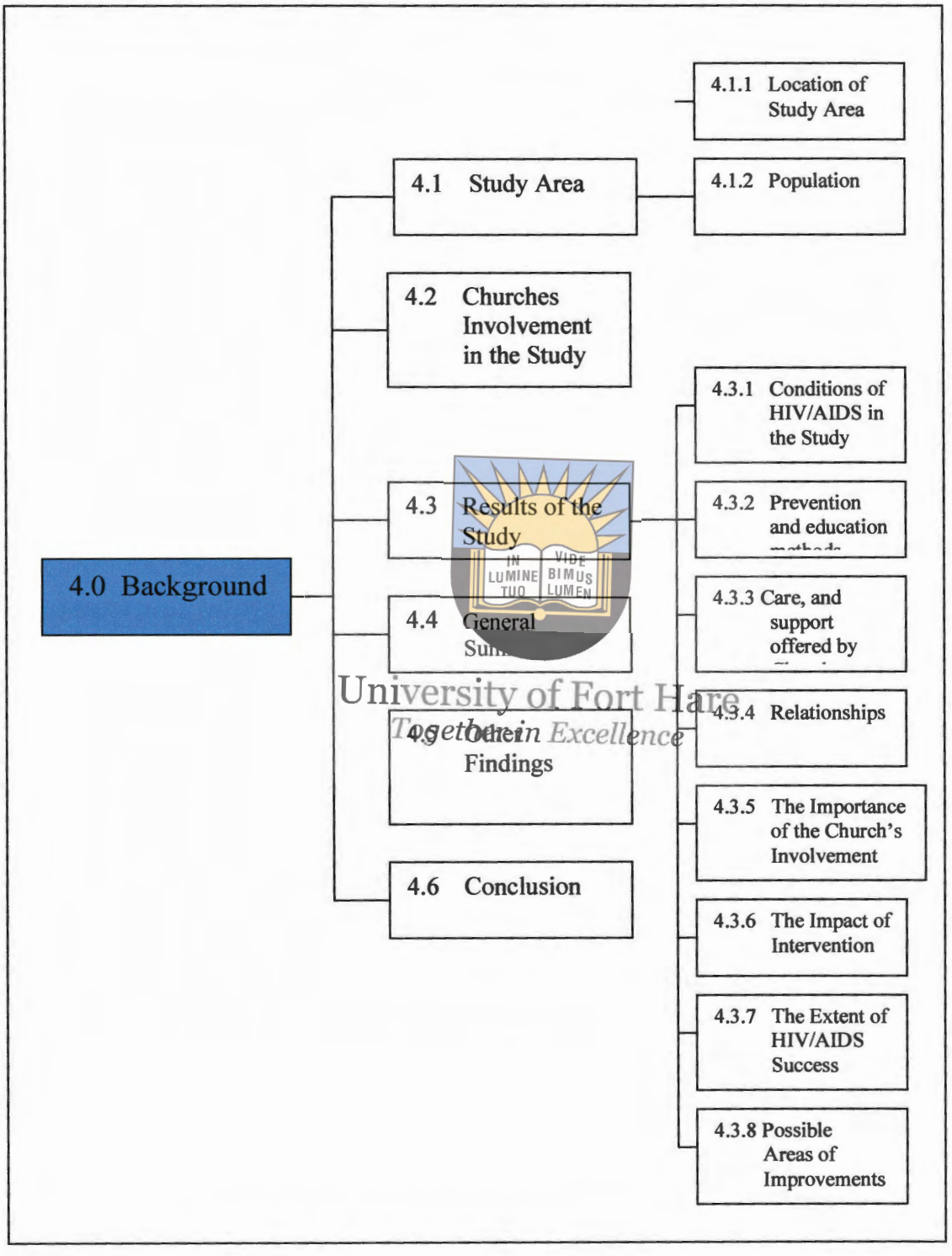
Data was analyzed by means of descriptive statistics namely frequencies and percentages which were presented in tables, graphs and diagrams.

3.7 **Summary**

This chapter presented the method of data collection as well as data analysis. It started with the paradigmatic perspective, the sampling methodology, and the methods of data collection as well as data analysis. The next chapter discusses the range of data gathered.

OUTLINE OF CHAPTER 4

Case Study and Findings



CHAPTER 4

CASE STUDY AND FINDINGS

4.0 INTRODUCTION

This chapter focuses on findings obtained by means of research questionnaire interviews and focus group discussions. The data obtained formed the basis of the analysis of the findings. It can safely be concluded from the outcome of the study, the interviews and the questionnaires that were administered in King William's Town, Bhisho, and Zwelitsha (the area of study), were successful. The results are presented in the form of tables and graphs. Before then a brief presentation of the status quo of the study area is made.

4.1 STUDY AREA

To put the study in context there is the need for a brief outline of the study area which is done in the following sections

4.1.1 Location of the study area

Bhisho, King Williams Town, and Zwelitsha are in the Eastern Cape Province of South Africa and are part of Buffalo City Municipality which falls within the ADM (see Figure 4.1 and Figure 4.2). Bhisho-King Williams Town serves as the Provincial Capital of the Eastern Cape Province.

4.1.2 Population

The population of Bhisho, King Williams Town and Zwelitsha, in terms of age, is indicated in Table 4.1.2. The combined population of the three settlements is 54 226. King Williams Town, with 28 118 residents has the largest population (51.9 per cent) followed by Zwelitsha, with 19 628 people (36.2 per cent) and lastly Bhisho which has a population of 6 480 (11.9 per cent).

TABLE 4.1.2 Population of Bhisho, King Williams Town and Zwelitsha

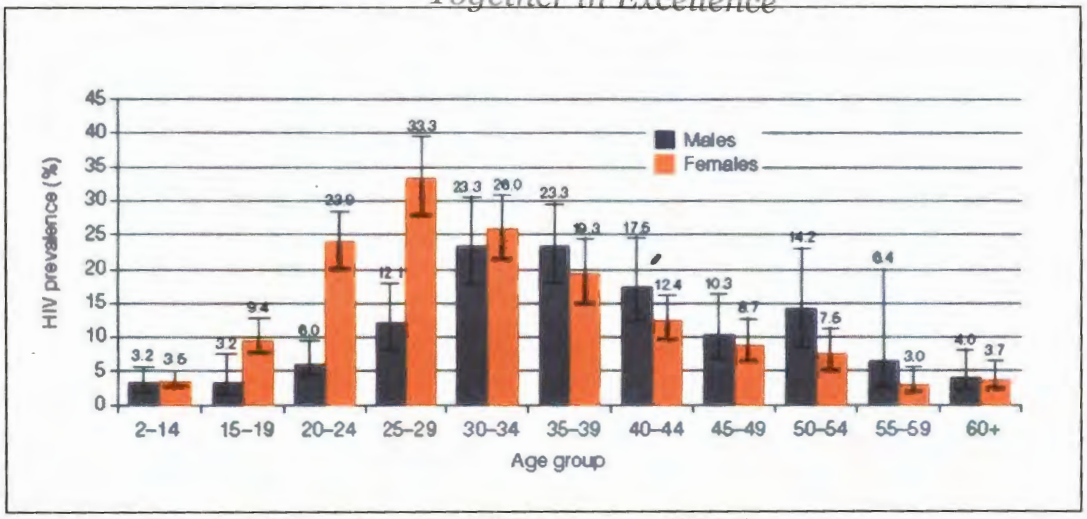
	Bhisho	King William's Town	Zwelitsha	Total
0-4	565	2243	1321	**4130**
5-9	700	2601	1701	**5002**
10-14	784	2907	1	**5676**
15-19	729	3120	2382	**6230**
20-24	438	2310	1948	**4696**
25-29	427	2296	1776	**4499**
30-34	521	2455	1548	**4524**
35-39	661	2493	1467	**4622**
40-44	612	2278	1292	**4182**
45-49	438	1793	1025	**3255**
50-54	220	1192	715	**2128**
55-59	150	830	615	**1596**
60-64	91	568	617	**1276**
65-69	58	366	497	**921**
70-74	35	278	351	**664**
75-79	24	193	189	**407**
80-84	22	123	132	**277**
85+	3	70	67	**139**
Total	**6480**	**28118**	**19628**	**54226**

Source: www.str.com.ua (Statistic South Africa – 2005).

