ADDRESSING THE HIV AND AIDS STIGMA:
A PASTORAL APPROACH
FOR CHURCH LEADERS IN KHAYELITSHA

Thesis presented in partial fulfillment of the requirements for the degree of Master of Theology: Clinical Pastoral Care (HIV and AIDS Ministry and Counseling) at Stellenbosch University.

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DECLARATION

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ABSTRACT

A research study was conducted in the form of a literature review to explore the situation of HIV and AIDS stigma in Khayelitsha in order to propose a Pastoral Approach for church leaders in that township. In this regard, the research study established that HIV and AIDS related stigma is the main barrier to any effort in fighting the HIV and AIDS epidemic. The aims of the research were to understand the causes and the effects of HIV and AIDS stigma, examine the Church as a healing community, construct a biblical and theological reflection on HIV and AIDS stigma, and make recommendations useful for the church in dealing with HIV and AIDS stigma. The research indicated that 'stigma' is a term that was used throughout history to mean a mark put on people who are regarded as different from others. In terms of HIV and AIDS, stigma is seen as an attitude shaping the way PLWHA are treated in the community. Among the causes of stigma related to HIV and AIDS are the fear of HIV and AIDS as a dangerous and infectious disease, the link between HIV and AIDS and sexual immorality, lack or distortion of information about HIV and AIDS, lack or withdrawal of resources from PLWHA, gender imbalance, and gossip and insults directed at PLWHA. According to research, the effects that come from HIV and AIDS stigma are devastating. They include fear of disclosure of HIV and AIDS status, difficulty in providing care and support for PLWHA, and acceleration of death for PLWHA. As for the biblical and theological reflection on HIV and AIDS stigma, it has been established that leprosy was the biblical disease compared to HIV and AIDS. While the OT model isolated people living with leprosy, Jesus accepted them and healed them in the NT. The OT model has often been used by the church to marginalise PLWHA on the grounds that it is God's punishment for sexual sin. The research does not deny the fact that God punishes sin through disease, but it is important to note that disease is not found to be the only form of God's punishment, and, in fact, one may not conclude that every disease is a consequence of sin. After all, God dealt with sin by punishing Jesus, who died on the cross to pay for the debts of sinners, and they are now allowed to enter God's kingdom freely. The Church is thus meant to be a community where holistic healing takes place through activities such as the teaching and preaching of God's word, *koinōnia* and *diakōnia,* as well as through prayer. In that sense, PLWHA are also included in the Body of Christ as charismatic beings, and should receive care spiritually, emotionally, relationally, and physically just as they also contribute uniquely to the wellbeing of the Church. The research suggests that in Khayelitsha, church leaders should join hands against HIV and AIDS stigma. They first of all need to confess any former failure to take action, and then work on a paradigm shift in order to change the way they have been dealing

with PLWHA in their churches. In obedience to the mission of Jesus Christ, the Bible should be interpreted in a way that does not stigmatize PLWHA, but rather stimulates church leaders in Khayelitsha to stand up and take care of those who are suffering.

SAMEVATTING

Die konteks van die studie is die situasie van MIV en VIGS binne die Township van Khayelitsha. Ditfokus op die vraagstuk van stigma ten einde ‘n pastoralebenadering vir kerkleiers in Khayelitshateontwerp. Alhoewel die faktor van deelnemendewaarneming ‘n rolsalspeel, is die navorsinghoofsaaklik ‘n literatuurstudie.

Die voorveronderstelling van die navorsingsontwerp is datstigmatiseringbinne die spesifiekekultuursituasie van Khayelitshaeen van die grootseremmendefaktore is om die epidemiedoeltreffendtebestuur. Die verderedoel van die navorsing is om die oorsaaklikefaktoreasook die effek van stigmatiseringbinnehier die Township teverken; omtebepaalwat word pastoraalverstaanonder die term ‘Die Kerk as ‘n HelendeGemeenskap’; omvanuit ‘n Bybelseperspektiefteologiesnate dink oor stigma binne die epidemieasookomvoorstelletemaak vir doeltreffendekerklikeleierskap.

Die term ‘stigma’ in die geskiedenis is gebruikommenseteetiketteer as verkillend en hulsodoende van ‘n bepaaldegemeenskapteisoleer. Stigmatisering dui dan op ‘n bepaaldelewenstyl en houdingwatmensewatleef met MIV & VIGS binne ‘n bepaaldesosialekontekstehanteer.Daarbestaan ‘n noueverbandtussenvrees en stigmatisering.Dit is die vreesomdeur die virus geïnfekteerteraak . MIV & VIGS is inderdaadgekoppelaan die vrees vir dood en sterwe. Daarbestaanook die assosiasie van seksueleimmoraliteit. Voorts is daar die faktor van ontoepas; ikeinligtingoor die toestand en die gevaar van onvoldoendemedikasie en ondersteuningstelsels. Die virus dring die gender-vraagstukbinne en gee aanleidng tot skinder en suspisie.

Dit is bevinddatdateen van die grootsteremmendefaktore is die vreesomteontsluit. Mensewilniehul status weetnie. Daar is dikwelsproblemerakendeondersteuningstelsels in die Township watniedoeltreffend is nie. Toepaslikesorgontbreekook.

‘nBybelse en teologieserefleksiesiendikwelsmelaatsheid as ‘n ekwivalent van die virus. In die OT is mensedikwelsvanuit die gemeenskapgeban. Daarteenoor het Jesus melaatsesaanvaar en genees. Die verband met melaatsheid gee dikwelsdaartoeaanleidingdatmensewat met MIV & VIGS leef, gemarginaliseer word en dat MIV & VIGS as ‘n straf van God op seksuelesondegesien word.

Die navorsingerken die verbandtussensonde en straf. Die verbandsonde-siektekanegterniekousaaloorsaaklikgesien word as ‘n verklaringsbeginselnie. Die verband is

nielogies-reglynignie. Die feit is dat Jesus onsstrafgedra het en datsyplaasvervangendelyding ‘n anderteologiesedinamika in die verbandsonde-siekte-strafinbring.Sondaars is bevry en kan die koninkryk van God binnekom.Die kerk is dus die gemeenskapwaarbinneholistiesehelingkanplaasvinddeurmiddel van lering en prediking van God se woord. *Koinonia, diakonia* en gebedspeelook in diéverband ‘n rol. Mensewatleef met MIV & VIGS moet as integraal in die gemeenskap van gelowigesgesien word. Hulle is geregtig op sorg. Hullemoetspiritueel, emosioneel, relasioneel en fisiekversorg word.Hullekan ‘n rolspeel in die welsyn van die kerk en deelookin die *charisma* van die Gees.

Die navorsingstelvoordatkerkleiers in Khayalitshasaamhandemoetvat in die stryd teen MIV & VIGS. Die kerkmoetbewuswees van misluktepogings in die verlede. Die kerkbenodig ‘n paradigmaskuif ten opsigte van bedieningsbenaderings. In die lig van die sending van Christusmoet die Bybelniegeïnterpreteer word omtestigmatiseernie, maar ommenseteversorg en kerkleierstemotiveeromtoepaslikestrategieëteontwikkelommensewatlypastoraaltehanteer.

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I will exalt you, my God the King; I will praise your name forever and ever.

Every day I will praise you and extol your name forever and ever.

Great is the Lord and most worthy of praise; his greatness no-one can fathom.

One generation will commend your works to another; they will tell of your mighty acts.

They will speak of the glorious splendour of your majesty, and I will meditate on your wonderful works.

They will tell of the power of your awesome works, and I will proclaim your great deeds.

They will celebrate your abundant goodness and joyfully sing of your righteousness.

Ps 145:1-7 NIV

DEDICATION

This research study is dedicated to my father, Kosani BARANSHIKIRIYE, whose pastoral ministry has been an inspiration to me.

LIST OF ABBREVIATIONS AND ACRONYMS

AIDS: Acquired Immuno-deficiency Syndrome

ART: Anti-Retroviral Treatment

ARVs: Antiretroviral

Col.: Colossians

Cor.: Corinthians

Deut.: Deuteronomy

Eph.: Ephesians

Ezek.: Ezekiel

FHI: Family Health International

Gal.: Galatians

Gen.: Genesis

HAART: Highly active antiretroviral treatment

Heb: Hebrew

HIV: Human Immuno-deficiency Virus

HSRC: Human Science Research Council

ICASA: International Conference on AIDS and STIs in Africa

ICRW: The International Centre for Research on Women

Isa: Isaiah

Jer.: Jeremiah

Lev.: Leviticus

LWF: Lutheran World Federation

MARPs: Most at risk populations

Matt.: Matthew

MOUs: Midwife obstetric units

MSF: Médecins Sans Frontières

NAP: National AIDS Plan

NSP: National Strategic Plan

NT: New Testament

OT: Old Testament

PGWC: Provincial Government of the Western Cape

Phil.: Philippians

PLWHA: People Living with HIV and AIDS

PMTCT: prevention of mother-to-child-transmission of HIV

Ps: Psalm

Rev.: Revelation

Rom.: Romans

SACC: South African Council of Churches

STIs: Sexually Transmitted Infections

TAC: Treatment Action Campaign

TB: Tuberculosis

Thess.: Thessalonians

UCT: University of Cape Town

UNAIDS: Joint United Nations Programmes on HIV and AIDS

UNPAD: United Nations Program for Development

USA: United States of America

USAID: United States Agency for International Development

VCT: Voluntary Counselling and Testing

WCC: World Council of Churches

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CHAPTER ONE

INTRODUCTION

1.0 Introduction

Despite efforts to reduce the prevalence and impact of HIV and AIDS in South Africa through prevention and treatment programmes, reports continue to show a significant increase in HIV and AIDS prevalence. A report by Avert[1] (2011:1) indicates that in 2009, an estimated 5.6 million people in South Africa were living with HIV and AIDS, and an estimated 310,000 South Africans died of AIDS, thereby making South Africa the leading country internationally as far as HIV prevalence is concerned. With regard to ways of HIV transmission, according to the Joint United Nations Programmes on HIV and AIDS (UNAIDS) (2010:20), the predominant ways of HIV transmission in South Africa are through heterosexual sex as well as from mother to child, while intergenerational sex, multiple concurrent partners, a low rate of condom use, excessive use of alcohol and low rates of male circumcision are also believed to be the drivers of the epidemic. In addition, the same UNAIDS report identifies that the most at-risk populations (MARPs) are known to have a higher than average HIV prevalence when compared to the general population because of their involvement in risk behaviour and the fact that they are often marginalized and stigmatized. Furthermore, the HIV and AIDS pandemic is characterised by policies that promote stigmatization and discrimination, and create barriers to HIV prevention and treatment (UNAIDS, 2010:31).

As far as the Church[2] is concerned, it is widely known that in the earlier stages of the HIV and AIDS pandemic, the religious sector was seen as part of the problem instead of being part of the solution, due to the fact that church leaders and faith-based organisations (FBOs) ignored the implications of the disease and delayed responding to the problem due to moralistic and judgemental stances that contributed to stigma, silence and secrecy. However,

[1]Avert is a Southern African charity organisation that endeavours to reverse the situation caused by HIV and AIDS.

[2]See 1.7.4 for a detailed understanding of 'Church' as used within the context of this research.

as time went by, church leaders in Africa started perceiving the need for intervention, and many of them have since started taking action by establishing activities and programmes to respond to the problem of HIV and AIDS in their churches, even though there are others who are still not involved due to their hostile attitudes towards People Living with HIV and AIDS (PLWHA) (Kalipeni & Mbungua, 2005:1).

In Africa, the HIV and AIDS pandemic is widespread and has serious consequences for the continent at large, as Africa is widely considered the epicentre of the HIV and AIDS epidemic, and the impact of the disease on that continent has been devastating (Miller, 2008:5). This can be illustrated by the fact that the effects of the AIDS epidemic on households are devastating, as many families are losing their income earners while still having to provide AIDS care at home for sick relatives, thus reducing their capacity to earn money for their families. Furthermore, many of those dying of AIDS have surviving partners who are themselves infected and in need of care, and they leave behind orphans who are grieving and struggling to survive without a parent's care and support (Ngubane, 2010:21).

