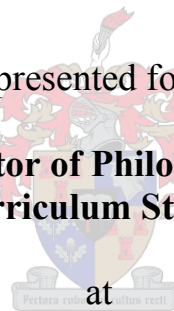


INVESTIGATING FACTORS RELEVANT TO A MULTICULTURAL HIV/AIDS CURRICULUM FOR ASSEMBLIES OF GOD PASTORS IN SOUTH AFRICA

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Dissertation presented for the degree of

**Doctor of Philosophy
(Curriculum Studies)**



STELLENBOSCH UNIVERSITY

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March 2009

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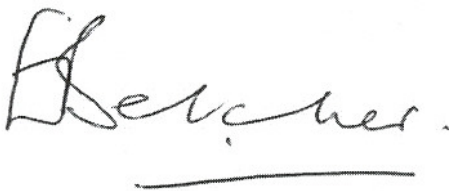
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Title of dissertation

Investigating factors relevant to a multicultural HIV/AIDS curriculum for
Assemblies of God pastors in South Africa

Candidate

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25 September 2008

ABSTRACT

The HIV/AIDS crisis in South Africa has reached pandemic levels, with over 1 000 deaths per day. The church in South Africa represents a largely untapped resource for addressing this problem. One of the largest Evangelical church groups in South Africa is the Assemblies of God (AOG/SA). This church group consists of three culturally distinct fraternals: The Group (white), The Association (coloured), and The Movement (black). Although they function under one executive committee, these fraternals have remained organizationally distinct even after the dismantling of apartheid laws in 1991. On the issue of HIV/AIDS, all three fraternals have remained largely quiet and uninvolved. They have made no attempt to strategize on a unified response to the pandemic, nor have they attempted to promote culturally relevant curricula capable of empowering their pastors and theological students to respond effectively to this crisis.

The research consisted of two phases, following Rothman and Thomas's Intervention Research model (1994), with special emphasis on the design and development component. The first phase identified and assessed educational, cultural, and religious factors relevant to the development and delivery of a clergy-focused multicultural curriculum intervention addressing the HIV/AIDS pandemic in South Africa. Data-gathering strategy for the first phase consisted of semi-structured interviews with ethnographic notions.

The target groups for the first phase of the research included 15 credentialed AOG/SA pastors and the three fraternal leaders. The leaders and fraternal members participated in semi-structured interviews designed to establish cultural and religious points of divergence pertaining to topics surrounding the AIDS pandemic (e.g. sickness, death, sexuality and gender roles).

The second phase of the research consisted of the development and delivery of a curriculum intervention. Integrating the cultural and religious factors identified in the first phase of the research, the nine-day curriculum intervention was presented to 34 tertiary-level theological students in two culturally distinct venues. The content of the curriculum primarily emphasized aspects of gender, tradition, and culture as they relate to HIV/AIDS and surrounding issues. The intervention utilized three curriculum theories that were deemed

relevant to the educational context of South Africa: humanistic curriculum theory, social reconstructionist curriculum theory and dialogue curriculum theory.

Data-gathering strategies for the second phase of the research utilized both quantitative and qualitative instruments with ethnographic notions. The quantitative instruments included the Scale of Basic HIV/AIDS Knowledge (SHAK), Personal Reflections of Men with HIV/AIDS (PRM) and Personal Reflections of Women with HIV/AIDS (PRW). Reflective journaling was used to acquire qualitative data from student participants.

Scores significantly improved on the SHAK in both venues. Scores on the PRW improved in both venues, significantly so in one. Unexpectedly, scores on the PRM declined at both venues, although not significantly so. Males with HIV/AIDS were viewed more negatively by both genders at the end of the intervention in both venues. Reflective journal entries indicated that students at both venues clearly perceived a need for the church to be involved in the pandemic; many proposed that sex education should be taking place within the context of church youth ministry. Affective responses were markedly positive for those suffering with AIDS, particularly females. The data clearly indicated that the curriculum was effective in two culturally distinct venues.

OPSOMMING

Die krisis rondom HIV/vigs in Suid-Afrika het pandemiese vlakke bereik, met meer as 1 000 sterftes per dag. In Suid-Afrika is die kerk 'n hulpbron wat meestal nog nie ingespan is om die probleem te help aanspreek nie. Een van die grootste Evangeliese kerkgroepe in Suid-Afrika is die Assemblies of God (AOG/SA). Hierdie kerkgroep bestaan uit drie kultuur-eie fraterniteite: 'The Group' (wit), 'The Association' (kleurling), en 'The Movement' (swart). Hoewel hierdie fraterniteite onder een uitvoerende komitee funksioneer, het hulle selfs ná die afskaffing van die apartheidswette in 1991 organisatories apart gebly. Al drie fraterniteite het tot op hede meestal onbetrokke gebly met betrekking tot die HIV/vigs-kwessie en nog geen uitsprake daarvoor gemaak nie. Hulle het nog geen poging aangewend om 'n eenvormige strategie te ontwikkel om die pandemie aan te spreek nie, en hulle het ook nog nie probeer om kultureel-relevante kurrikula te bevorder wat hul pastore en teologiestudente kan bemagtig om op 'n doeltreffende wyse op hierdie krisis te reageer nie.

Die navorsing, gebaseer op Rothman en Thomas se Intervensie-navorsingsmodel (1994), het uit twee fases bestaan, met besondere klem op die ontwerp-en-ontwikkeling-komponent. Die eerste fase het die opvoedkundige, kulturele en geloofsfaktore geïdentifiseer wat betekenisvol is vir die ontwikkeling en uitvoering van 'n multikulturele kurrikulum-intervensie, gefokus op die kerklui, om die HIV/vigs-pandemie in Suid-Afrika aan te spreek. Vir die eerste fase is van semi-gestruktureerde onderhoude met etnografiese begrippe as data-insamelingstrategie gebruik gemaak.

Die teikengroep vir die eerste fase van die navorsing het 15 uitgeordende pastore van die AOG/SA en die drie fraterniteite se leiers bestaan. Die leiers en lede van die fraterniteite het deelgeneem aan semi-gestruktureerde onderhoude wat ontwerp is om punte van verskil op grond van kultuur en geloof vas te stel, met betrekking tot onderwerpe rakende die vigs-pandemie (bv. siekte, sterfte, seksualiteit en gender-rolle).

Die tweede fase van die navorsing het die ontwikkeling en uitvoering van 'n kurrikulum-intervensie behels. Die kurrikulum-intervensie, wat nege dae geduur het, het die kulturele en geloofsfaktore geïntegreer wat in die eerste fase van die navorsing geïdentifiseer is, en is aan 34 tersiêre-vlak teologiese studente aangebied by twee kultuur-eie lokale. Die inhoud van die kurrikulum beklemtoon in die eerste plek aspekte van gender, tradisie, en kultuur, soos hulle

betrekking het op HIV/vigs en verwante kwessies. Die intervensie het drie kurrikulumteorieë toegepas wat verband hou met die opvoedkundige konteks in Suid-Afrika: die humanistiese kurrikulumteorie, die sosiaal-rekonstruksionistiese kurrikulumteorie en die dialoog-kurrikulumteorie.

Data-insamelingstrategieë vir die tweede fase van die navorsing het van beide kwantitatiewe en kwalitatiewe instrumente met etnografiese begrippe gebruik gemaak. Die kwantitatiewe instrumente het die volgende ingesluit: die Skaal van basiese HIV/vigs-kennis (Engels: 'Scale of basic HIV/AIDS knowledge [SHAK]'), Persoonlike refleksie deur mans met HIV/vigs (Engels: 'Personal reflections of men with HIV/AIDS [PRM]') en Persoonlike refleksie deur vroue met HIV/vigs (Engels: 'Personal reflections of women with HIV/AIDS [PRW]'). Kwalitatiewe data is vanuit die deelnemende studente se refleksiejoernale verkry.

Tellings op die Skaal van basiese HIV/vigs-kennis (SHAK) het by beide lokale noemenswaardig verbeter. Die tellings op die Persoonlike refleksie deur mans met HIV/vigs (PRM) het in albei lokale verbeter, en was veral hoër by die een lokaal. 'n Onverwagse resultaat was dat die tellings op die Persoonlike refleksie deur vroue met HIV/vigs (PRW) by albei lokale gedaal het, alhoewel die daling nie noemenswaardig was nie. Albei geslagte se siening van mans met HIV/vigs was teen die einde van die intervensie negatiewer. Die inhoud van die refleksiejoernale het aangedui dat studente by beide lokale 'n duidelike behoefte geïdentifiseer het vir kerkbetrokkenheid by die pandemie, en verskeie deelnemers het voorgestel dat seksopvoeding binne die konteks van jeugbediening in die kerk aangebied behoort te word. Affektiewe response was merkbaar positief by diegene met vigs, veral vroue. Die data het duidelik aangetoon dat die kurrikulum effektief was in twee kultuur-eie lokale.

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ACRONYMS

AAGA	=	African Assemblies of God Alliance
AIC	=	African Independent Churches
SAAGA	=	Southern African Assemblies of God Alliance
COSATU	=	Congress of South African Trade Unions
TAC	=	Treatment Action Campaign
MTCT	=	Mother to Child Transmission
PMTCT	=	Prevention of Mother to Children Therapy
HSRC	=	Human Sciences Research Council
SANAC	=	South African National AIDS Council
ARV	=	Anti-retroviral
ART	=	Anti-retroviral therapy
STD	=	Sexually transmitted disease
EPMS	=	Extra- or pre-marital sex
D&D	=	Design and development
PAPP	=	Problem analysis and project planning
IGS	=	Information gathering and synthesis
HCT	=	Humanistic Curriculum Theory
SRCT	=	Social Reconstructionist Curriculum Theory
DCT	=	Dialogue curriculum theory
EDPT	=	Early development and pilot testing
EAD	=	Evaluation and advanced development
CAD	=	Collecting and analyzing data
RIUFC	=	Replicating the intervention under field conditions

CHAPTER 1

ORIENTATION TO THE RESEARCH

This first chapter of this dissertation will include an introduction to the research, a statement of the problem and purpose as well as the background and significance of the problem. The research question and design will precede a section on methodology including definition of terms, limitations and assumptions.

1.1 INTRODUCTION

In his writings, John Mbiti, African theologian and philosopher, notes that in the east African languages he studied, "there are no concrete words or expressions to convey the idea of a distant future ... according to traditional concepts, time is a two-dimensional phenomenon, with a long past, a present and virtually no future" (Mbiti, 1969:17). This may be indicative of the way that Africans see life in general ... moving backwards between past and present rather than as a process of moving forward into the future. But the pandemic of HIV/AIDS has created a terminal obstacle in the present, from birth to life to early death, and it is slowly destroying the potential *future* of Africa in a way that leaves many looking to the past, and unable to move forward into the future. Entire generations have disappeared, leaving only the youngest and oldest to fend for themselves. Without the removal of this obstacle of HIV/AIDS, the future of South Africa's church and its people may be bleak and unchangeable. The church and its pastors, if unified in their training and strategy, have the ability to re-channel lives and purpose, to break through the terminal barrier of AIDS and begin a *life-fulfilling movement* in the direction of the future.

1.2 STATEMENT OF THE PROBLEM

The problem addressed in this research related to pastoral training pertaining to the HIV/AIDS pandemic in South Africa for pastoral students coming from the three culturally distinct Assemblies of God/South Africa (AOG/SA) fraternals (*The Group, The Association and The Movement*). Within the available AOG/SA pastoral training curriculum available through Cape Theological Seminary (the main tuition campus for Global School of Theology/SA), there has been no attempt to address HIV/AIDS issues across cultural lines or

any attempt to design a specialized curriculum to assist the AOG/SA in preparing its pastors for the pandemic. In addition, there were two conditions effecting the problem. Firstly, the three fraternals have remained culturally distinct in their membership in spite of the advent of democracy and the beginning of the dismantling of apartheid laws in 1991. Secondly, the AOG/SA has not made a formal attempt to equip their credentialed pastors to respond to the causes, effects and needs presented by the HIV/AIDS pandemic.

1.3 STATEMENT OF THE PURPOSE

The purpose of this research was to identify and assess educational, cultural, and religious/theological factors that would be relevant to the development and design of a multicultural curriculum to train AOG/SA pastors to respond to, and deal effectively with, the AIDS pandemic and its victims in South Africa.

In particular, the research investigated how one can educate three culturally diverse groups of students (in three culturally distinct classroom settings), most of whom were preparing to work under the same umbrella organization, but who have found their denomination continuing to maintain what are, in essence, culturally exclusive fraternals. All will probably experience the AIDS pandemic in some way. The challenge was to create dialogue within the fraternals through a curriculum designed to address HIV/AIDS. The ultimate goal of the research was that this curriculum intervention would help the culturally diverse fraternals understand and empathize with each other on how the disease will affect them, their congregations, and South African society, in general. A secondary goal was that this curriculum approach would encourage the three fraternals to dialogue with each other about preparing to shoulder South Africa's HIV/AIDS burden collectively.

1.4 BACKGROUND AND SIGNIFICANCE

1.4.1 The position of the AOG/SA on HIV/AIDS

According to the AOG/SA national church office, there are at present 2 000 AOG/SA churches, more than 1 200 officially credentialed ministers and about one million member/adherents under the covering of the AOG/SA. Within the AOG/SA there are three culturally distinct fraternals – *The Group*, *The Association* and *The Movement*.¹ This continued division of church organizational structures along cultural lines, more than a

¹ The fraternal memberships fall along racial lines with *The Group* consisting of white pastors, *The Association* being made up of coloured pastors and *The Movement* being made up of black pastors.

decade after the advent of democracy and apartheid laws have been lifted, provided an interesting laboratory for assessing and evaluating HIV/AIDS curriculum needs for pastors within the unique multicultural society which is found in South Africa.

AOG/SA leadership abides by a policy of individual church autonomy. Each pastor is responsible for his/her own education about the disease of HIV/AIDS and the church's outreach in ministry to AIDS victims and their families. Because of this policy of autonomy, many pastors have been left without direction in the AIDS pandemic and remain uneducated about the potentially crucial role of church leadership in this crisis. It was noted that the fraternals were dealing with the pandemic in different ways.

The Group had not provided education for their pastors pertaining to AIDS² and had not done long-range or strategic ministry planning in regard to the disease and its predicted impact on South African society (Coetzee, 2005). The Association had an AIDS office with one representative appointed to assist pastors regarding AIDS issues. The approach of this office was similar to the approach of The Group office. The Association HIV/AIDS representative was not financially supported by the denomination in any way and usually funded activities out-of-pocket (Johns, 2005). This lack of funding had hampered attempts to provide training and education for pastors in The Association. The Movement had made a small attempt at AIDS training for its pastors; however, many of The Movement pastors still seemed reluctant to talk about AIDS with their congregations, in spite of informal reports of large numbers of weekly funerals that were quietly attributed to AIDS. According to one of The Movement pastors informally interviewed by the researcher, there appeared to be a high level of discomfort in talking about the disease from the pulpit (Faye, 2004). One could argue that this might be because AIDS is considered to be a disease of the sexually promiscuous: in essence, a result of the behaviour of sinners, or of those outside the church.

The researcher had served as an AIDS educator on the tertiary-level at Cape Theological Seminary (CTS) for the past seven years (BA level). Since 2001, when students, many of whom come from AOG/SA churches, were asked in class how many of their pastors had spoken about or taught on the subject of HIV/AIDS from the church pulpit, very few acknowledged in the positive. The disease was perceived as either a part of a topic that is

² The AOG/SA (*The Group*) did establish an office to assist their churches with social outreach including HIV/AIDS, but the office was shut down in 2003. It opened its doors again in 2004 with the name *Over the Wall*, but at this time its function is to provide access to resources and help pastors find once-off overseas funding for various social outreach projects. Educating pastors and strategic planning regarding HIV/AIDS for the AOG/SA churches as a group is not a part of the portfolio, according to Lindsey Coetzee, Managing Director (MD).

taboo or one that is thought to be of little importance, as was evidenced by the responses of some of the fraternal members who were interviewed for this dissertation (Appendix A – Transcription of interview responses, 2006:245-246).

Another point of concern was that there appeared to be very few church-sanctioned ministry initiatives within the AOG/SA for HIV/AIDS victims and their families. The few ministries that were functioning³ did so as an outreach of an autonomous local church and did not fall under national church purview. It seemed as though the small number of AOG/SA churches which were active in the area of AIDS had attempted to connect with already established ministries rather than to strategically vision and develop ministry outreaches or to network *within* their own organization. In fact, Lindsey Coetzee, MD of *Over the Wall*⁴ indicated that one of her primary functions was to help churches "network" with already established services, many of which reflected strong governmental or secular views that might be outside church philosophy and religious ideology (Coetzee, 2005).

1.4.2 AIDS and the South African Church

When HIV/AIDS officially arrived on the world scene in the early 1980s, society did not realise how the disease would impact the continent of Africa, and specifically South Africa. South Africa is now "home to more HIV positive people than any other in the world" (Nassaratt, 2004:13). According to the UNAIDS Fact Sheet on Africa dated April 2005, 5.3 million South African citizens are HIV positive (UNAIDS, 2005). The *World Development Report 2000/2001*, stated that the projected life expectancy for South Africans had dropped from 57 years of age in the 1970s to 47 years of age in 2000 (World Bank, 2001:139). According to the World Bank, if the AIDS pandemic had not happened in South Africa the average "life expectancy would have reached 64 years of age by 2010-2015" (Nassaratt, 2004:24).

This terminal, yet easily preventable, disease had reached epidemic proportions and was striking at the heart of every facet of the South African society including government, education, transportation, and industry. The church, too, was beginning to feel the impact of the disease in ways that may have never been anticipated.

³ Examples: Urban Edge AOG in Durbanville has an AIDS clinic in Fisantekraal, Tableview AOG is working in conjunction with the local government family clinics to provide monthly food bags for AIDS patients, and The Rock AOG in Paarl has a feeding and care scheme for AIDS victims

⁴ Explanation of *Over the Wall* in footnote 2.

However, in the midst of the pandemic, the church seemed to be mysteriously quiet. Reasons for this silence needed to be explored. Nattrass (2004:41) is of the opinion that "[t]he history of AIDS policy in South Africa is a sorry tale of missed opportunities, inadequate analysis, bureaucratic failure and political mismanagement". One explanation of the church's lack of response might be that during attempts to deal with the crises, the national South African AIDS Programme Director was placed under the Department of Health. Provinces throughout the country followed this example by placing responsibility for their AIDS initiatives within their health departments. This, in essence, placed the AIDS epidemic in the category of a health problem rather than a social problem, thereby "limiting the potential for a multi-sectoral coordinated response" (Nassaratt, 2004:43). It was strongly possible that a point of confusion in the church's response to HIV/AIDS could have been the government's categorization of AIDS as only a health problem and not something which could have been additionally addressed as a social and/or moral problem in which the church could be of assistance to government and society. The lack of involvement with and response to this epidemic became the *soup de jour*⁵ in many churches across the country in spite of the fact that the mortality rate from HIV/AIDS in South Africa continued to rise on a steady basis with daily projections of 1 000 deaths and 1 500 new infections (Nicolay, 2006:2).

Also contributing to the lack of church response was a lack of information about those infected with HIV. The South African government conducted a census every five years, with the last census taking place in 2001. There was little or no up-to-the-minute census information regarding the impact of AIDS on the country and its general population. This lack of information left the government and the church increasingly unable to predict and strategically plan for what was needed in the future. The South African government, like those of other countries, had been providing yearly population-based studies which relied on antenatal clinic statistics. However, according to the examples of other countries, "these [studies] indicate that antenatal clinic data tend, if anything, to underestimate the HIV prevalence among sexually active women" (Whiteside & Sunter, 2000:52). This is significant because it was these antenatal statistics that were translated onto the population of the country to estimate the HIV infection rate of important population groups such as adult males, adult females and children – in essence, the population of South Africa (Whiteside & Sunter, 2000:52-53). This could have led one to believe that the number of infections was higher than was being reported at the time. Under-reporting might realistically hamper future church

⁵ The use of this term indicates that it is the choice of the day in many churches.

strategies for participation in pandemic relief and assistance because the size and severity of the problem was not fully predicted or realized.

1.4.3 Women in the South African Church

AIDS and the lack of church response was a large area of concern for this research; but, of even more significance was the effect that AIDS might have on women in the church. A large percentage of South African church membership is made up of women. In the most recent South African census (2001), the data showed that female membership was 8% higher than that of males in the "Pentecostal/Charismatic churches," (Statistics South Africa, 2004a:24). Because the AOG/SA was found within the "Pentecostal/Charismatic church" category, it was surmised that its membership was predominantly female. This fact should make it necessary for the AOG/SA to investigate how the majority of its membership will be affected by the HIV/AIDS pandemic.

It was significant that women are more easily infected by HIV during the sexual act as result of their biological makeup (Van Dyk, 2005:24-25). During the 1980s and well into the 1990s, the HIV infection rate of men exceeded that of women; however, by 1997, it was noted that women were 33% more likely to contract the HI virus through unsafe sexual practices (Tisdale & Tisdale, 1999:34). This strong trend continues today as is indicated by a new study reported in the *South African Medical Journal/March 2007*. This study found that "among young people in the 15-24 year age group, females accounted for 90% of all recent HIV infections" (Rehle, Shisana, Pillay, Zuma, Puren & Parker, 2007:197). Of direct importance to this study was the fact that this statistic was likely to impact AOG/SA church membership and the function of community outreach in the future.

There should be concern within the AOG/SA leadership that according to UNAIDS, in sub-Saharan Africa, "women and girls make up almost 57% of adults living with HIV ... overall three quarters of all women with HIV worldwide live in this region" (UNAIDS, 2005:1). In South Africa, between the ages of 15-24, a woman was four times more likely to become infected with the HI virus than her male counterpart (UNAIDS, 2006:5). In the 20-29 age group (the prime childbearing age), women were six times more likely to become infected with the virus (Rehle et al., 2007:197). It was also of note that according to a press release from the UNAIDS Global Coalition on Women and AIDS, "[m]ost sexually transmitted HIV infections in females occur either inside marriage or in relationships women believe to be monogamous" (UNAIDS, 2004).

In light of the higher percentage of female members in AOG/SA churches, it was imperative that the church also examine how some of its theological teachings may have left women in a position of little or no choice when it comes to making personal sexual choices. The church's open and honest examination of their contribution to this problem might, in turn, assist women and give them support and strengthen their ability to navigate the dangerous waters of HIV infection. According to Maluleke and Nadar (2002:14), theologians who write about the violence against women in South Africa, there is an "unholy trinity of religion, culture and the silent power of gender socialization" which underwrites a culture of violence against women. This culture of violence can, and does, result in women being abused sexually within their marriages and male/female relationships. This, in turn, is very likely to contribute further to the spread of the HI virus.

Biblical mandates found in church teachings that are sometimes used to justify abuse in marriage can include headship of the male over the female, submission on the part of the wife towards the husband, and the idea that divorce is not permissible or that divorce will bring down the 'wrath of God' on those who participate (Maluleke & Nadar, 2002:9). The cultural practice of lobola (the practice of offering a bride price) may have been created with good intentions and is thought by some to be based on scriptural principles (e.g. Genesis 24 and Genesis 29:18), but it is "open to blatant abuse so that [it] becomes oppressive and violent" (Maluleke & Nadar, 2002:14). Gender socialization sometimes leads women to remain passive in their sexual choices, even when they are presented with dangerous or life-threatening options regarding their sexuality. Rakoczy (2000:17) states that:

Society norms for boys and men say that they are to be leaders, authority figures, independent, strong and aggressive, sexually assertive and successful, ambitious and competitive while girls and women are to be followers, obedient, dependent, weak and passive, chaste, gentle, nice and kind.

There are also other gender-based beliefs attributed to some African cultures that leave women at the mercy of unsafe sexual practices, for instance polygyny, the ritual of female cleansing after the death of a husband, or the culturally accepted belief that men are permitted and even encouraged to have sexual relationships outside of marriage (Tisdale & Tisdale, 1999:26, 34). The latter idea came through strongly in the researcher's interviews with *Movement* fraternal pastors (Appendix A – Transcription of interview responses, 2006:254-255). Gender-based beliefs that leave women at the mercy of unsafe sexual practices may contribute to a higher incidence of HIV infection in the female population.

Statistical evidence pertaining to the AIDS pandemic in South Africa showed that women in the church will be more profoundly affected by HIV/AIDS, leaving a cultural and societal imbalance, as well as a basic gender imbalance in the future (Whiteside & Sunter, 2000:78-80). This will have an impact on South African society, and in particular on AOG/SA membership and function. An example of this impact might be in the area of volunteerism. Many churches rely on volunteers for social outreach ministries, including ministry to AIDS victims and their families. The *World Values Survey* (1999-2004b) indicates that volunteerism in churches is higher among women than it is among men and it shows a 17% higher participation rate in religious volunteerism on the part of South African females. These facts were fundamentally important because they indicate that many churches will in future battle to fulfil their continued volunteer functions in the communities where needs are even greater because of HIV/AIDS.

In summary, the background of the research issue at hand noted that the church has been strangely silent on the issue of AIDS and that female membership in AOG/SA churches was larger, but is now being impacted more significantly by the pandemic. A majority of female church members would seem to imply a responsibility on the part of church leadership to address the issue; however, that does not appear to have been the case. Female suffering in this pandemic may ultimately impact not only church membership but the social outreach and community volunteer function of the church, a function that is urgently needed to help the South African government deal with the AIDS pandemic in South African communities.

1.4.4 A general overview of South African theological students: The politicization of education in South Africa

The final facet of the background and significance of the research problem was the politicization of education in South Africa. Since the main focus of this study was to develop an HIV/AIDS curriculum that covers the cultural spectrum of the South African AOG/SA church, it was important to note the culturally diverse educational background of the theology students who would benefit from the proposed curriculum intervention. This was done by looking at the related areas of history and educational practice in South African education during the 20th century.

1.4.4.1 Education and the influence of migrant labour laws

The apartheid years from 1948-1978⁶ began with the rise of the National Party to power and quickly brought about, through legislation, four culturally distinct political groups (black, coloured, Indian and white), all being educated on a multiplicity of levels and supervised through 19 different education departments (Steyn, 2003:2). New apartheid laws, in particular the Group Areas Act of 1950, mandated the distinct separation of all races in South African society. This law prescribed where various South Africans could live, be educated, work, raise their families and be buried according to culture and/or skin colour.

The migrant labour systems, which evolved as a result of the Group Areas Act, left many primary and secondary age students, male and female, living in dysfunctional models of the traditional African family. This was largely a result of men (fathers) being forced to work great distances from home or to live in single-sex hostels at their place of work. Families were never allowed to accompany them. This family model was the opposite of the traditional African family in which families were strongly patriarchal.

One of the major results of the migrant labour system was the absence of a father in the home. This can be surmised to have had a somewhat negative impact on learners. A study by Mandara, Murray and Joyner (2005:218) concluded that the "lack of everyday socialization from fathers will place father-absent boys at risk for not developing traits such as independence and assertiveness". In relation to this study, a deficiency in these two important traits (independence and assertiveness) would probably be significant for people who are training to lead church congregations, particularly as it related to dealing with difficult topics in the church dialogue (e.g. AIDS or matters of sexuality). It was also of note to this study that the majority of AOG/SA pastors are male (Appendix A – Transcription of interview responses, 2006:260-263).

If boys are impacted by the absence of a father in the home, then it was logical that girls might also be affected. This same research showed that girls in father-absent homes do develop traits of independence and assertiveness, but that "the negative emotional toll of not having a close relationship with their fathers" leaves them with a tendency to "seek out the

⁶ The reason the researcher gives these years for apartheid lies in the fact that the *formal* beginning of the dismantling of apartheid began around 1977-1978. The United Nations condemned South Africa in 1962 for its apartheid laws, but not much changed. Then the international arms embargo against South Africa became mandatory in 1977 November. In early 1978 the World Conference against Racism dealt with apartheid at its international meeting and the world ostracized South Africa. It was at this point that the South African government began to respond to outside pressure and changes began to take place. However, many egregious atrocities of apartheid continued to take place until the legal repeal of the laws in 1994.

loving they missed from their fathers in babies and other men" (Mandara et al., 2005:218). This could possibly be significant in this study for two reasons: (a) understanding why women appear to remain in subservient roles in churches throughout the Assemblies of God in South Africa; (b) sexual promiscuity which results in a large number of illegitimate babies being born to single mothers. It is a known fact that single mothers struggle to rise above the poverty level. It could be proposed that the latter reason is complicit in the growing number of HIV infections throughout South Africa.

This deficiency in gender role development (male and female) may have negatively impacted many South African learners in this study who were at the mercy of apartheid laws which forced their fathers to live away from the family during their formative developmental and educational years. It was also of importance that, although apartheid laws had been lifted, migrant labour was still prevalent and continued to affect many South African families even up to the present.

1.4.4.2 Education and the impact of poverty and violence

Another aspect of the cultural and educational background and its impact on learners was the living conditions brought about by poverty and its impact on learners. According to the researcher's interpretation of Maslow's Hierarchy of Needs, poverty and violence within the South African context could have impacted learners across the racial spectrum. As early as 1934, Maslow proposed that "human needs arrange themselves in hierarchies of prepotency...the appearance of one need usually rests on the prior satisfaction of another, more pre-potent need" (Maslow, 1934:2). Two studies (Lester et al, 1983 and Summerlin et al, 1996) both confirm that unsatisfied human needs as described in Maslow's writings hinder movement toward self-actualization and mental health. Both are considered to be important for effective learning.

The first most urgent level of need in Maslow's hierarchy consists of physical survival needs (e.g. water, food, sleep, warmth, exercise). The widespread poverty and living conditions of many South Africans during the time of apartheid, and into the present, indicates that many of these needs were not or are not met. If these base needs were not or are not met, it might, according to Maslow's theory, have some bearing upon a learner's educational experience (e.g. school attendance would be hindered or denied, or the ability to learn might be hindered or ineffective because of malnutrition). It could be surmised that when these baser needs are not met the body switches into preservation mode and outside stimulus is found difficult to

receive, process and retain. One could argue that many learners in South Africa have struggled, and continue to struggle, through these very physiological needs which have gone unmet. This could conceivably impact their ability and motivation to learn.

Although there are many learners in South Africa who struggled with the fallout of poverty, there are also South African learners who do not live in poverty and are fortunate enough to have all of the first-level needs met. This leads to a review of Maslow's second step on the Hierarchy of Needs which calls for physical safety, economic security and freedom from threats (Maslow, 1934:6).

Today's learners in many South African schools are confronted with daily threats of safety, particularly from gangs. One often hears about the activity of gang members not only inside the schools but outside on the playground and areas surrounding the schools. This type of activity can leave a learner unable to concentrate and focus on the work at hand. It can also lead to absenteeism when a learner is fearful of walking to school. Teachers also suffer from a lack of security which could ultimately affect the learner. A recent study by the HSRC notes that "violence in schools was common" and this may be another factor that contributes to the attrition of South African teachers (HSRC, 2005b). Teachers queried in the HSRC study had been exposed to the display of a weapon, assault, fighting over weapons, rape, shooting, and killing on school property. The highest percentages of incidents (40.7%) were in the area of weapon displays and assault (HSRC, 2005b). Maslow (1934:7) goes on to explain the child's need for safety and states that "the child's need for safety is his preference for some kind of undisrupted routine or rhythm. He seems to want a predictable, orderly world ... injustice, unfairness, or inconsistency in the parents [or at school] makes a child feel anxious and unsafe". Osofsky (1999:37) gives a comprehensive review on the many ramifications of children who experience violence and explains how it has a direct effect on their ability to function in everyday life, including in the classroom. Indirectly, the learners' anxiety is likely to have some bearing on their desire to engage in the learning process. It could also be surmised that this is a somewhat frequent occurrence in some South African schools and something which might have easily impacted learners past, present and future at CTS or GST/NW.

Maslow (1934:19) proposes several other steps in his Hierarchy of Needs (love/social belonging, esteem and self-actualization), but concludes that they are arranged in levels of pre-potency and that the higher levels are difficult to reach if the first two are not met to some degree.

1.4.4.3 Education and racial identity development

A third factor which might have impacted students' cultural and educational background in South Africa was the development of their racial or ethnic identity. It could be surmised that during the years of apartheid in South Africa this important process of personal growth was hampered through oppression and racism. A strong racial identity in learners might have enhanced the educational process because identity contributes to a feeling of safety, reduces stress and enhances self-esteem and confidence. All are thought to contribute strongly to the effectiveness and success of the learning and the educational process (Tatum, 2003:75-80).

Continuing along the lines of racial identity development and its impact on South African education, it could be stated that in the days of apartheid whites were considered to be dominant and blacks were considered to be subordinate. This was not a result of population numbers, but was a condition of apartheid law and society. As a result of this positioning it is proposed that many of the subordinates were stunted in the development of their racial identity and subsequently, this negatively impacted their educational processes. Tatum, a psychologist with a specialization in racial identity development, asserts that "because of the risks inherent in unequal relationships, the subordinates [e.g., the blacks in South Africa under the laws of apartheid] often develop covert ways of resisting or undermining the power of the dominant group. One form of resistance is 'not learning'" (Tatum, 2003:26).

Kohl (in Tatum, 2003:134-135) describes this form of resistance:

Not-learning tends to take place when someone has to deal with unavoidable challenges to her or his personal and family loyalties, integrity, and identity. In such situations, there are forced choices and no apparent middle ground. To agree to learn from a stranger who does not respect your integrity [or culture] causes a major loss of self. The only alternative is to not-learn and reject their world.

This description of 'not learning' could be said to be truly representative of the 'liberation before education' policy which was adopted by many South African youth leaders during the apartheid struggle.

Rejection of learning also entails anger and resentment which is labelled in the fieldwork of Signithia Fordham and John Ogbu as a common psychological pattern called "oppositional social identity" (Tatum, 2003:60). According to Fordham and Ogbu, "This oppositional stance both protects one's identity from the psychological assault of racism and keeps the dominant group at a distance" (Tatum, 2003:60). According to Tatum (2003:64), "[i]t is clear that oppositional identity can interfere with academic achievement and it may be tempting for

educators to blame the adolescents [students] themselves for their academic decline". In reality, it appears that the students are only withdrawing to protect themselves from the onslaught of negative stimulus.

1.4.4.4 Disparity in education and educational opportunity

School segregation and unequal educational opportunities could also have impacted South African learners. Although official and legally enforced cultural divisions in education did not begin until the late 1940s, subtle, strong and somewhat legal divisions and separation of the races were beginning as early as 1905 with the first court interpretation taking place in 1911 (Davenport & Saunders, 2000:673). One of the earliest signs of school segregation was seen in the Western Cape. According to Davenport and Saunders (2000:673) this was a result of the interpretation of the School Board Act (1905) in which the wording "European parentage and extraction" was declared to legally mean "white children only". A specific example of how this contributed to cultural segregation is the negative impact that it had on coloured employment when age-linked educational qualifications were used to determine entry into industrial apprenticeships in 1922 (Davenport & Saunders, 2000:673). In essence, as a result of segregation, specialized job training, and possibly higher education opportunity, was denied to those who were not white.

1.4.4.4.1 Disparity and separation resulting from language

A secondary component of cultural segregation which impacted learners from different cultures was found in educational separation by language medium. Bilingual schools (which provided dual or parallel medium instruction) were readily available in the early days of South Africa and their benefits for learners were considered positive, as research has shown (Pluddeman, Braam, October & Wabba, 2004:11). However, these schools eventually came under fire from Afrikaner separatists who "felt threatened by the power of English and who sought to limit its influence" (Pluddeman et al., 2004:11). Throughout the apartheid years, as the government intensified its control of the education system, it maintained two sets of white public schools – those that enrolled English- and Afrikaans-speaking students respectively. According to Thompson (2001:195-196), the language used in the child's home (English, Afrikaans, Xhosa, Zulu) was usually the prime determining factor for the medium of school he/she attended.

Separate educational mediums⁷ which were dictated by the learner's first language ('mother tongue'), probably served to further segregate South African learners from one another. This separation by language medium dominated across the cultural spectrum. It should be noted that there were some exceptions to this with regard to dual medium schools in the Western Cape. In contrast, South African schools which provide bilingual environments today are viewed by some as providing a positive environmental factor of diversity (which is considered essential and empowering for nation building) rather than a negative environmental factor of cultural separation, as was the case in previous times (Western Cape Education Department, 2002:10).

This is a relevant point to this study in that the fraternals of the AOG/SA have remained culturally distinct and, by their own admission, some of the fraternal members speak one language only. This language dilemma has probably resulted from the aforementioned educational dynamic. It is this language variable which might be complicit in keeping the fraternals separated by culture and could possibly hamper their efforts to cooperate in combating the HIV/AIDS pandemic in the country.

1.4.4.4.2 Disparity in government financial support for education

A third component of unequal opportunity was found in the area of governmental financial support for educational institutions. Prior to 1948, black South African education was financially supported by government, but primarily relegated to church-based mission institutions. A further segregation of the cultures began to take place regarding government financing and support as the government began to withdraw its financial support for these institutions and place the money into public education. With this shift in support, the ability of these mission schools to provide a quality education for black South Africans came under strain. They were faced with educating a larger percentage of the population, and with less money to do so. The Nationalist government also began to see these mission schools as transmitters of dangerous and alien ideas to their African students. Dr. H. F. Verwoerd, then Minister of Native Affairs, was frank in his assessment of the boundaries and purposes for Bantu education:

⁷ For example, single-medium schools that were set up with a predominant language of instruction OR parallel medium schools where learners were separated into instructional groups based on their first language (what was previously known as the 'mother tongue').

Native education should be controlled in such a way that it should be in accord with the policy of the state ... If the native in South Africa today in any kind of school in existence is being taught to expect that he will live his adult life under a policy of equal rights, he is making a big mistake ... There is no place for him in the European community above the level of certain forms of labour (Thompson, 2001:196).

In 1953 the Bantu Education Act was instituted and the central government assumed control of and greatly expanded the reach of public black South African education (Thompson, 2001:196). As a result of this new legislation, it became difficult for non-governmental or privately owned schools to continue in their former role. This lack of government financial support may have made higher education less accessible to blacks and forced some to attend schools where apartheid philosophies were espoused. This would have placed students in a difficult, threatening and offensive environment for their educational experiences.

During the 1960s, the government also assumed control of coloured and Indian schools, but the quality of education in the various cultural and economic categories remained unequal. Education, by law, was compulsory for all whites; however, it was not made compulsory for other South Africans. Although this was probably not the first priority of the South African government at that time, it could have conceivably sent a message to black, coloured and Indian South Africans that education was less important for them than it was for their white counterparts. One statistic that may be indicative of the continuation of this negative message and its impact is that in South Africa today 65% of whites have completed high school while only 14% of blacks have a high school diploma (Integrated Regional Information Network-IRIN, 2006). In addition, disparity remains in educational institutions throughout the country. The Educational Research Unit at the University of Witwatersrand reports that in rural areas 43% of South African schools have no electricity, 27% have no running water and 80% have no library (IRIN, 2006).

Discrimination in the area of education appeared not only in segregation through language of instruction, the quality of educational institutions and the removal of government support for church-based mission schools, but it was also evident in the money spent on each student. In 1948 the government spent six times as much per student on white learners as on black learners, and by 1969 black class numbers were almost seven times larger than white ones (Davenport & Saunders, 2000:674-677). Teachers in black schools were also less qualified

and paid less than their white counterparts for the same kind of work.⁸ Black teachers were paid less even if they had the same qualifications as white teachers (Thompson, 2001:197). Coloured and Indian institutions were also considered inferior in function to white schools, but to a lesser degree.

This disparity is of significance for this study because the pastors and students who will be trained by the proposed curriculum will be coming from very different levels of educational standard and experience which may have an impact on their levels of academic excellence and ability or desire to engage in the classroom environment.

1.4.4.4.3 Disparity in matric results

A sign of the cultural inequalities in education could be seen in the matric results of students. According to Thompson, "[i]n 1978, when there were 5 times as many black African children as white children ... only 12 014 Africans passed the matriculation examination or its equivalent ... whereas three times as many Whites did so" (Thompson, 2001:196). As a tertiary-level lecturer for the past nine years, the researcher perceives that many recent South African matriculants (in particular reference to those who have enrolled in the researcher's HIV/AIDS-oriented course at Cape Theological Seminary) have been negatively impacted by the seemingly ineffective public educational systems that characterized non-white education during the apartheid era. In informal discussions with the researcher, students at Cape Theological Seminary (who come from all areas of the country) have shared information about their own school experiences. Many describe schools that are lacking even the most basic of equipment (such as textbooks, paper and chalk), buildings that are deteriorating and have no running water or ablution facilities, teachers who are poorly educated and trained and ill-equipped to deal with multi-cultural classrooms, teachers and principals who are frequently absent from their responsibilities, large student:teacher ratios, and school violence.

These kinds of conditions are not conducive to providing a fertile learning environment or encouraging students to successfully complete their education, as can be seen in matric results throughout the country. The matric rates have steadily declined since 2003 although there is still almost a 20% increase in improvement overall since the 1999 exams. The pass rates since 1999, which are a matter of public record, are as follows:

⁸ This was noted in the De Lange Commission Report of 1978 which disclosed that nearly all white teachers had twelve years schooling and one-third of them had degrees, only 2.45% of African teachers were degreed, only 16.09% had passed Standard Ten (Grade 12), only 62.9% had passed Standard Eight and 18.56% had not gone further than Standard Six (Davenport & Saunders, 2000:674).

TABLE 1.1: MATRIC RESULTS 1999-2007

Year	Matriculation Pass Rate
1999	48.9%
2000	57.9%
2001	61.7%
2002	68.9%
2003	73.7%
2004	70.7%
2005	68.3%
2006	66.6%
2007	65.2%

It is of concern that the pass rates from 2003 until the present have steadily declined. These years should have begun to show positive results from democracy and an increased emphasis on the importance of 'education for all' by the new government. However, it appears that the opposite effect may have come about. This is significant in light of the fact that the 2006 matriculants began as a cohort in 1995 and have had 12 years of schooling in a democratically transformed non-racial single education system.

The overall matric pass rate for the country in 2006 was 66.6% according to the Parliamentary Monitoring Group 2007. A total of 528 525 students wrote the exam, but only 351 503 passed. It is proposed that in many countries of the world this pass rate would be unacceptable. Nationally, the number of South African schools that had a 50% pass rate or below increased from 1 591 in 2005 to 1 710 in 2006. This shows an increase of 9% for this downward trend. The largest increase in the number of schools with a 50% or below pass rate was in the KwaZulu-Natal and Limpopo provinces. There were 139 schools (5%) with a matric pass rate below 20%. The number of students passing the matric exam *without endorsement* increased almost 10% between 2005 and 2006; however, those passing *with*

endorsement decreased 9% from 86 531 in 2005 to 85 830 in 2006⁹ (Parliamentary Monitoring Group, 2007). This general decline has taken place in spite of the report that the then Education Minister, Naledi Pandor, made to Parliament stating that in the last 30 months (2004-2005), South Africa had built 179 schools and the government had set aside \$1.5 million (21% of the national budget) for educational expenses (IRIN, 2006).

1.4.4.4.4 *Disparity in instruction and curriculum*

A fourth component of inequality and discrimination in South African schools was found in the disparity of school curriculum and instruction across the various cultures. The Bantu Education Act of 1953 led to instruction and curriculum for black schools being designed with the government's Bantu philosophy being fully espoused. It was not well received by many students and faculty in these institutions. The *Afrikaans Medium Decree*¹⁰ was one of the curriculum components that was not well received and was probably somewhat complicit in the outbreak of the Soweto student riots in 1976.

This disparity continued onto the levels of higher education in the country. In 1959, opposed by tertiary-level students and faculty, Parliament passed the Extension of University Education Act which prohibited established universities (4 English-language universities, 4 Afrikaans-language universities and one bilingual correspondence university) from accepting black students "except with the special permission of a cabinet minister" (Thompson, 2001:197).

Cape Theological Seminary, a fully multiracial tertiary-level seminary and the researcher's institution of employ, was only allowed to open its doors for Assemblies of God theological training after a special act of Parliament in 1986 (Johns, 2006). This special act declared that although the school property was zoned for "all white" education, an exception was made to allow students from all cultures to learn and live in dormitories together. This exception was rare in its day because it was devoid of any of the normally imposed racial quotas (Johns, 2006).

⁹ Passing "without endorsement" does not allow one to go on to university without additional bridging courses. In the case of South Africa, a bridging year would be required. Passing "with endorsement" allows one to move straight to university training if they desire to do so.

¹⁰ The Afrikaans Medium Decree of 1974 (File 6.8.3 of 17.10.74) was published by Deputy Minister of Bantu Education, Punt Janson, and forced all schools for blacks to use the Afrikaans language as the medium for instruction in mathematics, social sciences, geography and history for Std V/Grade 7 and above. It also mandated that English was to be used for general science and practical subjects. The only courses taught in the 'mother tongue' were religious instruction, music and physical science.

1.4.5 Summary

To summarize, the politicization within the South African education system caused inequality in the educational experiences of learners and might continue to be subtly reinforced today throughout South African society and culture. It can be seen that students educated during the years of apartheid and beyond might continue to be at a disadvantage if they were black and this disadvantage would translate into their later educational experiences. In direct application to this study, it could be concluded that students' cultural and educational backgrounds have, and possibly continue to, impact them and their educational experiences in the following ways:

- The dysfunctional traditional African family structure, particularly in the rural areas as a result of migrant labour and the Group Areas Act of 1950 and beyond, was likely to have had some negative impact on learners. Evidence of the impact that participatory fathers can have on the educational process of their children can be found in a recent study by McBride, Schoppe-Sullivan and Ho at the University of Illinois.¹¹
- Educational outcome objectives as well as the Bantu education system (i.e., subservience to whites espoused in the Bantu Education philosophy) and courses which, by law, were taught in second or third languages of mastery rather than the comfort of the mother-tongue language, may have negatively affected educational outcomes and/or discouraged the desire for good quality general education or higher education on the part of South African blacks. This could possibly have resulted in acceptance of low quality education or an attitude of non-education that is passed on from generation to generation, affecting learners even today.
- Inferior educational institutions, a lack of basic educational and classroom equipment (including textbooks), large class sizes, poorly trained teachers, and a lack of government funding might have made public education distasteful to a percentage of the black population and contributed to deficiencies in the culture of learning and teaching (Steyn, 2003:329).
- Societal factors including poverty and violence could have had a negative impact on learners as they related to their educational and social experiences. Although integration into public

¹¹ This study, found in the *Journal of Applied Developmental Psychology*, March-April 2005, Vol. 26, Issue 2, pp. 201-216, states that a father's involvement in the education of his children can compensate for some of the negative influences children face (e.g., poverty, violence and racism). This involvement also seems to lessen the impact of growing up in a low-income home or poor neighborhood or attending a school that has few resources. He generally concludes that a father's involvement mediates some of the negative effects of environmental stressors on the child.

schools has increased, a lack of integration in a sizeable percentage of public educational institutions (particularly those in poor areas) probably remains strong partly as a result of the slow pace of integration in living locations. Living locations are a significant factor in determining the student's choice for school attendance. Ex-Model C schools, which need to comply with the Schools Act of 1997 at present, are providing scholarships to students from poor areas that are academically capable and also excel in sports. In essence, the *cream of the crop* from poorer schools and communities are being removed through scholarships. This has resulted in a further reduction in the number of academically capable students attending poorer schools, students who would normally serve as important peer role models and student leaders to uplift schools in poorer locations.

- There is a lack of positive racial identity development in the black culture, which possibly leads to covert resistance of education received at the hands of the dominant group (Tatum, 2003; Wakefield & Hudley, 2007).

Since 1994 there have been drastic changes throughout the South African public educational system, including integration and affirmative action, various attempts at different types and styles of curriculum, teacher training and upgrading, class sizes, school finances and school administration. However, as a result of their experiences, some of these students may have left the educational system with negative feelings and experiences which carry over into their attitudes towards formal learning and a desire for a good quality of higher education. In a world where educationalists are exploring new and relevant styles of multicultural teaching and learning, new types of educational pedagogy and curriculum could be of value to South Africa and what appears to be its somewhat polarized multicultural population.

This research examined several factors related to the Assemblies of God in South Africa, namely culturally divided and autonomous policies of the AOG/SA with regard to HIV/AIDS; the prevalence of HIV/AIDS infections in South Africa and the impact that this disease will have on the female population of the AOG/SA churches; and an evaluation of the students' educational and cultural backgrounds that might impact learning about a particularly controversial topic in a multicultural environment. The research attempted to evaluate factors of an educational, cultural and religious nature that were of importance in educating theological students and pastors from all three fraternals of the AOG/SA for the issues surrounding HIV/AIDS. It is these factors that were taken into consideration in the design and development of a culturally relevant and effective HIV/AIDS curriculum for the AOG in South Africa.

1.5 RESEARCH QUESTION

The research question for this study had two parts:

1. What are the educational, cultural and religious factors that may be relevant to the design and content of HIV/AIDS curriculum developed for AOG/SA pastors and pastors-in-training?
2. Would an HIV/AIDS curriculum intervention which integrates these factors into its design and content be effective in the different AOG/SA fraternal cultural settings to:
 - a. Increase students' basic knowledge of HIV/AIDS?
 - b. Influence students' gender views toward men and women infected with HIV/AIDS?
 - c. Affect students' perceptions of people (in general) infected with HIV/AIDS?
 - d. Lead students to accept the position that pastors should play a role in addressing the HIV/AIDS pandemic within the church?

1.6 RESEARCH DESIGN

This study, which was empirical in nature, followed the intervention research design model with special emphasis on one facet of the research model called design and development (D&D). There are three facets of this research design – knowledge development (KD), knowledge utilization (KU), and design and development (D&D). According to Rothman and Thomas (1994:8), "the facets may be independent in how they are carried out by researchers and practitioners or they may be conducted so that they are interrelated purposely and systematically in a linked sequence".

After examination of the various facets, it was concluded that D&D was the most relevant and applicable to the research problem and that it would be successful in developing a curriculum intervention for HIV/AIDS. Various components of the research would include ethnographic notions, semi-structured interviews, pre-/post-testing and reflective journaling to gather both quantitative and qualitative data for methodological triangulation. The research focused on (a) the task of determining topics of relevance and importance to HIV/AIDS education for AOG/SA pastors and pastors in training; and (b) the design of an effective HIV/AIDS curriculum intervention for the South African context.

The first step of the research design was entitled Problem Analysis and Project Planning (PAPP). This step involved the researcher's participation in six years of teaching various

forms of an HIV/AIDS course at the tertiary level and informally interviewing key clients about the problem of HIV/AIDS, including the lack of (a) the AOG/SA's involvement in the HIV/AIDS pandemic; and (b) the provision of training on the topic of HIV/AIDS for its pastors. Each year students and faculty at the researcher's school informally agreed that the HIV/AIDS course was relevant for pastors-in-training, but that more support was needed by church leadership to encourage the training of pastors. However, church leadership did little to become involved or to discuss the matter with the fraternal-at-large. As a result of this, the researcher set up interviews with each of the fraternal executive leaders and a sampling of the fraternal membership (18 total) to discuss the topic of HIV/AIDS (and other matters related to AIDS) through semi-structured interviews.

The second step of the research, according to the research methodology, was entitled Information Gathering and Synthesis (IGS). This step of the research design took place through semi-structured interviews with AOG/SA fraternal executive leaders and a sampling of pastors (all male) from each of the three fraternal. A total of 18 interviews were scheduled and completed. Interviews were done in various locations throughout the country at the convenience of the interviewee concerned. A general pre-determined set of suggested questions (7 closed-form for demographic information, 16 open-form to prompt discussion) were discussed in semi-structured interviews which were approximately 60 minutes in length (Appendix B).

The third step of the research was entitled Design. The researcher had previously designed a course on HIV/AIDS that had been evolving over six previous years. This provided a readily available prototype for use during this phase (Appendix C – Syllabus and class schedule 2005). This prototype included a course syllabus and curriculum design that was upgraded and revised from year to year up to the end of 2007 (Appendix D – Syllabus and class schedule 2007). Although the extent of the research problem (a lack of pastoral training and a lack of church involvement on the grassroots and leadership level) had only been observed informally and never officially documented, the researcher had noted that many of the class graduates in this course had gone on to become involved in HIV/AIDS outreach and ministry. Several had communicated how valuable their training had been and had commented on the deficiency of information that their pastors and church congregations had on the topic of HIV/AIDS. In essence, although this did not follow the normal protocol of the design phase, it was considered to be "functional analysis" which helps to establish a kind of relationship

"between environmental changes and behaviours related to the problem" (Rothman & Thomas, 1994:34).

The fourth step of the research was Early Development and Pilot Testing (EDPT) which took place at Cape Theological Seminary with a randomly selected class of university-level students, all of whom were training for ministry. The only stipulation for participants was that they were officially enrolled in the class through CTS or GST/NW. Race and gender were not components to qualify for entrance into the class and enrolment in the class was completely random and uncontrolled. CTS has a fully multicultural student body and students in the class ranged in age from 18 to 45 years of age. GST/NW has a predominantly black student body and students ranged in age from 19 to 60 years of age. A class at CTS was used to pilot test the prototype of the curriculum before advancing to fifth step of the research model. The prototype, which had been created by the researcher, had evolved over six years as it was taught at the seminary. The mode of delivery had consistently been a 50-minute class that met three times per week over a 12-week period (30 hours of class contact) with a South African value of 11.25 credits. Both quantitative and qualitative feedback from the students enrolled in the course was obtained to help refine and modify the prototype for advanced development into a two-week/three-hours-a-day concentrated block course (30 hours of class contact) for delivery around the country. The reason for the change in the delivery mode was that the researcher and church executives who had been approached about the delivery of the class surmised that a full 12-week course of HIV/AIDS education was not a realistic goal for pastors in the midst of their very busy schedules. A two-week course was considered to be a much more manageable goal for the target clients.

The fifth step of the research was entitled Evaluation and Advanced Development (EAD). During this step of the research, the prototype was revised and presented in a two-week block class for two culturally 'pure' classes, one white and one black, using materials that were developed, field tested and revised as a result of input from the semi-structured interviews and the pilot test class. It was hoped that the use of these two final classes would help in determining the effectiveness of the new curriculum design across the multicultural context.

Although it was considered important, the final step of D&D, Dissemination, was not completed for this research project. The vast scope of dissemination to all pastors throughout the country would essentially take several years for completion and was not considered to be an integral part of this particular research project.

1.6.1 Ethnographic notions

The ethnographic notions in this research were crucial as they helped the researcher to understand the multiple perspectives of the situation being studied (Macmillan & Schumacher, 2001:16). The ethnographic focus, for this research, was on cultural patterns of action or thinking relating to beliefs about sickness, death, HIV/AIDS and gender/sexuality issues. Each was of significance to the design and content of the curriculum proposed.

1.6.2 Semi-structured interviews

Semi-structured interviews were conducted with the executive leader (or his selected representative) of each of the three fraternals of the Assemblies of God South Africa. These interviews served as the information gathering and synthesis (IGS) step of the D&D phase of intervention research. This step helped in setting the content foundation for the curriculum intervention. The interviews inquired about each fraternal executive's view on his own South African culture of origin as it related to sickness, death, HIV/AIDS and gender/sexuality issues. Cultural beliefs and religious issues pertaining to perceptions and/or teachings of Scripture which surround the AIDS pandemic (e.g., gender roles, sexuality, orphans, poverty) were also explored (Appendix B).

Subsequent to these three semi-structured interviews with the executive leaders of each fraternal, a semi-structured interview took place with a sampling of AOG/SA pastors (five pastors) from each of the three fraternals. The reason for these secondary interviews related to the fact that there were large cultural variances which were casually observed within each fraternal. Secondary interviews were an attempt to validate the fraternal executive's views on topics discussed (i.e., to determine whether the leader was in touch with his pastors who were working at the grass roots of the organization). This gave the researcher more varied and comprehensive information on the practical aspects of handling HIV/AIDS in the communities where fraternal pastors lived and worked. It was also anticipated that information gleaned from the secondary interview could be of relevance to the proposed curriculum.

1.6.3 Quantitative and qualitative questionnaires

Participants in each class setting were given three questionnaires with open- and closed-form questions. The closed-form questionnaire provided basic demographic and ethnographic information, showed involvement in previous HIV/AIDS education and interest, and were generally hoped to be of assistance in interpreting and categorizing answers (Appendix E –

Student registration form, Appendix F – Learning needs assessment). Closed-form questionnaires were of significance in this phase of the research because of the varied cultures represented within each class setting as well as a need for some reference point in organizing data. Open-form questionnaires attempted to document students' attitudes towards AIDS and people with AIDS, and their feelings about HIV/AIDS curriculum and training as it pertained to those entering church ministry. These open-form questionnaires also provided a response mechanism for feedback on the perception of the AIDS pandemic in South Africa, the church's involvement and issues of a cultural and religious nature.

All class participants were asked to answer questions on three quantitative questionnaires at pre- and post-curriculum intervention. These were as follows:

1. Scale of HIV/AIDS knowledge (30 question, 5-point Likert-scale) (Appendix G)
2. Personal reflection on the disease of HIV/AIDS – Men (13-question, 7-point semantic differential scale) (Appendix H)
3. Personal reflection on the disease of HIV/AIDS – Women (13-question, 7-point semantic differential scale) (Appendix I).

Prior to implementation, the classroom questionnaires were evaluated by a panel of educators in the areas of research, HIV/AIDS, theology and South African culture and terminology. This panel was used to validate the face and content validity of the questions and questionnaire format to ensure minimal bias in the design of the instrument. The responses received from the three fraternal executives and fraternal interviews, as well as from pre- and post-test student questionnaires, were used in helping to construct and evaluate the effectiveness of a curriculum design and method used to train AOG/SA pastors and pastors-in-training.

1.6.4 Reflective journaling

The HIV/AIDS curriculum prototype was field tested on a class of pastors-in-training at CTS and then subsequently on two culturally 'pure' classes of pastors-in-training (one at CTS and another at GST/NW) to determine effectiveness. Reflective journaling was used to monitor student responses of a qualitative nature throughout the class. Insight gained from journals was used in conjunction with results from the pre- and post-test comparisons to evaluate the general effectiveness of the selected curriculum design and intervention (Appendix J – Journaling questions: days 1-9).

1.7 METHODOLOGY

1.7.1 Intervention research: Design & development (D & D)

The key descriptor for intervention research and inquiry is the word 'practical'. There are three main phases of this type of research. Rothman and Thomas (1994:3) describe them as follows:

1. Intervention knowledge development (KD), which is based on empirical research to extend the knowledge of human behaviour as it relates to human service intervention;
2. Intervention knowledge utilization (KU), where the findings from KD research are linked to and utilized in a practical application;
3. Intervention design and development (D&D), which pertains to research directed at developing innovative interventions.

Each phase has a different objective and methodology, but they are all similar in two aspects – their genre of applied research, and a specific "intervention mission" (Rothman & Thomas, 1994:4). One of the main differences of D&D from KD and KU is that it "takes as its original point of departure a given real-world problem and practical goal, rather than a hypothesis to be tested or a theory to be explored" (Rothman & Thomas, 1994:12).

The focus of this research project was intervention design and development (D&D) which included six main steps. They were (a) problem analysis and project planning; (b) information gathering and synthesis; (c) design; (d) early development and pilot-testing; (e) evaluation and advanced development; and (f) dissemination (Rothman & Thomas, 1994:9).

Of the utmost significance and value to this project was the fact that approaches to this research required "explicit, sensitive involvement with the kinds of people, ... users, who will be implicated in the practice implementation of the intervention" (Rothman & Thomas, 1994:13).

1.7.2 Semi-structured interviews

An important part of this research was semi-structured interviews. Semi-structured interviews tend to be flexible and explorative and to allow for changes in dialogue. They focus on collecting and formally capturing details about feelings and experiences and begin with more general questions or topics which can lead to dialogue about unforeseen issues. This was a function that was important to this study. In general, semi-structured interviews "attempt to

understand the complex behaviour of members of society without imposing any *a priori* categorization that may limit the field of inquiry" (Denzin & Lincoln, 2000:653).

1.7.3 Quantitative and qualitative questionnaires

Qualitative questions can focus on experience or behaviour, opinions and values, feelings, knowledge, sensory perceptions and the individual's background or demographic information (McMillan & Schumacher, 2001:445). It was surmised that this type of open-ended questioning would "put a minimum of restraint on the answers and their expression" but provide a frame of reference or boundary for respondent's answers (Kerlinger, 1986:442). Qualitative questions had another advantage in that the responses to such questions could suggest possibilities of relations and hypotheses which could possibly enhance future research (Kerlinger, 1986:443).

1.7.4 Reflective journaling

Reflective journaling is a method that is frequently mentioned in educational literature as an "active learning technique" that enhances reflective practice (Blake, 2005:1). It is a means of self-examination that involves looking back at what has happened in an effort to improve or encourage professional growth. "Reflection is intimately linked with the process of learning – learning from, learning that, learning to do, learning to be" (Moon, 1999:100). For this particular study, a semi-structured type of reflective journaling was required for each group of students who participated in the presentation of the curriculum.

Personal reflection "encourages learners to examine motives related to their worldview, ethical behaviours, and basic beliefs about who they are and what they want to become" (Phipps, 2005:2). Critical reflection is considered to be the highest form of reflection "because it does not just stimulate personal understanding but also has the potential to instigate social change. Rather political in nature it allows participants to question current rules and procedures and challenge the status quo" (Phipps, 2005:2). Reflective journals were directed at the teacher of the course, providing the student with an opportunity for recording reactions to class materials, activities and interaction (Phipps, 2005:1). In essence, these journals were a powerful tool for enhancing critical thinking skills and monitoring effectiveness. They were also highly advantageous because of the need for confidentiality, the controversial subject that was being covered, and the need for privacy.

1.8 TARGET GROUP OF THE RESEARCH

The target population of the first part of the research consisted of credentialed AOG/SA pastors. They could be serving full- or part-time in their pastoral ministry. The targeted population of the second part were theological students who were pastors-in-training at the regional tertiary-level Assemblies of God theological training school, Cape Theological Seminary (CTS) and Global School of Theology/NW (GST/NW). A credentialed pastor was the senior pastor of at least one AOG/SA church. The size of the congregation was not a factor in this research. Churches pastored by respondents could work or reside in areas that are cosmopolitan, metropolitan, suburban, small town or rural. Pastors were members of one of the three AOG/SA fraternals: The Group, The Association, and The Movement. Participation in the research was non-discriminatory. Participants were at least 18 years of age, and either male or female, single or married.¹²

1.9 DEFINITION OF TERMS

The terms used in this dissertation are defined below:

Fraternal:	A group of people with common interests and/or background and profession.
The Group:	The pastoral group with a "white" culture from the AOG/SA.
The Movement:	The pastoral group with a "black" culture from the AOG/SA.
The Association:	The pastoral group with a "coloured" culture from the AOG/SA.
Assemblies of God/SA:	The Assemblies of God in South Africa is made up of The Group, The Association and The Movement.
Cape Theological Seminary:	The regional tertiary-level theological training school for The Assemblies of God International (USA) offering BA- and MA-level courses. It serves nine

¹² It should be noted that there were very few female or single pastors in the AOG/SA; however, their input was valued along with the predominantly male respondent population.

countries in Southern Africa: South Africa, Swaziland, Lesotho, Botswana, Namibia, Zimbabwe, Zambia, Mozambique and Angola.

- Global School of Theology/SA:** The South African arm of Global University USA. Global School of Theology/SA is registered and accredited by the South African Department of Education to offer BA- and MA-level courses in theological training.
- Global School of Theology/NW:** One of the branches of Global School of Theology/SA. It is located in Rustenburg, South Africa.
- Bantu Education:** A term for the official state system of separate education for black people, formerly in operation under apartheid in South Africa.
- Culture:** The customs, world views and achievements of a particular group of people.¹³
- Traditional African Culture:** A universal system of African belief and practice that is distinct from the Christian beliefs, theology and/or practices of the Assemblies of God/South Africa.

1.10 LIMITATIONS OF THE STUDY

1. Since students in South Africa come from a diverse cultural background, it was not assumed that this study would result in generalizable answers.
2. This study focused solely on the three fraternals of the AOG/SA, namely The Group (white pastors), The Association (coloured pastors) and The Movement (black pastors). The Association, for the purposes of this study, includes the Indian population of South Africa.

¹³ According to Sewell (2005:79) the definition of the term “culture” has many aspects. The definition that is most relevant to the use of the term in this study is that culture stands for a concrete and bounded world of beliefs (cultural values) and practices (languages). Culture in this study does not refer to religion, as such.

3. The study used ministerial students (those training for ministry) to field test the curriculum. It was a small sampling of 34 students, but was reflective of the Assemblies of God and evangelical/Pentecostal churches at large.
4. The study was specifically geared for South Africa and not for the continent of Africa at large. Information gathered was not widely generalizeable.
5. The curriculum design developed and utilized in the study was aimed at pastors-in-training. However, it was hoped that the curriculum could also prove to be effective for pastors already active in local churches of the AOG/SA.
6. Student participants in the study were training at CTS and GST/NW in South Africa. They were training for ministry in, or in conjunction with, a Pentecostal church. Not all were training specifically for ministry within the AOG/SA.
7. This research was not attempting to address the pros and cons of whether the AOG/SA is a true denomination or has erred in remaining split along cultural and racial lines in their fraternals since the democratic elections of 1994. The research was only attempting to assist in providing a curriculum design which will assist the three fraternals in working together on the issue of HIV/AIDS.
8. The assessment and evaluation of AOG/SA governance documents and structure was not a comprehensive evaluation of the church's governance and policy. Conclusions were limited to the role of women in leadership as it related to the church's ability to respond to the HIV/AIDS pandemic.
9. In applying the concepts of “culture” and “ethnographic notions”, broadly accepted definitions of the terms were utilized. These broad definitions became identifying principles used to reflect organizational realities and group perspectives from within the three culturally (ethnically) distinct fraternals of the AOG/SA. Therefore, the results of this research were not intended to inform or reflect more recent developments within reconstructionist and dialogical approaches to culture and ethnicity.

1.11 ASSUMPTIONS OF THE STUDY

The researcher assumed that:

- varying educational levels exist between the AOG/SA fraternals;
- varying cultural differences and beliefs exist between the AOG/SA fraternals which have a direct bearing on their responses to people with AIDS;

- the AOG/SA was without an intentional strategy for intervention pertaining to a lack of education for its pastors on the topic of HIV/AIDS;
- there was a need for motivation of church involvement with the problem of HIV/AIDS;
- most of the participants lacked formal training on the topic of HIV/AIDS; and
- the three fraternals of the AOG/SA lacked a cooperative strategy regarding AIDS and the church in South Africa.
- women are equally effective in ministry positions, and the Scriptures make provision for women in ministry leadership.

1.12 CONCLUSION

The results of the research were utilized in designing an HIV/AIDS curriculum for all AOG/SA pastors. At present, South Africa has the highest number of HIV infections of any country in the world with an estimated 1 000 deaths per day. Because of its number of pastors and adherents, the AOG/SA is in a position to make a valuable and substantial contribution to South African society in addressing and assisting with all aspects of the pandemic. However, to do this in a relevant and effective way will require a broad understanding of the problem, effective training, dialogue and cooperation across the fraternals within the AOG/SA church. Specialized curriculum and subsequent training will need to pay special attention to the diverse cultural environment that is uniquely South African.

CHAPTER 2

REVIEW OF THE LITERATURE

2.1 INTRODUCTION

This chapter will provide an overview of the history of the Assemblies of God/South Africa and proceed to a selected summary of the history of HIV/AIDS in the world and particularly in South Africa. A brief section on the South African churches and HIV/AIDS will introduce three subsequent sections pertaining to the research question. The first of these will examine educational factors which may influence responses to people with AIDS. The second will examine cultural factors which may influence responses to people with AIDS, and the last section will examine the religious views of the AOG/SA on matters pertaining to gender and leadership and how these views may influence responses to people with AIDS.