Analysis of the population figures shows that the 0-19 years group with a population of 19 504 constituted 36 per cent. The population of those 65 and over is 2 408 and this is 4.4 per cent. The 'active' population (working age i.e. 20-64) constituted 56 per cent. A threatening situation exists in the study area in terms of the HIV/AIDS problem. Of the 26 082 persons in the working age group (20-64 years) in the study area, 22 523 of the population (86.4 per cent) in the study area, falls within the age group with the highest prevalence of HIV South Africa (see Figure 4. 1).

The dependency ratio is going to rise dramatically in future. In addition, the economic base is going to be eroded because the number of people who will be available for work will be drastically reduced as a result of AIDS and the mortality related to it. The number of orphans will increase. (See Chapter 2 for the effects of HIV/AIDS).

Figure 4.1 HIV prevalence by sex and age group, South Africa 2005



Source: South African National HIV Survey (2005).

4.2 CHURCHES INVOLVED IN THE STUDY

In this study, information was gathered from various churches. These results were generated after 20 churches were given research questionnaires. The focus groups and interviews also involved these churches. Table 4.1.3 to 4.1.5 shows the churches involved.

TABLE 4.1.3 CHURCHES IN BHISHO

1. Community Church
2. Assemblies of God
3. Brownlee Congregational Church
4. Methodist Church of South Africa
5. Seventh Day Adventist Church

TABLE 4.1.4 CHURCHES IN KING WILLIAMS TOWN

1. Sacred Heart Catholic Church
2. Presbyterian Church
3. Methodist Emmanuel Church
4. Potters House
5. Goodness Christian Church
6. Ebenezer Family Church
7. Jesus is the Answer Ministry
8. Abundant life Ministry
9. Holy Trinity Anglican Church
10. Christ Reconciliation Power
11. Victory Life Evangelical Temple

Table 4.1.5 CHURCHES VISITED IN ZWELITSHA

1. Roman Catholic Church
2. Bantu Church of Christ
3. Anglican Church
4. Old Apostolic Church

There were 8 orthodox churches and 12 charismatic/Pentecostal churches and each had its own unique way of participating in caring, supporting, and educating the infected people living with HIV/AIDS. Table 4.2 shows the orthodox and charismatic/Pentecostal grouping.

Table 4.2 Orthodox and Charismatic/Pentecostal churches studied

CHARISMATIC AND PENTECOSTAL CHURCHES	PLACE	ORTHODOX CHURCHES	PLACE
Community Church	Bhisho	Brownlee Congregational Church	Bhisho
Assemblies of God	Bhisho	Methodist Church of South Africa	Bhisho
Seventh Day Adventist Church	Bhisho	Sacred Heart Catholic Church	King William's Town
Potter's House	King William's Town	Presbyterian Church	King William's Town
Good News Christian Church	King William's Town	Methodist Emmanuel Church	King William's Town
Ebenezer Family Church	King William's Town	Holy Trinity Anglican Church	King William's Town
Jesus is the Answer Ministry	King William's Town	Roman Catholic Church	Zwelitsha

Abundant Life Ministry	King William's Town	Anglican Church	Zwelitsha
Christ Reconciliation Power	King William's Town		
Victory Life Evangelical Temple	King William's Town		
Bantu Church of Christ	Zwelitsha		
Old Apostolic Church	Zwelitsha		

Source: Field work in 2006

4.3 RESULTS OF THE STUDY

4.3.1 Conditions of HIV/AIDS sufferers.

It was discovered that the condition in which the HIV and AIDS sufferers were in was not satisfactory. A brief survey of 10 HIV/AIDS sufferers selected by convenience and availability (see Chapter 3 for convenient sampling) was done. A large number was not deemed necessary since this was not the focus of the study. These were introduced by friends and relatives. For the purpose of this study, their identities are being withheld. It emerged that they earned insufficient wages and as such they could not eat a well-balanced diet. They said what they earned was not enough for them to buy the drugs which have been prescribed for them by the doctors.

4.3.2 Prevention and educational methods used by the Churches

All the 20 churches (100 per cent) reported that they had some form of preventive and educational measures in place. These were:

- Awareness campaign among the youth;
- Preaching and emphasizing the practice of abstinence before marriage;
- Workshops and seminars on HIV/AIDS prevention;
- Films and other media presentations on HIV/AIDS;
- Support groups. (One of the churches designated its HIV/AIDS support groups as '*YIBANENCEBA*' which translates into ' Have Mercy")
- HIV/AIDS prevention education sessions with family groupings within the church and the community in which the church is situated. One of the churches reported that it linked its activities with the Ginsburg Clinic. This particular church also had a HIV/AIDS office (the only one among the 20 churches in the study). The church also gave First Aid training and had so far trained 180 people in King Williams Town and surrounding areas.

It must be mentioned that the degrees of use of these measures varied because while others (16 churches or 80 per cent) combined many of the measures listed, 2 of (20 per cent) of the churches' measures came in the form of 'preaching' on abstinence).

In terms of effectiveness of the prevention and education measures, 12 out the 20 churches (60 per cent) considered their programmes effective.

4.3.3 Care and support offered by the church

To the question of voluntary declaration of HIV/AIDS status, almost all the churches (18 of them or 90 per cent) responded that people there had voluntarily reported their statuses. Only one church (10 per cent) reported in the negative.

However, those churches which reported of voluntary declarations also mentioned that there was still a great hesitancy in reporting cases. They had observed that there was still a lot of fear of being ostracized by family and community. Many go into denial and do not want to accept that they have HIV/AIDS. This means that there are many within the churches that are not getting the necessary support offered by the churches because they are not declaring their statuses.

In terms of numbers, the number of cases being reported in the past 2 years ranged between 2 and 20 for individual churches (18 out of twenty or 90 per cent). Two of the churches (10 per cent) did not divulge their numbers for fear of being stigmatized. These figures are high and encouraging. If the trend continues, it is hoped that more and more infected people will come forward to declare their statuses and hence obtain the necessary help in terms of emotional, physical and medical support.

Care mechanisms of churches

14 out of the 16 respondents to this question (87.5 per cent) reported that they had some form of support mechanism in place. Only 12, 5 per cent did not and they mentioned lack of resources and problems of organizing

such a structure as the main reasons. For those who did have support structures. The care mechanisms comprised the following in various combinations:

- Counseling; (100 per cent of churches)
- Food parcels (78.6 per cent of churches);
- Spiritual support (praying with sufferers was one form) (100 per cent of churches);
- Assisting as the need arose (100 per cent);
- Financial support for the needy (42,9 per cent of churches) ; and
- Medication and home-based care (28.5 per cent).

All the churches (100 per cent) used more than two of the above mechanisms. Only one church used all the above. That particular church was the only one which had an HIV/AIDS office. This church was also the only one which reported that they extended this support to others outside the church (i. e. non-members). One of the 4 churches which provided medication and home care reported that it was able to do this because it received outside funding including from the European Union (EU). 2 out of the 4 who did not respond to the questionnaire mentioned in a follow-up session that they had no specific support mechanism but treated problems 'case by case'.

The overall impression is that even though support and care mechanisms are in place in most of the churches, their operation is not comprehensive enough (with the exception of one of the churches). That most of them (15 out of 16) did not mention that they extended care to non-members indicates limited action.

4.3.4 Relationships that exist between the church, the community, government and other role players in the control of the HIV/AIDS.

Of the 16 churches who responded to this question all of them (100 per cent) reported of having related to an outside body in the prevention and control of HIV/AIDS. All the churches related with the community within which they operated but only 50 per cent had any relationship with two organizations. None of the churches had relationship with more than two organizations. This finding shows that even though the churches are contributing to the education and prevention of HIV/AIDS, their efforts are more isolated. This indicates that there is the need for more concerted action and coordination with outside bodies than presently exists.