In addition, church leaders in Africa have been looked to for intervention in the fight against HIV and AIDS, even though this intervention has been limited by certain issues such as "internal divisions; lack of knowledge about HIV and AIDS and international development funding mechanisms; denial; stigma and discrimination; and, poor modelling of Christian values by the leadership" (ICASA, 2003:6). Despite these limitations, church leaders have nonetheless always been looked to provide a solution for HIV and AIDS and its consequences. For example, the coordinator of HIV and AIDS work at the Lutheran World Federation (LWF) has called on the Church in South Africa to combat HIV and AIDS as it once took on South Africa's apartheid system (LWF, 2011:1). In this regard, ICASA (2003:6) comments, "The Church's response is strengthened by: development of a new theology of grace; changes in Church leadership modalities and training; increased transparency, accountability and integrity; changes in congregational attitudes and behaviour, especially with regard to harmful cultural traditions and PLWHA; and, flexibility in its responses and program designs". This shows the need for church leaders in Africa to stand up and lead their churches into an unwavering fight against HIV and AIDS stigma.

However, one needs to acknowledge even small efforts towards relieving HIV and AIDS stigma. The ICASA (2003:3) acknowledges that in the midst of continuous stigma, attempts

at stigma relief are obvious in that some individuals, families and communities have so far overcome negative attitudes, and shown acts of compassion, care and support to PLWHA.

In the religious sector, cases of non-stigmatization have been recorded in which church leaders have been seen to be involved in activities focusing on helping people infected and affected by HIV and AIDS. Some Church leaders have shown willingness to carry the burden of funerals and ministry for the sick and dying. Even though they appear to be very few, the initial efforts to fight HIV and AIDS stigma and discrimination are hopeful (UNAIDS, 2005:15; O'Reilly 2006:24). In addition, as Kamaara (2004:50) claims, in general, the Church is to be applauded for having done a lot in areas of home-based care for HIV positive children as well as initiating and running other programmes supporting PLWHA in Africa.

It is thus fair to acknowledge the Church's contribution towards the fight against HIV and AIDS, a contribution which also helps in the effort to eradicate stigma in South Africa as well as elsewhere. At the beginning of the HIV epidemic, the Church in South Africa was extremely judgemental and moralistic, but as time went by, due to awareness that HIV and AIDS was slowly invading the Church itself, there was a change in the way the Church perceived the HIV and AIDS crisis (Denis, 2009:72; Fourie, 2006:60;). As Denis further observes, the Church's involvement in the area of HIV and AIDS in South Africa can be seen in two instances: the fact that attempts to develop a "theology of AIDS" were made as early as 1990, and the efforts of various denominations to develop programmes aimed at helping PLWHA by setting up hospitals and orphanages in different South African societies. However, Church intervention in South Africa has not been always helpful, due to the fact that some churches propose sexual abstinence and marital faithfulness, which reinforces stigma. Denis (2009:81) points out that even though adherence to the Christian norms of sexual behaviour is helpful in curbing the risk of HIV infection, the fact that the Church in South Africa promotes abstinence and faithfulness may not be helpful, as it might unintentionally foster denial, stigma and discrimination. Hence, there is still a need to de-stigmatize the language of addressing the means to deal with HIV and AIDS.

In the light of the situation described above, this research study was conducted to investigate the response of church leaders in addressing the stigma fuelled by the HIV and AIDS scourge in Khayelitsha. The first chapter of this research study provides a background to the study and focuses on the problem identification, problem statement, research study question, research study objectives, the meaning of the study for Practical Theology, and research

study methodology. Conceptualization and the overview of HIV and AIDS in Khayelitsha will also be dealt with in this chapter. Before the end of the chapter, a brief overview of HIV and AIDS stigma since the beginning of the HIV and AIDS pandemic will be provided.

1.1 Problem Identification

HIV and AIDS are related to many issues such as despair, poverty, fear, isolation, discrimination and stigma (USAID, 2006:2). Among those issues, stigma is regarded as the most dangerous, because it is a significant barrier in the fight against HIV and AIDS. This is reflected in the fact that the issue of stigma is accorded paramount importance in contemporary health policy, research agendas and programmes on HIV and AIDS. Due to the way stigma has been characterised by reactions from individuals, communities, and even nations, and has moved from sympathy and caring to silence, denial, fear, anger, and even violence, it has been recognized as a key factor that needs to be addressed to create an effective and sustained response for HIV prevention, care, support, treatment, and impact mitigation (Ullah, 2011:97). Stigma related to HIV and AIDS is a significant barrier to the prevention of HIV infection and to providing care for PLWHA in their communities as it becomes difficult to find a way to get involved in helping PLWHA when many people are afraid to be seen with PLWHA. According to a qualitative research study conducted by Meiberg et al. (2008:51), "there is still a strong HIV and AIDS-related stigma in South Africa". This was made clear by the fact that most participants involved in that qualitative research agreed that PLHWA are often neglected, ignored and isolated. Moreover, Mulligan (2010:73) also emphasizes that "South Africa is gripped by HIV and there is still a tremendous amount of stigma and shame attached to HIV infection. Preventative efforts become increasingly difficult where there is little openness about infection, and sexual myths that place women and girls at high risk of abuse spread more easily in that environment".

In addition, other study findings, for example those of Zaccagnini (2010:2), indicated that PLWHA still had difficulty getting employment, women were being rejected by their husbands when found to be HIV positive, family members were being blamed by their relatives for being HIV positive, and PLWHA were even being rejected by friends who feared being seen with someone living with HIV. This situation makes it difficult to help PLWHA, and it becomes even worse when it happens among church leaders, by whom PLWHA expect to be treated with dignity. For that reason, the focus of this research study is

on drawing up a pastoral approach for church leaders in Khayelitsha in dealing with the stigma of HIV and AIDS.

1.2 Statement of the Problem

The stigma of HIV and AIDS is a reality which PLWHA face in their communities due to discrimination and marginalization by others. In the researcher's experience in 2010 at Nolungile Youth Clinic in Khayelitsha, stigma was one of the biggest challenges for the HIV positive clients seen in therapy. Nolungile Youth Clinic was built by MSF in 2004 in Site C and itaims atofferingHIV and AIDS counselling, testing and treatment to young people between 12 and 24 years old in Khayelitsha (MSF, 2009:3). During thetime the researcher spent counselling young people living with HIV and AIDS in that clinic, cases of accusation, rejection, discrimination for being HIV positive as well as the fear of HIV status disclosure were presented by most of the clients.

Clearly, the kind of stigma PLWHA face is a stumbling block to any helpful action that might be taken by the Church and community for the benefit of PLWHA. What is more stigmatizing to PLWHA is that they face discrimination even in the Church where they expect to be accepted. HIV and AIDS-related stigma has long been recognized as a crucial barrier to the prevention, care and treatment of HIV and AIDS, yet not enough is being done to combat it (Cloete et al., 2010:3; Meiberg et al., 2008:51; International Centre for Research study on Women [ICRW], 2006:1). In this regard, the Church must take action in addressing the stigma of HIV and AIDS, with the clergy taking the lead. For this reason, this research study aimed to explore the challenge of the HIV and AIDS-related stigma in churches and communities in order to suggest possible avenues for church leadership intervention. Special attention was paid to Church leaders in Khayelitsha, a large township near the city of Cape Town in South Africa.

The problem this thesis thus seeks to address is the challenge brought about by HIV and AIDS stigma to PLWHA in Khayelitsha as they face discrimination, exclusion, and rejection in their churches where they expected to find acceptance, care, and support.

1.3 Research Question

Considering the nature of the HIV and AIDS stigma and how PLWHA are affected by such a stigma in their churches and communities, a question that arises is: "How can church leaders

assist PLWHA in addressing HIV and AIDS stigmatization within their churches in Khayelitsha?"

1.4 Research Objectives

In the light of the above, the objectives of this research study are:

- To understand the causes and effects of the HIV and AIDS stigma in relation to Khayelitsha;
- To examine the nature of the Church as a place of healing in relation to HIV and AIDS stigma in Khayelitsha;
- To construct a pastoral, biblical, and theological approach which church leaders can use to address HIV and AIDS stigmatization in Khayelitsha;
- To make recommendations useful for assisting church leaders to address HIV and AIDS stigma in their churches in Khayelitsha.

1.5 The Significance of this Research Study for Practical Theology

Louw (2008:71) describes the nature and the task of Practical Theology as follows: "Practical theology is the science of the theological, critical and hermeneutical reflection on the intention and meaning of human actions as expressed in the practice of ministry and the heart of faithful daily living. It is related to life skills within the realm of spirituality. In this regard Practical Theology is connected to the praxis and will of God within the encounter of God and human beings". Reflecting on Louw's understanding, it is fair to say that Practical Theology has to do with the relationship between God and man; God appears to His people and communicates to them His word which must be contextually interpreted and understood in order to be applied to the people's context, and must then be communicated to them so that it influences their lives.

Furthermore, Practical Theology can be interpreted as being instrumental in making the word of God relevant to people's lives, which calls for a hermeneutical approach. With regard to the relationship between Practical Theology and a hermeneutical approach, Hendriks (2004:19) and Polling (2010:199) see Practical Theology as a continuing hermeneutical concern that discerns how the Word of God should be proclaimed in word and deed to the world by means of moving from theory (word) to practice (deeds). In this view, it is important to highlight the concept of discernment which is significant in the sense that the interpretation of God's word requires careful thought and reliance on the Holy Spirit through

prayer and the study of God's Word to avoid falling into wrong interpretations that go against God's will. This agrees with the idea of inhabitational theology, which has to do with an interpretation of Scripture that goes beyond moralistic thought to determine appropriate God-images in times of specific existential issues such as illness and stigma (Louw, 2008:92-93).

In this respect, this research study makes use of hermeneutics as it seeks to look at a better biblical interpretation useful in dealing with HIV and AIDS stigma. Louw (2003:210) points out that 'hermeneutics' is the event of *hermeneuein*, i.e. the process in which meaning is transferred through communication. Rossouw (1980:17, as cited in Louw, 2003:210) is of the opinion that *Hermeneuein* indicates 'interpreting', 'explaining' or 'translating', "Hermeneutics therefore has to do with explanation, with speech, with translation, with communicating a message, with interpreting something for people who want to hear and understand" (Smit, 1998:276, as cited in Louw, 2003:210). In this way, understanding and communication move between two entities or texts within contexts.

Reflecting on theological hermeneutics, Louw (2003:210) refers to Hodgson's two movements, the first being *critical-interpretive thinking* which entails a *backward questioning movement* from the interpreter, through the textual media, to the root of the revelatory experience and actual message. The second movement is a *practical-appropriative thinking* and *existential-contextual experience from the root experience* (message) *forward*, via the media, to the interpreter (self-understanding, identity) and his/her context (situation).

To better emphasize the hermeneutical aspect of Practical Theology, Ganzevoort (2009:3-4) suggests that it can be described as the hermeneutics of lived religion which is enhanced by a study of religious sources such as the Bible, and religious ideas such as doctrines, that make it easy to relate with praxis. In this regard, Ganzevoort (2009:4) goes on to mention two hermeneutical approaches defining the field of Practical Theology: the first one, which is the classical focus on the relationship between text and reader, leads to the identification of interpretation or to a study of the relation between belief and practice; the second, in its broader terms, stresses the procedure of human interpretation which puts existential themes at the centre of examination.

Put another way, the first approach qualifies Practical Theology as a field that moves closer to religious tradition, Church, and biblical or systematic theology, while the second one is more related to social sciences and the broad realm of world views and religions. For the purpose of this research study, the first approach is of great importance in its focus on

religion, Church, and other branches of theology, since the research study advocates a process of transformation which is found in the essence of Practical Theology. To emphasise the kind of transformation which Practical Theology endeavours to achieve, it is useful to refer to the fact that Practical Theology "aims at a more profound and more adequate spiritual life" (Ganzevoort, 2009:4) resulting from critical and constructive reflection on the life and work of Christians in all the varied contexts in which that life takes place, "with the intention of facilitating transformation of life in all its dimensions in accordance with Christian gospel" (Gerkin, 1991:64).