An extensive search revealed a lack of published material available on the views of AOG/SA pastors on the cultural issues pertaining to HIV/AIDS and religious views which might influence the response of AOG/SA pastors to those infected with AIDS. To overcome this deficiency, primary research was conducted in the form of 18 first-hand interviews with AOG/SA pastors. These interviews have been included in the literature review to provide a foundation for understanding the background of the research context and environment. They were also utilized to fulfil part of the second phase of the intervention research methodology (information gathering and synthesis), which will be discussed and explained further in Chapter 4.

2.2 AN OVERVIEW OF THE HISTORY OF THE ASSEMBLIES OF GOD/SOUTH AFRICA

An important part of understanding this research was to perceive the crucial need for a multicultural approach in the curriculum. This was better understood as the history of the AOG/SA's three culturally distinct fraternals was reviewed.

The AOG/SA is one of the lesser known church denominations in South Africa. There were minimal written sources available for the researcher's perusal. However, in his foreword to the book *From Africa's Soil* by Dr. Peter Watt, David Bosch (UNISA) states:

One would, however, be gravely mistaken if one were to think that the Assemblies of God is unimportant or irrelevant in the current South African context. The fact that it is not widely known is as much due to its general ethos as to its style and ecclesial nature (Watt, 1992:11).

The beginnings of this indigenous¹⁴ church date back to 1908. Those who founded the church did not intend to collaborate with each other, nor did they team up to establish a specific church named The Assemblies of God. Their coming together was a result of two things: (a) a need for fellowship; and (b) a need for help in dealing with government pressure (Watt, 1992:19).

By the 1930s the church was expanding with the establishment of churches in Lesotho, Natal and Mozambique, as well as South Africa. The church was still exclusively made up of African congregations, with the exception of one coloured congregation in the Johannesburg area and one congregation in Durban (also known as 'The Green Church') that was a mix of coloured and white congregants (Watt, 1992:26, 31). It was not until 1935 that white congregations were allowed to come under the umbrella of the organization (Watt, 1992:29). A crucial decision that influenced the foundational design of the Assemblies of God came about in 1932 when the Assemblies of God USA and the South African district council mutually agreed to the reorganization of the Assemblies of God "as a separate national church known as the Assemblies of God in South Africa" (Watt, 1992:26).

The most unique factor about the AOG/SA was that the black congregations developed before the white ones. This proved to be a fundamental factor in determining later inter-racial relationships (Watt, 1992:29).

It was during the years from 1936-1944 that the AOG/SA executive became multiracial. The idea was that each racial group should be represented on the executive. By 1944 the Assemblies of God was developing among all the population groups of South Africa. This was a significant development in that indigenous leadership had arisen from black South Africa rather than white South Africa (Watt, 1992:40).

In the years 1944-1964 there was a tremendous spirit of cooperation and yet a rift was growing. With regard to this rift, Watt (1992:58) states:

¹⁴ The word *indigenous* in this context means native to or having originated in and growing naturally in. An indigenous church is a church that grows naturally in its home environment. It is considered to be self-governing, self-propagating and self-supporting (Hodges,1993:22).

A simplistic view of the Assemblies of God of that time would be that the Movement simply reflected the divisions of South African society and government policy. In fact, while some groups were limited to a particular race, others were not. The important division that was developing was not between black and white; it was the division between the indigenous and expatriate streams.

Both streams embraced, to a varying degree, blacks and whites; however, the indigenous stream (under Bhengu & Mullen) was growing so rapidly that the expatriate stream became concerned about its power and influence. The clash would eventually focus on Bhengu's leadership (Watt, 1992:58).

With apartheid laws looming in South African society and a quickly evolving fracture developing between the indigenous and expatriate stream of the organization, Hubert Phillips (founder of the Emmanuel Mission) proposed to Alfred Gumede in 1959 that the Assemblies of God divide along racial lines. This was put forward on the grounds that the one General Conference meeting including all of the groups had become cumbersome and lengthy (Watt, 1992:58). These lengthy meetings were a result of issues that were necessary to discuss but only relevant to a particular racial group.¹⁵ It was envisioned that this separation would allow each group to have their own constitution and look after their own business (Watt, 1992:58).

In essence, this is where the beginnings of three culturally distinct fraternals of the Assemblies of God began. The division continues today, probably strongly reinforced by the years of apartheid law. In spite of the lifting of apartheid laws and over a decade of democratic rule in South Africa, there has been little movement for the fraternals to unite under one executive.

2.3 A SELECTED SUMMARY OF THE HISTORY OF HIV/AIDS IN THE WORLD AND PARTICULARLY IN SOUTH AFRICA

The next section of the literature review will examine three topics:

- (a) the origination of HIV/AIDS;
- (b) HIV/AIDS in Southern Africa and its indirect impact on South Africa; and
- (c) the pandemic of HIV/AIDS and its impact on education in South Africa.

¹⁵ These issues were a result of societal issues in South Africa and directly related to the apartheid policy.

2.3.1 The origination of HIV/AIDS

The literature reviewed on HIV/AIDS agreed unanimously that the first signs of the AIDS virus appeared on the world scene in 1981, although indicators of the disease were presenting as early as 1979 (Whiteside & Sunter, 2000:1). This new phenomenon in the medical world was noted when a very rare form of pneumonia (caused by the *Pneumocystis carinii* parasite), cytomegalovirus infections,¹⁶ thrush and a rare form of skin cancer called Kaposi's sarcoma presented in several young homosexual patients simultaneously (Van Dyk, 2005:4). Worldwide the first known victims of this disease were all homosexual; therefore, it logically became known as a disease of homosexuals.

Following quickly upon the heels of this medical malady was the appearance of a condition in heterosexual populations located in Central Africa, which weakened the immune system, caused diarrhoea and weight loss (Van Dyk, 2005:4). In sub-Saharan Africa, the significant weight loss which characterized this disease resulted in the nickname "slim disease" or "slimmers' disease" (Van Dyk, 2005:4). Multiple conditions which presented with this phenomenon established it as a syndrome¹⁷ and it was given the name Acquired Immunodeficiency Syndrome (AIDS).

In 1983 came the discovery that AIDS was caused by a virus (lymphadenopathy-associated virus [LAV] and human T-cell lymphotropic virus type III [HTLVIII]) (Van Dyk, 2005:4). It was not until 1986 that the virus that caused AIDS was identified by two scientists, a French doctor named Luc Montagnier, and an American doctor named Robert Gallo (Whiteside & Sunter, 2000:2). The virus was subsequently named the Human Immunodeficiency Virus (HIV). The original discovery of the virus was the subject of a court case so intense that it threatened to undermine bilateral talks in 1987 between the then French Prime Minister, Jacques Chirac, and the American president, Ronald Regan (Van Dyk, 2005:4). After years of dispute, *joint credit* for the discovery of the virus was given to both scientists, Gallo and Montagnier (Rawling, 1994:342-260). Montagnier was given credit for the original isolation of the HI virus and Gallo was given credit for being able to propagate the virus in cell culture and for developing the critically needed diagnostic tests for the HI virus (Van Dyk, 2005:4).

There are now two known viruses associated with AIDS: HIV1 and HIV2. HIV1 is associated with infections in Central, East and Southern Africa, North and South America,

¹⁶ This is a genus of Herpes viruses and literally means "very big cell virus"

¹⁷ The term *syndrome* denotes a collection of signs and symptoms or illnesses that occur together and, in this case, characterize HIV infection.

Europe and the rest of the world. HIV2 is found primarily in West Africa (Cape Verde Islands, Guinea-Bissau and Senegal). The two viruses are similar in nature, but differ in the amount of time it takes for infected people to present with symptoms¹⁸ (Van Dyk, 2005:4-5).

2.3.2 HIV/AIDS in South and Southern Africa

Today, after the 25th anniversary of this world-wide pandemic, statistics on HIV/AIDS continue to overwhelm the world. The 2006 AIDS Epidemic Update (UNAIDS, 2006:2) gives the latest statistics on the pandemic in an epidemic update. They are as follows:

Location	Adults and children living with HIV
Oceania	81 000
Caribbean	250 000
Middle East/North Africa	460 000
Western & Central Europe	740 000
East Asia	750 000
North America	1.4 million
Eastern Europe/Central Asia	1.7 million
Latin America	1.7 million
South/Southeast Asia	7.8 million
Sub-Saharan Africa	24.7 million

This report indicates that sub-Saharan Africa has a significantly higher number of infections than the rest of the world. According to the UNAIDS 2006 AIDS Epidemic Update (UNAIDS, 2006:1) there were approximately 39.5 million people living with HIV worldwide and 17.7 million (45%) of these were women. Sub-Saharan Africa constitutes 24.7 million of these cases, which is 63% of the global total. Worldwide, HIV infections of children under the age of 15 registered at 2.3 million. New infections of HIV in 2006 totalled 4.3 million and sub-Saharan Africa constituted 2.8 million of these cases, a significant 65% of the total. This breaks down to an average of 7 600 new infections each day. Deaths worldwide resulting from AIDS in 2006 registered at 2.9 million. During the same time period, sub-Saharan

¹⁸ HIV1 generally presents in 3-5 years; HIV2 generally presents in 8-10 years.

Africa deaths from AIDS registered at 2.1 million, which is 72% of all HIV deaths worldwide (UNAIDS, 2006:10).

Southern Africa¹⁹ has been particularly hard hit by the pandemic, as statistics show. The UNAIDS 2006 AIDS Epidemic Update reported that 34% of deaths globally occurred in this area of the world and 32% of people with HIV lived in this region. For South Africa, and those countries sharing border territory or whose borders are found within South Africa (seven countries in total), the statistics of HIV infection should be noted. According to UNAIDS (2006:10-15), infection percentages in these countries were as follows:

Zimbabwe	20.1%
Botswana	24.1%
South Africa	18.8%
Swaziland	33.4%
Lesotho	23.2%
Namibia	19.6%
Mozambique	16.0%

It was of direct importance to this study to note the infection rates of women in these Southern African countries. According to the UNAIDS 2006 report, South Africa showed a rise of 35% in antenatal statistics, from a 22.4% infection rate in 1999 up to a 30.2% infection rate in 2005 (UNAIDS, 2006:11). The infection prevalence in women was estimated to be close to 17% as opposed to 4.4% in men (HSRC, 2005a). Death rates from *natural causes*²⁰ for women aged 25-34 increased five-fold between 1997 and 2004. According to the Actuarial Society of South Africa, in 2005 the life expectancy for South Africans (both men and women) was below 50 years of age in three provinces – Eastern Cape, Free State, and KwaZulu-Natal (UNAIDS, 2006:11).

The Ministry of Health and Social Welfare of Swaziland reported in 2005 that the infection rate for Swazi women aged 15-24 who visited antenatal clinics was 39% (UNAIDS, 2006:13). Namibia showed an infection rate in the worst affected areas of the country at 43%

¹⁹ For this study it includes Zimbabwe, South Africa, Swaziland, Botswana, Lesotho, Namibia, Mozambique, Malawi, Zambia, Madagascar and Mauritius—11 countries total.

²⁰ According to the Actuarial Society of South Africa 2005, as cited in the UNAIDS 2006 report, a large proportion of the rising trend in death rates is attributable to the AIDS epidemic (UNAIDS, 2006: 11).

(UNAIDS, 2006:13). Zimbabwe averaged an infection rate of 22.5% (down from an average of 33% between 1996 and 2004)²¹ but has now deteriorated to a life expectancy of 34 years for women (UNAIDS, 2006:11). In Lesotho, women between 18 and 24 years of age had an HIV infection rate that increased dramatically. Lesotho women between the ages of 18 and 19 showed an infection rate of 10%, but by age 22 their infection rate had increased to 30% and then jumped to 40% by the age of 24 (UNAIDS, 2006:15). In Botswana, pregnant women between the ages of 25 and 39 showed an infection rate of 40%, which increased to 50% between the ages of 30 and 34 (UNAIDS, 2006:14). Even though Botswana females delayed their sexual debut, the statistics quickly changed once they became sexually active. Although the overall infection rate of Mozambique was relatively low compared to other countries in the region, it had the highest increase of infections in pregnant women between 2000 and 2004 (11% up to 16%), which constituted a 45% increase in the number of infections (UNAIDS, 2006:15).

It was apparent from these statistics that women are a high risk category for AIDS and it was likely that the infection rate in countries surrounding South Africa would have a direct impact on South Africa's future infection levels. This could result from many factors including tourism, cross-border industry and immigration (both legal and illegal). For the purposes of this study, the infection rate of females in and around South Africa was an important factor because the AOG/SA had a higher number of female members. This made the church an important and ideal place for AIDS education to take place.

For education to take place, pastors would need to be educated. Within the Assemblies of God, pastoral and theological education in Southern Africa is facilitated and encouraged through a blanket organization called the African Assemblies of God Alliance (AAGA). AAGA includes voluntary representation from each of the national churches in the region and came into being during the late 1980s. According to Reverend Don Tucker, Area Director for Africa's Harvest (A/G USA):

It [AAGA] was solely the initiative of national [African] church leaders who began to express an interest in a continental, fraternal organization to promote collaboration, fellowship and a stronger, united front for the A/G [Assemblies of God] in Africa ... SAAGA is the South and Southern Africa arm of AAGA ... a regional part of the continental whole (Tucker, 2007).

²¹ According to UNAIDS 2005 "inconsistencies and biases in some of the data mean that the extent of the decline in HIV prevalence might not be as substantial as indicated by the antenatal clinic HIV data". In addition, "[h]igh mortality rates have contributed considerably to the decline in HIV prevalence" (UNAIDS, 2006).

AAGA/SAAGA has played a strong role in promoting cooperation amongst African churches and has significantly increased the level of emphasis on educational training for ministers of the Assemblies of God church all over Africa. This has taken place in cooperation with the organization entitled Africa's Hope, formerly known as the Africa Theological and Training Services (ATTS). AAGA is significant for two reasons: (a) it provides a continent-wide forum of leaders to encourage HIV/AIDS education; and (b) it provides an avenue to promote national church ownership of pastoral training so that information is readily accessible on the grassroots/community level where it is likely to have the most concentrated impact. This would be important to the dissemination of a curriculum intervention geared for AOG/SA pastors.

2.3.3 HIV/AIDS in South Africa

In South Africa specifically, the AIDS epidemic was of great concern. According to the 2003 statistics from the Actuarial Society of South Africa, 947 people died from AIDS each day and there were 1 443 new HIV infections daily (Nicolay, 2006:2). The first two cases of HIV/AIDS were documented in 1982 in two homosexual men (Fourie, 2006:xvi). It took nearly nine years for the number of heterosexual cases to equal the number of homosexual cases in the country (Fourie, 2006:xvi). In fact, in the beginning the epidemic appeared to be completely homosexual in its orientation. It was of interest to note that surveys carried out in the 1980s found virtually no HIV infection in the black population of South Africa (Fourie, 2006:xvi).

Upon the initial appearance of the first two homosexual cases, the Deputy Director General of the Department of Health, Dr. J. Gilliard, warned the public that the disease was only found in a "high risk" group and could only be transmitted sexually or by needles used by drug addicts.²² It was clear in the early days of the epidemic that the South African government saw no urgency to deal with this new disease because it was only afflicting "marginalized" groups which were viewed as expendable (Grundlingh, 2001:3). It was implied that the public should be protected from these marginalized groups rather than the government protecting the marginalized groups from the disease (Grundlingh, 2001:3). The following progression in the percentages of infection (Fourie, 2006:xvi) indicate how rapidly AIDS took hold in South Africa:

²² *Beeld*, 10/1/1983

1990	HIV prevalence in SA	0.8%
1994	HIV prevalence in SA	7.6%
1999	HIV prevalence in SA	22.4%
2004	HIV prevalence in SA	29.4%

Many warnings regarding the disease were sounded throughout the 1980s, but went unheeded by those in leadership. In the early 1990s the new ANC government's Health Desk was aware of what was happening but did not appear to comprehend the magnitude or potency of HI virus infections in the country. Fourie (2006:4) quotes Mary Crewe, Director for the University of Pretoria Centre for the Study of AIDS, who alludes to a probable reason for the new government's distraction and lack of comprehension:

The irony ... is that although the new government did have a good, inclusive and multi-faceted AIDS strategy at its disposal in 1994, the structural impediments, together with the fact that South African society was in the midst of a fundamental social constitutional change, distracted policy implementers from adequately addressing this issue.

South Africa is now 25 years into the pandemic and many families have been touched by the disease in one way or another. The high incidence of HIV infection in children and women, a significant number of orphans²³ and a correspondingly high level of female infections²⁴ are strong indicators that AIDS is not simply a health issue any longer. It has become a social issue affecting both family and community. AIDS is affecting homes and communities in ways that initially seemed almost incomprehensible. The large numbers of people infected, sick and unable to work or care for their families are now seemingly beginning to overwhelm a system that appears to be already overloaded with the poor, needy, uneducated, under-educated and unemployed. This is of relevance to this study because one of the central tenets of the church's mission is the caring for the poor and needy. HIV/AIDS will most certainly impact the church through this avenue. As a result, it will be imperative for pastors to be educated about the disease of AIDS and its impact on society.

²³ According to AVERT (2007), in 2005 there were 1.2 million AIDS orphans in South Africa, which makes up 49% of all AIDS orphans in Southern Africa.

²⁴ According to AVERT (2007), in 2005 there were 3.1 million women in South Africa infected with HIV.

2.3.4 HIV/AIDS in South Africa and its impact on the education system

Of significance to this study was the fact that the primary age for HIV infection in South Africa ranges from 15-24 years of age (40% of new infections took place in this age group²⁵) and seemed to correlate with the ages where a significant drop occurred in those attending school.²⁶ There were possibly other factors contributing to this drop (e.g. the lack of finance for higher education and unemployment), but it was not unreasonable to assume that AIDS might be one of the contributing factors because of the high infection and death rate throughout the country in this prime school age group.

Another component of education affected by HIV/AIDS was the number of available teachers. This has a direct bearing on the quality of education available in the country. A study on the demand and supply of educators in South African Public Schools released by the HSRC (2005c) found that 12.7% of all educators in South Africa are HIV positive with the highest infection levels of teachers presenting in two provinces: KwaZulu-Natal (21.8%) and Mpumalanga (19.1%) (HSRC, 2005c). Infection rates of 10% but less than 19% were found in the Eastern Cape (13.8%), Free State (12.4%) and North-West (10.4%) (HSRC, 2005c). Lowest infection levels were found in Limpopo (8.6%), Gauteng (6.4%), the Northern Cape (4.3%) and the Western Cape (1.1%) (HSRC, 2005c). This same report indicated that of a total of more than 356 000 educators in the South African public schools, 10 000 to 23 500 were in need of immediate antiretroviral treatment (ART) depending on which diagnostic definition of AIDS was used.²⁷

²⁵ This information comes from the Kaiser Family Foundation– *Fact Sheet: The Global HIV/AIDS Epidemic* (2006).

²⁶ The numbers of uneducated or under-educated were reflected in the educational statistics (2001 Census) of the country. Of those 20 years and older, 17.9% indicated that they had no schooling. Those attending school (from ages 5-24) peaked at the age of 12 with 95.7% attending (Statistics South Africa, 2004a: 35). However, according to the 2001 Census, this percentage dramatically fell from 95.7% to 14% by the age of 24 with a noticeable 12-point drop between the ages of 18 and 19 (Statistics South Africa, 2004a: 38). While the 2001 Census indicated that 14% of 24-year-olds were attending school, the 1996 Census indicated that 23% of 24-year-olds were attending an educational institution. This pointed to a nine-point negative drop between the 1996 and 2001 Census and indicated backward movement with regard to the levels of education in the country (Statistics South Africa, 2004a: 35).

²⁷ There are two different definitions of AIDS and both are based upon CD4 counts in the patient. There is the conservative World Health Organization guideline of CD4= <200 cells/mm *or* the US Dept. of Health and Human Services which follows a diagnostic guideline of CD4=<350cells/mm. With the WHO definition, the patient will usually have been bedridden for *more than 50%* of the day for over a month. With the USDHHS definition, the patient will usually have been bedridden for up to 50% of the day during the past month. In either case the teacher would be unable to work. It is of concern that South Africa presently uses the World Health Organization definition for an AIDS diagnosis (CD4=<200 cells/mm), which means teachers are more severely incapacitated before they are eligible to receive medicinal help from the government.

The impact of AIDS on the South African education system appears to be widespread and would therefore be likely to affect the function of the church in several ways, a situation that confirms the relevance of this study. A drop in the educational levels and quality throughout South African communities would result in more needs throughout the community as lower educational levels translate into more needs within the community (e.g. AIDS orphans, poverty, unemployment, and lack of medical care for the sick and dying). More community needs would, in turn, translate into a need for educated and properly trained church leaders to help organize and supervise relief efforts.

2.4 SOUTH AFRICAN CHURCH POTENTIAL AND AIDS

On analysing the issues surrounding AIDS in South Africa, it becomes clear that the pandemic is indicative of a breakdown of the family and morality; in essence, it is a social or community issue. This pandemic, which now infects over five million people, creates a scenario in which the South African church could be of considerable value and assistance to the government. The church, because of its central mission, should be equipped for, and focused towards, social outreach. This could make a significant contribution to the relief of the pandemic as churches are present in almost every community, large and small, urban and rural, in South Africa. However, at present, the church is perceived as the "least likely" to be effective in teaching about AIDS, according to a 2007 survey of South African young people (Kaiser, 2007:11).

The church, if trained properly and led effectively, could be of major assistance in the fight against AIDS. Although some may question the potential size and strength of South Africa's mainline churches, it is interesting to note the following statistics from the World Values Survey, South Africa (1999-2004a): 80% of men and 90% of women affirmed their membership in a "religious denomination"; in addition, 60% of the men and 80% of the women affirmed that "religion" was important in their life. These statistics appear to point to a country that is religious and has strong denominational affiliations.

Directly related to this study, a small sampling of church growth at the provincial level also gave interesting insight into the situation in South Africa. In *Census 2001: Primary Tables Mpumalanga Census '96 – 2001 Compared*, a strong growth pattern was noted in "Pentecostal churches" [of which the AOG/SA is a member] between 1996 and 2001. In 1996 there were 96 911 men and 113 362 women who belonged to a Pentecostal church for a combined total of 210 273. By 2001 these numbers had increased to 140 564 males and 174

412 females for a combined total of 314 976. Between 1996 and 2001 there was an increase of 7% in male membership, a 6.5% increase in female membership and an *overall increase* in membership of 6.7% (Statistics SA, 2004b:24-32). It was noted that this is not the case in every province, but it provided a sampling of growth in membership of Pentecostal churches in South Africa.

According to the 2001 census statistics (SA Statistics, 2004a), South Africa had 30.0 million people who affiliated with a Christian church in 1996. This number expanded to 35.8 million by 2001, an increase of almost 9% overall. This increase, as it pertains to this research, points to a steadily increasing force of people who could, if trained properly, assist South Africa in the AIDS pandemic. The following statistics gave an actual breakdown by province of church growth from the 1996 and 2001 census:

Province	1996 Census	2001 Census	% of church growth
Eastern Cape	5.1 million	5.6 million	9%
Western Cape	3.1 million	3.7 million	8%
KwaZulu-Natal	5.6 million	6.8 million	8%
Gauteng	5.2 million	6.7 million	8%
Limpopo	3.1 million	3.6 million	9%
North-West	2.9 million	3.4 million	9%
Mpumalanga	2.1 million	2.6 million	8%
Free State	2.3 million	2.6 million	9%
Northern Cape	705 000	780 000	9%

Although the topic of this study related to the AOG/SA (a strongly fundamental Pentecostal Christian denomination), another statistic that indirectly related to church size and potential church help in the pandemic was highlighted. This statistic pertained to the growth that had taken place in the Zionist Christian church/African Independent churches between the 1996 and 2001 Census. In every province the percentages of affiliation/membership had increased, with notable increases in the Western Cape and Northern Cape. Those figures were reported as follows (Statistics SA, 2004a):

Province	% of ZCC/AIC growth
Eastern Cape	+5%
Western Cape	+9.1%
KwaZulu-Natal	+4.3%
Gauteng	+4.6%
Limpopo	+5.2%
North West	+7.8%
Mpumalanga	+6.7%
Free State	+8.8%
Northern Cape	+9.3%

In summation, South African churches, with their growing numbers, should be viewed by the South African government as a *community* resource that can and will assist them as they begin to combat the AIDS pandemic in South Africa. However, church assistance will be more effective and relevant if the church is educated and prepared by its leaders to assist both the community and the country at large. This can only be achieved through the relevant training of its leaders, old and new, to be educated and effectively outspoken on the matter.

2.5 EDUCATIONAL FACTORS INFLUENCING RESPONSES TO PEOPLE WITH AIDS

For the purposes of this research, educational factors that might influence responses to people with AIDS were examined. The need for education regarding HIV/AIDS has been heralded as one of the keys to any success in reducing or attempting to eliminate the disease. The need for specific education on the topic was particularly urgent for those in jobs that were oriented towards care-giving professions, such as pastors. This related directly to the target group of this research. Topics covered in this section of the study included:

- A lack of educational requirements in the credentialing process of the AOG/SA
- The deficiency of Global University/CTS curriculum with regard to specific contextual social issues

- The lack of determination across all of the AOG/SA fraternals to educate pastors and pastors-in-training regarding social and community issues such as AIDS
- South African government officials' positions on HIV/AIDS
- Levels of illiteracy in South Africa that hamper HIV/AIDS awareness
- The importance of morality/character training in conjunction with effective sex education for youth and young adults.

2.5.1 Lack of educational requirements for AOG/SA pastors

In this study, the first and most important educational factor identified that might influence responses to people with AIDS, particularly with regard to the target group of this study, was the lack of minimum educational requirements for those receiving ministerial credentials within the AOG/SA fraternals. Across the AOG/SA fraternals (The Group, The Association and The Movement) there were not any specific educational requirements for pastors to be credentialed. The wide variance in educational qualifications was shown clearly by the researcher's interviews with a sampling of 15 AOG pastors and the three fraternal leaders (Appendix K – General demographics of each fraternal sampling). The educational levels of The Group pastors ranged from technikon (N=1:5), university (N=2:5) to post-graduate (N=2:5) with only one respondent having any specific theological training. The Association pastors had educational levels which ranged from technikon (N=1:5), diploma (N=1:5), BA (N=1:5) and BA + HDE (N=2:5), with only one respondent having any theological training. In The Movement sampling, educational levels ranged from a Std 9 certificate (N=1:5), matric (N=1:5), diploma (N=2:5) to a BA (N=1:5). In this sampling there was one diploma and one BA degree that were specifically in the field of theology. Therefore, across the entire fraternal sampling, only four of the 15 respondents had any specific theological training qualifications. In addition, the leaders of these three fraternals were similar in their academic qualifications with all three having diploma-level training in a secular field. None of the leaders had any formal theological training.

The importance of the data to this study is that they showed the lack of a prescribed course of study for the qualification of ministerial credentials within each of the AOG/SA fraternals. This, in turn, indicated that there was no consistent exposure in pastoral education pertaining to social issues, such as HIV/AIDS, and that each pastor was left to informally educate himself regarding the disease. The importance of this was noted for this research in two ways. Firstly, as a result of inconsistent training of their leaders and pastors, the fraternals may

struggle to promote or provide appropriate responses to community needs in the area of HIV/AIDS. Secondly, the AOG/SA, with its one million members, is presently left without unified direction on how the church could/should respond to the crisis of HIV/AIDS in South Africa.

2.5.2 Deficiency in existing available curriculum for AOG/SA pastors

A second educational factor that was identified as relevant to the target group of this study was the deficiency in the ministerial training curriculum offered by the regional tertiary-level theological training institution of the Assemblies of God USA. Although AOG/SA pastors are not required to obtain theological training, it was of note that the regional theological training school for the Assemblies of God USA²⁸ is located in South Africa (Cape Town). The school, CTS, offers the curriculum of Global University USA under the name Global School of Theology/South Africa (GST/SA). The GST/SA curriculum is fully accredited and registered with the South African Department of Education (DoE) and the Distance Education and Training Council (DETC) to offer a BA in Bible/Theology and an MA in Ministerial Studies with specific study tracks in leadership, education and biblical studies.

A review of the Global BA level curriculum (the target level of this study), which has been developed over the past 35 years, showed that the curriculum is significantly international in scope yet does not offer any subjects pertaining to social and community issues (such as HIV/AIDS) within the specific country context of its delivery worldwide.

The significance of this information for the study was that if AOG/SA pastors enrolled for training at the seminary level, courses would be unavailable to enlighten or direct them in the area of social and community matters particularly related to HIV/AIDS.

2.5.3 Education of the public sector: The South African government and government officials' responses to AIDS

In addition to no mandatory AIDS training through the AOG/USA seminary, it was noted that pastors, and those in pastoral training, were dependent on self-directed, self-motivated secular public education regarding the issue of HIV/AIDS. In South Africa, the education of the public regarding HIV/AIDS has been influenced by what appears to be misinformation or

²⁸ This is a mission school that was set up and is funded by the Assemblies of God USA to offer advanced theological training for the Southern Africa region, including the countries of South Africa, Swaziland, Lesotho, Namibia, Botswana, Zimbabwe, Mozambique, Tanzania and Angola.

denial on the part of political representatives of the government. Specific examples of this are the views of both the President and the Minister of Health of South Africa at the time of this study.²⁹ Because there is tremendous confidence in and respect for elders and leaders in many African cultures, a percentage of the general South African public may possibly be swayed by the statements of government leaders. With regard to sub-groups within the target group of this study, it was assumed that their casual and independent learning on the matter of AIDS (which is necessitated by a lack of direction and instruction from church officials) might be influenced by government leaders' lack of perspective and information regarding the disease.

The mixed signals sent by the government may have subtly demonstrated that they had abdicated their responsibility to educate the public on appropriate responses to AIDS and people with HIV/AIDS. The subsequent confusion on the part of some citizens was very clear in one of the confidential fraternal interviews. The question was asked, "In your culture, does the community ever reject or ignore those who are infected with the HI virus or who are sick with AIDS?" The interviewee stated, "[P]eople are getting accustomed and getting informed [about the disease] ... but the government does not know if it is coming or going." (Anonymous interview of a Movement pastor, 2007 March). This response reflected the notion that the general public in South Africa, including the church and its leaders, is tired of waiting for the government to act and has proceeded to attempt to educate themselves.

2.5.3.1 The Ugandan response to AIDS compared to the South African response

Although the South African government did not appear to respond in an effective way when AIDS first emerged, the government of Uganda did respond, which made a significant difference in the HIV/AIDS infection levels of its citizens. The Ugandan response provided an excellent role model for South Africa, particularly as it related to church involvement. Uganda's first AIDS diagnosis took place in 1982, and in 1986 it was the first African country to establish the National AIDS Control Program (Kaiser, 2005:1). According to the Centre for Disease Control (USA), Uganda responded with strong public commitment, mass mobilization and education efforts, and political openness about HIV/AIDS (CDC, 2007).

²⁹ Examples of this could be the statement made in 2000 by the president of South Africa at the International AIDS Conference in Durban. He stated that extreme poverty, not AIDS, was the "world's biggest killer" (Power, 2003: 63). Another example is the idea propagated by the Minister of Health (XVI International AIDS Conference, Toronto, Canada, 13-18 August 2006) that garlic, African potato, spinach, lemon juice and beetroot will boost the immune system and help ward off AIDS.

This is a result of the Ugandans' proactive education and awareness programmes, the strong proactive government leadership of President Museveni, the creation of an environment for open discussion at all levels and the promotion of abstinence (or at a minimum, the promotion of a reduction in the number of sexual partners) from an early point in the pandemic. Today Uganda has one of the lowest infection rates in Africa at 4.1%. This percentage is well below the average HIV infection rates in sub-Saharan African countries of 7.5% and is significantly below the average infection rate in Southern African countries of 18% (Kaiser, 2005:1).

It appeared in the beginning that the pandemic would overwhelm Uganda; however, to the contrary, statistics showed that in antenatal clinics the infection rate in pregnant women went down from 31% in 1990 to 8.3% in 2002 in the capital city of Kampala (UNAIDS, n.d. (b):3). Other Ugandan antenatal clinics reported similarly dramatic reductions in infection during the same period (UNAIDS, n.d. (b):3). Today, the Ugandan government has 13 active HIV/AIDS control programmes functioning in its government ministries, plus 2 000 indigenous Ugandan non-governmental and faith-based organizations which contribute to the national response (CDC, 2007). These results were important to this study because of the perceived lack of involvement of the AOG/SA with regard to the AIDS pandemic. Denis (2003:73) underscores the importance of the Ugandan model: "It is the synergy between state, non-governmental organizations (NGOs) and religious groups, which explains the change in behaviour of Ugandans."

In comparison, South Africa placed most AIDS initiatives under the jurisdiction of the Department of Health, and many of the organizations contributing to the national response were foreign rather than indigenous. According to Fourie (2006:142-143), the development of the HIV and AIDS/STD Strategic Plan for South Africa 2000-2005 was an attempt to bring all of the stakeholders to the table. It was praised for its "holistic approach and comprehensive grasp of the issues that needed to be addressed in order for South Africa to prevail in the battle against AIDS" (Fourie, 2006:143). However, the continued rise of infections in the country showed that the plan had not been effective or successful to the desired degree.

One of the structures that was developed to drive the programme's implementation was the South African National AIDS Council (SANAC). However, shortly after being launched SANAC became a target of great criticism from the South African media and the country's AIDS civil society because the majority of its members were government officials, and its

membership was devoid of scientists, clinicians, pharmaceutical company representatives and the AIDS Consortium (a network representing about 200 NGOs) (Fourie, 2006:145). This was indicative of the country's failure to form strategic partnerships that could ultimately bring about the effectual implementation of the plan and effectively educate the general public.

2.5.3.2 The Ugandan response to antiretroviral therapy compared to the South African response

Antiretroviral therapy (ART) is another topic for public education and treatment in the fight against HIV/AIDS and could strongly influence how one person responds to another person who is infected with the virus. In Africa, it is likely that there will always be some fear and stigma attached to the disease; but if persons with AIDS were seen to be able to continue with their normal day-to-day duties, it is probable that the stigma and fear could be lessened.

The differences in the way South Africa and Uganda handled the issue of ART was notable. ART was made available in a significant way to those living in Uganda. By June 2005, an estimated 52 000 - 64 000 people, or about 35% - 43% of those estimated to be in need, were receiving ART. Since June 2004, ART has been made available to Ugandans free of charge through public clinics (Kaiser, 2005:2).

In contrast, the South African government has been very slow to provide ART. In fact, the Treatment Action Campaign (TAC) even charged the Minister of Health at the time with "genocide" because of her department's slow movement in taking action against the disease (Fourie, 2006:160). Fourie (2006:161) continued:

The president and his Minister of Health have acted to delay the implementation of life-saving measures at every possible turn: at the time of writing, AIDS civil society in South Africa are still entangled in legal challenges with the government in an effort to get ARVs and MTCT prevention programmes implemented at public facilities.

As a result of misinformation and denial on the part of South African leaders, the ART debate (e.g. toxic vs. safe, expensive vs. affordable), rather than the important topics pertaining to education, prevention and the value of human life, has been at the heart of South Africa's AIDS pandemic. By the end of 2005 there were over one million people in the country that needed ART treatment and only an estimated 178 000 to 235 000 were receiving it (Kaiser, 2006:2). Although treatment for South Africans appeared to be inadequate up to this time, it was to the government's credit that approximately 78.7% of HIV-positive pregnant women

received Nevirapene by the end of 2004 to help reduce the possibility of transmitting HIV to their infants (Kaiser, 2006:2).

2.5.3.3 The South African government's response to condom education and distribution

Another area that was of note in the South African government's handling of AIDS was that of condom distribution and education regarding the use of condoms. At the time of this research there seemed to be misinformation, resulting from public AIDS education, that condoms were 100% effective in stopping the HI virus. According to Hearst and Chen (2004:39), "estimates of [condom] effectiveness from individual studies vary widely" and the level of effectiveness is mostly attributed to correct use. These estimates randomly vary because of aspects such as leakage, breakage, slippage and improper use (Hearst & Chen, 2004:39). However, they state that overall, "condoms are roughly 90 percent effective in preventing HIV transmission" (Hearst & Chen, 2004:40). This leaves a general failure rate of 10%.

This percentage, although low, is significant when one is considering the possibility of contracting a disease which is incurable, ultimately fatal, and completely preventable. However, the public perception, particularly in young people, seemed to remain that condoms would dependably prevent one from contracting the virus. In high schools visited by the researcher from 1997-2002, students generally equated the terms "safe sex" and "condoms". In a report published by The Kaiser Foundation in March 2007, 58% of the young people interviewed reported feeling "small or no risk" of contracting HIV because they "always use a condom" when having sex (Kaiser, 2007:25). However, in places like Uganda, where the pandemic had essentially been curbed, a push for abstinence, faithfulness and "reducing the number of individuals' sex partners appears to have been more important than promoting the use of condoms" (Hearst & Chen, 2004:39).

According to UNAIDS, the South African government distributed 360 million free male condoms in 2004/5 (30 million per month) and aimed to increase this to 425 million in 2005/6 (UNAIDS, n.d. (a):1). However, most infection statistics in South Africa point to a continued increase in the infection rate. This is a possible indicator that condoms are not working in reducing virus transmissions as effectively as the government had hoped, or that traditions and/or negative perceptions of condoms were inhibiting usage. The latter will be discussed in this dissertation in Section 2.6.5.2.

A strong educational component will be required to change the perception that condoms are not 100% effective or safe. The words "safe" and "effective" are being used interchangeably in this matter, and are probably resulting in ineffective public education.

2.5.4 The educational factor of illiteracy and its impact on AIDS awareness

Another educational factor that might influence responses to people with AIDS relates to a matter of 'non-education' in the form of illiteracy. Large amounts of printed materials were handed out freely by both governmental and non-governmental agencies in South Africa to educate the population regarding HIV/AIDS. However, it is obvious that in the case of illiterate people, information transmission and assimilation could not take place.

With regard to the target group of this study, it must be remembered that pastors are likely to have illiterate people in their communities and congregations; therefore it could be assumed that every church has the possibility of reaching out to those who are illiterate and helping to decrease this problem. This, in turn, might help to educate those in need about the disease of HIV/AIDS.

The problem of illiteracy in South Africa is considerable. A recent study by the Consortium for Research on Educational Access: Transition and Equity (CREATE) reports that in South Africa, "recent studies of achievement indicate large numbers of learners failing to reach specified achievement levels and many remaining illiterate after 6 or more years of school" (Veerle, Brahm, Nazir, Motala, Moyo & Ngobe, 2006). According to a summary of the literacy statistics from 1995-2001³⁰ (Aitchison & Harley, 2004:2) done for the University of KwaZulu-Natal, the number of functionally illiterate (less than Grade 7 level of education) stood at 9.6 million, which was 32% of the South African population. It was noted that roughly half of this number (4.7 million) had "no schooling" at all. If every church in every community were able to support or promote a literacy class or programme, great inroads into AIDS education could be made; however, this could only be achieved through the educating of pastors regarding this social dilemma.

2.5.5 Character, moral and sex education in the context of HIV/AIDS education and church outreach

Putting the prevalent problem of illiteracy aside, it was obvious that many organizations were doing their best to study the problem of AIDS and educate the population through written

³⁰ Included in this summary were the 1995 October Household Survey, 1996 General Population Census and the 2001 General Population Census.

documents, many particularly geared for the youth. Examples were the Centre for the Study of AIDS (<http://www.csa.za.org>), which is located at the University of Pretoria; the Centre for AIDS Development, Research and Evaluation (CADRE) (<http://www.cadre.org.za>); LoveLife, which is geared for corporate, parent and youth education (<http://www.lovelife.org.za>); and the AIDS Consortium (<http://aidsconsortium.org.za>), which is a network of 300 not-for-profit community-based groups.

Sir John Francis Bacon's statement, "Knowledge is power" directly applies to the life-threatening disease of AIDS; however, education that pertains only to the facts about the disease does not give strength or 'backbone' to young people or adults who are making choices regarding their sexuality. Character and strong moral convictions are the cement that, along with facts, will steer teens and young adults well in times of confusion and decision making.

2.5.5.1 Curriculum addressing character and morality training as it relates to sexuality

The last education factor that will be dealt with in this section of the literature review is the lack of educational curriculum in AOG/SA churches that encourages the development of morality and character in conjunction with effective sex education for the youth and young adults. Since AOG/SA churches are autonomous and because there is no leadership focus or centralized plan with regard to youth/young adult ministry, this type of curriculum did not officially exist within AOG/SA structures. Since over 50% of new HIV infections fall into the 15-24 age group, the church should try to make a unified and significant impact in this area.

Research on the topic showed that the problem of premature sexual involvement and multiple sexual partners had reached a serious level in the youth population. According to a recent Kaiser Family Foundation survey measuring HIV/AIDS awareness (Kaiser, 2007:24), it was noted that two-thirds (67%) of young South Africans had engaged in sexual intercourse. Of these nearly 50% were between 15 and 19 years old and 88% were between 20 and 24 years old. The survey further reports that fewer than half (45%) of these young people "always" used a condom and 17% "never" used a condom (Kaiser, 2007:24). Over half (53%) said that they thought their partner was having sex with other people or that they were unsure about their partner having sex with other people (Kaiser, 2007:24). The result was that more than 4 out of 10 (42%) young people who were sexually active in the last 12 months were unsure of whether their partner was involved sexually with others (Kaiser, 2007:24). These statistics

should cause the church to acknowledge that young people in the church and community are in need of support and relevant teaching regarding their sexuality, particularly in light of the high prevalence of HIV, an infection which is contracted sexually 95% of the time.

Many AOG churches had youth groups/young adult groups where these topics (character, morality, sex education) have been dealt with, but there appeared to be no consistency in the message or method of how and what they taught, nor was there any plan for educating the trainers. The direction of this type of training was left to the discretion of the pastor. If the pastor was uneducated or unaware of the issues, then it was probable that little action would be facilitated through the church. This type of personal and social development for young people was obviously considered to be crucial in the fight against AIDS and a point which should be considered as one prepares young people to deal with the risks of AIDS.

Some would question the success or relevance of this kind of training, feeling that it carries a hidden prudish agenda of the church. Those who question may have the mistaken impression that morality is nothing more than a justification for constraint (Herman, 2000:29). Some would even go as far as to say it infringes on or hampers personal rights. This has been evidenced in American schools with the idea that moral education is "contradictory" rather than "complementary" (Bebeau, Rest & Narvaez, 1999:18). South African education has also shown signs of this attitude, as demonstrated by the removal of any kind of religious training from the public schools in recent years. To regard morality as simply contradictory or constraining in nature is to miss the purpose, as pointed out by Herman's (2000:31) statement that "[a] reasonable morality is well integrated into ordinary living, not something we are endlessly at war with (like a diet), nor a distant goal towards which we direct substantial amounts of energy".

For the purposes of this research, morality was rather considered to be a set of boundaries which kept human beings directed, and in the case of sexuality and possible HIV or STD infection, protected. Gert (2005) defines morality as an informal public system applying to all rational persons, governing behaviour that affects others, and has the lessening of evil or harm as its goal".

Another facet of this section is character training or development. Character development is basically about "self-regulation and discipline" within the context of society (Bebeau et al., 1999:18). The two components, morality and character, work together. One protects the spirit of the person and the other protects the spirit of society. Morality is a personal choice and, in

many cases, may be religious in nature. Character, on the other hand, is a choice for the good of community or society. One without the other will result in imbalance. Morality and character regulate personal, spiritual and societal boundaries of appropriateness and acceptability. Both are reflective of matters concerning basic socialization for the good of all and both are usually of the highest concern to parents and educators as children move from adolescence to adulthood. The two together, character and moral education, provide a positive component in a person's life.

According to Pritchard (1988:470-471), research continues to point to the positive outcomes of character and morality:

Researchers are finding evidence to support the claim that improving elements of character is associated with better academic performance. Research studies indicate that students who are self-disciplined (Etzioni 1984), or who identify themselves with traditional values, namely religiosity, hard work, and the value of learning (Ginsburg and Hanson 1986), tend to score higher on achievement tests than students who do not identify with these qualities. This suggests that the cultivation of character not only produces students who are morally better but may also improve the development of their academic skills.

Many teachers and hands-on practitioners have held the same view for years. They closely observe the need for morality and character and observe what is effective in the lives of their students. Morality and character are cooperative factors in the outcome of performance, and performance (whether academic, relational or spiritual) is an outcome or extension of behaviour. The ultimate goal of moral and character education should be positive behaviour or positive behaviour change, a change for the good of the person and the good of society. Moral education and character education can be positive change agents and are heteronomous (handed down through generations) and autonomous (self-governing, independent) in nature, not one or the other as some would propose (Bebeau et al., 1999:19).

There will always be public debate on moral and character issues related to sexuality, and much of it will come from the side of the church. Agreement on the issues will not be unanimous amongst persons involved in the debate. The focus of the debate should be to change the reality that many are dying from a preventable disease each day. In South Africa it is important that schools, churches and government work in tandem to identify and contextualize realistic and meaningful outcomes for character and moral training to bring about long-term success and slow the pandemic of HIV/AIDS.

2.5.5.2 Curriculum addressing sex education and abstinence training

In addition to character and moral education, it was perceived that sex education with abstinence training is necessary as the second educational component of changing sexual behaviour in a meaningful and effective way. However, it is considered important that sex education and abstinence training are not offered in isolation from character and moral education. According to the Guttmacher Report on Public Policy (2003) there was no conclusive proof that abstinence-only programmes were successful in any country in the world in reducing HIV transmission (Dailard, 2003:6). Value-free education which encompasses only the facts of HIV accompanied by a strong push for abstinence is likely to prove ineffectual in cultivating a healthy and strong ability to make good decisions regarding one's sexuality. Sinding (2005:40) emphasizes that "we must recognize the complexity of sexual relations, which embrace every facet of our lives, including issues of culture, tradition, power and status". To attempt to teach sex education alone (apart from character, morals and even culture) is to isolate the facts from these decision-motivating and decision-strengthening components. The researcher does not imply that sex education and abstinence training without character and moral education are ineffective, but that a combined effort would be more effective in motivating, guiding and strengthening decisions related to sexuality.

2.5.5.2.1 Research pertaining to the impact of Christian morals and character on sexual decision making

One of the examples of the effectiveness of religion-based morals and character on sexual decision making was presented in a comparative study that took place in KwaZulu-Natal (KZN) during 1998-1999. The study was based on a year's ethnographic research that included a survey of 334 households and 78 in-depth interviews. Young people who attended mainline churches (Anglican, Methodist, Presbyterian and Roman Catholic), Pentecostal churches, Zionist-Apostolic churches and a control group of non-church goers participated in the study. The research took place in the small town of Edenvale, KZN. In question were the reasons for higher and lower incidences of extra- and pre-marital sex (EPMS) among church youth. Results indicated a strong identification with abstinence in the more dynamic and charismatic religions such as the Pentecostals (which would include the AOG/SA) and the African Independent churches (AIC).

In every category of the research results, young people from the Pentecostal church scored better than those from other churches. Categories included questions regarding illegitimate children, average age at birth of first child, belonging to a church at the time of illegitimate

conception, abstinence from pre-marital sex and support for the use of condoms. Young people were questioned regarding abstaining from EPMS. Only 13% of non-churchgoers indicated no involvement in EPMS, 29% of mainline youth indicated no involvement, 36% of AIC-Apostolic youth abstained, 19% of the Zionist group reported abstinence, but a significant 61% of Pentecostal youth reported abstaining from EPMS (Garner, 2000:58).

Reasons given in the study for this wide variance and the high score for Pentecostal youth were insignificant (low) levels of training or involvement in four crucial areas: indoctrination (an understanding of the biblical view of sexuality), religious experience (spiritual resources that lead a young person away from counter-culture experimentation and involvement), exclusion (to put at peril your identification and inclusion in the "church family") and socialisation (peer pressure – or showing concern for and encouraging one another) (Garner, 2000:64-66).

It seems that the mainline churches were falling short in the area of instructing their youth regarding important life, community and societal issues, including that of sexuality. The Pentecostal churches in this study were very strong in their youth development and education and their involvement appeared to produce tangible results. However, these results are not generalizable. Only further research would indicate if this result is truly applicable to Pentecostal churches in general.

2.5.5.2.2 Exceptions to abstinence training

Many religious proponents of sex education believe that promoting abstinence or fidelity is biblical and the only way to prevent HIV transmission. While it is true that sexual purity before and after marriage is biblical in nature and that refraining from sexual intercourse is the only guaranteed action that will prevent HIV infection 100%, it is not true that the independent message of abstinence and/or fidelity is always safe or completely understood. There are many married women who remain faithful in monogamous relationships because of the church message of abstinence or sexual fidelity, but who have been infected with HIV as a result of their partner's infidelity.

Various studies in the past 10 years in Cambodia, sub-Saharan Africa and India indicate infection percentages of 50% and above in women who were infected by an unfaithful partner while remaining sexually faithful in their marriages (Sinding, 2005:38). One particular study in India indicated that more than 88% of the women in the study were infected with HIV while in monogamous relationships (Newman, Sarin, Kumarasamy, Amalraj, Rogers,

Madhivanan, Flanigan, Cu-Uvin, McGarvey, Mayer & Solomon, 2000:250). So, although abstinence should be a strong component of any sex education, it is imperative that the exceptions to its safety and effectiveness be noted and discussed. With regard to this study, it was this kind of information that was important to the curriculum in order to help pastors understand the fragile, weak and sometimes non-existent nature of women's rights in emerging countries such as South Africa.

2.5.5.3 Research relevant to contextualized and community-based sex education

A study that was published in *International Family Planning Perspectives* (Erulkar, Ettyang, Onoka, Nyagah & Muyonga, 2004), reported on the Nyeri Youth Health Project in Kenya. As part of the project, sexual and reproductive health behaviour was gauged in a programme that was culturally sensitive and contextualized. In this study the success of the programme was attributed to the contextualization of the curriculum. This was a 36-month project aimed at measuring considerable changes in young people's sexual and reproductive health-related behaviour as a result of providing a culturally sensitive health programme. The catalytic factor in this study was the use of locally designed, culturally sensitive adolescent reproductive health programmes. A sampling of results for males and females indicated a reduction in the initiation of sex for a three-year period, a reduction in the number of sexual partners, and increases in abstaining from sexual relations for the last six months of the study (Erulkar et al., 2004:63-64). All three outcomes could be considered positive behaviour outcomes which might lead to a reduction in HIV infection. Although this particular study did not have any religious components, it did indicate the relative success of using curriculum that is contextualized and culturally sensitive, another item of interest to this research.

A second study (community-based in its orientation), relating to the effects of HIV prevention on behavioural change, noted that the highest percentages (33% - 49.5%) of behavioural change regarding condom usage and multiple sex partners for adults and young people took place in high- and medium-risk groups through voluntary counselling and testing, peer counselling, school-based programmes and workplace programmes (Bollinger, Cooper-Arnold & Stover, 2004:27-31). A third study on communities, opportunities and adolescents' sexual behaviour in KwaZulu-Natal, South Africa, noted that higher levels of education and participation in community sports for females reduced the probability of having had sex in the 12 months prior to the survey, although these two factors seemed to have no bearing on the behaviour of the young men in the study (Kaufman, Clark, Manzini &

May, 2004:261-274). Again, all outcomes could be considered relevant as they apply to the desired outcomes of this research.

Each of the studies point to behaviour changes that, at a minimum, slowed the transmission of HIV in young people through morals training, character training and/or basic sex education and abstinence training, and indicate that community-based and/or contextualized education is effective. Changes in participants' behaviour took place through relational and community efforts, with an emphasis on education. If church leaders were educated about the facts related to AIDS, the church would be able to make a significant contribution by providing and participating in community education. Another important finding of these studies was that contextualized curriculum is effective.

In conclusion, for the purposes of this study there were numerous educational factors that influenced responses to AIDS within the AOG fraternals. They were:

- A lack of educational requirements for AOG/SA pastors in South Africa
- A deficiency in the curriculum presently available for AOG/SA pastors
- The South African government and government's official response to AIDS
- Illiteracy in AOG/SA churches and communities
- A lack of character, moral and sex education curriculum in AOG/SA churches.

Each of these factors were addressed in the curriculum intervention that was the goal of this study.

2.6 CULTURAL FACTORS INFLUENCING RESPONSES TO PEOPLE WITH AIDS

In keeping with the research question, the second area of importance which might influence people's responses to those with AIDS was culture. 'Culture' is a broad term and can represent many things; however, for the purposes of this study the South African Oxford Dictionary definition (Soanes, 2002:211) is used: "arts, customs (including collective thinking or opinion) and institutions of a nation, people or group".

Since AIDS is primarily a sexual disease with 95% of infections resulting from sexual intercourse, questions regarding the disease evoked strong responses depending on which cultural group within the three AOG/SA fraternals was interviewed. Prior to the research, the researcher tentatively identified some of the varying cultural beliefs found within the three

AOG/SA fraternals and examined how those beliefs might influence responses to people with HIV/AIDS. To the researcher's knowledge, nothing had been published about HIV/AIDS from the perspective of AOG/SA pastors. Since the AOG/SA is a unique church with Pentecostal/evangelical views, and their three fraternals had remained separated by culture in spite of the abolishment of apartheid laws over a decade ago, much of the information in this section came from individual face-to-face semi-structured interviews with the three leaders of the AOG/SA fraternals and a sampling of five pastors from each fraternal (18 total). The following topics were examined from a cultural perspective:

- Cultural views and beliefs about poverty
- Cultural views and beliefs about sickness, healthcare and death
- Cultural views and beliefs about sexuality and its relation to HIV/AIDS
- Cultural views and beliefs about the role of women in South African culture.

2.6.1 Cultural views and beliefs about poverty

The first topic to be examined was general views and beliefs on poverty. Studies on HIV/AIDS have shown that although poverty does not directly cause AIDS, it is considered a catalyst in fuelling the pandemic through many avenues.

Poverty flows in two streams, generational and situational (Payne, 2005:3). Generational poverty is the type of poverty that has existed for two generations or longer. Situational poverty is caused by adverse circumstances (e.g., those brought about by divorce, illness, death or unemployment) and lasts a shorter period of time. In South Africa a large percentage of the population live in generational poverty which could be largely attributed to various historical factors including colonialism, slavery, extended civil and military conflict, migration, geographic disadvantage, and poor governance (Fourie, 2006:26). It is a known reality that unsafe sexual practices fuelled by power relations which are skewed in favour of men, low levels of education and unemployable skills, and the migrant labour system also feed the pandemic (Fourie, 2006:28-31). The link between the prevalence of unsafe sexual behaviour and economic security poses a difficult challenge for AIDS education and attempted interventions.

Another dominant component of poverty and the pandemic is malnutrition. Poverty is complicit in the malnutrition scenario in that the staple diet of most poor South Africans consists of starch (maize meal and bread) and fat (cheap cuts of meat or offal that may be

cooked into a type of stew). Poverty-stricken people cannot afford fresh fruit, vegetables and dairy items. The statistics on the government's school nutrition programme provide a general indication of the prevalence of poverty in South Africa. According to Ms. N. Rakwena, the Director of the National School Nutrition Programme for the South African Department of Education, approximately six million children in over 18 000 South African schools were targeted to receive supplemental nutrition each day during the 2007-2008 school year (Rakwena, 2007). Taking into account that in 2001 there were 14.7 million young people between the school-going ages of 5 and 19, it was clear that nearly half (41%) of all school learners were living at the level of poverty that necessitated or allowed for participation in a school feeding programme (Statistics South Africa, 2001).

It was evident that the HIV/AIDS pandemic is fuelled by poverty in many different ways, and it is the mindset of those living in poverty that influences their unwillingness to respond to the risk of AIDS. With this in mind, the topic of poverty alleviation would have to be acknowledged when preparing pastors to rally communities to intervene in the AIDS pandemic.

2.6.1.1 Poverty: Feedback of interviews from fraternal leaders

Interviews with the leaders and pastors of each of the AOG/SA fraternals pointed to a lack of knowledge regarding poverty. During anonymous semi-structured interviews, the researcher noted the responses given when each participant was asked for a definition of poverty. The leader of The Group (white) used the words "lack of" in their definition of poverty. The leader of The Association (coloured) used the words "inability to" and the leader of The Movement (black) said that poverty was "a state where one cannot provide for oneself" (Appendix A – Transcription of interview responses, 2006:254-255).

2.6.1.2 Poverty: Feedback of interviews from The Group

The fraternal responses pertaining to a definition of poverty was varied. The Group pastors gave different definitions ranging from "living a lack", "not being able to pay for transport, electricity and food", "inability to feed, clothe, house and educate", "being unemployed, living in a shack, not being able to meet basic needs" to "being homeless and not being able to meet the expectation that the media portrays". When asked to give three factors that contribute to poverty, all five of The Group pastors (N=5:5) mentioned lack of schooling or a "lack of education" as one of the factors. Three of the five (N=3:5) gave responses which

included the words "mentality" or "attitude" (Appendix A – Transcription of interview responses, 2006:254-255).

2.6.1.3 Poverty: Feedback of interviews from The Association

The Association pastors gave varied responses when the researcher asked for a definition of poverty. Responses included "cannot afford the necessities", "inability to provide", "not having", and two began their definition with the words "a lack of". When asked for three factors which contribute to poverty, four of the five respondents (N=4:5) alluded to a lack of education. Two of the five (N=2:5) mentioned dependency as a factor contributing to poverty. Other factors mentioned were substance abuse, poor work ethic, complacency, apartheid and unemployment (Appendix A – Transcription of interview responses, 2006:254-255).

2.6.1.4 Poverty: Feedback of interviews from The Movement

When a definition of poverty was requested from The Movement pastors, descriptions used were: "inability to", "being destitute", "living without", "the condition of not having", and "a state of being poor or helpless". When asked to give three factors which contribute to poverty, all five (N=5:5) listed a lack of education and two (N=2:5) mentioned a "dysfunctional/broken family" or "family cycle". Only one (N=1:5) mentioned "joblessness" and one pastor specifically noted that he "did not feel that unemployment contributes to poverty" because "family will always help, the community structure is strong". It was of interest that three of the five (N=3:5) were unable to list three things contributing to poverty (Appendix A – Transcription of interview responses, 2006:254-255).

2.6.1.5 Poverty: Summary of the Interviews

The first conclusion that was drawn from these interview responses points strongly to a feeling that a "lack of education" was probably complicit in the development and maintenance of poverty. While education, or a lack of it, might have been the primary factor contributing to poverty, it was noted that job creation and economic development were just as important in alleviating poverty. None of the respondents alluded to this fact. According to Salim Valley, a senior education researcher at Witwatersrand University, "tens of thousands of people ... pass their exams but are unable to get jobs ... pupils see the example of those that haven't been able to find work for 10 years [and] their motivation goes, and they resign themselves [to the situation]" (IRIN, 2006:2).

Secondly, it was apparent that most of the pastors had only a marginal knowledge of what constituted poverty and, in what appeared to be the poorest of the fraternals (The Movement), seemed to have very little idea what factors contributed to poverty. In short, it was "a lack of", the "inability to" or a "state of being". These statements are egocentric in nature and mainly refer to unemployment and the inability to acquire material possessions, which are only two components of poverty.

From these responses it was evident that the curriculum intervention would need to contain general teaching on poverty and its diverse personal and societal components. With the pandemic of HIV/AIDS being fuelled by poverty, it was important for the participants to have a good working knowledge of the problem and some good ideas on how to begin steps to address the problem on the local level. The responses also pointed to the fact that educational interventions and community action for better educational opportunities and support should be high on the action agenda of the church.

2.6.2 Cultural views and beliefs about sickness, healthcare and death

Highly relevant to this research was the general study of perceptions of sickness, healthcare and death within the South African context. Because HIV/AIDS is, in the majority of South African cases, a terminal disease it was deemed important for those studying HIV/AIDS in South Africa to have some background on perceptions and understanding of the varying views of sickness, healthcare and healthcare providers, and death. It was through this varied grid of thought that HIV/AIDS education would have to be filtered if it were to be adaptable, relevant and effective within the South African context for AOG/SA pastors.

2.6.2.1 *Traditional African*³¹ views and perceptions of sickness

The first component to be addressed in this section was a general view of sickness in the South African context. Beliefs and responses to sickness, its causes and cures, or a resulting death, were bound up in many cultural beliefs and traditions. Some of these beliefs and responses were considered sophisticated, others were not. Strong cultural beliefs and traditions regarding sickness and death in the South African context must be taken into account when talking and teaching about the pandemic of AIDS. Not only does the disease of HIV/AIDS involve a lengthy and painful illness, it invariably results in death. HIV/AIDS deaths are claiming many more young people (15-30 years of age) than the elderly; in the

³¹ 'Traditional African' refers to a universal system of African belief and practice that is distinct from the Christian beliefs, theology and/or practice of the AOG/SA.

traditional African mind, the deaths of so many young victims are suspect (Van Dyk, 2005:117-118). In the African language of Igbo (Nigerian), untimely deaths that are outside the normal aging and biological weakening of the body are regarded as contrary to cosmic order and called *mgbabiri-onwu* which literally means "jumping the queue of dying" (Okwu, 1979:19).

It was imperative that the planned curriculum intervention resulting from this study would instruct and enlighten pastors from diverse backgrounds, many of whom appeared to be uninformed about cultural beliefs regarding sickness and death. This was important firstly so that their counsel of infected and affected individuals would be relevant and understood, taking into consideration generations of cultural beliefs which would not be altered suddenly. Secondly, many of the beliefs of traditional African medicine appeared to conflict with theological views held by the AOG/SA church. Since the majority of the population in South Africa was black and it was thought that the church's participation was crucial in educating and motivating the community about HIV/AIDS, it was regarded as important for church leaders to remain aware of and sensitive to cultural beliefs entrenched in the community mindset. It was only through mutual respect of community members and their beliefs and traditions that AIDS education and intervention would be successful.

Basic beliefs in traditional Africa pertaining to the sources of sickness were almost always viewed through the assumption of something specific or deliberate. Questions asked by those inflicted with the illness, as well as their loved ones, were "Why?" and "Who?" (e.g. "Why am I sick?" and "Who caused me to be sick?"). Illness, mental as well as physical, was thought to be caused "by disharmony between a person and the ancestors, by a god or spirits, by witches and sorcerers, by natural causes, or by a breakdown in human relationships" (Van Dyk, 2005:116). According to Austine Okwu, the son of a renowned African traditional healer:

Health ... is not considered merely a biological matter; it is the well-being of the human body and soul in total harmony. The determinants of human health and disease are seen as caused not by germs, but by tensions and aggressions within social interrelations as well as by the malevolence of supernatural forces. Therefore, good health can only be preserved by the observance of social norms and taboos, the maintenance of a harmonious relationship with the members of the supernatural world, and the resolution of interpersonal and intra-group strains and tensions. (Okwu, 1979:21)

Although many traditional African religions saw God as creator or a supreme being, they believed that He was removed and distant and they considered him far too important to be

bothered with everyday problems such as sickness. Mbiti (1969:29) states, "God is no stranger to African peoples, and in traditional life there are no atheists." An old Ashanti proverb says, "No one shows a child the Supreme Being" meaning that everyone is aware of God's existence and that even children intuitively know him (Mbiti, 1969:29). In a study of nearly 300 people groups from all over Africa outside the traditional Muslim and Christian community, Mbiti (1969:29) stated, "[W]ithout a single exception, people have a notion of God as the Supreme Being". However, in terms of everyday life, particularly as it relates to illness, the attributes that most traditional Africans speak of in relation to God are omnipotence (He is almighty) and transcendence (He is distant) (Mbiti, 1969:31-32). It was God's attribute of omnipotence which placed him in a position of power over "the spirits and natural phenomena" and left them to rule and reign in the affairs of human life (Mbiti, 1969:32). In the minds of traditional Africans this placed the spirit of the ancestors in subservience to God but at his beck and call to do his bidding. It was this position of subservience that enabled these spirits to serve as mediators between God and man (Mbiti, 1969:30-32). It is not difficult to see why the spirits of the ancestors would hold such power in the mind of a traditional African. Mbiti (1969:36) explains this notion by saying if God is viewed as "good", then His actions towards his people will be good if the mediators are kept happy and do their job. If the ancestors are unhappy, then, in the thinking of the traditional African, they might allow natural phenomena, evil spirits and the actions of witches and sorcerers to inflict illness or death upon them or a loved one. It was this removal of protection from the ancestral spirits that most traditional Africans feared.

2.6.2.2 Sickness: Feedback of interviews from leaders and fraternal

Part of the research for this dissertation topic involved first-hand interviews with the three leaders and a pastoral sampling from each of the three AOG/SA fraternal pertaining to sickness. This section provides the responses of these participants pertaining to this question.

Interview responses of the various AOG/SA fraternal and their leaders seemed to mirror some of the facts and ideas regarding sickness presented in the literature. Question #1S (Appendix B) read, "According to your culture, what are the viewpoints surrounding illness and its causes?"

Members of The Group were varied in their responses, with three of the five (N=3:5) stating that sickness could result from "lifestyle" or "neglect". Two of the five (N=2:5) stated that heredity might play a part and two of the five (N=2:5) replied that sickness was not

necessarily a direct result of a person's sin or that "God has no part" in it. These answers mirrored the leader's answer which referred to not taking care of oneself, or neglect of one's health (Appendix A – Transcription of interview responses, 2006:237-238).

With regard to The Association answers, the unanimous response (N=5:5) referred to a lack of care for oneself. Two of the pastors (N=2:5) also alluded to sickness being caused by "sin" or "loose living", while a third mentioned that sometimes sickness is caused by "poverty". The leader of The Association was in total agreement with the pastors of his fraternal. He stated that sickness might be caused by "not eating correctly" (neglect) or "not walking right with God", which could be equated with sin or loose living (Appendix A – Transcription of interview responses, 2006:237-238).

The Movement was unanimous (N=5:5) that sickness was usually caused by "bewitching". Other terms noted were "spirit of disharmony" and "witchcraft". These views strongly reflect the literature on the topic and agree fully with the leader of The Movement who stated that the person might be "bewitched" (Appendix A – Transcription of interview responses, 2006:238).

2.6.3 Traditional African views and perceptions of healthcare

To understand the views of healthcare in traditional African thinking, one must first understand the traditional African view of illness. The explanation of illness in traditional African thinking was that, "there is both an immediate cause and an ultimate cause for disease or misfortune" (van Dyk, 2005:116). The immediate cause of an illness would be a germ or virus; however, the fundamental cause might be far more complex. The person who has fallen ill would ask, "Who?" There was always a feeling that sickness was caused by the actions of another person. Van Dyk (2005:117) gives a simple example:

A person with AIDS may, for instance, fully understand that the immediate cause of her illness is a virus or a germ, but she will nevertheless still ask: 'Why me and not my neighbour? While I sleep only with my husband, my neighbour is running around with many men.' The only answer that will really satisfy this woman is that *someone*, by means of magical manipulation, has 'caused' or 'sent' the virus to make her, rather than her neighbour, ill.

For this reason, many Africans will consult both kinds of doctors, a traditional healer and a Western healthcare professional. In Western society, medicine was regarded as the principal response to a biological function of sickness (Okwu, 1979:22). In the African context, healing would be composed of medicine and religious rituals in an integrated and institutionalized process because "the combined process is seen not only as a means of healing disease, but as

a means of promoting man's overall well-being" (Okwu, 1979:22). In traditional Africa, sorcerers and witches were blamed for many illnesses although their abilities and powers were quite different. A witch was "thought to have supernatural abilities, commit evil deeds and cast spells with the help of mythical animals and supernatural creatures" (e.g., the *tokoloshe*), and a sorcerer may "act anti-socially to cause harm to people" by misusing their knowledge of medicine or herbs and/or natural ability (Van Dyk, 2005:117).

Hammond-Tooke's research made it clear that these beliefs pertaining to illness were strongly entrenched in rural and urban Africans. In one particular study it was noted that 72% of rural and 45% of urban Africans believed that witchcraft or sorcery could be a cause of illness (Hammond-Tooke, 1989:123). This study also noted that 8% of rural and 7% of urban Africans believed that ancestors could be a cause of illness (Hammond-Tooke, 1989:123).