4.3.5 The importance of the church's involvement of HIV/AIDS issues

There is the acceptance by the churches studied that the church has an important role to play in the prevention, education and caring for HIV/AIDS sufferers. All the 19 churches (95 per cent) who responded, agreed that the church has an important role to play in the prevention, education and caring for HIV/AIDS sufferers. The various reasons for this position are stated below:

- Providing hope and love for HIV/AIDS sufferers through God's forgiveness and hope;
- Making the whole church aware of HIV/AIDS issue;
- Removing the stigma;
- Improving morals and preaching abstinence before marriage and through that reducing premature sexual activities which promote the acquisition and the spread of HIV/AIDS; and

- By not shying away from the issue, many lives would be saved because the church has much influence in the community.

Two of the churches not unsurprisingly looked at the church's (the Christian Churches together) role in terms of the ' good Samaritan' (Luke 10: 30-37) and as a result saw it as a primary obligation of the church to take care of those infected and affected by HIV/AIDS. This position is in line with the contention of Browning (1991) who, in similar vein and with the same source, supports his position that there are practical obligations of the Christian life.

Emotional and spiritual support is very vital. One aspect that came to the fore in this aspect was the emotional support which the churches emphasized. This was expressed in the form of prayer which most of them said they offered to sufferers. (See section 4.3.3).

4.3.6 The impact of the interventions in the lives of the people living with HIV/AIDS

This was one of the difficult aspects to measure or assess. The focus group discussions were really helpful in this instance because they provided a forum and the opportunity for others, apart from the priests and secretaries of the churches, to bring out their inputs. By means of the focus group discussions, others people (for instance members of the congregations) who happened to be in direct contact with the sufferers were able to tell how these efforts are having a positive impact on the sufferers (see Chapter 3 for composition of the focus groups).

10 out the 18 churches (55.6 per cent) that responded to this question had not been able to access the impact of their intervention strategies or had not thought of it at the time of the study. 44.4 per cent stated that the

interventions have had positive impact on the HIV/AIDS sufferers they had been dealing with. Reasons given for this claim were that more people were disclosing their statuses and that all those affected and infected with the HIV/AIDS felt welcome because they saw that the church did not discriminate against them but rather supported them. The sufferers also saw the tangible efforts of the church because they were looked after in terms of their physicals needs.

For the overall assessment of the impact issue, one cannot make a conclusive statement because of the large number of churches which could not provide assessments. However, some generalizations could be made. There has been no frontal attack on the issue. It has been assumed by many of the churches (gauging by the number which had not been able to access the impact or had not thought of it) the churches that providing help 'as or when necessary' was the 'right thing'. Another factor which might have created this situation is that not many people are declaring their statuses and even for those who do, confidentiality may prevent the priest from acting openly to provide the necessary support. One church explained that it had not been able to access the situation because of lack of cases in that particular church. If one went by the infection rate in South Africa (see Chapter 3) then it will appear strange that a church of that stature did not have sufficient cases to be able to access. It is suggested here that this is an instance of non-declaration of statuses. This is one factor which is restricting the churches' ability to help HIV/AIDS sufferers in the early stages of the infection and onset of the disease.

4.3.7 The extent to which the HIV/AIDS programmes of the churches have been a success or failure

The respondent churches expressed various degrees of success. 85. 7 per cent of the churches which had programmes indicated that they had been successful. Only 14.3 per cent reported that their programmes had not been successful and they attributed the lack of success to inadequate resources especially finance so they could not run their activities the way they had wanted. Those who reported that they had been successful gave the following reasons:

- 14.3 per cent had been able to obtain international funding for their programmes;
- One of the churches had been running the programmes for the past four years with the support – financial and other- from church members;
- Sufferers had expressed appreciation for the unconditional acceptance of the church; and
- More people have become aware of the HIV/AIDS issue through the programmes. Many people within the churches and the community have come to consider the HIV/AIDS issue as a serious matter.

The overall analysis shows that the church had reached out to sufferers and their relatives/families. The members within the church who are infected and affected are not large in number. Those who had been bold enough to declare their statuses are being offered help as discussed earlier. It is satisfying that much work is rather being done with the 'outsiders' or non- members. It came out that most churches in the study (87.5 per cent) have involved themselves in counselling, hospital visitations, food parcels, home-based care and support of some kind.

About 30 per cent of the churches reported visiting HIV/AIDS sufferers on a weekly basis. Those which did not have specific programmes have indicated that they intend doing so and others mentioned that that they intended increasing the scope of their programmes (see section 4.3.3). It was discovered that most of the Churches specifically prayed for HIV/AIDS sufferers as well. The finding is relevant because it shows that the church is moving away from the notion of punishment for wrong-doers' and from the idea that sufferers are objects of God's wrath which had previously dominated Church – HIV/AIDS sufferers' relationship to a notion of 'God cares'. This change of attitude and the actions taken by the churches in the study area can be described as Christianity in action or the operationalization of practical theology (Browning, 1991:57).

4.3.8 Possible areas of improvements

The churches acknowledged that there were certain areas where measures and actions geared toward HIV/AIDS education, prevention, care and support could be improved. These were:

- Getting through to the youngsters the importance of life and how not to lose it to something that is preventable as HIV/AIDS;
- Increased emphasis on abstinence before marriage and change of moral attitudes;
- Imparting of life skills;
- Adopting God's teaching and adapting it to modern life and getting it through to the young ones that it is their individual responsibility to protect themselves;
- Monthly awareness functions in the church instead of waiting for certain occasions which might occur once or twice a year; and

- Expansion of home-based care programmes;

TABLE 4.3 A general summary of some of the findings

ORTHODOX CHURCHES	PLACE	SOME INTERVIEW/QUESTIONNAIRE RESULTS AND COMMENTS
Methodist Church	Bhisho	Visits the sick and pray. Because people do not come out to declare their status they do not have any support group programmes. Intending to start soon
Roman Catholic Church	Zwelitsha	Awareness campaigns are done by certain groups in the church. Hospital visitations are done.
Anglican Church	King Williams-Town	Has established an AIDS office whereby they provide Home Based Care, educate in AIDS prevention and work in close association with Ginsberg Clinics. Workshops to school and prisons. Trained ± 180 people in King William's Town. [illegible]-test and post-test counselling.
Brownlee Church	Bhisho	Do not have any HIV/Aids programmes
Catholic Church	King Williams-Town	Have an AIDS office where they do counselling and workshops. They give food parcels, do needlework to keep HIV-sufferers busy. Financial support from the church. Has run the AIDS office for 4 years now. Keep the church aware of progress.
Methodist Church	Zwelitsha	No formal structures but however, awareness is always highlighted. A guest speaker has been invited to present a talk on HIV/Aids in 2005. Lack of support and no educational programmes exist.
Anglican Church	Zwelitsha	AIDS awareness programmes are due to be formed soon.
Methodist Emmanuel Church	King Williams-Town	Could not answer any questions since nothing concerning HIV/Aids programmes are being done or implemented.

CHARISMATIC/ PENTECOSTAL CHURCHES	PLACE	SOME OF THE INTERVIEW/ QUESTIONNAIRE RESULTS AND COMMENTS
Community Church	Bhisho	Awareness event on HIV/Aids annually. Support group meets once a week consisting of affected and infected people. Training given to support group on a quarterly basis. Training given to church as an annual event.
Seventh Day Adventist Church	Bhisho	Not yet started any HIV/Aids events, but intending to do so soon.
Bantu Church of Christ	Zwelitsha	They only preach on sexual immoralities.
Potter's house	King Williams-Town	Holds seminars, preaching, Doctors for Life films are shown to the church and the public by educating people against HIV/Aids – especially to schools and the townships. They do counselling and provide moral support.
Jesus is the Answer Ministry	King Williams-Town	Have awareness campaigns among the youth, hospital visitations. Teaches biblical principles on Holiness. Some within and outside the church declare their HIV status. Support them emotionally and financially.
Abundant Life Church	King Williams – Town	Teaches sex after marriage and abstinence. Their support mechanism is that of a leader chosen to be the head of a "Care Ministry" by reaching out to the HIV/Aids sufferers.
Ebenezer Family Church	King Williams-Town	Handles workshops and awareness campaigns within the church and is very effective. Visits the sick, prays for them and supports them financially. Spiritual upliftment and counselling. Established home-cells.
Old Apostolic Church	Zwelitsha	Not yet started any support group programmes. Preaches abstinence and visits the sick. Few declare their HIV status.
Christ Reconciliation Church	King Williams–Town	Certain Pastor commented that the main preventative method is Jesus Christ and church members should be 'born again'. Educational programme is the Word of God.