In other words, Practical Theology has to do with adequate interpretation of the gospel that must foster transformation in the lives of people in order to change their present practices and encourage them to adopt a new way of living inspired by the word of God after a careful interpretation (Fowler, 1985:52). This is what Dingemans (1996:87) means when he refers to the shift from the application of biblical data and statements of faith to the primary task of investigation of Christian practice which leads to Practical Theology being understood as a science of action.

Since this research focuses on the stigma of HIV and AIDS, the subject requires an accurate interpretation and application of God's word, because according to the findings of this research study, some interpretations tend to reinforce the stigma that PLWHA face. Therefore, since it is the task of Practical Theology to challenge and "unmask the systematic distortions in the person, social, cultural, historical and religious models of human transformation" (Fowler, 1985:52), this research study contributes to Practical Theology in that it studies scripture by exposing theories and interpretations that hold HIV and AIDS to be a punishment from God, thereby making PLWHA feel burdened by stigmatisation due to their HIV status. Moreover, the contribution this research study makes to Practical Theology is through its suggestion of the Church being a place of healing for PLWHA through believers being transformed by the gospel to see PLWHA as equal human beings who are worthy of God's love. Through this, Practical Theology can play a role in such a way that church leaders in Khayelitsha can use available means of healing and enhance healing through acceptance and integration of PLWHA in their churches. It is thus helpful for this research study to refer to Practical Theology as an application of theology to life and ministry. In this regard, Smith (2008:203) presents Practical Theology as having subdivisions, such as preaching, teaching, children's ministry, youth ministry, missions, counselling, pasturing and leadership, which deal with converting theology into practical

ministry. As Practical Theology is about the practical application of God's Word, it has the key characteristic of seeking to apply theological reflection to solving real-life problems. Its point of departure is a problem in the real world, that is, a real-life situation that is not as it should be. By means of a rigorous analysis of the problem, its causes and possible solutions, the research study seeks to come up with suggestions useful for transforming the situation.

1.6 Research Methodology

This study adopts the Practical Theological Approach as a research study methodology. Reflecting on Practical Theology research, Smith (2008:205-207) outlines the following four sequential steps which contain the seeds of a simple, logical approach for research study projects in the field of Practical Theology:

Identify a real-life problem: the point of departure is a problem in the real world, one that the researcher has noticed and is concerned about. This is usually something of concern in the Church or community. Based on initial, unscientific observations and reflections, the researcher states a problem and the underlying forces at work that are causing it. With regard to the current study, this first step applies to the fact that HIV and AIDS-related stigma was identified as a real problem in the Church and community, as it makes difficult any effort by church leaders to curb the spread of HIV and AIDS.

Interpret the world as it is: The research study itself begins with a systematic investigation of the situation. By doing descriptive research using both empirical and literary methods, the researcher sets about interpreting the what, the how and the why of the problem. What is the real situation (first impressions might be mistaken). How did the present situation develop? Why is the situation the way it is? In this step, this research study is based on a literature review as it investigates the real situation surrounding HIV and AIDS stigmatisation by exploring the causes and consequences of such stigmatisation in order to pave the way for exploring methods of dealing with HIV and AIDS stigmatization in Khayelitsha.

Interpret the world as it should be. Cowan (2000, as cited in Smith, 2008:205) describes this step as follows: "We carefully select some aspect of our faith tradition.... We undertake a historically and critically informed exegesis of the material chosen from our traditions". Under the rubric of 'our faith tradition', Cowan includes "scriptural text, theological classic, church teaching, etc." For evangelical theologians, the scriptures hold centre stage; the other traditional resources simply inform them. In this sense, this research study agrees with

Cowan's idea in that the third and fourth chapters deal with an interpretation of scriptural passages through looking at both the New Testament and Old Testament notions of disease and stigmatisation, and suggesting what route church leaders in Khayelitsha should follow in order to imitate the good example of Jesus as they deal with stigmatisation today.

Interpret contemporary obligations: The final step is to develop a feasible action that faithfully represents the will of God as interpreted in one's faith tradition, and provides a do-able remedy to the problem. Cowan (2000, as cited in Smith, 2008:207) describes the ideal: "We plan an adequately detailed intervention based on the possibility that we have chosen, implement it carefully, and rigorously evaluate both what practical difference it made....". Not every study can end with implementation; often the research study must be content with offering recommendations. In fact, as Dingemans (1996:92) posits, "... all practical theological work aims toward making suggestions and recommendations in order to improve and transform the existing practice". This is done because of the nature of Practical Theology as a theological discipline that develops theory for the practice of the churches as religious communities in society (Gräb, 2003:83). For this reason, the fifth chapter of this research study gives recommendations on how church leaders in Khayelitsha can deal with HIV and AIDS stigmatisation in their churches and communities in order to change the situation from stigmatizing PLWHA to accepting them.

As far as data collection is concerned, this research study is based only on a review of related literature. As Neuman (2011:111) suggests, "literature review is based on the assumption that knowledge accumulates and that people learn from and build on what others have done. Scientific research study is a collective effort of many researchers who share their results with one another as a community". In this sense, this research study draws its data from the work already done by other researchers. According to Cooper & Schindler (1998:257) and Walsh & Wigens (2003:17), information sources are classified into two types: **primary** and **secondary** data collection. While the first involves collecting of original data by the researcher and agents known by him/her to answer the research study question, the second is about going through pre-existing sources, making use of studies made by others for their own purposes to answer the research study question. In addition, the secondary method of data collection is "used as the sole basis for a research study, since in many research study situations one cannot conduct primary research study because of physical, legal, or cost influence" (Cooper & Schindler, 1998:257).

In this regard, sources such as textbooks, topic books, journals, magazines and newspapers, CD-ROMs and the internet, as well as reports, are useful for collecting information.

For that reason, information needed for this research study was collected through a study of existing literature. This method of data collection involves a researcher spending time and energy in academic libraries to find and review relevant information and previous work done by others on a chosen topic (Walsh & Wigens, 2003:49). The Pastoral approach this research study has drawn was mainly based on the study of Scripture in order to challenge existing biblical interpretations that reinforce stigma on PLWHA; the researcher has made use of available literature as the source of data. That is to say, information was collected from the Internet as well as from libraries available for the researcher's use, with the Bible holding a prominent place in this study. In addition to the study of available literature, the researcher made use of participatory observation. According to Mason (2006:86), a data collection method is known as participatory observation when the researcher conceptualizes him/herself as active and reflexive in the research process.In this way, the experience which the researcher has gained through conducting clinical therapy at site C Nolungile Youth Clinic in Khayelitsha, has also been a useful tool in guiding thisresearch study.

1.7 Conceptualisation

1.7.1 General Definitions of Stigma

In order to continue with the research study on stigma and draw implications as to how it relates to HIV and AIDS, it is helpful to understand its definition. In this research study, the word 'stigma' is used interchangeably with 'stigmatization'.

In general terms, stigma is characterized by "feelings of disapproval that people have about particular illnesses or ways of behaving" (Wehmeier, 2005:1452). In this definition, stigma is seen as connected to the current physical and behavioural state of a person, which make him/her either accepted or rejected.

In relation to a society, Burke & Burke (2006:1) view stigma as "an attribute used to set the affected person or groups apart from the normalized social order, and this separation implies devaluation". In this view, stigmatization refers to a process of devaluation, where certain attributes are foregrounded and regarded as discreditable or unworthy. The kind of social stigma that cause a stigmatised person to be regarded as undesirable stems from a particular

characteristic, such as a physical deformity, or from negative attitudes toward the behaviour of a group, such as homosexuals or commercial sex workers (Visser, 2007:1).

Clearly, the above definitions present stigma as a way of undermining a person for having characteristics that cause him/her to be viewed negatively by the community.

1.7.2 The Historic Development of 'Stigma'

The word 'stigma' has evolved throughout history. It can be traced back to the ancient Greeks who used it as a mark or sign imprinted onto certain types of people having negative characteristics that caused them to be identified as different from other Greek citizens. For example, as Chavez (2006:1) points out, in ancient Greece, 'stigma' meant the branding of slaves, who were often foreigners or prisoners of war, in order to distinguish them from the rest of the Greek population.

Etymologically, the English word 'stigma' originates from Latin and Greek. The word stigma was borrowed from Latin in about 1400 AD. The Greek term 'stigmatos' referred to a mark, spot, puncture, or brand, especially one made by a pointed instrument. This was derived from a root word form *stig-* , root of *stizein* which means 'to mark' or 'to tattoo'. Until 1596, the word stigma had the same function as in the ancient Greek world, being still used to mean a special mark burned on the skin of a slave or criminal" (Burke & Burke, 2006:2). Stigma is thus understood as a 'label' that sets a person apart from others, linking the labelled person to undesirable characteristics (Chavez, 2006:1).

However, the word 'stigma' has not continued to be used only to denote a 'visible mark'. In its development over the course of history, it has taken on a figurative shape. Burke & Burke (2006:2) affirm that the figurative sense of a mark of disgrace or shame was first recorded in English before 1619. Today, this word is mostly used with unseen realities in mind to depict a non-visible 'mark' that a person may have because of various life circumstances (Baldwin, 2005:23).

While still looking at the meaning of the word 'stigma', it is worth looking at the terms derived from it, namely the verb 'to stigmatize' and the plural 'stigmata'.

Just as the English word 'stigma' was borrowed from other languages, its verb, 'to stigmatise', which classically means to 'mark' or 'label', also originated from French, Latin, and Greek (Burke & Burke, 2006:3). When used in the sense of 'invisible marks', the verb

can mean to treat somebody in a way that makes him/her feel very unworthy or unimportant (Wehmeier, 2005:1452).

On the other hand, 'stigmata', which is the plural of the word 'stigma', was also used in a religious context. The word 'stigmata' is the plural of the Greek word 'stigma'. This was an ancient name for marks that were pricked or branded onto the bodies of slaves and soldiers for identification purposes. Interestingly, 'stigmata' has also been used to refer to the marks of the wounds on the crucified body of Christ. Thus, the term 'stigmata' also refers to marks that look like the wounds made by nails on the body of Jesus Christ, believed by some Christians to have appeared as holy marks on the bodies of some saints (Wehmeier, 2005:1452). According to such a belief, the marks appear on the same spots as those on Jesus' body, including the nail wounds on the feet and the hands, the spear wound in the side, the head wounds from the thorny crown, and the scourge marks over the entire body especially on the back (Saunders, 2003:1). The Apostle Paul also used the word 'stigmata' to refer to his relationship with Christ. In Gal. 6:17, he states, '…I bear on my body the marks of Jesus.' According to Campbell (2000:611), the "marks" (stigmata) which Paul was referring to meant signs of ownership. Since the stigmata were usually branded on slaves and cattle, the scars on Paul's body, caused by persecution for Christ's sake, demonstrated that he belonged to Jesus whom he served, and was not just a people-pleaser.

Like Paul, believers bear the marks of Christ. There are two kinds of stigmata that believers can have, namely 'visible' and 'invisible'. "Those who describe stigmata categorize these experiences as divine or mystical. History tells us that many bear ecstatic marks on their hands, feet, side, or brow mirroring the wounds of the Passion of Christ with corresponding and intense sufferings. These are called visible stigmata. Others only have the sufferings, without any outward marks, and these phenomena are called invisible stigmata" (Snow, 2010:2).

Since this research study is based on Khayelitsha Township which is predominantly of *amaXhosa* culture, it would be helpful to include the Xhosa word for stigma. According to the *Greater Dictionary of IsiXhosa,* the *IsiXhosa* word for stigma is *'ucalucalulo'* and means *'discrimination'* (Tshabe & Shoba, 2006:262). The Xhosa meaning of this word is used in different contexts, including discrimination against PLWHA.