Another possible cause of illness, according to traditional African culture, was that of pollution. Pollution was connected with ritual impurities and these impurities were usually associated with sexual intercourse, activities of the reproductive system or situations where one came into contact with death, such as the handling of corpses (Van Dyk, 2005:119).

The strongly entrenched cultural belief in the power of traditional African healers was an area of concern with regard to HIV/AIDS. The results of a cross-sectional study of 233 traditional healers on their knowledge, beliefs and practices showed that although "most healers had a correct knowledge of the major HIV transmission routes, prevention methods and ARV treatment, their knowledge was poorer on other HIV transmission routes ... and 21% believed that there is a cure for AIDS" (Peltzer, Mngqundaniso & Petros, 2006:611).

2.6.3.1 Traditional African healthcare: Feedback of interviews (leaders and fraternals)

Interview responses of the various AOG/SA fraternals and their leaders seemed to mirror many of the facts and ideas regarding traditional African healthcare presented in the literature. Question #3S (Appendix B) read, "According to your culture, what is the view of traditional African healthcare and healthcare providers?" The responses to Question #3S are found in Table 2.1 below. They are related to the participants' views and responses on traditional African healthcare.

TABLE 2.1: QUESTION #3S (RESPONSES OF LEADERS AND FRATERNALS)

According to your culture, what is the view of traditional African healthcare and healthcare providers? (Traditional African healthcare could include sangomas, witchdoctors, crystals, or anything outside the formal structures of the medical community.)

Traditional African Healthcare	Leader	Response #1	Response #2	Response #3	Response #4	Response #5
The Group	99% of people do not accept	Hocus pocus and snake oil	Taboo, charlatans	Great sense of caution	Increasing interest because of cost, but last resort	Evil, used by the devil
The Association	No response	Sceptical and critical	Might be influenced to try them	Might be used because govt. is giving them status	Not receptive - an act of desperation	Somewhat receptive - an act of desperation
The Movement	Respected and feared	Respect and fear	Viewed in positive light – there to help people	To diagnose cause of disease	Our original God-given thing – always first	Positive view

(Source: Appendix A– Transcription of interview responses, 2006:238-239)

Pastors from The Group had very little positive to say about traditional African medicine. Their views on traditional medicine were described with words such as "hocus pocus", "taboo", or "evil". On this particular question, the leader of The Group mirrored the responses of his fraternal and stated that 99% of people in his culture did not accept traditional medicine (Appendix A – Transcription of interview responses, 2006:238-239).

2.6.3.2 Western-style healthcare: Feedback of interviews (leaders)

On the topic of Western-style healthcare, the responses of the fraternal leaders varied when they were asked about their culture's view of Western-style healthcare and medical doctors. Question #2S (Appendix B) read, "According to your culture, what is the view of Western-style healthcare and medical *doctors*?" Responses to Question #2S are shown in Table 2.2 below:

TABLE 2.2: QUESTION #2S (RESPONSES OF LEADERS AND FRATERNALS)

According to your culture, what is the view of Western-style healthcare and medical doctors?

Western-style healthcare	Leader	#1	#2	#3	#4	#5
The Group	Well received-trusted	High regard and trust	Trusted	Respect	High respect	Legitimate
The Association	Viewed in terms of economics, seen through eyes of apartheid	Good-people use them	People quite dependent on them, valued	Positive, but poverty keeps many away	Very good and trusted	Acceptable ... but last resort for many, too expensive
The Movement	Beginning to view doctors as help	Many will go	Some are becoming enlightened that it is working	Go for medicine to treat their illness	Recognized, but takes a secondary place	A few negative feelings, but most are positive

(Source: Appendix A – Transcription of interview responses, 2006:238-239)

The leaders of both The Group and The Association were positive in their responses, stating that "Western-style healthcare is very well received and trusted" and that there is "no problem with doctors". The Association leader stated that Western-style healthcare was "viewed in terms of economics" adding that the medical system was viewed with scepticism because it was still "seen through the eyes of apartheid". When asked about Western-style healthcare, The Movement leader gave a slightly different response from the other two leaders, which correlated with the literature. He said that people would go to a doctor, but that this "was not always so". He stated that his people are beginning to view doctors as the "help" they need, but in the past they might have gone to both Western and traditional doctors (Appendix A – Transcription of interview responses, 2006:238).

2.6.3.3 Traditional African and Western-style healthcare: The Group feedback

Pastoral samplings from each fraternal mirrored their leaders in opinions on traditional and Western-style healthcare. The Group pastors used terms such as "trust", "respect" and "legitimate" to describe Western-style healthcare and medical doctors (refer to Table 2.2). Their views on traditional medicine were negative and they described this kind of medicine in

terms of "snake oil," "hocus pocus", "taboo", "charlatans", "last resort", and "evil, used by the devil". However, it was noted by one of The Group respondents (N=1:5) that there might be an increasing interest in "homeopathic or natural" remedies because of the cost of medical care and the deterioration of government hospitals. Two of The Group respondents (N=2:5) mentioned an increasing acceptance of "crystals" and "acupuncture" in their culture (Appendix A – Transcription of interviews responses, 2006:238-239).

2.6.3.4 Traditional African and Western-style healthcare: The Association feedback

The Association fraternal had generally positive views on Western healthcare with descriptors such as "a good thing", "they are valued", "viewed in a positive light", and "trusted" (refer to Table 2.2). However, their responses indicated that poverty, economics and poor day clinic systems kept many afflicted people away. As a result, this fraternal seemed a little more open to traditional African medicine than The Group fraternal, as indicated by comments such as the following:

- Might be used by poor people as the "only way out" to get an answer or healing.
- Coloured people would not normally use them unless they move into a black township where they might be influenced to "try this kind of thing".
- People will use them because the medical community is allowing them some status; however, using them is usually a result of desperation and not wanting to face ill-run medical clinics where they have to stand in long queues.
- Few people would go; they are not receptive to this kind of medicine. If they go, it is out of "desperation".
- People are somewhat receptive (usually out of desperation).

(Appendix A – Transcription of interview responses, 2006:239)

2.6.3.5 Traditional African and Western-style healthcare: The Movement feedback

The Movement fraternal, in contrast to The Association and The Group, gave very positive responses when asked about their culture's view on traditional medicine and doctors. Their responses indicated complete support (N=5:5) for traditional doctors and included phrases or comments such as "respect and fear for the sangoma", "traditional healers are there to help", "It is viewed as our original or God-given right to visit a traditional healer", "It must always come first", and "It is believed that the spirits reveal to them how to heal us" (refer to Table

2.2). There was minimal indication of any negative feelings towards sangomas or traditional medicine and it was made clear in the interviews that these views were prevalent both inside and outside the church community. Only one of The Movement pastors (N=1:5) mentioned any negative descriptors regarding traditional medicine with the statement, "Lately some frauds have come on the scene." Three of The Movement respondents (N=3:5) mentioned visiting both kinds of doctors, traditional and Western-style, a point which was supported in the literature (Appendix A – Transcription of interview responses, 2006:239).

2.6.3.6 *Sickness and healthcare: Significance of interviews*

The significance of this information for this study is that widely varying views on sickness and medical care in the South African context were noted. Those working with AIDS patients and those who may want to minister in an AIDS environment must be educated on the cultural views of how sickness and various kinds of medical help are perceived by the patients. There are important differences to be acknowledged between Western thinking and traditional African thinking when counselling someone who is sick. In addition, traditional philosophies did not necessarily distinguish between physical and mental illness, but saw illness as affecting the whole human being including the person's relationship with his or her ancestors and the community (Van Dyk, 2005:195). All systems (physical, mental and social) were interconnected and a change in one would effect changes in another (Van Dyk, 2005:195). Within the framework of this knowledge, the proposed curriculum design would need to promote tolerance and understanding for other cultural views of sickness and treatment, as well as patience on the part of all pastors and community members as AIDS victims and their families come to grips with the illness and its impact on their lives.

2.6.4 *Cultural views and beliefs about death, causes of death and the after-death experience*³²

As a natural extension of feedback pertaining to a terminal illness, the next part of the research dealt with cultural thinking on death, what may cause death and the understanding of what happens to a person after his/her death. Since HIV/AIDS was a terminal disease and would result in eventual death it was important for participants in this curriculum intervention to have a cultural understanding of the different views and beliefs that the victim might have. Death in the traditional African setting was viewed in many different ways, but for the purposes of this dissertation, the researcher looked at a general view of this subject, according

³² "After-death" experience can refer to a spiritual experience or the actual physical experience of burying the body.

to Assemblies of God fraternal member responses, and did not try to cover every possible cultural view that might be present in South Africa.

Essentially, the traditional African view of death was quite similar to the Judeo-Christian concept. Death was viewed as the consequence of disobedience and sin against the will and order of the Creator. Within the Judeo-Christian culture this idea was presented in the biblical book of Romans 6:23: "For the wages of sin is death ... but the gift [the reward] of God is eternal life." Traditional Africans believed that "in order to maintain the cosmic order of dying (that is, to die old and thus be enshrined in the roll of revered forefathers) one must observe the laws of nature, the norms of social behaviour and expectations laid down by the ancestors, who are the architects of social morality and public order" (Okwu, 1979:20). In essence, many cultures believe that sin or unnatural living will cause one to die young.

Throughout history humankind has learned to accept that death is part of the natural rhythm of life and yet in the traditional African cultures, death was still thought to have some external cause. In the Western mindset, this external cause would logically be hard living, sickness, or old age; however, in the traditional African mind the external cause might have been attributed to magic, sorcery, some kind of witchcraft, a curse, the living-dead/ancestral spirits, or even God. Mbiti (1969:155) indicates that this thinking is "found in every African society, though with varying degrees of emphasis". It was interesting to note Mbiti's (1969:156) explanation of the ramifications of this thinking:

One or more of the causes of death must always be given for virtually every death in African villages. This means that, although death is acknowledged as having come into the world and remained there ever since, it is unnatural and preventable on the personal level because it is always caused by another agent. If that agent did not *cause* it, then the individual would not die. Such is the logic and such is the philosophy concerning the immediate functioning of death among human beings.

The illnesses that accompanied AIDS have caused various fears. These include the fear of uncertainty, the fear of impairment, the fear of stigma and ostracism, the fear of sexuality and, of course, the fear of death. These fears have transcended all cultures (black, white, coloured, and Indian) regardless of cultural beliefs.

Within the Judeo-Christian tradition, when a person died it was generally believed he or she would go to a place called heaven and live eternally as was mentioned in the biblical books of Revelation (Chapter 21) and Philippians (Chapter 3:20). Traditional African thinking on the

subject was a bit more complex. There were two Swahili words³³ which Mbiti used to describe and explain the general African view of past, present and future with future referring to the afterlife. They were "Sasa", which means "now period" and "Zamani", which alludes to the future (Mbiti, 1969:21). It is believed that when Africans die, they remain in the Sasa as a member of the "living dead" for as long as they are remembered *by name* by family and friends who knew them. Those who die and have no one to remember them were thought to enter the Zamani immediately. This process of remembrance (while the loved one remained in the Sasa) could continue for four or five generations until the last person who personally knew the deceased dies. At that point the deceased would leave the Sasa and enter into a state of "collective immortality" (Mbiti, 1969:26). The Sasa provided for immortality and was similar in nature to the eternal life spoken of in the Judeo-Christian belief. To be forgotten and cast into the Zamani (or not to be remembered) was the worst possible fear for an African. Pertaining to this research, because there was a lot of stigma and rejection surrounding HIV/AIDS in South Africa, there could logically be fear that the victims' families would become angry and reject them which, in line with traditional African thinking, would condemn them to the fate of the Zamani.

2.6.4.1 Cultural views and beliefs regarding after-death experiences: Feedback of the interviews (leaders and fraternal)

In the interviews that were done with a sampling of pastors from each fraternal on this topic, there were various views on the causes of death and on where a person might go after death. Some were reflected in the literature and others were not. Question #3D (Appendix B) asked, "In the thinking of your culture, is there a belief in the afterlife or a place similar to the Christian concept of heaven?" The leaders and pastoral sampling across all three fraternals unanimously agreed that in the thinking of their cultures there was a belief in the afterlife and a place similar to the Christian concept of heaven. This view was strongly paralleled in the literature and would indicate a good cross-cultural point of agreement for all three fraternals (Appendix A – Transcription of interview responses, 2006:241).

Another point of interest regarding the answers to Question #3D was that many of the answers from The Group and The Association pastors referred to "heaven and hell"; however, answers from The Movement pastors strongly indicated an "afterlife" or "spirit world" which

³³ Mbiti (1969) feels that to use English words to describe these ideas would be confusing, so he uses Swahili terms to cover *general* African thinking which the researcher feels could be applied to South African tribal peoples.

involved the "ancestors". Only two (N=2:5) of The Movement pastors mentioned the word "God" and only one made reference to "heaven and hell" (Appendix A – Transcription of interview responses, 2006:241).

When asked Question #1D (Appendix B), "In the thinking of your culture, is it possible for outside spiritual forces to cause a person's death?", the responses were varied. Responses are found in Table 2.3 below:

TABLE 2.3: QUESTION #1D (RESPONSES OF LEADERS AND FRATERNAL MEMBERS)

In the thinking of your culture, is it possible for outside spiritual forces to cause a person's death?

Death caused by outside spiritual forces?	Leader	Response #1	Response #2	Response #3	Response #4	Response #5
The Group	No	No	No	No	No	Yes
The Association	No	Yes	Yes, but not the norm	Not really	No	Yes
The Movement	Yes	Yes	Yes	Yes	Yes	Yes

(Source: Appendix A – Transcription of interview responses, 2006:240)

The leader of The Group stated, "No, if it is your time, it is your time"; he implied it was a matter of fate. The Association leader simply stated, "No" and The Movement leader stated, "Yes, once a person dies people immediately wonder who might have bewitched them." He proceeded to give an example of this type of suspicion in the form of a story: "A man dies of 'Xhosa's malaria' – and one of the men at the funeral encourages everyone to go and find out what 'actually' killed the man because certainly a 'little tiny mosquito' would not have enough power to 'kill' a man" (Appendix A – Transcription of interview responses, 2006:240).

The sampling from each fraternal gave a variety of responses to the same question. The majority of the five pastors from The Group (N=4:5) answered "No" to the question which asked about the possibility of outside spiritual forces causing a person's death. One of The Group pastors (N=1:5), however, answered "Yes" and explained that "it is becoming more of a prevalent thinking because people are becoming more aware of the spiritual realm as a result of Hollywood personalities, such as Madonna, making such a public display of their spirituality" (Appendix A – Transcription of interview responses, 2006:240).

The sampling from The Association was somewhat divided on the answer to this question with only one (N=1:5) answering "No", three (N=3:5) answering "Yes" and one (N=1:5) responding "Not really". The Movement pastors were unanimous (N=5:5) in their answer

regarding spiritual forces being able to cause the death of a person with all responding "Yes" and giving various explanations that reflected views presented in the literature. The explanations were as follows:

- This happened as a result of "bewitching" or "anger of the ancestors".
- "Sudden unexplained death" always brings on the suspicion of outside causes.
- The death of someone young always brings on the suspicion of an outside cause of death.
- Accidental unexpected death always brings the suspicion of evil spirits being involved (i.e., someone dying in their sleep or in a car crash).
- When a person dies people won't be satisfied until they go to the "witchdoctor" to find out what happened. They want to know who killed the person ... they do believe in forces "beyond what we see". (Appendix A – Transcription of interview responses, 2006:240)

A follow-up question to the question regarding the possibility of death being caused by outside forces was asked of participants. Question #2D (Appendix B) stated, "In your opinion, would religious people (*people who attend your church*) agree with your answer?" The Group and its leader responded with a unanimous "Yes". The Association pastors and leader all responded "Yes", with one non-response. The Movement pastors were split on the decision, with the leader giving an ambiguous answer of, "Yes, but a few might say they don't agree." Three (N=3:5) of the Movement pastors answered "Yes" and two (N=2:5) answered "No" (Appendix A – Transcription of interview responses, 2006:240-241). The significance of this question is that many of these cultural ideas are held by people in the church. This fact indicates that if pastors are going to be effective and relevant in dealing with AIDS victims and their families, they need to be educated about the cultural beliefs of their parishioners on issues pertaining to death, causes of death and the after-death experience.

2.6.4.2 Cultural views regarding burial: Feedback of the interviews with The Group, The Association and The Movement

A natural follow-up to a question regarding death had to do with burying the dead. Question #4D (Appendix B) contained three parts and read, "How does your culture feel about the burial of the dead? Where and how is it prescribed that burial of the dead take place? Is cremation allowed or encouraged?" The answers to Question #4D are reflected in Table 2.4 below:

TABLE 2.4: QUESTION #4D (RESPONSES OF LEADERS AND FRATERNAL MEMBERS)

How does your culture feel about the burial of the dead? *Where* and *how* is it prescribed that burial of the dead take place? Is cremation allowed or encouraged?

Burial of the dead – rituals? Cremation?	Leader	#1	#2	#3	#4	#5
The Group	Anything is acceptable Cremation? Yes	Cremation 75% of time Seldom open casket	Quite traditional Cremation accepted	Cremation 60% of time, open casket rare	Cremation 85% of time, never an open casket	Cremation 50% of time, no prescribed procedure
The Association	Growing Muslim influence apparent Cremation? No	Open casket normal ... big family affair Food Cremation? Very little	Funeral-goers dress up Open casket, lengthy service Cremation? 20% of time	Family affair, no prescribed rituals Cremation? No issue anymore	Open casket, everybody included, body must leave from the house Cremation? Not common	Open casket community affair, all day long Cremation? 50% of time
The Movement	Cremation is not allowed Wrap corpse in animal skin or blanket	Cremation is totally taboo – Body wrapped Family converses with the corpse	Cremation is not allowed – body buried face up in special blanket, on land of ancestors	Cremation is a disgrace Body buried facing east on traditional mat, next to ancestors	Cremation is absolutely unacceptable Body buried in place of birth near ancestors, wrapped in brand new blanket	Cremation is strange Dead are buried near forefathers, body is wrapped in animal skin or cloth Family converse with the corpse

(Source: Appendix A – Transcription of interview responses, 2006:242-244)

The responses revealed some strong opinions. The overall picture that emerged was that the culture of The Group pastors was very accepting of cremation, that funerals were somewhat "sanitized" to this procedure, and there was very seldom an open casket in their churches and culture. The Association pastors responded that funerals were still very traditional and cremation was not well accepted. Funerals in this culture were big family affairs with a great deal of fellowship, but no particular rituals were mentioned as predominant. However, it was noted in the responses that many of The Association pastors dealt with open caskets most of the time. The Movement pastors were unanimous (N=5:5) that cremation was unacceptable and even disgraceful in their culture. They were adamant that the deceased must be buried close to their ancestors. Various rituals were mentioned, but only two were identical. They pertained to speaking with the body of the dead person and wrapping the body of the deceased in either a particular kind of blanket or an animal skin. It was also noted that this was done only for men, and not women and children (Appendix A – Transcription of interview responses, 2006:243-244).

2.6.4.3 Death, causes of death and after-death experience: Significance of the interviews

These interviews were significant because they indicated that it would be important for the curriculum design to include the different perspectives of sickness and death as reflected in the views of the three fraternals. Because HIV/AIDS is a terminal disease, cultural information about death and burials would be of benefit to all of the pastors and give them understanding that would likewise be of benefit to the unity of the fraternals.³⁴

2.6.5 Cultural views and beliefs about sexuality and its relation to HIV/AIDS

Sickness, healthcare and death were all issues that were important to those who were working with victims of a terminal condition called AIDS. But also of importance was a cultural overview on the topic of sexuality and how it related to HIV/AIDS. Sexuality and its relation to AIDS should be addressed as a part of the planned curriculum intervention because 95% of HIV infections are spread through sexual intercourse. Perceptions of the disease were

³⁴ Although the curriculum intervention proposed in this study would not be able to cover the topic extensively, it was noted that a class or unit on cross-cultural counselling skills would be of benefit for pastors as it related to empathetic counselling for those who are grieving over the loss of loved ones who died from HIV/AIDS. The differences between traditional healing counsellors and Western counselling are wide and varied. Knowledge of both would be important as pastors attempt to educate and counsel victims and their family members when the condition of HIV/AIDS is involved.

surrounded by a host of cultural beliefs which could interfere with attempts to change risky behaviours leading to infection.

In traditional African thinking sexuality is not only a biological function, it also serves religious and social functions (Mbiti, 1969:146). Among some African ethnic groups, there were religious rituals that culminated in the actual or symbolic act of sexual intercourse. The sexual act was considered to be a 'sacrament' signifying inward spiritual values. The social functions of sex in marriage were broad and wide-ranging and strongly tied to kinship and family. Examples might have included a brother of the deceased caring for and procreating with their sister-in-law when a husband is employed away from home, hospitality (custom of the host offering his wife to a guest), polygyny or help with procreation if a couple is unable to conceive (Mbiti, 1969:147). All of these actions were considered sacred and respectable.

Breaches of these rituals and traditions were taken seriously and dealt with harshly when discovered by the community. When sexual offences were discovered (such as adultery, fornication, incest, rape, homosexual relations or intimacy between relatives), they were considered an affront to the community and severely punished. This punishment was sometimes physical and involved actions such as whipping, stoning to death or having a body part mutilated. In most cases a ritual cleansing would follow so that other misfortunes would be averted (Mbiti, 1969:147-148). Mbiti notes that the severity of punishment has been relaxed a bit in modern times, but not altogether abandoned (Mbiti, 1969:147).

2.6.5.1 Cultural views of sexuality for procreation

The sexual act for procreation was of prime importance in traditional African thinking. Africans believed that they ultimately ensured their own personal immortality through their children (Van Dyk, 2005:120). It was these very children who would remember the deceased by name after they died, allowing them to remain in the Sasa. Without children, one was more quickly forgotten and banished into the Zamani. This was a fate that all Africans wished to avoid. According to traditional African expectations, the pressure to procreate was strong and the inability to provide children for one's husband was equal to "committing genocide" (Mbiti, 1969:110).

Children were also of importance for other reasons in the day-to-day life of an African. In Africa, children were considered as wealth and a guarantee of the community's survival. According to Mbiti (1969:110), "children are the buds of society, and every birth is the arrival of 'spring' when life shoots out and the community thrives".

If procreation held this kind of weight in African society, it was clear that any attempt to prevent the sexual/ physical act that leads to it would be met with resistance and, in some cases, hostility. AIDS was primarily an STD and this fact had ramifications for various components of AIDS education. One example of the issues causing confusion was the teaching and encouragement of condom usage. Condom education had been one of the most widely supported methods of preventing transmission of the virus; however, there had been great resistance to their usage in many areas of Africa. Some of this resistance may have been a result of traditional African beliefs. Taylor (1990) found in his Rwandan work that resistance to condom usage was entangled in very specific social and cultural dimensions of society, including the gift of "self" (Taylor, 1990:1023-1028). Noted, too, were beliefs found in several parts of Africa that repeated doses of semen contributed to physical and mental health for a woman (Van Dyk, 2005:123).

2.6.5.2 Cultural views on condoms and condom usage

Because beliefs regarding sexuality for procreation and female health were strong and widespread there had been a resistance to condom usage in Africa. This resistance contributed to the spread of the AIDS pandemic. A specific example relating to South Africa was 2004 research pertaining to condom use within marital and cohabiting partnerships in KwaZulu-Natal. The study revealed that only 14% of men and 17% of women reported consistent or even occasional condom use in spite of the fact that over 80% of both men and women knew that condoms were effective in preventing HIV³⁵ (Maharaj & Cleland, 2004:119-121). These findings show that understanding the cultural issues and education would be crucial in changing the statistics pertaining to this issue.

2.6.6 Cultural views on HIV/AIDS (with reference to sexuality and community rejection): Feedback of the interviews (leaders and fraternal)

With direct reference to sexuality and the various views on HIV/AIDS, each of the fraternal leaders of the AOG/SA were asked Question #1H (Appendix B): "In your culture, how do people feel about the disease of HIV/AIDS?" This question indirectly solicited views on the disease as it related to sexuality. Two of the answers (The Group and The Movement) directly mentioned sexuality and the third (The Association) implied it by referring to procreation. The answers to Question #1H are provided in Table 2.5.

³⁵ A notable parallel finding in the same study found that only 2% of men with less than a secondary education used condoms consistently or occasionally while the figure grew to 21% of those with secondary or higher schooling (Maharaj & Cleland, 2004:119-121).

TABLE 2.5: QUESTION #1H (THE LEADERS' RESPONSES)

In your culture, how do people feel about the disease of HIV/AIDS?

The Leaders	How do people feel about the disease of HIV/AIDS?
The Group	People know it is there, but don't think it will happen to them. It is a black and homosexual disease.
The Association	There is a growing awareness, but it is too slow. There are whites who feel that this is the great equalizer ... to reduce black numbers. What is of grave concern is how they are NOT seeing it!
The Movement	The disease took us by surprise. We thought there is no such thing until people started dying from it. Now people don't want to talk about it because it is contracted from sexual intercourse ... and people don't want to talk about that in public.

(Source: Appendix A – Transcription of interview responses, 2006:244-245)

Each of the fraternal samplings was also asked question #1H (Appendix B): "In your culture, how do people feel about the disease of HIV/AIDS?" Responses were varied and ranged from complete denial of the existence of the disease to complete acceptance of the disease. The responses for The Group fraternal are found in Table 2.6. The responses for The Association fraternal are found in Table 2.7, and the responses for The Movement fraternal are found in Table 2.8.

TABLE 2.6: QUESTION #1H (THE GROUP FRATERNAL RESPONSES)

In your culture, how do people feel about the disease of HIV/AIDS?

The Group fraternal	How do people feel about the disease of HIV/AIDS?
#1	People don't feel it needs to be dealt with because it doesn't touch them. They see it purely as a health issue ... something quite personal. There are a lot of sceptics and the sceptics say that the activists need AIDS more than AIDS needs the activists.
#2	People say it doesn't exist ... they don't know anyone who has it.
#3	Young people are bored with it. Older people don't see it as their disease. It is not in their world.
#4	It is seen as a gay thing ... most whites don't think they will ever get it ... it is a black disease. Many whites are taking sexual risks because of this.
#5	Because of our church's location people are very aware of it. It is a bit taboo, but everybody knows someone who has the disease. It is kept quiet for fear of rejection.

(Source: Appendix A – Transcription of interview responses, 2006:244-245)

TABLE 2.7: QUESTION #1H (THE ASSOCIATION FRATERNAL RESPONSES)

In your culture, how do people feel about the disease of HIV/AIDS?

The Association fraternal	How do people feel about the disease of HIV/AIDS?
#1	It is out in the open and people are not afraid to speak of it. It carries a stigma because it is sexual. Awareness/education programmes have helped.
#2	People are aware and speaking about it, but there is still a lot of secrecy even in families. People are still scared about the reality of the disease.
#3	There is a growing awareness. At first there was apathy – now people are more open minded and realize it is not a plot; however, there is still stigma. Government needs to talk about emotional issues connected with this disease as well as physical.
#4	Even with education there is still a lot of stigma and fear.
#5	There is denial, stigma, shame ... but people are aware of it.

(Source: Appendix A – Transcription of interview responses, 2006:244-245)

TABLE 2.8: QUESTION #1H (THE MOVEMENT FRATERNAL RESPONSES)

In your culture, how do people feel about the disease of HIV/AIDS?

The Movement fraternal	How do people feel about the disease of HIV/AIDS?
#1	There is stigma, especially if you are married ... because this points to promiscuity. People are just starting to acknowledge the disease. At first they thought it was a political gimmick to keep blacks and whites apart (sexually) AFTER the apartheid laws were lifted. There is now acceptance that it is a killer.
#2	By now my people understand it is a real thing ... the majority of the people do talk about it because now we bury almost 10-15 people on a weekend and they all have diseases that are related to (or are a result of) AIDS. Fear? It differs from area to area ... but people do talk and will tell the burial services people that the person died of AIDS.
#3	They acknowledge that it exists ... but in my culture it has been associated with immoral sexual behaviour ... someone who is a fornicator or adulterer. It is also associated (sometimes) with a curse.

#4	The feeling in families, communities ... it differs. In the beginning of this AIDS issue, people were so scared of it and it was totally unacceptable. Even those who were infected would keep silent about it ... and live in denial of it. Most of the time it is viewed as a disease of sexual promiscuity ... a person with bad conduct.
#5	Firstly, when this thing of HIV/AIDS came to our culture, people thought that it was a spirit of witchcraft ... it was something strange. We viewed it as maybe a curse ... people were scared to discuss it. It was just a secret ... if you were diagnosed you kept it to yourself. If you happened to have the disease ... then you would be viewed as someone who was promiscuous. When an innocent baby gets HIV/AIDS ... the blame is put on the parent. I can see that things are getting better ... people are being taught about the disease ... they are getting to understand these things. It is not a curse, it is real, it is a disease.

(Source: Appendix A – Transcription of interview responses, 2006:244-245)

These responses were important as they related directly to the purpose of this research and seemed to verify that there were strong cultural differences in the AOG/SA fraternals regarding the perception of HIV/AIDS and its direct and indirect relation to sexuality. The results were that these differences (and possibly misunderstood views and beliefs) were at the root of a lack of cooperation on various AOG/SA church and community approaches to the pandemic. It could be proposed that this deficiency in understanding was contributing to an ineffective response of the AOG/SA church to the pandemic, while dialogue and teaching for tolerance and understanding could lead to a strong and relevant response in each church and community.

Question #2H (Appendix B) was asked as a follow-up question to Question #1H: "In your culture, does the community ever reject or ignore those who are infected with the HI virus or who are sick with AIDS?" This question indirectly related to views of sexuality because AIDS was largely viewed as a disease resulting from sexual promiscuity. Responses to Question #2H are found in Table 2.9 below:

TABLE 2.9: QUESTION #2H (LEADER AND FRATERNAL RESPONSES)

In your culture, does the community ever reject or ignore those who are infected with the HI virus or who are sick with AIDS?

Rejection of those with AIDS?	Leaders	#1	#2	#3	#4	#5
The Group	People are still scared - under 30s are better with it	Not been put to the test yet	To a point - but it is quickly changing	No, but there is more compassion for children	Yes, some fear and rejection	No, but this is because of educated community
The Association	Still a reluctance to acknowledge it – a result of a lack of education	Rejection is 50/50-older people want to be educated so they can help	No, lots of care and concern There are questions if a person looks sickly	No, not now – used to be. We teach about it and people are embracing those with AIDS	No, they are too busy helping them	Yes, because of denial there is some shunning – and some reluctance to be educated
The Movement	Yes, we do see it People are worried Ignorance plays BIG role	People are getting used to it, but there is still worry – ignorance plays a big role	In the beginning, people were pushed away ... now people are more accepting	No ... a person is a person by the others My people say ... <i>Umunu umunu ubuntu</i>	Yes, people are rejected or ignored	Yes, because people are scared ... the person might be bringing the curse into the house

(Source: Appendix A – Transcription of interview responses, 2006:245-246)

These responses show that the AOG/SA fraternalists reported a generally negative perception of HIV/AIDS as a result of a lack of knowledge about the disease, and in some cases the suspicion that the disease was related to witchcraft. However, it was also noted in their responses that rejection of HIV/AIDS victims was lessening in the South African culture. The negative reaction might have been somewhat linked to a negative perception of sexual promiscuity in each of the church fraternalists; however, in spite of the lessening of a negative perception of AIDS victims, there was room for improvement. The researcher hoped that the planned curriculum intervention could aid in this change. Changes in perceptions could occur as the different AOG/SA fraternalists become educated about the pandemic and begin to speak

about it more freely with their congregations and communities, in spite of the negative perception that the disease is primarily a result of sexual promiscuity.

2.6.7 Cultural views on boy/girl relationships, dating and marriage

With regard to sexuality in traditional African thinking it was interesting to note that the literature reflected very distinct views regarding puberty and young person's sexual awakening. The self-indulgent promiscuity and violent sexuality (such as rape and femicide) that is practiced by many of today's South African youth was apparently neither propagated nor tolerated in traditional African thinking (Mbiti, 1969:121-132). What was seen in the literature was the exact opposite. In traditional thinking one's sexuality was highly valued by the community as a "privilege and responsibility" (Mbiti, 1969:132). Initiation and puberty rites took place at various ages but were designed to "prepare young people in matters of sexual life, marriage, procreation and family responsibilities" (Mbiti, 1969:121-122). The key word in that statement was *prepare*; however, it does not appear that indulgence in sexual intercourse was promoted or allowed until marriage. The initiation rites in traditional African culture appeared to teach one that the value of one's sexuality was for the community and not just for individual pleasure. According to Mbiti (1969:127),

[t]he young people who have been initiated together become mystically and ritually bound to each other for the rest of their life: they are in effect one body, one group, one community, one people ... asserting group solidarity, and one at which the individual really feels that 'I am because we are; and since we are, therefore I am'.

2.6.7.1 Boy/girl Relationships, dating and marriage: Feedback of interviews with leaders

The literature regarding boy/girl relationships, dating and marriage showed that in traditional African settings, puberty was a time of instruction and teaching as well as a time to establish certain sexual boundaries and expectations. Interviews with the AOG/SA fraternal leaders and a fraternal sampling asked questions that had to do with the different cultural views of dating (boy/girl relationships) and courting. Although marriage was not specifically addressed, it was a natural extension of the questions, and views were expressed accordingly. Indirectly, these questions had to do with the perception of HIV/AIDS as it related to sexuality because the matter of sexuality in African society could be partially viewed in light of dating and courting norms. Answers across the AOG/SA fraternal varied and provided insight into cultural views of boy/girl relationships, dating and courting. Question #1GS (Appendix B) was worded in following manner: "In your culture, describe or explain the

most common and acceptable style of dating and/or courtship practices. Are young men and women allowed to have (or encouraged to have) friendly male/female relationships in high school and college or university?"

The leaders of the AOG/SA fraternals gave Question #1GS the following responses:

- The Group: "Dating begins in teen years, with marriage around 25 years of age. Everything (education, car, goods) comes first ... then marriage."
- The Association: "We are conservative. Dating would not take place in high school ... only group activities. Average coloured child is becoming sexually active around 12-13 years of age. Casual sex is becoming more acceptable. This is more of a Western influence."

The Movement: "Where boys and girls are together, there will be dating ... we don't worry about it." Lobola [bride price] governs the time and age of marriage ... it is still very prevalent inside and outside the church (Appendix A – Transcription of interview responses, 2006:247-249).

2.6.7.2 Boy/girl relationships and dating: Feedback of interviews with The Group

The Group pastors were unanimous (N=5:5) that "dating" (boy/girl relationships) began around the ages of 12-13. Three of the pastors (N=3:5) mentioned that young people were becoming sexually active between 12-14 years of age. Their consensus was that marriage would take place between the ages of 20 and 30 with an average age of 25 (Appendix A – Transcription of interview responses, 2006:247-248). This was a point of concern as it indicated anywhere from five to ten years of possible uncommitted sexual activity before the commitment of a marriage relationship was in place.

2.6.7.3 Boy/girl relationships and dating: Feedback of interviews with The Association

The Association pastors responded that "dating" would begin at the average age of 15 years. Only one pastor from The Association (N=1:5) mentioned young people becoming sexually active and gave the age of 16 as the beginning point. Marriage was projected to take place at an average age of 25, with the majority leaning more towards 21-23 years of age (Appendix A – Transcription of interview responses, 2006:248).

2.6.7.4 *Boy/girl relationships and dating: Feedback of interviews with The Movement*

The Movement pastors' responses differed somewhat from those of the first two groups. The age for "dating" ranged from 12-18, with an average of 15 years of age. Only one of The Movement pastors (N=1:5) mentioned any kind of sexual activity, stating that sometimes young people have sexual relations but "no penetration" was allowed. This was called "thigh sex". As far as marriage was concerned, The Movement pastors indicated that there were two factors that had to be taken into account for someone in their cultures who wanted to marry – "initiation school" (where many of the African cultures practise circumcision) and the ability to pay lobola³⁶. It was interesting to note the various statements on lobola and the reasons for justification. They were the following: "It is a custom"; "You pay for something of value for something *you* will value"; It is a "membership fee" into the wife's family; "It has a Biblical precedent in Genesis 24" (Abraham sending a servant with gifts to find a wife for Isaac); and it helps "build friendship" (Appendix A – Transcription of interview responses, 2006:248-249).

2.6.7.5 *Marriage and pregnancy outside marriage: Feedback of interviews with the leaders*

Question #2GS/Part 1 (Appendix B) pertained to issues of sexuality and was asked of all of the AOG/SA leaders and fraternal samplings. It was worded in the following way: "How does your culture view young women who become pregnant and bear children outside of the traditional marriage covenant relationship?" Within the same context, Question #2GS/Part 2 (Appendix B) asked, "How does this culture view the fathers of children born outside of the traditional marriage covenant?" As an extension of Question #2GS (Part 1 and Part 2), an additional question (#2GSa) was asked of respondents and read, "How are these men and women treated within the church?" Generally, the leaders of the fraternals responded in differing ways as it pertained to boys or girls. Their answers are found in Tables 2.10 and 2.11 below:

³⁶ Lobola is also known as a "bride price" – the price that is paid for one's wife.

TABLE 2.10: QUESTION #2GS/PART 1 + A (LEADERS' RESPONSES)

How does your culture view young women who become pregnant and bear children outside the traditional marriage covenant relationship? (a) How would this man/woman be treated within the church?

The Leaders - <i>GIRLS</i>	<i>Views of pregnancy outside traditional marriage covenant?</i>
The Group	People are quite relaxed about it
The Association	Previously viewed with disdain, now becoming more accepted
The Movement	Not well received

(Source: Appendix A – Transcription of interview responses, 2006:249-251)

TABLE 2.11: QUESTION #2GS/PART 2 + A (LEADERS' RESPONSES)

In the same context, how does this culture view the fathers of children born outside the traditional marriage covenant? (a) How would this man/woman be treated within the church?

The Leaders - <i>BOYS</i>	<i>Views of fathering children outside traditional marriage covenant?</i>
The Group	Some stigma, but acceptable
The Association	They are viewed as bastards
The Movement	Stigma attached to him ... he has insulted the girl's parents

(Source: Appendix A – Transcription of interview responses, 2006:249-251)

2.6.7.6 Marriage and pregnancy outside of marriage: Feedback of interviews with the fraternal

The fraternal responses were similar to their leaders with no obvious variations and are noted in Table 2.12 (GIRLS) and Table 2.13 (BOYS).

TABLE 2.12: QUESTION #2GS/PART 1 + A (FRATERNAL RESPONSES)

How does your culture view young women who become pregnant and bear children outside the traditional marriage covenant relationship? (a) How would this man/woman be treated within the church?

<u>GIRLS</u> Views of pregnancy outside marriage covenant?	#1	#2	#3	#4	#5
The Group	Socially incompetent Irresponsible	Some stigma but would not last long	Previously frowned upon, now accepted	High degree of acceptance	Totally acceptable
The Association	Disgrace but accepted	People are less critical than in the past – some stigma	A problem – she has caused shame	No one thinks much of it	Used to be taboo Shame Now seen as cool thing
The Movement	Considered insult to parents	Not as serious as in past – but not well received	A disgrace, but because of diversity is accepted	Disgrace	Disgrace

(Source: Appendix A – Transcription of interview responses, 2006:249-251)

TABLE 2.13: QUESTION #2GS – PART 2 + A (FRATERNAL RESPONSES)

In the same context, how does this culture view the fathers of children born outside of the traditional marriage covenant? (a) How would this man/woman be treated within the church?

<u>BOYS</u> Views of fathering children outside of marriage?	#1	#2	#3	#4	#5
The Group	He is stigmatized, now has financial burden	Expected to help financially	Mild stigma with little consequence	Would not be an issue	No stigma
The Association	Shock at his involvement, disappointment	Some stigma	Disappointment, he has lost his potential	Accepted, because it is common, some financial responsibility	Slowly being accepted – they have many sex partners
The Movement	Certain bias against him, he has insulted girl's parents!	He must look after the baby	It is not considered his child – he is innocent	Accepted because men can have more than one wife (partner)	You are a man! You have proved yourself!

(Source: Appendix A – Transcription of interview responses, 2006:249-251)

The responses of The Group pastors to Question #2GS/Parts 1-2 + A (Appendix B) indicate a general feeling that the girl would be "accepted" but that her actions would be frowned upon or viewed as "socially incompetent". For the father of the child, there would be "stigma". Three of the respondents (N=3:5) stated that the father would be expected to provide financial help for the mother and child, and two of the respondents (N=2:5) indicated that there would be no consequence for his actions (Appendix A – Transcription of interview responses, 2006:249-251).

The responses of The Association pastors to Question #2GS/Parts 1-2 + A (Appendix B) indicated that the girl's situation would be a "disgrace", a "shame" or "a problem" but that there would be "community acceptance". One respondent (N=1:5) indicated that it would be

viewed as a "cool thing" and another respondent (N=1:5) indicated that "no one thinks much of it". For the boy the responses varied. Descriptors given were "shock", "stigma", and "disappointment". However, two of the respondents (N=2:5) stated that the boy would be accepted and one additionally responded that the boy would be viewed as "having lost his potential". Only two of the respondents (N=2:5) indicated that there would be any kind of responsibility or financial expectation placed upon the young man.

The responses of The Movement pastors to Question #2GS/Parts 1-2 + A (Appendix B) were interesting and quite different from the answers of the other two fraternal samplings. Three of the respondents (N=3:5) used the word "disgrace" to describe the young woman. One respondent (N=1:5) indicated that her condition would be "considered an insult to her parents" and one stated that it would not be "well received". One respondent (N=1:5) stated that this kind of thing was "out of control" and that "it used to be serious". One respondent (N=1:5) stated that because of the "diversity of multicultural influence, it is accepted". One respondent (N=1:5) stated that this would be a disappointment to her parents because they would not be able to demand as much lobola because "men will look for and pay a higher price for a virgin".

With regard to the young man who had fathered a child outside of marriage (#2GS/Parts 2 + A), there seemed to be general acceptance of his actions. Responses of The Movement fraternal were as follows:

- There will be a certain bias against him unless he shows seriousness about what he has done. He has insulted the parents of the girl by taking her virginity.
- According to my culture, the boy must look after her and the baby. There is something similar to lobola that is required. Once he has paid that, he can go and not take any responsibility ... or he may marry her.
- With regard to the father of the child ... since the child is not considered "his" he is treated as "innocent". The grandmother will adopt and raise the child.
- The father of the child is accepted. This is because men in our culture are allowed to marry more than one wife, but a woman is not allowed to take multiple husbands.
- With regard to the man, most of the people will say "You are a man! You have proved yourself!" (Appendix A – Transcription of interview responses, 2006:251).

Table 2.13 compares the responses of the leaders and their fraternal members who respond to the second half of question #2GS/Part 2 and which pertain to boys who father illegitimate children.

2.6.7.7 *Boy/girl relationships, dating and marriage: Significance of the interviews*

The significance of this information for this study was that the cultures represented in the AOG/SA fraternal members generally stigmatize sexual activities that are engaged in outside of marriage and not for procreation. However, it was noted that for the females the stigma seemed to be more significant in the black fraternal. In spite of the promiscuity and the short-term, uncommitted relationships and tolerance of alternative lifestyle cultures that are being presented by the media, results from these interviews appeared to place value upon sexual faithfulness in committed marriage relationships for the purposes of procreation. It did not appear from fraternal responses that there had been a loosening of views regarding sexuality in South African cultures represented by the AOG/SA. Promiscuity does not appear to be condoned or promoted although the results and consequences of promiscuity seemed to be more acceptable to the respondents and those they represent today than in the past. This was reflected in the literature reviewed and in interviews with fraternal members. This particular information was relevant to this study in that HIV/AIDS is primarily a sexually transmitted disease. As a result, any attempt that might be made to encourage pastors from the three fraternal members to work cooperatively would require that the curriculum intervention teach about the different aspects and views on sexual abstinence and other means of reducing transmission, as well as sexuality within the cultures represented.

2.6.8 Cultural views and beliefs about the role of women

Another cultural factor that influenced responses to people with AIDS was the perceived role of women in the South African cultures represented in the membership of the AOG/SA fraternal members. In the words of Philippe Denis, "HIV/AIDS is ultimately a gender issue" (Denis, 2003:75). Cultural traditions that do not value women are contributing to the spread of HIV. This was supported by the fact that the majority of HIV/AIDS infections in sub-Saharan Africa were a result of heterosexual intercourse. According to the *AIDS Epidemic Update 2006* published by UNAIDS, 13.3 million of the 24.7 million cases of AIDS in sub-Saharan Africa were women (UNAIDS, 2006b:3-4). For every 10 adult men living with HIV, there were about 14 adult women who were infected with the virus (UNAIDS, 2006b:5).

This high number of female victims was a result of many factors, including those that are physiological, social, religious and cultural in nature. But it was specifically the cultural factors that were explored in this part of the dissertation, including a culture of violence towards women, the cultural expectations and value of virginity for females, and the traditional practice of polygyny. In South Africa, there are diverse cultures, and attitudes regarding women and their sexuality differ from culture to culture. The review in the following sections will not attempt to provide an exhaustive overview of all of these cultures, but will attempt to provide a general overview of South African culture.

2.6.8.1 The South African government's views of women

South Africa has had one of the most progressive constitutions in the world in which women's rights are protected. Since 1994, legislation has been passed that supports and protects women's rights, including the following:

- *Termination of Pregnancy Act of 1997* (provides for abortion on demand)
- *Recognition of Customary Marriages Acts of 1998* (provides for women married under customary law, and gives full majority and citizenship rights)
- *Domestic Violence Act of 1998* (makes provision for marital rape)
- *Maintenance Act of 1998* (entrenches the rights to financial maintenance of a child by both biological parents)
- *Conditions of Service Act of 1994* (stipulates minimum wages for domestic workers).

Since the laws of the land were established by the South African government and this democratic government ideally represented society and the many varied cultures in South Africa, it was assumed that women, who according to the 2001 Census make up 52.2% of the population, are seen as valued members of South African society and culture where they live and work (Statistics South Africa, 2001). And yet, if it were necessary for the government to pass legislation to protect the rights of females, it could be argued that South African culture and society do not reflect the same valuing of women that the government does. The latter scenario seems more likely in light of the statistics pertaining to violence against women in South African communities.

2.6.8.2 Violence against women

The statistics of gender violence in South Africa are noteworthy. In 2006, South Africa had the highest rape per capita statistics in the world with 1.19538 rapes per 1 000 people (Nation Master.com, 2006). In comparison the United Kingdom had 0.142172 rapes per 1 000 people and the United States of America reported 0.301318 rapes per 1 000 (Nation Master.com, 2006). Between April 2004 and March 2005, there were 55 114 reported rapes in South Africa with a conviction rate of 42% in regular courts and a conviction rate of 62% in newly established sexual offences courts (Amnesty International, 2006). The Amnesty International Report for 2007 reported 54 926 rapes with 42.7% of those being committed against children under the age of 18 (Amnesty International, 2007). Of the 54 926 rapes reported, the largest percentages were in Gauteng (11 923), followed closely by KwaZulu-Natal (9 614) (SAPS, 2005).

These statistics were high, but they were even more significant in that many women do not report rape for fear of being disbelieved by members of the criminal justice system, fear of reprisal and intimidation, shame, and knowing the offender (Vetten & Bhana, 2001). Therefore, realistically, these statistics were probably below the actual incidence. The "Victims of Crime Survey" conducted by Statistics South Africa found that only 50% of all women who admitted being raped reported the matter to police while another study covering three South African provinces (the Eastern Cape, Mpumalanga and the Northern Cape) found that only 25% reported the offence to the police (Vetten & Bhana, 2001). Compounding the problem was the disturbing view of some medical professionals. Doctors and nurses in a 2003 cross-sectional study by the Medical Research Councils' Gender-Based Violence and Health Initiative found that of the 155 healthcare workers interviewed, 59% of nurses and 40.9% of all doctors (including GPs) believed that "rape was not serious" (Christofides, Webster, Jewkes, Penn-Kekana, Martin, Abrahams & Kim, 2003:22). This study involved a sampling of care providers in all nine provinces and included district, regional and tertiary hospitals.

However, rape was only one facet of a culture of violence against women. According to Mathews, Abrahams, Martin, Vetten, van der Merwe and Jewkes (2004:4) in an MRC Policy Brief, a woman was killed by her intimate partner in South Africa every six hours (8.8 deaths

per 100 000 women 14 years and older). This was the highest rate of intimate femicide³⁷ that has ever been reported in research anywhere in the world (Mathews et al., 2004:4).³⁸

It was also noted that only 37.3% of female homicides (both intimate and non-intimate) resulted in convictions and that almost 70% of acquittals were a result of a lack of evidence (Mathews et al., 2004:3). Although most of the victims of female homicide were coloured, it is interesting to note that over 76% of the perpetrators were African, 11% were white, 9% were coloured and 2.6% were Indian (Mathews et al., 2004:2).

While this violence may not be a direct result of traditional African culture, one could say that these statistics point to a general culture of violence towards women in some South African communities. This culture of unequal power between men and women, which is frequently apparent in sexual relationships, puts women at higher risk of contracting the HI virus and, in the minds of some, has a "direct relationship to the growing prevalence of AIDS" (Haddad, 2002:95).

2.6.8.3 Cultural expectations of female virginity and lobola

Although the culture of violence towards women in South Africa is often sexual in nature, the cultural factors that were next explored were more directly related to the control of women or the perception that women were property. These two factors were the expectation of virginity and virginity testing, and the practice of lobola.

With regard to virginity testing, there were a few humorous stories about attempts to test males for virginity but, in essence, the primary focus of virginity testing was aimed at females. The practice of virginity testing reinforced the way men perceive women, as someone (something) who must be maintained in a certain way and at a certain level. The expectation seemed to be that women would remain sexually 'unused' and 'clean' before marriage; whereas, it was noted that this was not the expectation for men (Barker & Ricardo, 2005). The idea that the price of lobola would be higher for females who are virgins than for those who are not reinforced this cultural expectation. This kind of thinking had been prevalent for generations throughout the world and was even reflected in the biblical passage of Exodus 22:17 where there was reference to a "bride price for virgins" (NIV).

³⁷ Intimate femicide is the killing of a female person by an intimate partner, while *non-intimate femicide* is the killing of a woman by someone other than an intimate partner and *female homicide* entails both intimate and non-intimate femicide.

³⁸ For women 14 years and older the following statistics applied: White women 2.8 per 100 000; coloured women 18.3 per 100 000; Indian women 7.5 per 100 000 and African women 8.9 per 100 000 (Mathews et al., 2004:2).

In the Zulu culture, note was made that female virginity was valued by the fact that rather than the standard "ten head of cattle" for a bride, an eleventh cow would be presented to the mother of a young lady who was found to be a virgin (Bruce, 2005:52). The mother's cow was known as *inkomo kamama* (Bruce, 2005:52). Mbiti (1969:145) states that "[i]n some societies the marriage breaks down completely if the bride is not a virgin at the time of the wedding". In the Batoro culture, "if the girl is found to be a virgin the aunt is given a cow and another cow is sent to her mother together with the sheets having the stains of the blood of virginity. These stains of virginity are the greatest credit to the mother and family of the bride"; in essence, "[v]irginity symbolizes purity not only of the body but also of moral life; and a virgin bride is the greatest glory and crown to her parents, husband and relatives" (Mbiti, 1969:140-141).

2.6.8.4 Biblical views of virginity

Since the proposed curriculum design involved the teaching of AOG/SA pastors, it was of relevance to look at a general overview of virginity from the biblical standpoint in both the Old and New Testament. In the Old Testament "virginity is not viewed primarily in terms of purity but in terms of property" (Bruce, 2005:55). One example is that "the father collects a bride price from the man who marries his daughter or from one who seduces or rapes her; this bride price is compensation for the loss of her virginity that is viewed as the father's sexual property" (Bruce, 2005:56). According to Frymer-Kensky (1998:84),

The male members of the family have the prerogative and the duty to maintain the chastity of the young women of the family. The chastity of the girl thereby becomes an indicator of the social worth of the family and the men in it. The honour of the family is at stake, for real men have the strength and cunning to protect and control their women.

In the New Testament the teachings of the Apostle Paul came to the fore when virginity was discussed. Paul's writing in 1 Corinthians 7 was one of the scriptural passages that were used to teach on abstinence and virginity. However, some of Paul's teachings have seemingly been misinterpreted and may have resulted in the sexual oppression of women, particularly through church teachings. According to Bruce (2004) in New Testament times there was a change in the view of virginity as it had appeared in the Old Testament. Regarding the New Testament view, Bruce (2004:24) states:

In New Testament times, virginity was valued and women's sexuality continued to be controlled, but at least the idea was more egalitarian [than in the Old Testament]; that men and women should be virgins before marriage ...

[and] there were some who thought that virginity should be a permanent state that would allow them to devote themselves to the things of the Lord in the crisis of the end times [*parousia*].³⁹

Bruce (2004) further argues that Paul did not attempt to restrict women by advocating that their sexuality be controlled. The way in which Paul expressed himself in 1 Corinthians 7 shows him to be moderate and also indicates that he is expressing his own opinion (1 Cor. 7 verse 25), not attempting to impose it on anyone (Bruce, 2004:22). This tone of writing could have been a bit of reverse psychology in an attempt to gain compliance, or it could also be viewed as leaving his readers room to reject his advice (Bruce, 2004:22).

No matter how one approaches the topic of virginity – whether as a reflection of 'property' or as an indicator of a 'clean body and moral life' – virginity as presented in the literature was something to be protected and valued.

In South African society and culture virginity appears to be valued, particularly in the traditional African culture. This idea was corroborated in first-hand interviews with AOG/SA pastors who were interviewed for this research. When asked how boys who father illegitimate children (boys who are obviously sexually active before marriage) are treated in their culture, the pastors were fairly unanimous that there would be no lasting consequences for the young man (refer to Table 2.13), but they indicated that there would be mild stigma attached to the boys and that disappointment would be shown in them. For girls, in most cases, it was quite the opposite (refer to Table 2.12). The table shows that the words "disgrace" and "shame" were prevalent descriptors with all five of The Movement pastors and The Movement leader who could be assumed to be representative of traditional African culture. Yet, many of the pastors from all three fraternals indicated that young people between the ages of 12-18 years of age were becoming engaged in sexual activities (Appendix A – Transcription of interview responses, 2006:249-251). This indicated that this sampling of pastors was aware that sexual involvements are happening in a younger age group within their communities and cultures than was previously the case. As a result, the proposed curriculum intervention should include dialogue and teaching to address this issue in various cultural settings as part of an HIV/AIDS curriculum for AOG/SA pastors and pastors-in-training.

³⁹ *Parousia* refers to the second coming of Christ.

2.6.8.5 Multiple sexual partners within marriage, varying expectations for men and women: Feedback from interviews with leaders and fraternal

To take the virginity and sexual purity issue a step further, the interviews with the fraternal explored the issue of married men and married women having more than one sexual partner. This was relevant to this study in that it further explored the different expectations for men and women regarding sexual fidelity within the cultures of the AOG/SA fraternal. It was of importance to this study because of the statistics which showed that HIV was often transmitted in marriages where females remained faithful and monogamous (Newman et al., 2000:250). Question #3GS (Appendix B) asked, "How does your culture view or treat married men who have more than one sexual partner? Is it encouraged, discouraged or generally ignored?" Table 2.14 reveals and compares the responses of the AOG/SA leaders and their fraternal pertaining to this question.

TABLE 2.14: QUESTION #3GS (LEADERS' AND FRATERNAL MEMBERS' RESPONSES)

How does your culture view or treat married men who have more than one sexual partner? Is it encouraged, discouraged or generally ignored?

<u>MEN</u> Married men, more than one sexual partner?	Leaders	#1	#2	#3	#4	#5
The Group	Un-acceptable but it's a man's world	Taboo	Not accepted	Frowned upon	Not acceptable	Socially acceptable as long as they do not get caught
The Association	Un-acceptable but tolerated	Taboo	Not encouraged	Seen with disdain, but no one is surprised	Terrible thing	Taboo, but it is accepted that men do these things
The Movement	It happens	It happens	Accepted	Necessary for a man to be a man	Accepted	Accepted and encouraged in initiation school

(Source: Appendix A – Transcription of interview responses, 2006:251-252)

When these fraternal members and their leaders were asked the same question about married women, the answers were diverse. Question #4GS (Appendix B) asked, "How does your culture view or treat married women who have more than one sexual partner? Is it encouraged, discouraged or generally ignored?" Again, these were relevant to this study in that they pointed to cultural expectations for female sexuality and fidelity inside marriage and also related to the high incidence of HIV transmission in females within monogamous marriage relationships (Sinding, 2005). The responses to this question are provided in Table 2.15 below:

TABLE 2.15: QUESTION #4GS (LEADERS' AND FRATERNAL MEMBERS' RESPONSES)

How does your culture view or treat married women who have more than one sexual partner?
Is it encouraged, discouraged or generally ignored?

<u>WOMEN</u> Married women, more than one sexual partner?	The Leaders	#1	#2	#3	#4	#5
The Group	Un-acceptable labelled a whore	Taboo	We have not dealt with this	Frowned upon even more – she is loose, a bad woman, a temptress	More stigma - it is not accepted	Not acceptable
The Association	Very un-acceptable	Taboo	Not encouraged - she definitely carries heavier stigma	Almost the unpardonable sin. She would be called a slut or prostitute	It is worse than a terrible thing ... she would be called a slut	Taboo, and considered worse than a man's infidelity
The Movement	It happens	It happens, but in the church she would be excommunicated	It is never allowed	It is un-acceptable	Not accepted She would be seen in much worse light	She would be seen as loose or a prostitute

(Source: Appendix A – Transcription of interview responses, 2006:251-252).

It was of interest to note that the descriptors of a married female who has more than one sexual partner (refer to Table 2.15) are somewhat stronger in The Group and The Association fraternal responses. This could be seen to indicate the value of fidelity for females in these two cultures. The Movement responses state that a married woman having more than one sexual partner is "unacceptable" or "never allowed", but in two responses there is also an allusion to the fact that "it happens". This might indicate a view of female sexuality that differs from those of The Group and The Association, but it was still clear from all of the responses that it was not acceptable within the South African cultures represented by the AOG/SA for married women to have more than one sexual partner. The deviation shown in The Movement pastors' responses could be viewed as somewhat contradictory to traditional African culture because the literature reflected strong views on the matter of female virginity and fidelity and did not seem to make allowances for any kind of promiscuous behaviour on the part of females.

For the purposes of the proposed curriculum design it was deemed important to help pastors become aware of and act upon what seemed to be a gender-based dual standard regarding sexual fidelity and to facilitate open discussion within their fraternals and churches about the differences.

2.6.8.6 The practice of polygyny and its relation to HIV/AIDS

The final cultural factor regarding the perception of women in South African cultures to be examined in this section of the research was the practice of polygyny. It was noted that when speaking of the practice of having more than one wife the correct term to use was the word 'polygyny'. According to the Oxford Dictionary, polygyny is the practice of having more than one wife at the same time (Soanes, 2002:689). The word 'polygamy', according to the same dictionary, is "the practice of having more than one wife or husband at the same time" (Soanes, 2002:689). For the purposes of this study, the researcher will look specifically at the practice of polygyny in the traditional African culture and how this cultural practice might have impacted the pandemic of HIV/AIDS, particularly as it related to women.

Within South Africa, polygyny was culturally allowed and even propagated, although it was considered to be in the category of an indigenous law. For women, a lack of full legal protection left some at the mercy of their husband or partner for provision even though they may have desired to end the relationship because of physical or mental abuse or the knowledge that their partner was engaging in risky sexual behaviours which could put them

at risk for HIV. It might be surmised that the practice of polygyny indirectly influenced the social and cultural expectation of multiple sexual partners for men, a practice which could be dangerous in light of the number of cases of HIV/AIDS in South Africa and neighbouring countries. According to the literature, in traditional African thinking virginity and marital fidelity were expected and valued for females, even though males did not appear to be held to the same standard.

On the opposite side of this practice, research has shown that Zulu males in South Africa are reported to prefer abstinence before marriage, but profess that they feel obliged to have sex before marriage for fear of social rejection (Varga, 2001:177). According to Barker and Ricardo (2005:17), this pressure was not only from male peers but "the Zulu young men report that young women also have a role in reinforcing traditional views about manhood and sexuality". In general, there was a strong link between a male's sexual conquests, which are associated with sexual competence or the desired recognition of being a real man, "rather than acts of intimacy" (Barker & Ricardo, 2005:16).

Throughout parts of Africa, polygyny was linked to the norm by which masculinity was expressed as sexual conquest and prowess, particularly as it related to fertility (Silberschmidt, 2001). This had important implications for sexual behaviours and the transmission of HIV/AIDS to women and children, especially as it related to the number of sexual partners a man may have and the prevalence of AIDS in South Africa. It could be proposed that while the tradition of polygyny placed men in a role of power over their wives, in its purest form it might be seen to discourage extra-marital affairs. However, times change, and according to Barker and Ricardo (2005), the change in thinking is being manifested in African society even as the tradition of polygyny is waning. Barker and Ricardo (2005:17) sum it up with the following statement:

[I]n some settings, the tradition has now become more informally interpreted as a man's right to have as many sexual partners as he wishes. And while the tradition per se has been dismantled by various social and economic factors and limited by the law in some countries, the normative discourse that a man needs more than one partner continues.

Under the heading of polygyny, it was noted that in the white European cultures of South Africa, there appeared to be a practice that was similar in nature to the practice of having many wives. The term for this practice was serial monogamy. Serial monogamy was a form of monogamy in which participants had only one marriage partner at any one time, but had multiple marriage partners throughout their lifetime. Because of the sexual relationships

involved, this type of relationship could be classed as risky in light of the HIV infection rate in South Africa.

The relevance of this information to this study was that these two forms of relationships, both of which presumably involved sexual relations, impacted women and promoted the transmission of the HI virus in the cultures represented by the AOG/SA fraternal. In the serial monogamy that is found in the South African Western cultures, women were somewhat empowered to leave or discontinue the relationship if they thought that they were in danger. This could include the contracting of AIDS from their partner's sexual infidelity. In polygyny, which was found in other South African cultures, women did not appear to have the freedom to leave or ask for protection in light of traditional expectations and norms which still prevail. This exposes many South African women and their children to the risk of unsafe sexual choices and harmful involvement.

For the purposes of this research, the cultural views and beliefs about the role of women in South African cultures would need to be a part of the curriculum intervention for AOG/SA pastors. All areas of concern that related directly to HIV/AIDS and women, including the culture of violence against South African women, the value of virginity and the practice of polygyny, would need to be explored and discussed as they relate to the different fraternal in the AOG/SA to provide insight and understanding for all.

2.7 RELIGIOUS VIEWS OF THE AOG/SA PERTAINING TO GENDER AND LEADERSHIP

As one can see from the literature review and interviews with AOG/SA leaders and fraternal members, some women are seemingly trapped in subservient and unequal roles within male/female relationships in the general South African context. This was also clearly evident in the AOG/SA church as will be shown by the responses of interviews with AOG/SA leaders and fraternal members in this section of the literature review. Whether intentional or unintentional, it was observed that the church may have been complicit in propagating the subservience of women and their ownership by men through some of their teachings and practices regarding the role of women, particularly within the marriage relationship. This phenomenon was generally addressed in Section 1.4.3 (Women in the South African Church).

The complicity of the church in propagating the subservience of women and their ownership by men was a crucial point for consideration in the curriculum intervention for training AOG/SA pastors regarding the AIDS pandemic in South Africa. Women, who have

constituted the majority of those suffering with the disease of HIV/AIDS, should have been taking leading roles in the church's response to the HIV/AIDS pandemic in South Africa. It would appear that they have been restrained because of the church and societal ideology that encouraged the idea that females are inferior members of the church family, particularly in the area of leadership. When one understood that the AOG/SA membership is predominantly female (refer to Section 1.4.3), that the majority of HIV infections in South Africa are found in females and that females are more likely to contract the disease (refer to Section 1.4.3) it became clear that females had a vested interest in helping to reduce the HIV/AIDS pandemic. It was logical to assume that female leadership in this area would be effective and productive primarily because female leaders would be able to identify and empathize with the gender issues of the majority of those suffering from HIV/AIDS. The role of the church in denying women leadership positions, including that of pastoral positions, should be addressed in future research.

In an attempt to understand why women are not taking more of a leadership role in the ministries of the church, specifically in ministry to HIV/AIDS victims, interviews were conducted with the AOG/SA leaders and their fraternal members pertaining to the leadership of women in the local church. The results of those interviews will be provided in this section of the literature review. However, before the examination of gender issues in leadership, the foundational ideas and requirements for leadership in the AOG/SA were examined with regard to men and women.

To begin the examination, there was a review of the template for AOG/SA church constitutions. Each AOG church operates under an umbrella constitution for the Assemblies of God/South Africa.⁴⁰ The constitution document is the basic template for other documentation (rules and regulations, including qualifications for leadership). In addition, each AOG/SA fraternal is allowed to draw up their own individual set of rules. This means that the fraternal have taken the general constitutional document and refined it to fit their particular culture (LaFoy, 2007). According to LaFoy, who is the leader of The Association, each fraternal has its own constitutional document. Each AOG/SA church is autonomous and is allowed in terms of culture to fine tune rules for oversight and administration according to

⁴⁰ This 1997 document appears to be outdated. Donovan Coetzee, the leader of The Group, informs the researcher that a new constitution is being drafted. The reference to gender disqualification in leadership has been strongly debated amongst fraternal members. For this reason, The Group's long-standing requirements on this matter are being reviewed and revised at present.

geographical location (e.g. accepted cultural norms might be quite different for a church in Sea Point than they are for a church in the North-West Province).

2.7.1 Religious views of AOG/SA pertaining to men in leadership: Feedback of interviews (leaders and fraternal)

In interviews with the leaders of each fraternal, the researcher found that their views on the role of women in leadership generally appeared to be gender-biased in light of legal trends in the country of South Africa (Section 2.6.8.1). The first group of questions they were asked (#1GC, Appendix B) referred to the role of men in leadership. These questions were asked to provide a point of comparison on the matter of gender issues in church leadership. The questions read as follows: "Within your church, what is the prescribed or scriptural teaching about men serving in leadership? Are there requirements for men who function in or who are elected to leadership positions? Are there any restrictions on men serving in a pastoral position?"

In response to these question all three leaders referred to the biblical book of 1 Timothy 3 (NIV) and specifically 1 Timothy 3:12 (NIV)⁴¹ (Appendix A – Transcription of interview responses, 2006:255-258). This passage (1 Timothy 3) addresses the qualifications for overseers (bishops) in verses 1-7 and goes on to describe the qualifications for deacons in 1 Timothy 3:8-12.

Overseers (also known as bishops or elders) and deacons were the two predominant positions of leadership within the New Testament church. The elder in that context was considered to be the one who directed the affairs of the church, particularly in the area of preaching and teaching, as described in 1 Timothy 5:17 (NIV).⁴² Many AOG/SA churches would reserve the position of elder exclusively for men, since they maintain that a woman is not eligible for this role. The fraternal interviews reported later in the dissertation will provide evidence of their attitude in this regard.

During their interviews all three fraternal leaders offered exceptions to these scriptural admonitions⁴³ on men in leadership. The Group leader noted that there are "no restrictions

⁴¹ 1 Timothy 3:12 reads, "A deacon must be the husband of but one wife and must manage his children and his household well."

⁴² 1 Timothy 5:17 reads, "The elders who direct the affairs of the church well are worthy of double honour, especially those whose work is preaching and teaching."

⁴³ Exceptions noted were mainly about divorce. Divorce has always been a controversial issue in regards to church leadership because of the admonition in 1 Timothy 3:12 which reads "... husband of one wife ...". Many conservative Christian churches, with what appears to be the exception of the AOG/SA, do not allow divorcees to serve in leadership.

when someone [a man] goes through a divorce – they are just asked to step away from leadership until the matter is sorted out". The Association leader noted that if a person is divorced, "we judge every case on its own merits". The Movement leader answered along the same lines as the other two but specifically mentioned that in church elections for elder and/or deacon, "sometimes people elect their friends even though the person may not fulfil scriptural requirements" (Appendix A – Transcription of interview responses, 2006:255-258).