	King Williams-Town	He only prays for those who declare their status to him.
Victory Life Evangelical Temple	King Williams-Town	Preaches and prays for them. Sunday school is set up for praying for the sick and educating them about HIV/Aids.
Assemblies of God	Bhisho	Lays more emphasis on the preaching of abstinence in the church.

Source: field work, 2006

4.5 Other findings

The focus group discussions, apart from its contributions to the findings reported in the previous sections, also yielded some interesting data which needs to be mentioned. There was indication that participants have good knowledge about behaviour which encouraged the spread of HIV/AIDS.

Table 4.4 Sexual behaviour and HIV/AIDS

Question	Yes %	No %
Do you think it is acceptable to use a condom with a spouse to protect against AIDS?	15.3	84.7
Can you get AIDS if you have sex with someone who looks perfectly healthy?	95.2	4.8
Has your best friend slept with anyone other than her spouse in the last twelve months?	75.4	24.6
Have you ever talked to your husband or wife about the chances that you or he might get infected with AIDS?	40.1	59.9
Do you suspect or know that your husband or wife has had sexual relations with other women apart from you since you were married?	71.6	28.4

Have you yourself slept with anyone other than your husband or your wife in the last 12 months?	2.1	87.9
Have you ever heard a talk at the clinic/hospital about how people can protect themselves against AIDS?	95.4	4.6
Have you ever heard a radio programme about how people can protect themselves against AIDS?	89.8	10.2
Has someone like a Community Based Distribution agent or a Health Surveillance Assistant ever come to your home to give you counselling?	81.3	18.7

Source: Fieldwork, 2006

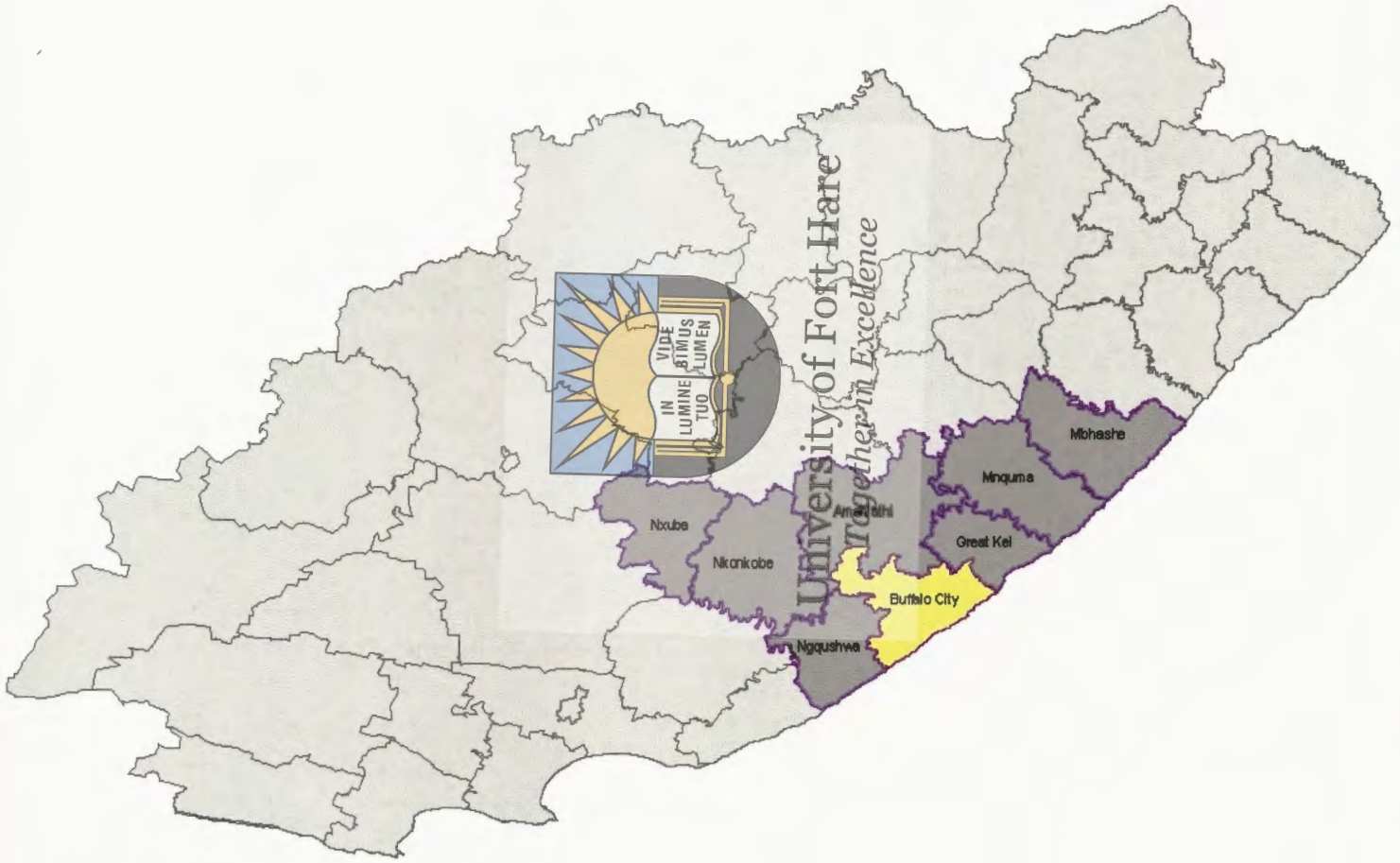
4.6 CONCLUSION

This chapter looked at the findings obtained through the questionnaires, survey, interviews and focus group discussions. It was established that most of the churches studied used one form or other of preventive and education methods. The effectiveness of these is difficult to access but most of the churches indicated that they had had positive impacts. Most of the churches have support and care mechanism in operation. However, even though the number which voluntarily declares their statuses is on the increase, there is still much hesitancy. Thus, the effectiveness of the churches' effort is also felt in the wider community (outside their congregations). The churches have extended their education, prevention, care and support activities to those in the communities in which they operate. The churches reported that their efforts have been successful albeit limited in some areas. There is therefore the realization that more could be done. Some aspects of their intervention strategies are provided in Table 4.4. To ensure anonymity, the names and locations of the churches are not provided. The orders in which the questionnaire results

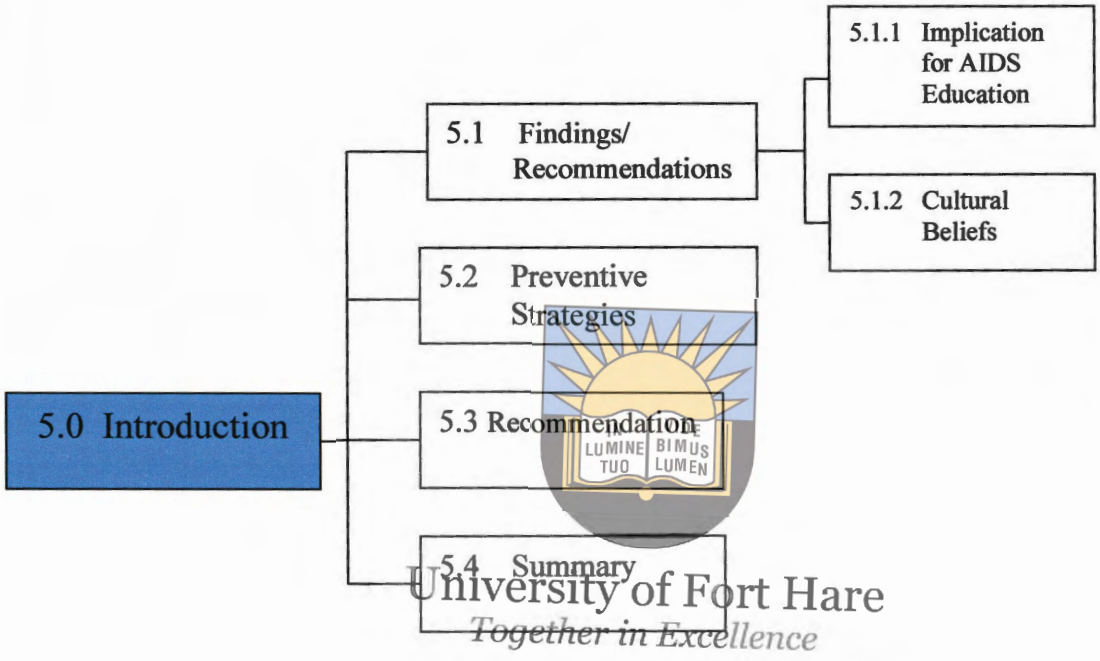
appear do not correspond to names of churches and places in Table 4.3. It on the whole, it could be concluded that the church in the study area has been functional in terms of the demands of practical theology as discussed in Chapter 2.