1.7.3 Stigma in Relation to HIV and AIDS

As this research study has already established, the word 'stigma' was in use long before HIV and AIDS was discovered. When HIV and AIDS came onto the scene, it joined a list of many other situations such as physical disabilities, slavery, and foreignness by which people were stigmatised. That is why, as the ICASA (2003:12) puts it, stigma and discrimination in the context of HIV and AIDS can be traced back to the time when HIV and AIDS was first described, and to the subsequent identification of 'high-risk groups' as being the majority of individuals initially infected by HIV. In addition, stigma is related to HIV and AIDS in referring to the community's negative attitudes towards PLWHA and related factors. Herek and Mitnick (as cited in Visser, 2007:1) are thus correct in affirming that AIDS-related stigma can be defined as prejudice, discounting, discrediting and discrimination directed at people perceived to have AIDS or be infected with HIV, and at the individuals, groups and communities associated with them. One can also say that the relationship between HIV and AIDS and stigma has to do with the nature of the disease, and is caused by the fear of certain factors surrounding HIV and AIDS such as isolation, rejection and labelling of PLWHA and their families and friends, fear of infection, misunderstanding of how infection occurs, associating HIV with immorality, and fear of death (Dube, 2007:21). This results in treatment, mostly associated with the sexual method of HIV transmission and the fact that it is known to be a dangerous and deadly disease, which imposes 'invisible marks' on PLWHA and leads to them being labelled as unworthy of any consideration in the society, which also causes them to feel depressed. As Baldwin (2005:23) states, PLWHA are often 'stigmatized' or looked down on because of their health status. This attitude may be caused by the fact that the diagnosis of AIDS is usually associated with sexual immorality.

According to Swann Jr. (2008:207-208), the Academic Education Development Centre on AIDS and Community Health defines HIV-related stigma as follows:

> HIV and AIDS stigma refers to all unfavourable attitudes, beliefs, and policies directed toward people perceived to have HIV and AIDS as well as toward their significant others and loved ones, close associates, social groups, and communities. Patterns of prejudice, which include devaluing, discounting, discrediting, and discriminating against these groups of people, play into and strengthen existing social inequalities especially those of gender, sexuality, and race-that are at the root of HIV-related stigma.

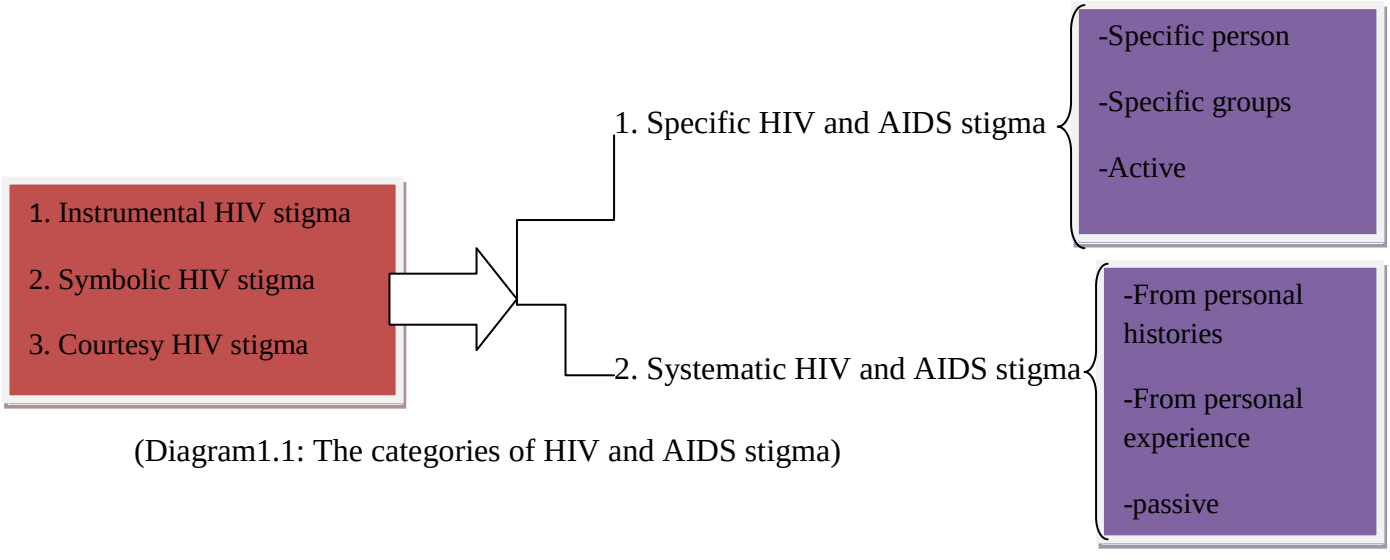
With this definition, Swann Jr. (2008:208) further mentions three categories of HIV and AIDS stigma:

• *Instrumental HIV-related stigma*: a reflection of the fear and apprehension likely to be associated with any deadly and transmissible illness;

• *Symbolic HIV-related stigma*: the use of HIV and AIDS stigma to express attitudes toward the social groups or 'lifestyles' perceived to be associated with the disease;

• *Courtesy HIV-related stigma*: stigmatization of people connected to the issue of HIV and AIDS or HIV-positive people.

To explain this further, these three categories of HIV and AIDS stigma can be fitted into two categories: systematic and specific. On the one hand, HIV and AIDS-related stigma is defined as 'systematic' when it does not necessarily need to be directed toward a specific individual in order to have an impact. On the other hand, HIV and AIDS-related stigma is described as 'specific' when it is directed toward a specific person or group of people. Systematic HIV and AIDS-related stigma is passively manifested, while specific HIV and AIDS-related stigma is actively shown. Systematic HIV and AIDS-related stigma is also born out of personal histories, beliefs, fears, biases and prejudices, and combines with the images, messages, stories and myths individuals have experienced and continue to experience, to produce a mindset about the illness. As far as the impact is concerned, systematic HIV and AIDS-related stigma informs and motivates specific HIV and AIDS-related stigma, as individuals are required to make decisions for themselves or about others in situations where HIV and AIDS is an obvious issue. The categories of HIV and AIDS stigma can be presented in the following way:



(Diagram1.1: The categories of HIV and AIDS stigma)

1.7.4 The Definition of 'Church'

According to Grudem (1994:853), the Church is defined as "the community of all true believers for all time". This definition is based on Eph. 5:25, which says that "Christ loved the Church and gave himself up for her". This can be understood to mean that the term 'Church' refers to all believers whom Jesus died for. As one looks further into Scripture, there is an indication of the Church being both 'local' and 'universal'. For example, Paul refers to the Church in the house: "greet also the Church in their house" (Rom. 16:5), but the Bible also talks about the Church in general, or universally: "So the Church throughout Judea and Galilee and Samaria had peace and was built up" (Acts 9:31). The word 'Church' comes from the Greek '*ekklesia'* which in most cases means a meeting or assembly of a local congregation of believers. Etymologically, '*Ekklesia'* has two parts, '*ek'* which means '*out from'*, and '*kaleō'* meaning to '*call*.' thus indicating the gathering of those who are 'called out' from the world; that is, the believers, designated by another Greek word '*kuriake'* meaning '*belonging to the Lord*' (Marshall et al., 1996:200; Browden 2005:228; Fahlbusch, et al., 2005:48).

In talking about the Church, there are many different types of churches that can be distinguished. For example, the Church is known as an institution in a sense that it is an organised human community (Benson, 2007:23). The Church is also a mystical communion in that it is a communion of believers who come together for fellowship (Benson, 2007:33; Van Gelder, 2000:111; Guembe, 1994:92). Another definition of the Church holds that it is a sacrament, meaning that it is a sign, an instrument of God for salvation through its missionary activity and enculturation (Benson, 2007:50-51, Guembe, 1994:86). In this way, the Church plays the role of a herald, messenger, and bearer of God's Word to the people as it becomes His servant by being of service to the world (Benson, 2007:56, 62). The Church is often referred to as the 'body of Christ' in that it is made up of people that come together as one body with the same purpose and goal (Benson, 2007:82; Van Gelder, 2000:110).

From the many types of churches, Browden (2005:111) and Guembe (1994:81) distinguish two fundamental understandings of 'Church', namely the *universal Church* and the *local church*. In the former, the Church is seen as an assembly of authentic believers (only visible through the eyes of faith). This is a great company of the redeemed that no one can number, the Church known only to God, the one great universal Church spanning all time and space, and of which all Christians are members. This type of Church came to be known as 'the invisible Church'. The latter, *the local church*, is the external Church, an assembly of people

who meet in the liturgy and for the reception of the sacraments, a locally gathered congregation of those who profess the faith of the gospel and live obediently for Christ. This type of Church is also known as 'the visible Church', members of which are those recorded in the congregation's register. This kind of Church also distinguishes different denominations.

This research study uses the word *'Church'* throughout. Due to the fact that the research study did not follow an empirical design, it could not focus on a specific denomination or congregation in Khayelitsha, and therefore, the word *'Church'* in this study has a universal meaning. This means that the study refers to the general body of Christ in Khayelitsha. However, even though this research study draws attention to the Church in general, it does not ignore the existence of various congregations in Khayelitsha. For this reason, the implications of this research study will also be very relevant for individual congregations.

1.8 A Brief Review of Khayelitsha Concerning the Fight against HIV and AIDS

According to history, Khayelitsha (meaning 'New Home') was built during the 1980s to house the city's 'legal' black population, and sprawls across a flat plain covering 15km², far from the effortless beauty for which Cape Town is famous (Médecins Sans Frontières [MSF], 2008: 1).

Located in the Western Cape on the outskirts of the Cape Town in South Africa, Khayelitsha is a large township with around 500,000 inhabitants and with one of the highest HIV prevalence rates in South Africa. The conditions of life in the township are very difficult as the majority of the population lives in informal housing, and there are alarming rates of poverty, unemployment and crime, including sexual violence. Thus, Khayelitsha carries one of the highest burdens of both HIV and tuberculosis (TB) in the country (MSF, 2008:1). The economic hardships faced by the inhabitants of Khayelitsha make them so impoverished that many households rely on casual jobs, subsistence gardening or trading, old age pensions or mutual borrowing and assistance for survival. The scourge of HIV has stretched these survival strategies to breaking point in many cases (MSF, 2008:2).

Looking at such a situation, it would be fair to say that there is a great need to get involved in the fight against HIV and AIDS which is so relevant in Khayelitsha. "HIV and AIDS is an emergency that demands a sustained and expanded response to ensure more people have access to long-term treatment. Without it, millions of people worldwide will die

unnecessarily. This is no time to quit when the battle is not even halfway from won" (MSF, 2010:1).

The aim of this research study is to design a pastoral approach useful for Church leaders in addressing HIV and AIDS stigma. Since Khayelitsha is the focus of the study, it will be useful to look at what has so far been done in terms of responding to the challenge of HIV and AIDS in this township. The following outline showing the response to HIV and AIDS in Khayelitsha reflects the content of the 2007-2008 and 2008-2009 MSF Khayelitsha Annual Activity Reports:

In January 1999, a pilot programme to prevent mother-to-child transmission (PMTCT) in Khayelitsha at the Site B Day Hospital, which was the first government-run PMTCT programme in South Africa, was launched by the Western Cape Department of Health. This programme was supported by MSF.

In early 2000, MSF and the Provincial Administration of the Western Cape (now the Provincial Government of the Western Cape or PGWC) started an HIV and AIDS care and treatment programme at the primary health care level via three community health centres.

In May 2001, the first patient was started on anti-retroviral treatment (ART), after a long struggle to obtain access to affordable, quality, generic antiretrovirals (ARVs). Initially the aim of this pilot programme was to demonstrate the feasibility of ART at the primary health care level in a resource-limited, peri-urban setting.

As of 2004, objectives changed with regard to scaling-up, and the Khayelitsha ART programme was fully integrated into the Provincial ART Programme. Today, the Khayelitsha programme aims to show the feasibility of achieving the targets set forth in the National Strategic Plan (NSP) for HIV and AIDS and Sexually Transmitted Infections (STIs), including achieving "universal coverage" of ART needs by 2011. This is coupled with efforts to find new tools to measure HIV incidence in order to contribute towards the NSP's target of reducing the rate of new HIV infections by 50% by 2011.