It appeared that exceptions would be made to some of the requirements for men; however, there was no mention in any of the interviews of exceptions or flexibility with regard to women serving in leadership. Instead, exceptions were made to allow what might appear to be questionably qualified men to serve. It could be deduced from these answers that the leaders were thinking that a questionably qualified man is more suitable for church leadership positions than a qualified woman.

The fraternalists were somewhat varied in their responses to the three parts of question #1GC (Appendix B): "Within your church, what is the prescribed or scriptural teaching about men serving in leadership? Are there requirements for men who function in or who are elected to leadership positions? Are there any restrictions on men serving in a pastoral position?" Their responses are found in Table 2.16.

TABLE 2.16: QUESTION #1GC (FRATERNAL RESPONSES)

Within your church, what is the prescribed or scriptural teaching about men serving in leadership? Are there requirements for men who function in or who are elected to leadership positions? Are there any restrictions on men serving in a pastoral position?

Qualification for men in church leadership?	Response #1	Response #2	Response #3	Response #4	Response #5
The Group	We do not take a legalistic approach ... especially on divorce. He must have good reputation	We follow scriptural principles 1 Tim. 3 – except for divorce	We follow the prescribed scriptural teaching in 1 Tim. 3 Probably not a divorced pastor, but a divorced elder or deacon would be allowed	We follow scripture 1 Tim. 3. Home must be in order. Divorce not a problem	We follow scriptural principles of 1 Tim 3 ... apply principles for both genders

The Association	We stick to scriptural principles 1 Tim. 3	We follow the scriptural foundation in 1 Tim. 3. Most leaders, men, divorce allowed	We follow scriptural principles of 1 Tim. 3, Acts 6, Titus Divorced okay – calling approved by elders	We first look for his giftings He must be trained in Bible school	We fall in line with scriptural teaching 1 Tim. 3
The Movement	We follow scriptural principles 1 Tim. 3 – but sometimes someone outside the principles is elected There is objection; this pollutes the church	We base on scriptural teaching of 1 Tim. 3 He must have a calling validated by the local church – only men	Scriptural requirement of 1 Tim. 3 Not for women	According to the Bible he must have calling validated by the assembly	In line with 1 Tim. 3 ... must fulfil scripture if he is to be elected

(Source: Appendix A – Transcription of interview responses, 2006:255-258).

The researcher noted that these responses were fairly consistent in their use of 1 Timothy 3 as a basis for leadership qualifications. Many of the responders referred only to men in their answers. A few were very specific in their use of the pronoun "he" when it came to persons eligible for leadership positions; however, one Group pastor (refer to Table 2.16, Response #5) clearly displayed no gender bias and stated that men or women were measured against these scriptural qualifications for leadership according to 1 Timothy 3.

These responses seemed to indicate that men were considered the prime candidates for leadership positions in AOG/SA churches and that there was little encouragement/support or tolerance for women in leadership positions.

2.7.2 Religious views of AOG/SA pertaining to women in leadership: Feedback of interviews (leaders and fraternal)

The next section of the interview asked the fraternal leaders the following questions (Question #2GC in Appendix B): "Within your church, what is the prescribed or scriptural teaching about women serving in leadership? Are there requirements for women who function in or who are elected to leadership positions? Are there any restrictions on women serving in a pastoral position?"

The responses of the leaders to the questions in #2GC (Appendix B) were somewhat varied and are found below in Table 2.17:

TABLE 2.17: QUESTION #2GC (LEADER RESPONSES)

Within your church, what is the prescribed or scriptural teaching about women serving in leadership? Are there requirements for women who function in or who are elected to leadership positions? Are there any restrictions on women serving in a pastoral position?

The Leaders – Women in leadership?	Responses
The Group	For women it is the same as for men. They can pastor and can serve as executives.
The Association	We have a few serving in a pastoral role. They are now serving communion, ministering the Word ... but some men will still walk out if a woman takes the lead. This is a cultural thing more than scriptural. We have prevailed upon the men to return.
The Movement	There are no women in leadership. Scripturally we do not see, as a rule, women leading ... those in the Bible are only exceptions. There are about three women pastors in The Movement, but this is not the norm. There was a time when a woman was allowed to rise to leadership ... but she felt odd and was a misfit ... and the situation died a natural death.

(Source: Appendix A – Transcription of interview responses, 2006:255-258)

The Group leader indicated that qualifications are the same for men and women in leadership, including the position of pastor. This statement seemed to indicate some openness on the part of leadership for a woman to hold a church leadership position. However, the other two fraternal leaders' responses seemed to indicate a lack of openness toward any women in leadership. The Association leader seemed to allude to the fact that women are now being allowed to fulfil certain roles of leadership in spite of objections from men in the congregation. He also indicated that Association leadership was encouraging tolerance on the part of men in the church who objected to female leadership.

Observations were made that The Movement leadership had very little tolerance for women in leadership. Later in the dissertation, the interviews with The Movement fraternal members will indicate that there seemed to be a schism between The Movement leadership and members of their fraternal with regard to the matter of women in leadership within the church.

Continuing this same line of questioning, the next step was to interview the fraternal members of each of the three AOG/SA arms pertaining to requirements for women in leadership. The following questions (#2GC Appendix B) were posed to each of the fraternal members:

Within your church, what is the prescribed or scriptural teaching about women serving in leadership? Are there requirements for women who function in or who are elected to leadership positions? Are there any restrictions on women serving in a pastoral position?

The responses from each fraternal varied. They are presented below.

The Group – Fraternal responses to Question #2GC:

Pastor #1 – "It seems that there is a disconnect between doctrine and practice as few women presently serve in leadership. We have to ask, 'Are present views sustainable from Scripture?' We are neglectful of actually wrestling with the issue of women in leadership. I believe women should be able to serve. Women elders? Many do the work of elder without the title. I always have women in elder meetings for perspective."

Pastor #2 – "[Women] are treated just like men ... we apply scriptural principles (1 Timothy 3). In my opinion, they can pastor and I have two female elders in my church."

Pastor #3 – "The requirements are similar as they are for a man. At this stage there are no senior female pastors. It isn't about qualifications; it is about being a woman."

Pastor #4 – "There are a couple of women pastors ... but we are going through a change on this matter. There are no female elders, but women are allowed to serve as deacons. Women are the most reliable people in the church."

Pastor #5 – "They are allowed to pastor ... no problem. But there would be debate. They can serve as deacons, but according to the AOG constitution they are not allowed to serve as elders. The younger generation is transitioning out of this, though (Appendix A – Transcription of interview responses, 2006:255-258).

The Association Fraternal was asked the same question regarding women in leadership positions of the church (Question #2GC, Appendix B) and the responses were as follows:

The Association – Fraternal responses to Question #2GC:

Pastor #1 – "We look at qualifications for the position of deaconess. The scripture that we apply to men would apply to women. We do not allow women pastors or women elders. We do submit ourselves to any woman's ministry – but do not allow them to hold administrative powers over a man."

Pastor #2 – "We do have female leaders because most churches have more women than men. They play key roles, but do not carry titles or biblical titles like elder, deacon, or pastor. A woman can pastor and can serve in leadership ... but she must fall in line with scriptural principles."

Pastor #3 – "They are allowed to serve as deacons or pastor. They are not allowed to serve as elders. They [women] are equal in the world, but not in the church. In our church, women deacons tend to be intimidated by male elders."

Pastor #4 – "We have no bias. They can serve in any area including elder. Our stand is very radical for The Association."

Pastor #5 – "It is a matter of interpretation. I always refer to Micah 6:4 – 'I sent Moses to lead you, also Aaron and *Miriam*.' In our church there are no female leaders. You can be a gift to the body whether male or female ... referring to the priesthood of believers. Regarding the possibility of a female pastor ... the older people have a problem with it ... but the younger, no so much. I think our teaching should not be on male or female, but on giftings of leadership" (Appendix A – Transcription of interview responses, 2006:255-258).

The responses of The Movement fraternal differed notably from those of The Association and The Group on the issue of women in leadership. Interview responses to Question #2GC (Appendix B) were as follows:

The Movement – Fraternal responses to Question #2GC:

Pastor #1 – "We have a few women pastors but it is not the norm, we don't necessarily allow it. They should be allowed to work in their area of gifting, whatever that might be. Scripturally, we don't see women leading as the norm ... it is the exception."

Pastor #2 – "Joel 2:28 is used as scriptural basis for involvement of women. We (me and many of my colleagues) see no reason why a woman should not be part of ministry or leadership. We don't object to women in ministry ... but we seem to limit them. Women cannot pastor ... they must always be under the supervision of a man. The church

[denomination] as a whole does not agree on this issue ... the younger guys have no problem with women ... it is the older guys."

Pastor #3 – "We do not use the title of 'pastor' when it comes to females. We call them church planters, local missionaries, but actually the women are not given the same rights as men when it comes to ministry. There are no female pastors in The Movement. A woman can plant a church, but once the church has been established then she is asked to step aside and let a man take over. They will not even ordain her ... she cannot hold credentials. The younger men have no problem with women ... it is the older pastors."

Pastor #4 – "In my church we do have women in positions of leadership ... except as pastor. But in the other structures, they are allowed. Women in The Movement who serve as pastors are not given open recognition ... not given a title ... even though their work is the same as a male pastor. They are not given appointments or transfers as men. If a woman pioneers a church ... when souls are gathered and people get saved ... then they bring a man in ... someone who is already in the ministry. I think this comes from our cultural background ... men are always in leadership. Women do not serve in this way!"

Pastor #5 – "There is still a lot of negative attitude towards women in leadership. I think it is because people view things according to their tradition rather than Scripture. Women are not called 'pastors' ... they are called 'workers'. I would have no problem with a female pastor. It happens that a woman will pioneer a church and then The Movement will send in a man to pastor the church ... it is coming to our attention that this is wrong" (Appendix A – Transcription of interview responses, 2006:257-258)

The data indicated that the views of The Movement fraternal differed some from those of their leadership. In fact, some stated that they did not agree with leadership on this issue, perceiving the stance of the leadership towards women in leadership as being unfair.

Although there is not a direct or strong institutional relationship at present, it was of interest to note that the Assemblies of God International (USA), one of the churches whose missionaries helped to found the AOG/SA, strongly supports the role of women in ministry. This was evident from their position paper, published in 1990, entitled "The role of women in ministry as described in Holy Scripture" (Appendix L). A panel of 13 biblical scholars served on the committee which prepared the position paper, several of whom were considered to be expert scholars in biblical languages and interpretation.⁴⁴ After an extensive review of

⁴⁴ The writers of this document are named on page 7 of Appendix L.

scriptures pertaining to women in the church, the position of this panel was summarized as follows (refer to Appendix L, 1990:5-6):

After examining the various translations and interpretations of biblical passages relating to the role of women in the first-century church, and desiring to apply biblical principles to contemporary church practice, we conclude that we cannot find convincing evidence that the ministry of women is restricted according to some sacred or immutable principle.

This information is important to this research for the following reasons:

- The AOG/SA constitution has, until recently, not encouraged and, in some cases not allowed, the service of women in church leadership, particularly as it relates to the position of elder or pastor.
- It is women who have the most vested interest in stopping the high numbers of infections because they are the gender with the higher number of infections.
- AOG/SA leadership and their fraternal members are somewhat divided on this issue, which is leading to confusion and ultimately a lack of church direction in light of the HIV/AIDS pandemic.
- Strong leadership (whether by males or females) and coordination of AOG/SA church ministries addressing HIV/AIDS could make a significant and effective contribution to South African communities.

2.8 SUMMARY

The researcher concluded that the factors that would interfere with or hinder any attempt to educate the three AOG/SA fraternals together on the topic of HIV/AIDS were vast and complicated. Church leadership had remained quiet on the issue of HIV/AIDS, which was directly impacting the response of pastors to the pandemic. The design and purpose of the curriculum would need to be cooperative, multicultural and adaptable, bearing in mind the variances in learners' background in education, culture and religious views.

An aggressive re-sensitizing on the realities of HIV/AIDS was needed. This meant that learning components would need to instruct not only in the cognitive domain, but in the affective and psychomotor domains as well. The integration of views from all three fraternals would ideally provide a culturally sensitive and relevant classroom/learning experience that would be theologically sound according to AOG/SA doctrine, and would address gender inequalities.

It was concluded that the desired curriculum approach should be kinetic,⁴⁵ didactic⁴⁶ and participative. At its core, the curriculum should reflect a dichogamous⁴⁷ dynamic to encourage a gender-unified ecclesiastical vision for the HIV/AIDS pandemic and a cooperative focus that was culturally sensitive within the context of South Africa.

⁴⁵ Lively

⁴⁶ To instruct, inform, entertain with pleasure

⁴⁷ Allowing for male/female cross-fertilization

CHAPTER 3

CURRICULUM HISTORY, THEORY AND PEDAGOGICAL IMPLICATIONS

This chapter will include a brief and general overview of curriculum history, followed by a closer examination of three curriculum theories: the humanistic, social reconstructionist and dialogue curriculum theories. Theories will be examined and discussed in light of their pedagogical implications for the design of curriculum intervention which will be used to train AOG/SA pastors and pastors-in-training on the topic of HIV/AIDS.

3.1 INTRODUCTION

As the researcher examined the educational, cultural and religious background of AOG/SA pastors and pastors-in-training, those who are the potential market for this curriculum intervention, several factors related to the target group became apparent. It would be these factors that would need to be addressed within the foundation of the curriculum design.

The first factor was the inequality of education and educational experiences within the South African context (refer to Section 1.4.4). Some of the pastors and pastoral students may have suffered from the residual effect of a poor quality and/or emotionally negative educational experience as a result of the social dynamics of apartheid. Secondly, there appeared to be a significant deficiency in theological education and pastoral training pertaining to social issues (e.g. HIV/AIDS) prescribed by the AOG/SA. This factor had probably resulted from a lack on the part of AOG/SA leadership to prescribe or encourage theological training for licensure and/or ordination. Thirdly, gender inequality and discrimination were clearly evident in AOG/SA churches as they related to the view of females in leadership. In addition, a discrepancy with regard to the cultural expectations of appropriate sexual behaviour for men and women was also apparent, according to fraternal interviews (Appendix A – Transcription of interview responses, 2006:247-252; 255-258). Lastly, according to those interviewed, there had been no attempt to lead the three fraternal in working cooperatively on the HIV/AIDS issue. This lack of leadership and cooperation might be attributed to significantly different views on sexuality and HIV/AIDS as was evidenced in fraternal and leader interviews on the matter.

From these factors it was concluded that a multicultural HIV/AIDS curriculum intervention for AOG/SA pastors was needed. The search for appropriate and effective curriculum models was begun with these factors in mind. As a result, three models were selected to form the foundation of the curriculum design that was used in this research. These will be explained after a brief introduction to the history of curriculum theory and design.

3.2 A BRIEF OVERVIEW TO THE HISTORY OF CURRICULUM THEORY

The concept of education, and therefore ultimately the prioritization of education's core subjects (curriculum), has been debated for centuries. Philosophies pertaining to education and teaching were recorded as early as the Ancient Greeks and Romans, and are found in the sayings of some of the most well known of those scholars (McNeil, 2006:18):

- Socrates (469-399 BC): "Know thyself – the unexamined life cannot succeed."
- Plato (427-347 BC): "The learner is not an empty vessel to be filled, but a flame to be ignited."
- Aristotle (384-322 BC): "Education is an internal process assisted by external agencies in which the individuals actualize their potential."

It is the last statement, attributed to Aristotle, that would become a key factor in designing a curriculum for AOG/SA pastors. For many, education is viewed as an external process producing outwardly visible knowledge, knowledge that helps its learners cope in life. However, for education to reach beyond life-coping and become life-changing in value, it must stimulate the beginning of an internal process in the learners that will ultimately facilitate the actualization of their potential. It is this kind of stimulation that would be necessary in the design of an HIV/AIDS curriculum for AOG/SA pastors.

3.2.1 Early curriculum history: 1500-1800 AD

According to the literature, curriculum historians did not agree on the seminal beginnings of curriculum theory but noted that there were both European origins (1582 and 1633) and North American origins (1823-1923). The European examples source the word "curriculum" (from the Latin *currere* meaning *to run*, or *curriculum* meaning *a race course*) in writings at the University of Leiden (Holland) in 1582 and again at the University of Glasgow in 1633. North American historians lean heavily on the works of Franklin Bobbit's *The Curriculum* (1893) and Charles W. Eliot who was instrumental in publishing the findings of *The Committee of Ten* (1893) and *The Committee of Fifteen* (1895) when identifying the seminal

stage of curriculum development and science (Pinar, Reynolds, Slattery & Taubman, 1995:70-71).

Throughout the centuries there were many who helped to shape educational thought on curriculum. One of those was Johann Pestalozzi (1746-1827), a Swiss educator who advocated the idea that the natural development of the student and sensory experiences should guide education. Frederick Froebel (1782-1852), a German educator, considered to be the father of the kindergarten movement, was another influential person in this area. Froebel's method of learning placed a heavy emphasis on play, using manipulatives with expression/exploration as its foundation. A third significant influence on curriculum theory was the German psychologist Johann Herbart (1776-1841), who believed that education should help develop character and prepare one for social usefulness.

Colonel Francis Parker (1837-1902), who was influenced by Pestalozzi and Froebel, continued to pioneer educational and curricular thought. Parker's method was called the Quincy System. This system integrated a more natural approach to language learning, and geographical/historical learning was complemented through the introduction of the field-trip concept. John Dewey (1859-1952) continued to influence and change educational thought and was reported to be greatly influenced by the Quincy System. In 1897, Dewey wrote "My Pedagogic Creed", a document with five articles; this creed later became a staple of educationalists the world over. In this publication, Dewey expressed his philosophy on students, schools and curriculum. Dewey's philosophies can be summed up in the following six points:

1. Schools should be an extension of the community, representing real life.
2. Individuals are social, thus education is a "social process".
3. Education should begin with psychological insight of the student.
4. Education is the "continuing reconstruction of experience".
5. There is a difference between thinking and reflective thinking.
6. Teachers cannot train a student to think, but can create a desire (through proper conditions) to *motivate* thinking. (Lemlech, 1994:26-27)

It was not until the late 1800s that the science of curriculum design began *to be* considered as an elite and influential specialization of educational theory (Bellack, 1969:283-284). Today, the science of curriculum design requires a great deal of background and expertise, not only

in a specific subject matter, but also in psychology, child development and the sciences of pedagogy and andragogy. Curriculum design has developed into an inclusive science that combines facets of education, culture and society.

3.2.2 Curriculum history and theory: 1900s to the present

A review of the serious beginnings of curriculum science during the end of the 19th century and the early days of the 20th century revealed that there appeared to be confusion regarding the ultimate purpose of education and, in turn, curriculum. It was evident that the context that set the foundation for the serious beginning of curriculum science was complex. There were those who embraced the idea that curriculum should entail the integration of information (e.g. to group subjects around problems, to use the facts from one discipline to illuminate another). Another group of practitioners thought curriculum should be the correlation of information (e.g. relating ideas from different subject matter). It was of interest that in the early formulations of curriculum science, the idea of correlation was viewed as a threat because it ultimately questioned the usefulness of the basic division of subject matter that had been part of the standard school curriculum for decades (McNeil, 2006:301).

3.2.2.1 Developmentalists vs. Behaviourists

McNeil (2006:303) points out that the predominant views of the day found practitioners and theorists aligning themselves with one of two categories of thinking: the Developmentalists wanted to fit the curriculum to the nature of the child, while the Behaviourists thought it best to train students for specific capacities, rather than developing the mind through various subjects.

In addition to the debate between developmentalism and behaviourism, at the core of the historical context was a debate about specifically *what* should be taught. In summary, the debate could be separated into four camps of thought. The first was that of the Classical Humanists. The influence of this group, which was led by Charles W. Eliot, spanned the late 19th/very early 20th century. This group favoured the liberal arts and the transmission of traditional values and culture, and seemed most concerned with "mental discipline" and the "muscle of the mind" (Pinar et al, 1995:73) The second group, the Developmentalists, were influential from 1900-1920. G. Stanley Hall was one of the leaders of this group that strove for more of a child-centred curriculum. This group's philosophy revolved around the ideas that the content of curriculum could be determined from the study of child development (e.g. fitting the school to the child instead of fitting the child to the school), and that different

levels of curriculum should be available to students with varied abilities (slower vs. faster). According to Pinar (1995:89), Hall's rationale for "individualization" was a result of his support for the doctrine of laissez-faire, ultimately to "identify the gifted child" rather than to provide opportunities for the maximum development of each individual.

3.2.2.2 Theories of Social Efficacy and Social Reconstructionism

The third camp, also influential in the period from 1900 to 1920, was labelled the Social Efficiency group. The main visionary of this group was John Franklin Bobbitt; his ideas were published in an article entitled "The Elimination of Waste in Education". This group saw curriculum as a mechanism to prepare students for roles in newly industrialized society, and their ultimate goal was an education system that was working at 100% efficiency. This was a philosophy which many thought catered to the wealthy upper class and helped to maintain the social order of the day. The group was also noted for its cutting-edge influence in the push for curriculum tailored to train students for job specifications and social needs. Success in adult life was the most important goal of this theory.

The fourth camp, which was eventually predominant in the 1930s and beyond, was begun by George Counts and was known as the Social Reconstructionist group. Harold O. Rugg and later Theodore Brameld were also integral to this group of educational theorists. The fundamental thinking of the group was that curriculum provided social change by enlightening students towards justice and equality which, in turn, would help to remake society. Counts espoused the notion that "curriculum without a social perspective leads to intellectualism and self-absorption" (Pinar et al., 1995:127). His theories were famously summed up with the acerbic quote: "The genuinely free man is not a person who spends the day contemplating his own navel, but rather the one who loses himself in a great cause or glorious adventure" (Counts, 1932:23). It was this debate-laden backdrop which set the stage for the development of curriculum science.

3.2.3 Summary

In the early 1900s, academics and practitioners in the field of education attempted to come to an agreement on what curriculum should or should not address. Many questions were posed about the organization of subject matter, but the result was the recognition by all involved in the debate that the *most important focus* of school curriculum was to help learners "solve problems relevant to their own lives" (McNeil, 2006:305). This premise required that curriculum content be designed and executed in an inter-disciplinary fashion (correlation of

information) rather than the separate teaching of various independent subjects. This idea would serve as an important foundational premise for any curriculum intervention designed for the purposes of this research.

With this brief overview of the beginning formations of curriculum science, there was a preliminary examination of more in-depth details pertaining to three theories of curriculum, all of which were considered to be of value in developing an HIV/AIDS curriculum intervention for AOG/SA pastors and pastors-in-training. Those three theories are the humanistic curriculum theory, the social reconstructionist theory and the dialogue curriculum theory.

3.3 HUMANISTIC CURRICULUM AS IT APPLIES TO AOG/SA AND HIV/AIDS CURRICULUM

The humanistic approach to curriculum is considered to be a person-centred approach based on humanistic psychology, but with an emphasis on *conscious* mental process and emotional integration into the learning process rather than the *unconscious* affect addressed in Freudian theory. Learning and activities within the curriculum are innovative and geared towards self-renewal and autonomy of thought. Central to the humanistic curriculum is the belief that the learning must be *relevant* to the learner.

Some educational practitioners, and parents alike, have misunderstood the approach through the years, presuming it promotes easy subject matter and a lack of academic rigor and discipline. According to McNeil (2006:4), it could be said, on the contrary, that humanistic curriculum "offers an alternative to dull courses and depersonalization". Combs, Avila and Purkey (1971:101) address this misunderstanding concisely with the statement, "Humanism is not anti-intellectual, it seeks to make intelligence functional." For the purposes of this study, an HIV/AIDS curriculum for pastors should provide *functional intelligence* that is relevant for all participants. At its best, humanistic curriculum theory positively influences the classroom or learning environment by providing for the elements of relationship, interaction and relevancy, all of which might lead to increased motivation for learning and retention. Each of these elements involves positive emotion to one degree or another⁴⁸, which is thought to be valuable to the learning process. The element of positive emotion is considered to be important to an HIV/AIDS curriculum as many South Africans presently

⁴⁸ For example, the factor of *relationship* could promote positive feelings of love or belonging, while the factor of *relevancy* could lead to a feeling of satisfaction and self-esteem.

experience negative emotions with regard to this topic. Goleman (1995) espoused two ideas in reference to the separate works of Joseph LeDoux and Mihaly Csikszentmihalyi. The first, in reference to Csikszentmihalyi, was that the power of emotion can guide *effective* effort (Goleman, 1995:95). At the other end of the spectrum, in reference to LeDoux's work, Goleman (1995:26) notes that emotional distress (negative or disturbed emotion) creates deficits in a child's intellectual abilities which may ultimately cripple his or her *capacity* to learn. This point was considered to be important because of the environment (high crime, poverty, inequality and racism) in which many South Africans have resided or reside presently. The successful classroom cultivation of factors that induce positive emotions (such as relationship, interaction and relevancy) could ultimately lead to knowledge assimilation, one of the most coveted outcomes for educational practitioners. When teaching on a life and death topic such as HIV/AIDS the transference of information should be a teacher's *minimal* goal. Assimilation of information *and* experience should be *ultimate* goal.

Bell and Schniedewind (1987:56) emphasize the importance of involvement and participation in the learning process:

Humanistic education assumes people want to learn and can be trusted to pursue their own learning if it is what they perceive they need to know. In this view, learning is an active process that necessitates involvement and participation. Since learning, by definition, involves a change in perception that affects personal meaning, it is this, rather than an accumulation of facts, which teachers should emphasize.

It is clear from the literature that both cognitive and affective elements in learning are integrated in humanistic theory. Bell and Schniedewind (1987:56) further point out that "[l]ong lasting learning takes place when knowledge is *connected to the affective state* of the learner". With relation to an HIV/AIDS curriculum, cognitive knowledge about the disease is considered to be important as there appears to have been a general deficiency of information on the topic in previous classes at CTS. Additionally, the affective knowledge (emotions, feelings and attitudes) surrounding the disease appeared to be deficient as well. Students from previous classes at CTS knew little about the disease and said that the disease was not their problem or that the disease was not as widespread as the media were reporting. In general, denial of the disease's seriousness within previous class populations seemed to be prevalent. This attitude could be attributed to many things, but might foundationally be attributed to the shamed nature of the disease because of its sexual transmission. Because of the sexual connotations connected to the disease it is not discussed, or it is discussed in negative terms.

This could logically hinder a healthy assimilation of cognitive and affective information. With this in mind, humanistic curriculum theory could be of benefit in helping to educate pastors regarding HIV/AIDS because of its combination approach to integrating cognitive and affective knowledge.

3.3.1 The role of the teacher

Although the approach to learners and learning that takes place in the classroom is of importance in humanistic curriculum, it is also important to acknowledge the role of the teacher. He/she is important to the success and effectiveness of this approach to curriculum. Without mutual trust between the student and the teacher, motivation is likely to be deficient. McNeil (2006:5) notes three ways in which trust could be developed:

1. Listening comprehensively to the student's "reality";
2. Respecting and valuing the student and his/her ideas;
3. Ensuring transparency on the part of the teacher.

Transparency of the teacher, particularly on a difficult topic like HIV/AIDS, would be of great importance. In its absence students might not learn to gauge feelings in an emotionally honest and appropriate way. If teachers were deficient in this area this would be likely to influence their students. In addition, trust would need to be developed through familiarity and predictability. Mutual trust would be difficult to achieve without transparency, for it encourages open communication between student and teacher.

3.3.2 Content forms: Consciousness and confluence

In humanistic curriculum theory there are two prevalent content forms. The first is consciousness and the second is confluence. The form of consciousness is connected to transcendence and spirituality, and includes the students' search for meaning and purpose in the world around them. It was assumed in this research that most of the students, because of their profession of Christian faith and decision to train for ministry in a Pentecostal denomination, would already have begun internally processing spirituality and self-awareness upon entrance to the class. For that reason it was not viewed as a major need of the curriculum design, although aspects of the Christian faith and its teachings might need to be taught or reinforced as they relate to HIV/AIDS and/or sexuality.

The confluent form of curriculum theory integrates the cognitive domain (knowledge and ability) with the affective domain (attitude, values and emotions). The integration of the two

(cognitive and affective) allows for the integration of personal meaning in what the students learn, thereby enhancing relevance and ultimately assimilation. According to Shapiro (1987:159-161), confluent curriculum includes the following elements:

- Participation – consent, power sharing, negotiation and joint responsibility
- Integration – of thinking, feelings and action
- Relevance – close relation to the needs and lives of students; significance emotionally and intellectually
- Self – seeing self as a legitimate object of learning
- Goal – to develop the person as a whole within human society.

Each of the five elements was seen to be relative to the design of an HIV/AIDS curriculum for AOG/SA pastors.

3.3.2.1 *Third force psychology*

The confluent form of humanistic curriculum, which involves the integration of affective and cognitive elements, resulted from the influence of what is known as "third force psychology" (McNeil, 2006:13). Third force psychology received its name because it addressed the short-fall in behaviourism and Freudian psychologies. One of the predominant theorists in third force psychology was Abraham Maslow who believed in the encouragement of self-actualization through expression, experimentation and feedback (Maslow, 1979:13-27). Carl Rogers, also considered to be a major contributor to the thinking of third force psychology, saw teachers in the learning process as *facilitators* rather than *directors*. With regard to this study, it was noted that the confluent form and third force psychology were relevant to the design of an HIV/AIDS curriculum for AOG/SA pastors because an HIV/AIDS curriculum involved the component topics of sexuality and sexual choices. An attempt to *direct* the choices of participants in this sphere of their lives would most surely lead to resistance and failure, whereas an attempt to *facilitate* their choices (through the integration of a cognitive/affective approach to the topic) would probably result in greater success. According to McNeil (2006:8), "positive emotions [that] are associated with higher level processing such as reflection and problem solving" will ultimately lead to better choices on the part of those involved in the learning process. It was this high-level processing through reflection and problem solving which the researcher saw as the goal of HIV/AIDS education for pastors

and pastors-in-training within the AOG/SA fraternals if the training were to be effective and involve long-term positive effects within pastors, their churches and communities.

3.3.3 Critiques of humanistic curriculum theory

While reviewing the literature, note was taken of humanistic curriculum theory criticism. In essence, complaints/concerns were registered in three areas, as described by McNeil, (2006:19-20):

1. Methods and techniques are not evaluated in terms of consequences for learners. Highly charged emotional activities may have long-term effects and should be researched before widespread use.
2. On one end of the spectrum there were complaints that humanistic curriculum theory was not concerned enough about individual experiences. Within the theory there is a demand for conformity with little allowance for questioning (e.g. If one is expected to emote, then everyone will emote ... whether they like it or not.)
3. On the opposite end of the spectrum, humanistic curriculum theory was criticized for giving *too much* emphasis to individualism rather than the collective needs of the group (e.g. Everybody may emote and there are no boundaries to this experience ... one may do exactly as one pleases).

Although criticisms of the methodology were given consideration within this research, it was surmised that the first point of criticism was not likely to be a problem as an outgrowth of an HIV/AIDS class design for AOG/SA pastors because of their religious and faith experience and commitment to a helping profession. Pertaining to the context of the curriculum topic of HIV/AIDS, emotional activities were deemed to be appropriate and desirable within the context of the students' religious experience and calling. It was theorized that one of the major objectives of the curriculum would be to *re-sensitize* students emotionally to the seriousness of the pandemic, as many in previous classes appeared to have been desensitized by over-exposure to the disease through popular educational prevention programmes.

In relation to the second and third points of criticism, one would strive to maintain a balance between individualism and conformity. Within the context of Africa, it was assumed that it would be a greater challenge to dismantle a conformist mindset than to put limitations on an individualistic mindset. This was because of generally accepted views of the traditional

African community, similar to ubuntu.⁴⁹ The aim of this study was to find a *balance* between independent thinking regarding sexuality and what appears to be a conformist mindset, reflected in the statements, "Everybody is doing it" and "It is expected".

3.3.4 Summary

Elements of humanistic curriculum theory would be of clear benefit when teaching about HIV/AIDS to pastors and pastors-in-training within the AOG/SA because sexuality is at the core of human emotional experience, and HIV/AIDS is essentially a sexually transmitted disease. Sexual behaviour and attitudes are not likely to be governed or changed by a single cognitive knowledge component within the curriculum. There would need to be a complementary affective component to balance the cognitive component if the curriculum were to have any lasting influence or to change thinking and behaviour in the South African community context in terms of human sexuality.

In addition, a humanistic approach within the curriculum theory was thought to promote qualitative forms of inquiry and evaluation. This was considered to be important to a curriculum designed to teach about HIV/AIDS to pastors and pastors-in-training because of the general nature of the AIDS pandemic in South Africa. A good deal of quantitative research had already been done on the topic as was evident from projects presented on websites such as UNAIDS, The Kaiser Foundation and HRSC. Quantitative data on HIV/AIDS casualties and infections were in abundance, but many of the clues to the solution of the pandemic lay within the realm of *qualitative* research. Eisner (1978:198) explains this idea:

Qualitative methods tend to emphasize the importance of context in understanding, they tend to place great emphasis on the historical conditions within which events and situations occur, and they tend to argue that pieces cannot be understood aside from their relationship to the whole in which they participate. To understand an event or situation one must perceive it as an aspect of a larger pattern, rather than an entity whose characteristics can be isolated and reduced to quantities.

In summary, a humanistic approach to the topic of HIV/AIDS would have many positive facets (cognitive, affective, and individualistic); however, the developed curriculum would need to focus on more than just the individual since HIV/AIDS is also a community and social problem. The researcher recognized that the curriculum design required an additional sociological component to emphasize the real-life context of the disease and its influence on

⁴⁹ Ubuntu denotes the African concept that a person is a person through other people

South African society. This naturally led to incorporation of the next curriculum theory in this research, the social reconstructionist curriculum theory.

3.4 SOCIAL RECONSTRUCTIONIST CURRICULUM THEORY AS IT APPLIES TO AOG/SA AND HIV/AIDS CURRICULUM

The serious beginnings of curriculum science in the early 20th century witnessed many varied streams of thought, some complementary and some contradictory, but all seemed to shift and struggle for predominance in a rapidly changing world. Kliebard (1987:208) describes this changing process:

Curriculum fashions, it has long been noted, are subject to wide pendulum swings. While this metaphor conveys something of the shifting positions that are constantly occurring in the educational world, the phenomenon might best be seen as a stream with several currents, one stronger than others. None ever completely dries up. When the weather and other conditions are right, a weak or insignificant current assumes more force and prominence only to decline when conditions particularly conducive to its newfound strength no longer prevail.

Kliebard's statement partially explains the historical shift in curriculum emphasis from humanistic curriculum to social reconstructionist theory. Industrialization seemingly forced a change of mindset when it came to the purpose of curriculum, yet the influence of humanism lingered in the background. In the course of the study the researcher found two educational streams of thought on HIV/AIDS, each with a different current, and both changing rapidly as the disease intensified and spread. One stream was focused mainly on the individual and his/her sexuality. The other was communal in nature and focused on society. The changes in South African society had forced a change of thinking about education and curriculum pertaining to HIV/AIDS. The curriculum design needed to be relevant and had to address a host of issues as they pertained to both the individual *and* the impact of the disease on society. Therefore, the social reconstructionist theory of curriculum was examined for possible use in an HIV/AIDS curriculum for AOG/SA pastors.

3.4.1 Harold O. Rugg, George S. Counts and Theodore Brameld

The social reconstructionist theory proposes that curriculum should be designed to emphasize the social, political and economic development of society. In essence, this theory supports the idea that curriculum should effect social change. The embryonic phase of social

reconstructionism appeared in the late 1920s and blossomed in the 1930s under the influence of educators Harold O. Rugg, George S. Counts and Theodore Brameld.

Rugg (1886-1960), who was a social studies educator, theorized about economics, particularly about laissez-faire, the predominant economic philosophy of the day. He advocated the idea that "poverty could no longer be rationalized as an inevitable phenomenon" but could be understood as a "direct consequence" of social and economic arrangements that people had the power to change (Stanley, 1992:12). Counts (1889-1974) took this view in a more radical direction with the idea that "society was in a state of crisis" and this necessitated the creation of a new social order (Stanley, 1992:13). His bent towards socialism frightened educators of the day until his views later became tempered with allowances for "capitalism in some form" (Stanley, 1992:14).

Brameld (1904-1987), who was more than 15 years younger than Rugg and Counts, began his theorizing around 1935. His views did not come to the fore until after World War II when reconstructionism began to decline. Brameld was more revolutionary in his views than was Rugg and Counts, having been influenced by orthodox Marxism. He believed that violence was an acceptable "last resort" for change (Stanley, 1992:16-17). The primary goal of all three men was the eradication of poverty in a country that obviously had the industrial and technological means to do so (Stanley, 1992:19).

With regard to HIV/AIDS curriculum for AOG/SA pastors, the theories of these three social reconstructionist theorists were valuable as the researcher examined a large number of social factors connected to HIV/AIDS and its effect on South Africans.

3.4.2 John Dewey

John Dewey (1859-1952), a predecessor of Counts who greatly influenced Counts's ideas, was a leading authority in the field of education, particularly in curriculum development. His essay entitled "My Pedagogic Creed" was, and still is, considered a work of great importance, seminal work for subsequent curriculum theorists and educationalists. The essay, which was presented as five articles of declaration, made several points which contributed to the formulation of the social reconstructionist theory of curriculum. Four of the more salient points (Dewey, 1897:77-80) are highlighted as follows:

- [A]ll education proceeds by the participation of the individual in the social consciousness of the race (Article 1).

- [T]he school is primarily a social institution. Education being a social process, the school is simply that form of community life in which all those agencies are concentrated that will be most effective in bringing the child to share in the inherited resources of the race, and to use his own powers for social ends (Article 2).
- [M]uch of present education fails because it neglects this fundamental principle of the school as a form of community life (Article 2).
- [E]ducation is the fundamental method of social progress and reform (Article 5).

It is this notion of the strong bond between education and society (Dewey 1897) that makes the social reconstructionist theory and its parent philosophy one that could be applicable to an HIV/AIDS curriculum. Education is among those social institutions that are *negatively* impacted by AIDS, yet one might surmise that education (the institution and its curriculum) could and should *positively* contribute to the slowing down or cessation of the AIDS pandemic in South Africa.

3.4.3 Social reconstructionist theory applied in the South African context

Counts (1932) emphasized the importance of teachers and the power that they could exert in giving direction to society. His statements were made in the aftermath of Black Thursday and the crash of the USA stock market in 1929. Note the strong similarity to the condition in South Africa today in his description of society in the USA at that time:

Here is a society that manifests the most extra ordinary contradictions ... dire poverty walks hand in hand with the most extravagant living the world has ever known; an abundance of goods of all kinds is coupled with privation, misery, and even starvation; ... breakfastless children march to school past bankrupt shops ... strong men by the million walk the streets in futile search for employment and with the exhaustion of hope enter the ranks of the damned; ... racketeers and gangsters with the connivance of public officials fasten themselves on the channels of trade and exact a toll at the end of a machine gun (Flinders & Thornton, 1997:25-26).

However, Counts ended this grim scenario with the statement: "[T]he present situation is ... freighted with hope and promise. The age is pregnant with possibilities" (Flinders & Thornton, 1997:26). The church, with well-trained pastors serving as key educators and outreach coordinators in every community, could contribute towards providing hope and promise in the context of the HIV/AIDS pandemic in South Africa.

3.4.4 The role of the teacher

Throughout his writings, Counts encouraged teachers to "become a social force of some magnitude" and to impact "the social conscience" (Flinders & Thornton, 1997:24). He believed that by striving to influence attitudes, ideas and behaviour, teachers would make education a force for social regeneration that would work in tandem with the forces of social order (Flinders & Thornton, 1997:25). Counts's dissertation supervisor and colleague, Albion Small, urged educators to be "makers" of society and a "leverage for timely and radical social reform", and he emphasized that their true role was to help bring about a better society (Stanley, 1992:5). Church pastors are excellently suited to this role of community teacher, if motivated and trained properly. Stephen Lewis, UN Special Envoy for HIV/AIDS in Africa, in his address to church leaders in 2002, made a case for pastors to lead in this pandemic when he stated, "Who else, beyond yourselves, is so well-placed to lead? Who else has such a network of voices at the grass-roots level? Who else has access to all communities once a week, every week, across the continent?" (Lewis, 2002)

A social reconstructionist curriculum designed for AOG/SA pastors could be in line with Count's vision. Pastors have access to their congregation, as well as to entire communities, on a weekly or bi-weekly basis. If unified in their approach they could become a force of magnitude for educating and leading social change as it relates to the pandemic of HIV/AIDS.

In reviewing the literature it appeared that the primary purpose of the social reconstructionist curriculum was for the teacher to educate the learner about societal problems and then encourage involvement, solutions and ultimately change. Counts, Rugg and Brameld "shared a conviction that education can, and should be, employed to help solve social problems and reconstruct the socio-cultural order to create a more ideal society" (Stanley, 1992:6). This could be done through various means, as explained by McNeil, (2006:24-25):

- Making a critical survey of the community
- Gaining a view of how the situation or problem is impacting, locally and internationally
- Examining historical causes and trends
- Comprehending political practices that impact the situation
- Making proposals for change
- Considering how to meet the needs of the majority of the people.

3.4.5 Summary

In social reconstructionist theory there were various components to the role of teacher which included linking learning to student goals on a local and/or international level, stressing cooperation with the community, serving as a resource person, and incorporating class projects into the curriculum which demanded interdependence. In this regard McNeil (2006:25) makes the point that activities and dialogue should continually challenge student beliefs so as "to develop critical consciousness". Without the development of critical consciousness, learning would continue to maintain the dominant social order, leaving many at the mercy of or on the outside of the system. The main thrust of this type of curriculum was that schools address "ongoing social and economic problems by raising up a new generation critically attuned to the defects of the social system and prepared to do something about it" (Kliebard, 1987:187). Although some of the curriculum theorists promoted social revolution, it was Counts who surmised that the evils of society (e.g. oppression, injustice, inequality and poverty) could "be corrected not by revolution but by school programs that directed the new generation to [change] the fundamental values undergirding the capitalist economy" (Kliebard, 1987:195) In the end, the philosophy of individualism and the child-centred curriculum, although not discarded, was marginalized and the idea of collectivism predominated.

Collectivism within the context of the HIV/AIDS pandemic was a concept which was of great interest to this research because the pandemic was affecting South Africa in a collective way. A collectivist approach to the curriculum was desirable in the classroom, but a collectivist vision on the part of all three AOG/SA fraternalists as they work on the pandemic was desired *beyond* the classroom experience. Cooperation among the fraternalists would not happen immediately, but the approach to the curriculum would lay important groundwork in the lives of pastoral students as they began to see the possibilities of their individual and collective roles in the pandemic. The mentality of collectivism would be encouraged in this classroom through the deliberate curriculum design and bring about a homogenous team of pastors knowledgeable about HIV and its impact on society. It was determined that social reconstructionist theory contained valuable components to be incorporated into the new curriculum design.

3.5 DIALOGUE CURRICULUM THEORY AS IT APPLIES TO AOG/SA AND HIV/AIDS CURRICULUM

The third curriculum theory to be reviewed was a 21st century theory model of teaching and learning rather than a specific curriculum theory. However, when compared with the theories and methodologies of humanism and social reconstructionism, the dialogue curriculum theory appeared to complement the other two theories, as is shown in Table 3.1 below:

TABLE 3.1: COMPARISON OF CURRICULUM THEORIES/METHODOLOGIES

Curriculum theory and methodology	Humanistic curriculum theory	Social reconstructionist theory	Dialogue curriculum theory
Purpose	The development of the individual to fill his prescribed role in society	To encourage learners to take action towards a more just society	Conflict prevention and resolution; the development of the individual <i>within</i> society
Topics/subjects	Topics vary; approach to individual is most important	Topics vary; approach to society is most important; strong emphasis on social political and economic development of society	Topics vary; integrative approach to individual <i>and</i> society is the key
Teacher's role	Nurturing, emotional; resource and facilitator	Relates local, national and international goals to students' goals; stresses cooperation with community; challenges beliefs to develop critical awareness; a resource and catalyst	Facilitator and organizer; activity designer; encourages learners to find their voice and use power they were born with; a co-learner
Results	Experiences contributing to personal liberation and development; personal growth, integrity and autonomy	Student involvement, solutions; ultimately change in society for the good of all (eradication of poverty)	Learning which is pragmatic, focused, accountable. Action as a team; to build civil society which distinguishes domination from democracy

Because of the strong complementary function of the dialogue curriculum theory, and the uniqueness of the HIV/AIDS curriculum topic, its examination was pursued for this research. This theory was of interest not so much for its ability to transmit information, but because it transcended cultures, a component that was important to the proposed curriculum intervention.

3.5.1 Jane Vella and the beginnings of dialogue curriculum theory

Jane Vella created the dialogue theory model as an extension of themes which were found in Paulo Friere's work and presented it in her book *Training through Dialogue* (1995). Dr Vella, an American-born educator who began her educational career in Harlem (inner city New York), worked with community education in 40 countries throughout her life. Her community education theory was different from the formal academic theories of curriculum previously discussed in this dissertation, but it contained value and wisdom as it related to an HIV/AIDS curriculum for community pastors. The method of learning through this design was primarily viewed to be of value to the students; however, the proposed modelling of the method in the process of teaching would also enhance the students' experience and provide an exemplary teaching template for students' future use in communities throughout South Africa.

Vella (2002) explains her model as a "humanistic/integrated" approach, with emphasis on the word dialogue and its definition. *Dia* means "between" and *logos* means "word": hence, *dia* + *logos* = "the word between us" (Vella, 2002:3).

In referring to the ideas of Malcolm Knowles, Vella (2002:3) says that "adults [students] have enough life experience to be in dialogue with any teacher about any subject and will learn new knowledge, attitudes, or skills best in relation to that life experience". This is important in that many of the pastoral students have life experiences with HIV/AIDS that would be central to their motivation and learning.

3.5.2 The 12 interconnected principles: The roles of teacher and student

According to Vella (2002:4), the foundational principles of dialogue curriculum theory entailed 12 interconnected principles which were needed to engage in this type of learning experience:

1. Needs assessment (participation of the learner required in this)
2. Safe environment and process
3. Sound relationship between teacher and learner, as well as between learner and learner

4. Sequence of content and reinforcement
5. Praxis: action with reflection or learning by doing
6. Respect for learners as decision makers
7. Ideas, feelings and actions: cognitive, affective and psychomotor aspects of learning
8. Immediacy of the learning
9. Clear roles and role development
10. Teamwork and the use of small groups
11. Engagement of the learners in what they are doing
12. Accountability (How do they know they know?)

The idea of interconnectedness of each of the 12 principles in Vella's method was based upon a portion of Zohar's (n.d.) theory of quantum thinking. Quantum thinking (sometimes referred to as "systems thinking") tends to promote thinking that is insightful, creative and aimed at generating meaning and stressing relationships and connections between things.

Dialogue education is driven by six quantum concepts: relatedness, a holistic perspective, duality, uncertainty, participation and energy (Vella, 2002:30-31). By applying these six concepts to the 12 principles of Vella's theory the classroom experience is given cohesiveness and focus, since it ties the learners, the teacher and the learning process together through cognitive, affective and psychomotor experiences. For example, the concept of *relatedness* refers to the idea that each of the 12 principles is related to the others. A *holistic perspective* argues that the whole is far more than the sum of its parts. Learners will absorb more than is formally taught. The concept of *duality* invites questioning as well as diverse thinking and answers. *Uncertainty* leads the learners to apply constructed theories to new contexts. *Participation* refers to learners being a part of what they observe, taking into account varying perceptions of reality, context and culture. Lastly, learning (as well as teaching) demands *energy*, and dialogue education is designed to raise and sustain the positive energy of learners for enhanced assimilation and retention.⁵⁰

Each of the 12 main principles within the dialogue theory model was thought to be of importance for HIV/AIDS education in this research. In the following paragraphs, the

⁵⁰ Reference Bell and Schniedewind in Section 3.3

researcher briefly explores how these principles would work within the context of educating pastors about HIV/AIDS.

3.5.2.1 The first principle

The first principle is needs assessment. A needs assessment undertaken by a teacher, involving learner input, honours the context of the learner, which ultimately leads to respect and motivation. The first principle involves listening to or encouraging written responses from students and hearing what it is that the student regards as important within the context of the topic. According to Vella (2002:7), a needs assessment does not form or dictate the class: it simply "informs it". It was theorized that when adult learners are uninterested it was because of neglect or omission of themes that were important to them. Vella (2002:6) explains this by saying that "[m]otivation is magically enhanced ... when we teach them about their own themes. People are naturally excited to learn anything that helps them understand ... their own lives."

3.5.2.2 The second principle

The second principle is safety. Safety refers not only to physical safety, but also to mental and emotional safety within several areas: (a) the design of the learning task; (b) the experience and competence of the teacher; (c) the design of the small groups; and (d) safety in the design of the materials used (Vella, 2002:8-10). This does not mean that risk (a healthy component for growth) would be eliminated for the sake of the lesson, but only that the lesson should be designed with a balanced approach for challenge *and* safety. The power of safety is complemented when students find their voice, a process which is facilitated through small groups. The sequencing of events from easy to complex and the creation of a non-judgmental environment also enhance a feeling of safety on the part of the learner. This second principle was given importance in the design of the curriculum because HIV/AIDS was considered by many of the students to be risky or unsafe because of strong cultural and sexual components.

3.5.2.3 The third principle

The third principle of the dialogue curriculum theory is sound relationships. The relationship between the learner and teacher is surmised to be central to motivation and learning. Vella (2002:11) states, "In order to be sound, this relationship must transcend personal likes and dislikes and obvious differences in wealth and power." For the South African context, this

was a crucial point in the curriculum design. Powerful relationship was enhanced as trust was experienced across the racial and economic barriers.

3.5.2.4 The fourth principle

The fourth principle is sequence and reinforcement. Sequence in this context refers to programming activities from simple to complex, as well as from group-supported to individual efforts (Vella, 2002:12-13). Reinforcement would result from an appropriate sequence design, but could also be achieved through mutual accountability in the design of the curriculum. Because of the perceived social components that go with HIV/AIDS, it was thought that mutual accountability would function as an important part of the curriculum design within the South African context.

3.5.2.5 The fifth principle

Praxis, a word of Greek origin meaning action with reflection, is the core concept of the fifth principle. Vella (2002:14) refers to praxis as a "beautiful dance" between inductive (particular to general) and deductive (general to particular) forms of learning. Both can lead to reflection, action and application if learning tasks are designed properly. As this relates to HIV/AIDS, reflection was seen to be important. If one takes the disease through both processes of inductive and deductive thinking, it could motivate learners to see the bigger picture and apply the details to their lives in a deductive way (i.e., the AIDS pandemic is created as we risk infection through unsafe sexual behaviour). Inversely, the details could motivate one to become part of the bigger solution (through inductive reasoning).

3.5.2.6 The sixth principle

The sixth principle addresses respect for learners as decision makers. With regard to this principle, Vella (2002) distinguishes between the student as the object and the student as the subject and decision maker. The student as object denotes something physical or mental of which a student as subject is cognitively aware. The student as subject is an individual whose actions or responses are studied and valued (Vella, 2002:130). To enhance interest in the topic and motivation for creative learning, students would be invited to make critical analyses of topics covered through their consultative voice (a suggestion) or their deliberative voice (a decision) (Vella, 2002:16). Both voices are valued responses which lead to reflection and learning. Vella (2002:17) points out that "[i]nviting learners to be subjects of their own learning is indeed the practice of freedom".

3.5.2.7 The seventh principle

Ideas, feelings and actions are all part of the seventh principle. One cannot successfully teach only cognitive matter about a topic like HIV/AIDS. It was hypothesized that this type of teaching was what had de-sensitized many students to the AIDS pandemic, as was observed in casual conversations. Large amounts of content on a topic can lead to fear and/or disengagement on the part of learners (Vella, 2002:17-18). Teachers should always try to incorporate the three aspects of learning – ideas (cognitive), feelings (affective), and actions (psychomotor) - in the teaching/learning design. This type of design can disarm fear, increase safety, and encourage real change at all levels, which ultimately helps students reach their potential.

3.5.2.8 The eighth principle

The eighth principle is immediacy. This principle recognizes that "leaders need to see the immediate usefulness of new learning: the skills, the knowledge or attitudes they are working to acquire" (Vella, 2002:19). This would take deliberate planning on the part of the teacher but ultimately would affect the learner's determination to continue and succeed. Because many of the theological students participating in the research had loved ones living with the disease, a large percentage of the learning had immediacy and relevance. Assimilation and use were observed by the researcher to be almost immediate as students applied new ideas and concepts to a disease that had been limited to linear thinking.

3.5.2.9 The ninth principle

The ninth principle addresses the topic of clear roles. This includes the roles of the teacher, the learner and their communication. The application of this principle could be a delicate matter, particularly as it relates to gender, culture and academic rank. However, clear roles can lead to respect, sound relationships and safety. There should be open dialogue between teachers and learners and this is best accomplished through clear role delineation and understanding. Throughout this principle, the teacher is both decision maker and listener; and he or she must respect the learners' energy level, joining them in searching for meaningful learning within their own context (Vella, 2002:34).

3.5.2.10 The tenth principle

The tenth principle is teamwork. Teamwork is both a process and a principle (Vella, 2002:22). In essence, teamwork provides safety that promotes the sharing of responsibility. In a team, learning will be enhanced by peers (Vella, 2002:23). It is also interesting to note that

peers can hold significant authority over others in their group. They can provide the energy of competition and can ultimately provide safety for the learner who is struggling with concepts, attitudes and skills. This concept was at the core of the curriculum design for HIV/AIDS. It was noted that the quiet individual shame that had been so much a part of the pandemic was continuing to accelerate the growth of the problem. Only through teamwork could the quiet shame of the disease be addressed effectively. The classroom appeared to be an ideal location for the beginning of a team approach.

3.5.2.11 *The eleventh principle*

Engagement is the eleventh principle for dialogue curriculum education. Learning participation is the key to this principle. Vella (2002:25) makes a strong point about engagement when she says:

When we do not use dialogue and instead ask learners to be passive, they do indeed learn. They learn how to be passive, to be "good" ... they learn that they have no power, except to obey. That is not the goal of learning.

When learners are engaged, it means that they are not only engaged in the learning but also in a relationship. This relationship provides for safety, respect and even reinforcement. There was a critical need for *interconnectedness* with regard to HIV/AIDS. Pastors needed to know that they were not working in isolation, but that there were others who were confronting the problem and needed support in doing so. Engagement was central to the process and outcome.

3.5.2.12 *The twelfth principle*

The last principle is that of accountability. According to Vella (2002:25), "[a]ccountability is a synthesis principle – it is a result of all the other principles". Each of the 12 principles is accountable to another (e.g. "teacher" is accountable to "needs assessment", "relationship" is accountable to "safety", "praxis" is accountable to "sequence and reinforcement"). Accountability holds the process together and it was crucial for pastors as they were dealing in an environment where no one appeared to be accountable because of shamed silence and inactivity. Accountability emerges from a context in which learning is characterized by visibility of learning and action.

3.6 CONCLUSION

Each of the three curriculum models/theories reviewed for this study were examined for useful components which would be relevant and effective in training AOG/SA pastors about HIV/AIDS.

Humanistic curriculum theory was valued for its relevance to and usefulness in individual learners' lives. The integration of cognitive, affective and psychomotor components was seen to be a highly effective way to re-sensitize learners to the disease of HIV/AIDS and the lack of church involvement with regard to the pandemic.

The social reconstructionist theory was reviewed because it addressed social change as a result of curriculum content and focus. Another desirable component of this theory was the role of the teacher. The role of the pastor as a community teacher should be explored and encouraged within the context of the curriculum. The need for the church to become involved in a collective outreach for the betterment of the community and the country was evident. This curriculum theory model would be helpful in motivating learners towards that objective.

The third and last theory model, dialogue curriculum theory, was chosen not only for the way it enhanced the study and the understanding of community issues, but for the way it valued and facilitated the individual and his/her voice in the process. It was theorized that the valuing of an individual's voice could *ultimately* translate into the valuing of a culture, which would become an objective of this classroom experience. There was hope that the valuing of each person in the process would eventually translate into a cooperative church effort and focus on the issue of HIV/AIDS.

CHAPTER 4

METHODOLOGY AND RESEARCH PROCESS

4.1 INTRODUCTION

This chapter will include an overview of the intervention research model in addition to the research process leading to the completion of the Design and Development phase (D&D). Included in the steps of this phase are project analysis and planning (PAPP), information gathering and synthesis (IGS), design, early development and pilot testing (EDPT), evaluation and advanced development (EAD), and dissemination.

4.2 AN OVERVIEW OF THE COMPLETE INTERVENTION RESEARCH MODEL

The intervention research model provides an integrative perspective for human service research. It is an approach to research that provides effective results that are primarily practical. The model addresses three problems:

- How to search and make appropriate use of research findings and potential application;
- How research methods can be used to design and develop human service technology; and
- How research for practical use in human service differs from conventional behavioural and social science research. (Rothman & Thomas, 1994:3)

There are three main interrelated/independent phases in the intervention research design: knowledge development (KD), knowledge utilization (KU), and design and development (D&D). These will be defined in the following paragraphs. Although there are critical differences in their objectives and methodologies, these three phases have two things in common: (a) they are in the genre of applied research, and (b) they have a specific intervention mission (Rothman & Thomas, 1994:3-4). Generally, all three of the phases are designed for shedding light on or providing possible solutions to practical problems for personal and/or social nature. They are also effective in (a) defining how to produce change

in conditions affecting problems, (b) determining the appropriateness and/or effect of the intervention, and (c) determining how to develop new interventions with general applications.

As was noted earlier, there are three specific phases to intervention research and each has its primary function. The first of these phases is KD, which entails empirical research to extend the knowledge of human behaviour. It is primarily used to create findings that will apply to the understanding and/or solution of problems. This phase also provides fuel for the other phases and may or may not be linked to KU or D&D (Rothman & Thomas, 1994:3-4).

The second phase is known as KU. KU is a research means through which the findings of KD are linked and utilized in practical application. Its primary purpose is to convert knowledge from theory and empirical research to knowledge with the purpose of application (Rothman & Thomas, 1994:3, 6).

The last of the three phases is D&D. D&D is research directed towards developing innovative interventions. It seeks primarily to construct a systematic methodology for evolving human service interventions that will effect change and draws on professional experience (Rothman & Thomas, 1994:3, 6, 8).

This common focus on *intervention* brings these phases of research inquiry together under the heading of intervention research. The practical and social aspects of the results are why this model was chosen for this research project involving curriculum design and training of pastors and pastoral students in the area of HIV/AIDS. In particular, the D&D phase was emphasized in this research because it addressed the need to involve professional training and experience in effecting change.

4.3 INTRODUCTION TO THE METHODOLOGY

This research was based upon the methodology of intervention research (Rothman & Thomas, 1994) with emphasis on the D&D phase. The model consisted of six somewhat overlapping steps in the implementation of a study (refer to Appendix R). They were as follows (cf. Rothman & Thomas, 1994:9-10):

1. Problem analysis and project planning
2. Information gathering and synthesis
3. Design
4. Early development and pilot testing

5. Evaluation and advanced development
6. Dissemination.

Each phase of this methodology design had multiple components which will be discussed later in this chapter. For the purposes of this research, only the first five steps were used. Step 6, Dissemination, was not implemented as a part of this research. Because of the nature of the product, the large variances in the target client population, and the vast amount of territory that would have to be covered to reach all of the target client population, it was accepted that dissemination of the end product would not be feasible within the confines of the research period.

4.4 STEP 1: PROBLEM ANALYSIS AND PROJECT PLANNING (PAPP)

The first step of the research design was entitled problem analysis and project planning (PAPP). The different components of PAPP were five-fold and included:

1. Identifying and involving clients
2. Gaining entry and cooperation from settings
3. Identifying concerns of the population
4. Analysing the identified problem
5. Setting goals and objectives (cf. Rothman & Thomas, 1994:27-31).

4.4.1 Background for PAPP

The embryonic motivation for the research started in 1997 while the researcher was a lecturer on HIV/AIDS at the Cape Theological Seminary (CTS) in Cape Town, South Africa. CTS is the tertiary-level regional theological training seminary for the Assemblies of God.

A new pastoral ministries course entitled *Community Health: HIV/AIDS and Beyond* was initially offered during the first academic term of 2002. The course was offered six times over the next three years with the last offering during the second term of 2005. The course evolved continually and was changed in an attempt to (a) identify the most effective formula for delivery, (b) address rapidly changing information on the disease and the resulting pandemic, and (c) encourage church involvement with the results of the AIDS pandemic. A sample of the 2005 course syllabus and class schedule can be found in Appendix C.

A total of 82 students enrolled for the course during this three-year period. Some of the students who had graduated and entered ministry had informally communicated with the researcher, relating how valuable and relevant their training had been. Approximately 35 of those students became directly involved in ministry to AIDS victims or in AIDS education (primarily with local church youth groups) as a result of their training at CTS between 2002 and 2005.

Some of these former students also informally communicated the fact that, according to the observations in their community, the pandemic was increasing in size; many of those they worked with or ministered to were becoming infected. There was additional concern communicated regarding the silence of church leaders and pastors, and a lack of action on the part of pastors they worked under. These former students, in most cases, were viewed by their supervising pastors as junior ministry partners (e.g. associate pastors and youth pastors) and were allowed little input into the running of the churches they served. As a result of their subordinate status, they felt powerless to question the silence or lack of activity on the pastor's part. However, they encouraged the researcher to continue teaching the course because of the growth of the pandemic and the increasing relevance of the course's content to the South African context.

4.4.2 Client base divided

One of the fundamental problems in this phase was that the client base for an envisioned intervention was divided. It was relatively easy to convince ministerial students of the need within the context of their ministry training. Many had come from school environments and communities where they had seen and felt the impact of AIDS. In contrast, getting church leaders and pastors interested and involved in the problem, particularly as it related to training, was a much greater challenge. While pastors were seeing evidence of AIDS within the context of their congregations and communities, they seemed to be modelling denial and a lack of response to the pandemic. Whether this was a result of a lack of knowledge or an intentional decision could not be determined without further investigation.

Government had placed the problem of AIDS under its provincial health departments. This action may have sent a message to church leaders that church help was not needed, in spite of the fact that many in the public sector were viewing AIDS not only as a health problem but a social problem as well; HIV/AIDS as a social problem was something the church should have been well equipped to deal with (Nassaratt, 2004:43).

4.4.3 Student analysis of the problem

Rothman and Thomas (1994:29) argue that intervention researchers must avoid imposing external views of the problem or its solution. Without ignoring this warning, the researcher proceeded to move forward carefully on planning an intervention primarily because the need appeared so great. In no way was there an attempt to impose particular views upon the clientele; the training only attempted to direct students' attention to the matter in the hope that knowledge of HIV/AIDS would motivate clientele involvement. Convincing half of the clientele (pastors and fraternal leaders) that a problem existed or exploring a possible solution with them was seemingly not an available option. The other half of the clientele (students training for ministry) generally seemed to be convinced of the problem and the need for training; some were already expressing concern about the lack of action on the part of the church. Thus, church leaders were not requesting any type of help or even indicating a desire to dialogue with CTS on the matter, but students were.

As a result the researcher proceeded to interview students informally, who were regarded as key informants, about what they had experienced in their home churches and how they were feeling about the situation (Rothman & Thomas, 1994:30). Their reports were fairly consistent across the various AOG/SA fraternals:

- Church fraternal leaders were silent on the AIDS issue. They did not appear to be visioning a solution or coordinating any AIDS-related ministry activity or training for pastors at the local level.
- Pastors were silent on the AIDS issue. There was no talk about the disease publicly and pastors did not preach sermons on the moral issues that might surround the topic of HIV/AIDS, despite the fact that many in their communities were infected. The researcher noted one exception: The Group pastors were somewhat suspicious of the pandemic because they, for the most part, were not seeing AIDS manifested in their communities. In spite of this, stigmatization of AIDS victims was seemingly being allowed to continue within many of the churches. It appeared from students' perspectives that few churches had any type of ministry or outreach for those infected and affected by AIDS. Such ministries may have ultimately been perceived as a possible drain on church resources; this might have led pastors to ignore the situation as long as possible.

- There seemed to be a general lack of basic knowledge and concern among pastors and leaders on the disease and how it was impacting the church, as well as the many facets of community and society at large.

4.4.3.1 Divided fraternal

To compound the problem of uninvolved pastors, the three AOG/SA fraternal were still divided and largely self-defined by culture. At this point there did not appear to be any discussion between them regarding the need for a cooperative effort or strategic planning to address the issue. It was hypothesized that this lack of cooperation was possibly rooted in large cultural variances across the fraternal. These differences might have led to distinctly different approaches to, and perspectives of, sexuality, sickness, medical treatment, death, and gender issues.

Motivating the three fraternal to address this issue in a united effort would take a great deal of dialogue and time. Ultimately, the researcher was not in a position of authority to lead this kind of process. However, the researcher did have direct access to students who were entering the ministry so the decision was made to focus on this half of the clientele and target population. It was thought that if students were re-sensitized to and educated about the pandemic, the current silence of the churches would be replaced by a desire for dialogue and cooperation as younger pastors take over senior positions in each fraternal. This will remain a long-term goal for the researcher. In the short term, local community churches will have someone on the staff to understand and address the disease and its fallout when the need is officially acknowledged.

4.4.4 Goals and objectives

The last component of PAPP was to set goals and objectives for the possible intervention as determined by the researcher. The four goals and six objectives are set out below:

GOALS

- To raise awareness amongst pastors and pastors-in-training of the HIV/AIDS pandemic in South Africa and the possible role of the church in responding to it;
- To conduct face-to-face semi-structured interviews with the three fraternal leaders, in addition to a sampling of five pastors from each fraternal, to determine points of agreement and difference regarding issues that surrounded the pandemic. Areas that would be of particular interest to the researcher were their disparate views on sexuality,

sickness, death, healthcare and general gender issues (particularly as the latter related to women in church leadership positions);

- To design a flexible-delivery tertiary-level course for AOG/SA ministerial students that would prepare them for an AIDS-sensitive ministry within the context of South Africa's AIDS pandemic; and
- To determine the general effectiveness of the course in more than one cultural context.

OBJECTIVES

- Within the time frame of the course, students will begin to examine a possible role in response to the pandemic as future church leaders, citizens or individuals;
- Within the time frame of the course, students will express openly and honestly their feelings about the pandemic in South Africa;
- Within the time frame of the course, students will show a significant increase in functional knowledge of the disease of HIV/AIDS;
- Within the time frame of the course, students will become more knowledgeable and compassionate in their reflections on victims (both male and female) of the disease of HIV/AIDS;
- Within the time frame of the course, students will begin to envision specific ways in which the local church could assist the community that is struggling to cope with HIV/AIDS; and
- By June 2009, the researcher will complete a research-based, up-to-date and relevant HIV/AIDS course for ministerial students which will assist them as they enter the ministry within the context of South Africa's AIDS pandemic.

Having determined these goals and objectives, the researcher moved on to the second phase of the research model, which was information gathering and synthesis.

4.5 STEP 2: INFORMATION GATHERING AND SYNTHESIS

Rothman and Thomas (1994:31-33) call the second step of D&D information gathering and synthesis (IGS). There were three possible steps in this part: (a) to use existing information sources, (b) to study natural examples, and (c) to identify functional elements of successful models (Rothman & Thomas, 1994:31-33).

4.5.1 Existing sources

The first of the three steps was accomplished within the literature review. Within that context, there was an examination of (a) educational differences and (b) the history of the AOG/SA church and the beginnings of its three culturally exclusive fraternal. Students within the research population came from varied educational backgrounds as a result of apartheid. Their cultural separation appeared to be maintained as a result of the continued cultural separation of the fraternal.

4.5.2 Studying natural examples

The examination of basic cultural differences within the context of South Africa posed a problem. There was no literature available on the cultural variations within the AOG/SA fraternal pertaining to the topic of the study. To carry out this step of the research model, interviews were designed for each of the fraternal leaders (The Group, The Association and The Movement), and five pastors were selected from each fraternal through a convenience sampling procedure. Inclusion of this latter group was designed to broaden the information base (Leedy & Ormrod, 2001:218-219). One objective of the fraternal interviews was the substantiation of the views of each leader. This whole interview process was part of the component called "studying natural examples" as specified in Rothman and Thomas (1994:32).