FIGURE 4.2

Source: (Statistic South Africa, 2006)



OUTLINE OF CHAPTER 5
Findings and Recommendations



CHAPTER 5

FINDINGS AND RECOMMENDATIONS

5.0 INTRODUCTION

HIV and AIDS is a crisis which cannot be wished away. It is also not going to disappear within a short time. It is a threat to the social and economic foundations of any community in general and the Amathole District Municipality in particular. All role players including the church should therefore, define their positions with regards to its control and the minimization of its impact. Role players such as the Church, the Government and the NGOs are to come together so that the burden will be light. The Church, the Government and other stakeholders are to have an existing common relationship in order to have successful control programmes on HIV/AIDS prevention.

As the HIV/AIDS epidemic matures, the demand for care of those living with HIV/AIDS rises.

5.1 Findings

On the basis of the analysis of the data gathered and analyzed, the following findings and recommendations are made:

- With regards to those diagnosed with HIV/AIDS the level of anxiety is always high. The way in which HIV progresses to AIDS is a gradual process that moves through various phases. The World

Health Organisation (WHO) divides HIV infection into four stages. These divisions should be seen as a guide only.

- HIV enters the body duplicating itself rapidly in the CD4 cells. There are few or no signs that a person is infected. Swollen lymph glands are common, but are not usually a cause for alarm.
- This stage is typically characterized by minor skin problems, head or chest colds and weight loss. Herpes zoster (also known as shingles) often occurs during this stage.
- During this period, the amount of HIV in the body, or the viral load, is increasing. In the process it is destroying more and more CD4 cells. More serious problems begin to occur, such as profound weight loss, chronic diarrhoea, fever, oral thrush (a common fungus in the mouth), vaginal thrush, pneumonia (lung infection) and TB.
- Very serious diseases, some of which are seldom found in HIV-negative people, occur. These include a kind of lung infection called pneumocystis carinii pneumonia, oesophageal thrush (a fungal infection in the throat), infection of the brain such as toxoplasmosis and cryptococcal meningitis, severe diarrhoea, profound weight loss and cancer such as Kaposi's sarcoma (Khomanani Red Ribbon Resource, 2005:5-6)

With regards to how HIV progresses to AIDS, support networks whereby the community agencies, including the Church should give support to the sick in the midst of despair and to help people living with HIV/AIDS (PLWHA) and their dependants, should be assisted. The network support should include medical and paramedical staff, social services, charitable organizations, faith communities, and professional counsellors or

psychologists. Women are particularly vulnerable because they are disadvantaged by cultural practices which deny them power to decide on issues. One important remedy is education, and to create opportunities to foster empowerment, and the skill to say "no" to unwanted or unsafe sex. Also, women are to be provided with friendly services and to ensure that girls and women have access to appropriate health care services at places and times that are convenient and acceptable to them (Fact Sheet, 10-13).

5.1.1 **Implications for AIDS Education**

Convincing Africans to use condoms is so difficult, and why African woman often insist on having children, even if they are found to be HIV positive. Every person has the right to education. No learner shall be denied access to education on the basis of his or her actual or perceived HIV status. Again, every person has the right to relevant and factual HIV and AIDS information, knowledge and skills that is appropriate to their age, gender, culture, language and context. The involvement of people living with HIV/AIDS to educate them and inform should be promoted at all levels of the education sector. Many Africans have their own theory about the origin of the disease. There are guiding principles for PLHA. There are also legal framework policies implemented in accordance with all relevant national laws, codes and regulations policies and collective agreements. All these are drafted for public comments in Education Sector Policy (ESP) on HIV/AIDS (February 2005 issue). Human rights should be a tool for the empowerment of both persons and communities, in order to restore their dignity and enhance the quality of life. Talking openly and providing information are

key ways for people to teach young children and teenagers how to protect themselves from the virus.

5.1.2 **Cultural beliefs and problems of HIV/AIDS with use of condoms**

According to the authors of the book entitled 'Meeting Christ in HIV/AIDS', one of the prevention measures is the use of condoms. Condoms are thin latex rubber balloons that covers the penis during sexual intercourse. It protects the man's penis from the woman's vaginal fluids, and it prevents infection passing from one to another. As a short-term solution, it is to stop unwanted pregnancies and the spread of HIV viruses. Condoms therefore give a measure of protection that is certainly better than none. When a person is having unsafe sex or is HIV positive, it is very important that condoms are used to prevent the transmission. When condoms are used they must be used correctly, and must not be used after the expiry date.

This has nothing to do with ignorance, but with a very specific social and cultural dimension of sexuality, Rwandans believe that the flow of fluids involved in sexual intercourse and reproduction represent the exchange of "gifts of self" which they see as very important in a relationship. Rwandans believe that the use of condoms will block this important flow between two partners that may also block the flow of fertility, and cause all sorts of sickness. Many Rwandan women fear that the condom might remain in the vagina after intercourse and that they risk becoming "blocked beings." In a culture where health and pathology are conceived in terms of "flow" and "blockage" it is understandable that women cannot imagine how a "blockage" device could also be a healthy device. (Van Dyk, 2001: 64).

Recently, there was a report in the Daily Dispatch of October 23, 2006 written by a reporter calling Eastern Cape pastors to join in the fight against HIV and AIDS (see **Appendix 2**). From what was gathered from the article report, one can see that many pastors are lacking information concerning HIV/AIDS issues. Pastors need to be educated on what HIV really is. In the absence of a cure, what role should be played by churches in promoting the ABC strategy and education and communication campaign? Questions that one may ask is 'are the Churches really praying for the sick'? What then is the duty of the church in our communities? Though some are really doing well as names of such people were mentioned in the article report, many more such leaders in all churches are needed.

5.2 **Prevention Strategy**

In the Southern African Journal of HIV Medicine of August 2004 edition, there was a conference report on prevention of mother-to-child transmission which was held in Bangkok from 11 to 16 July 2004. There were 19 500 attendees from all over the globe with a high representation from Asian countries. South Africa was well represented by a large contingent including politicians, researchers, activists and government officials. One of the issues is on antiretroviral drugs for pregnant women to treat their HIV infection or to prevent HIV infection in infants.

It takes a lot of courage to do what you know is right for you, to make your own choices and decisions, but if more of us are able to do that, then we will really start to turn the tide against HIV/AIDS (www.aidsinfo.co.za:13).

Once HIV is in the body it is there to stay, and once a person develops AIDS there is no known cure for it, therefore, prevention is the best solution. HIV/AIDS prevention should be tackled with all available resources. Some prevention complexities need to be addressed at the greater society (macro-level), through measures such as strengthening or changing government policies, modifying laws, and enforcing new laws or human rights policies. Other prevention strategies must address the behavioural, social and cultural context (micro-level) of the individual. At macro level, the South African government should recognize the magnitude of the HIV epidemic in the country, and the Church also needs to face this challenge. Nurses and midwives also can play an important role in promoting such awareness. However, it is at the micro-level, where behavioural, social and cultural influences have the most effect on communities, families, and individuals that nurses and midwives can make the greatest contribution to HIV prevention. Although HIV prevention and harm reduction have been separated into challenges at the macro and micro levels, in practice, they are interdependent and closely related (Fact Sheet, 12).

In the study, it is established that the most common form of HIV transmission (as well as other STD transmissions) is through sexual intercourse or through sexual contact with infected persons. It also passes on from mother to unborn child or to her infant child through breastfeeding. This finding has been confirmed in various studies (Khomanani Red Ribbon Resource, 2006: 5).