Since its inception, the Khayelitsha programme has been developed in close collaboration with both the Western Cape Department of Health and the City of Cape Town Health Services. Khayelitsha is considered to be a provincial sentinel monitoring site, and receives significant technical support from the Infectious Disease Epidemiology Unit of the School of Public Health and Family Medicine at the University of Cape Town (UCT). Many local non-

governmental organisations have played a critical role in the success of this programme, with the Treatment Action Campaign (TAC) being particularly important in promoting openness about HIV and empowering people living with HIV and AIDS (PLWHA) through treatment literacy and other strategies.

Since this pioneering programme was launched more than seven years ago, over 10,000 people have successfully been started on life-saving ART at seven sites in Khayelitsha. More than 93% of them are still alive and continue to receive care.

Two dedicated youth clinics (for people under 25 years of age) have been opened in Khayelitsha: Site C Youth Clinic was built by MSF in 2004 and Site B Youth Clinic was built by the Evangelical Church in 2006. Both these clinics are major service points for family-planning and treatment of sexually transmitted diseases in youth. They offer a major potential for prevention of HIV and increased uptake of Voluntary Counselling and Testing (VCT).

In 2006, the City of Cape Town implemented a pilot programme of routine ('opt-out') testing for youth ('accelerated counselling and testing' or ACTS). This led to an immediate increase in HIV testing rates amongst youth, and further increases were experienced in a revival of the pilot testing strategy in late 2007. Interestingly, the female to male ratio has been 60:40, slightly above the existing ratio in adults, and the HIV infection rate has been lower.

A new service dedicated to reaching men and offering VCT and treatment of sexually transmitted diseases at Site C taxi rank was opened at the end of 2007 as a pilot to test the impact of such a clinic on improved male access to HIV testing, a major challenge in Khayelitsha and elsewhere. This initiative is a partnership between PGWC, City Health, Hope Worldwide, and MSF.

In December 2004, a pilot project was established to initiate ART for pregnant women with CD4 counts below 200 cells/µl at the midwife obstetric units (MOUs) at primary care level. This strategy is particularly relevant now that the new national PMTCT guidelines have been revised to recommend ART for all HIV-positive pregnant women with CD4 counts <250 cells/µl and dual therapy for those with CD4 counts > 250 cells/µl.

Given that HIV and TB are two diseases that often affect the same patients, and given limited available health staff in Khayelitsha, integration of the two programmes became a priority in 2003. During that year, a pilot clinic was launched, namely, the Ubuntu clinic in Site B,

where TB and HIV services, including ART, were integrated. This model has since been extended to other clinics in Khayelitsha.

The treatment clubs that comprise the same group of clients whose appointments have been harmonised, and sessions are modular and can theoretically be placed outside of the clinic to further reduce congestion. As of the end of July 2008, 760 clients had been recruited into 10 clubs. An evaluation is currently underway.

At Nolungile clinic in Site C, in 2008, the ARV unit launched fast track services for stable adults with good adherence on ART for four years or more. This service, the so-called 'green clinic', and adherence clubs, with their special focus on treatment literacy at Ubuntu Clinic, are helping to adapt adherence support strategies for long-term patients while addressing quality concerns that can arise when services are overloaded.

In 2007, MSF began an adherence forum to bring together adherence counsellors working for Lifeline (Site C and Site B), namely, Wola Nani (Kuyasa and Matthew Goniwe), and Hope World Wide (Site C Youth). The monthly meetings allow for review of outcomes (including enrolment, loss to follow-up, etc.), enable counsellors to share experiences and receive training on new guidelines, and give a platform for all parties to address gaps in support services.

The special needs of children and youth are increasingly being recognised in South Africa, particularly the specific needs of children who started treatment when very young and are entering adolescence. In May 2008, ART services were launched at the Site C Youth Clinic, and adherence counsellors were trained in providing support specific to the youth. ART services at the Site B Youth Clinic started in August 2008. Some progress has been made, but much more needs to be done to provide adolescent-friendly services, including psycho-social support.

For children on ART, specific adherence support is provided to their caregivers, but more needs to be done to educate and support them directly as primary beneficiaries. In addition to other strategies, in the latter half of 2008, MSF and its partners plan on recruiting more children on ART into "Zip Zap", a circus school programme for children, in place since 2005, to address the fact that 'classical' support groups are not well-adapted for children.

TAC's long-running work in Khayelitsha emphasises rejection of discrimination, support of openness about HIV, community promotion of HIV prevention, VCT, and TB/HIV care and treatment, and empowerment of PLWHAs through treatment literacy and other strategies.

In Khayelitsha, the Church has also done well in its involvement in the fight against HIV and AIDS, according to a research study conducted on the interplay between HIV and AIDS treatment availability and HIV and AIDS prevention programming in Khayelitsha. Levy et al. (2005:505) point out that St. Michael's Anglican Church in Khayelitsha began as early as 1995 to address HIV and AIDS within the local parish. In 2001, the minister of this church founded a programme named *Fikelela*, the slogan of which is "This church is HIV and AIDS friendly." The success of this programme led to the issue of a national mandate by the Anglican Church of South Africa that all Anglican churches should emulate the Fikelela programme locally. This mandate expanded Fikelela's impact from the local to the provincial and national level, and was backed by organizational and financial support. The expanded Fikelela programme now includes support groups, home-based care, youth training, and HIV and AIDS task groups at more than 40 Anglican churches. Fikelela also runs an orphanage for HIV-positive children in Khayelitsha, to whom it supplies ARVs. In the review of what is happening in Khayelitsha as far as HIV and AIDS intervention is concerned, it has been mentioned that one of the ARV clinics was built by the Evangelical Church. Moreover, The Guardian (26/08/2010 P.18) reports that in addition to such efforts, a pastor by the name of Xola Skosana preached a sermon with the theme "Jesus had HIV" in an attempt to break the silence and stigma surrounding HIV and AIDS in the Church in Khayelitsha. Though not everyone appreciated the fact that Pastor Xola "defiled" the Lord's name by associating Him with a disease that is connected to sexual immorality, the pastor himself took an HIV test after the sermon, and many young people followed his example.

More efforts from the religious side are apparent in that the 'Without Walls Christian Family Church' has an Aids Pandemic Outreach Centre (APOC) in Khayelitsha, which employs Christian initiatives to assist PLWHA and their families through community transformation, orphan and child support and home based care, as well as support groups (Without Walls Christian Family Church, 2011:2-4).

Despite all that has been done so far, HIV and AIDS remains a huge challenge in Khayelitsha. As the MSF report (2010:1) states,

> Here in Khayelitsha it is painfully clear that the global HIV and AIDS emergency is not over. Worldwide, 33 million people live with the disease that continues to wipe out two million lives a year. 6 million people in sub-Saharan Africa are in need of antiretroviral treatment, while only 30 % have access to the life-saving drugs they need, either because they are too expensive, because they are simply not available, or because donor funded treatment is waning. Time is running out for the nine million people worldwide in need of treatment. Without care, most people with HIV will die within three years.

This situation illustrates the fact that there is still a lot to be done, and a search for more creative ways of intervention could be very helpful. As stated in the 2007-2008 Khayelitsha Annual Report, (MSF, 2008:3), the large burden of HIV in Khayelitsha will require that innovative strategies be found to improve access, reduce stigma, and increase uptake of services. In addition, an important priority for the future is for Community-based HIV 'wellness services' for HIV-positive people not eligible yet for treatment to be properly implemented in Khayelitsha. Still, as the 2008-2009 Khayelitsha Annual Report (MSF, 2010:20) points out, many challenges remain obvious in terms of scaling-up antiretroviral therapy (ART) in resource-limited settings, while at the same time promoting long-term retention in care. Because lack of clinical staff (both doctors and nurses) is one of the main core factors affecting both increased access to and long term retention on ART, different models of care need to be adapted to the needs of different patients. For this reason, patients enrolling on ART, particularly those with low CD4 counts, need intensive clinical and counselling care during treatment initiation. For long–term and stable patients, innovative models are needed for the frequency and duration of clinic visits to be streamlined, with the majority being rapidly screened at two- or three- monthly medicine 'pick up' points and clinical visits and 'safety bloods' once or twice a year.

In the light of the above facts about HIV and AIDS intervention initiatives in Khayelitsha, this research study strives to look at areas in which PLWHA in Khayelitsha are still facing HIV and AIDS related stigma, in order to work out possible ways of intervention by church leaders.

1.9 A Brief Overview of HIV and AIDS Stigma

As noted earlier, the community's attitude towards PLWHA has been that of discriminating against them. This is evident in the way people in the community feel uncomfortable to be seen in the company of PLWHA (Meiberg et al., 2008:51). Research shows that in various areas of the community such as homes, churches, workplaces and public places, the way

PLWHA are treated indicates that they are not always welcome. This can be seen in the way PLWHA are often avoided in terms of associating and sharing with others in different ways. As the statement of the ICRW (2006:5) clarifies, the physical isolation of PLWHA is widespread and ranges from isolation within the home and in community gathering places such as teashops, markets and places of worship to workplaces, schools and hospitals. In such places, people are reluctant to sit next to anyone known or suspected to be infected or living with HIV.

In addition, the ICRW (2006:5) and Avert (2011:3) talk about PLWHA being kept away from significant family or community events in which they used to take part with others before being infected with HIV. Similarly, friends and neighbours with whom they used to associate before they were known to be infected or living with HIV run away from them and lose interest in them. It is also clear that family and community roles and responsibilities which they used to assume are often taken away from them, and they are left with no sense of power, being viewed as no longer able to do anything. Such mistreatment makes PLWHA lose their respect and identity in their families and communities.

In fact, the discrimination expressed against PLWHA in any form sets them at nought, causing them to live in isolation and feel unwelcome in their communities, thus increasing the stigma that weakens their immune systems while providing an opportunity for the viral load to accelerate in their bodies.

The response towards the advent of HIV and AIDS on the national and international level deserves consideration. In the community, the advent of HIV and AIDS, just like any other new and unusual event or disease, has created different feelings and responses among people. An example of this was the curiosity about the origin of HIV which even drew the attention of scientific efforts (Panos, 1988: 71-72). In this regard, the presence of HIV and AIDS brought two aspects of community response, **denial** and **blame**.

With regard to denial, people have a tendency to deny the presence of HIV and AIDS in their communities. This was seen even at national level. For instance, several African and Asian governments for a long time refused to admit that HIV and AIDS was an issue in their countries. They declined to talk about HIV and AIDS abroad, and refused to allow publicity about it, prohibiting researchers and physicians from talking to the press (Gordenker et al, 1995:28-29). As a substitute to tackling a problem, it is natural for human beings to blame others for misfortunes beyond their control, and this applies particularly to AIDS; at times in

the past, certain groups of people who seemed to be leading lives different from the norms of the society were often blamed (Panos, 1988:67-68). In addition, as could be noticed in South Africa, "due to the fact that the epidemic in South Africa is younger than in several African countries to the north of the country such as Uganda, Zambia and Zimbabwe, there has been a tendency to blame 'outsiders' for the arrival of HIV infection in South Africa, even though South Africa has more reported cases of HIV and AIDS cases than in the countries being blamed combined" (Simbayi, 2010:12).

In his book *The Political Management of HIV and AIDS in South Africa*, Fourie (2006:58-59) reports how at the time when the first cases of HIV were discovered in South Africa under the apartheid government, homosexuals, black people, commercial sex workers and intravenous drug users were blamed for introducing the virus into society. Those groups were viewed as 'deviant' by the politicians who thought that they put the rest of the society in danger, and even the government supported the idea that the coming of HIV and AIDS in South Africa was a God-given solution to these outcasts' deviant behaviour, as a just punishment that would remove them from South African society.

Relating HIV and AIDS to certain groups often has to do with the nature and transmission of HIV and AIDS as well as its dangerous effects. Regarding HIV and AIDS as a result of immorality has often created two groups of people in a society, the safe and the vulnerable; since HIV is widely transmitted through sexual intercourse and associated with certain groups, those who do not belong to such groups, or who identify themselves as sexually moral, tend to label members of endangered groups in such a way that HIV becomes more associated with 'gay men,' 'drug users,' or 'prostitutes', with the assumption that if you do not belong to any of those groups, then you are on the safe side (Gordenker, 1995:30). Furthermore, it has also been common in South Africa for people to blame each other on racial grounds for bringing and spreading the disease in the country. This finger-pointing creates a false sense of security through denial of one's own racial group's exposure and vulnerability to HIV (Simbayi, 2010:5).