4.5.2.1 Interview process: fraternal leaders

Face-to-face interviews with each of the leaders of the three fraternal were requested by means of an introductory letter (Appendix M). This letter proposed a date, time and place for the interview, and gave a general description of the purpose of the interview. Also enclosed with this introductory letter was a signed letter from the researcher's promoter validating the research project (Appendix M). The researcher offered to conduct the interview in a location that was most convenient for the interviewee even if this necessitated travel to the Johannesburg or Durban area⁵¹. This placed interviews on the interviewee's home 'turf' which allowed for a relaxed environment within the context of the person's job environment, enhancing possible camaraderie and personal rapport (Bernard, 1995:211-213).

Once the researcher had been contacted by an interviewee and a confirmation of the date, time and place had been made, a second follow-up letter was mailed (or faxed) to confirm the

⁵¹ Headquarter cities for the leaders were as follows: Cape Town – The Group; Durban – The Association; Henley-on-Klip – The Movement.

meeting in writing (Appendix N). This letter included a copy of the questions (Appendix B) and an Informed Consent Form (Appendix Q). Within the text of the Informed Consent Form, the researcher clearly requested permission to tape record the interview for data-gathering purposes.

Interviews were semi-structured in nature so as to allow for clarification or probing within the interview (Leedy & Ormrod, 2001:196). Semi-structured interviews were surmised to be more flexible in light of the broad range of topics that would be addressed with the interviewees.

Because previous models pertaining to the AOG/SA and HIV/AIDS education and involvement practices were unavailable for examination, the researcher was unable to address step three of this part of the research: identifying functional elements of successful models. As far as the researcher was able to ascertain, at that time CTS was the only university-level theological schools in South Africa that offered an HIV/AIDS course as part of its theological training curriculum.

Since no models were available to be examined, the researcher became convinced that obtaining information from the three fraternal leaders would provide a starting point for dialogue about the problem. This methodology would give the researcher insight into variances between each of the fraternal (and their dominant culture); this information could be incorporated into the training materials for ministerial students.

The interviews of the fraternal leaders took place in Henley-on-Klip near Johannesburg as well as in Cape Town. The Movement leader fell gravely ill a week before the interview and requested to send his general secretary in his place. The researcher agreed to this request. For that particular interview the researcher travelled to Henley-on-Klip to accommodate the General Secretary. The Group leader was interviewed at his headquarters office in Cape Town. The Association leader, a resident of Durban, opted to have his interview at CTS because he was in Cape Town at the time.

These semi-structured interviews were conducted in private and varied in duration from 60 to 90 minutes. Coffee and tea were served at each interview and the researcher reviewed the Informed Consent Form with the interviewee to ensure the interviewee had no unanswered questions or concerns. The interviews were audio taped. Because the topics addressed were of a sensitive nature, those being interviewed were told that if they wanted to say something "off the record", they were free to request that the audio recorder be turned off momentarily.

It was understood that "off the record" statements would not be a part of the recorded interview and were only for the information of the researcher. None of the three leaders requested this "off the record" option during their interview time.

Probing of some answers did take place during the interview time to gain elaboration of detail, further explanations and clarification of responses (Macmillan & Schumacher, 2001:448). However, these probes were minimal, as time was limited and topics were broad.

Tapes were transcribed after all of the interviews were conducted. Summarized responses are found in Appendix A. Words within quotations indicate terms or phrases that were particularly noteworthy. The researcher followed up each interview with a note of thanks for the interviewee's time and participation.

4.5.2.2 Interview process: Fraternal members

The researcher then secured interviews with five pastors from each fraternal through a non-randomized convenience sampling (Leedy & Ormrod, 2001:218). Because all three fraternals were represented in Cape Town, the majority of the interviews took place there. Several of the pastors interviewed were originally from other parts of South Africa and were not native to the Western Cape. They were only under employment in the area.

Each of the 15 pastors interviewed was over 25 years of age and the pastor of a church. The size and location of the church (rural or urban) was not relevant to this study; however, inclusion in the sampling required that the pastor be credentialed and his church affiliated with the AOG/SA. The researcher phoned targeted pastors to determine their willingness to participate in the interview process. Phone numbers were secured from an official church minister's directory. The researcher was acquainted with at least 50% of those interviewed; these acquaintances had been made through previous church meetings or fraternal functions.

The research project was explained to each targeted pastor by telephone. If the pastor was willing to participate, a date, time and place for the interview were agreed upon. A follow-up letter, similar to the one mailed to the fraternal leaders, was then mailed to the cooperating pastor, along with a letter from the researcher's promoter introducing the research project (Appendix O) and an Informed Consent Form (Appendix Q). Also included in the mailing was a list of the questions that would be asked during the interview (Appendix B).

The researcher attempted to accommodate the pastors' busy schedules when conducting the interviews. In most cases, the researcher travelled to an office or church to conduct the

interviews. In one case, the researcher flew to Johannesburg to accommodate the interviewee's schedule.

Semi-structured interviews were conducted in private and varied in duration from 60 to 90 minutes. Following the same procedures used with the leaders, the researcher first reviewed the Informed Consent Form with each interviewee to ensure the interviewee had no unanswered questions or concerns. Interviews were audio taped. Interview procedures were identical to those of the leaders and "off the record" requests were honoured. Only two of the pastors requested an "off the record" comment during their interview, and both comments were very brief. It was understood that comments "off the record" would not be used as part of the recorded interview; they were only for the researcher's information.

Probing of some answers did take place during the interview time to gain elaboration of detail, further explanations and clarification of responses (cf. Macmillan & Schumacher, 2001:448). However, these probes were minimal, as time was limited and topics were broad. Upon completion of the interview, each pastor was verbally thanked and given a box of chocolates as a small token of appreciation.

Audio tapes were transcribed after all interviews were conducted. Summarized responses are found in Appendix A. Terms or phrases that were particularly noteworthy were placed within quotations to indicate their importance.

The results of these 18 face-to-face semi-structured interviews (3 leaders and 15 pastors) were summarized for integration into the prototype curriculum content that would later be used for the envisioned curriculum intervention.

4.5.2.3 Identifying functional elements of successful models

Although there were no successful curriculum models relating directly to the AOG/SA, the researcher reviewed and evaluated three curriculum theories which held promise for enhancing the focus and delivery of the future curriculum intervention. The three theories examined for applicability were:

1. Humanistic curriculum theory (HCT)
2. Social reconstructionist curriculum theory (SRCT)
3. Dialogue curriculum theory (DCT).

Components of each were closely reviewed (refer to Chapter 3). The objective of this review was identification of curricular elements that would enable the researcher to design a relevant

and effective HIV/AIDS curriculum intervention. This intervention would serve to train AOG/SA pastors and pastors-in-training within the context of South Africa.

4.5.2.3.1 Humanistic curriculum theory

HCT, as reviewed in Chapter 3, contained numerous positive aspects that would allow for individualism and, at the same time, ultimately promote community, something of importance to the topic of HIV/AIDS. Of special interest was the HCT belief that learning should be relevant to the learner, making intelligence functional. In addition, classroom activities encouraging trust, transparency and positive emotion were ultimately associated with higher level processing such as reflection and problem solving (McNeil, 2006:8).

4.5.2.3.2 Social reconstructionist curriculum theory

The SRCT model was reviewed for its societal focus. HIV/AIDS is considered to be a sexual disease, but many of its facets are socially rooted and in need of close examination and acknowledgement by those receiving the intervention. Without the identification of core contributories, the problem would only be addressed superficially.

In addition to SRCT's primary emphasis on social, political and economic development, special note was taken of the contribution of the teacher as role model, resource and catalyst. Social change can be encouraged after (a) the examination of historical causes and trends, (b) reflection on political practices which might be impacting the problem, and (c) consideration of the effects, which range from local to international. All were important factors to AOG/SA pastors pertaining to the AIDS pandemic within the South African context.

4.5.2.3.3 Dialogue curriculum theory

The third curriculum design to be examined was DCT. DCT is essentially a learning theory that has been derived from SRCT in acknowledgement of the writings and philosophy of Paulo Freire. DCT was included in these reviews because it strongly complemented the other two curriculum theories examined in this study (refer to Table 3.1). Of primary importance was the fact that DCT provides for student ownership and accountability of the problem being addressed. It attempts to transcend culture through its dynamic dialogue approach to a topic, which was believed to be an important component for any curriculum in post-apartheid South Africa. Thirdly, the methods emerging out of DCT are extremely practical: its 12 basic principles include aspects such as needs assessment, relationship, praxis, respect, immediacy and teamwork. Lastly, the role of the teacher as co-learner, facilitator and activity designer in

a DCT-based curriculum would provide a role model for students' and pastors' work in their own community.

4.6 STEP 3: DESIGN

The third step of Rothman and Thomas's (1994) intervention research model is design. The authors note that the third and fourth phases of the intervention research model (design and early development/pilot testing) are interrelated (Rothman & Thomas, 1994:33). During the design step the emphasis falls on two aspects: (a) the observational system (i.e., measurement instruments) and (b) the procedural elements of the intervention (i.e., curriculum design and implementation). Of key importance to this phase of the study was the development of the working parts of the observational system. To determine the focus of observational measurements, desired behaviours had to be defined. The researcher had assessed six classes during 2002 through 2005. As a result of teaching the same topic in six classroom settings, it was concluded that two prime areas would need to be measured and compared through pre- and post-testing. These areas were (a) basic functional knowledge of HIV/AIDS and (b) attitude to and empathy for those with AIDS. Measurements and comparisons in these areas would provide quantitative data relating to the desired change in knowledge. In addition, qualitative data would be obtained through personal journaling on classroom topics and experiences.

4.6.1 Observation element: Measurement design

With these goals in mind, the researcher designed three instruments for pre- and post-testing:

1. Scale of HIV/AIDS knowledge (SHAK) (Appendix G)
2. Personal reflections on disease of HIV/AIDS – Men (PRM) (Appendix H)
3. Personal reflections on disease of HIV/AIDS – Women (PRW) (Appendix I).

SHAK was designed with 30 matrix questions, all directed at measuring functional knowledge of HIV/AIDS. The term "functional knowledge" was defined as knowledge pertaining to HIV/AIDS that might be used by a person on a daily basis in his/her own life or in the life of a family member. The SHAK instrument was based on a 5-point Likert-scale with responses categorized as "strongly disagree", "disagree", "not sure", "agree", and "strongly agree". According to McMillan and Schumacher (2001:261), such scales are used commonly in questionnaires because "they allow fairly accurate assessments" of knowledge or beliefs. In addition to the Likert-scale design of SHAK, basic demographic information

was also requested of students (e.g. regarding gender, culture and race); however, the instrument remained anonymous in its orientation and students were requested not to place their names on the forms. Demographic information would be used to measure and compare differences within culture, in line with the three AOG/SA fraternal divisions. Pre- and post-test scores were collated through randomly assigned student numbers.

The second and third instruments (PRM and PRW) were designed to contain identical questions but requested participant reflection according to gender (i.e., men with HIV/AIDS; women with HIV/AIDS). The rationale supporting the use of these instruments was a theme noted in the literature review. Women comprise the group with the highest number of HIV infections and yet some cultural views and theological teachings may have left women unable to make safe sexual choices (see Section 2.6.8). Measuring different views on the disease of HIV/AIDS according to gender was thought to be of value to this research. Questions were based upon a 7-point semantic differential scale. A 7-point scale was utilized to allow for "neutrality ... [so that there would be] enough gradation to give meaningful data, yet not be too tedious" (Al-Hindawe, 1996).

All three instruments (SHAK, PRM and PRW) were constructed with matrix questions. The advantages to matrix questions are the efficient use of space, shortened completion time, and an increase in comparability for the researcher and respondent (Babbie, 1990:140). One of the dangers of a matrix design is that it can foster a response set, which is defined as "a pattern of agreeing with all of the statements" (Babbie, 1990:140). Response sets can be reduced by altering statements representing different orientations, a common research practice known as reverse scoring (Babbie, 1990:140). For this research reverse scoring was used in all three instruments (SHAK, PRM and PRW). On the SHAK, reverse scoring was used on questions 1, 2, 3, 6, 8, 12, 15, 18, 19, 20, 21, 23, 26, 27 and 29. On the PRM and PRW, reverse scoring was used on questions 2, 4, 6, 7, 9 and 12.

All participants were requested to complete the SHAK at pre- and post-test; however, the PRM and PRW tests were administered in a split-group design to avoid testing as a threat to internal validity (Campbell & Stanley, 1963:5, 9, 53).

In addition to the semantic differential design of PRM and PRW, basic demographic information was also requested of students (e.g. gender, culture and race). The instrument designed to gather demographic information remained anonymous in its orientation and

students were requested not to place their names on the form. Pre- and post-test scores were collated through randomly assigned student numbers.

Each questionnaire was submitted to a panel of three academics for evaluation and critique prior to administering it in the classroom. Two were doctoral-level academics and the third was a master's-level academic that was solicited for her expertise regarding South African culture and language.

To complement the quantitative data, a qualitative response was also built into the research design. This would provide triangulation of the data. As Mathison (1988:15) notes: "The value of triangulation is not as a technological solution to a data collection and analysis problem, it is as a technique which provides more and better evidence from which researchers can *construct meaningful propositions* about the social world."

For this part of the observation design, the researcher required semi-structured journal entries in conjunction with class activities. Student writings were requested in response to each day's classroom activities. Of particular interest were students' affective responses to the activities. These journal entries are contained in Appendix D under "Class Schedule" and are noted in bold underlined caps throughout that document. Journal responses were designed to elicit a reflective (affective/feeling) response, in writing, on classroom instruction. A secondary motive of this exercise, on the part of the researcher, was the subtle reinforcement or rethinking of the day's lesson in the mind of the student. Journals were graded only for participation/submission and not content. Students were given the choice of identifying journals through a randomly assigned number or their name. Regardless of the chosen method of identification, students were assured that journals would remain anonymous and be destroyed upon completion of the research.

With measurement instruments designed, the researcher moved on to the next component of the design phase which entailed the procedural elements of the intervention.

4.6.2 Procedural element: Curriculum intervention design

A prototype for the curriculum intervention was designed in reference to six previous classes which the researcher taught from 2002-2005. The initial offering of the class had taken place in 2002 and included a very broad topic base. There was consistency in the fact that the course was always offered over a 15-week schedule utilizing three 50-minute sessions per week; however, each time the course was offered, the content was revised and adjusted according to perceived needs and updated information on the disease and pandemic. The

2005 course offering (Appendix C) included an emphasis on trench gardening⁵². Other topics in the 2005 course included basic human anatomy, stigma, prevention, changing unsafe behaviour, condoms/condom safety, abstinence training, STDs, TB, sexual abuse, rape, abortion, HIV testing, home-based care, and legal rights of AIDS victims. In addition, students were assigned written reviews of materials designed and used by the Assemblies of God USA for AIDS education in Africa.

According to informal conversations with previous students, the course had been successful in educating them on an academic level about the disease. However, in addition to training ministerial students, the researcher ultimately envisioned training AOG/SA pastors outside of CTS. In light of a desire to appeal to this secondary client group, it was believed that the gardening component would not be practical. The academic approach to the topic needed to be adjusted to include a more affective approach/response for student/pastor relevance and interest. With these thoughts in mind, the researcher redesigned the 2005 course by deleting the gardening component and some non-essential topics, and adding several topics or components that were supportive of the three curriculum designs reviewed for use. Each revision, together with the curriculum design it centred on, is listed in Table 4.1 below:

⁵² A trench garden is a type of organic garden designed to be planted in very limited space (1 metre by 2 metres). It can yield enough nutrition to adequately supplement the diet of an AIDS patient and their immediate family (e.g., four people) at a cost of R100 per year (R10=\$1).

TABLE 4.1: CURRICULUM REVISIONS LINKED TO CURRICULUM DESIGN

Class design addition/revision	Curriculum design modelled*
Individual learning needs assessment (LNA) (Appendix F)	DCT HCT
Group analysis of the problem, Parts 1 and 2 (Appendix P)	DCT SRCT
A stronger emphasis on male/female reproductive systems (as opposed to general anatomy)	HCT
The addition of media components portraying relevant events pertaining to AIDS, particularly in South Africa	HCT SRCT
A broader view of the legal and ethical aspects of HIV/AIDS	SRCT HCT
A societal component addressing the church's role in the community and society as it related to the disease of HIV/AIDS	SRCT
Cultural views gleaned from the interviews of the three fraternals, in hopes that they would encourage dialogue and enlighten students from all three fraternals	DCT

*DCT=Dialogue curriculum theory; HCT=Humanistic curriculum theory; SRCT=Social reconstructionist curriculum theory

In accordance with the DCT, the number of class lectures was reduced and interactive classroom discussion was increased. A journal component was added for individual feedback on classroom discussions and activities.

The pilot test conducted during August-November 2007 maintained a 15-week schedule with classes meeting three times per week for 50 minutes each session. For the convenience of the researcher, the course was held at CTS.

With the operations and procedural design formulated, the researcher initiated the next phase of the intervention research model: early development and pilot testing (EDPT).

4.7 STEP 4: EARLY DEVELOPMENT AND PILOT TESTING

Much of the early development of the curriculum intervention had taken place in conjunction with the design step. Curriculum content, which had been used in previous classes (2002-2005), was evaluated and revised for use in the pilot test.

4.7.1 Delivery site and class size determined

The next step was to determine a mode of delivery and the delivery site. The pilot test would, of necessity, take place at CTS during the second school term (August through November 2007). CTS was the main campus for theological training in the AOG/SA, and it was where the majority of the ministerial training students were enrolled. Class enrolment was not controlled by the researcher and was random with reference to size and cultural orientation.

Because CTS was a fully multicultural tertiary-level seminary, the researcher had hoped for a class with a minimum of 10 students representing all three fraternal cultures in the AOG/SA. Only four students enrolled for the class, even though the researcher had been assured by the Registrar's office approximately eight weeks before the course began that the class would probably be fully multicultural (e.g. contain representatives from all 3 AOG/SA fraternals) and have 10-15 students. The small enrolment was beyond the control of the researcher; enrolment in the class was strongly encouraged by the administration, but was not required. All classes during the 2002 to 2005 period had ranged in size from 10 to 20 students. The small enrolment in the pilot class seemed to be an exception to this norm and may be attributable to low student intake for that term.

For the class that finally developed, all enrolled students were male. Three were South Africans of colour and one was a Namibian citizen of colour. Classes were held for 50 minutes on Mondays, Wednesdays and Thursdays. An obvious limitation of the pilot group was its size. It was hoped that within the course structure, small groups would be used for discussion according to DCT; however, this class of four students constituted a "small group" and the researcher proceeded on those grounds.

4.7.2 Learning needs assessment

The researcher received the class roster two weeks prior to the beginning of class from the CTS Registrar's Office. Upon receiving the names of students, the researcher placed an Individual LNA form (Appendix F) in their campus mailbox. This form was designed in accordance with DCT. This form provided individual feedback regarding what students felt were the most pressing needs in their education pertaining to HIV/AIDS. The researcher requested that the forms be submitted to her *before* the first class session.

An informal assessment of the returned forms indicated that the students were not homogeneous in their assessment of personal needs and desires pertaining to HIV/AIDS information. Some indicated that this education was needed for their own personal growth;

others approached personal needs and desires from a perspective of job training, expressing a desire to equip themselves for future ministry.

As an interesting side note, one of the students in the pilot group had been diagnosed as HIV+ less than 30 days prior to enrolling in the class and was immediately placed on antiretrovirals. This explained his desire for personal education as opposed to a desire for job training. The researcher was initially unaware of this medical diagnosis; she was not informed by the student until after the first week of class. This student then chose to keep the diagnosis confidential until he felt comfortable to tell the class personally. However, it was like a living laboratory to watch this student present with multiple symptoms and side effects from medication as the class progressed. Even though the enrolment was very small, two of the students never took note of their classmate's condition. As the class progressed, one student began to suspect that his classmate was HIV+ and eventually approached the teacher about the matter. Because of her commitment to confidentiality, the teacher was unable to respond. She did encourage the inquiring student to talk to his friend about the matter.

4.7.3 Presentation of measurement instruments

On the first day of the pilot test class, the researcher distributed the Informed Consent Form (Appendix Q), gave a brief explanation of the research, and requested the students' signatures. Before providing any other direction, the researcher asked each student to complete all three measurement instruments (SHAK, PRM and PRW). Instruments were submitted to the students in the following order:

1. PRM (Appendix H)
2. PRW (Appendix I)
3. SHAK (Appendix G)

This order of presentation was used to avoid the stimulation of thinking about the disease or the pandemic that could be stimulated by the content of SHAK. The PRM and PRW forms were considered to be the least demanding to answer since they were gender specific and required no prior learning. By administering the PRM and PRW first, it was hoped that students would be prompted to answer from an affective base before they progressed to a larger, more specific instrument (SHAK). It was feared that administering SHAK first might trigger analytical thinking about the disease and pandemic according to gender. After the measurement instruments were completed, the remainder of the initial class time was used for questions regarding the syllabus and class schedule, in addition to personal introductions of

the students and teacher. In accordance with DCT, each person was asked to share some information about themselves, what their future plans were, and what they expected to receive from the course.

After the first day of class, the researcher proceeded to follow the class syllabus and class schedule (see Appendix D). The majority of the topics contained in the LNA list were included within the curriculum design. The LNA responses from the pilot test class had not indicated that any particular emphasis should be added or subtracted from the proposed schedule.

4.7.4 Class analysis of the problem

During the second day of class, the researcher introduced the form, Analysis of the Problem (AP) (see Appendix P). The AP was an exercise in line with DCT. It was suggested that this analysis activity was a good way for the teacher to ascertain cultural perspectives and beliefs that might impact the students' study of the problem. It also provided a sense of ownership for those attending the class in that it allowed students to participate in analysing the problem according to their grid of knowledge and cultural perspective. This was an engaging exercise that generated diverse and robust dialogue, and everyone participated actively.

The second benefit of the AP exercise was that it sequentially led students to think about the full impact of the disease, from an individual perspective to its national impact. It was done with particular emphasis on the church's view of the disease because this would be important for those entering the ministry. Surprisingly, this exercise required two full days to allow ample time for discussion and feedback. This change (two days) was noted for future development and revision of the course.

4.7.5 Goals in accordance with curriculum theories

Throughout the semester, several curriculum goals were utilized in conjunction with the curriculum theories employed. Those features are summarized as follows:

- Attention was given to providing opportunities for individual thinking and expression. Students were mentored during the semester through individual interaction on the topic with the researcher outside the classroom (HCT).
- Thinking skills were not only evaluated in light of the individual, but also in light of how they might affect the church, the community, the city, the nation and ultimately the

southern Africa region. The betterment of society was a predominant theme (HCT, DCT).

- Learners were encouraged to be accountable and take action regarding the disease of AIDS, both within their church environments, and within their own individual lives (SRCT).
- The political dynamics of the pandemic were examined and critiqued (e.g. the reason for the lack of access to ARVs, speeches given by the Minister of Health, and the South African president's views on AIDS) (SRCT).
- The classroom environment was nurturing and accepting, allowing for the varying levels and quality of student educational experiences and the multi-cultural dynamics. The teacher served as a resource person and facilitator, as well as a co-learner (HCT, SRCT, DCT).
- Learning was practical. Students were encouraged to make each other accountable for their thinking and actions (or lack of action) (HCT, DCT).
- Students were provided with numerous resources and contacts to aid them in addressing the issue of HIV/AIDS in their community (SRCT, DCT).

4.7.6 Summary

At the conclusion of the semester, post-tests for all three instruments were administered. It was of note that one of the students in the pilot test group (not the HIV+ student) became seriously ill in approximately week 12 of the 15-week term. He was absent for many days at the end of the term and was not present on the day of post-testing leaving the researcher with only three complete pre- and post-test results for analysis. Because of this, it was felt that a pre- and post-test comparison would be misleading and results were not reported. However, this small sampling did provide an opportunity to evaluate the envisioned course and the assessment procedures utilized in the advanced development step of the study.

Students' journals were also collected. For the pilot-test group, the journals did not turn out as the researcher had hoped. Few, if any, substantive entries were made. Many of the journals contained only notes from the class lectures.⁵³ Adjustments were planned to address this problem in the advanced development phase.

⁵³ These entries were not *personal reflection* on their class activities as had been requested. The researcher owns responsibility for part of the lack of response. Students had been told on the second day of class they would be

4.8 STEP 5: EVALUATION AND ADVANCED DEVELOPMENT

The fifth step of the research design model entailed the evaluation and advanced development (EAD). According to Rothman and Thomas (1994:37), there are four main parts to this phase:

1. Selecting an experimental design;
2. Collecting and analyzing data;
3. Replicating the intervention under field conditions; and
4. Refining the intervention.

Informed by these four prescribed parts, the researcher proceeded with the selection of an experimental design appropriate to the research.

4.8.1 Selecting an experimental design

The intervention research design was primarily qualitative in nature, with a small, but significant, quantitative component. For the qualitative component a purposeful sampling model (i.e., non-probability) was chosen. This type of sampling is the most commonly used in educational research (McMillan & Schumacher, 2001:174). According to Patton (1990:169) purposeful sampling involves "selecting information rich cases for study in-depth" when a researcher desires understanding about those cases without desiring or needing to generalize to all such cases. Purposeful sampling looks for information-rich key informants. Key informants are chosen based on their perceived knowledge of the phenomenon being studied. In this case, the key informants were students training to enter the AOG/SA ministry from all three culturally divided fraternals. Because most would eventually enter the ministry as pastors, their views and thinking on HIV/AIDS and its surrounding issues were important to the future ministry of the AOG/SA. As such, the results would not need to be generalized to other populations. One of the advantages of purposeful sampling is that a few cases studied in depth may yield rich insights about the topic.

4.8.2 Qualitative component

The qualitative component of the design consisted of two elements. The first was a Student Registration Form (Appendix E) and the second was an individual student journal. The first provided basic demographic and ethnographic information, in addition to formal education background levels. This form was used to help interpret and categorize answers that were of a

held accountable for their journal entries. However, without reminders and follow-up over the 15-week period, many of them forgot or did not take the assignment seriously.

qualitative nature. Individual student journals containing responses to semi-structured questions and ethnographic information would be used for feedback. This differed from the pilot test class in that the design for the advanced development groups incorporated semi-structured questions on specific topics for each day's journal entry. Student reflections would (a) allow the students to reflect honestly on the topics being addressed in class, and (b) give the researcher insight into the effectiveness of the curriculum intervention. These student reflections would also provide ethnographic and cultural alignment within the students' thinking on the matter of AIDS. Journal entries would be examined for reflection on daily activities prescribed within the curriculum intervention, as well as reflection of the individual within the context of the topic.

4.8.3 Quantitative component

The quantitative phase of the design utilized a pre-experimental pre-test/post-test design (Campbell & Stanley, 1963:7). This design allowed the researcher to evaluate the responses of two distinct groups within the AOG/SA fraternals: The Group and The Movement. Although a sampling from The Association was desired, one was not available within the context of a formal AOG/SA academic setting.⁵⁴

This pre-experimental, pre-test/post-test design is still widely used in educational research and, although not considered the strongest design in terms of threats to internal validity, seemed to adequately address the problem in this study (Campbell & Stanley, 1963:7). Although uncontrolled threats to internal validity were cause for concern in this type of design, it was reasoned that the majority of these threats could be addressed relatively easily within the context of the intervention treatment (Campbell & Stanley, 1963:7; McMillan & Schumacher 2001:330-333). The main reason for this choice was the researcher's personal knowledge of the extreme diversity of the subjects being studied and the great need for possible adaptation once the research was under way. A secondary reason was that educational research had never been done on this particular sampling and a basic, straightforward, established design for educational research was a good beginning point. This design was viewed as one that could serve as a foundation for future research.

⁵⁴ It is possible that an Association sample would have developed at CTS, but there was no guarantee of this from the administration, and it was felt that a delay of more than a year would be detrimental to the research. Realizing that the lack of an Association sampling was not crucial to the research, the researcher attempted to get a class made up of Association pastors in the Durban area. Plans appeared to be working well, but at the last minute the class did not materialize. So the researcher, in consultation with her promoter, decided to proceed without The Association sample.

The goal of the pre-test/post-test design would not be to compare results across groups. The groups were anticipated to be too varied with regard to (a) intervention delivery site (including classroom, equipment and administration) and (b) student population. The research was limited to gathering pre- and post-comparisons within each group. These comparisons were important not only to measure change within the group, but to indicate the degree of success of the curriculum's adaptability for future interventions.

Students in each group were assessed in reference to their knowledge of AIDS and attitude towards those with AIDS, based on gender, at pre-test. They were then exposed to the intervention treatment and, finally, reassessed at post-test. The instruments utilized at pre-tests and post-tests included the SHAK, PRM and PRW.

4.8.4 Collecting and analysing data

The collecting and analysing of data (CAD) was the second component of the evaluation and advanced development phase (EAD). CAD took place in two ways: quantitative data was collected through three measurement instruments (SHAK, PRM and PRW) and qualitative data was collected through reflective journaling by the student participants.

According to Rothman and Thomas's (1994:38) research strategy, two or more independent observers would help ensure the reliability and replicability of the findings. However, this was not attempted because journaling and quantitative instruments would provide a permanent written record of reactions and responses as a result of the intervention. Thus a permanent written record from each participant in the intervention would lessen the need for an independent observer.

The two populations selected for the research intervention were considered to be representative of two of the three main cultural streams of the AOG/SA. The educational, cultural, and religious factors identified in the review of the literature and, more specifically, the semi-structured interviews of AOG/SA leaders and fraternal pastors, were assumed to be embodied in these student samples by virtue of the fact that the students would represent fraternal cultures. Therefore, the data collected and analysed using qualitative methodologies would provide insight into observable commonalities and differences between the groups.

The pilot test group was a small sampling of four male students, one of whom dropped out of the class before the term ended because of illness. The content of the HIV/AIDS class offered from 2002-2005 had been altered somewhat for the pilot test in accordance with information received through the semi-structured interviews of AOG/SA leaders and fraternal members.

This was an attempt on the part of the researcher to educate across the fraternal spectrum. The class had taken place over an entire term, meeting three times a week for 50 minutes in the course of 15 weeks. This had been the format of the class since 2002 because a term-length class is a common component of a traditional higher education programme within a tertiary-level school setting.

4.8.5 Change in class duration and format

As the pilot test class progressed, the researcher became aware that a shorter, more compressed version of the class would need to be created for teaching pastors throughout the AOG/SA. In contrast to the 15-week term defining the course in the pilot study, the revised curriculum was packaged for presentation in a 10-day (four hours per day) schedule, in alignment with the formal educational setting of CTS and its annual block-course format. It was hoped that this adjustment in delivery format would make the intervention acceptable within both a formal setting for ministerial students and an informal setting for pastors in the field.

In addition, the researcher realized that to promote dialogue about HIV/AIDS and its surrounding issues within and across the fraternal, the format of class activities would need to become more interactive and cooperative in nature than the format utilized in the pilot test class. The pilot test class had been a small sampling of students that should have functioned with all of the dynamics of a small group. The researcher noted, however, that students in this pilot study had been reluctant to share openly because the topics being discussed were of a sensitive or taboo nature (Kagan, 1994:2, 4). Participation and open dialogue would need to be encouraged and facilitated more actively.

Other minor changes to the curriculum made for the advanced development phase were (a) the installation of a monitoring system for reflective journaling and (b) a two-day allowance for group/class dialogue on the Analysis of the Problem Form. With these basic changes instituted for the advanced development phase of the intervention, the researcher began to deliver the intervention and to collect and analyse the quantitative and qualitative data described earlier.

4.8.6 Course delivery

A few days before class began, a Learning Needs Assessment (Appendix F) was delivered to each student's school mailbox. The researcher requested that students review the form and fill it in before the class began. These forms could either be returned to the researcher before the

class began or on the first day of class. An Informed Consent Form (Appendix Q) was distributed the first day of each block course; the research was briefly explained and signatures requested. Along with the Informed Consent Form, a Student Registration Form (Appendix E) was distributed to students in order to gather basic demographic information. This information would allow the researcher to become acquainted with each student quickly, and it would provide information for categorizing answers later in the research process.

4.8.6.1 Quantitative data: Measurement instruments

The researcher decided that quantitative data would be collected in the form of pre- and post-test responses to three instruments (SHAK, PRM, and PRW). Instruments would be submitted to students at the beginning of the first class session before any introductions or instruction had taken place. The instruments would again be administered to students at the beginning of the last class session. This instrument-administering strategy was designed to minimize conversation or instruction which might influence responses. The PRM and PRW would be administered to students first since it was thought that those instruments would not stimulate critical thinking that could impact responses.

Distribution of these instruments (PRM and PRW) would utilize a randomized split-group design (Campbell & Stanley, 1963:53). After dividing the classroom, students were numbered and split into two groups. Students who had the lower numbers (e.g. 1, 2, 3, 4) were given the PRM. Students who had the higher numbers (e.g. 5, 6, 7, 8) were given the PRW. This process would be reversed on the last day of class. Thus, students who completed the PRM at pre-test would complete the PRW at post-test, and students who completed the PRW at pre-test would complete the PRM at post-test.

Immediately after the completion of the PRM and PRW, all students would complete the SHAK, so that a pre-test evaluation of their basic HIV/AIDS knowledge could be obtained. The SHAK would again be administered to students as a post-test on the last day of class, immediately after the administration of the post-test PRM and PRW instruments.

Data generated at pre-test and post-test would be analysed differently. The data generated by the SHAK would be analysed by utilizing a paired, two-sample t-test (two tail). The data generated by PRM and PRW would be analysed by utilizing a t-test for independent sample means with equal variance between the groups assumed (one tail).

4.8.6.2 *Qualitative data: Reflective journaling*

The qualitative data collection would be facilitated by reflective journaling. Each student was requested to keep a daily journal and respond to semi-structured questions provided by the researcher. These questions usually directed the student to reflect on the day's activities during the intervention. Personal reflection journaling was surmised to be of value in this research for the following reasons: (a) self-development, (b) empowerment/emancipation through thought and knowledge and (c) decision-making or resolution of uncertainty (Moon, 1999:77). There are many additional purposes for journal writing, including (a) immersion in critical thinking about personal and cultural constructs, (b) encouragement to own one's learning, (c) to deepen learning and (d) encouragement or enhancement of problem-solving skills (Moon, 1999:188-193). Each of these purposes could be of value in fostering the examination of the AIDS pandemic in South Africa. They could also promote and encourage personal examination regarding the private subject matter of one's sexuality. Because of the great variety of differences in sexual thought and experience and the cultural influences upon these differences, it was thought that students' journals containing their reflection on the class content, discussions or activities might provide a meaningful and accessible avenue of examination for the research.

Emotion was also recognized as playing an important role in addressing the HIV/AIDS pandemic; however, according to Moon (1999:29), the "role of emotion in reflection is not clear". Nonetheless, a person's emotional response (or reaction) to an area under consideration in counselling can "make the difference between moving towards new behaviours or remaining stuck with old patterns" (Moon, 1999:29). An emotional response was felt to be important in light of the AOG/SA's history of silence on the AIDS pandemic and it provided another significant reason for reflective journaling.

According to Schon's perspectives on reflection, there are two possibilities for reflective activity. The first is reflection *in* action and the second is reflection *on* action (Moon, 1999:43-44). For the purposes of this intervention, it was thought that reflection *on* action was the appropriate choice because reflection *on* action was reflection on learning and informing action, in addition to theory building. The ultimate objective of the curriculum intervention would be to inform, with the hope of encouraging further action and theory building about the church and AIDS in South Africa.

The pilot test class had been asked to keep journals and had been given very loosely-structured journal-relevant questions relevant to their class schedule (Appendix D). For the advanced development of the intervention, the journal-relevant questions were designed to encourage more reflection in the affective realm (Appendix J). In tandem with daily activities, the journal entries addressed the following nine questions:

1. Do you have any previous education regarding AIDS? As you learned about and discussed AIDS in class today, how did you feel? Briefly describe your emotions.
2. It is a tragedy when anyone contracts the HI virus, but some situations make us more heart sore than others. Today we discussed an article from *TIME* magazine. It describes the lives of five AIDS victims. Which of these accounts stirred up your emotions the most and why?
3. In today's class we did a thinking exercise called Corners. During the exercise you were asked "As a Christian, which of the following jobs would you want to have during the HIV/AIDS pandemic in South Africa and why?" (Your choices are Minister of Health, pastor, school teacher, medical doctor working in a government clinic or HIV/AIDS educator.)
4. As you watched the movie *Beat the Drum*, what were your feelings? Did it give you hope? What one thing stood out to you about the little boy in the movie? Was there anything else in the movie that seemed culturally interesting or culturally different?
5. Do you believe that educating young people about STDs and AIDS should be a part of church youth group curriculum? Why or why not? At what age should this begin and who should teach it? Whose teaching, in your opinion, would be received with the most credibility and influence? Why?
- 6(a) As you viewed the movie *Yesterday*, what were some of the social problems or needs that you saw as a result of HIV infection in the lead character's family? Could a community church be of help with any of these problems? Which problems and how? Describe briefly.
- 6(b) Optional Question: Relate six of the 15 character traits discussed in class (empathy, excellence, fairness, forgiveness, gratitude, honesty, humility, kindness, loyalty, patience, perseverance, respect, responsibility, self-control, service) to your personal ideas and beliefs about sex.

7. Imagine you are the senior pastor of a church in your community. As you are aware, the Bible is specific about boundaries and expectations for our sexual behaviour and relationships as Christians. If you were to teach on this topic, what do you think would be the response from your congregation? Would it be received well? Why or why not?
8. After yesterday's and today's discussion on unsafe sexual behaviour, sexual immorality and self-control, were you challenged to look at your own views on sexuality? Why or why not?
9. Testing: Would you be willing to test for HIV if you had engaged in risky behaviour? Would you be willing to serve as a role model for testing in your church?

During the pilot test class, the journaling assignment had been given on the second day of class; however, it was not until the end of the term that the researcher discovered that the journaling had not been maintained by the class. Two things were concluded as a result of this discovery: (a) students were not well acquainted with the concept of journaling and (b) explanation, reinforcement, and continual monitoring were necessary for the successful completion of the journaling assignment. As a result, the researcher put in place a monitoring system for journaling during the advanced stage of the intervention. Journals were checked for completion each day as students entered class, and completion of the assignment was noted on the class roster. If the assignment was missing, students were encouraged to complete the neglected entry and submit it along with the next day's assignment. A recheck was done the following day. As a result of this system of monitoring, very few assignments went uncompleted.

At the end of the intervention, students were requested to submit their journals, identified only by their assigned class number; names were to be omitted on the front. Even so, many wrote their name along with their class number on the journals before submitting them at the end of the intervention. To maintain anonymity, the researcher hired an independent employee to organize journal entries according to class, day of assignment and a simple coding. The coding consisted of the student's class number plus their ethnicity/race (B=black, W=white, C=coloured) and a gender designation (M=male, F=female). Thus, a typical coding might read "#4BF", which would stand for black female designated #4. This kept the entries anonymous and made analysis of each question easier.

Students were informed that they would be given credit for the submission of the journals, but not graded on the content of the journal entries that were made. Answers were not

categorized as being right and wrong. The total credit given for the submission of the journal was 10% of the final grade.

Journal entries were summarized according to question for each of the two classes. Data comparisons would only be made within classes. This would be done in an attempt to identify areas that would need to be addressed as future interventions were developed and refined.

4.8.7 Replicating the intervention under field conditions

According to the intervention research design of Rothman and Thomas, the next step of EAD was replicating the intervention under field conditions (RIUFC). Rothman and Thomas (1994:38-39) note that during this step, "a primary goal of intervention research is to develop interventions that are effective in a variety of real-life contexts with those who actually experience the problem".

In settings that represented two of the three AOG/SA fraternal, two contrasting real-life contexts were selected for the implementation and testing of the curriculum intervention. The first was CTS in Cape Town and the second was the GST/NW in Rustenburg (Thlabane). Both are tertiary-level South African institutions training Assemblies of God pastors.

These two institutions were selected because of their common mission and diverse cultures. Table 4.2 below compares these institutions with reference to nine variables:

TABLE 4.2: COMPARISON OF TWO INTERVENTION SITES

COMPARISON OF TWO INTERVENTION SITES	<u>Intervention site #1</u> Cape Theological Seminary Cape Town, South Africa	<u>Intervention site #2</u> Global School of Theology/North-West Rustenburg, South Africa (Thlabane Township)
Location	Northern suburbs, Cape Town surrounded by industry and business	Rural township setting, two informal settlements within 1 km
Basic infrastructure	<ul style="list-style-type: none"> • Running water (hot/cold) • Electricity • Ablution facilities throughout campus 	<ul style="list-style-type: none"> • Running water (cold) • Electricity (but unavailable for duration of the class) • Limited availability of ablution facilities
Facility	<ul style="list-style-type: none"> • Excellent, well maintained • Spacious, classrooms (carpeted) • Desks and chairs • Gardens, paved roads, walkways and working phone system 	<ul style="list-style-type: none"> • Lacking, not well maintained, in need of maintenance • Small, barren classrooms (bare concrete floors) • Few desks and chairs (most broken)

COMPARISON OF TWO INTERVENTION SITES	<u>Intervention site #1</u> Cape Theological Seminary Cape Town, South Africa	<u>Intervention site #2</u> Global School of Theology/North-West Rustenburg, South Africa (Thlabane Township)
	<ul style="list-style-type: none"> • Class presentation equipment available (white boards, overhead projectors, video data projectors, flip charts) • Library (15 000+ volumes) • 25-bay computer lab with wireless capacity throughout campus 	<ul style="list-style-type: none"> • No gardens; red mud • Few paved walkways or roads • Class equipment limited to blackboard (no chalk provided) • Sporadic phone availability • No computer facility or computers • No functional library
Administration	<ul style="list-style-type: none"> • 15 full- and part-time administrators • 6 full-time support staff (gardener, housekeepers, cooks, maintenance personnel) • Good support for teachers, good communication with staff and faculty 	<ul style="list-style-type: none"> • 3 full-time administrators • 5 support staff (factotum, gardener, housekeepers, secretary, and part-time cook) • Low support for teachers, little or no communication with staff and faculty
Security	<ul style="list-style-type: none"> • Very good, buildings secured, night lighting, security company services 	<ul style="list-style-type: none"> • Very poor, campus not secure (open to foot traffic), no night lighting, robbery a constant threat
Food services	2 full- time cooks prepare 3 meals per day, plus tea—adequate nutrition	1 part-time cook and 2 student helpers prepare 3 meals per day (little protein, mostly starch); very poor nutrition
Fees	Textbooks and study guides included	Textbooks and study guides not included
Student population	<ul style="list-style-type: none"> • Primarily white SA ethnic groups represented⁵⁵ (8 students) 	<ul style="list-style-type: none"> • Only black SA ethnic group represented (26 students) • Some international students
Language of instruction	English (English for this group was a first or second language)	English (English for this group was a second or third language)

The marked differences in the intervention sites provided distinct challenges from the perspective of the researcher. The research goal was to provide an equivalent, not identical, educational experience, adapted to each context, in which to monitor and test the effectiveness of the curriculum intervention.

⁵⁵ The class population for the intervention was primarily white with one coloured student. Normally classes at CTS have a broad cultural representation, but this was a unique situation which impacted the research results.

4.8.7.1 *The first intervention site – Cape Theological Seminary (CTS)*

The first intervention was done at CTS with a class of eight students (7 whites and 1 coloured; 4 females and 4 males). The date of the intervention was January 2008. The institution is located in the northern suburbs of Cape Town, surrounded by light business and industry. The school is well maintained and has all the services needed in an educational institution. The property is surrounded by a fence and has 24-hour security available.

4.8.7.1.1 Preparation and design

Apart from the first day and last day, classes met from 07:40 to 13:00 with a chapel break from 09:40-10:30 and tea time from 10:35-11:00. Maximum classroom time for each day was four hours. The duration of the intervention was 10 days, with a final examination scheduled the week following class. Five- to ten-minute breaks were given throughout the morning at appropriate intervals (Caine & Caine, 1994:33). These breaks worked well to refresh students; they returned within the allotted time frame resulting in minimal disruption of class times. On the first day of class, a syllabus and class schedule was given to the students. The class schedule provided students with a daily schedule of activities and assignment due dates (including assigned readings from the text). This schedule encouraged students to plan ahead and come to class prepared.

4.8.7.1.2 Situation analysis

The researcher arrived early each morning to unlock and set up the classroom. One of the main duties each day was to put 10 to 15 brightly coloured laminated signs on the walls around the room, on the class door, and in the hallway area leading to the classroom. These signs contained small pieces of information about each day's lesson. Signs included articles taken from the previous day's newspapers; these articles were displayed to stimulate interest in and inform students about current events related to AIDS. The signs were developed to stimulate thinking and questioning, and to immerse students in the topic for each day's class (Caine & Caine, 1994:91-92). One aspect of the interactive curriculum design was that these small pieces of information (i.e., signs) would serve several purposes by: (a) stimulating thinking (b) providing interesting information for conversation within the class (c) reinforcing information presented in class and (d) encouraging students to be observant.

To encourage informal dialogue, information sharing and a developing sense of community, the class was stocked with an open tea/coffee table, freshly baked treats and/or fresh fruit

each morning (Vella, 2002:6-7). Students participated in providing baked goods and volunteered to clean up each day.

After refreshments, the first activity was a five-minute spiritual thought⁵⁶ presented by a student volunteer. Topics for these devotional presentations were assigned by the researcher ahead of time and were related to the instructional topics that were presented throughout the intervention.⁵⁷ These presentations were an important practical exercise for students because they allowed the student presenters to practise speaking to their peers about topics that are often avoided within a church context (e.g. sexual purity).

4.8.7.1.3 *Administrative support*

Excellent support for the intervention was provided by the CTS administration. The researcher received a list of all enrolled students and their student identification numbers prior to the first day of class. Students were notified where and when the class would meet and the beginning date of the class. Textbooks had also been distributed ahead of time. Students were prepared to begin work as soon as they entered the class. The housekeeping staff had cleaned and prepared the classroom in advance, and the researcher was able to set up a few days before the class began so that no time was wasted on the first day of class.⁵⁸

4.8.7.1.4 *Lesson plan components*

Lesson plans were designed to address three main educational components each day. Each day began with a small-group activity, a small-group discussion, or a visual object lesson. This activity was designed to enrich the learning environment, contribute to the camaraderie of the class and break down walls of fear and silence regarding difficult topics (Caine & Caine, 1994:30-31). Small-group discussions were also perceived to be less threatening for open and honest discussion (Vella, 2002:9). The composition of these small groups remained unchanged throughout the course to aid in the development of building familiarity and trust.

⁵⁶ Both institutions encouraged a short devotional to begin each class. This activity was in keeping with a regular class activity.

⁵⁷ These topics were all directly selected from scriptures on topics of concern to the class (i.e., compassion, orphans & widows, caring for the sick, sexual purity, end times, the good Samaritan, holy living and relationship).

⁵⁸ Because of a shortage of housekeepers to do daily maintenance, the researcher cleaned the room each day after the class had ended. This was important to the intervention because it allowed the researcher to model assuming responsibility for and ownership of the facilities and equipment, as well as pride in the appearance of the learning environment. There was hope that this attitude would influence student responses when they assumed the role of community teacher or church leader.

The second component of each day's class was an instructional period addressing material from the text. These teaching sessions covered a range of serious topics and were important content elements in assisting students to understand the pandemic of AIDS in South Africa. One technique utilized during these instructional times required the researcher to identify controversial information or topics from the lecture. The researcher would then ask students to discuss the issue briefly in their small groups and report their thoughts, thus providing a safe environment to share conclusions (Vella, 2002:9).

The third component of the daily class design was classroom discussion and activity, or a media presentation followed by discussion. These discussions primarily addressed cultural issues and were intended to add an affective element to the earlier presentations in order to supplement learning (Caine & Caine, 1994:90). The majority of the media components were South African in origin and served two primary purposes: (a) they presented AIDS-related information from a cultural perspective and (b) they exposed students to ministry resources that were available within their own context. Amongst the media components were various 30-minute segments (on AIDS and related topics) from the SABC television production "Special Assignment" and two South African movies which were produced about the AIDS pandemic within the country (*Beat the Drum* and *Yesterday*).

Media components of the intervention were viewed in a media room in another venue on campus that was specifically equipped for media presentations. This permitted advance set-up, preventing wasted class time. The change of physical setting also promoted increased engagement with the subject being presented.

In addition to the three main components of the intervention, there were (a) important instructional elements of the intervention that incorporated the views of all cultures represented in South African society and (b) basic sexual education, moral and character training, and scriptural teaching regarding sexuality. Inequitable or discriminatory gender practices (both inside and outside the church context) were addressed whenever possible and students were given ample time and opportunity for discussion. Students were also required to develop written reviews of materials that were designed for, and used by, the South African church regarding the AIDS pandemic. This exercise acquainted students with materials that were available for use in their churches and ministry; some of these resources are available at no cost.

A summary of how the curriculum theory components were integrated into classroom activities is shown in Table 4.3:

TABLE 4.3: INTEGRATION OF CURRICULUM THEORY COMPONENTS IN ACTIVITY DESIGN

ACTIVITY	INTEGRATION OF CURRICULUM THEORY ⁵⁹ COMPONENTS
Social breaks	<ul style="list-style-type: none"> • participation (HCT) • "community life" (SRCT) • relationships (DCT)
Organization – all class assignments with due dates provided on first day of class Learning needs assessment (LNA)	<ul style="list-style-type: none"> • cognitive realm goals (HCT) • teacher as facilitator, organizer and activity designer (HCT, SRCT, DCT) • LNA="listening to the student" (HCT, DCT)
Immersion signs throughout classroom	<ul style="list-style-type: none"> • functional intelligence (HCT) • interaction, relevance (HCT) • promote thinking to effect social change (SRCT) • thinking that connects things, promotes reinforcement, provides reality of immediacy (DCT)
Student devotional presentation on difficult topic	<ul style="list-style-type: none"> • opportunity for autonomy of thought (HCT) • encouragement and stimulation of the individual (HCT) • tackling difficult topics encourages dialogue and change in society (SRCT) • "praxis" ("learning by doing") (DCT) • engagement of learners (DCT) • provides safe environment for learning (DCT) • listening and valuing students' thoughts and ideas (HCT, DCT)
<u>Component 1</u> – Small-group activity or discussion; participative visual object lesson	<ul style="list-style-type: none"> • provides for interaction (HCT) • addresses cognitive and affective elements (HCT) • encourages dialogue with a goal towards solutions (SRCT, DCT) • values the learner's voice (HCT, DCT) • teaches respectful dialogue within community (DCT) • allows for creativity in thinking (DCT) • provides for connectivity and relationship (DCT) • provides setting for accountability to the group (DCT) • allows for teacher transparency (HCT)
<u>Component 2</u> – Instruction on serious topics from text,	<ul style="list-style-type: none"> • functional intelligence, relevance (HCT) • immediacy (DCT)

⁵⁹ HCT=Humanistic curriculum theory; SRCT=Social reconstructionist curriculum theory; DCT=Dialogue curriculum theory

ACTIVITY	INTEGRATION OF CURRICULUM THEORY ⁵⁹ COMPONENTS
breakout groups to discussions	<ul style="list-style-type: none"> • integration of information (HCT) • emphasize social, political or economic development (SRCT) • education on societal problems to encourage involvement, solutions, change (SRCT) • assessment of and engagement with the problem (DCT) • value of all cultures re: topics (HCT, SRCT, DCT) • sequencing of the information (DCT)
<u>Component 3</u> – Media presentation on current topic	<ul style="list-style-type: none"> • relevancy (HCT) • strong affective elements (HCT) • teacher facilitates rather than directs learning (HCT) • teacher educates students about social problems (SRCT) • connecting real-life to the text lessons (DCT) • allows for and encourages reflection (DCT) • accountability for information (DCT)
Review of AIDS materials	<ul style="list-style-type: none"> • relevancy, functionality (HCT) • teacher sharing solutions (SRCT) • immediacy (something to be used immediately) (DCT) • engagement in learning (DCT)

In summary, it can be said that the CTS intervention site was an excellent educational facility. It provided for all of the logistical needs of the curriculum, and greatly facilitated and enhanced the delivery of the intervention.

4.8.7.2 The second intervention site –Global School of Theology/NW (GST/NW)

The second intervention site was GST/NW with an enrolment of 26 students (all African; 2 females and 24 males). The intervention took place in March 2008. The facility was in poor physical condition. The location was semi-rural, and adjacent to the Thlabane Township outside of Rustenburg.⁶⁰ Electrical service to the campus had been turned off by the municipality and remained off for the duration of the class. This initially posed a serious problem for the researcher because of the media components in the intervention. Local foot traffic trespassed on the campus daily. Security was absent, as evidenced by two robberies within the past year and one robbery which took place during the week of the intervention. Phone service was sporadic and the campus was without computer facilities or equipment. The classroom was very small and cramped for 27 adults. There were three students seated at each table and tables were approximately a chair's depth apart. Heat in the North-West

⁶⁰ A garbage dump and two informal settlements were located near the campus.

Province during that time of year was of concern, exacerbated by the crowded condition of the classroom and very little ventilation.

4.8.7.2.1 Preparation and design

On the first day, students arrived in class unprepared, having no writing pads, pens or textbooks. A day after class had begun, new students continued to arrive at the class requesting to be admitted. The researcher supplied arch lever files, exam pads, journals, pens and textbooks for the students at her own expense. Each day, tea was served by the institution from 09:30 until 10:00, just prior to the beginning of class. In addition, five- to ten-minute breaks were provided when needed throughout the class time (Caine & Caine, 1994:33).⁶¹

Maximum classroom time for each day was three hours. This was one hour less than the class time available at the first intervention site. In all pre-intervention conversations and communication with the GST/NW administration, four hours of class time had been agreed upon for this particular class. The duration of the class was scheduled to be 10 days, with a final examination on the last day of class. However, after arrival on campus, the researcher was informed that only nine days were available for instruction. The school would be dismissed a day early so that students could travel home early for the Easter weekend. This meant that only eight days of actual instruction time were available at this venue. This was two days less than the CTS intervention.

Prior to the distribution of the LNA, the pre- and post-test forms were completed and the syllabus and class schedule were given to the students. The class schedule informed students of the daily schedule of activities and assignment due dates (including readings from the text). This information encouraged students to plan ahead and to come to class prepared.

Prior to the CTS intervention, the LNA form (Appendix F) had been distributed for student response. At the GST/NW intervention, the distribution of the LNA form was not possible because there was no indication beforehand which students were enrolled in the class. However, the LNA form was distributed and discussed in small groups on the first day of class and the conclusions of each group were discussed by the entire class in a report-back session.

⁶¹ Instead of providing coffee and baked goods each day as had been done at the first intervention site, the researcher provided fresh fruit (bananas, apples, pears) at these breaks, noting that the students' diet seemed to consist primarily of starch items such as bread and mealie-meal porridge ("pap"). It was hoped that added nutrition would increase the students' attention span.

4.8.7.2.2 *Administrative support*

Support by the administration at GST/NW was poor. The class had been approved five months prior to the researcher's arrival. Upon arrival (three days prior to the beginning date of class), no one was able to inform the researcher how many students had registered for the class or where the class would meet. After some discussion, a classroom was finally agreed upon, but those in charge were unable to locate the keys to the classroom door. The designated classroom had not been cleaned or prepared for use. This lack of planning required the researcher to clean before setting up the classroom for instruction.

In order to set up, it was necessary to bring in 10 small tables and 30 chairs from other classrooms, as the room was completely empty. Note was made that this removal of tables and chairs left the four remaining classrooms without any furniture. Other faculty members had not been apprised of this special class offering and were upset that their classrooms had no furniture when they arrived to teach on Monday morning. With this development, all other GST/NW classes were dismissed and all students were encouraged to join the intervention class. In addition, since many of the students had not been informed of the location or beginning time of the class, a few arrived late the first day or did not arrive until the second day of class.

4.8.7.2.3 *Situation analysis*

The researcher arrived early each morning to unlock and set up the classroom. As previously noted, security was a serious concern at the second intervention site, so the room was locked and all teaching supplies removed each night. In addition, a small can of pepper spray was kept in the room during teaching time for additional security. Students were informed of this and instructed how to use the spray if the opportunity arose. The pattern of duties and activities that applied for the first site was replicated at the second site. Brightly coloured signs were put up to begin immersion on the day's topic (see Section 4.8.7.1.2); (b) student-led devotional thoughts were presented each morning (see Section 4.8.7.1.2) and (c) three main educational components were dealt with each day (see Section 4.8.7.1.4), including small group activities, small group discussions, visual object lessons and lectures on relevant topics with break-out discussion groups and media presentations.

To encourage informal dialogue, information-sharing and the development of a sense of community, the researcher had planned to provide a refreshment time at the beginning of class (Vella, 2002:6-7). However, this did not happen as planned because students were given

a coffee break/refreshment time each day just prior to the beginning of class. As a result, the researcher scheduled a break half way through the class time and fresh fruit was provided. These breaks were well received by students and provided a much needed nutritional element to their diet.

At the second intervention site, media components posed a significant challenge, as the school was without electricity for the duration of the course. Rather than delete these items from the intervention, the researcher purchased a small generator to enable the class to view these media presentations. Since the school had no classroom equipment, a screen was borrowed from a local HIV/AIDS educator. The serious security threats on campus forced the researcher to set up and dismantle the generator and media equipment each night and remove them from campus. The classroom did not have curtains to help darken the room, so black refuse bags were taped over the windows during the third daily component.

In summary: the second intervention site was substandard, lacking even the most basic educational equipment and supplies. Each day posed challenges, forcing adaptation of the intervention to this semi-rural setting. The entire burden for the cost of the class was borne by the researcher (including all paper supplies, textbooks, generator, and daily fruit). The condition of the site threatened the effectiveness of the delivery of the curriculum intervention; however, adaptations and adjustments made throughout the nine days permitted the delivery of a relevant and effective educational experience for the learners as will be shown in the results (Chapter 5).

4.9 STEP 6: DISSEMINATION

According to the intervention research model of Rothman and Thomas (1994:39), the sixth and final step was dissemination. The dissemination step included (a) the identification of potential markets (b) the creation of a demand for the intervention and (c) the provision of technical support for adopters. As with all research, dissemination was the ultimate goal; however, in the case of this research, the stated goal was the determination of the content and effectiveness of the intervention. The researcher viewed dissemination as a separate exercise that would evolve over time.

The potential market had already been identified as AOG/SA students training for ministry and AOG/SA pastors serving in the local churches. A secondary market has more recently been realized; other theological schools have now requested input for their own courses

attempting to educate students on HIV/AIDS. Demand for the course has already been established and the CTS is now offering the course on a yearly basis.

Lastly, technical support was not viewed as a relevant expected outcome of this research because the goal was to train trainers at the grassroots level who would provide church and community support within their own context. As a result of these factors, the dissemination phase was not included as part of the research design.

4.10 SUMMARY

The selection of the intervention research model (Rothman & Thomas, 1994) served as the framework for this research. The model was well defined and easily adapted for use in investigating the research question. Five of the six prescribed steps of the model were utilized and became the blueprint for conducting the research. The research was conducted in two organizationally related but culturally, educationally and logistically distinct venues. The model facilitated organizing the results generated in those venues through the application of the intervention.

CHAPTER 5

RESULTS, RECOMMENDATIONS AND REFLECTIONS

5.1 INTRODUCTION

This chapter will give a condensed summary of the dissertation and will include a restatement of the two-part research question in addition to a presentation of the results of the research in the form of quantitative and qualitative examinations. Recommendations for additional research will be proposed and the researcher's professional reflections will conclude the chapter.

5.2 RESTATEMENT OF THE RESEARCH QUESTION

The purpose of the research question as delineated in Chapter 1, Section 1.5, was two-fold. The first phase of the research sought to identify and assess educational, cultural and religious factors that were relevant to the content and design of a multi-cultural curriculum intervention to train AOG/SA pastors and pastors-in-training in the area of HIV/AIDS.

The second phase of the research question sought to determine if a curriculum intervention integrating educational, cultural and religious factors would be effective in training theological students about AIDS, particularly as it addressed the following areas of concern:

- Students' basic knowledge of HIV/AIDS
- Students' gender views toward men and women infected with HIV/AIDS
- Students' perceptions of people infected with HIV/AIDS
- Students' perceptions of the role of the church in addressing the HIV/AIDS pandemic.

5.3 RESEARCH QUESTION PART ONE: EDUCATIONAL FACTORS

The educational factors identified as relevant to the intervention strategy were divided into four categories: (a) historical/environmental, affecting learners within the South African educational context, and directly related to the mental state of the learner and/or his learning environment, (b) church organizational factors directly related to the Assemblies of God and its educational requirements for pastors, (c) governmental response and leadership

(government education regarding AIDS, condom education and distribution) and (d) lack of training pertaining to character and moral education as it relates to sexual behaviour. It was surmised that factors from all four categories would have some bearing upon an HIV/AIDS curriculum intervention designed for AOG/SA pastors and pastors-in-training.

5.3.1 Historical/environmental factors

The first items to be reviewed were the historical/environmental factors. These factors were related to the social history and educational background of learners in South Africa, particularly as they related to the politicization of education within apartheid South Africa. The intervention strategy took into account that although apartheid law was abolished in 1991, the residual effect of its impact might still continue to be internalized by some learners. One of the results of apartheid was an administrative structure of 19 different education departments which carried out the mandate of a distinct separation of all races in South African societal structures (Section 1.4.4.1).

Against the background of the politically-guided societal structures of apartheid, several historical/environmental factors were seen to have possibly impacted learners (from one or more of the three cultural groups in this study) and their educational experiences in various ways. These included (a) the migrant labour laws (Section 1.4.4.1), (b) the impact of poverty and violence (Section 1.4.4.2), (c) a deficiency in the area of racial identity development (Section 1.4.4.3) and (d) a lack of equal educational opportunity (Sections 1.4.4.4 & 1.4.4.5).

It was important to note that the average age of participants in the fraternal interviews was 47.9 years of age which indicated that their prime schooling years⁶² were 1964-1976. The average age of the theological student samplings was 27 years of age with prime schooling years falling within the years 1985-1997. Both groups fell under apartheid law to some extent during their educational years, an important point of reference to this section and to the development of the curriculum intervention.

Historical/environmental factors that were seen to have the potential to influence the learner and his/her learning environment were taken into consideration in the design of the curriculum intervention. Table 5.1 indicates four historical/environmental factors that were examined, the possible manifested outcome within the student or his/her learning environment, and how the outcome was addressed within the design of the classroom experience. It should be noted that these factors did not apply to all of the students in the

⁶² Prime schooling years are considered to be ages 6-18.

study, but allowances were made in the curriculum design and content for those who might have been impacted or influenced by one or more of these historical/environmental factors.

TABLE 5.1: HISTORICAL/ENVIRONMENTAL EDUCATIONAL FACTORS ADDRESSED WITHIN THE CURRICULUM INTERVENTION

Historical/environmental educational factors	Possible outcomes in students	Addressed in the curriculum intervention
Migrant labour laws (Section 1.4.4.1)	<ul style="list-style-type: none"> • Fatherless homes • Boys: lack of independence and assertiveness • Girls: negative emotional toll, subservience to men 	<ul style="list-style-type: none"> • Individual positive reinforcement, encouragement • Esteem-building exercises • Critical thinking exercises • Unit on leadership skills • Presenting good male role models • Presenting good female role models • Allowing students to plan and lead some of the activities (confidence building)
Poverty and violence (Section 1.4.4.2)	<ul style="list-style-type: none"> • Malnutrition • Fear, feeling of victimization • Lack of safe school environment • Lack of school supplies and good quality educational materials 	<ul style="list-style-type: none"> • Nutrition offered each day • All supplies (including texts, papers, pens) provided, if needed • All educational equipment needed was provided (e.g., media) • Security issues discussed as a class, classroom made as secure as possible • Student participation in safety concerns
Deficiency in racial identity development (Section 1.4.4.3)	<ul style="list-style-type: none"> • Negative feelings about education from 'dominant' provider • Rejection of educational experience, not wanting to learn 	<ul style="list-style-type: none"> • Open discussion of feelings regarding race and culture • Learning activities (such as media presentations or handouts) represented all races equally • Giving students a choice whether to join in with activities • Using peer social interaction in learning activities • Allowing students to openly and honestly express themselves in class and journal writing, as well as in class discussions
Lack of Equal Educational Opportunity (Sections 1.4.4.4 &	<ul style="list-style-type: none"> • Low quality of education • Discrimination through language • Low standard of achievement • Low expectations of academic 	<ul style="list-style-type: none"> • High quality of materials used • Took pride in educational environment • Language deficiencies addressed

Historical/environmental educational factors	Possible outcomes in students	Addressed in the curriculum intervention
1.4.4.5)	performance	in a positive way <ul style="list-style-type: none"> • High standard of achievement promoted and achieved • Positive reinforcement for good effort and work • Low academic performance noted and addressed one-on-one • One-on-one help (student/teacher)

5.3.2 Church organizational factors

The second category of educational factors was church organizational factors which were directly related to the Assemblies of God and its educational requirements for the position of pastor. As discussed in Chapter 2, Sections 2.5.1 and 2.5.2, there was a lack of educational requirements for the credentialing process of the AOG/SA pastors and a deficiency in the present curriculum that was relevant to AOG/SA pastors, particularly as it related to social issues such as HIV/AIDS.

A lack of educational requirements for pastoral credentialing was an area of concern. In Section 2.5.1 it was noted that of the 15 fraternal members interviewed, only four (N=4:15) had any specific academic theological/pastoral training. None of the fraternal leaders (N=0:3) had achieved any academic theological/pastoral training in spite of the fact that they provided administrative and spiritual oversight for over 1 200 credentialed pastors. This was considered to be problematic as it pertained to leaders and/or pastors observing the need for or value of specialized training particularly as it related to social concerns such as HIV/AIDS.⁶³

In addition to a lack of educational requirements for credentialing, a deficiency was noted in the available curriculum at the time for those who wished to be trained in the area of HIV/AIDS. Curriculum for AOG/SA pastoral training is offered through Cape Theological Seminary, the main tuition campus for Global School of Theology/ SA (GST/SA). Within the curriculum requirements for a three- or four-year B.A., GST/SA did not offer any course on the topic of HIV/AIDS.

⁶³ It was noted that in the past year, two of the fraternals have established national level AIDS desks to begin working with their pastors on the issue. It was thought that this may have resulted from a heightened awareness of the issues brought about by the leader and fraternal interviews during the research.

These two areas of concern were addressed within the context of the curriculum intervention through discussion and small-group exercises. One of the first exercises that the classes did was to meet in small groups to discuss and analyse the problem of AIDS and the silence of the AOG/SA church (refer to Appendix P – Analysis of the Problem, Parts 1 and 2).

As small groups reported back on their discussions to the class at large, students acknowledged and affirmed that the church should be addressing the problem of HIV/AIDS, and that every pastor should be educated about the disease and its social components. In the Day 1 journal entry (Appendix J), it was observed that the students in both venues acknowledged the extent of the disease and its potential impact on the country. Their abbreviated journal entries for Journal Question – Day 1 are noted in Table 5.2:

TABLE 5.2: RESPONSE TO DAY 1 JOURNAL

As you learned about and discussed AIDS today, how did you feel? Briefly describe the emotions you were feeling as a result of your small-group discussion.

INTERVENTION #1 (CTS)

Student Code*	After the first day of class, how did you feel?
FW#1	Shocked at reality, saddened by the knowledge, appalled at government's passivity, outraged by ignorance, irritated by the stigma.
MW#2	I realized many have no idea of the reality of this problem. Glad to be in the class!
MW#3	Shocked, felt bad for not doing anything.
MW#4	Shocked, fear, sad for those who have suffered.
FW#5	Hard to hear the facts, seemed unreal/impossible, felt a sense of responsibility, challenged, inspired to make a change.
FW#6	Upset that my church is silent on this, sad because pastors don't want to know, embarrassed, angry, fearful, devastated by the stories, confused, helpless, yet thankful and hopeful.
MC#7	Alarmed at stats, shocked that the topic of AIDS is not being spoken about in our churches. As a leader, I have betrayed people by not being informed.
FW#8	Shocked, overwhelmed, sad, I won't be able to make a difference when so many are infected.