5.3 **RECOMMENDATIONS**

A recommended solution is the expansion of voluntary testing and counselling among the sexually active and teaching them about condoms and making them easily available without embarrassment. It is recognized that certain faith communities (e.g. Catholics) do not accept the use of condoms and therefore this recommendation should not be seen as undermining the doctrine of these churches.

- Proper planning and management of supplies and other resources are essential in reducing the occupational risk of HIV infection. Such measures should include risk assessment, setting of standards and protocol that address safety, risk reduction, post-exposure follow-up and first-aid.

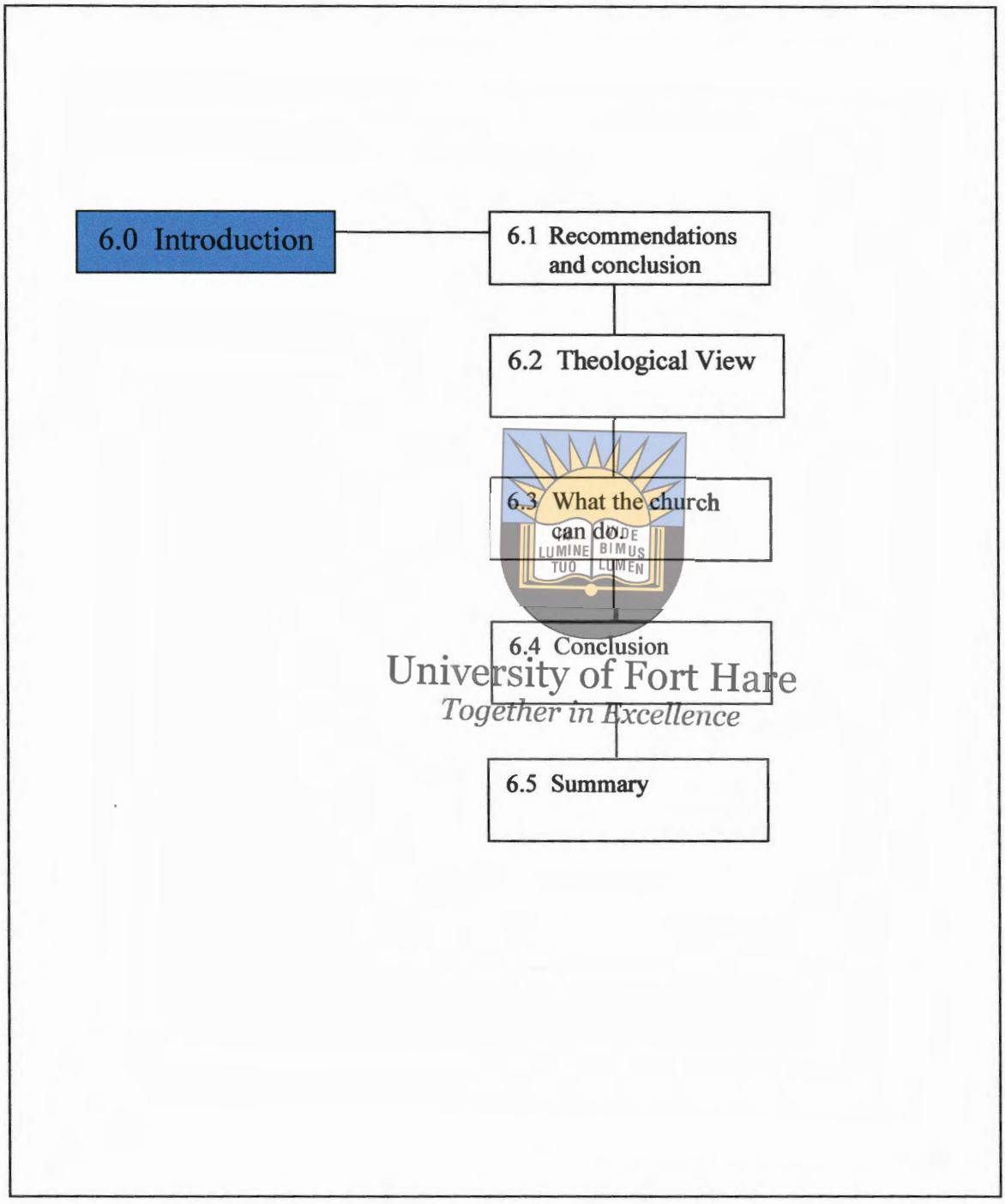
- Occupational risk can be reduced by introducing measures to prevent or reduce stress, maintain an optimum workload, orientate new staff and provide education and supervision (Fact Sheets, 2000:11-6).

- Promoting condoms is simply not enough. Talking about ARV success stories is also not enough. Teaching healthcare professionals' disease management is not enough. Money could be directed towards not only prevention but changing perceptions of the disease. Changing perceptions will mean that people can make informed decisions (Kaisernetwork, Haart: 1, 3).

5.4 **Summary**

These discussions in this chapter revolved around HIV and AIDS and its preventive strategies. The role players and their decision making is the key in respect to the findings of the study. With regards to the findings, a recommended solution was discussed whereby there should be voluntary testing and counselling. At the time one receives HIV-positive test results, the sufferer has the right to have post-test counselling. This will ensure that a second test after three months means counseling will be needed. By doing that, it reduces the stress because being HIV-infected is a very difficult thing for a person to cope with, as they may find themselves thinking about how much time they have left to live. Some people with HIV find that this is a challenge and make every moment count in their lives to achieve their goals in the time left. These motivated people with HIV and AIDS are very inspiring to all of us.

OUTLINE OF CHAPTER 6
Recommendations and Conclusions



CHAPTER 6 CONCLUSION

6.0 **Introduction**

The concluding chapter reflects back to the objectives of the study. As stated in the introductory part of chapter one, the overall objective of the study is to determine the role players of churches caring, supporting, educating and fighting against the spread of HIV/AIDS viruses in the regions of Bhisho, King William's town, and Zwelitsha. HIV/AIDS started as a so-called 'gay disease'. Now it is seen as an African disease (Untitled Document 2006, Stellenbosch University). It has become a global emergency with devastating effects on development and an economic burden, especially on developing nations. A number of HIV/AIDS-related problems such as stigma, rejection, discrimination, denial, fatalism and cultural practices have arisen. Based on the study, below are the recommendations and the conclusions.

6.1 **Recommendation and Conclusion**

As Christians, we are already equipped to bring to those in need the comfort of the Holy Spirit, emotional strength and an assurance of the love of God. Our Lord has called His Church to be a people who care for others (Matthew 25: 31-46). The AIDS pandemic presents the church with a challenge to take the word of our Lord in Matthew 25 and make it a reality. Again HIV/AIDS pandemic challenges the Church to rediscover and strengthen its

ministry to those under threat of death or now dying. According to the author of a book entitled 'Facing Death and the Life After', Billy Graham said 'death is an enemy' but we need to die in dignity. The apostle Paul, who was very sensitive to the needs of hurting individuals, wrote that we who are strong must bear the weaknesses and help carry the burdens of those who are weaker. Probably, Paul was writing about those who had doubts, fears, and sinful lifestyles (Collins, 1988).

As it is written in Acts 26:19-28, it is clear that the Church was not only in evangelizing, teaching, and disciplined community; it was also called a healing community. The church believes that hope is not lost when a person is infected with HIV; it believes that the spiritual resources of the church can be used to help people to accept, and to come to terms with, their own mortality. In all these concerns churches are well placed to work with local communities. Faith Based Organizations (FBOs) are providing holistic complementary care across the spectrum and is a major contributor to the national response. FBO's again have taken the lead in many countries besides the Church with provision of care for orphans and vulnerable children. This care has taken the form of institutional care, community-based fostering and adoption, day care centers, street children programmes and hospices for abandoned and HIV positive children. Although many countries will not have adequate resources to address all these components, each country can be working toward comprehensive care. These cares can be **Home care**, **Community care**, and **District Hospital care**. In June 1986, the World Council of Churches (WCC) study group which looked into ways the Church could become involved in the AIDS crisis recommended in four main areas for the churches response:

. Pastoral care
. Social ministry
. Education
. Prevention

When the Church properly responds to people living with HIV/AIDS, both ministering to them and learning from their suffering, its relationship to them will indeed make a difference. The Church needs to create an atmosphere of openness and acceptance. St Basil the Great taught that it is up to those in leadership positions in the church to create an environment, an ethos, a "disposition" for the cultivation of goodness and love in the community. To help members of churches and the communities understand the full dimension and impact of HIV/AIDS in their lives, participatory approaches are crucial.