In South Africa, despite the establishment of the National AIDS Plan (NAP) in 1994 under President Nelson Mandela (Fourie, 2006:107), former President Thabo Mbeki is well known for advocating 'HIV and AIDS denialism' which was characterised by an assumption that the HIV virus cannot cause AIDS. This denialism resulted in people not taking the precautions needed to deal with the virus, such as ART, and consequently caused a large number of

deaths (Tangelder, 2003:2-3). About President Mbeki's denialism, Avert (2010:5) says, "The arguments and polices against providing AZT and Nevirapine, personified by Mbeki and Manto, soon evolved into a much wider questioning of all antiretroviral drugs, including those used as treatment. This was part of a wider branch of thinking, referred to as denialism, which argued that HIV did not cause AIDS and instead resulted from socio-economic factors or 'lifestyle' choices." Moreover, part of Mbeki's 'denialism' was that he was sceptical about the epidemic in South Africa. By stating that poverty should be considered to be the main contributing factor to AIDS, he denied any possibility of HIV being the cause of AIDS. He based his assumption on the theory that since HIV is a virus, it cannot cause AIDS which is a syndrome (Fourie, 2006:154).

Furthermore, countries that denied the presence of HIV and AIDS among their people thought that the disease originated from other parts of the world, with Africa and Haiti being mostly blamed for the origin of HIV and AIDS. As part of efforts to avoid the spread of HIV and AIDS, foreign travellers have often been refused entry into other countries on the grounds of their being suspected of being, or reported to be, HIV positive. Strict government policies that included serious and compulsory screening and searching, as well as demanding proof of HIV status were imposed on people seeking permission to enter into a country, especially those coming from countries suspected to be highly affected by HIV and AIDS. These policies also allowed for the turning down of any application from a person found to be HIV positive for fear that such a person would endanger the citizens of the country he/she was entering. Moreover, quarantine, which was practiced even long before it was known how contagious the HIV virus is, became a tool for responding to the modes of HIV transmission, as did the development of diagnostic tests in order to identify infected individuals and so establish exclusionary policies serving as boundaries between the 'sick' and the 'healthy' (Panos, 1988:69; Gordenker et al 1995:34,113). As Simbayi (2010:11) further observes, many countries have sought to shift the blame for HIV and AIDS onto foreigners. He gives the examples of the USA, Cuba and India as countries that have been known to set up policies dictating that people from other countries were to be tested because they were considered as being at high risk for HIV infection, even if they came from countries with a lower rate of HIV cases than they themselves had. Eventually, however, the USA reportedly lifted the travel ban on PLWHA from other countries.

The attitudes that were reported to be stigmatizing PLWHA have been found in both the health and public labour sectors. As far as the health sector is concerned, it has been widely

reported in hospitals around the world that medical practitioners have denied treatment to PLWHA for various reasons. The most common reason why health workers have been so hesitant to treat PLWHA has been the fear of infection, a fear which has been scientifically proven to be unfounded since a very limited number of cases of infection have occurred through medical practitioners' contact with PLWHA (Orr & Patient, 2004: 11; Gordenker et al, 1995:114).

As for the situation in the labour sector, most companies have been screening employment candidates prior to their being employed. It has also often been mentioned that employees have been persecuted if they are known to be HIV positive. In the Panos document (1988:112), examples are given of a number of companies in Spain, France, and the UK which decided to screen potential employees before offering them work.

Restrictions launched against PLWHA in the community can be seen as tampering with the human rights and dignity of PLWHA in order to promote those of uninfected individuals, therefore favouring the welfare of the uninfected over that of those who are infected. In addition, such discriminatory isolation of PLWHA does not accord with the medical research study findings demonstrating that transmission routes of HIV do not include normal social control and isolation of HIV-positive people (Panos, 1988: iv). Furthermore, measures taken to quarantine or refuse entry to PLWHA have proven to be merely offensive, and do not help to stop the spread of HIV and AIDS, since the disease has already spread all over the world in ways that were beyond the control of immigration officials and policies. In fact, it was realised that the spread of HIV wasnot due to foreign immigrants; therefore, refusing entry for PLWHA would be an attempt to create boundaries for the HIV virus which, in reality, has none. This is supported by the WHO, which made a similar observation about the failure of such immigration measures (Gordenker et al, 1995:117).

However, the stigma attached to HIV and AIDS has changed since the disease was discovered. This is evident in the fact that, as time went by, the more people became aware of the reality of HIV and AIDS, the more they changed their attitude towards PLWHA. In fact, with the spread of HIV and AIDS in the community, more people were infected and/or affected by the disease and therefore saw the need to react to it. For instance, in 1987, President Kenneth Kaunda of Zambia announced that his son had died of AIDS, and Kaunda thereafter played a key role in persuading policy-makers in other African countries to abandon their earlier reluctance to acknowledge the AIDS problem, even though it took some

years before governments could implement HIV and AIDS policies. In South Africa, the fact that notable politicians like Nelson Mandela, the former President and Mangosuthu Buthelezi his Minister of Home Affairs took the challenge to disclose that HIV/AIDS was the cause of the death of their children was another example of disclosure (Ntsimane, 2006:11).

It is also clear that the stigma attached to HIV and AIDS began to be addressed as people came to understand the facts about HIV and AIDS, and started getting involved step by step. The more knowledge about HIV and AIDS increased, the more the response to the pandemic changed, to the point where there is now something being done to accommodate PLWHA, even in policy making. For example, the national policy in the South African constitution, which was put in place in 1996, took the rights of PLWHA into account in such way that non-discrimination in public health in South Africa is ensured (Van Dyk, 2008:429). Van Dyk (2008:430) further refers to areas in which PLWHA are to be considered equal to others:

- Liberty, autonomy, security of persons, and freedom of movement;
- Confidentiality and privacy of information about the health and HIV status of PLWHA;
- Avoiding HIV testing without the individual's consent;
- Promoting HIV and AIDS education and/or
- Employment without HIV testing as a requirement;
- Insurance for PLWHA;
- Fair treatment by the media; and
- The right to safer sex.

The content of the national policy ensures acceptance of PLWHA and is instrumental in the reduction of stigma, thus setting an example which anyone involved in efforts to care for PLWHA might learn from.

1.10 Definition of Key Terms

The key terms used in this research study are defined in the following way:

- *HIV*: an acronym for Human Immuno-Deficiency Virus (Van Dyk, 2008:4).
- *AIDS*: an acronym for Acquired Immune Deficiency Syndrome (Van Dyk, 2008:4). Van Dyk gives the further explanation that AIDS is said to be acquired because it is not an inherited disease but comes from a virus outside the body. Immunity is the

body's natural ability to fight against any kind of disease and infection, while a deficiency is a failure of the body's immune system to defend against diseases and infections entering it. As for syndrome, it is a group of signs and symptoms that characterise the condition of a patient who has become infected.

- *Stigma*: the shame or disgrace that is caused by a certain characteristic which makes someone different from others in a negative way. According to Ullah (2011:97), stigma is generally defined as prejudice, discounting, discrediting, and discriminating, and is a reality of everyday life for PLWHA, their families, and those directly associated with this pandemic disease. In the sense of this research study, stigma is therefore used in the context of HIV and AIDS.
- *A PastoralApproach*: according to the Concise Oxford English Dictionary, an approach is "a way of doing or thinking aboutsomething such as a problem or a task" (Wehmeier, 2005:61). Following that definition, a pastoral approach is a suggested way of applying pastoral principles in dealing with a problem that is affecting people in the church or community.
- *Church Leaders*: a leader is a person in charge of leading or commanding a group, organisation, or country (Soanes & Stevenson, 2008:809). In the case of this study, church leaders are those in charge of leading churches in Khayelitsha.
- *Khayelitsha*: a large township on the outskirt of Cape Town in the Western Cape Province of South Africa (MSF, 2008:1).

1.11 Conclusion

The first chapter, by way of introduction, described the layout of this research study, the conceptualization of the term 'stigma' and how it relates to HIV and AIDS, and gave a brief overview of Khayelitsha, which is the focus of the study. In the research study background it has been established that HIV and AIDS stigma is the most serious problem faced by PLWHA. The research study further poses the question of how church leaders can use a pastoral approach to take action in leading their churches in the fight against HIV and AIDS stigma in Khayelitsha. The chapter also refers to the word 'stigma' as a term historically used to designate a brand or mark put on foreign people such as slaves to distinguish them from other citizens; this relates to HIV and AIDS in that PLWHA are seen as different from others because they carry a deadly and wasting disease. The terminology of 'Church' as used by this research has been discussed as well. Other things mentioned in this chapter are the link between this research study and Practical Theology, as well as the research study

methodology which has been identified as being a literature review. The first chapter also gave a brief overview of what has been happening in Khayelitsha in the area of HIV and AIDS intervention, emphasising that although a lot has already been done in Khayelitsha, the persistence of HIV and AIDS related stigma means that a lot still has to be done in efforts to eradicate it, and church leaders are therefore expected to act. Finally a brief overview of what has been happening in the area of HIV and AIDS stigma since the discovery of HIV and AIDS and the definition of key terms have also been dealt with in this introductory chapter.

In the second chapter, this research study will look at the causes and consequences of HIV and AIDS stigma. The causes of HIV and AIDS stigma discussed in Chapter 2 are the fact that people are afraid to associate with PLWHA because HIV and AIDS is a dangerous, infectious and incurable disease, and that information about HIV and AIDS transmission is often distorted. Other factors causing HIV and AIDS stigma are the silence regarding HIV and AIDS, the link between HIV, sex, and sexual morality, poverty, and gossip and insults, as well as gender imbalance. The chapter will further point out some causes and effects of HIV and AIDS stigma. Normally, stigma results in the fear of HIV and AIDS status disclosure, thus hampering any initiative to implement care and prevention programmes. Furthermore, stigma is one of the main factors responsible for the acceleration of death for PLWHA. These causes and effects of HIV and AIDS stigma are very important to consider before engaging in any battle against HIV and AIDS-related stigma.

In the third chapter the biblical and theological reflection of stigma will be discussed. In this chapter, stigma in relation to diseases will be explored. A disease that is especially identified as being comparable to modern HIV and AIDS is leprosy. In this regard, the Old Testament (OT) paradigm of rejection and the New Testament (NT) paradigm of acceptance will be discussed in relation to HIV and AIDS in order to find a way of encouraging the Church to address HIV and AIDS stigma.

In the fourth chapter, the healing mission of the Church in times of HIV and AIDS stigma will be discussed. Drawing from Jesus Christ's way of holistic healing, the chapter will discuss the involvement of the Church in the healing of the whole person through acceptance of PLWHA in their midst as people valued by God, and the use of church activities as a means for that healing.

In chapter five, a suggested pastoral approach for church leaders in dealing with HIV and AIDS stigma in Khayelitsha will be presented. In order to engage in the fight against HIV

and AIDS stigma, church leaders in Khayelitsha are advised to confess their failure to be in the forefront in the fight. They are then requested to stand up and take action by changing their paradigms in order to fulfil their God-given task to care for His people who are suffering. Finally, Chapter six will serve as a conclusion to this research study.

CHAPTER TWO

THE CAUSES AND EFFECTS OF HIV AND AIDS STIGMA

2.0 Introduction

In the first chapter of this research study, it has been established that stigma is recognised as the leading barrier to the fight against the scourge of HIV and AIDS. In that chapter a definition of stigma and its terminology was discussed, as well as a specific explanation of the word 'stigma' when linked to HIV and AIDS. Since this research study takes Khayelitsha as its area of focus, it was useful to look at the situation in that township as far as HIV and AIDS is concerned. Now, since one of the goals of this research study is to understand the causes and effects of HIV and AIDS stigma in order to suggest a pastoral approach for church leaders to deal with it in Khayelitsha, it is important to investigate factors that cause HIV and AIDS stigma as well as the effects it brings. This second chapter therefore fits into the bigger picture of the research study in that it follows the second step of the Practical Theology research methodology adopted for this study. In this step, the world is interpreted as it is through interpreting the what, the how and the why of the problem by looking at the causes and effects of HIV and AIDS stigma. In other words, it is essential for this research study to look into the causes and consequences of HIV and AIDS stigma in order to gain an understanding of what is happening in the Church and community in Khayelitsha, and this is useful in the attempt to elaborate anapproach for church leaders to follow in order to deal with HIV and AIDS stigma in their respective churches and communities.