*F=female, M=male, W=white, C=coloured, B=black

INTERVENTION #2 (GST/NW)

Student Code*	After the first day of class, how did you feel?
MB#1	Pain and worry, wished I had known sooner.
MB#2	Perplexed/shocked.
MB#3	Shocked, felt bad.
MB#4	Fear and shock.
MB#5	Concern, challenged; happy – this is important to know.
MB#6	Sad/bad.
MB#7	Shocked, amazed, sad.
MB#8	Feel great! Grateful for the teaching.
MB#9	Emotions are "too high".
MB#10	For the first time I realize the impact of this disease.
MB#11	Feel good to have knowledge.
MB#12	Very challenged, see the need.
MB#13	Sad, helpless.
MB#14	Interested, eager to know.
MB#15	Excited and challenged.
MB#16	Good, because I want to know more.
MB#17	Empowered, realized how important it is for the people to get involved.
MB#18	So afraid and realized we must be involved.
MB#19	Happy/panicked.
MB#20	I felt a responsibility to help.
MB#21	Happy because now I know what to do (ready to get involved) – fear is gone.
MB#22	I felt a responsibility to help.
FB#23	So touched – my brothers and sisters are dying because of a lack of knowledge.
MB#24	Felt challenged to the extreme.
FB#25	Very interesting, learned things I didn't know.
MB#26	Guilt and challenged.

*F=female, M=male, W=white, C=coloured, B=black

A subsequent activity that addressed the need for pastors to have knowledge pertained to Question 1 on the Analysis of the Problem, Part 1 (Appendix P). The Analysis of the Problem

activity involved a small-group discussion that led to a larger class discussion. Student responses indicating reasons for a lack of involvement by the AOG/SA churches in South Africa were that church leaders (a) felt embarrassed about sexual issues, (b) had a lack of education, (c) did not really want to know ('ignorance is bliss') and (d) demonstrated an attitude of 'it's not my responsibility'. It was of interest in Intervention #1, that only one of the students (N=1:8) noted that his/her pastor had spoken about AIDS in church. In Intervention #2, the percentage was even lower with two students (N=2:26) acknowledging that their pastor had spoken about the disease in church.

When participants were asked if their church provided any teaching on HIV/AIDS for children, youth, adults or old people, (e.g., youth groups, young adult groups, children's Sunday school, small groups) only two students (N=2:8) in Intervention #1 and four students (N=4:26) in Intervention #2 answered in the affirmative. Through observation of group discussion within the classroom, it was noted that students felt "leadership" was responsible for the lack of education and involvement on this issue. As leaders-in-training they saw the importance and value of being educated about the topic.

5.3.3 Governmental response and leadership factors

The third category of educational factors pertained to the area of governmental response and leadership. These factors addressed a lack of AIDS education in the public sector, specifically government leader contributions (Section 2.5.3), condom education for the public sector (Section 2.5.3.3) and illiteracy as it impacts attempts to provide HIV/AIDS education (Section 2.5.4).

Each one of these factors was perceived to contribute to the education of the public on the issue of AIDS, including student participants in this research. The curriculum intervention contained curricular components designed to address each issue; however, it should be noted that illiteracy did not receive the attention it was due, because the class time was very limited. This lack of emphasis will be addressed in the recommendations section of this chapter.

5.3.3.1 Government and community leadership factors

South African government leadership amidst the AIDS pandemic was an issue that was addressed several times during the intervention. Analysis of the Problem, Parts 1 and 2 (Appendix P) contained several questions for small-group discussion that requested participants to discuss the role of government in the pandemic. Small-group discussions and class responses were consistent, indicating that government should be leading the way during

this time of crisis. Moreover, students agreed that the church should play a complementary role in the government's educational attempts.

On Day 3 a participatory class exercise was facilitated requesting students to make a choice as to which role of leadership they would like to fill. Choices were Minister of Health, school teacher, medical doctor, HIV/AIDS educator and pastor. Students were asked to group themselves throughout the classroom according to the role that they had chosen (e.g. all of those wanting to be the Minister of Health should stand together, all of those wanting to be a school teacher should stand together). They then were asked to share with the class their explanation of why this role appealed to them. In the Intervention #1 group, half of the students (N=4:8) wanted to serve as the Minister of Health, the key reason being "change". It was of note that none of the participants desired the role of pastor in the pandemic, although all were training for the ministry. In the Intervention #2 group, the largest percentage of students wanted to be pastors (N=9:26). Qualification of their choice revolved around the words, "help", "encourage" and "care for" (Table 5.3). In Intervention #2, those who chose the position as Minister of Health were not received well by their classmates. Possible interpretations of this reaction may have been an indication as to how the Minister of Health was viewed within the group at large or a reflection of how the class viewed the Minister of Health's job performance.⁶⁴

More light was shed on the leadership question through the responses to the Day 3 journal question (Appendix J). This question requested students to reflect on the same activity in their daily journal by indicating which leadership role they would prefer to fill during the pandemic and why. Choices were the Minister of Health, the pastor of a church, a school teacher, a medical doctor working in a government clinic and an HIV/AIDS educator. Responses were diverse, but they revealed that students were aware of the important role of leadership in government and community. Responses for Intervention #1 and Intervention #2 (along with a brief qualifier) can be seen in the Table 5.3 below:

⁶⁴ On this point of possible interpretation, several of the students in the class had siblings who were HIV+, or had lost loved ones to AIDS because of a lack of treatment or medication. One of the participants shared that she had four infected siblings and was the only child in the family not infected with the virus.

TABLE 5.3: RESPONSE TO DAY 3 JOURNAL**INTERVENTION #1 (CTS): JOURNAL QUESTION #3: LEADERSHIP**

Student code	Role desired*	Why? Qualification of response
FW#1	HIV/AIDS educator	Empowerment
MW#2	Minister of Health	Change
MW#3	School teacher	Teach values and morals
MW#4	Minister of Health	Influence over change
FW#5	Minister of Health	Influence over change
FM#6	Minister of Health	Make right decisions
MC#7	HIV/AIDS educator	Increase awareness
FW#8	School teacher	Teach morals and values

*Minister of Health N=4:8; School teacher N=2:8; HIV/AIDS educator N=2:8; Medical doctor N=0:8; Pastor N=0:8

INTERVENTION #2 (GST/NW): JOURNAL QUESTION #3/LEADERSHIP

Student code	Role desired*	Why? Qualification of response
MB#1	HIV/AIDS Educator	Provide knowledge
MB#2	Pastor	Shepherd the people
MB#3	Pastor	Influence
MB#4	Pastor	Counsel and help people
MB#5	Pastor	Help others
MB#6	HIV/AIDS educator	Because of ignorance of people
MB#7	Minister of Health	Influence
MB#8	Medical doctor	Challenge to help people
MB#9	Pastor	Power of working together
MB#10	HIV/AIDS educator	Specialization and exclusivity of job
MB#11	Pastor	To help all

Student code	Role desired*	Why? Qualification of response
MB#12	Minister of Health	Opportunity to communicate help
MB#13	Medical doctor	Frontline fighter
MB#14	Minister of Health	Power to work with others
MB#15	HIV/AIDS educator	Knowledge is power
MB#16	Medical doctor	Working with others
MB#17	Pastor	Teach morals
MB#18	School teacher	Responsible for educating young people for life
MB#19	Medical doctor	Care for people
MB#20	School teacher	Reach and equip
MB#21	Pastor	Encourage others; access to equip
MB#22	School teacher	Build into the future
FB#23	Medical doctor	To help suffering people
MB#24	Pastor	Care for people
FB#25	HIV/AIDS educator	Because knowledge is needed
MB#26	HIV/AIDS educator	Have an active role with people; influence

*Pastor N=9:26; HIV/AIDS educator N=6:26; Medical doctor N=5:26; Minister of Health N=3:26; School teacher N=3:26

5.3.3.2 Condom education and distribution

A secondary area examined under educational factors related to governmental response and leadership was that of condom education and distribution. With regard to the curriculum intervention, this topic was covered from multiple perspectives with candour. Included within the day's discussion were items such as distribution of condoms by government, effectiveness, usage and cultural views pertaining to birth control (as condoms are also viewed by many as a form of birth control). Class discussion and debate regarding the distribution of free condoms to high school youth was encouraged. Some of the participants voiced the opinion that they and their peers interpreted the free distribution of condoms in their high schools as permission or encouragement to engage in sexual activity, in opposition to the negative verbal warnings they received from parents, church and others within the

community. This indicated that students were receiving confused messages from authority figures as it pertained to condom use and sexual activity.

It was of interest to note in class discussions that only a few of the students had discussed anything about sexuality (including condom usage) in their church youth group, although many acknowledged that they had sexually active peers.⁶⁵ A significant number of the fraternal interview respondents (N=15:18) acknowledged that boy/girl "dating" was likely to begin between 12-15 years of age (Sections 2.6.7.2, 2.6.7.3 & 2.6.7.4). Only a third (N=6:18) of the respondents acknowledged that sexual activity was taking place in their culture within the early teens (12-15 years of age), in spite of the fact that new HIV infections were registering at 40% in the 15-24 age group (Section 2.3.4). This seemed to indicate that fraternal members and their leaders were out of touch with the statistical reality pertaining to South African young people and the prevalence of sexual activity. This would be an important item to note for curriculum content within the intervention.

Journal entry Day 5 (Appendix J) asked students to reflect on whether they would envision the church taking a role in teaching young people about sex, particularly STDS and AIDS. (This question was seen to relate indirectly to the discussion of the condom issue, hence its inclusion in this section.) In the Intervention #1 group, the participants were unanimous (N=8:8) that the church should be involved in this kind of training and that it should begin between the ages of 10 and 12. In the Intervention #2 group, participants were unanimous (N=26:26) that the church should be educating young people about sexual matters; however, there was a wide variance on what age that education should begin. Ages ranged from "crèche" age (N=1:26), 6-8 years of age (N=8:26), 10 years of age (N=6:26), 12 years of age (N=9:26), 14-15 years of age (N=2:26) to 20 years of age (N=1:26). This wide variance of answers seemed to indicate some confusion on the appropriate age for, or need of, sexual education. This might have resulted from the respondents' awareness within their culture of the need of sexual training from a much younger age; this was noted for further discussion and teaching in subsequent interventions.

In addition, the topic of sexual behaviour and condom usage (birth control) indirectly linked dialogue in the curriculum intervention to cultural views of procreation. With a variance of views between the three AOG/SA cultures, it was determined that traditional African views

⁶⁵ Refer to Section 2.5.5.1 – Kaiser Family Foundation research shows that 67% of young South Africans are sexually active, including 50% of 15-19-year-olds.

of procreation and children would be included in the curriculum intervention content to promote further understanding between the fraternals.

5.3.3.3 Lack of training pertaining to character and morals education related to sexual behaviour

The last educational factor considered was a lack of training in schools and churches pertaining to character and morals education as it related to sexual behaviour. Section 2.5.5.1 indicated that premature sexual involvement and multiple sexual partners had reached a serious level in the South African youth population. Because HIV is primarily transmitted through sexual relationships,⁶⁶ it was surmised that education pertaining to character and moral issues related to sexual activity would be of value in helping young people make informed choices and should be included in the curriculum intervention.

Students in the intervention shared that many of their AOG/SA churches had youth groups where character and morality training pertaining to sexual activity were addressed, but the message was inconsistent in its frequency of presentation and content. The pastors, according to students, seemed to be the person in leadership that encouraged the presentation of this type of information. If the pastor was uneducated or unaware, then facilitation of teaching appeared deficient, according to class discussions.

It was also of note that, according to student discussions, South African public school life-orientation training was generally devoid of values, which should have been intrinsic to the life orientation curriculum. The physical facts of sex were taught without any reference to character and/or morality. Yet, research has shown that teachers and researchers recognize that moral and character education can be positive change agents for young people, not only in their sexual choices but also in their school performance (Section 2.5.5.1). None of the participants in either intervention site had received this kind of training at school and approximately half of the students in both intervention groups (N=4:8, N=13:26) had not experienced any training of this type through their churches.

As part of the curriculum intervention, there were several participatory lessons (small-group discussions, games and object lessons) on character traits and morals, particularly as they relate to sexual choices. They were discussed in small groups and were well received. Comments from participants were positive, and more activities were requested. When asked

⁶⁶ It is estimated that 95% of all HIV infections take place through sexual contact.

how many of the participants had ever experienced this kind of teaching, none replied in the affirmative.

One classroom activity had to do with matching 15 character traits (i.e., empathy, excellence, fairness, forgiveness, gratitude, honesty, humility, kindness, loyalty, patience, perseverance, respect, responsibility, self-control and service) with their definitions. Many of the participants had not been exposed to character training, so discussion within the small groups was excellent. As the exercise progressed, the researcher asked for feedback on which character traits the class felt were the most important. For Intervention Group #1, three main character traits received votes as the most important. They were forgiveness, respect and self-control. For Intervention Group #2 votes leaned heavily towards loyalty, perseverance and forgiveness.

An additional classroom activity revolved around small-group examination and discussion of scriptural standards (morals) for sexual behaviour. It was of interest to note that students in both intervention groups had not been exposed to many of the scriptures used in the activity despite the fact that they had attended church for many years, were committed Christians and were training for the ministry. This pointed to a deficiency with regard to scriptural teaching on the issues of sexuality within their churches, a topic to be included in the curriculum intervention content.

5.4 RESEARCH QUESTION PART ONE: CULTURAL FACTORS

Cultural factors were determined through individual interviews with a sampling of AOG/SA fraternal members and their leaders. Questions during the interview pertained to topics that were perceived to be directly or indirectly related to HIV/AIDS. Interviews attempted to highlight cultural differences between the views of each fraternal. Included in those topics were the following:

- Poverty
- Causes of sickness
- Acceptance of various types of healthcare (traditional African vs. Western)
- Death and causes of death
- Cultural views of sexuality in relation to HIV/AIDS.

Responses from the interviews were examined in their entirety in Chapter 2, but will be reviewed in a condensed form for this results section of the research for the benefit of the reader.

5.4.1 Poverty

Because poverty was considered to be one of the social components that feed the HIV/AIDS pandemic, it was thought to be an important cultural factor to examine for possible inclusion in the curriculum intervention content. Results from the phase-one interviews indicated that there was not a consistent knowledge across the fraternals regarding poverty (Section 2.6.1). According to interview responses, poverty was defined as a lack of, a state of mind, not being able to afford the basics, and an inability to provide. It was noted that respondents struggled to define the term.

When participants were asked to name three items that contributed to poverty, there was an almost unanimous response (N=17:18) across the three fraternals that a lack of education was a contributing factor. Other items that were thought to contribute to poverty were apartheid, a poor work ethic, substance abuse, complacency, joblessness or unemployment and dependency. Again, it was noted that this was perceived as a very difficult question and respondents (particularly those from The Movement) did not provide an answer easily. Of note was the fact that three of The Movement pastors (N=3:6) were entirely unable to list three factors contributing to poverty (Appendix A – Transcription of interview responses, 2006:254-255).

Because the topic of poverty appeared to be so unfamiliar to most of the respondents, it was decided that this curriculum intervention, within a limited time frame, would not be able to address the topic adequately. The topic was removed from this particular curriculum intervention content. That decision is addressed during the recommendations sections of this chapter.

5.4.2 Views of sickness, healthcare and death

Views of sickness, healthcare and death were examined in Section 2.6.2. They included views and perceptions of how sickness is caused, as well as views pertaining to the legitimacy and acceptance of traditional African medicine/healthcare and Western-style medicine/healthcare (Appendix A – Transcription of interview responses, 2006:237-239).

5.4.2.1 Causes of sickness

The cause of sickness was the first topic to be addressed. The responses were varied, with two-thirds (N=12:18) stating that sickness is caused by lifestyle issues or neglect of health, and the other third (N=6:18) stating that in the thinking of their culture sickness was usually caused by "bewitching" (Section 2.6.2.2). This variance in fraternal thinking made the topic excellent for inclusion in the curriculum content.

5.4.2.2 Traditional African medicine/healthcare vs. Western-style medicine/healthcare

Traditional African medicine/healthcare was the next topic addressed within the cultures of the AOG/SA fraternal. The groups were again split on their answers, with two-thirds (N=11:18) stating that traditional African medicine/healthcare was not legitimate or that it was only used in desperation. The other third (N=7:18) unanimously agreed that this type of medicine/healthcare was well respected and their God-given right to use (Section 2.6.3.1).

In comparison, the fraternal were more in agreement pertaining to their opinions of Western-style medicine/healthcare. More than two-thirds (N=15:18) stated that this type of healthcare was respected and well received in contrast to the two respondents (N=3:18) who stated that it was respected but viewed in terms of economics. Only one respondent stated that Western-style medicine/healthcare would be a second choice to traditional African medicine (Section 2.6.3.2). The variances on the views pertaining to two different kinds of healthcare made it an excellent cultural topic for inclusion in the curriculum intervention content as it applied to HIV/AIDS. This was surmised because the condition of HIV/AIDS will require a medicinal response and long-term healthcare. In their responses to healthcare needs, the community (church and government) will need to tailor their healthcare responses effectively to address and incorporate cultural thinking for receptivity and effectiveness.

5.4.2.3 Death: causes of death or after-death experiences

The last topic examined in this section was death, including the causes of death or after-death experiences.⁶⁷ When asked if outside spiritual forces could cause a person's death, the respondents reflected differences in their thinking. All of The Movement pastors, three of The Association pastors, one of The Group pastors and one of the fraternal leaders (N=10:18) were of the opinion that, in the thinking of the culture they represented, outside spiritual forces could cause a person's death. In opposition to that view, two of the leaders, four of The

⁶⁷ After-death experience in this instance can refer to a spiritual experience or the actual physical experience of burying the body.

Group pastors and two of The Association pastors (N=8:18) stated that this would not be representative of the thinking in their culture.

Burial was another topic that provided diverging views for the fraternals. According to the interviews, over one-third of the respondents (N=8:18) stated that cremation was not an option in the thinking of the cultures they represented, and the remainder (N=10:18) said that cremation was allowed or accepted within their representative culture. Neither The Group nor The Association pastors indicated any outstanding rituals or traditions associated with burials in their culture; however, The Movement pastors indicated some strong cultural traditions (e.g. location of the burial, preparation of the body) that would be viewed very differently or misunderstood in relation to cultural traditions in The Group and The Association fraternals.

The views on death and burial reflected strong differences from fraternal to fraternal. Both topics were included in the content of the curriculum intervention to promote understanding across the fraternals on issues of death as they might relate to HIV/AIDS.

5.4.2.4 Cultural responses to AIDS

Each of the cultures represented by the three fraternals and their leaders was interviewed about their culture's view of AIDS (Question #1H – Appendix B). A majority of The Group (N=5:6) stated that the disease does not relate to their communities because they do not see it often. The Association was unanimous in its response (N=6:6) that in the thinking of their culture there is some stigma attached to the disease because it is primarily spread through sexual behaviour. The Movement agreed that there is stigma attached to the disease; but four of its members (N=4:6) stated that the stigma was strong and tied to the lack of acceptance for sexual promiscuity, while two (N=2:6) stated that there was stigma but people were coming to terms with the disease.

A subsequent question asked if there was rejection of people in the community who had the disease of HIV/AIDS. The Group pastors were split on this issue, with three (N=3:6) stating "Yes", two (N=2:6) stating "No" and one (N=1:6) responding that he was not sure. (This was an interesting response since five of the pastors (N=5:6) had stated that the disease did not really relate to their communities and they did not see it often.) The Association pastors were also split, with two (N=2:6) responding "Yes" and four (N=4:6) responding "No". The Movement pastors' answers were the most consistent with four (N=4:6) responding "Yes" and two (N=2:6) responding "No".

Stigmatization of the disease and rejection of people with the disease were considered to be important topics for inclusion in the curriculum intervention. As can be seen from the responses, there appeared to be confusion and a need for teaching on the issue. Pastors, through relevant and effective teaching, could aid in eliminating this confusion and lead communities to reduce the stigmatization of the disease and its victims, many of whom are not infected through sexual promiscuity. Further indication of change in participant thinking on this topic will be presented later in this section, together with quantitative and qualitative research results on the topic.

5.4.2.5 Cultural responses to pregnancy outside of marriage and multiple sex partners within marriage

The next questions on cultural issues pertained to views of sexual behaviour inside and outside of marriage, with an emphasis on gender inequities (Section 2.6.7.5). Fraternal members were asked how, within the views of their representative culture, men and women involved in a pregnancy outside of marriage are viewed. The responses related to men and women were varied and indicated a need for further discussion. This made the topic a good selection for inclusion in the curriculum intervention as it complemented earlier cultural issues of procreation and birth control.

Two-thirds of the pastors (N=12:18) agreed that there would be little or no stigmatization of a young woman who fell pregnant outside of marriage (Section 2.6.7.5). Six of the pastors (N=6:18) stated that she would be considered a disgrace and there would be some stigma attached to her.

Young men involved in a pregnancy outside of marriage (fathering a child out of wedlock) were viewed differently by the pastors with the majority (N=17:18) stating that the boy would not be rejected or stigmatized as a result of his female partner's pregnancy. In fact, various statements from The Movement pastors indicated the pregnancy would be considered an insult to the young woman's parents but that it would also be considered proof of manhood and worthy of commendation. This type of behaviour would be regarded as acceptable because, in the thinking of their culture, men can have more than one wife or sexual partner.

The next set of questions enquired about the cultural views and treatment of men and women who have more than one sexual partner within marriage. Again, gender inequality was apparent. The pastors were almost unanimous (N=16:18) that, within their cultures, this type of activity for women was not permissible. However, they were more divided when it came

to men, with The Group and The Association pastors giving identical answers. For five of the pastors in each of these two fraternals (N=10:12), it was not considered permissible and for two in each fraternal (N=4:12) it was considered permissible. The Movement varied greatly on this point with all five pastors (N=6:6) stating that it was permissible for men to have multiple sexual partners within marriage.

It was noted within these two questions that there seemed to be inequality in the way men and women are viewed in terms of sexual behaviour. This was also noted in Chapter 2 under cultural views pertaining to polygyny (Section 2.6.8.6) and female virginity/lobola (Section 2.6.8.3). Since these are sexual issues and HIV/AIDS is considered to be a disease related to sexual behaviour, inclusion of the topic (gender inequality pertaining to sexual behaviour) was considered of importance for dialogue with pastors-in-training. The ecclesiastical nature of the participants' career choice made the examination of Scripture and biblical views pertaining to virginity (Section 2.6.8.4) a good addition to the curriculum intervention as well, since students appeared deficient in this area, according to class interactions on the topic.

5.5 RESEARCH QUESTION PART ONE: RELIGIOUS FACTORS

Religious factors were determined through individual interviews with a sampling of AOG/SA fraternal members and their leaders. Questions during the interviews pertained to the topic of men and women in church leadership (Section 2.7). Women in the South African church (Section 1.4.3), as well as women throughout South Africa (Section 2.3.1 and 2.3.2), are all suffering from HIV/AIDS in far greater numbers than men. As a result, it would seem to be logical that females would be allowed to serve in church leadership positions to lead, spiritually (Section 2.7) as well as voluntarily (Section 1.4.3), in providing relief efforts to those infected and affected. But, as research shows, this was not the case across the fraternal spectrum of cultures and, in the case of the culture with the highest numbers of female infections (The Movement), female church leadership on the part of females is not accepted at all.

5.5.1 Religious views pertaining to gender equality in leadership

The first area of examination was that of men in leadership within the church (Section 2.7.1). The question (Question #1GC – Appendix B) asked about the prescribed or scriptural teaching pertaining to men serving in leadership and whether there were any requirements or restrictions on men serving in a pastoral position. Fifteen of the respondents (N=15:18)

referred to 1 Timothy 3:12 when replying to this question. Many conservative churches⁶⁸ interpret this passage to mean that only men may serve in leadership positions. Those who did not refer to this Scripture (N=3:18) indicated in their answers that the man must have a calling that is validated by the congregation, or that he must have some Bible school training. In some cases they stated that they do not take a legalistic approach to the matter (Section 2.7.1 – Table 2.16).

Issues that some churches would consider as disqualifying a candidate for leadership (divorce, moral indiscretions, or a lack of qualifications) would not necessarily disqualify a man from serving in the AOG/SA leadership. One of The Movement pastors indicated that sometimes men are elected to leadership by their friends, even though the person may not fulfil scriptural requirements. During the interviews it was indicated that usually nothing could be done about this kind of situation. This response could have indicated that present leadership was not assertive enough to address the problem, a point which relates to Section 1.4.4.1 and the impact of father-absent home life. Another possibility could point to the dilemma that leaders in such a position are in conflict about speaking out on moral issues if they themselves have been known to engage in similar activity.

Generally, responses could be interpreted in several ways. The first might reflect tolerance for an unqualified male to serve in an elected position, rather than allowing a functionally qualified female to stand for election. It could also be interpreted to mean that there is a shortage of qualified males to serve in leadership. Only one of The Group pastors clearly displayed no gender bias in his response and indicated that men and women were measured against these scriptural qualifications for leadership according to 1 Timothy 3:12.

The second question was identical to the first but referred to females in church leadership positions (such as pastor, elder or deacon). A majority of The Group pastors (N=5:6) seemed to indicate that there was some change going on in this area of church practice. Prior to this time, according to the AOG/SA constitution, women were not allowed to serve in church leadership, particularly not in the position of elder. However, responses indicated that this was no longer the case and that things were slowly changing.

The pastors of The Association also seemed to vary in their answers. Three of the pastors (N=3:6) responded that women would not be allowed to serve in the role of pastor or to serve as deacons. Three of the respondents (N=3:6) stated that there would be some allowances for

⁶⁸ The AOG/SA would be considered to be a conservative evangelical group.

women in leadership. These were qualified responses and they indicated that things are changing.

The Movement pastors' responses were homogeneous (N=6:6). They indicated that women are not allowed to serve in leadership positions within their churches. If a woman did serve in a leadership capacity (e.g. pastor of a new church plant), she would not be given a title and would be replaced by a male leader as soon as the work became successful. Three of the respondents (N=3:6) indicated that they did not necessarily agree with this position and that the differences seemed greatest when comparing the opinions of the older and younger generation of pastors.

As a result of these divergent opinions and the gender inequality that was perceived in regards to sexual behaviour, it was surmised that leadership issues which revolve around gender in leadership should be a part of the curriculum intervention. The topic of gender inequality was integrated into many of the class discussions to allow for open discussion and diverse points of view. This topic also came to the fore in many of the media presentations of the intervention. Responses to the media presentations were emotional when gender-based unfairness (both male and female) was discussed.

5.5.2 Summary

The factors that were determined to be relevant to the curriculum intervention were substantial and broad in scope. Educational, cultural and religious factors examined were all considered important to the curriculum content because of the varying views between fraternalists. They were incorporated into the intervention to provide a thorough coverage of topics directly and indirectly pertaining to HIV/AIDS. Not all students were impacted by all factors, but it was determined that each factor applied to one or more of the students participating in the intervention and was therefore relevant for inclusion.

5.6 RESEARCH QUESTION PART TWO: EFFECTIVENESS OF CURRICULUM INTERVENTION

Part two of the research question sought to determine if a curriculum intervention integrating educational, cultural and religious factors would be effective in training theological students about AIDS, particularly as it addressed the following areas of concern:

- Area One: Students' basic knowledge of HIV/AIDS.
- Area Two: Students' gender views toward men and women infected with HIV/AIDS

- Area Three: Students' perceptions of people (in general) infected with HIV/AIDS
- Area Four: Students' perceptions on the role of the church in addressing the HIV/AIDS pandemic.

Effectiveness was determined through both quantitative and qualitative methods to provide a triangulated perspective of the data (refer to Section 4.6.1). Student performance in Area One was examined quantitatively by means of a self-report instrument designed to assess the respondents' basic knowledge of HIV/AIDS. Student performance in Area Two was examined quantitatively by the means of a self-report instrument designed to assess the respondents' gender-specific perception of those with AIDS.

Student reflections in Areas Three and Four were captured qualitatively by means of daily reflective journals that were compiled by each student participating in the intervention. The use of journals for student reflection had not been successful during the pilot test phase of the research. In contrast, the reflective journals during the advanced development step contained substantial responses that were of value to the research.

5.6.1 Area One: Student knowledge of HIV/AIDS (quantitative data)

Quantitative data were collected in the form of pre- and post-test responses on a *Scale of HIV/AIDS Knowledge* (SHAK) (Appendix G). The SHAK contained 30 matrix questions, all directed at evaluating a respondent's functional⁶⁹ knowledge of HIV/AIDS. The SHAK utilized a five-point Likert-scale that included some reverse scoring to reduce response sets (Babbie, 1990:140). Responses were categorized as "Strongly disagree", "Disagree", "Not sure", "Agree", and "Strongly agree". The instrument was completed anonymously at both intervention sites. The demographic information requested on each instrument required the respondent to identify only gender, race and culture. Demographic information for each intervention site is found in Table 5.4:

⁶⁹ *Functional knowledge* was defined as knowledge pertaining to HIV/AIDS that might be used by a person on a daily basis in his/her own life or in the life of a family member.

TABLE 5.4: SUMMARY OF DEMOGRAPHIC VARIABLES AT BOTH INTERVENTION SITES

Intervention Site	N	Race *	Gender	Age range	Prior HIV/AIDS education
(#1) CTS	8	W = 7** C = 1 B = 0	Male = 4 Female = 4	19 - 44	Yes = 4 No = 4
(#2) GST/NW	26	W = 0 C = 0 B = 26***	Male = 24 Female = 2	19 - 65	Yes = 16 No = 10

*W=white; C=coloured; B=black

**Cultures represented: English (N=5:8); Afrikaans (N=2:8)

***Cultures represented: Sotho (N=10:26); Tswana (N=6:26); Zulu (N=1:26); Tsonga (N=3:26); Ndebele (N=3:26); Zambian (N=1:26); Mozambican (N=1:26); Other (N=1:26)

The results of the SHAK (pre- and post-test scores) at both intervention sites are found in Tables 5.5 and 5.6 below:

TABLE 5.5: SHAK RESULTS/INTERVENTION SITE #1 (CTS)

Summary of the paired sample t-test for the Scale of HIV/AIDS Knowledge

	Subjects (N)	Mean	SD	df	t-value	p
Pre-intervention	8	116.38	8.19	7	-5.49	<.001
Post-intervention	8	130.63	6.63			

The CTS students gained a great deal from the intervention, with post-test scores significantly higher than pre-test scores, beyond the $p < .001$ level. The SHAK performed as expected and the SD decreased numerically at post-test, indicating a more homogeneous reflection of their basic knowledge of AIDS.

TABLE 5.6: SHAK RESULTS/INTERVENTION SITE #2 (GST/NW)

Summary of the paired sample t-test for the Scale of HIV/AIDS Knowledge

	Subjects (N)	Mean	SD	df	t-value	p
Pre-intervention	26	112.77	11.74	25	-3.29	<.01
Post-intervention	26	119.73	12.19			

Results from the second intervention were highly significant ($p < .01$), and in the predicted direction. There was a slight but non-significant increase in variability of scores, as measured by the SD. This slight increase in variability, in contrast to the post-test variability at Site #1, may have resulted from uncontrollable external factors (reference Table 4.2, Sections 4.8.7.2, 4.8.7.2.1, 4.8.7.2.2 and 4.8.7.2.3) that had an influence at the time of the intervention.

These results indicate that the curriculum intervention provided at both venues was effective in increasing theological students' basic knowledge of AIDS.

5.6.2 Area Two: Students' gender views towards men and women infected with HIV/AIDS

The second area that was examined to determine the effectiveness of the curriculum intervention was students' perceptions of men with AIDS and students' perceptions of women with AIDS. Based on the literature review and the fraternal interviews (Sections 2.6.7, 2.6.8 and 2.7), it was apparent that a majority of the males had some negative perceptions and unrealistic expectations of females in the area of sexual behaviour. Women comprise the gender group with the highest number of HIV infections and yet some cultural and theological teaching may leave them unable to make safe sexual choices. Because HIV/AIDS is a sexually transmitted disease, the topic of gender perceptions pertaining to sexuality was determined to be of importance within the curriculum intervention. It should be noted that the topic of gender perceptions pertaining to sexuality was not presented to the classes in depth as a separate unit; however, it was addressed in many of the class activities and lectures.

To measure the effectiveness of the curriculum intervention on this issue, two quantitative instruments were used: *Personal Reflections of Men with HIV/AIDS* (PRM) and *Personal Reflections of Women with HIV/AIDS* (PRW) (Appendix H; Appendix I). These instruments contained identical questions and requested participant reflection according to gender. They were constructed with 13 matrix questions that utilized a 7-point semantic differential scale.

Reverse scoring was used to reduce response sets, and a split-group design was used to avoid testing as a threat to internal validity (refer to Section 4.6.1).

The instruments were completed anonymously at both intervention sites. The demographic information requested on each instrument required the respondent to identify only gender, race, and culture (refer back to Table 5.4 for demographic results).

Tables 5.7 and 5.8 present the results for both intervention sites pertaining to *Personal Reflections of Men with HIV/AIDS*.

TABLE 5.7: PRM RESULTS/INTERVENTION SITE #1 (CTS)

Summary of the paired sample t-test for the Personal Reflections of **Men** with AIDS

	Subjects (N)	Mean	SD	df	t-value	p
Pre-intervention	4	57.25	6.70	3	1.45	ns
Post-intervention	4	50.75	5.91			

It was originally assumed that post-test scores would increase significantly for both men and women as a result of the curriculum intervention; however, the opposite, albeit not significant, result occurred with the PRM at both intervention sites. The fact that it happened at both sites is an important finding that merits additional research. The consistent theme in the curriculum challenging gender stereotypes should be explored within the context of the curriculum intervention. Specifically, additional research should address the question of the impact of the presenter's gender on the outcome of the PRM.

TABLE 5.8: PRM RESULTS/INTERVENTION SITE #2 (GST/NW)

Summary of the paired sample t-test for the Personal Reflections of **Men** with AIDS

	Subjects (N)	Mean	SD	df	t-value	p
Pre-intervention	13	62.54	8.04	12	1.30	ns
Post-intervention	13	57.92	9.43			

As with the CTS students, the GST/NW students viewed men with AIDS in a more negative light at post-intervention, although the difference was not significant. Again, one must ask whether the gender of the presenter influenced the post-intervention average, or whether it was due entirely to the curriculum content. Additional research is needed. Although the SD

for the CTS group decreased, the SD for the GST/NW group increased. The change in variance in both venues was not significant.

Tables 5.9 and 5.10 contain the results for both intervention sites pertaining to *Personal Reflections of Women with HIV/AIDS*.

TABLE 5.9: PRW RESULTS/INTERVENTION SITE #1 (CTS)

Summary of the paired sample t-test for the Personal Reflections of **Women** with AIDS

	Subjects (N)	Mean	SD	df	t-value	p
Pre-intervention	4	51.75	4.99	6	-2.00	<.05
Post-intervention	4	62.25	9.22			

According to the results, the respondents' views of women increased significantly ($p < .05$). This result was expected as a result of the intervention. Though the SD increased numerically, the change was not significant.⁷⁰

TABLE 5.10: PRW RESULTS/INTERVENTION SITE #2 (GST/NW)

Summary of the paired sample t-test for the Personal Reflections of **Women** with AIDS

	Subjects (N)	Mean	SD	df	t-value	p
Pre-intervention	13	61.77	8.65	24	-1.32	ns
Post-intervention	13	66.70	10.25			

Within the second intervention, test scores increased in a positive direction, but not at a significant level. The t-value approached significance, but would have needed to be larger than -1.71 to reach significance at the .05 level. Perceptions became somewhat more varied at post-test, as indicated by the non-significant increase in post-test SD. It is plausible that opinions changed for some, but not for all of the participants. The class was predominantly male (N=24:26). The gender of the instructor and/or strong cultural gender issues could have affected these scores. Additional research would be needed to determine the impact of these variables.

⁷⁰ The F-test for homogeneity of variance yielded a non-significant F value of 3.41. The critical value of F at the .05 level of significance is 9.28, when $df=3$.

These results indicated that the curriculum intervention provided at both venues was somewhat effective in addressing students' existing gender views towards men and women infected with HIV/AIDS. Although the respondents' perceptions of women increased in a positive direction (significantly so at CTS), their perceptions of men decreased questionably at both venues, although not significantly so. It was concluded that more research would be necessary to determine the inconsistencies in these gender-specific test results.

5.6.3 Area Three: Students' perceptions of people infected with HIV/AIDS

The third area of evaluation for effectiveness related to students' general perceptions of people with HIV/AIDS. These were compiled from daily entries in students' journals. Journal entries were structured; students were given questions that provided guidance pertaining to issues covered (Moon, 1999:195). Reflective journaling was utilized to enhance their learning, to deepen their quality of the learning, and to increase their active involvement in the learning process (Moon, 1999: 189-190). It was surmised that reflections would allow the students to reflect honestly on the topics being addressed in class, and that this would give the researcher insight into further needs within the curriculum intervention.

The primary goal of the Day 2 journal entry (Appendix J) was to obtain students' reflections on class activities aimed at determining feelings about those with HIV/AIDS. The researcher was looking for reflections of emotion and compassion with regard to those with the disease. This was judged as important because of the stigmatization generally experienced by those who have the disease. An additional goal of this exercise was to provide students with an example of the personal and societal context of this disease.

The Day 2 journal entry was a response to the article entitled "Death Stalks a Continent" (TIME, 2001). Within the article were real-life scenarios describing the lives of five African AIDS victims: a TB patient, a female outcast, a truck driver, a prostitute and a child who had been infected by his mother. Students were asked to reflect on which scenarios in the article evoked the strongest emotion and why. It was anticipated that the reading of the article would begin the process of re-sensitizing students to the plight of AIDS victims. The three female victims in the article (the outcast, the prostitute and the child) were all victims of the disease through family neglect or rejection. The two male victims in the story (the truck driver and the TB patient) knowingly took sexual risks and were unconcerned about possibly infecting others. Samplings of student responses are shown in Table 5.11.

TABLE 5.11: INTERVENTION SITE #1 (CTS) - RESPONSES TO VICTIMS OF AIDS - JOURNAL QUESTION DAY 2

Student Code	Character	Why?
FW#1	Child	It demonstrates the innocence of those who get the virus ... innocent children die. This is sad, very sad ...
MW#2	Outcast	Because her employer fired her without finding out exactly what was wrong with her ... she begins a downward spiral to eventually becoming nothing ... her mother kicks her out of the house and eventually the entire community begins to treat her like a dog ... all stem from ignorance and a lack of education on the situation.
MW#3	Truck driver	Shocking ... I think it is because the situation can relate to a white man. In South Africa, HIV/AIDS is mostly connected to the black cultures, but this situation seems to be the most real to me (as a white person). I can relate to it better.
MW#4	Child	A 3-year-old child does not deserve not to know the joy of youth. She should be playing outside, making friends and learning new things ... instead she lies in bed almost not knowing a day of health. Jesus help us if we don't help the next generation be a better one. A feeling of deep sorrow filled my heart, as I fight back the tears. I realize how blessed I truly am!!
FW#5	Outcast	She was a hardworking woman who dedicated her life to earning money so that she could support her children, but when they found out that she was HIV+ her family (those she supported) abandoned her. She was courageous enough to be honest, but she was rejected because of it. No one in the family helped her. I can't believe how a community would treat someone with HIV.
FW#6	All of them	No treatment, just rejection ... go home and die. A mother who cares more about the money her daughter earns than her daughter. With the prostitute, it was the arrogance of the men in her culture. The fact that the embarrassment about sexuality looms more important than future health risks. I feel helpless when I read about the child ... because the government refused to license or finance the use of Nevirapine.
MC#7	Outcast	I was appalled by the lack of compassion, especially from her mother. The fact that her children were ashamed ... whether it was fear or ignorance it shows the need for AIDS education.
FW#8	Truck driver	It was shocking to read about how he thought men will die if they don't have sex ... he is upsetting to me because he knows of the risk of carrying the disease to his family, but he does it anyway.

Results: Outcast (N=3:8); Child (N=2:8); Truck driver (N=2:8); "All of them" (N=1:8)

It was of interest to note that three students in Intervention Site #1 chose the scenario of the outcast as being the most affective. Other affective choices were the child victim (N=2:8), the truck driver (N=2:8) and "all of them" (N=1:8) (although this respondent mentions only the three female victims in her "Why?" response). Qualifiers for the responses to the female victims were sentient words such as *pity, innocence, sad, ignorant, sorrow, tears, abandoned, helpless* and *appalled*. The qualifiers for the male victims (the TB patient and the truck driver) were the words *upsetting* and *shocking*. In addition, many of the journal responses revealed some empathic or analytical evaluation of what was happening within the personal and societal context of an AIDS victim's life.

Responses from those in Intervention site #2, dominated by males (N=24:26), were unexpectedly emotional and empathetic. Responses are found in Table 5.12:

TABLE 5.12: INTERVENTION SITE #2 (GST/NW) - RESPONSES TO VICTIMS OF AIDS - JOURNAL QUESTION DAY 2

Student code	Character	Why?
MB#1	Prostitute	What she is doing is dangerous ... will worsen the situation. She should ask for help.
MB#2	Prostitute	She had to do something she didn't want to ... something that nobody on earth deserves. She had no choice ... she had a need.
MB#3	Outcast	To see a woman in pain, sorrow and shame ... all because she was sick with AIDS.
MB#4	Outcast	This person is sick and needs attention and comfort ... if you send her away she may commit suicide.
MB#5	Prostitute	... the life she lived is not a good life. The prostitute was "like enjoying the life", but she didn't know HIV/AIDS was killing people.
MB#6	Prostitute	Because she had to do a thing that she didn't want to do. Poverty leads her to prostitution.
MB#7	Prostitute	I had a wrong idea about them (prostitutes), but this lady changed my heart. No one wants to be a prostitute but they are forced by matters arising from their homes ... to support their families.
MB#8	Outcast	Because she was expelled by her family because of her HIV status whereas her brother is undergoing the same thing and is not expelled or rejected.
MB#9	Truck driver	He has no time for his family because he travels, and then prostitutes sell their bodies to him at a hotel.

Student code	Character	Why?
MB#10	Child	In the second half of the story, regarding Tsepho (AIDS orphan) ... makes me angry how the relatives wait like scavengers for his HIV mother to die!
MB#11	Child	I cannot run, because God has called me to take care of these children.
MB#12	Prostitute	I feel so very sorry for her because she is putting herself at risk of HIV because of the pressure to care for her kids.
MB#13	Child	She came into the world, not of her own choice, and has to suffer the consequences of her father's actions. It tears me up inside to read the pain she underwent.
MB#14	Truck driver	The man is selfish and stupid. He doesn't take responsibility for his wife's health. He is inviting death into their marriage ... he is unfaithful and unworthy to have such a faithful woman in his life ... he doesn't think about the future of his family and of his life. That for me is just PLAIN STUPID!
MB#15	TB patient and Outcast	This patient is very much ignorant and is likely to put the lives of those who care for him on the line. The outcast ... rejection and ignorance will lead to disrespect. Acceptance will prolong the lives of many and dreams and futures will be reached.
MB#16	Child	Tsepho – being ostracized by the community. The worry will affect him!
MB#17	Truck driver	Stirred my emotions because of his selfish attitude. Made me angry.
MB#18	Truck driver	I pity his wife because she didn't know what was happening.
MB#19	Truck driver	It is a painful and unfair situation ... his wife can do what he does, but she chooses not to. At the end of the day she suffers this virus and dies.
MB#20	Truck driver	I am disappointed with his behaviour. He is busy spreading HIV/AIDS to innocent husbands and boyfriends of these women including his innocent wife.
MB#21	Truck driver	Stirred up my emotions especially when I think about the poor woman – he doesn't think about the future of his family ... he could leave his children fatherless.
MB#22	Child	The child is an innocent victim. He/she carries the evil of one of the two people who brought that child into the world. Sad to see babies carrying the burden of suffering because of ignorance, irresponsibility, and a lust for sex.
FB#23	Outcast	I was so touched ... no one supported her; they sent her away even from her home.
MB#24	Child	This child never had the privilege to experience life.

Student code	Character	Why?
FB#25	Outcast	She had nowhere to go or get help. No treatment, no support, no encouragement – her own children were ashamed and frightened of her.
MB#26	Prostitute	She is vulnerable. She is willing to earn a living some other way but can do little to change her situation. She is in constant danger from her work. When there is no money she is stressed and traumatized by perpetual poverty. Loneliness haunts her ... she is ostracized.

Results: Prostitute (N=7:26); Truck driver (N=7:26); Child (N=6:26); Outcast (N=5:26); TB patient (N=1:26)

Of note was the fact that the two females in the class both empathized most with the female outcast. Their identical choice could have been a coincidence, a result of after-class discussion, or may have resulted from a response of empathy with women in their cultural context who contract AIDS.⁷¹ The other 24 students (all males) were evenly distributed in their choices for the victim that evoked the strongest emotional response. Seven (N=7:24) chose the prostitute, seven (N=7:24) chose the truck driver, six (N=6:24) indicated a sentient response to the child and one responded emotionally to the TB patient. Three of the men (N=3:24) empathized with the female outcast. Many of the responses displayed an analysis or evaluation of the scenario pointing to injustice or the unfairness of the situation. One of the males (MB#7) stated that he had previously held the wrong idea about prostitutes, admitting that the prostitute's story had impacted him. As with the qualifiers recorded by students in Intervention #1, many were affective words such as *pain, sorrow, shame, suffer, selfish, stupid, unfaithful, unworthy, pity, unfair, disappointed, innocent victim, sad, vulnerable, traumatized, loneliness* and *ostracized*.

After two days of class (over 7 hours of instruction), this exercise was a means of determining what students were thinking. It appeared that the intervention was impacting their thoughts pertaining to people with HIV/AIDS. Responses in their journals at this point were quite different from some of the responses that had been expressed in class discussions two days earlier during the Analysis of the Problem exercise (refer to Section 4.7.4).⁷²

⁷¹ It was noted that one of the females in the class came from a family where her four sisters were infected with the virus and the other female came from a very remote rural area where it appeared that very little was known about the disease. (This was determined by her responses in class). This kind of stigmatization could have taken place in their home environments.

⁷² Typical responses to people with AIDS on the first day of class had been that those infected are sexually promiscuous and they are getting what they deserve; it is a gay disease; it is God's judgment for their behaviour;

Responses appeared to show more empathy for AIDS victims, but (as was seen with responses to the truck driver and the TB patient) continued to display an unsympathetic tone for people who freely (i.e. without financial need) engaged in sexual behaviour that might infect them or their family members.

An additional activity designed to assess students' perceptions of those with AIDS was presented near the end of the intervention. This exercise was entitled "Attitudes". There was a brief in-class discussion of the cost of antiretroviral medication over a lifetime. The class was informed that a pharmaceutical company had provided a "scholarship" for one "deserving" person to receive free treatment for life. Three candidates were introduced to the class: (a) Jack – a plastic surgeon who specializes in reconstructive surgery on children with birth defects and burns; (b) Sally – a health worker; and (c) Nomsa – a domestic worker.

Additional information was gradually given to the class about each person in an attempt to help students decide who should receive the free treatment. These pieces of information contained details designed to evoke an emotional response (e.g. "Sally is a single parent with three small children"). The exercise continued, with descriptors being assigned to each candidate, as the class attempted to decide who would be the most worthy candidate for the free treatment. The exercise was not addressed in their journals, but class responses clearly indicated that students had begun examining AIDS victims from many different perspectives before judging them. The stereotyping that had taken place early in the intervention was diminishing.

One of the primary goals of the intervention was to change general perceptions of those with AIDS. From the results of quantitative instruments and classroom responses it appeared that planned changes were taking place in the perceptions of the participants and that the curriculum intervention could be regarded as effective.

5.6.4 Area Four: Students' perceptions on the role of the church in addressing HIV/AIDS

The fourth area examined for effectiveness of the curriculum intervention was that of student reflections on the role of the church in addressing HIV/AIDS. This area was analyzed through the students' reflective journal responses to questions presented on both Day 5 and Day 7 (Appendix J). Question 5 addressed whether the church should educate young people

it is a disease of poverty. Some of the students even questioned the reality of the disease, thinking that statistics were grossly exaggerated because they never knew or observed anyone who had the disease.

about STDs and AIDS. Responses were qualified with a "Why?" or "Why Not?" explanation. Responses were coded for categorization as follows: T=training and preparation; S=spiritual; K=knowledge; M=moral; and C=church's responsibility. Responses from each intervention site can be seen in Table 5.13 and Table 5.14 respectively:

TABLE 5.13: INTERVENTION SITE #1 (CTS) – SHOULD THE CHURCH TEACH THEIR YOUNG PEOPLE ABOUT STDS AND HIV? - JOURNAL QUESTION DAY 5

Student Code	Summary Response Yes/No	Explanation
FW#1	Yes	Parents and churches are not addressing the matter all ... many young people are so unaware of the danger that is out there. (K)
MW#2	Yes	I do ... we tend to look away and think that it's not the church's problem. ... in truth, many children and youth are sexually active. The school's programme does not offer them a solution for the guilt and pain that they have to face from rejection and un-forgiveness. (S)
MW#3	Yes	... it should be part of youth group curriculum. The church is in the business of helping kids set up values and build character ... so it can be very effective. (M)
MW#4	Yes	... this curriculum should definitely be part of the youth group teaching. It is important to equip the young people with the knowledge to make the appropriate decisions before they make the bad ones. (K)
FW#5	Yes	I definitely believe that educating young people about STDs and AIDS should be a part of the church youth group curriculum ... this is imperative and will be instrumental in changing the statistics with regard to STDs and AIDS. If we only teach how to have safe sex, but don't teach them the reality of possible consequences, then we are doing them an injustice. (T)
FW#6	Yes	STD and AIDS education should definitely be part of our youth group curriculum. Not everyone realizes the need in our day and age. These topics are so important because most young people are completely uninformed. We push abstinence so much, but never tell them WHY! (T)
MC#7	Yes	After the video today ... I realized the necessity to educate young people on these matters. I would make it compulsory because there is so much ignorance about the whole matter. The current information teenagers have on the subject is quite shocking, and as a result they do not know the necessary prevention measures. (K)
FW#8	Yes	I do think it should be part of church youth group curriculum. Teenagers need to be educated about these things so they can be aware of how serious it is and how it can be prevented. Kids make the mistake of getting sexually involved but don't realize how and what serious consequences there are for

Student Code	Summary Response Yes/No	Explanation
		their actions. (K)

Results: Yes (N=8:8), No (N=0:8)

K (N=4:8), T (N=2:8), M (N=1:8), S (N=1:8)

Reasons: (T)=training and preparation, (S)=spiritual, (K)=knowledge, (C)=church's responsibility, (M)=moral reasons

TABLE 5.14: INTERVENTION SITE #2 (GST/NW) – SHOULD THE CHURCH TEACH THEIR YOUNG PEOPLE ABOUT STDS AND HIV? - JOURNAL QUESTION DAY 5

Student Code	Summary Response Yes/No	Explanation
MB#1	Yes	I strongly believe that educating young people about STDs and AIDS should be a part of church youth group curriculum ... we have so many young teenagers in the church who are not mature spiritually. (S)
MB#2	Yes	I believe that it is the best thing that the church can do. Young people are taught to use condoms so it encourages sex ... but in the church they must be taught to abstain until marriage. Bend the tree when it is still small ... it is better at an early age (11-14). (T)
MB#3	Yes	Because it will help young people to get knowledge and make up their mind concerning STDs and AIDS ... [they] will be able to fight against [it] in the community. (K)
MB#4	Yes	It is good to teach about it from a spiritual perspective (spiritual doctrine) ... and it must start young (8-10 years old). The teaching will be contagious if committed young people teach other young people. (S)
MB#5	Yes	So that they cannot do sex and not know that there is responsibility. Because some of them have this AIDS, so they need to know about it. (K)
MB#6	Yes	Because some young people are ignorant about this disease ... some of their parents are not able to freely talk about it with them. (K)
MB#7	Yes	It should be for adults too. Because in church they focus on spiritual development forgetting the physical. (K)
MB#8	Yes	Because this will be great help from this generation to the coming generation. As one of the students in our class said, prevention is better than cure. (T)

Student Code	Summary Response Yes/No	Explanation
MB#9	Yes	Young people want to know more about the diseases that are taking place in our communities. Gone are the days when we used to hide things from our young people. If we as the church are not talking about it, the secular world will tell them ... and we are not going to like it. (T)
MB#10	Yes	Young people today are exposed to sex through different sources and none put it in a spiritual context ... it is shown as entertainment. Those same sources dismally fail to warn them about these diseases. The church should lead the way in teaching about sex. (S)
MB#11	Yes	Because they need to grow up knowing these things. By educating we will reduce the number of young people who get sick. (K)
MB#12	Yes	It is good to teach young people about this before they get involved ... to grow a healthy church we need to look at morality. (M)
MB#13	Yes	Because people need to know of the dangers that are part of their sexuality. (K)
MB#14	Yes	Knowledge is power. People are dying because of a lack of knowledge. I believe that teaching will somehow reduce the risks of being infected. (K)
MB#15	Yes	There are 2.1 million children younger than 15 infected. We need to educate them on how to live with and take care of the infected and take precautions as they do. (T)
MB#16	Yes	Because HIV is killing young people in the church. (C)
MB#17	Yes	Because I believe those in the church are just like those outside the church. They need to know the risks of falling in love outside of marriage and an unplanned sex life. (T)
MB#18	Yes	Because they need to know the risks of sleeping with many partners. They need to know that each time they have sex with a new partner they double the number of people in their sexual history. (K)
MB#19	Yes	Because church is the best place to teach young people about a good moral life. (M)
MB#20	Yes	It is important that young people have full knowledge of STDs and AIDS. (K)
MB#21	Yes	It is a wonderful thing to educate young people about this in church. It seems that most young people come to know the Lord while they are suffering from the disease. It would also equip youth when they are doing their mission [evangelism] ... they will know what to do when they find people who are suffering from these things. It will also help young people not to take chances in sleeping around with strangers before marriage. (T)
MB#22	Yes	It should not only be part of church youth, but should be generalized to all

Student Code	Summary Response Yes/No	Explanation
		youth groups irrespective of church or religious affiliation. (K)
FB#23	Yes	Because young people move so fast these days. Some of those who are innocent are mixing with those who are indulging in sex and drugs and it causes a lot of peer pressure. (K)
MB#24	Yes	Because it will help young people to know that we understand their sexual feelings and are not shying away from it. (K)
FB#25	Yes	Because 50% of the people in the church are young people. Educating them about this is important because there is great risk. The more they know, the more they will be able to know how to protect themselves. (K)
MB#26	Yes	Because it is a physio-spiritual approach to address these issues. Whether in church or not, youth are an experimental age group, very inquisitive thinkers and critical rationalists. Their sexual curiosity and exploration leads them to high-risk behaviour. They need to know how their bodies work and how to cope with its sexual functions in the right way. (K)

Results: Yes (N=26:26), No (N=0:26)

T (N=6:26), K (N=14:26), S (N=3:26), M (N=2:26,) C (N=1:26)

Reasons: (T)=training and preparation, (S)=spiritual, (K)=knowledge, (C)=church's responsibility, (M)=moral reasons

Students in both interventions were unanimous in their belief (N=34:34) that a curriculum for church youth should include training about STDs and AIDS. The majority did not believe this training was for spiritual or moral reasons, as might be assumed from a class of pastors-in-training. Of the 34 possible votes, more than three-fourths (N=26:34) indicated that students should receive this information as training and preparation for life or simply as knowledge (the facts). The remaining third (N=8:34) indicated that this was linked to moral training, spiritual development, or it was simply the church's responsibility. The data indicates that students saw the value of the information for life in general, not just as a part of the church agenda to propagate doctrine and thinking. Even so, it was apparent from their unanimous responses (N=34:34) that training about STDs and AIDS should be a function of the church. This indicated a clear shift from their first-day journal responses (Table 5.2).

Although students unanimously saw a need for this kind of training for the youth and felt that the church should function in this role, they expressed some hesitancy regarding educating the church as a whole. The Day 7 journal entry asked students to put themselves in the

position of a senior pastor with knowledge of biblical boundaries and expectations for sexual behaviour and relationships. With that position and knowledge in mind, they were asked to reflect on what might happen if they taught (or preached) on this subject in their church. Responses from students at Intervention site #1 are found in Table 5.15:

TABLE 5.15: INTERVENTION SITE #1 (CTS) – HOW WOULD BIBLICAL TEACHING ON BOUNDARIES AND EXPECTATIONS FOR SEXUAL BEHAVIOUR BE RECEIVED BY YOUR CONGREGATION? - JOURNAL QUESTION DAY 7

Student Code	Received well? Yes/No/Not sure	Explanation
FW#1	Not sure	Might take awhile to open up ... shock at first because parents don't like to talk about it. That is more reason to do it! Teens would be very welcoming of any information because there is such a lack of open, honest communication especially in a spiritual context.
MW#2	Not sure	Would cause good and bad reactions. Truth is many of the churches today don't educate for fear of embarrassment. The younger people would welcome it, not the older. There is a fear of losing members if things don't go right. Because of this mindset the church is weak in combating the fight against HIV/AIDS.
MW#3	No	Very difficult topic ... in general it would not be welcomed. People don't want to hear about what they should not do because it will make them feel bad. But the pastor should mention it anyway, in the light of encouraging sexual purity instead of asking how far is too far.
MW#4	Yes	I would structure a sermon message that is empowering, educating and teaching them that these are biblical principals by which we should live. I could not be 100% sure about the response of the older crowd ... in the past people were very conservative and did not dare mention anything about sex or sexual promiscuity. Because of the older mentality, many young people do not know how to conduct themselves in an appropriate manner.
FW#5	Not sure	A mixed response. Shock from the older folks ... appreciated by the teens. Many feel parents (and not the church) should address this topic. But many parents don't educate or encourage their children in this area. Some parents would appreciate the church addressing this issue since they are very embarrassed and uneducated on the topic.
FW#6	Not sure	Probably more positive than negative. Pastors must stand strong and speak on difficult topics. The church needs to wake up ... there will always be people who oppose the truth. Teens will always accept this kind of teaching ... they are eager to learn.
MC#7	Not sure	Not everybody would be comfortable. Some believe that sex is a private matter and should not be discussed publicly. Many are afraid the teaching will go against their desires. Some see it as sensitive and

Student Code	Received well? Yes/No/Not sure	Explanation
		feel everyone should discover for themselves.
FW#8	Not sure	Mixed. Some would appreciate it because they want to know. Others might not welcome it because they feel awkward, embarrassed or shy about sexual behaviour.

Results: Yes (N=1:8), No (N=1:8), Not sure (N=6:8)

Responses from Intervention site #1 participants indicated that they were predominantly unsure (N=6:8) of how teaching on sexuality might be received within their church context. The primary reason was that the topic could cause embarrassment or discomfort. Half (N=4:8) mentioned that teens would be accepting of the teaching. Five of the group (N=5:8) stated that age would be a factor. One (N=1:8) stated that education on these matters is important and one (N=1:8) stated that this kind of teaching would not be welcomed, further stating that this is a difficult topic and "people do not want to hear what they should not do" (refer to Table 5.15). Overall, it appeared that the group saw the need for this kind of training, but they seemed unsure how such instruction would be received or how to teach/lead on the topic. Their hesitancy was apparent from their journal entries. The responses from the Intervention site #2 group are found in Table 5.16:

TABLE 5.16: INTERVENTION SITE #2 (GST/NW) – HOW WOULD BIBLICAL TEACHING ON BOUNDARIES AND EXPECTATIONS FOR SEXUAL BEHAVIOUR BE RECEIVED BY YOUR CONGREGATION? - JOURNAL QUESTION DAY 7

Student Code	Received well? Yes/No/Not sure	Explanation
MB#1	Yes	If I use Scripture, it will appeal to them and show them that God is concerned about their sexuality.
MB#2	No	Both young and old people would be negative. In rural areas people don't want their pastor to talk about it. Young people don't want to hear because they say you are denying them pleasure ... you are diluting the word of God with the things of the world ... the only time they will believe that AIDS is there is when they are infected.
MB#3	Yes	Teaching on sexuality according to Scripture would receive a positive response.

Student Code	Received well? Yes/No/Not sure	Explanation
MB#4	Not sure	You will find both positive and negative because of different beliefs and culture. If I want to make it effective there is no way I can combine an African father with his daughter and teach them about sexuality ... that is taboo. Nor can I combine an African mother with her son and teach about sexuality. I would prefer to divide them into groups that are comfortable for them and then teach about sexuality without hindrance and negative response. In some communities, combining family members is why they are responding negatively.
MB#5	Yes	They will see me as doing my job. I will teach the church before I teach the community. The church will then be a part of teaching the community.
MB#6	No	Sexuality should be taught about at the wedding, not on a Sunday. It will be better as a pastor to be sensitive to your congregation ... know what they want and what they don't want.
MB#7	Yes	Because it is relevant to many, not only in the church but in the community. I am sure they will listen and act upon what I have taught them.
MB#8	Not sure	It would depend upon every individual's belief. Some would come from cultures where it is taboo. To others it would be music to their ears ... a great help to many that may help them not to fall into a trap.
MB#9	Not sure	Some will be negative, some will be positive. In my day only adults spoke about this ... not young men or young ladies.
MB#10	Yes	Each group (young, old, unmarried, married) has its own behaviour to adhere to. All age groups are looking a lot and gaining nothing ... just a lack of self-control can destroy you and you will be left with nothing but regret. I would beg them to be teachable and correctable.
MB#11	Yes	Because I will help them to know the truth. They will love you because you tell them the truth about life and God.
MB#12	Yes	But the presentation will have to have some conditions (e.g. age, gender). The church will respond positively to this subject if only I include Bible scriptures to prove my points.
MB#13	Yes	Depends on the method of approach. Sexuality is not something that Africans associate with God. It is viewed as an act of nature for biological and survival reasons.
MB#14	Not sure	Positive and negative. Positive in a sense that they are taking the first step to approach the issues ... a breakthrough. Negative in a sense that there may still be a fear of AIDS and some may be embarrassed talking about sexuality openly (because of different cultures, morals and beliefs) It would require patience and continuous teaching ...

Student Code	Received well? Yes/No/Not sure	Explanation
		eventually it would sink in.
MB#15	Yes	As a pastor, my community knows that all I do is of God ... so they will respond because I will be teaching them from the Scriptures ... the living word of God.
MB#16	No	It is probable that the reason for the reluctance of pastors, churches and individuals to minister to persons with HIV infections and AIDS is that they have a <i>negative</i> feeling against the lifestyle of the persons who have been infected.
MB#17	Yes	They will respond well if I explain it well.
MB#18	Not sure	Probably both positive and negative. They will keep silent because they are afraid ... but then some Christians <i>are</i> afraid of the truth. I am a Pedi-speaking person and in our culture I can say that people will be perplexed. It's a taboo, abomination.
MB#19	Yes	Might be some hesitation. I would firstly invite the members of the community as well as the church members. The topic will be more sensitive to church members, particularly the elderly. The two groups will react in different ways (Christian/secular), but I believe young people will respond positively. The vocabulary will have to be a different one to the one they are used to.
MB#20	Yes	As a pastor in the community I am commissioned to lead the congregation. I do not fear their reaction. The word of God speaks to these matters. I would encourage them to live a pure life.
MB#21	Yes	Because in my community a pastor is a highly considered agent of heaven. This will make a great impact to teach them about these things.
MB#22	Not sure	The reaction is not much of an issue when it comes to teaching about God's standpoint on sexual immorality. God has set guidelines that I deem to be right. Their reaction will depend on your approach and the attitude of your presentation to the congregation. I would use friendly persuasion. This presentation should not just be to the church...but also involve the community. We are going to succeed. ⁷³
FB#23	No	Because as an African church this topic has never been taught about, it would have to be introduced in the right way and the people told how the virus is killing people. In my village there are lots of people who did not go to school because of poverty. They will respond positively if, as a senior pastor, I become wise and observe their needs.

⁷³ He expressed some uncertainty about the response of the congregation; however, he was quite confident in his ability to present this topic effectively.

Student Code	Received well? Yes/No/Not sure	Explanation
MB#24	Not sure	Probably both positive and negative depending on which age group is listening. The approach will always count. You must give specific reasons why you are addressing this topic.
FB#25	Not sure	Both negative and positive. Young people will respond positively because they are so interested on this issue ... they are zealous to know about it. The older people might feel I am disrespecting them. Talking about sex with your children has always been a disgrace ... parents are not comfortable with it. Lastly, a pastor is seen as a spiritual person ... they would see him talking about sex as surprising and unusual. Sex is not considered a spiritual issue.
MB#26	No	Because this would be considered culturally deviant. Teaching on sexuality is strictly for initiation school masters, a specially designated office for the elderly of the community. In some instances the response would be divided because of evidence from the Scripture. Tolerance might be given if the congregation is split ... men on their own and women in a separate group. A mixed group would not easily be tolerated.

Results: Yes (N=13:26), No (N=5:26), Not sure (N=8:26)

The results of the responses from the Intervention site #2 participants appeared to be more diverse than those from the first group. Half of the group (N=13:26) said that teaching on this topic would be received well in their churches. The other half of the class held divided opinions, with over half of that second group (N=8:26) not sure about the response to this kind of teaching. The remainder stated (N=5:26) that this kind of teaching would not be received well. The reasons given for their various responses are summarized below:

RESPONSE: Yes

Summary of reasons given

- Scriptural teaching is received well.
- The information is relevant; it is the truth.
- There is great respect for the pastor.
- It would depend on the method.
- It would be seen as community outreach to help others: the church would approve.

RESPONSE: No**Summary of reasons given**

- This is not something a pastor speaks about.
- This is not a spiritual matter.
- The people don't want the truth.
- There is a negative feeling towards the lifestyle that causes AIDS.
- This topic should only be taught at initiation school.

RESPONSE: Not sure**Summary of reasons given**

- You would have to separate the sexes (female and male) to talk about this topic.
- Cultural traditions would impact this teaching.
- This topic is only spoken of by adults; children should not hear.
- They have a fear of the truth.
- The approach of the teacher would be very important to acceptance.

Five respondents in this sub-group (N=5:26) addressed age as a factor in the acceptance of teaching on the topic, stating that young people would welcome the information, but older people would not. This reflected a smaller percentage on this point than that observed in the first intervention group. Statements that were considered to be reflective of cultural orientation were also contained in several of the answers (refer to Table 5.16). These were:

- In rural areas people don't want to hear about it.
- Young people do not want to hear about it because they say you are denying them pleasure.
- It is taboo for an African father to sit with his daughter or an African mother to sit with her son during this kind of teaching.
- Teaching on sexuality should be a part of the wedding, not Sunday church.
- In Africa, sexual matters are not considered spiritual ... only a matter of biology and survival.
- Parents talking about sex with a child, is a disgrace.

- Talking about sexuality is culturally deviant ... this should be restricted to initiation school masters.
- Men and women must be separated to talk about this topic.
- The only time they will believe that AIDS is there is when they are infected.
- In some cultures, the discussion of sexuality is taboo.
- Sexuality is not something Africans associate with God.

There were numerous class activities (in addition to the journals) where the church's role in the AIDS pandemic was discussed. Students appeared to recognize a need not only to educate their congregations about the disease, but to make them aware of the pandemic. A majority of the students had entered the class unaware of the extent of the pandemic (as was obvious from their Day 1 journal responses – Table 5.2). Later in the intervention, they acknowledged that their churches were unaware as well. However, it was apparent from this exercise that there was some hesitancy about how to lead this kind of change.

With this in mind, a large portion of Day 8 was spent discussing how to lead change effectively. Although this was not the main focus of the intervention, students felt empowered by this information and saw it as highly relevant to their situation. The exercise was seen as one which would help to equip them to lead a difficult change process. The following topics were discussed:

- Why people resist change
- Responses to change
- Reactions to resistance
- An eight-stage process for leading change
- Seven successful components that must all work together for change.