The AIDS pandemic should be regarded as a unique opportunity to revive and reinforce the values of responsibility, sexual integrity, healthy relationships, human dignity and mutual respect. Alcohol may increase risk of HIV from oral sex; therefore, if a person wants to play it safe, they should avoid drinking before having sex because it impairs their judgments (Roosevelt, 2004:34). Focus group discussion in churches could be encouraged as a vital ministry. Questions such as the following could be raised: what does the church uniquely bring to efforts to face the challenges of HIV/AIDS? Has the church become a ghetto, isolated from the life of the people? Does the church touch people's existential lives? How can the church deal with, and be responsive to, the life of the community? How can the church be supported in identifying its priorities, and in tackling difficult

issues related to its identity, life and mission? How can the church identify effective and relevant action to meet the challenge of HIV/AIDS? How can those in the church best reflect on what they have learned in meeting this challenge? The role of the church should be seen in the light of its particular cultural contexts as well as in the light of the universal gospel message (Facing AIDS, 2001: 6 ,76, 78, 80)

The church is slow in reacting to social issues. There is minimal dialogue with youth, and the Church faces difficulties in preparing young people for sexuality. Religion and sexuality are not seen as contradictory, but finding practical approaches has been problematic. Moreover, many priests are poorly informed about HIV/AIDS. Their only source of information is what they read in newspapers or see on television. Action on HIV/AIDS is left to non-governmental organizations; it is not something the church is involved in. Therefore a need for priests to receive education on human sexuality is recognized.

There is an experience from a parish in Lebanon which is just one of many examples illustrating the need to equip churches with appropriate knowledge, skills and attitudes in meeting the challenge of HIV/AIDS. To promote the prevention of HIV-infection, frightening messages, using such images as skeletons, skulls, coffins and even open wounds, which have often been transmitted in hope of scaring people into behavioural change. Such messages are harmful. Not only do they suggest that unless one has such symptoms one is not infected, but they add to the stigma attached to those who are actually infected. The message in a preventive campaign should therefore prepare people to take care of the infected and to show support for them (Facing AIDS, 2001: 84).

Preventive work is indeed more effective when it engages persons who are living with HIV/AIDS. People listen and react when they hear the story of a person who is present before them, rather than merely seeing words on a page or drawings on a poster. Openness about HIV should be promoted, both to effect change and to extend support to those infected or affected.

Pastoral Care and Counseling

In practice AIDS counselling is often combined with health education (Moses & Plummer, 1994: 123-127) understanding as teaching a client or patient how to behave and providing relevant information. When a test is negative, counselling focuses on:

- The need to make changes to one's lifestyle so that one remains HIV negative
- Advice about whether to return for a second test three months after the first test. This will ensure that you were not tested in the window period, giving a false negative.

When a test is positive, the counsellor will advise on:

- How to live a healthy life to delay the onset of AIDS.
- How to deal with the issue of disclosure. What your rights are in this regard. How best to help your family and friends understand your HIV status should you choose to disclose.
- How to know whether you need to go onto antiretroviral treatment.
- How to make decisions to prevent others from getting HIV, for example by always having sex with a condom (Khomanani Red Ribbon resource 2006: 24, 25).

Overall it should be seen as a helping or supporting process aimed at assisting persons in coping with their life-situation and accepting what has affected them, and may address physical, practical, psychological, social and spiritual needs. The goal of AIDS counseling in particular is twofold:

- To help infected persons come to terms with their situation; and to promote coping stress strategies for the infected and affected, including preventing or reducing HIV-transmission.
- Many professional counselors would benefit from additional training in this specialized area. With proper training, concerned and dedicated volunteers may also be very good counselors (Facing AIDS, 2001: 85).

6.2 **Theological View**

The practical concern is how people will use the knowledge of God about holiness, obedience and faithfulness for daily living. We are in a period of social reconstruction. On the one hand, we have relied in recent centuries too much on theoretical and technical reason to solve our problems. On the other hand, we have relied too much on blind custom and tradition. We swing from one extreme to the other because we lack a clear idea of how practical reason and tradition relate to one another. We now have returned to the category of the practical in search of a shared praxis that will enable us to either reconstruct tradition or to learn to exercise our practical wisdom without it. These seem the two basis choices. In each case, the exercise of practical wisdom with or without tradition – the debate is over competing images of what is variously called practical wisdom, practical reason, or

phronesis. Practical reason is generally thought to be exercise by individuals. It is like individual talking to themselves and going through the steps of practical thinking in a form of silent conversations. One may ask can theology be practical. A theologian as recent as Karl Barth saw theology as the systematic interpretation of God's self-disclosure to the Christian Church (Barth 1936, 47-70). There was no role for human understanding, action, or practice in the construal of God's self-disclosure. In this view, theology is practical only by applying God's revelation as directly and purely as possible to the concrete situation of life. The theologian moves from revelation to the human, from theory to practical, and from revealed knowledge to application.

Theology can be practical if we bring practical concerns to it from the beginning. We come to the theological task with questions shaped by the secular and religious practices in which we are implicated – sometimes uncomfortably. These practices are meaningful or theory-laden. By using the phrase *theory-laden,* I mean to rule out in advance the widely held assumption that theory is distinct from practice. We are so embedded in our practices, take them so much for granted, and view them as so natural and self-evident that one can never take time to abstract the theory from the practice and look at it as something in itself.

When one is faced with crisis, it makes one a bit weary just to think about it. For instance, the HIV/AIDS crisis. Yet that is why we represent life in terms of metaphors of pilgrimage, trials, and struggles. Modern life may be becoming so dynamic that we all will fail because we cannot keep up with the pace. Novel, fresh, and critical practical thinking helps us to establish

more settled and predictable cultures governing our everyday behaviors. The believing community should conform itself totally to the Word of God revealed in scripture (Barth, 1936: 187-247). This, I believe, is a classic expression of the theory-to-practical model of theology. It also affected the thought and life of the Churches.

6.3 **What the Church can do**

This study has proven the dramatic spread of AIDS and its devastating impact on those directly affected. The AIDS pandemic analyses a cluster of inter-related factors which are the theological and ethical perspectives that informs, arising from our understanding of AIDS; the effects of poverty on individuals and communities; issues of justice and human rights; the understanding of human relationships; and the understanding of human sexuality. Of these the factor of sexuality has received the least attention within the ecumenical community. Exploration of these themes has brought me face-to-face with issues, understandings and attitudes which have major consequences for the churches in responding to the pandemic. (Facing AIDS, 2001: 93). Through their witness to the gospel of reconciliation, the value of each person and the importance of responsible life in community, the churches have a distinctive and crucial role to play in facing the challenges raised by HIV/AIDS. If witness is to be visible and active, it is essential to highlight the following concerns for common reflection and action:

A. **The Life of the Churches: responses to the challenge of HIV/AIDS**

1. Should provide a climate of love, acceptance and support for those who are vulnerable to, or affected by HIV/AIDS.

2. Should reflect together on the theological basis for their response to the challenges posed by HIV/AIDS.

3. Should reflect together on the ethical issues raised by the pandemic, interpret them in their local context and offer guidance to those confronted by difficult choices.

4. Should participate in the discussion in society at large of ethical issues posed by HIV/AIDS and to support their own members who, as health care professionals, face difficult ethical choices in the areas of prevention and care.

B. **The witness of the Churches in relation to immediate effects and causes of HIV/AIDS.**

1. Should work for better care for persons affected by HIV/AIDS.

2. Should promote the sharing of accurate information about HIV/AIDS, to promote a climate of open discussion and to work against the spread of misinformation and fear.

C. **The witness of the churches in relation to long-term causes and factors encouraging the spread of HIV/AIDS.**

1. Special attention should be focused on situations that increase vulnerability to AIDS such as migrant labour, mass refugee movements and commercial sex activity.