2.1 The Causes of HIV and AIDS Stigma

HIV and AIDS stigma is caused by a number of factors, as indicated by various research studies. For example, in the study conducted in two South African communities in Kwazulu-Natal, Campbell et al. (2007:408-412) determined that the causes of HIV and AIDS stigma include: fear of HIV and AIDS; lack of HIV and AIDS-related information; lack of social spaces to engage in dialogue about HIV and AIDS. The study further reveals that the link between HIV and AIDS, sexual morality and the control of women and young people, the lack of adequate HIV and AIDS management services, and the way in which poverty shapes

people's reactions to HIV and AIDS contribute to HIV and AIDS stigma. These findings have come alongside those of other research, such as the Avert report (2011:2) on HIV and AIDS stigma which stipulates that the contributing factors to HIV and AIDS stigma are as follows:

- HIV and AIDS is a life-threatening disease, and therefore people react to it in strong ways.
- HIV infection is associated with behaviours (such as homosexuality, drug addiction, prostitution or promiscuity) that are already stigmatised in many societies.
- Most people become infected with HIV through sex, which often carries moral baggage.
- There is a lot of inaccurate information about how HIV is transmitted, creating irrational behaviour and misperceptions of personal risk.
- HIV infection is often thought to be the result of personal irresponsibility.
- Religious or moral beliefs lead some people to believe that being infected with HIV is the result of moral fault (such as promiscuity or 'deviant sex') that deserves to be punished.

However, due to the size of this research study, its aim is not to point out every single cause of HIV and AIDS stigma, but to focus on some causes which were found in the literature to be relevant to Khayelitsha, which is the area of focus for this research study. For this reason, in its endeavour to understand the causes of HIV and AIDS stigma, this section spotlights fear of HIV and AIDS, lack of HIV and AIDS-related information, silence about HIV and AIDS, the link between HIV, sex, and sexual morality, poverty, gossip and insults, and gender imbalance. These causes of HIV and AIDS stigma were selected for this research study because they are reported in the literature as the main causes of HIV and AIDS stigma in South Africa in general (Avert, 2011:2; Simbayi, 2010:7); and in Khayelitsha in particular (Maughan-Brown, 2007:6; Mlobeli, 2007:2).

2.1.1 Fear of HIV and AIDS

As has been discussed, the fear of the HIV and AIDS pandemic constitutes one of the factors that fuel stigma. Apparently, the fear of HIV and AIDS as a cause of HIV and AIDS-related stigma is found within the context of HIV and AIDS presenting itself as a dangerous and transmissible disease with no cure. According to the USAID (2005:15), several studies have identified the fear of contracting the HIV virus through casual transmission as a key factor contributing to the stigmatizing attitude of people who avoid associating with PLWHA.

Therefore, due to this fear of transmission, people avoid associating with PLWHA, regardless of the ways in which it is transmitted. To emphasize this fact, the ICRW (2006:3) states that based on the assumption that HIV is often thought to be highly contagious, people habitually suspect that individuals with HIV or AIDS pose a significant threat to the community as a whole.

Consequently, fear concerning the danger of HIV and AIDS leads people who are not living with HIV and AIDS to be very careful not to come close to PLWHA, because all they see in them, whether they are aware of the means of transmission or not, is sickness, infection, and death. According to Brown et al. (2001:4-5), the sources of stigma include fear of illness, fear of contagion and fear of death. Such fears evoke a common reaction among health workers, co-workers, and caregivers, as well as the general population, in that they resort to stigma as one means of coping with the fear that any contact with a member of an affected group (e.g. by caring for or sharing utensils with a PLWHA) will undoubtedly result in contracting the virus. This fear of HIV and AIDS is further exacerbated due to an understanding that there is no cure for HIV and AIDS (Avert, 2011:2; Maughan-Brown, 2007:4).

In addition, the fear of HIV and AIDS as a dangerous, highly contagious disease has led to instances where PLWHA are not even allowed to share the same seats with others in a church for fear of transmission. As Yesudian (2006:14) observes, "There have been instances when PLWHIV and AIDS are left alone on the pew, while others squeeze themselves on a single pew that does not have much space for them. Others don't allow their children to play with other children whose parents are considered to be HIV+". In this regard, Yesudian shows that the fear of HIV and AIDS is so prevalent that it can be manifested anywhere, even in the Church, where people may expect to find love and care. The incurability of HIV and AIDS divides people to the point of thinking that mere contact, such as sharing a seat with PLWHA, can result in infection with a disease that lasts a lifetime. In this way, the fear of the virus and the concern about transmission through daily casual contact leads directly to stigma expressed in the form of isolation of PLWHA in all aspects of daily life, either in the home, at social gathering places, at health facilities or even sometimes in places of worship (Ogden & Nyblade, 2005:15).

This research study focuses on Khayelitsha which is predominantly of *amaXhosa* culture as mentioned earlier. The *amaXhosa* concept of sickness and death is worth mentioning in this regard. In her research study on the *amaXhosa* concept of illness and death, Mlobeli

(2007:16) makes the point that HIV and AIDS is identified as a *'killer'*. As she states, AIDS is identified as a deadly disease and in the *IsiXhosa* language, its name is "*Gawulayo*", which means *'killer'*. In the same way, HIV and AIDS is feared in the *amaXhosa* culture as a dangerous disease that is capable of destroying the whole nation. As Mabeqa (2005:42) also observes, when the noun *'Ugawulayo',* which literally means 'that which chops down', is used to refer to AIDS, it is understood in a more reprimanding way by those who understand the *amaXhosa* culture, and the *amaXhosa* have opted to use this term for AIDS because it is an incurable disease which eventually leads to the death of many people. In addition, Dowling (2001:3) reveals that the HIV and AIDS pandemic is referred to in *IsiXhosa* as *'Umbulalasizwe'*which means, 'The *Killer/finisher of the Nation'*. The words such as *'bulala'* (*kill), shaya* (*beat)* and '*qeda*' (*finish)* portray composite pictures of a dominant personality. In this way, HIV and AIDS becomes a famous South African 'personality', feared and hated, but to some extent wondered at for its power and ability to wreak havoc on a nation. Furthermore, the fact that HIV and AIDS is perceived as a plague comes from the word *'ubhubhane'* that is taken from the root verb *'bhubha'* which means *'die'* and which is given in both *IsiXhosa* and *IsiZulu* dictionaries to mean that HIV and AIDS is primarily named in relation to death. In addition, the fact that HIV and AIDS is a disease with no cure is also translated in the *IsiXhosa* language as *a disease which kills and which cannot be cured (isifo esibulalayo nesinganyangekiyo).*

Having that concept in mind, it would be fair to hypothesise that in Khayelitsha, the majority of people may hold the view that whenever they see PLWHA; all they see in them is death. With this fear in mind, there is a need to talk about the issue of lack of information about HIV and AIDS which could be a cause of that fear.

2.1.2 Lack of HIV and AIDS-related Information

While the fear of HIV transmission has been identified as a source of HIV and AIDS stigma, lack of information about HIV and AIDS-related issues is another factor that contributes to HIV and AIDS stigma. This lack of information about HIV and AIDS in the communities can be explained by the fact that people may have little or no information, or even have information distorted by false beliefs about HIV transmission, thereby associating such transmission with condoms, witchcraft and race. For example, in the two South African groups on which Campbell et al. (2007) conducted a research study, most people had a certain degree of information about HIV and AIDS, but it was marred by failure to translate

such information into action due to false beliefs about HIV and AIDS, and lack of power on the part of women to negotiate safer sex with their husbands.

Lack of information about HIV and AIDS can also be noticed in places where poor infrastructure hinders communication efforts. As Ashforth (2001:3) purports, public education programmes become costly and difficult among illiterate and semi-literate populations due to the lack of extensive communications infrastructures in the rural areas where HIV prevalence is highest. This would imply that while members of the population have access to the information needed to promote awareness of HIV and AIDS, others find access to information a challenge. However, as time has passed, circumstances described in Ashforth's findings appear to have changed; Campbell et al. (2007:408) claim that in their research study, while it was clear that some people lacked information, most of them had basic factual information about HIV and AIDS, even in the remotest rural areas where poor roads and unaffordable transport limited people's contact with the outside world, and where people had limited access to television or radio, with little HIV and AIDS awareness work being done. Similarly, empirical research study conducted by Thiede et al. (2004:7) in Cape Town townships revealed that the role widely played by clinic health workers in conveying information about HIV prevention services available at the clinic, the apparent role of information transmitted via radio and television, as well as on posters at clinics, and in brochures and leaflets used in campaigns, have all been useful in educating people about HIV and AIDS-related issues. In South Africa, national and sub-national HIV and AIDS communication programmes are conducted by government and non-governmental organisations (NGOs) in schools and universities, as well as workplaces. Also, HIV and AIDS awareness campaigns are run through the use of media, and different stakeholders such as the Department of Health's Khomanani Campaign, Soul City, Soul Buddyz and Love Life are involved, making a significant impact in ensuring wide national exposure of AIDS-related knowledge (Human Science Research Council [HCRS], 2009:6).

It is thus clear that lack of information is not to be regarded as a cause of HIV and AIDS stigma per se, because whether people have information or not, stigma is still prevalent. As Ullah (2011:100) confirms, studies prove that even though most people in families, hospitals and communities are aware that HIV is not transmitted through casual contact, they are still hesitant to share utensils or sit near PLWHA or health care providers working with PLWHA, for fear of being infected by chance. Similarly, a study done by Maughan-Brown (2007:6) in the area of Cape Town suggests that irrational fear of HIV infection could be based not only

on a lack of knowledge concerning HIV transmission, but also on lack of trust in this knowledge, thereby constituting a significant aspect of the stigmatising environment. This is mostly due to the fact that people may know about the proven modes of HIV transmission but are still doubtful because of fear of contracting the virus through unlikely ways of transmission. This is because correct knowledge about proven routes of infection coexists with misconceptions, resulting in a lack of confidence about how HIV is or is not transmitted (Ogden & Nyblade, 2005:17).

Moreover, even though the information about HIV and AIDS is widely accessed, it is evident that some people have mistaken perceptions regarding condoms, which they regard as carriers of the virus instead of considering them to be tools of protection against it. To support this point, Campbell et al. (2007:408) state, "However it was clear that many experienced this information as quite alien. Despite having grasped basic factual information about HIV and AIDS, people battled to 'translate' this information in ways that made sense to them. Thus, for example, one young man expressed great fear and uncertainty about the claim that condoms would protect his sexual health, in the context of his belief (commonly held in his community) that the lubricant in condoms (which looks like tiny 'worms' when a condom is filled with water) was in fact the HIV virus, implanted in condoms by malicious supporters of the old *apartheid* regime seeking to kill black South Africans." In fact, the notion of a link between HIV and apartheid is popular in South Africa. Another example, mentioned by Ashforth (2001:4-5), is that in Soweto in the 1990s, people used to joke that AIDS stood for 'American Invention to Discourage Sex.' Doubting that the 'apartheid regime' would ever act in the true interests of black people, they insisted that free condoms were really intended to reduce the black birth rate in order to secure white domination. However, apart from the view that condoms were promoted for the wrong motives, another study done by Campbell et al. (2009:11-12) in another South African community revealed that although young people had adequate information about HIV and AIDS, when it came to condom use, most of them were curious about having sex without using a condom, and also believed that using a condom reduced the pleasure of sex and meant that one did not trust one's sexual partner.