By the time the intervention was complete, many of the students in both intervention sites were commenting that they needed to get the information about AIDS to their young people. They could no longer remain inactive.

In conclusion, it was apparent that the intervention had a positive effect on students' perceptions of the role of the church in addressing the HIV/AIDS pandemic.

5.7 SUMMARY

The two parts of the research question were addressed in previous sections. In part one (refer to Sections 5.3, 5.4, 5.5), it was determined that the educational, cultural and religious factors examined were relevant for inclusion in the curriculum intervention, primarily as a result of the diversity displayed amongst the AOG/SA fraternals.

In part two of the research question (refer to Section 5.6), the effectiveness of the curriculum intervention was examined in all four areas of concern. Results of both quantitative and qualitative data-gathering efforts indicated that the curriculum intervention had been effective in the following areas:

- Knowledge of AIDS significantly increased at both intervention sites.
- Students' views towards men and women infected with HIV/AIDS did not all move in the anticipated direction. Results indicated a significant improvement in the views of women at the CTS site and a near-significant improvement at the GST/NW site. The views of men at both sites decreased, but not significantly so.
- There was a sensitization of students' perceptions (determined qualitatively) of people infected with HIV/AIDS.
- The intervention intensified and strengthened students' perceptions on the role of the church in addressing the HIV/AIDS pandemic (determined qualitatively).

5.8 RECOMMENDATIONS FOR FUTURE RESEARCH

Throughout the research, several areas were noted for further examination and additional research. Most of the areas presented here pertain specifically to the effectiveness of this HIV/AIDS curriculum intervention. Others are outside the parameters of the research, but highlight important questions that emerged during the course of the research.

The first and most foundational recommendation for further study pertains to the makeup of the student populations examined. The proposed design of this research included a coloured class population; it was hoped that the research would document results on all three cultural divisions of the AOG/SA. However, due to logistical complications and lack of cooperation by significant gate-keepers, that population group was unavailable. These unforeseen limitations were beyond the control of the researcher. It was agreed in consultation between

the promoter and researcher that the omission would not seriously jeopardize the results of this research.

In addition, valuable insight into the curriculum intervention could be provided if the study were repeated with multicultural classroom populations. The research indicated that the multicultural design of the intervention was effective in a single-culture classroom population. The assumption would logically follow that it would also prove effective in a multicultural classroom. A multicultural classroom environment might enhance the impact of the curriculum intervention. It would also be of value to test the curriculum intervention in a variety of tertiary-level theological institutions, those connected to church groups other than the AOG/SA.

Another recommendation for further research would be to repeat this curriculum intervention with a representative sample of AOG/SA pastors. Within the student population of the second intervention site (GST/NW), a few of the students were already serving or had served as AOG/SA pastors. If the feedback from these students is indicative of the response from the AOG/SA population, the curriculum would be positively received and would meet a perceived need. This examination could be refined by a stratified sampling distinguishing between rural and urban pastors.

Two additional studies are recommended, both pertaining to the presenter of the curriculum intervention. The first would examine the impact, if any, of the presenter's gender, on student outcomes (both quantitative and qualitative). This recommendation results from students' comments in the second intervention site regarding their preference of not mixing genders when the topic of sexuality is being discussed. Because the presenter of this research intervention was female, there were questions as to whether gender influenced some of the results apart from the impact of the curriculum. Subjects should be randomly assigned to two treatment groups, with male and female presenters. Of particular interest, such a design could assess if the PRM scores decrease, as in this research, when the curriculum is presented by males. Another recommendation in this regard would be that research be used to determine if a homogeneous class performs best when the presenter is of the same race/culture.

With regard to the instruments used in gathering data, a study is needed to formally (statistically) establish the reliability and validity of all three quantitative instruments (SHAK, PRM, PRW). Although these instruments were reviewed for face validity by professionals in

the HIV/AIDS field, and they performed as expected in the research, statistical validation would advance this line of research.

It would also be of value to the research if the instruments used in gathering quantitative data could be expanded to measure change in the thinking of participants on several suggested topics. These topics were noted as points of variance in interviews of the three fraternal. They were addressed within the curriculum, but measurements of change in participants' views could prove to be valuable. These topics were (a) various belief systems on sickness and healing (b) tolerance of other cultural views on medical treatment and death (c) the issue of stigmatization (d) issues pertaining to abstinence and (e) issues on the gender-based dual standards that appeared to be present regarding sexual infidelity.

As was stated within the research, the intervention was unable to effectively address the topics of poverty and illiteracy due to time constraints. Although quite distinct, these topics provide integral insights to the AIDS pandemic. It is recommended that the topics be explored within a short seminar format prior to student participation in the HIV/AIDS curriculum training. It is surmised that these seminars would provide a broad foundation for study in the area of HIV/AIDS which would benefit pastors and communities.

Lastly, the researcher made two informal observations during her class time at each intervention site, and recommends further examination of each. They were as follows:

1. There appeared to be a misunderstanding of the perceptions about the biological/physical attributes of the disease of HIV/AIDS. It was noted in both intervention sites that HIV/AIDS was perceived as a "blood disease". This misunderstanding was primarily based on the fact that blood is taken to test for the disease. When students were informed that the virus is also found in other body fluids (particularly semen and breast milk), they questioned the presenter: "But they say it is a blood disease. They take our blood to test for the disease." Upon further questioning, it became clear that the groups did not equate blood with sexual activity. This insight helped the researcher to understand why students expressed confusion when told that sexual intercourse can represent risky behaviour. The students' biological and chemical knowledge was possibly not sophisticated enough to understand that blood can be present within body fluids, albeit unseen. If this assumption were substantiated by further research, it could provide an excellent clue for educators who are trying to teach others about the virus.

2. The second observation, which took place at the GST/NW intervention site, concerned the role of nutrition. As was noted in Section 4.8.7.2.1 (footnote 58), the students at this site were given fruit during their break times as a boost of nutrition (e.g. vitamin C). Fruit was provided because the students' diet seemed to be deficient in protein, fresh fruits and vegetables. One day, the fruit at the break consisted of only bananas, and most of the class ate one. For the duration of the class (2½ hours), the students' attention levels were heightened noticeably. As far as could be ascertained, this was not a result of any unique feature in the curriculum design or content presentation. The contrast between student engagement with the course material before and after this nutritious break was striking and worthy of further investigation to ascertain the role of this specific kind of nutrition in students' engagement and performance.

5.9 REFLECTION

My reflection on this research will be presented in the following paragraphs. These will be reflections not only on the research, but on my internal growth and change as a professional in the field of education.

This research has been a long, intense process: however, as I reflect on it, I am grateful for the process. I have become stronger in all areas of my educational expertise, and with that strength I am enthused and excited. The horizons of educational experiences in the distance do not look as straight and narrow as I had previously envisioned. The sky appears to be the limit!

The first and most foundational observation is that I have actually begun to enjoy the research process. One of my loves in life is creating something from nothing by putting all of the pieces together. I am now convinced that research is nothing more than an intense exercise of examining and putting pieces together so that one can see a larger picture. In the end, a number of big pictures create a grand picture. Education is ultimately a team effort to create a grand picture. It is in this process of "creating together" that I feel most fulfilled.

Secondly, curriculum theory has opened a new world to me. For about a year after the beginning of my dissertation process, I questioned why I was in the Curriculum Studies Department at Stellenbosch for my doctoral studies. My interests had never been in that field; the terminology and concepts were foreign. As a professional, I felt threatened and thought that I had made a terrible mistake. Within time, I came to see this issue quite differently.

Before my work on this project, the concepts and theories of curriculum design were seen outside the box of my educationalist mind-set. Curriculum study and design, in my mind, was a topic for the ‘geeks’ of education and I was not a geek. I always prided myself on being a creative teacher in designing and presenting the classroom learning environments and experiences. However, my creativity had never overflowed into the actual creation of the curriculum. Through my studies and this research project, I have come to realize that I can help my students in ever more effective ways through the deliberate and informed design of my own curriculum to accompany my love of creative learning presentations. Ultimately this has produced in me an increasing amount of freedom within the educational process.

Many of the students in these interventions were numb and overloaded from all of the AIDS information they had previously received. None of it had meant much to them, or it had overwhelmed them to the extent that they had shut down emotionally on the topic. I felt that my job, as their teacher, was in part to re-sensitize them to the disease, to its victims, to the effects of the pandemic on our country and continent. It was important that my students see those infected with the HI virus as people and victims; victims of their own ignorance; victims of a killer disease; victims of a lack of education; victims of cultural practices that were depersonalizing, cruel and risky; victims of poverty; victims of gender discrimination; and victims of a government that has done a poor job of providing even the most basic of health care. Ultimately, within the context of this intervention, they were victims of churches that were uneducated about the pandemic and just did not seem to care about people outside their own doors. My goal was to promote change and the most effective way for that to happen was to educate the church leaders of tomorrow.

There were many times in the classroom that I had ‘light-bulb moments’; moments that gave me great insight into why AIDS educational programmes are not successful or effective or why churches are so silent on the matter. Many of these insights resulted from simple respectful dialogue between student and teacher or student and student. It was amazing to watch simple dialogue transcend multiple cultures with so little effort.

Before the intervention, students at CTS were suspicious and unreceptive to this course on HIV/AIDS. According to their statements, the topic was not perceived as being relevant to their life situations. They were not interested, they knew all they needed to know, and they had stereotyped those who were infected with AIDS. However, after applying the Rothman and Thomas intervention model to the problem, it was noted that the CTS class was the one that made more progress.

The GST/NW class, although suspicious of a "white woman" coming to teach them about this highly sensitive topic, was quite eager to learn. I could actually feel their desire to get questions answered when they entered the classroom for the first time. When polled, the majority of the class revealed that someone close to them had died from AIDS. It would have made more sense for that class to make more progress because the information was so relevant to their lives; however, I believe that there were some strong cultural barriers, barriers discovered throughout the intervention, that were difficult to overcome in their attempt to get information (e.g. a female teacher, two female peers sitting in a class of 24 males, the wide variance of ages ranging from 18 to 65 years of age and the taboo nature of a private topic being discussed publicly). With the realization that the length of the course was only nine days, it was amazing how quickly they did progress. This spoke strongly to me about the importance of contextualization in all aspects of the curriculum intervention. In the end, I was very pleased with the progress they did make, despite of the obstacles that stood in our way. It showed me that the curriculum intervention, if deliberately contextualized, had tremendous promise to reach those needing it the most, and that it was something which would be beneficial in training pastors as well as theological students.

I saw first-hand the impact that affective classroom activities contribute to teaching about the disease of AIDS. Never will I forget the tears on the faces of my students at the end of a presentation of the movie *Yesterday*. Males and females alike were so moved that not a word could be spoken for minutes. The tears said it all. I knew in that moment that they had regained their focus on the reality of suffering humanity and the ultimate triumph of good over evil within the most defeating of circumstances.

Lastly, my experiences at these two vastly different learning institutions gave me tremendous insight into and compassion for South African teachers who work under incredibly poor conditions every day for very little pay and even less recognition. They are truly heroes. The second intervention site tested every fibre of my commitment to education. It left me exhausted and questioning at the end of each day. And yet, there were moments during which I saw victory emerging out of the struggle. It was exciting to see the hunger in the faces of my students. It was gratifying to watch them break into broad smiles as their questions were finally answered. It was heartbreaking to hear them share with the class how a brother or sister had died from the disease because they "didn't know".

It was humbling to be thanked so many times for coming to "teach us like an expert." These moments made it all worthwhile and left me ready to face the next day, whatever challenge it might bring.

In the end, my mission to change the way young, up-and-coming pastors see AIDS was complete, as one young man pulled me aside after class and said, "I cannot remain silent any longer. I will teach my church these things." At that moment, there was the realization that the seed that I had planted and watered in the classroom had sprouted and it was time to go plant another field of potential change in South Africa's church.

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APPENDIX A

Results of Transcribed Interviews – Church Leaders and Pastors from Each Fraternal

Leaders from the three fraternals of the AOG/SA--demographics:*

The Group: The leader is white, English speaking, over 30 years in the ministry, 56 years of age with a national diploma as a land surveyor. He supervises 100 pastors (most are white, a few coloured and black) and does not pastor his own church

The Association: The leader is coloured and states that his culture is "no different from the white European culture". He is an English speaker with 38 years in the ministry, 63 years old and has completed a university diploma level education. There are 2 000 pastors (mainly coloured, 12% Indian, 5% black) under his leadership and he no longer pastors his own church.

The Movement: The leader is a black South African (Venda) whose primary language is Venda. He has served in the ministry for 23 years, is 61 years of age and has completed a technical college diploma. He supervises 500 pastors (45% Xhosa, the rest are Zulu and other) and personally pastors a church of 200 people.

**For the demographics on pastoral samplings from each fraternal see the conclusion of this document.*

The Leaders

SICKNESS

#1S According to your culture, what are the viewpoints surrounding illness and its causes?

The Group – not taking care of yourself, neglect of your health

The Association – various reasons ... blame others for your illness ("someone has caused this"), not walking right with God, not eating correctly

The Movement – the person might be "bewitched" or they may feel "someone has done this to me"

The Fraternal responses to Question #1S on sickness:

The Group –

1. Sickness could be a matter of lifestyle, habits, genetics but "God has no part" in their illness.
2. Sickness could be a result of "fate" or "ignorance" in areas of diet (etc).
3. Sickness is a result of their own "neglect" – another possibility – hereditary.
4. Sickness is a result of "bad lifestyle".
5. Sickness could be a result of "natural causes" or life in a "sinful world" but not necessarily a direct result of person's sin.

The Association –

1. Sickness is a result of "sin" – God allowed it. A few might say "a lack of care for themselves".
2. Sickness is a result of "loose living" (drinking, smoking), or a result of "lifestyle".

3. Sickness is a result of "natural causes" or "neglect of my own health". There is a relation of "cause and effect".
4. Sickness is a result of "unhealthy living".
5. Sickness is a result of poverty or genetics; a lack of discipline on the part of the person who has become sick.

The Movement –

1. Sickness is a result of "bewitching".
2. Sickness can be a result of "bewitching" ... the more educated ones are now connecting sickness to lifestyle and surrounding health issues.
3. Sickness would be the "influence of" or "caused by disharmony between" the ancestors and the person who gets sick or it could be brought on by an evil spirit which enters the picture because of a "break in relationships". The spirit of "disharmony" can make one sick.
4. In most instances it is associated with "witchcraft".
5. Illness and disease in our culture are linked with "witchcraft" ... when a person is ill, he is considered to be "bewitched".

The Leaders

SICKNESS

#2S According to your culture, what is the view of Western-style healthcare and medical doctors? What is the view of traditional African healthcare and healthcare providers?

(Traditional African includes sangomas, witchdoctors, crystals, etc. ... anything outside the formal structures of the medical community)

The Group – Western-style healthcare is very well received, trusted. Traditional healthcare – 99% of people in my culture do not accept.

The Association – Western-style healthcare is viewed in terms of economics. There is no problem with doctors ... it is the system that is viewed with scepticism (still viewed through "apartheid"). Traditional African – no response.

The Movement – Western-style healthcare-- people will go to a doctor but that was not always so. Now they're beginning to view doctors as the "help" they need. In the past they might go to both (Western/traditional.) Traditional – they are "respected and feared".

The Fraternal responses to Question #2S on Sickness:

The Group –

1. Western – High degree of regard, good level of trust.
Traditional – Small fringe might embrace them, but most would see them as "hocus pocus and snake oil".
2. Western – Great, they are trusted, no problem with them.
Traditional – "Taboo, charlatans"—younger generation, because of TV, is open to "new age thinking" (e.g. crystals).
3. Western – There is a healthy respect for them.
Traditional – "Great sense of caution" towards them.
4. Western – "High respect" for them.

Traditional – Increasing interest because of cost and deterioration of government hospitals (e.g. mostly homeopathic or natural remedies). Sangoma would be a "last resort".

5. Western – Fine and legitimate.

Traditional – Sangoma would be "evil, used by the devil". There is a general acceptance of crystals, acupuncture, etc.

The Association -

1. Western – "A good thing, they use them."

Traditional – "Mostly sceptical and critical"—poorer folks might view as the "only way out" to get answer or healing.

2. Western – People are quite dependant on them, they are valued and viewed in a positive light.

Traditional – Coloured people would not normally use them unless they move into a black township where they might be influenced to "try" this kind of thing.

3. Western – People are positive about them, they are considered to be instruments to aid in healing, but *poverty* keeps many away.

Traditional – People will use them because the medical community is allowing them some status; however, using them is usually a result of desperation and not wanting to face ill-run medical clinics where they have to stand in long lines.

4. Western – Doctors at the day clinics are not the best, doctors at major hospitals are very, very good—"trusted".

Traditional – Few people would go, they are not receptive to this kind of medicine. If they go, it is out of "desperation".

5. Western – "Okay", but most would go as a last resort (because it is too expensive).

Traditional – People are somewhat receptive (usually out of desperation).

The Movement –

1. Western – Many will go to a doctor and not a sangoma because they have got help.

Traditional – Respect and fear for sangoma ... lately some frauds have come on the scene ... this is a negative to the people.

2. Some of our group are becoming "enlightened" and realize that "medical science" is working for us. This group *might* go to a sangoma, but only as a last resort, i.e., the medicine that the Western doctor gave me did not help, maybe I can appeal to the spirits.

Traditional – the older generation believes that only "traditional healers" are there to help them ... they are viewed in a positive light.

3. Western – They will go to him for medicine to treat their illness or help "cure" them.

Traditional – People would go to a traditional healer to diagnose the "cause" (more emotional, spiritual cause) of the disease.

4. Western – They are recognized by our people, but they take a secondary place.

We would go to them for a medical certificate for work, death certificate or minor ailments such as flu or headache ... things we might use medicine for. Traditional – It is viewed as our "original" or "God-given" thing ... it must always come first.

5. Western – A few have negative feelings towards Western medicine ... but the majority view it as something helpful. Most will go to clinics or hospitals. Traditional – People have a positive view towards "sangomas, witchdoctors" ... it is believed that the spirits reveal to them how to heal us.

The Leaders**DEATH**

#1D *In the thinking of your culture, is it possible for outside spiritual forces to cause a person's death?*

The Group – No, "If it is your time, it is your time"—a matter of fate.

The Association – No, it is not possible for spiritual forces to cause a person's death.

The Movement – Yes, once a person dies people immediately wonder *who* might have "bewitched" them. *Example of this: A man dies of "Xhosa's malaria"—a man at the funeral encourages everyone to go and find out what "actually" killed the man ... because certainly a "little tiny mosquito" could not "kill" a man.*

The Fraternal responses to Question #1D on Death:**The Group**

1. No, most are pretty rational—a few might believe it is some kind of curse.
2. No
3. No, "life and death" are in the "hands of God".
4. No
5. Yes, it is becoming more of a prevalent thinking because people are becoming more aware of the "spiritual realm" (as a result of Hollywood personalities such as Madonna making such a public display of their "spirituality").

The Association

1. Yes
2. Yes, but not the norm
3. "Not really"
4. No
5. Yes

The Movement

1. Yes, because of "bewitching" or "anger of the ancestors"
2. Yes (a "sudden unexplained death" always brings the suspicion of evil spirits being involved).
3. Yes (the death of someone young always bring on the suspicion of outside causes of death)
4. Yes (accidental, unexpected death always brings the suspicion of evil spirits being involved ... i.e., someone dying in their sleep or in a car crash).
5. Yes ... when a person dies people won't be satisfied until they go to the "witchdoctor" to find out what happened. They want to know who killed the person ... they do believe in forces "beyond what we see".

The Leaders**DEATH**

#2D – *In your opinion, would religious people (people who attend church) agree with your answer?*

The Group – Yes

The Association – Yes, most would agree.

The Movement – Yes, but a few might say they don't agree.

The Fraternal responses to Question #2D on Death:**The Group**

1. Yes, for the most part
2. Yes
3. Yes, most believe God is sovereign.
4. Yes, "life is in God's hands" but some might not feel that God would cause death. Pentecost was very "blue collar" in its beginnings ... and that group is more inclined to put an emphasis on demons or the force of demons.
5. Yes

The Association

1. Yes, they would say "God is in control" and "He allows" things to happen.
2. Yes
3. Yes
4. Yes
5. No response

The Movement

1. Yes – but in the township culture "less and less people are believing such things".
2. No
3. Yes
4. Yes
5. No ... "because they now understand the protection of God upon our lives". Before we got saved, we believed in these things. But after we came to know Jesus Christ ... we believe that he is our protector and our shepherd."

The Leaders**DEATH**

#3D – *In the thinking of your culture is there a belief in the afterlife or a place similar to the Christian concept of "heaven"? Is there a belief in a spirit world different from the world we live in?*

The Group – Yes, they think there is something out there ... but may not be sure what it is or how it works.

The Association – Yes, those in church believe in heaven. Outside the church, I would say, yes ... but there is growing scepticism on what the church embraces.

The Movement – Yes ... this is why there is a strong belief in the ancestors. It is not necessarily "heaven", but they believe you will go to a place where you can influence the ones left behind.

The Fraternal responses to Question #3D on Death:**The Group**

1. Yes, on all counts
2. Yes, strong inside and outside the church ... more so because the "occult" has become so prevalent.
3. Generally yes, they believe in "heaven" but are cautious about "hell".
4. There is confusion and I don't believe people spend much time thinking about it. Generally there is a belief in "heaven" ... but they are somewhat suspicious of "hell".

5. Yes ... I would probably say it is 50/50 ... [those who believe and those who don't] There is more of a tendency towards believing in a spirit world ... it has become a "socially acceptable" topic.

The Association

1. The majority of people believe in heaven or hell. There is strong belief in an outside world of foreign spirits (e.g. tokoloshe or snakes in dreams).
2. Yes, on all counts
3. Yes
4. Yes ... but there are a few atheists in our culture.
5. Yes, there is a belief in heaven or hell ... no so much in reincarnation. I have noted that some of our young people are picking up beliefs in "reincarnation" at the university.

The Movement

1. Yes (Example: We bury the person with mealies or corn to plant in the next life. When a chief dies, a servant must go along ... sometimes they are buried alive, sometimes the servant is killed and then buried. Since the servant serves as an "offering" ... sometimes they are just grabbed and thrown into the grave.) This is similar to Egyptian beliefs.
2. Yes ... in my culture there are few people who do not associate themselves with God ... even if they are not devout Christians. They believe that there is a God and they view the ancestors as the mediators between themselves and God.
3. Yes ... there is no concept such as heaven and hell but they do believe in life after death. They believe that there is a God and that *they are spirit*.
4. Yes ... in our culture there is a belief that there is a "world of the ancestors".
5. Yes ... because we believe in the ancestors. It is the "spirit" of the dead person and their *influence* that lives on ... not the actual person.

The Leaders

DEATH

#4D – How does your culture feel about the burial of the dead? Where and how is it prescribed that burial of the dead take place? Is cremation allowed or encouraged?

The Group – "Anything goes" – no prescribed way of doing it. There are no rituals that must be adhered to. Cremation takes place about 90% of the time.

The Association – There is a growing Muslim influence.

1. Rituals? Out of fear of the body being dug up and used for muti, the family will dig a "hole inside of a hole". In the first hole they will bury the body. The second hole is filled with concrete to prevent scavengers from getting to the body.
2. Open casket and open grieving is quite the norm ... this is not the same as in the European culture.
3. Apartheid would force people to have private funerals because they did not want others to know that they were actually coloured (when they were passing for white).
Cremation? Not widely accepted for two reasons: 1) Its incompatible with the anticipated bodily resurrection at Christ's second coming; 2) Its similarity to Hindu practices. I have noted that a few people want cremation to make sure the person is "completely dead" ... so they don't wake up in a dark coffin.

The Movement – burial sometimes takes place in a graveyard, sometimes burial takes place on the family plot [property]. This was done until the government said we could not do this for "health" [sanitation] reasons. Graves are to be 2 metres deep.

1. Rituals? – Corpse of a man (not women and children) must be wrapped in the skin of animal (goat or cow) and placed in the ground facing east.
2. Meat of the animal is eaten afterwards at the funeral supper.
3. Cremation? No, this is considered totally taboo ... out of respect for the dead person's body.

The Fraternal responses to Question #4D on Death:

The Group –

1. Pretty sanitized, very seldom (5%) is there an open casket. There is a trend towards memorial services or private cremations (75% of the time). This is because graveyards are poorly kept and usually in a bad part of town. Whites prefer something more "sanitized".
2. Funerals are a very quiet traditional affair, no rituals, cremation is totally accepted.
3. Most people just want to get it over with ... "keep the body away from me". Most do memorial services or private services at the crematorium. Open casket is rare ... done only at family's request. Cremation takes place approximately 60% of the time.
4. Nothing unusual, but never an open casket, no rituals. Cremation takes place 85% of the time.
5. Everything goes. There are no rituals *per se* ... one exception might be that the Afrikaner pays high respect to the dead with an expensive coffin. Cremation takes place approximately 50% of the time.

The Association –

1. Funeral is usually a big family thing ... all day affair. Food afterwards is a big thing with lots of fellowship. Open casket is "normal". Pall bearer is an important role and having your name on the programme is a big deal. Cremation is starting to take place in the community, but in the church we see 99% "traditional burial".
2. A lot of time and money are spent on burial ... people believe the deceased must have a "decent" burial. Funerals are "dress up" affairs, services lengthy with an open casket. Cremation takes place approximately 20% of the time. Resistance to cremation is a result of questions regarding the resurrection (Christian) and a need to "visit the grave" and decorate [for grieving purposes]. Cremation is "allowed" but it is not popular.
3. Family will rally for funeral. There is no "prescribed" way [ritual] except that the when taking the body into the service it must go in feet first and coming out the body must go head first. Cremation is not so much an issue anymore. With regard to cremation ... there is striving for "independent thought" in the coloured community ... they don't want their lives to be influenced by whites or blacks.
4. The body will go to the morgue first, and then to the house. The "dead must leave from the house" to go to the church. It is open casket with a service at the cemetery. "Everybody" is included. If it is a suicide then the body is not allowed in the sanctuary. Cremation is not used a lot because people believe they must get "closure from closing the grave".
5. The funeral is a whole day affair ... open casket. You could call it a "community affair". Rituals are usually from the undertaker ... not prescribed in the culture. Special requests for the body are respected. Cremation takes place approximately 50% of the time. Of late, it has become a prominent topic because of "land issues".

The Movement –

1. The male corpse is wrapped in the skin of an animal (normally a cow or goat). Meat of the animal is eaten after the funeral. Body is placed in the ground facing east. Cremation is not done ... out of respect for the corpse. Cremation is "totally taboo" at present ... but this is changing due to land issues. There is a need to see the corpse for "closure". The

family of the deceased will "converse" with the corpse in hopes of persuading the spirit of the deceased not to return to the family home.

2. In the olden days, there were not any mortuaries. The corpse would be kept in the house for two days. Someone would take a horse and go to all of the relatives and inform them that their family member had passed on ... and inform them of the funeral date. On the third day they would bury the body. Jeyes Fluid would be used to wipe the body down (and used to clean the house) – to keep the odour down. The body must be buried "face up" and it is wrapped in a special blanket. Cremation is not allowed ... the body of the dead is respected in my culture very much.
3. The person must be buried next to their ancestors. It is assumed that the dead person will communicate with previously buried family. There is great respect for the dead. They must be buried facing east and are wrapped with a cloth or animal skins (men only) and they must lie on a traditional mat ... because if you don't provide the mat, the person will come back and ask you why you did not include their mat!? The animal that is slaughtered must be slaughtered in a particular way to show respect to the dead person. Cremation ... is a disgrace in our culture ... not accepted!
4. It is something that is respected in our culture ... they cannot just be buried anyhow, anywhere. It must be at the place of their birth (even though his life may be far away) ... the family will come and take the body back to where the person was born ... where the forefathers were. The person must be wrapped in a brand new blanket ... because the deceased might come back and during the night ... and come to complain because he is 'getting cold.'. Sometimes they wrap the body in an animal skin. Cremation ... it is absolutely unacceptable.
5. The body is taken to the place of the "forefathers". People will speak to the corpse ... believing that the dead person "hears". If a person died through an accident ... the women will not go to the graveyard, they stay at home. Only the men will go to the graveyard to bury the body ... even if the dead person is a woman. In the olden days they would wrap the body in the skin of an animal and cloth. This was done because many times there were not any coffins. Coffins are a sign of progress! Cremation ... is something "strange" ... if you cremate something it is "unsettling."

The Leaders

HIV/AIDS

#1H – In your culture, how do people feel about the disease of HIV/AIDS?

The Group – People know it is there but don't think it will happen to them. It is a "black and homosexual" disease.

The Association – There is a growing awareness, but it is too slow. There are whites who feel that this is the "great equalizer" ... to reduce black numbers. *"What is of grave concern is how they are NOT seeing it."*

The Movement – This disease took us by surprise. We thought there is no such thing until people started dying from it. Now people don't want to talk about it because it is contracted from sexual intercourse ... and people don't want to talk about that in public.

The Fraternal responses to Question #1H on HIV/AIDS:

The Group –

1. People "don't feel it needs to be dealt with" because "it doesn't touch them." They see it purely as a "health issue" ... something quite personal. There are a lot of sceptics and the sceptics say that "the activists need AIDS more than AIDS needs the activists".
2. People say it doesn't exist ... they don't know anyone who has it.

3. Young people are bored with it. Older people don't see it as their disease. It is not "in their world" ...
4. It is seen as a "gay thing" ... Most whites don't think they will ever get it ... it is a "black disease". Many whites are taking sexual risks because of this.
5. Because of our church's location people are very aware of it. It is a bit taboo, but everybody knows someone who has the disease. It is kept quiet for fear of rejection.

The Association -

1. It is out in the open and people are not afraid to speak of it. It carries a stigma because it is sexual. Awareness/education programmes have helped.
2. People are aware and speaking about it but there is still a lot of secrecy even in families. People are still scared about the reality of the disease.
3. There is a growing awareness. At first there was apathy – now people are more open minded and realize it is not a "plot"; however, there is still stigma. Government needs to talk about emotional issues connected with this disease as well as physical.
4. Even with education there is still a lot of stigma and fear.
5. There is denial, stigma, shame ... but people are aware of it.

The Movement –

1. There is stigma, especially if you are married ... because this points to promiscuity. People are just starting to acknowledge the disease. At first they thought it was a "political gimmick" to keep blacks and whites apart [sexually] AFTER the apartheid laws were lifted. There is now acceptance that it is "a killer".
2. By now my people understand it as a real thing ... the majority of the people do talk about it because now we bury almost 10-15 people on a weekend and they all have diseases that are related to [or are a result of] AIDS. Fear? It differs from area to area ... but people do talk and will tell the burial services people that the person died of AIDS.
3. They acknowledge that it exists ... but in my culture it has been associated with immoral sexual behaviour ... someone who is a fornicator or adulterer. It is also associated [sometimes] with a "curse".
4. The feeling in families, communities ... it differs. In the beginning of this AIDS issue, people were so scared of it and it was totally unacceptable. Even those who were infected would keep silent about it ... and live in denial of it. Most of the time it is viewed as a disease of sexual promiscuity ... a person with "bad conduct".
5. Firstly when this thing of HIV/AIDS came to our culture, people thought that it was a spirit of "witchcraft" ... it was something strange. We viewed it as maybe a "curse" ... people were scared to discuss it. It was just a secret ... if you were diagnosed you kept it to yourself. If you happened to have the disease ... then you would be viewed as someone who was "promiscuous". When an innocent baby gets HIV/AIDS ... the blame is put on the parent. I can see that things are getting better ... people are being taught about the disease ... they are getting to understand these things. It is not a curse, it is real, it is a disease.

The Leaders

HIV/AIDS

#2H – *In your culture, does the community ever reject or ignore those who are infected with the HI virus or who are sick with AIDS?*

The Group – People are still scared and nervous about it because they don't understand completely how you get it. The under 30s relate better to those with this disease.

The Association – There is still a reluctance to acknowledge it [the disease] but this is from a lack of education. The communities are now beginning to say "we must do something" which is being seen through several actions ... including the adoption of orphans.

The Movement – Yes, we do see rejection. People are "worried" and uncomfortable with one they might suspect is sick (e.g. sitting next to person on communion day). Ignorance plays a BIG role in rejection.

The Fraternal responses to Question #2H on HIV/AIDS:

The Group –

1. "I don't see that we have been put to the test yet ..."
2. To a point ... but that is quickly changing.
3. No, but there is more compassion for the children.
4. Yes, some fear and rejection. The average person would keep their distance.
5. No, but this is a more educated community. "If anything, I see people with AIDS withdrawing more ... not because of stigma ... but because their sickness becomes more and more pronounced." There is stigma of any sick person ... no one wants to be around a sick person.

The Association –

1. I would say the rejection is 50/50 ... older people are eager to be educated to help ... they seem more compassionate.
2. There is a lot of care and concern ... a willingness to help. I have not seen outward rejection, but do see some "questions" if a person looks sickly.
3. In the past there was obvious rejection ... but not now. We teach about it and the community is embracing those with AIDS.
4. In general, no. They are too busy helping them.
5. Because there is denial, there is some "shunning" or hesitancy to touch. I have also noted some reluctance to be trained in how to care for those with AIDS.

The Movement –

1. People are getting accustomed and informed ... but there is still worry. Ignorance plays a big role in this response. The government needs to make up its mind how IT is going to respond! People are confused.
2. At the beginning, when we were not aware [knowledgeable] of this disease and its causes ... there was fear ... people were pushed away. Now that there is awareness, the people are more accepting.
3. To my experience, "no I have never seen this." In my culture there is a saying ... "a person is a person by the others." (Umunu umunu ubuntu???)
4. Yes, people can be rejected or ignored.
5. Yes, it does happen. There is a lot of rejection. Because people are scared of HIV. They kick them out because they are scared ... not because they reject the person. The person might be bringing the "curse" into the house.

The Leaders

HIV/AIDS

#3H – In your culture, is there a difference in how men with the disease of AIDS are treated and cared for in comparison to how women with AIDS are treated or cared for?

The Group – There is probably more sympathy towards a woman because she is more vulnerable.

The Association – There is greater empathy towards women. There is anger towards men who infect their innocent wives.

The Movement – Both are treated the same.

The Fraternal responses to Question #3H on HIV/AIDS:

The Group –

1. None that I have observed, but the "view" in general is that women are the victims and the men are the perpetrators.
2. No – AIDS is AIDS.
3. None noticed ... but there is great concern for the children.
4. Haven't experienced any.
5. No difference

The Association –

1. They are viewed the same.
2. There is more sympathy for women.
3. No
4. Not a lot of experience with this, but what little I have is that there is more care for the women (women are perceived as the victim and it is the women who are doing the caring ... women caring for women is more "comfortable").
5. Yes, men are treated or looked at more negatively. Women are viewed as the victims.

The Movement –

1. There is no difference ... but in the early days we would have viewed the woman as "promiscuous".
2. No ... it is the same now. In the beginning they viewed the women as "promiscuous" and for the man it would be okay.
3. Yes, women are seen as lose (prostitutes) ... men who are infected are thought of as "a man." They are treated about the same when it comes to care except that it is more comfortable for a women to care for a woman.
4. Sometimes it differs. Females suffer the most from this. There is one case in KZN where they stoned a female just for being HIV positive.
5. Yes, because there has been a negative attitude towards women in the black culture for a long time. If the same thing happens to a man and woman they will be treated differently.

The Leaders

GENDER AND SEXUALITY ISSUES

#IGS – *In your culture, describe or explain the most common and acceptable style of dating and/or courtship practices. Are young men and women allowed to have (or encouraged to have) friendly male/female relationships in high school and college or university?*

The Group – Dating begins in the teen years. Marriage happens around 25+ years of age. Everything (education, car, acquire goods) comes first ... then marriage.

The Association – We are very conservative in our culture. "When we hear of white mothers putting their daughters on the pill at 13, it blows our minds!" Dating would never take place in high school ... only group activities at that time. But the average coloured child is becoming sexually active from 12-13 years of age. For church children is it older. Casual sex is becoming more acceptable – this is a more Western influence which is affecting us.

The Movement – "Where boys and girls are together, there will be dating" [boy/girl relationships] ...we don't worry about it. Lobola [bride price] governs the time and age of marriage ... it is still very prevalent inside and outside the church.

The Fraternal responses to Question #1GS on Gender and Sexuality Issues:

The Group –

1. Dating is taking place from age 12. Serious dating can start too young and they become physically active. Marriage is taking two streams ... those marrying very young around 21, 22 years of age and those marrying later ... around 30. I have noted that they either "get married and go on to make a life or they make a life and then get married."
2. Dating and sleeping together is taking place around 13 – 14 years of age. By Std. 8 many have a steady partner. Marriage, on average, would take place around the age of 25 or older. Much of this young sexual activity is a result of boredom ... there is no place for the kids to go and nothing for them to do.
3. Boy/girl dating begins around 12. By Std. 8 they are starting to seriously date. Marriage, on average, would take place around 25.
4. Dating or sleeping together begins around 12-13 years of age. I have also noted that older boys (Std. 7-8) are using the younger girls for sex. Dating begins at university level around 18-19 years of age. Courting for marriage begins in late 20s, early 30s. Church kids date later. Average age for marriage is in the early 20s. Boy/girl relationships have become very casual with living together and no thought of marriage.
5. Boy/girl relationships begin from 13 years of age. Marriage takes place in late 20s, early 30s. "Affordability" is a huge issue.

The Association –

1. Boy/girl relationships begin around 14-15 years of age ... this is "puppy love". I have noted that kids take advantage of their parents' trust. Parents know that the kids need to socialize and allow them to go out ... but things are not always as they appear. Courting begins around 20-21 years of age. Average age for marriage is 24-25 years of age.
2. Boy/girl relationships begin with some physical contact around 13 years of age. Around 16-17 they get into sexual activity. Dating is acceptable on the university level.
3. Dating begins around 15, 16 years of age. Marriage takes place around 21, 22.
4. Boy/girl relationships begin around 15. Dating begins around 21. Marriage, on the average, takes place in the upper/late 20s. Reason? Economics
5. Boy/girl relationships begin in their teen years. Serious dating might begin around 17. Marriage, on average, takes place in early 20s.

The Movement –

1. Where boys and girls are together, there will be relationships (dating, courting). Ability to provide lobola determines age of marriage.
2. According to my culture ... though it might differ from place to place ... a person must be at least 18 years of age to begin dating. Courting (as a male) might begin around 21. Marriage ... there is no specific age, anything above 20 ... there is no pressure to marry. Lobola? Yes, we have to pay it. I paid it for my wife. It is a "custom" ... by asking a certain number of cows for the girl ... we are not selling her to you ... the relationship must be based upon something (you pay something of value for something YOU will value). If you don't pay lobola ... "easy come, easy go". No scriptural basis for lobola as far as I know.
3. A man cannot begin to look to marry until he is circumcised ... you are not a "man" until you are circumcised. You are just a boy. Circumcision takes place around 18, 19, or 20 ... so any time after that you are allowed to take a wife. Lobola is an issue. Lobola is like a membership fee ... I pay the family to allow me to take their daughter and to become a part of the family. Dating takes place from 15 years of age and upwards ... but there should be no "sexual intercourse penetration." Sometimes they do have sex without penetration ... "tight sex" [thigh sex].

4. Dating starts around 14-15 years of age. This type of male/female relationship is not really accepted in high school ... but it happens. Courting-it was the late 20s for me. In the Xhosa culture you do not think about getting married until you go to the initiation school. Lobola is a matter of must. It is a compulsory custom that the families must discuss before the marriage takes place. This custom is taken from Abraham [in the Bible] ... when he sends his servant to get a wife for Isaac. The servant took with him animals and jewellery, etc.
5. There is a new culture now ... you might see kids dating at 12-13 years of age. They are in couples! They know a lot of things ... they also experiment. There are those parents who are strict and protective and will not allow their children to mix or date. But there are parents who are allowing their children to go out while still in high school. But in the olden days, you needed first to mature ... maybe 20 years of age ... then you would approach women. But these days it is something that is accepted for younger kids to date. Courting would begin around 20-25. Lobola is still around and used. It is based on scriptures in Genesis ... the guy looking for a wife for Abraham's son had to bring gifts to trade for her. They [the parents of the man] negotiate the price of the bride ... in that way we are "building friendship" with the family ... but you can get some negative outcomes. If one pays a lot of money for a women, he might [think he has the right to] treat her badly.

The Leaders

GENDER AND SEXUALITY ISSUES

#2GS – How does your culture view young women who become pregnant and bear children outside the traditional marriage covenant relationship? In the same context, how does this culture view the fathers of children born outside of the traditional marriage covenant? How are these men and women treated within the church?

The Group – With the girls, people are quite relaxed about it. Everybody "lives together". Hollywood is influencing this. With the boys, there is some stigma, but it is "acceptable". Within the church they would be supported and helped ... although it would not be viewed in a good light. If they are leaders, they would be asked to step down from leadership and the matter would be made public "so that others may be warned" (scriptural handling of sin in leaders).

The Association – It is changing with regard to girls ... two generations ago this situation would be viewed with "disdain". It is now becoming more and more accepted ... even schools want to start classes for young women who fall pregnant so that they can finish their education. With regard to the young men ... they are viewed as "bastards". Within the church these young people are not rejected as in days gone by. There is help and support.

The Movement – With regard to girls ... they are not well received. With the boys there is a stigma attached to him. If it were my daughter I would think, "He has insulted me by taking daughter's virginity". In the church the reaction would be the same ... not well received. There would be punishment until the person/persons publicly repent.

Fraternal responses to Question #2GS on Gender and Sexuality Issues:

The Group –

1. With regard to the girl, she is frowned upon, regarded as "socially incompetent" ... it is not a moral issue, just shows "irresponsibility". The young man is stigmatized and thought of as one who has a financial burden. Within the church, the grandparents would have a responsibility to help raise this child. There would be no public discipline, but it would not be kept secret. We would not isolate or be judgmental. We would talk to the

youth group about how this couple got to this point. They would not be allowed to hold leadership positions during this time.

2. There would be a stigma attached to the girl ... but it wouldn't last too long. The younger generation is much more accepting of this situation. With the boys, he would be expected to help financially with the child ... but this would not be demanded. Within the church these young people would still be accepted ... not kicked out. They would be expected to take financial responsibility for what has happened.
3. Regarding the girls ... the older generation "frowns" on this. The younger generation just says "it happens". It is not a shock like it used to be. With the boys, there would be a mild stigma with little consequence. Within the church there would be no discipline, but they could not serve in leadership during this time.
4. With the girls there would be a high degree of "acceptance". For the boys, this would not be an "issue". Within the church, they would be disciplined and removed from leadership positions. In our church, men are excommunicated if they are not supporting any child they have fathered (this is written in the church bylaws).
5. For the girls, this is totally acceptable. For the boys there is no stigma placed upon them. Within the church ... this is not a big thing ... people are accepting ... there is a "culture of acceptance".

The Association –

1. For the girl this would be a "disgrace, but accepted". She would not be ostracized. For the boy there would be shock at his involvement, disappointment in him, but it would not last long. Within the church there would be discipline and a public announcement. The two of them would be under discipline until the child is born. They would not be allowed to hold leadership positions, but would be allowed to participate in communion and other church activities. Their behaviour would be under scrutiny to observe "... are they grieving what they have done?"
2. I'm seeing this as a frequent occurrence for the girls. People are less critical than in the past. There is some stigma, but it is lessened because of "community acceptance and the frequency of occurrence". For the boys, there would be some stigma and the community response would be similar to that of the girls. The problem is that many of these young men father more than one child. Within the church, both would be disciplined ("sin must be exposed"). We would not publicly humiliate them ... there would be consideration of the person/persons because this is a difficult burden to carry.
3. For the girl, it is considered to be a problem ... she has caused shame ... but the main goal is to help her. Many times the father is not known, but when he is there is "disappointment" in him. He is also seen as one who has "lost his potential." There would be financial expectations put upon him and he might be expected to drop out of school to fulfil these. There is huge pressure to marry ... many times this is to relieve the parent's shame. Within the church counselling and support would be given (our church saw the error of its ways in past public disciplines and the pastor publicly apologized - the church cheered and cried!)
4. For the girl ... no one thinks much of it. For the boy, it is accepted because it is so common. For the boy there is financial responsibility expected on his part. Within the church there is discipline and a public announcement. They would not be allowed to participate in public ministry until AFTER the child arrived. In our church we are trying to educate the children and help them to see that this is not an easy road to take [this might be used as an example to help them see].
5. For the girl it used to be "taboo/shame". Now it is just happening ... some even see it as a "cool thing". For the boys, it is slowly being accepted that they can have multiple sexual partners. Within the church, if they decide to marry and remain faithful ... they will be

treated with respect. If one runs away ... they lose their credibility. We used to publicly discipline and then discovered that the Scripture being used to back up this approach was mainly focused on the discipline of leaders. Discipline in our church is subtle and would only be made public if the same thing happens 2-3 times. They would not be allowed to participate in public ministry and the church would put accountability partners in place to help them through this time.

The Movement –

1. For the girl, it is considered an insult to her parents. For the boy, there will be a certain bias against him unless he shows seriousness about what he has done. He has insulted the parents of the girl by taking her virginity. Within the church, they would be viewed and treated the same. Public discipline would be levelled until there is a public apology. By doing this they have disgraced all of the other young people in the church ... repentance is necessary. This is a John 8 issue.
2. With the woman, it is a problem. It used to be serious. It is not as serious any more. It is kind of out of control ... we've become used to it. It appears normal ... but it is not well received. Regarding the fathers ... according to my culture, the boy must look after her and the baby. There is something similar to lobola that is required. Once he has paid that, he can go and not take any responsibility ... or he may marry her. Within the church this is not accepted at all. Both would be publicly disciplined.
3. It is an embarrassment, an abomination, a "disgrace" ... but because of diversity of multi-cultural influence, it is accepted. But the child will not be regarded as the son or daughter of that mother and father ... the grandmother will adopt the child. The actual parents will never "own" the child. With regard to the father of the child ... since the child is not considered to be "his" ... he is treated as an "innocent." In the church, there might be punishment in the form of excommunication. The length of this would depend on the repentance shown and communication with the church elders.
4. Young women who fall pregnant are considered a "disgrace" and may even be chased away from the family. The father of the child is accepted. This is because men in our culture are allowed to marry more than one wife but a woman is not allowed to take multiple husbands. In the church ... if they come to Christ, there is nothing we can do ... but they must get married. They are forgiven and we go on.
5. These women are viewed as a "disgrace". When parents are bringing up a female child, lobola is one of the goals that they have in mind. If a young lady taints herself this way, they will treat her differently. Men will look for – and pay a higher price for – a virgin! With regard to the man, most of the people will say, "You are man! You have proved yourself!" Within the church, there would be counselling. If these young people are part of the leadership there would be a sort of discipline ... but it is not done with hatred. It is "discipline" done with love. We try to give them direction.

The Leaders

GENDER AND SEXUALITY ISSUES

#3-4GS – *How does your culture view or treat married men who have more than one sexual partner? Is it encouraged, discouraged or generally ignored? How does your culture view or treat married women who have more than one sexual partner?*

The Group – For men it is "unacceptable" but people also say "it is a man's world" and they are more tolerant of him. For women it is "unacceptable" and she is labelled as a "whore".

The Association – For men it is "unacceptable but tolerated". For women it is "very unacceptable" and she is viewed in a very bad light.

The Movement – With regard to men, people would say "it happens". With regard to women they would say "it happens".

Fraternal responses to Questions #3-4GS on Gender and Sexuality Issues:

The Group –

1. For men it is taboo. For women it is taboo.
2. For men, it is not accepted. For women it is something we have not dealt with.
3. For men, it is "frowned" upon. For women it is "frowned upon even more". Women carry a stigma as "loose" or a "bad woman" ... people think "it must have been her who enticed him."
4. For men, it is grounds for divorce ... not acceptable. For women ... there is more stigma, it is not accepted.
5. For men it is viewed as "socially acceptable" as long as they don't get caught.
For women – it is not acceptable.
These days I am seeing more women pressurizing men to have sex than the other way around.

The Association –

1. For men – it is "taboo". For women – it is "taboo".
2. For men – it is definitely not encouraged. For women it is not encouraged and she definitely carries a heavier stigma than the man if it happens.
3. For men – they are "looked upon with disdain—but no one is surprised". For women it is almost the "unpardonable sin". She would be called a slut or a prostitute.
4. For men it is a "terrible thing"- negative. For women – it is worse. She would be called a "slut"
5. For men it is "taboo" but it is accepted that men can/will do these things. For women, it is "taboo" ... but considered much worse.

The Movement –

1. For men, people would say "it happens" ... and it is the same for women. In the church it is NOT acceptable...they would be excommunicated.
2. In my culture it is accepted for a man to have multiple partners ... they say "a man is free to do that." There is nothing tangible that they base this on...it probably has something to do with how the culture views men as "dominant". For women...this is never allowed. In the church neither is acceptable.
3. In order for a man to be "man" he should have multiple sexual partners. You are praised for this! We cannot use the term "fornicator" for a man. For women it is unacceptable. Neither would be allowed to engage in this kind of behaviour in the church.
4. It is accepted for men ... unless they are "saved" [in the church]. It is not acceptable for a woman ... she would be seen in a much worse light than the man.
5. Culturally it is accepted ... even when you come from the bush [initiation school] as a young man, they tell you that you cannot be a man and "sleep at home every night". They are told that they need to "sleep around". If you have more than one woman ... they do have names for you. For a woman to do this ... she would be considered "loose" or a "prostitute" ... it is a problem.

The Leaders

ORPHANS

#1OR – How does your culture view and care for orphans (children under the age of 18) whose parents have died of natural or accidental causes such as a car accident? What happens to these children? Where do they go? Who cares for them? Are orphans whose parents have died of HIV/AIDS treated the same as other orphans?

The Group – We try to teach people to have a will to take care of this. The orphans don't always go to family. Orphans as a result of AIDS are "rare". The general thinking on orphans is that we "will take care of you, give you money ... but don't come here" [to live with us].

The Association – Extended family will take care of them. When they have to go to an orphanage it is a "shameful" thing for the family. IF children are orphaned because of AIDS, there is no fear of them ... they are treated the same.

The Movement - Orphans are kept with extended family ... we would not think anything of it. If they are orphaned as a result of AIDS, sometimes the grandparents will offer to raise a child so that the surviving spouse can start a new life.

The Fraternal responses to Question #1OR on Orphans:

The Group –

1. The church would step in and play the role of "family", help take care of financial responsibility to educate, accommodate and take care of legal issues/rights.
2. Children would go to an orphanage with "no shame" on the family. If the child is an AIDS orphan the family would care for them, but might keep the AIDS issue a secret to protect them from "stigma and shame".
3. The orphan would be taken in by family. If the state were to take the child, people would be shocked. If the child is an AIDS orphan ... there would be huge empathy ... many more people willing to help.
4. Orphans are not common, but when it happens there is great "discomfort" because of the massive expense involved in raising a child. If the child is an AIDS orphan it seems that there are many more who are willing to adopt or care for them. I'm not sure if this is a result of the media? The stars are doing it!
5. An orphan would be an "inconvenience" ... most would have no problem sending someone to an orphanage ... but there would be some shame on the family as a result. I have no experience with AIDS orphans.

The Association –

1. The orphans would be welcomed by friends and family (even neighbours) and will be looked after. An AIDS orphan would be treated no differently.
2. It would depend on the economics of the family involved. Most people are quite compassionate and will welcome the orphans. Small homes in our culture would pose a problem. I have not had a lot of exposure to AIDS orphans, but I think that most people would try to shield the child from victimization by saying the parent died of some other cause (TB, pneumonia).
3. The orphans would be accepted into the extended family. There would be shame on the family if they did not take them. An AIDS orphan would be treated the same.
4. It is unacceptable to send children to an orphanage in our culture. The family would rally and help the child.
5. The family would rally. There would be shame if the child is sent to an orphanage. If the child is an AIDS orphan, I see them being sent to the orphanage many times. It is usually an economic problem.

The Movement –

1. The orphan would stay with the family. If it is an AIDS orphan they would be taken care of by a relative of the parents.
2. The orphan would be taken in by family—whoever can afford it. An AIDS orphan would be treated the same.

3. The child would be absorbed into the family---to go to an orphanage would be a shame on the family. But "educated" people realize that sometimes this happens. Regarding an AIDS orphan "When one suffers, he does not suffer alone." "I am because we are ... since I am, therefore we are." These orphans would be taken care of and no one would be afraid of taking them in.
4. The family will take them in. We do not believe in orphanages. They might have to split up between the uncles, etc., but they would stay within the family. It would be a shame on the family if the child was sent to an orphanage. AIDS orphans ... through education of our families are starting to see things in a different way. These orphans would not be looked at any differently ... they would be welcome in our homes.
5. In our culture we have what we call an "extended family" ... so if it happens that I die and I have a child, then my brothers would look after the child. If the child went to an orphanage ... it would be a "shame". With an AIDS orphan, there would be some fear ... because of AIDS ... but people are now getting knowledge about the disease. There used to be a stigma ... if the parents died ... then the child might cause problems.

The Leaders

POVERTY

#1P – According to your culture define the term poverty. Name 3 main factors which contribute to poverty.

The Group – Poverty is "the curse", "lack" 3 factors contributing to it—born into it, lack of education, government leadership.

The Association – Poverty is the "inability to provide basic needs of a family" 3 factors contributing to it – —unemployment.

The Movement – Poverty is "a state where one cannot provide for oneself" 3 factors contributing to it – lack of education, lack of taking responsibility for oneself, laziness.

Fraternal responses to Question #1P on Poverty:

The Group –

1. Poverty is "not being able to pay for transport, electricity, food" 3 factors contributing to it — lack of education, mentality or attitude, illness.
2. Poverty is "living a lack" 3 factors contributing to it—ignorance, low self-esteem, lack of education.
3. Poverty is the "inability to feed, cloth, house and educate your family. "In my neighbourhood, it is not being able to afford a second or third car!" Three factors contributing to it – education, job opportunities, huge imbalances between first and third world countries.
4. Poverty is "being unemployed, living in a shack, not being able to meet the basic needs of clothing, food, school. Three factors contributing to it—lack of education, alcohol & drug abuse, "inbreeding" of an historical cycle.
5. Poverty is "being homeless ... not being able to meet the expectation the media portrays". Three factors contributing to it – lack of education, lack of desire to achieve or succeed ("handout mentality"), feeling of hopelessness, inability or lack of desire to create, consumerism, government has continued to breed "poverty mentality", wealth from outside the country.

The Association -

1. Poverty – "if a person cannot afford the basic necessities of life (house, schooling, food, clothes)".
Three factors contributing to it – lack of education (knowing how to manage finances), substance abuse, poverty leads to substance abuse ... it is cyclical.
2. Poverty is the "inability to provide for yourself because of a lack of finances or resources".
Three factors contributing to it – poor work ethic, complacency (accepting your circumstances), becoming dependent on other people.
3. Poverty is not having something to wear, something to eat, a place to sleep (probably not related to transport).
Three factors contributing to it – unemployment rate in South Africa, level of literacy in our community, lack of social development (our community is being neglected by government – money and infrastructure is all going to black communities. *Some of this may be a backlash of blacks because coloured people were treated a little better during apartheid years.*
4. Poverty is a "lack of proper housing, lack of money to cope with all of life's expenses".
Three factors contributing to it – apartheid, lack of education, wages given to non-whites in the country.
5. Poverty is a "lack of income, joblessness, a lack of education, can't afford the basics."
Three factors contributing to it – lack of family values, dependency syndrome (perpetuation of handout mentality – outsiders are contributing to this), lack of commitment to schooling. "EDUCATION SHOULD BE COMPULSORY FOR ALL!"

The Movement –

1. Poverty is the "inability to provide shelter and clothing."
Three things which contribute to this – lack of education, _____, _____.
2. Poverty is "being destitute ... not having anything."
Three things which contribute to this – family cycle (growing up in poverty), lack of education, _____.**
****Note:** *This respondent did not feel that **unemployment** contributes to poverty ... "because family will always help, the community structure is strong."*
3. Poverty is "living without food, clothes, without a shirt ... living without the basics ... living without physical needs".
Three things which contribute to this – bad governance (government – not taking care of the poor), illiteracy, natural disasters.
4. Poverty is "somebody who is in the condition of not having the means to live ... everything (no food, no shelter, no clothing)."
Three things which contribute to this – joblessness, low-paying jobs, illiteracy.
5. Poverty is "a state of being poor or helpless".
Three things which contribute to this – lack of education (ignorance), dysfunctional/broken family, _____.

The Leaders

GENDER ISSUES IN THE CHURCH

#1-2GC – *Within your church, what is the prescribed or scriptural teaching about men serving in leadership? Are there requirements for men who function in or who are elected to leadership positions? Are there any restrictions on men serving in a pastoral position?*

Within your church, what is the prescribed or scriptural teaching about women serving in leadership? Are there requirements for women who function in or who are elected to leadership positions? Are there any restrictions on women serving in a pastoral position?

The Group – For men we follow scriptural principles (1 Timothy 3). There are no restrictions when someone goes through a divorce – they are just asked to step away from leadership until the matter is sorted out. Each situation is viewed individually.

For women, it is the same as for men. They can pastor and can serve as executives.

The Association – For men we follow scriptural principles (1 Timothy 3)—they must be able to govern their own home, set an example in the home and community, and must be employed. If a person is divorced, we judge every case on its own merits.

For women we have a few serving in a pastoral role. They are now serving communion, ministering the word ... but some men will still walk out if a woman takes the lead. "This is a cultural thing more than scriptural." We have prevailed on them to return.

The Movement - For men we follow scriptural principles (1 Timothy 3) ... "husband of one wife ..." We do follow and teach scriptural principles ... but sometimes people elect their "friends" (even though the person may not fill scriptural requirements).

For women – there are no women in leadership. Scripturally we do not see (as a rule), women leading ... those in the Bible are only "exceptions". There are about three women pastors in the Movement, but this is not the norm. There was a time when a woman was allowed to rise to leadership – but she felt "odd," and was a misfit ... and it "died a natural death".

Fraternal responses to Questions #1-2GC on Gender Issues In The Church:

The Group –

1. **For men** – we do not take a "legalistic" approach to scriptural principles (e.g. divorce). For divorce, there is a requested stepping down/time-out until each situation can be individually evaluated. The man must have a good reputation in the workplace, in the neighbourhood/community as well as in the church – no debt problem, good citizen, "ability" [gifting] and be a team player.
For women – there seems that there is a *disconnect* between doctrine and practice. [Presently few women serve in leadership]. We have to ask "are present views sustainable from Scripture?" We are neglectful of actually wrestling with the issue of women in leadership. I believe women should be able to serve. Women elders? Many do the "work of elder" without the title. I always have women in elder meetings for "perspective".
2. **For men** – we follow scriptural principles (I Timothy 3). If there is a divorce, we ask them to step down, but will allow him to return if all is in order.
For women – are treated just like the men ... we apply scriptural principles (1 Timothy 3). In my opinion, they can pastor and I have two female elders in my church.
3. **For men** – we follow prescribed scriptural teaching (I Timothy 3). If divorced prior to conversion we consider it their "old life." They are eligible for leadership. It would be unlikely that we would have a divorced senior pastor. Each case is viewed individually.
For women – the requirements are similar as they are for a man. At this stage there are no senior female pastors. "It isn't about 'qualifications' it is about being a woman."

4. **For men** – we follow scripture (1 Timothy 3) ... "home must be in order". If there is a divorce, we ask them to step down temporarily.
For women—there are a couple of women pastors ... but we are going through a change on this matter. There are no female elders, but women ARE allowed to serve as deacons. "Women are the most 'reliable' people in the church!"
5. **For men** – we follow scriptural principles (1 Timothy 3). We believe that these principles apply to *both* genders.
For women - They are allowed to pastor ... no problem. BUT there would be debate! They can serve as deacons, but according to the AOG constitution they are not allowed to serve as elders.
The younger generation is transitioning out of this, though.

The Association –

1. **For men** – we try to stick to scriptural perimeters and criteria (1 Timothy 3).
For women – we look at qualifications for the position of deaconess. The scripture that we apply to men would apply to women. We do not allow women pastors or women elders. "We do submit ourselves to any woman's ministry—but do not allow them to hold administrative powers over a man."
2. **For men** – we **follow** scriptural foundations (1 Timothy 3). Most leaders are men. If there is a divorce, we ask them to step down for a bit.
For women – we do **have** female leaders because "most churches have more women than men." They play key roles, but do not carry titles or biblical titles like elder, deacon, or pastor. A woman *can* pastor and can serve in leadership ... but she must fall in line with scriptural principles.
3. **For men** – we follow scriptural principles (Acts 6, Titus, Timothy 3). If he is divorced he would **still** be allowed to **serve**. If a man says he has a pastoral calling the final decision for his entrance into ministry would lie with the elders of the church.
For women – they are allowed to serve as deacons or pastor. They are not allowed to serve as elders. "They [women] are equal in the world, but not in the church." In our church, women deacons tend to be intimidated by male elders.
4. **For men** – to serve in leadership positions, we first look for "giftings". If he wants to enter **the** ministry, he **must** get training at Bible school. For a deacon or elder, local training will suffice.
For women – we have no bias. They can serve in any area including elder. Our stand is very "radical" for the Association!
5. **For men** – we fall in **line** with scriptural teaching (1 Timothy 3).
For women – it is a matter of interpretation. I always refer to Micah 6:4—' "I sent Moses to lead you, also Aaron and *Miriam*." In our church there are no female leaders. You can be a gift to the body whether male or female ... referring to the "priesthood of believers." Regarding the possibility of a female pastor ... the older people have a problem with it ... but the younger, not so much. I think our teaching should not be on *male or female*, but on *giftings* of leadership.

The Movement –

1. **For men** – we follow scriptural principles (1 Timothy 3) ... but sometimes someone outside the principles is elected. There are times that we would object to this kind of thing – it pollutes the church.
For women – we have a few women pastors but it is not the norm, we don't necessarily allow it. They should be allowed to work in their area of gifting, whatever that might be. *Scripturally*, we don't see women leading as the norm ... It is the "exception."

2. **For men** - we have scriptures that we base our teaching upon (I Tim 3:16). He must have a "calling" ... you must show "fruit". The local church validates the calling ... they **know** you best. In my church, if a person claims to be called of God, the first step he must take is to write a letter to the local leadership. The local leadership will scrutinize that and then it will be taken to "man's meeting" (no women allowed) and the letter will be read aloud where all will have an opportunity to say something.
For women – Joel 2:128 is used as scriptural basis for involvement of women. We (me and many of my colleagues) see no reason why a woman should not be part of ministry or leadership. We don't object to women in ministry ... but we seem to "limit them". Women cannot pastor ... she must always be under the supervision of a man. The church [denomination] as a whole does not agree on this issue ... the younger guys have no problem with women. It is the older guys.
3. **For men** – God is no discriminator of genders. We do believe that God uses males and females as HE likes. As long as "he" falls within scriptural requirements (I Timothy) for leadership, "he" would be allowed to serve. This does not hold true for women.
For women – we do not use the title of "pastor" when it comes to females. We call them *church planters, local missionaries*, but actually the women are not given the same rights as men when it comes to ministry. There are no female pastors in the Movement. A woman can plant a church but once the church has been established then she is asked to step aside and let a man take over. They will not even ordain her ... she cannot hold credentials. The younger men have no problem with women ... it is the older pastors.
4. **For men** – according to the Bible, he must be the husband of one wife, be able to manage his household. To serve as a pastor, he must have a "calling" ... **his** own local assembly can/will validate that calling. They know him, they see how he behaves.
For women - in my church we do have women in positions of leadership ... except as a "pastor." But in the other structures, they are allowed. Women in the Movement who serve as pastors are not given open recognition ... not given a title ... even though their work is the same as a male pastor. They are not given appointments or transfers as men. If a woman pioneers a church ... when souls are gathered and people get saved ... THEN they bring a man in ... someone who is already in the ministry. I think this comes from our cultural background ... men are always in leadership. Women do not serve in this way!
5. **For men** – we do have some scriptural teaching ... in Timothy 3:16 (husband of **one** wife, lead his family well) ... must fulfil this scripture if he is to be elected to leadership
For women – there is still a lot of negative attitude towards women in leadership. I think it is because people view things according to their "tradition" rather than scripture. Women are not called "pastors" ... they are called "workers". I would have no problem with a female pastor. It happens that a women will pioneer a church and then the Movement will send in a man to pastor the church ... it is coming to our attention that this is wrong.

The demographics on the pastoral samplings from each Fraternal*

**(Numbering in this section of the paper does not correlate with the numbers in the results section of the paper to protect the anonymity of the participants)*

The Group –

***Pastor #1* –**

1. White South African - English
2. First language – English, 2nd – Afrikaans
3. 10 years in full-time ministry
4. 30 years of age
5. Education: Certificate in theology (2 years post matric)
6. N/A
7. Yes, approximately 1000 people

***Pastor #2* –**

1. White South African - English
2. First language – English
3. 20 years in full-time ministry
4. 53 years of age
5. Postgraduate (law degree)
6. N/A
7. Yes, approximately 130-1 500 people

***Pastor #3* –**

1. White South African of mixed heritage (Greek and Afrikaans)
2. First language – English, 2nd – Afrikaans
3. 27 years in full-time ministry
4. 53 years of age
5. 3 years post high school in Bible/theology
6. N/A
7. Yes, approximately 1000 people

***Pastor #4* –**

1. White South African – English
2. First language – English, 2nd – Afrikaans
3. 12 years in pastoral ministry
4. 48 years of age
5. Diploma (technikon)
6. N/A
7. Yes, approximately 450 people

***Pastor #5* –**

1. White South African – English
2. First language – English, 2nd – Afrikaans
3. 25 years in pastoral ministry
4. 51 years of age
5. Postgraduate diploma
6. N/A

7. Yes, approximately 500

The Association –

Pastor #1 –

1. Cape Coloured
2. First language – English, 2nd – Afrikaans
3. 20 years in pastoral ministry
4. 54 years of age
5. Technikon
6. N/A
7. Yes, approximately 800+

Pastor #2 –

1. Cape Coloured
2. First language – Afrikaans, 2nd – English
3. 38 years in pastoral ministry
4. 57 years of age
5. Public Administration Diploma (2 years past matric)
6. N/A
7. Yes, approximately 110

Pastor #3 –

1. "Westernized" Cape Coloured
2. First language – English, 2nd – Afrikaans
3. 8 years in pastoral ministry
4. 40 years of age
5. Working on second B.A. degree
6. N/A
7. Yes, approximately 300

Pastor #4 –

1. "European" Coloured
2. First language – Afrikaans, 2nd – English
3. 20 years in pastoral ministry
4. 56 years of age
5. B.A. with an H.D.E.
6. N/A
7. Yes, approximately 150

Pastor #5 –

1. Coloured
2. First language – Afrikaans, 2nd – English
3. 13 years in pastoral ministry
4. 49 years of age
5. B.A. with an H.D.E.
6. N/A
7. Yes, approximately 200

The Movement –

Pastor #1 –

1. Tswana and "urban African"
2. First language – Tswana, 2nd – Afrikaans
3. 24 years in pastoral ministry
4. 60 years of age

5. Diploma in law
6. N/A
7. Yes, approximately 35

Pastor #2 –

1. Xhosa, "black South African"
2. First language – Xhosa, 2nd English
3. 16 years in pastoral ministry
4. 40 years of age
5. 3-year diploma ... has studied at the BA level, not finished yet
6. N/A
7. Yes, approximately 200+

Pastor #3 –

1. "African influenced by Western culture," Xhosa
2. First language – Xhosa, 2nd – English
3. 13 years in pastoral ministry
4. 41 years of age
5. BA in Bible/Theology
6. N/A
7. Yes, approximately 500

Pastor #4 –

1. Xhosa
2. First language – Xhosa, 2nd – English
3. 13 years in pastoral ministry
4. 56 years of age
5. Std. 9, took a few theological correspondence courses at the tertiary-level
6. N/A
7. Yes, approximately 200

Pastor #5 –

1. "Black South African", Xhosa
2. First language – Xhosa, 2nd – English (also speaks Zulu, Tswana)
3. 7 years in pastoral ministry
4. 30 years of age
5. Matric, planning to do theological studies at the tertiary-level
6. N/A
7. Yes, approximately 300

DEMOGRAPHICS BY GROUP
(According to the demographic questions 1-7)

The Group (White)
The Association (Coloured)
The Movement (Black)

1. Which culture would you consider to be your culture?

The Group – 100% "White South African" (20% specified "white Afrikaans")
The Association – 100% "coloured" (60% specified "Cape coloured", 20% "European coloured", 20% "coloured")
The Movement – 20% "Tswana", 80% "Xhosa" (60% specified "black South African")

2. What is your first language? Second language?

The Group –

First language: 100% first language English

Second language: 80% second language of Afrikaans
20% stated "no second language"

The Association –

First language: 60% first language Afrikaans, 40% first language of English;

Second language: 40% second language of Afrikaans, 60% second language of English

The Movement –

First Language: 20% first language Tswana, 80% first language Xhosa;

Second Language: 20% second language Afrikaans, 80% second language English

3. How many years have you spent in pastoral ministry?

The Group -

Lowest – 10 years

Highest – 27 years

***Average** – 18.5 years

The Association –

Lowest – 8 years

Highest – 38 years

***Average** – 23 years

The Movement –

Lowest – 7 years

Highest – 24 years

***Average** – 15.5 years

**Average combined years in ministry for all 3 groups* – 19 yrs. pastoral ministry

4. What is your age?

The Group –

Youngest – 30 years

Oldest – 53 years

***Average** - 47 years

The Association –

Youngest – 40 years

Oldest – 57 years

***Average** – 51.2 years

The Movement –**Youngest – 30 years****Oldest – 60 years*****Average – 45.4 years******Average combined years of age for all 3 groups – 47.9 years of age*****5. Up to what level of education have you completed?*****The Group –***

20% Technikon

40% University (3-4 yr)

40% Postgraduate

The Association –

20% Technikon

20% Diploma

20% University (BA) 40% Postgraduate

The Movement –

20% - Std. 9

20% Matric

20% Technikon

40% University (3-4 yr)

6. This question did not apply to the fraternal samplings ... only the 3 executives.**7. Do you personally pastor a church and if so, what is the size of the congregation?*****The Group –*****Yes – 100% are pastoring****No –****Smallest congregation – 450****Largest congregation – 1300******Average congregation size – 850******The Association –*****Yes – 100% are pastoring****No –****Smallest congregation – 110****Largest congregation – 800******Average congregation size – 312******The Movement –*****Yes – 100% are pastoring****No –****Smallest congregation – 200****Largest congregation – 500******Average congregation size – 280*******Average congregation size for all 3 group combined – 481 members***

APPENDIX B

INTERVIEW WITH EMILY JOHNS – Ph.D. at Stellenbosch University

Date & Time: _____

1. Which culture would you consider to be your culture?
2. What is your first language? Second language?
3. How many years have you spent in pastoral ministry?
4. What is your age?
5. Up to what level of education have you completed? (primary, secondary, technikon, graduate, post-graduate)
6. As an executive leader how many pastors are under your leadership supervision? Would you provide an approximate *cultural* breakdown of the pastors you supervise?
7. Do you personally pastor a church and if so, what is the size of the congregation in that church?