2. Churches should educate and involve youth and men in order to prevent the spread of HIV and AIDS.

3. Churches should address the pandemic of drug use and the role which this plays in the spread of HIV/AIDS and to develop locally relevant responses in terms of care, de-addiction, rehabilitation and prevention (Facing AIDS, 2001: 94, 95).

A good number of faith communities throughout the world have been working tirelessly, compassionately and with great success in fighting the spread of HIV/AIDS as well as caring for those who are infected by this epidemic. Faith communities have, in recognition of the global nature or HIV/AIDS, started partnerships in their local settings, nationally and internationally for mutual empowerment with knowledge, attitudes and skills needed to make informed, compassionate and effective responses to the HIV/AIDS epidemic at all levels.

These partnerships are based on the realization that the church has as its great asset, the members, with their commitment and collective determination to join hands in caring for and supporting people living with HIV/AIDS, are our most important resource. In this group there are those

whose talents have never been tapped. These people are usually referred to as the frozen assets of the church – doctors, social workers, nurses, psychologists, etc. Once these people are brought in at the invitation of church leaders, they usually show great concern and perform excellently in the performance of their tasks.

The need to identify and encourage the right people in the church to get involved is very important. AIDS was almost entirely associated with people and behaviours that were in direct defiance of the principles set down by God in His holy word (Brown, 2004: 53). There has been confusion on what constitutes the most appropriate church response to HIV/AIDS. Among other things churches can:

1. After listening to people living with HIV/AIDS (PLWHA), encourage them to assist in the education of the whole congregation on issues that relate to the care and support of PLWHA. This can only be done if they are encouraged to disclose their status. Once they do so, they must never doubt the support of the church, especially the leadership. Leaders must provide a climate of love, acceptance and support for those affected and infected by HIV/AIDS, thus fighting the stigma.

2. Identify groups that are of key importance for informing, motivating and guiding in responding to HIV/AIDS. These could be women, girls, young men's guild, youth groups, trained pastors, lay leaders, youth and children's leaders, the church hierarchy, special resource people and people living with HIV/AIDS.

6.4 **Conclusion**

The sooner faith communities set up structures that help and revisit how the Scripture has been interpreted to promote the stigmatization, exclusion and suffering of people with HIV/AIDS, the better. By doing this, faith communities will render effective programmes in prevention, care and support and alleviate the suffering of those already affected and infected by HIV. The Church, the government and other stakeholders are to have an existing common relationship in order to have successful control programmes on HIV and AIDS. These role players are to have good and available resources to support their programmes. The Church has a vision and commitment to people living with HIV and AIDS therefore with the plan of action, the ecumenical family envisions a transformed and life-giving church, embodying and thus proclaiming the abundant life to which we are called, and thereby capable of meeting the challenges presented by the epidemic.

By commitment, the church will also condemn discrimination and stigmatization of people living with HIV/AIDS as a sin and as contrary to the will of God. The church will also launch a global effort to stimulate theological and ethical reflection, dialogue and exchange on issues related to HIV/AIDS (Piot, 2004:18).

6.5 **Summary**

This chapter reflects back to the role of the church towards HIV/AIDS epidemic, its challenges and cultural practices. It also talks about preventive

measures such as abstinence, education, care and support. It provides the theological basis in response to the challenges posed by HIV/AIDS. According to (Okwu, 1978:88, Sow, 1980:66, and Gyeke, 1987:102), despite the differences between Africans from different cultures in terms of geography, linguistics, religiosity and ways of life, there is a dominant socio-religious philosophy shared by all Africans. To talk of an overarching African perspective or African worldview that can be distinguished from a Western and an Eastern perspective is therefore possible.

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APPENDICES

Appendix 1 -------- Questionnaires for various Churches

Supervisor: Rev. K. Bohnen

Researcher: L. Afari-Twumasi

Background information concerning the Study

The Department of Theology and Religion at the University of Fort Hare is currently conducting a number of research projects on a variety of topical issues affecting today's society. One of the issues being looked into is that of HIV and AIDS which is spreading widely in our modern society in which we live. Despite the campaign which has been going on in all sorts of media concerning awareness, people are still ignorant about the whole issue of this killer disease.

The Church has now taken upon itself to preach against condom use and how to prevent infection by abstaining from sex before marriage. Other important issues like educating, caring and supporting those who have been infected are the challenges which the Church is facing today. Other role players are the government and the NGO'S. Right now, only a few studies have been carried throughout Amathole District Municipality for the black population in the Eastern part of South Africa. The questionnaire asks pertinent questions about HIV/AIDS and the role which the church plays. One has to complete it as honestly as possible.

APPENDIX 1

QUESTIONNAIRE:

(A) GENERAL QUESTIONS

Name: _____ Gender: M / F Age: ____ Date: _____

Name of Church: _____

Location: _____

Year of Establishments: _____

Position in the Church:
(i) Priest / Reverend
(ii) Elder
(iii) Member/Congregation
(iv) Other (specify) _____

(B) RESEARCH QUESTIONS

QUESTION 1: What are the precautionary measures or interventions taking place in the churches towards the prevention, education and care and support of the HIV/AIDS infected and affected people.

1.1 PREVENTIVE METHODS USED BY THE CHURCH

- What prevention methods are being adopted by the Church to promote attitude and behaviour among the members with respect to HIV/AIDS prevention? (e.g. Life skills education, advocacy workshops, awareness campaigns, etc.)

_____

_____

_____

_____

1.2 EDUCATIONAL METHOD ADOPTED BY THE CHURCH

- What educational programmes does the church have towards its people, especially the HIV/AIDS infected and affected people?

_____

_____

- How effective are these programmes?

1.3 CARE AND SUPPORT OFFERED BY THE CHURCH

1.3.1 Do members voluntarily come out to declare their HIV/AIDS status?

Yes / No

- If no, what do you think are the main reasons?

- If yes, how many have done so?

1.3.2 Does your Church have any care and support mechanisms for those living with HIV/AIDS? Yes/No

- If no, why not?
- If yes, what are and support mechanisms does your Church have towards HIV/AIDS patients and their families?

QUESTION 2: What is the impact of intervention in the lives of people living with HIV/AIDS and those without HIV/AIDS diseases in the church?

To what extent have these interventions benefited the people?

2.1 What impact have the above interventions had on the members of the Church?

_____

_____

_____

QUESTION 3: TO WHAT EXTENT HAVE THE HIV/AIDS PROGRAMMES ADOPTED BY THE CHURCH BEEN A SUCCESS OR FAILURE?

3.1 Have the HIV/Aids programmes adopted by the Church been successful or unsuccessful? Yes / No

3.2 If yes, how successful are they?

_____

_____

_____

3.3 If no, why not?

_____

_____

_____

QUESTION 4: WHAT RELATIONSHIP EXISTS BETWEEN THE CHURCH, COMMUNITY, GOVERNMENT AND OTHER ROLE PLAYERS IN THE CONTROL OF THE EPIDEMIC?

4.1 Is there any relationship between the Church and the following bodies in handling the HIV/Aids issue?

HIV issues:

- Community
- Government
- NGO's
- Others (specify) _____

4.2 If yes, how strong is the relationship?

4.3 How is the relationship maintained?

QUESTION 5: WHAT CAN WE LEARN FROM THIS RESEARCH?

5.1 What do you think is the importance of the church's involvement in HIV/Aids issues?

_____

_____

_____

5.2 Do you think the church is playing a major role towards HIV/Aids patients?

Yes / No

Explain your answer:

_____

_____

_____

_____

5.3 Are you satisfied with what the Church is doing for its members in HIV/Aids related activities?

Yes / No

Explain your answer:

_____

_____

_____

_____

_____

_____

5.4 What area do you want the Church to improve in its role towards HIV/Aids in the following areas:

- Prevention: _____

_____

_____

- Education _____

_____

_____

- Care and Support _____

_____

_____

5.5 How can the Church be supported in identifying its priorities in handling HIV/Aids related issues?

_____

_____

_____

5.6 What are the problems facing the Church in handling HIV/Aids related issues?

_____

_____

_____

5.7 How can these problems be addressed?

_____

_____

_____

Appendix 2: ---------- **Religion Article Report**