GENERAL QUESTIONS FOR ALL PARTICIPANTS

SICKNESS

#1S According to your culture, what are the viewpoints surrounding illness and its causes?

#2S According to your culture, what is the view of Western style healthcare and medical doctors?

#3S What is the view of traditional African healthcare and healthcare providers?

DEATH

#1D In the thinking of your culture, is it possible for outside spiritual forces to cause a person's death?

#2D In your opinion, would religious people (people who attend church) agree with your answer?

#3D In the thinking of your culture, is there a belief in the afterlife or a place similar to the Christian concept of "heaven"? Is there a belief in a spirit world different from the world we live in?

#4D How does your culture feel about the burial of the dead? *Where* and *how* is it prescribed that burial of the dead take place? Is cremation allowed or encouraged?

HIV/AIDS

#1H In your culture, how do people feel about the disease of HIV/AIDS?

#2H In your culture, does the community ever reject or ignore those who are infected with the HI virus or who are sick with AIDS?

#3H In your culture, is there a difference in how men with the disease of AIDS are treated and cared for in comparison to how women with AIDS are treated or cared for?

GENDER AND SEXUALITY ISSUES

#1GS In your culture, describe or explain the most common and acceptable style of dating and/or courtship practices. Are young men and women allowed to have (or encouraged to have) friendly male/female relationships in high school and college or university?

#2GS How does your culture view young women who become pregnant and bear children outside the traditional marriage covenant relationship? In the same context, how does this culture view the *fathers* of children born outside of the traditional marriage covenant?

#2GSa How are these men and women treated within the church?

#3GS How does your culture view or treat *married men* who have more than one sexual partner? Is it encouraged, discouraged or generally ignored?

#4GS How does your culture view or treat *married women* who have more than one sexual partner? Is it encouraged, discouraged or generally ignored?

ORPHANS

#1OR How does your culture view and care for orphans (children under the age of 18) whose parents have died of natural or accidental causes such as a car accident? What happens to these children? Where do they go? Who cares for them?

#2OR Are orphans whose parents have died of HIV/AIDS treated the same as other orphans?

POVERTY

#1P According to your culture define the term *poverty*.

#2P Name 3 factors which contribute to poverty.

GENDER ISSUES IN THE CHURCH

#1GC Within your church, what is the prescribed or scriptural teaching about **men serving in leadership**? Are there requirements for men who function in or who are elected to leadership positions? Are there any restrictions on men serving in a pastoral position?

#2GC Within your church, what is the prescribed or scriptural teaching about **women serving in leadership**? Are there requirements for women who function in or who are elected to leadership positions? Are there any restrictions on women serving in a pastoral position?

APPENDIX C

Community Health Issues: AIDS and Beyond

SYLLABUS August 2005

Course Description

Community Health Issues: AIDS and Beyond (4 credits)

This course presents a general survey of the nature and scope of basic community health issues in South Africa including, HIV/AIDS, STDs, sexual abuse, rape, and abortion. The primary emphasis of the class will be given to the examination of HIV/AIDS, the care of and ministry to AIDS victims and their families. It is hoped that this class will adequately educate pastoral students for ministry among AIDS sufferers and their families.

Course Objectives

At the conclusion of the course, the student will be able to:

1. Differentiate between HIV+ and full blown AIDS, and have a general knowledge of the disease of AIDS and how it is impacting South Africa and the region of Southern Africa.
2. Critique and become familiar with some of the AIDS materials that are presently used by the Assemblies of God in Southern Africa.
3. Identify the causes, effects and social ramifications of community health matters, with a heavy emphasis on HIV/AIDS.
4. Have a working knowledge of the health issues listed in the course description as well as a practical knowledge of fundamental and low cost home-based health care.
5. Identify and be able to counsel individuals and families who are affected by social health problems.
6. Plan, plant and care for a trench garden which will help AIDS victims and their families with nutrition to aide in the fight against the disease.

Textbooks

Butrin, JoAnn. Who Will Cry For Me? Pastoral Care for Persons with AIDS in Africa. Africa Harvest Projects and Coordination Office, Springfield: No copyright date given.

Edward the Elephant. Africa's Children. Randpark Ridge: South Africa, no date.

Tisdalle, Vern and Belva. AIDS & Me: Hope in the Crises of Human Tragedy. Africa: Operation Whole. Randpark Ridge: South Africa, 2000.

Tisdalle, Vern and Belva. R.E.A.P. (Resource Education for AIDS Prevention) A Study Guide for Teachers and Educators, Vol. 1-2. Africa: Operation Whole. Randpark Ridge: South Africa, 1999.

van Dyk, Alta. HIV/AIDS Care & Counselling: A Multidisciplinary Approach. (3rd. ed). Pearson Education South Africa: Pinelands, South Africa, 2005.

The Holy Bible.

Various articles and brochures, as well as outside readings as assigned by the mentor.

Assignment and UPEs

All assignments and UPEs are **due on the date prescribed** as outlined in the class schedule. **Late assignments and UPEs will not be accepted.** In the case of an assignment not being turned in, a point value of "0" will be given. The teacher requests that all assignments be done in proper APA form. Points will be deducted from the assignment for improper form.

Course Grades

The course grade will be determined from the following:

Folder Design

UPE #1 -

UPE #2 - The average of the 3 UPEs will constitute 60% of the grade for the

UPE #3 - course.

Project/Final Exam - 40%

Absences

A total/maximum of 3 absences *will be allowed for use in the event of sickness or emergency.* If a 4th absence is used, then the student will not be allowed to submit the final exam and will be dropped from the course. Your presence in class is **vital** to discussion and the learning experience.

Africa: Operation Whole (NGO) Certificate

Students who earn a grade of B or above will be given a certificate of completion in AIDS Awareness Education from the NGO *Africa: Operation Whole* (Johannesburg). If course work is successfully completed, students will be allowed to purchase their own copy of the REAP curriculum. Present cost for a 2 volume set is R1000.

Term Project/Final Exam

The term project and final will be combined and **due on the day that the final is scheduled.**

The term project is to design , plant and care for your own trench garden for the entire term. Each person will be responsible for their own garden. Students are expected to care for (water, weed, harvest) their own gardens and should keep a written diary of what they learn or observe during the experience. Students will be graded on their diaries, consistent care of the garden, appearance (neatness), and their working knowledge of the garden which will be examined in a face-to-face interview with the mentor. Forms will be provided for written documentation of the project at a later date.

CLASS SCHEDULE & ASSIGNMENTS
"Community Health Issues: HIV/AIDS and Beyond"

August 2005 – 2nd term

Mentor: Mrs. Emily Johns (Phone: 558-9514 or 083-454-1183)

Time: 11:00 – 11:50 (Tuesday, Thursday, Friday) – 4 credit class (lab)

SHORT CLASS SCHEDULE

1ST period – 0740-0820

2nd period – 0825-0905

3rd period – 0910-0950

4th period – 0955-1035

Tea Time – 1035-1100

Chapel: 1100-1300

Thursday, 4 August – Class Introduction, Notebook competition introduced

HIV/AIDS File Design (Due Friday, 12 August)

Points given for design, creativity and amount of time invested in the project. Purchase an arch lever file (large) and package of plastic sleeves(20). Please decorate/cover your file –it should be finished and ready to present to the class on Friday, 12 August. There will be prizes for the top 3 notebooks as judged by teacher and class.

Friday, 5 August – Vi Ramsey, substitute – body circulation and functions

Discussion: Article: "Death Stalks a Continent"

Assignment for Thursday, 11 August:

Van Dyk (textbook) – pp. 23-30 *Transmission of HIV*

REAP Curriculum – Chap. 4, pp. 22-27

Sexuality Explained With HIV/AIDS Facts

Be ready for discussion on Thursday, 11 August

Tuesday, 9 August – No class (Holiday)

Thursday, 11 August – Discussion of van Dyk text (pp. 23-30) and REAP Chap. 4 (pp. 22-27)

Handouts on sexual parts of the body

Friday, 12 August – Notebook competition judging

Continued discussion

For Tuesday, please read van Dyk (pp. 298-304)

17.1, Promo of Health and the Strengthening of the Immune System.

17.2 Nutrition

Tuesday, 16 August – Organic Trench Gardening

Handout booklets – all students should read from cover to cover!

Thursday, 18 August – Stake out gardens, prepare to plant (Wear Work Clothes)

Planting design (by rows) should be ready for Friday

Friday, 19 August – Garden Planting (Wear Work Clothes)

Some work may need to be done on the weekend to finish up
Once gardens are planted, they must be kept moist for 10 days!

Tuesday, 23 August – NO CLASS, EVERYONE AT CTS CAMP

Thursday, 25 August – Meet in the 2nd dining room

Video: "Breaking the Silence"

For Friday: Read Chapter 1 (van Dyk), pp. 1-22

Friday, 26 August - Discussion of Chapter 1 (van Dyk), pp. 1-22

Handout "Edward the Elephant" for UPE #1

UPE #1: Due Friday, 2 September

Tuesday, 30 August – Continue discussion of Chapter 1 (van Dyk)

Thursday, 1 September – Discussion & Review

Friday, 2 September – UPE #1

Objective Part: You are responsible for information in REAP Chapter 4 and van Dyk Chapters 1-2 (pp. 1-37) and The Trench Garden Manual.

Subjective Part: (to be done ahead of time and turned in today)

A written review of *Edward the Elephant* booklet. This should be a 3 page review (not including title page) of the booklet. Answer the following items in paragraph form: Do you like the booklet? Why or why not? How could it be improved? What changes would you make? Who is the target audience for this piece of literature? Who does it speak to/appeal to the most clearly? Would YOU use this piece of literature in your community? Give some ideas on how this booklet could be used most effectively. **Please note:** Assignment must be typed and be in *CTS Form and Style*. **A title page is not needed** ... just type a reference entry at the top of the page, double space beneath the reference entry and begin your paper. **LATE SUBMISSIONS WILL NOT BE ACCEPTED.**

For the dates of September 6,8,& 9....I will be in Nairobi, Kenya for a continent wide AIDS conference. Class will meet at the regular time in the library to complete reading assignments. You will be expected to sign in and out during this time.....just as if you were attending class. These are not free days and everyone is expected to be present.

You will find reading assignments for those days below. These do not have to be taken in any specific order. Since there are only 5 copies of the REAP curriculum, it would be good for some of you to read it on the first or second day rather than everyone trying to read it on the third day.

Tuesday, 6 September - Prevention in Traditional Africa (Chp. 7, van Dyk)

pp. 115-128—take special note of condom perceptions in the African context, pp. 122-124.

Thursday, 8 September - Changing Unsafe Behavior & Practices (Chp. 7, van Dyk)

pp. 129-144-take special note of "Prevention of Sexually Transmitted HIV" (various condoms and useage) pp. 131-136.

Friday, 9 September – REAP, Chapter 8 – Common or Condom Sense

Tuesday, 13 September – Stats Presentation & Review of "Prevention in Traditional Africa (Chp. 7, pp. 115-128) van Dyk

Thursday, 15 September – Plant Gardens

Friday, 16 September – continuation "Prevention" chapter

Tuesday, 20 September – Garden Work

Thursday, 22 September – Review of Condom chapters/material

Friday, 23 September – Continuation of Condom chapters/material

R & R begins at 12:00 noon!!!! Classes begin again on Tuesday, 4 October

Tuesday, 4 October – Pam Stenzel video "Physical Consequences of Pre-marital Sex"

Handout vocabulary page from REAP

ASSIGNMENT DUE ON 14 October: STD/STI Paper

Choose one of the STDs that you have heard mentioned in class or read about in your reading. Write a 4-5 page paper (typed in CTS Form & Style) on the topic. Papers should include a description of the STD, symptoms, how the disease is (or can be) transmitted or caught. Also include information on treatment, long term effects/after effects of the disease, and statistics on how prevalent the disease is in South Africa.

Please cite your sources of information – use at least 4 sources in preparing your paper. A proper reference page & title page is expected. Electronic sources are acceptable, but PLEASE do not just "copy and paste" information from the web-sites...that is plagiarism! This paper should be your own work in your own words.

Thursday, 6 October – STDs

Read Chapter 7 REAP Curriculum

Read van Dyk- (3.6, pp. 53, 54 and chart on pp. 59-61)

Friday, 7 October – STDs continued

Tuesday, 11 October – Tuberculosis

Read van Dyk – pp. 47-53

Know the definition of "opportunistic infection" – van Dyk (p. 43)

Thursday, 13 October – Tuberculosis continued

Friday, 14 October – UPE #2

You are responsible for material found in the following:

Van Dyk – Chapter 7 (pp. 115-144)

REAP, Chapter 8

Information on Tuberculosis, Information on STDs, Vocabulary page

YOUR STD PAPER IS DUE TODAY!

Tuesday, 18 October – RAPE

Read – van Dyk (p. 363 and 5.6-p. 84, 85)

Assignment Due: Friday, 4 November – Review of "Who Will Cry For Me?"

Write a 3-4 page reflection paper (typed in CTS Form and Style) on the booklet. Answer these questions: Did you like it? Was it informative? Was the subject matter presented in a way which held your attention? Is this something that you could use in your church? Why or why not? Did it teach you anything you did not know? What is the best or worst feature of this booklet?

Thursday, 20 October – Completion of RAPE topic, on to SEXUAL ABUSE

Read – REAP Chp. 16

Van Dyk – pp. 364-366 (Rights of Children)

Friday, 21 October – Continuation of SEXUAL ABUSE

Tuesday, 25 October – ABORTION, Termination of Pregnancy

Read: van Dyk p. 362, p. 366 (2nd and 3rd question on the page)

Thursday, 27 October – Symptoms of AIDS

Read: van Dyk pp. 38-46

Friday, 28 October – Symptoms of AIDS continued

Tuesday, 1 November – Testing for HIV

Read: Chapter 9 REAP

Thursday, 3 November – Home Based Care

"Who Will Cry For Me?" paper due

Friday, 4 November – CAMPUS STUDY DAY

FINALS 7-16 November

The time scheduled for your Community Health Final will be the day that your gardens are graded....you are responsible for them until that time.

17 November - CAMPUS CLEAN-UP DAY

18 November - GRADUATION REHEARSAL 9:00 a.m.

19 November – GRADUATION 3:00 p.m.

APPENDIX D

SYLLABUS – August 2007

Community Health Ministry: Sexuality and HIV/AIDS in South Africa

This course will concentrate on the topic of HIV/AIDS and its impact on South and Southern African. The primary emphasis of the course will be on ministry to those infected and affected by HIV/AIDS. Topics will include the medical fundamentals of AIDS, the church's role and responsibility along with a biblical/theological view of the pandemic, home-based care, trench gardening, economics of the disease, government policy and responses to the issue, legal issues pertaining to AIDS victims and their families and other human sexuality topics surrounding the pandemic.

Course Objectives:

At the conclusion of the course, the student will have or be able to:

1. Differentiate between HIV and AIDS and have a fundamental working knowledge of the disease (including testing and antiretroviral drugs) in adults and children .
2. A general overview of the disease's impact on South and Southern Africa.
3. An enlightened view of the church's role and responsibility
4. A solid understanding of the biblical/theological view of the pandemic
5. Administer and/or teach general home-based care principals for AIDS patients including nutrition and trench gardening.
6. A general working knowledge of the dynamics of ministering and counseling those infected and affected with HIV/AIDS.
7. Clarify their own values relating to a biblical view of sexuality and HIV/AIDS
8. Motivate others to respond to HIV/AIDS in responsible and effective ways.
9. Be knowledgeable of church and community resources that are available to HIV/AIDS victims
10. A general working knowledge of the economics of the disease, South African government policy and responses pertaining to those infected with HIV/AIDS, and legal issues/rights pertaining to AIDS victims and their families.
11. A working knowledge of other issues pertaining to human sexuality (e.g. sexual abuse, rape and abortion).
12. A familiarity with printed AIDS evangelism materials that are presently used by The Assemblies of God in South and Southern Africa.

Textbooks:

*Butrin, JoAnn. *Who Will Cry For Me? Pastoral Care for Persons with AIDS in Africa*. Springfield, MO: Africa Harvest Projects and Coordination Office, n.d.

*Author Unknown. *Edward the Elephant*. Randpark Ridge: Africa's Children, n.d.

*Tisdalle, Vern and Belva. *AIDS & Me: Hope in the Crises of Human Tragedy*. Randpark Ridge, SA: Africa Operation Whole, 2000.

**Tisdalle, Vern and Belva. *R.E.A.P. (Resource Education for AIDS Prevention). A Study Guide for Teachers and Educators, Vols. 1-2*. Randpark Ridge, SA: Africa Operation Whole, 1999.

***Van Dyk. Alta. *HIV/AIDS Care & Counseling: A Multidisciplinary Approach* (3rd edition). Pinelands, SA: Pearson Education South Africa, 2005.

The Holy Bible (NIV).

****Various articles and brochures, as well as outside readings assigned by the mentor.

*Will be provided free of charge

**Multiple copies on reserve in the library

***Student must purchase for class use

****A charge of R25.00 will be paid for extra class handouts

Assignments and UPEs

All assignments and UPEs are **due on the date prescribed** as outlined in the class schedule. **Late assignments and UPEs will not be accepted.** In the case of an assignment not being turned in, a point value of "0" will be given. The teacher requests that all assignments be done in proper Turabian form and style. Points will be deducted from the assignment for incorrect form.

Course Grades

The course grade will be determined from the following:

UPE #1 – 15%

UPE #2 – 15%

UPE #3 – 15%

UPE #4 – 15%

Project/Final Exam – 30%

Class Participation – 10% (this includes handing in extra assignments such as journal readings on time!)

Absences

A total/maximum of three absences will be allowed for use in the event of sickness or emergency. If a 4th absence occurs, then the student will not be allowed to submit the final exam and will be dropped from the course. Your presence in class is vital to discussion and the learning experience!

Africa: Operation Whole (NGO) Certification

Students who earn a grade of B (80%) or above will be given a certificate of completion in AIDS Awareness Education from the NGO *Africa: Operation Whole* (Randpark Ridge, Johannesburg). If course work is successfully completed, students will be allowed to purchase their own copy of the REAP curriculum. Present cost for the two volume set on disk is R25.00.

Term Project/Final Exam

(Still to be determined)

CLASS SCHEDULE & ASSIGNMENTS
"Community Health Ministry: Sexuality and HIV/AIDS in South Africa"
August 2007 – 2nd term

Mentor: Mrs. Emily Johns
Home: 021-558-9514
Cell: 079 481 6925
Time: MWF 7:40 – 8:30 am

SHORT CLASS SCHEDULE

1st period – 0740 – 0820
2nd period – 0825 – 0905
3rd period – 0910 – 0950
4th period – 0955 – 1035
Tea Time – 1035 – 1100
Chapel: 1100 - 1300

This course will concentrate on HIV/AIDS and how the pandemic is impacting South Africa and its southern Africa neighbors. Topics will include specifics regarding the disease, the church's role and responsibility along with a biblical/theological view of the pandemic, home-based care (including trench gardening), economics of the disease, government policy and responses to the issue, legal issues pertaining to victims and their families, and other topics surrounding the pandemic that pertain to human sexuality.

Monday, 20 August

Pre-tests administered
 Personal introductions – "Tell Us About Yourself"

Wednesday, 22 August

Begin class discussions on "Analysis of the Problem"
 (AIDS and the church in South Africa)

Friday, 24 August

Discussion of Reproductive Organs—Male and Female (using handouts and diagrams)
 Continue discussion on "Analysis of the Problem"

Monday, 27 August

Pop quiz??? ☺

Discuss "Analysis of the Problem" - Question #6
 Discuss article "Death Stalks A Continent"

JOURNAL ENTRY - Please write 2-3 paragraphs on your impressions of the article and bring your journals to class....we will be reading them aloud

*****SPIRITUAL EMPHASIS 28-30 AUGUST (Pastor Ian O'Brien)**

Wednesday, 29 August (SPIRITUAL EMPHASIS – Shortened class schedule)

Read and be ready to discuss: van Dyk, pp. 22-30 "The Transmission of AIDS"

Read and be ready to discuss: REAP Curriculum (on reserve in Library) pp. 22-27

"Sexuality Explained With HIV/AIDS Facts"

JOURNAL ENTRY – Re: your thoughts on the reading (2-3 paragraphs)

Friday, 31 August

Read and be ready to discuss: van Dyk, Chapter 1 (pp. 3-22)

"The Fundamental Facts About HIV/AIDS"

***Please note: Some of this may be difficult reading...please just read through it and become acquainted with the material. We will be discussing and explaining in class.*

JOURNAL ENTRY – Re: your thoughts on the reading (2-3 paragraphs)

Monday, 3 September

Video: "Breaking the Silence" (Meet in the 2nd Dining Room)

Continue discussion on Van Dyk, Chapter 1 (pp. 3-22)

Handout "Edward the Elephant" in preparation for UPE#1

JOURNAL ENTRY – Re: your thoughts on the video (2-3 paragraphs)

Wednesday, 5 September

Review together for UPE #1

Friday, 7 September – UPE#1 (This exam will be in two parts)

Objective Part: You are responsible for information in REAP Chapter 4 and van Dyk, Chapter 1

Subjective Part: (to be done ahead of time and turned in today)

A written review of the *Edward the Elephant* booklet. This should be a three page review of the booklet. Answer the following items in paragraph form:

Do you like the booklet? Why or why not?

How could it be improved? What changes would you make?

Who is the target audience for this piece of literature?

Who does it speak to/appeal to the most clearly?

Would YOU use this piece of literature in your community?

Give some of your own ideas on how this booklet could be used most effectively.

Please note: Your assignment must be typed and be in CTS Form and Style. **A title page is not needed....just type a reference entry at the top of the page, double space beneath the reference entry and begin your paper. LATE SUBMISSIONS WILL NOT BE ACCEPTED!! Please submit your papers by e-mail attachment. Send to emjohns@mweb.co.za. Thank you!**

Monday, 10 September

Video: "The Physical Consequences of Pre-Marital Sex" with Pam Stenzel

JOURNAL ENTRY – Re: your impressions of the video

Begin discussions on STD/STIs – Please note the paper due for UPE#2!!

***MISSIONS CONVENTION, 11-13 SEPTEMBER

Wednesday, 12 September (MISSIONS CONVENTION – Shortened class schedule)

Read and be ready to discuss: van Dyk pp. 53, 54 (3.6) and chart on pp. 59-61
REAP, Chapter 7

Friday, 14 September - NO CLASS (Work on your STD/STI paper)**Monday, 17 September – NO CLASS (Work on your STD/STI paper)****Wednesday, 19 September – NO CLASS (Work on your STD/STI paper)****Friday, 21 September – UPE #2**

Objective Part: Material in van Dyk (pp. 53,54, 59-61) and
REAP Chapter 7

Subjective Part: STD/STI Paper

Choose one of the STDs that you have heard mentioned in class or read about in your reading. Write a 4-5 page paper (typed in CTS Form and Style) on this particular disease. Papers should include a description of the STD, symptoms, how the disease is (or can be) transmitted or caught. Also include information on treatment, long term effects/after effects of the disease, and statistics on how prevalent the disease is in South Africa.

Please cite your sources of information – use at least 4 sources in preparing your paper (you will find LOTS of stuff on the internet!) A proper reference page and title page is expected. Electronic sources are acceptable, but PLEASE do not just "copy and paste" information from the web-sites...that is plagiarism! This paper should be your own work in your own words.

Paper should be submitted by e-mail attachment to emjohns@mweb.co.za. Thanks!

***CTS R & R Break Begins after work hour (21-30 September)
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Monday, 1 October –

Read and be ready to discuss: van Dyk, Chp. 7 (pp. 115-128) "Prevention in Traditional Africa"– take special note of condom perceptions in the African context on pp. 122-124.

JOURNAL ENTRY – Was there one thing in this chapter which really stood out to you? Was there something you had never heard before?

Wednesday, 3 October –

Read and be ready to discuss: van Dyk, Chp. 8 (pp. 129-144) "Changing Unsafe Behaviour and Practices" – take special note of the section "Prevention of Sexually Transmitted HIV" (various condoms and useage) pp. 131-136.

JOURNAL ENTRY – Of what value is all of this information?

***Thursday, 4 October - CAMPUS CLEAN-UP AND FAMILY DAY
--

Friday, 5 October –

Read and be ready to discuss: REAP, Chapter 8 "Common or Condom Sense"

JOURNAL ENTRY – Do you think we should talk to young people in the church youth group about condoms?

Monday, 8 October – Tuberculosis – An Opportunistic Infection

Read and be ready to discuss: van Dyk pp. 47-53

Know the definition of "opportunistic infection" (van Dyk p. 43)

Wednesday, 10 October

Read and be ready to discuss van Dyk, pp. 38-46 "Symptoms of AIDS"

Friday, 12 October

Continue discussion on symptoms of AIDS

Monday, 15 October – UPE #3

For this UPE you are responsible for: van Dyk, Chapters 7 & 8

REAP Chapter 8

Tuberculosis, pp. 47-53 (van Dyk)

Opportunistic Infection Definition, p. 43(van Dyk)

Symptoms of AIDS, pp. 38-46 (van Dyk)

Wednesday, 17 October

Read and be ready to discuss REAP, Chapter 9 "Testing for AIDS"

Handout "Who Will Cry For Me?" for UPE #4

Assignment due: Monday, 29 October – Review of "Who Will Cry For Me?"

Write a 3-4 page reflection paper (typed in CTS Form and Style) on the booklet "Who Will Cry For Me?" Answer these questions in your paper: Did you like it? Was it informative? Was the subject matter presented in a way which held your attention? Is this something that you could use in your church? Why or why not? Did it teach you anything you didn't know? Did it influence how you look at AIDS patients? What is the best or worst feature of this booklet?

Friday, 19 October – Video on Rape & Child Abuse in South Africa

JOURNAL ENTRY – Why do you think rape and child abuse are such a problem in South Africa?

Monday, 22 October – Topic: Abortion

Video: "Life, It's A Gift" (report to the 2nd dining room)

Handout on abortion

JOURNAL ENTRY – Did this video make you see your sexuality in a different light?

Wednesday, 24 October

Read and be ready to discuss van Dyk p. 298-304 "Nutrition" (17.1 & 17.2)

Introduction to Trench Gardens

Friday, 26 October

Home Based Care – Class Demonstration

Handouts on "LIGHT bags and 6 week medicine package for AIDS patients"

Monday, 29 October – UPE #4 Paper on "Who Will Cry For Me?" is DUE

Turn your paper in by e-mail attachment to emjohns@mweb.co.za. Thanks!

Wednesday, 31 October – A Biblical View of the Church's Responsibility and Role in the AIDS pandemic of South Africa

JOURNAL ENTRY – After the class discussion, do you see the church responding to the AIDS crises?

Friday, 2 November –

Read and be ready to discuss: "Legal, Ethical and Policy Issues" (van Dyk, pp. 334-366)

Monday, 5 November - Continuation of legal, ethical and policy issues as well as the church's responsibility and role

THE FINAL EXAM WILL COVER ANYTHING WE HAVE TOUCHED ON THIS SEMESTER...SO BE SURE YOU KEEP YOUR NOTES FOR STUDYING AT THE END.

YOUR JOURNALS WILL BE TURNED IN AS PART OF YOUR FINAL...SO BE SURE YOU KEEP THEM CURRENT!!

****FINAL EXAMS, 6-14 November

Wednesday, 14 November – SRC Family Day and Braai

Thursday, 15 November – Campus Clean Up

Saturday, 17 November – CTS Graduation

***M.A. PROGRAMME, 26 NOVEMBER – 7 DECEMBER
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APPENDIX E

Location (tick one): Cape Town ___ Durban ___ Rustenburg ___

Date: ___ / ___ / 2008
Date Month

STUDENT REGISTRATION

Name: _____
Surname First Name

Physical Address: _____

Postal Code

Mailing Address: _____

Postal Code

Home Phone: _____
Area Code

Cell Phone: _____

Family Details:

Wife's Name _____

Children's Names:

1. _____ Age _____

2. _____ Age _____

3. _____ Age _____

4. _____ Age _____

Education Level Completed: (*Tick highest level completed*)

Primary School _____ Grade _____

High School _____ Grade _____ Certificate _____

Matric _____ With exemption _____ Without exemption _____

Varsity:

2 yr. diploma _____

3 yr. BA _____

4 yr. BA _____

Other _____

Post Graduate:

M Level _____

Doctorate _____

What is your position and present place of employment?

How do you think you learn best?

By seeing _____ By hearing _____ By doing _____ Combination of these _____

APPENDIX F

Gender: Male _____ Female _____
 Culture: English _____ Afrikaans _____ Zulu _____ Xhosa _____ Sotho _____ Tswana _____ Other _____
 Race: Black _____ White _____ Coloured _____ Asian _____ Other _____

LEARNING NEEDS ASSESSMENT (LNA)
Community Health Ministry – Mentor: Emily Johns
2008

The Registrar's Office has informed me that you are registered for the upcoming class entitled "Community Health Ministry: HIV/AIDS" which will begin next week. Many of you know that this class will be concentrating primarily on HIV/AIDS. As a part of that class, I would like to hear from you BEFORE the class begins. Please follow the directions below and return this form to me before class begins on _____.

Instructions: Review the following list of proposed topics that might be covered in this class. Tick off the items that YOU would like to see addressed or that you feel are important in preparing you for future ministry with AIDS victims.

After completing the list, go to the bottom of the page and list 7 topics that are of the most importance to you in the order of most important to least important. (Number 1 will be the most important, Number 2 the second most important, etc.)

Learning Need Assessment – List of Possible Topics

- _____ The basics of the disease of HIV/AIDS (also including theories on the origin of the disease, testing & treatment)
- _____ The economic impact of AIDS on South Africa
- _____ Human sexuality issues surrounding the pandemic (i.e., sexual abuse, rape, abortion, sexually transmitted diseases)
- _____ Traditional African views pertaining to sexuality, sickness, death and dying
- _____ Legal issues pertaining to AIDS and AIDS victims
- _____ The impact of AIDS on Southern Africa (9 countries at the tip of Africa)
- _____ Condom usage and safety
- _____ AIDS Orphans

- _____ Tuberculosis (the majority of AIDS victims die of TB)
- _____ The Biblical/theological view of the AIDS pandemic
- _____ Abstinence training for youth/Abstinence training resources
- _____ Home-based care ministry for AIDS victims (including trench/organic gardens)
- _____ Counseling AIDS victims and their families
- _____ How pastors can lead their churches during the AIDS crises (including leadership tips on dealing with a tough topic in front of your congregation!)
- _____ The Church's role and responsibility in the AIDS crises
- _____ The role of the South African government in the AIDS crises
- _____ Resources to help pastors/churches in the AIDS crises
- _____ Other topic (please describe)_____

I would prioritize the topics of importance to me in the following way (1 is most important, 7 is least important):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Any additional comments? Please feel free to express them!

APPENDIX G

Gender: Male___ Female___
 Culture: English___ Afrikaans___ Zulu___ Xhosa___ Sotho___ Tswana___ Other_____ (state)
 Race: Black___ White___ Coloured___ Asian___ Other_____ (state)

SCALE OF HIV/AIDS KNOWLEDGE

Class # _____

NB: Please do NOT place your name on this form...thank you!

Directions: Each of the following questions has five (5) possible answers (Strongly Disagree, Disagree, Not Sure, Agree, Strongly Agree). Please tick (?) the one space that best reflects your opinion on each question.

For example, if you AGREE that AIDS is an infectious disease caused by a virus, you would tick the line under the column labeled "Agree", like this:

1. AIDS is an infectious disease caused by a virus.

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
			✓	

Question	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1. People can become infected with the HI virus by living near a hospital or care centre for AIDS patients.					
2. AIDS is common in older people.					
3. Young children can become infected by attending school with a child who is HIV+.					
4. A person can become infected by having unprotected sexual intercourse with someone who is HIV+.					
5. The HI virus can be spread from one person to another by needles that are used more than once for injections.					
6. There is a cure for HIV infection.					
7. A mother who is HIV+ can give the virus to her baby through breastfeeding.					
8. You can tell by looking at a person if he or she is HIV+.					
9. Being HIV+ weakens and eventually destroys the body's ability to protect itself against disease.					
10. A person can be infected with the HI virus and not have the condition called AIDS.					
11. AIDS is an infectious disease caused by a virus.					

Question	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
12. Someone who has been infected with the HI virus will have immediate symptoms indicating that they are HIV+.					
13. All babies born to an HIV+ mother will test HIV+ when they are born.					
14. All of the body fluids (tears, saliva, semen, sexual fluids, blood) contain some concentration of the HI virus.					
15. No cure exists for someone who is HIV+ at this time.					
16. People can become infected by working near someone who is HIV+.					
17. A pregnant woman who is HIV+ can give the virus to her baby during the birthing process.					
18. People can become infected with the HI virus by using public toilets.					
19. A vaccine is available that protects a person from the HI virus.					
20. People can become infected by the HI virus simply by eating food that has been prepared by a cook who is infected with the virus.					
21. People can become infected with the HI virus by sharing plates, forks, or glasses with someone who has AIDS.					
22. A person can become infected with the HI virus by deep kissing a person who is HIV+.					
23. People can become infected with the HI virus by drinking from a common communion cup at church.					
24. If a man and woman who are not infected with the HI virus engage only in sexual intercourse with each other, they will not become infected with the HI virus.					
25. The use of a condom during sexual intercourse can reduce the possibility of HIV transmission, but it will not always prevent it.					
26. Women can avoid becoming infected with the HI virus by using spermicidal foam during sexual intercourse.					
27. A healthy person can become infected with the HI virus by being coughed or sneezed on by someone who is HIV+.					
28. A baby born to an HIV+ woman will test HIV+ because the mother's antibodies are					

Question	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
found in his/her blood for up to 18 months after birth.					
29. The HI virus is very strong and can survive for a long period of time in the open air.					
30. Research is beginning to show that male circumcision is proving to be an important part of preventing HIV transmission in males.					

APPENDIX H

APPENDIX I

APPENDIX J

Gender: ... Male ___ Female ___
Culture: ..English ___ Afrikaans ___ Zulu ___ Xhosa ___ Sotho ___ Tswana ___ Other _____ (state)
Race: Black ___ White ___ Coloured ___ Asian ___ Other _____ (state)

JOURNAL ENTRY DAY 1

Do you have any previous education regarding AIDS? As you learned about and discussed AIDS in class today, how did you feel? Briefly describe your emotions.

JOURNAL ENTRY DAY 2

It is a tragedy when anyone contracts the HI virus, but some situations make us more heart sore than others. Today we discussed an article from *TIME* magazine. It describes the lives of five AIDS victims. Which of these accounts stirred up your emotions the most and why?

JOURNAL ENTRY DAY 3

In today's class we did a thinking exercise called Corners. During the exercise you were asked "As a Christian, which of the following jobs would you want to have during the HIV/AIDS pandemic in South Africa and why?" (Your choices are Health Minister, pastor, school teacher, medical doctor working in a government clinic or HIV/AIDS educator)

JOURNAL ENTRY DAY 4

As you watched the movie *Beat the Drum* what were your feelings? Did it give you hope? What one thing stood out to you about the little boy in the movie? Was there anything else in the movie that seemed culturally interesting or culturally different?

JOURNAL ENTRY DAY 5

Do you believe that educating your people about STDs and AIDS should be a part of church youth group curriculum? Why or why not? At what age should this begin and who should teach it? Whose teaching, in your opinion, would be received the most powerfully and why?

JOURNAL ENTRY DAY 6

As you viewed today's movie (*Yesterday*), what were some of the social problems or needs that you saw as a result of HIV infection in Yesterday's family? Could a community church be of help with any of these problems? Which problems and how? Describe briefly.

6b (Optional) Relate six of the prescribed character traits discussed in class to your personal ideas and beliefs about sex.

JOURNAL ENTRY DAY 7

Imagine you are the senior pastor of a church in your community. As you are aware, the Bible is specific about boundaries and expectations for our sexual behaviour and relationships as Christians. If you were to teach on this topic, what do you think would be the response from your congregation? Would it be received well? Why or why not?

JOURNAL ENTRY DAY 8

After yesterday and today's discussion on unsafe sexual behaviour, sexual immorality and self-control, were you challenged to look at your own views on sexuality? Why or why not?

JOURNAL ENTRY DAY 9

Testing: Would you be willing to test for HIV if you had engaged in risky behaviour?
Would you be willing to serve as a role model for testing in your church?

APPENDIX K

**GENERAL DEMOGRAPHICS OF EACH
FRATERNAL SAMPLING**

Fraternal		Movement	Association	Group	Description	Combined Average
<u>Race</u>	Black	100%			(20% referenced Tswana, 80% referenced "Xhosa", 60% referenced "black South African")	
	Coloured		100%		(60% referenced "Cape Coloured", 20% referenced "European Coloured")	
	White			100%	(20% referenced "white Afrikaans")	
<u>First Language</u>	English		40%	100%		
	Afrikaans		60%			
	Tswana Xhosa	20% 80%				
<u>Second Language</u>	English	80%	60%	80%		
	Afrikaans	20%	40%			
	Tswana Xhosa					
	None					20%
<u>Presently Pastoring</u>	Yes	100%	100%	100%		
	No					
<u>Yrs/Pastoral Ministry</u>	Lowest	7 yrs.	8 yrs.	10 yrs.		
	Highest	24 yrs.	38 yrs.	27 yrs.		
	Average	15.5 yrs	23 yrs.	18.5 yrs.		

Combined Average Years in Pastoral Ministry						19
<u>Age</u>	Youngest	30 yrs.	40 yrs.	30 yrs.		
	Oldest	60 yrs.	57 yrs.	53 yrs.		
	Average	45.4 yrs.	51.2 yrs.	47 yrs.		
Combined Average Age						47.9
<u>Level Education Completed</u>	Std. 9	20%				
	Technikon	20%	20%	20%		
	Matric	20%				
	Diploma		20%			
	University	40%	20%	40%		
	Post-grad		40%	40%		
<u>Size of Congregation</u>	Smallest	200	110	450		
	Largest	500	800	1300		
	Average	280	312	850		
Combined Average Size of Congregation						481

APPENDIX L

The Role of Women in Ministry as Described in Holy Scripture⁷⁴

This statement on the role of women in ministry was adopted as the official statement by the General Presbytery of the Assemblies of God on August 14-16, 1990.

Supernatural manifestations and gifts of the Holy Spirit have played a distinctive role in the origin, development, and growth of the Assemblies of God. From the earliest days of our organization, spiritual gifting has been evident in the ministries of many outstanding women. Divine enablement has also been seen in the spiritual leadership of women in other Pentecostal groups. The Pentecostal movement believes that the 20th-century outpouring of the Spirit is a true fulfillment of the scriptural prediction, "Your daughters shall prophecy ... and upon the handmaids in those days will I pour out my Spirit" (Joel 2:28, 29).

The Bible as Final Authority

The history and current practice of the Assemblies of God give demonstration that God can and does bless the public ministry of women. Yet there is currently much debate concerning the proper role of women in spiritual leadership. So it is appropriate to ask if Scripture describes any limits to this public ministry. We all agree that Scripture must be our final authority in settling questions of faith and practice. But when born-again, Spirit-filled Christians, following proper hermeneutical principles, come to reasonable but differing interpretations, we do well not to become dogmatic in support of one position. We affirm the inerrancy and authority of Scripture. We desire to know for certain what God expects of us. When we come to a sure understanding of His divine Word, we are committed to declaring and obeying those clear instructions. But we also exercise caution in giving authoritative importance to interpretations that do not have indisputable support from the whole of Scripture. Although the Holy Spirit may be active in the work of translation and interpretation, we cannot claim inerrancy for interpretations (even of extant Hebrew or Greek texts).

Historical and Global Precedent

In the early days of most revivals, when spiritual fervor is high and the Lord's return is expected at any time, there is often a place for, and acceptance of, the anointed ministry of women. Over time, however, concerns about organization and lines of authority begin to emerge, and the group moves toward a more structured ministry. As institutional concerns come to the forefront, the spiritual leadership of women is accepted less readily, and church leadership becomes predominately male. The experience of the Assemblies of God has been no exception to this progression.

Twentieth-century practice among Pentecostals around the world reveals evidence of a genuine struggle to apply biblical truth in various cultural contexts. In some settings, female spiritual leadership is readily accepted; in others, though women may have limited ministry, leadership posts are withheld from them. At times there is inconsistency between the leadership a female missionary has at home and that which she has on the field, or between her opportunities and those of a national female. Indeed, culture has influenced the extent of leadership a woman has been allowed to share. The Church must always be sensitive to cultural concerns, but it must look to Scripture for the truth that applies to all times and cultures.

⁷⁴ © 1990 General Council of the Assemblies of God - *The Role of Women in Ministry*

Biblical Examples of Women in Ministry

Old Testament history includes accounts of strong female leadership. Miriam was a prophet, one of the triumvirate of leaders God sent to Israel during the Exodus period (Exodus 15:20). Deborah, as prophet and judge, led the army of the Lord into successful combat (Judges 4 to 5). Huldah, also a prophet, authenticated the scroll of the Law found in the temple and helped spark the great religious reform in the days of Josiah (2 Kings 22; 2 Chronicles 34).

The New Testament also records ministering women in the Church Age. Tabitha (Dorcas) is called a disciple and had a ministry of helps (Acts 9:36). Philip had four virgin daughters who prophesied (Acts 21:8,9). Euodia and Syntyche were Paul's coworkers who shared in his struggle to spread the gospel (Philippians 4:2,3). Priscilla was another of Paul's exemplary "fellow workers in Christ Jesus" (Romans 16:3,4, NIV). In Romans 16, Paul greets a multitude of ministering persons, a large number of them women.

Phoebe, a leader in the church at Cenchrea, was highly commended to the church at Rome by Paul (Romans 16:1,2). Unfortunately, biases of modern English translators have sometimes obscured Phoebe's position of leadership, calling her a "servant" or "helper", etc. Yet Phoebe was diakonos of the church at Cenchrea. Paul often used this term for a minister or leader of a congregation and applied it specifically to Jesus Christ, Tychicus, Epaphras, Timothy, and to his own ministry. Depending on the context, diakonos is usually translated "deacon" or "minister." Though some translators have chosen the word deaconess (because Phoebe was a woman), such a distinction is not in the original Greek. It seems likely that diakonos was the designation for an official leadership position in the Early Church.

Junia was identified by Paul as an apostle (Romans 16:7). But many translators and scholars, unwilling to admit there could have been a female apostle, have since the 13th century masculinized her name to Junias. The biblical record shows that Paul was a strong advocate of women's ministry.

The instances of women filling leadership roles in the Bible should be taken as a divinely approved pattern, not as exceptions to divine decrees. Even a limited number of women with scripturally commended leadership roles should affirm that God does indeed call women to spiritual leadership.

A Biblical Survey of the Role of Women in Ministry

Of primary importance in defining the scriptural role of women in ministry is the biblical meaning of "ministry". Of Christ our great model, it was said, "For even the Son of man came not to be ministered unto, but to minister, and to give his life a ransom for many" (Mark 10:45). New Testament leadership, as modeled by Jesus, portrays the spiritual leader as a servant. The question of human authority is not of primary significance, though it naturally arises as organization and structure develop.

Genesis 2:18-25

Some expositors have taught that all women should be subordinate to adult men because Eve was created after Adam to be his helper ("help meet", KJV). Yet the word ezer ("helper") is never used in the Hebrew Bible with a subordinate meaning. Seventeen out of the twenty times it is used, it refers to God as the helper. Instead of being created as a subordinate, Eve was created to be a "suitable" (kenegdo) helper, or one "corresponding to" Adam.

Some argue that God created men and women with different characteristics and desires, and that these differences explain why leadership roles should be withheld from women. Others attribute these perceived differences to culture and social expectations imposed on children from birth to adulthood. Physical differences and distinctive biological functions are obvious; but it is only by implication that gender distinctives can be made to suggest leadership limitations.

Paul's Emphasis on Charismatic Ministry

Ministry in the New Testament is charismatic in nature. It is made possible and energized as the Holy Spirit sovereignly distributes spiritual gifts (charismata) to each member of the body of Christ (Romans 12:6-8; 1 Corinthians 12:7-11,27,28; Ephesians 4:7-12; I Peter 4: 10,11). While some gifts

are a spontaneous work of the Spirit and others are recognized ministry gifts to the Body, all are given for service without regard to gender differentiation. For example, the gift of prophecy is explicitly for both men and women:

"Your sons and your daughters shall prophesy" (Acts 2: 17). That women received and exercised this gift of the Spirit is well attested in the New Testament (Acts 21:9; 1 Corinthians 11 :5).

If Peter found certain statements by Paul hard to understand (2 Peter 3:16), then it is no surprise that we, who are removed by 1900 additional years of history, would share his struggle in interpreting some Pauline passages. And we, like Peter (2 Peter 3: 15), must respect and love our brothers and sisters who hold alternative interpretations on issues that are not critical to our salvation or standing before God. We only request that those interpretations be expressed and practiced in love and consideration for all of God's children, both men and women.

First Corinthians 11:3-12

The statement that "the man is the head of the woman" has for centuries been used to justify the practice of male superiority and to exclude women from spiritual leadership. Two alternative translations for *kephale* ("head"), debated widely by contemporary evangelical scholars, are (1) "authority over" and (2) "source" or "origin." Both meanings can be found in literature of Paul's time.

Taking the passage as a whole, the second meaning fits as well as or better than the first meaning, leading to the summary statement of verse 12: "As the woman is of the man, even so is the man also by the woman; but all things [are] of God." Even the relationship between the eternal Son and the Father-"the head of Christ is God" (11:3)-fits better as "source" than "authority over" (cf. John 8 :42). Without attempting to resolve this debate, we do not find sufficient evidence in *kephale* to deny leadership roles to women (in light of biblical examples of women in positions of spiritual authority, and in light of the whole counsel of Scripture).

First Corinthians 14:34-36

There are only two passages in the entire New Testament which might seem to contain a prohibition against the ministry of women (1 Corinthians 14:34 and 1 Timothy 2: 12). Since these must be placed along side Paul's other statements and practices, they can hardly be absolute, unequivocal prohibitions of the ministry of women. Instead, they seem to be teachings dealing with specific, local problems that needed correction.

There are various interpretations of what Paul was limiting when he said, "Let your women keep silence in the churches: for it is not permitted unto them to speak" (14:34). Options include (1) chatter in public services, (2) ecstatic disruptions, (3) certain authoritative ministries (such as judging prophecies), and (4) asking questions during the service. Yet, Paul does allow women to pray and prophesy in the corporate service (1 Corinthians 11 :5).

Although we may not solve all the difficulties of this chapter, we do conclude that this passage does not prohibit female leadership, but like the rest of the chapter, it admonishes that "all things be done decently and in order" (1 Corinthians 14:40).

First Timothy 2:11-15

The meaning and application of Paul's statement, "I suffer not a woman to teach, nor to usurp authority over the man" (1 Timothy 2: 12), have puzzled interpreters and resulted in a variety of positions on the role of women in ministry and spiritual leadership. Is the prohibition of women teaching and exercising authority a universal truth, or was Paul reporting his application of divine truth for the society and Christian community to which he and Timothy ministered?

From the above survey of passages on exemplary women in ministry, it is clear that Paul recognized the ministry of women. Yet there were some obvious problems concerning women in Ephesus. They were evidently given to immodest apparel and adornment (1 Timothy 2:9). The younger widows "learn to be idle ... and not only idle, but tattlers also and busybodies, speaking things which they ought not" (1 Timothy 5: 13). In his second letter to Timothy, Paul warned against

depraved persons (possibly including women) who manipulated "weak-willed", or "gullible", women (2 Timothy 3:6, NIV).

A reading of the entire passage of 1 Timothy 2:9-15 strongly suggests that Paul was giving Timothy advice about dealing with some heretical teachings and practices involving women in the church at Ephesus. The heresy may have been so serious that he had to say about the Ephesian women, "I am not allowing women to teach or have authority over a man." But we know from other passages that such an exclusion was not normative in Paul's ministry.

First Timothy 3:1-13

This entire passage has been held by some to confirm that all leaders and authorities in the Early Church were intended to be, and indeed were, males. It is true that the passage deals primarily with male leadership, most likely because of majority practice and expectations. When there were women leaders, like Phoebe, they would be expected to meet the same standards of character and behavior.

Translations of verse 11 present evidence of the translator's choice based on personal expectations. The word *gunaikas* can be translated as either "wives" or "women," depending on the translator's assumptions concerning the context. One rendering leaves the impression that these are qualifications for deacons' wives; the other suggests this exhortation is addressed to female spiritual leaders.

Although the first-century cultural milieu produced a primarily male church leadership, this passage along with other biblical evidence of female spiritual leadership (e.g. Acts 21:9; Romans 16:1-15; Philippians 4:2,3) demonstrates that female leadership was not prohibited, either for Paul's day or for today. Passages which imply that most leaders were male should not be made to say that women cannot be leaders.

Galatians 3:28

Those who oppose allowing women to hold positions of spiritual leadership must place contextual limitations on Galatians 3:28. "There is neither Jew nor Greek, there is neither bond nor free, there is neither male nor female: for ye are all one in Christ Jesus."

Some interpreters restrict the meaning of this triad to salvation by faith or oneness in Christ. That truth is certainly articulated throughout Scripture. Yet the verse carries a ring of universal application for all our relationships, not just an assurance that anyone can come to Christ. "Neither Jew nor Greek ... neither bond nor free ... neither male nor female" these are basic relationship principles to which faithful followers of Christ must give highest priority.

The God of the Bible has "no respect of persons" (Romans 2:11; cf. also 2 Samuel 14:14; 2 Chronicles 19:7; Acts 10:34; Ephesians 6:9). He calls whom He will and gives gifts and ministries as He chooses; man must not put limitations on divine prerogatives. In Christ we are truly set free from sin and its curse, which separate from God and elevate or demean according to race, social standing, or gender.

Therefore We Conclude

After examining the various translations and interpretations of biblical passages relating to the role of women in the first-century church, and desiring to apply biblical principles to contemporary church practice, we conclude that we cannot find convincing evidence that the ministry of women is restricted according to some sacred or immutable principle.

We are aware that the ministry and leadership of women are not accepted by some individuals, both within and outside the Christian community. We condemn all prejudice and self-promotion, by men or women. The existence in the secular world of bigotry against women cannot be denied. But there is no place for such an attitude in the body of Christ. We acknowledge that attitudes of secular society, based on long-standing practice and tradition, have influenced the application of biblical principles to local circumstances. We desire wisely to respect yet help redeem cultures which are at variance with Kingdom principles. Like Paul, we affirm the Great Commission takes priority over every other consideration. We must reach men and women for Christ, no matter what their cultural or ethnic customs may be. The message of redemption has been carried to remote parts of the world through the

ministry of dedicated, Spirit-filled men and women. A believer's gifts and anointing should still today make a way for his or her ministry. The Pentecostal ministry is not a profession to which men or women merely aspire; it must always be a divine calling, confirmed by the Spirit with a special gifting.

The Assemblies of God has been blessed and must continue to be blessed by the ministry of God's gifted and commissioned daughters. To the degree that we are convinced of our Pentecostal distinctives-that it is God who divinely calls and supernaturally anoints for ministry-we must continue to be open to the full use of women's gifts in ministry and spiritual leadership.

As we look on the fields ripe for harvest, may we not be guilty of sending away any of the reapers God calls. Let us entrust to these women of God the sacred sickle, and with our sincerest blessings thrust them out into the whitened fields.

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APPENDIX M

(Sent on CTS letterhead)
2 March 2006

Pastor Isaac Hleta
PO Box 706
Henley on Klip 1962

Dear Pastor Hleta:

Greetings from Cape Town!

First of all, let me introduce myself....I am the wife of Dr. Greg Johns, principal of Cape Theological Seminary. Presently I hold the position of Director of Post Graduate Studies at Cape Theological Seminary. Greg and I are both fully appointed missionaries with the Assemblies of God USA.

My main reason for writing is to request a time to interview you in conjunction with my Ph.D. dissertation through Stellenbosch University. The meeting would need to take 60-90 minutes and would be a semi-structured interview. I would be interviewing you as the executive leader of The Movement (AOG/SA). A list of questions would be forwarded to you in advance of our meeting, and I would be most willing to provide a translator for our meeting, if you would desire such.

My dissertation is in the area of the development of a fully multi-cultural curriculum in HIV/AIDS for AOG pastors. The interview questions would be on the topics of sickness, death/dying, HIV/AIDS, gender and sexuality issues, orphans, poverty and gender issues within the church which stem directly from scriptural teaching. I want to get the black South African cultural perspective from you as the leader of The Movement churches. For your information, I am also requesting interviews with Pastor Donovan Coetzee (leader of The Group) and Pastor Colin LaFoy (leader of The Association).

I will be up in Johannesburg on the 31 March and would be available to drive up to Henley on Klip for an interview at that time if that is convenient for you. The time of 10:00 a.m. would be the best time for my schedule that day as I have to be back in Johannesburg for other meetings around 4:00 p.m. I am also open to another date and time if this time is not convenient for your schedule.

Would you please contact me as soon as possible regarding this request and let me know if this date and time would be suitable for you? Your consideration in this matter would be greatly appreciated.

Respectfully,

Emily M. Johns, Director
Post Graduate Studies Centre
CAPE THEOLOGICAL SEMINARY

Enclosures - 1 letter from promoter

APPENDIX N

(Sent on CTS letterhead)

14 March 2008

Pastor Isaac Hleta
PO Box 706
Henley on Klip 19 62

Dear Pastor Hleta:

I am sending this letter to confirm our appointment for Friday, 31 March at 10:30 a.m. This appointment was confirmed through The Movement Secretary, Freddy Matsila. I have purchased an airline ticket to fly into the Johannesburg airport and will be renting a car and driving to Henley on Klip on the morning of 31 March specifically for this interview. I am truly looking forward to our time together.

I have requested one hour of your time to interview you regarding the questions on the attached form. Per my discussion with Pastor Matsila, I am forwarding these ahead of our interview time to give you ample opportunity to look over the questions in advance. Also enclosed is an Informed Consent Form. You will note on this form that I am requesting to tape record our interview. This is purely for accurate recording purposes and will allow me to engage in interview rather than to write notes as your answers are given. If you would prefer not to have your interview taped, please just say so and I will make an alternate plan. Please be assured that this tape will only serve purposes in line with the research and will be destroyed upon the completion of the research.

If you have any concerns or questions, please don't hesitate to contact me. My contact details are as follows:

Cell: 083-454-1183
Home: 021-558-9514
Work: 021-557-3997

Thank you for your time and cooperation in advance.

Respectfully,

Emily Johns, Director
Post Graduate Studies Centre
CAPE THEOLOGICAL SEMINARY

APPENDIX O

(Sent on CTS letterhead)

Date

Pastor
Church
Address

Dear Pastor _____:

Greetings!

Thank you for taking my phone call on ___date_____. This letter is to follow up on our phone conversation and confirm my appointment to interview you for my doctoral research project. Our agreed upon details are as follows:

Date: _____
Time: _____ **
Place: _____

**Please remember that 60-90 minutes will be required for this interview.

My dissertation is in the area of the development of a fully multi-cultural curriculum in HIV/AIDS for AOG/SA pastors. The interview questions will be on the topics of sickness, death/dying, HIV/AIDS, gender and sexuality issues, orphans, poverty and gender issues within the church which stem directly from scriptural teaching. You will note a letter of validation from my promoter, Professor Cornelia Roux, is enclosed.

Also enclosed is an Informed Consent Form. Please read through this before our meeting. You will note that I am asking to tape record our meeting. This is purely for the purpose of accurate recording. All tapes will be destroyed after the research is completed. If you would desire not to be recorded, please let me know and I will make provision for your request.

Thank you again for your willingness to participate in this research project. Your time and interest are greatly appreciated.

Respectfully,

Emily M. Johns, Director
Post Graduate Studies Centre
CAPE THEOLOGICAL SEMINARY

Enclosures – 1 letter from promoter, 1 Informed Consent Form

APPENDIX P

Analysis of the Problem – HIV/AIDS in South Africa

Part 1: Questions 1-5

The identified problem is based upon the fact that the country of South Africa has the highest number of AIDS infections in the world. The problem is two fold:

- 1) The AOG/SA does not formally educate its pastors on the issue of HIV/AIDS. There does not appear to be any dialogue or strategic planning by executive church officials pertaining to the pandemic. Culturally separate fraternals (The Group, The Association and The Movement) are not talking or strategizing about the pandemic amongst themselves or their leaders.
- 2) There is a lack of cooperation and coordination between AOG/SA churches on a). Matters pertaining to the AIDS pandemic; and b). Community initiatives to stem the pandemic.

With this in mind, please share your views on the following questions to the best of your ability:

1. AIDS is a big problem in South Africa; however, it appears that only a few churches are attempting to do anything about it. Why?

Does *your* church do any of the following? (Tick those that apply)

- Provide teaching on HIV/AIDS (children, youth, adults, old people)
- Pastor preaches on this topic from time to time
- Youth pastor speaks to the youth group regarding this matter
- Youth pastor provides programmes addressing sexual abstinence and safety
- Youth pastor/senior pastor liase with the community schools to provide assemblies or programmes on sexuality
- Offers community outreach ministry (i.e., gardens, feeding schemes, home-based care, counseling, testing) to those infected or affected by HIV/AIDS)

2. Who or what do you think is responsible for a lack of church involvement on this issue?

3. What are the negative consequences of neglecting or ignoring the problem of AIDS in your community? [If AIDS is not a problem in your community, what are the negative consequences of neglecting AIDS *in your country*?]

4. What underlying societal and cultural factors are contributing to the perpetuation (maintenance) of the problem of HIV/AIDS? _____

5. Does anyone benefit from having millions of infected and affected AIDS victims in South Africa? _____

Analysis of the Problem – HIV/AIDS in South Africa

Part 2: Questions 6-9

The identified problem is based upon the fact that the country of South Africa has the highest number of AIDS infections in the world. The problem is two fold:

- 1) The AOG/SA does not formally educate its pastors on the issue of HIV/AIDS. There does not appear to be any dialogue or strategic planning by executive church officials pertaining to the pandemic. Culturally separate fraternals (The Group, The Association and The Movement) are not talking or strategizing about the pandemic amongst themselves or their leaders.
- 2) There is a lack of cooperation and coordination between AOG/SA churches on a). Matters pertaining to the AIDS pandemic; and b). Community initiatives to stem the pandemic.

With this in mind, please share your views on the following questions to the best of your ability:

6. Whom/what is responsible for solving the HIV/AIDS problem in South Africa? Should the responsibility be shared? If so, by whom?

7. What behaviours/conditions need to change for South Africans to consider the problem of HIV/AIDS solved?

7a. What is needed to support these behavioural or conditional changes?

7b. What is an acceptable level of change in the AIDS crises? How will we know when things are getting better?

8. At what level of the country should the problem of AIDS be addressed (i.e., personal, church, local community, city, province national government)? Why?

8a. Is AIDS a multi-level problem requiring action at a variety of levels for change?

9. The problem of AIDS is a result of many things. Some of the following possibilities are listed. Please comment on each one:

a. Behaviour of key individuals:

b. Social environment:

c. Broader social conditions (e.g., unemployment)

d. Government and business policies

APPENDIX Q

Principal Investigator: Emily Johns

Version Date: _____

Study Title: *Investigating Factors Relevant to a Multicultural HIV/AIDS Curriculum for Assemblies of God pastors in South Africa*

Institution: Stellenbosch University

Informed Consent Document for Research

This informed consent applies to adults. Name of participant: _____

The following information is given to tell you about this research study. Please read this form carefully and ask any questions you may have. Your questions will be answered and you will be given a copy of this consent form for your records.

You do not have to participate in this research study, and you can stop being in this study at any time.

Purpose of the study:

The purpose of this research will be to assess and evaluate factors (educational, cultural and religious) that might be relevant to the development and design of a multicultural HIV/AIDS curriculum that will teach AOG/SA pastors to respond to, and deal effectively and compassionately with, the AIDS pandemic in their immediate communities.

The first part of the study will include interviews with the 3 executive leaders of the Assemblies of God/SA (or their designated replacement) and a sampling of five pastoral interviews from each fraternal (The Group, The Association, The Movement). A second section of the research will be the conducting of three HIV/AIDS classes for theological students. This study is part of my research as a doctoral student at Stellenbosch University and will be included in my dissertation work.

Note: This study will not seek information about individuals' HIV status or other similar personal information.

Involvement in the study:

If you choose to be a part of this study, you will be interviewed, asked questions about your church/denomination/community/culture, and your views on some of the social and cultural issues and/or ideas which surround HIV/AIDS.

First part - The interview will take place at your convenience, will last from 60-90 minutes and will be tape recorded with your consent. You may be contacted in the future for continued work on this study. While recording the interview is preferable to ensure more accurate data, if you choose not to be tape recorded, you may still participate in this study.

Second part - For classroom participants, you will be asked to respond in writing to activities or assignments given in class. These responses will be kept anonymous at all times.

Description of the discomforts, inconveniences, and/or risks that can be reasonably expected as a result of participation in this study:

If you take part in the interviews, you will be asked questions about your cultural and theological beliefs about issues that surround the HIV/AIDS crises. These topics may be private to you, and so you may not want to talk about them with a researcher. At any point in the interview, you can refuse to answer a question. Also, if you decide after the interview that you said more than you wanted to say, you may direct me to erase some parts of the interview. You may also request that the entire interview be withdrawn from the study.

Anticipated benefits from this study:

Although you may not receive any direct benefit from this study, it may give you a chance to reflect on HIV/AIDS, its surrounding issues and the role that the church in South Africa is playing as well as the cultural differences that affect the AOG/SA and its uniquely different fraternals.

What will happen if you decide to stop being in the study:

If you decide to stop being in this study, I will not contact you further and will not include your interview data in my research reports.

Who to contact:

If you should have any questions or concerns about this research study please contact me (Emily Johns) at 021-558-9514 (h) or 021-557-3997/8 (w) or you can contact my faculty promoter Professor Cornelia Roux, Faculty of Education at University of Stellenbosch-- phone 021-808-2300 or fax 021-808-2295.

Confidentiality Information:

All reasonable efforts will be made to keep the *personal information* in your research record private and confidential, but *absolute* confidentiality cannot be guaranteed. Your information may be shared with those in authority if you or someone else is in danger or if we are required to do so by law.

The interviews and any participant observation that would allow someone reading the study to identify you will be kept strictly confidential.

Your name, address, and phone number will be kept in a password-protected file on my personal computer, and I will be the only one who knows the password. Any published version of the research will use pseudonyms (false names), for both people and places.

Statement By Person Agreeing To Be In This Study

I have read this consent form and the research study has been explained to me verbally. All my questions have been answered, and I freely and voluntarily choose to take part in this study.

Signature of volunteer

Date

In addition, please indicate your approval/disapproval of the following procedures by checking the appropriate line.

I _____ agree _____ do not agree to be tape recorded.

Signature

Date

Printed name and title

APPENDIX R

Problem Analysis and Project Planning

Information Gathering & Synthesis

Design

Early Development and Pilot Testing

Evaluation and Advanced Development

Dissemination

Identify and analyse key problems	Identify and select relevant existing types of information (e.g. empirical research)	Identify design problems and intervention requirements	Develop plan for trial use in a pilot test	Plan evaluation in light of the degree of interventional development	Assess needs and points of access of potential consumers
Initiate state-of-art review	Identify relevant information sources	Specify boundaries of the domain of D&D	Create a limited operational model of the intervention for trial use in the pilot test site	Select evaluation methods (e.g. non-experimental, experimental), procedures, and techniques	Formulate dissemination plan
Determine feasibility (e.g. technical, financial, organizational, etc.)	Establish retrieval procedures	Select a D&D site	Determine the developmental research medium and/or procedure	Conduct pilot evaluation	Design and develop appropriate implementation procedures
Prepare project plan	Gather, process and store data	Use disciplined problem solving	Determine developmental and	Carry out systematic	Prepare user-ready innovation for

Problem Analysis and Project Planning

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		and creativity	monitoring instruments (e.g. logs)	evaluation	potential consumers
Set a development goal	Collect and analyse original data, as appropriate	Generate select, and assembly solution alternatives	Identify and address design problems	Revise intervention, as necessary	Develop means and media to reach potential consumers
			Revise intervention, as necessary		Test use of innovation in a "test market"
	Synthesize data and formulate conclusions	Formulate an initial intervention or other innovation model	Continue proceduralization and implementation of model		Monitor and evaluate use
			Plan field test and select a site		Revise (or reinvent) innovation as necessary
		Initiate proceduralization	Expand the trial field test as		Develop and conduct large scale

Problem Analysis and Project Planning

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Dissemination

informed by the
pilot

dissemination as
appropriate

Implement field test
and revise
intervention, as
necessary

Repeat above steps,
as necessary

**Taken from Rothman and Thomas (1994), *Intervention Research*, pp. 10-11