In addition to misconceptions accompanying information about HIV and AIDS, people who believe in African cosmology associate HIV and AIDS with witchcraft, holding that HIV and AIDS is a result of being bewitched by those who are not happy with one's success (Campbell et al, 2007: 408). To emphasize this point, it is worth mentioning that in Africa, every kind of evil, be it sickness, disability or anything hindering health or progress, may be

viewed as being caused by agents such as a witch or a sorcerer (Van Dyk, 2008:202). This is in line with the African belief that whenever something goes wrong, it is caused by a spiritual source, and that therefore, whenever evil or sickness comes, there must be someone to blame. Cases of premature death or untimely illness in Africa are almost always attributed to the action of invisible forces, taking witchcraft, especially, as an underlying cause (Ashforth, 2001:5). While such a perception is held about illness in general, when it comes to HIV and AIDS, due to its incurability and the way it brings about death after a person has wasted away, that perception becomes worse in many African countries, especially among the rural poor or people with the least education (Van Dyk, 2008:202). Thus, it is believed that a person cannot be infected with HIV unless a witch or a sorcerer has sent it. As Wreford (2009:13) hypothesises, the African belief about the connection between HIV and AIDS causation and witchcraft is explained by the fact that witchcraft helps to 'make sense' of the arrival of an unexplained illness with mysterious similarities, in symptoms and aetiology, to the recognised phenomenon of witchcraft, and this ascription of blame to witchcraft serves as a disguise or safeguard against the greater shame of accepting a diagnosis of having a highly dangerous and stigmatized disease. Moreover, as Wreford (2009:13) further argues, according to his research study on religious interpretations and witchcraft in the negotiation of health strategies for HIV and AIDS in South Africa, knowledge about the medical implications of HIV and AIDS does not mean that people refrain from seeing witchcraft as the cause of it; even among professional health workers reacting in denial of HIV positive status, it can be found that they insist on witchcraft causation, especially when they personally face an HIV positive diagnosis. Wreford gives the example of a health worker who, despite her biomedical education and training, decided to go to the Eastern Cape to consult a traditional healer after she tested HIV positive, and upon her return to Paarl, told her colleague that the traditional healer had diagnosed that "Someone has poured this on me. Now, I am better"!

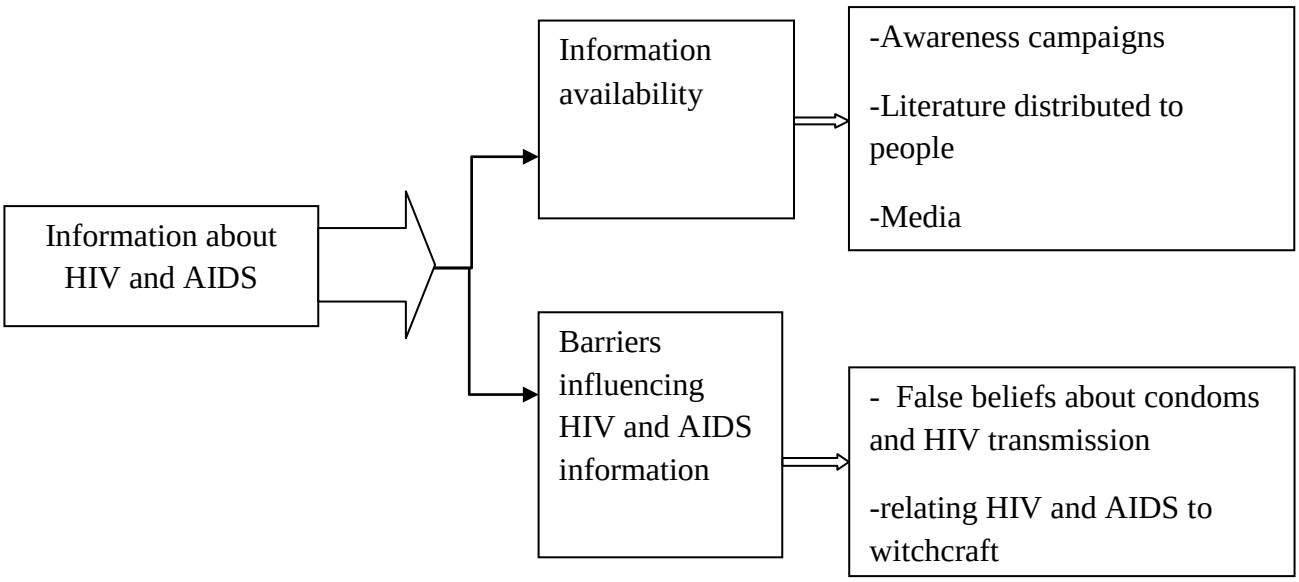
The connection between HIV and witchcraft is also noticed in other parts of Africa. For example, a research study done on witchcraft and HIV and AIDS in the Caprivi region of Namibia revealed that in the case of HIV and AIDS, some witchcraft narratives offer a plausible explanation when a person who owns assets that would spark jealousy dies of HIV and AIDS, while those who do not have anything worth being bewitched for are thought to have brought the illness upon themselves (Thomas, 2010:285). The research study further indicates that the conclusion about witchcraft being the cause of HIV and AIDS is also due to

the fact that information about the cause of death in hospital is often withheld by medical practitioners in the case of HIV and AIDS, and this leads people to conclude, out of confusion, that it is nothing other than witchcraft (Thomas, 2010:284).

Furthermore, the issue of regarding HIV and AIDS to be a result of witchcraft is common in the *amaXhosa* culture. In a research study done on the *Intercultural Communication in Three Eastern Cape HIV and AIDS Clinics*, Mandla (2009:90) concluded that "Culture influences how people receive health education, messages, perceptions about HIV risks, accessibility of risk reduction strategies, negotiation for safer sex practices and health seeking behaviours. Each culture provides its members with ways of becoming ill, of shaping their suffering into a recognizable illness entity, of explaining its cause, and of getting some treatment for it". Mandla mentions that the *amaXhosa* culture is based on strong beliefs in natural forces and white and black magic, and that the *amaXhosa* community is governed according to a flexible hierarchical system. This set of beliefs results in the fact that in the case of sickness, *amaXhosa* people rely on traditional healers to provide answers through traditional medicines. For this reason, even HIV and AIDS is, according to the findings of that research study, at times described as witchcraft or breaking of religious taboos, just as ill-health and other misfortunes are blamed on social or supernatural causes. To illustrate this point, Mandla (2009:91-92) refers to a case in one of the HIV and AIDS clinics in which she conducted her research study where a patient who was on ARVs came to see the doctor for a check-up. When the doctor wanted to find out whether she had been taking her ARVs regularly, the patient answered that she had stopped them because she had discovered through her traditional healer that she was not actually HIV positive, but that her problem was that people, including her aunt, were not happy with her promotion in her new job and were trying to get rid of her. The patient claimed that since she had received powerful *umuthi* (traditional medicine) from her traditional healer which was protecting her from the evil spirit; it had helped her enough so that she did not need ARVs any longer. Even when the doctor tried to convince her about the medical implications of defaulting on her ART, she would not agree with him since she was already adamant that her traditional healer would take care of anything that might come up. From this encounter it is clear, as observed above, that "The idea that HIV is caused by organisms that are invisible to the naked eye is something which is not necessarily understood and accepted in *amaXhosa* culture. Even the so-called educated people, as much as they know the causes and effects of this pandemic, they associate this killer disease with witchcraft, evil spirits, curses, and the wrath of the ancestors" (Mandla,

2009:95). As one can then deduce, the belief about HIV and AIDS being the result of witchcraft which needs the unconditional intervention of a traditional healer is dominant in Khayelitsha which is predominantly of *amaXhosa* culture.

As can be noticed, lack of information results in the public lacking full awareness of what HIV and AIDS entails. People thus remain ignorant about the disease, thereby increasing the stigma connected to it. This, then, calls for a platform through which information can be distributed to ensure that ignorance about HIV and AIDS is dealt with. The call for information and education in the area of HIV and AIDS is also vital for Khayelitsha, despite the work already done there. In fact, there is a lot happening in Khayelitsha already with regard to the distribution of information about HIV and AIDS. As mentioned earlier, people in Khayelitsha get a great deal of information through awareness campaigns and the media, as well as from printed material produced and distributed by the Treatment Action Campaign (TAC) and the City of Cape Town at clinics and various points in the community in efforts to greatly emphasise the facts about the spread, prevention, and treatment of TB and HIV in Khayelitsha. Moreover, education sessions both in the clinics and in the community door-to-door campaigns cover topics such as drug-resistant TB, infection control, use of masks, TB treatment adherence and the complexities of TB/HIV co-infection, such as difficulty in diagnosing smear-negative TB in HIV-positive clients (MSF, 2008: 18). However, the way this information is received and perceived is not always as it should be, due to the presence of people with various beliefs from the remote areas of Eastern Cape moving to Khayelitsha. For example, there may still be people with distorted information, holding a belief in myths about condoms and witchcraft as causing HIV transmission. That is why continual information, awareness, and education are required. In the churches, there has not been much found in literature about the distribution of information related to HIV and AIDS in Khayelitsha apart from the efforts of the Philisanani project in training church leaders, as mentioned in Chapter One. However, it is very important for church leaders in Khayelitsha to get involved in information dissemination in order to ensure that people within their reach are well informed on issues related to HIV and AIDS. Information about HIV and AIDS can be represented as shown in the following diagram.



(Diagram 2.1: Information about HIV and AIDS).

2.1.3 Silence about HIV and AIDS

The third cause to be discussed concerning the causes of HIV and AIDS stigma is the silence related to HIV and AIDS and sexuality. Campbell et al (2007:408-412) term such a silence 'lack of social spaces to talk about HIV and AIDS'. This definition conveys a sense of not talking openly or not allowing any dialogue about the HIV and AIDS in the community. As a result, PLWHA are hindered from expressing their feelings about the disease even if they wanted to, for fear of facing a great deal of stigma. Boesten (2007:13) explains the relationship between stigma and lack of social spaces as "stigma feed[ing] into this lack of space and the lack of discussion also feed[ing] into stigma". This statement suggests that the lack of social spaces in which HIV and AIDS and sexuality can be discussed opens the door for stigma, which also influences the silence about the disease. In addition, as has been discovered, access to information about HIV and AIDS does not guarantee the secession of stigma, and the persistent silence about HIV and AIDS does not depend on people's awareness of the disease; whether people know about the disease or not, this silence is still noticed. This is often because people are ashamed to speak about being infected with HIV, seeing it as a scandal when it happens either to their friends or in their families, thereby making it difficult or shameful for them to admit that a family member is HIV positive. It also results in people being afraid to be seen with someone living with HIV and AIDS for fear that they might be associated with them, putting their reputation at stake (Merafong City, 2011:6; Campbell et al., 2009:16; Notshe, 2007:54**).** This kind of silence exposes PLWHA to

daily prejudice which poses a significant barrier to tackling the epidemic unless leadership is provided to break the silence and remove the stigma and shame that surround it (Merafong City, 2011:6).

Furthermore, it can be seen that the silence surrounding HIV and AIDS is motivated by the culture of silence over certain other matters such as sex and sexuality, discussion of which is regarded as taboo in certain cultural settings. It is often believed that open talk about sex or related issues will increase promiscuity in a society, as everyone will then know about it and practice it. According to Campbell et al. (2009:14), in conservative traditional communities, strong social norms and inhibitions prohibit open talk about sex, especially among young people, holding that those who are willing to talk about HIV and AIDS and sex are considered as 'naughty', while those who do not are 'good'.

This culture of silence about matters related to sexuality can be noticed in the language used in various cultures where mentioning matters related to sexuality is done in the form of euphemisms or metaphors. In the *amaXhosa* culture, in order to avoid taboo words, euphemisms are used to describe sexual acts or body parts in a way deemed polite by the culture (Mabeqa, 2005:61). In a research study conducted by Cain on *Language Use and Sexual Communication Among Xhosa Speakers in Cape Town, South Africa*, interviews were carried out, mainly in Khayelitsha, to define the sexual terminology domains used by *IsiXhosa* speakers in Cape Town, and it was established that, while certain words are used as a matter of politeness and respect when talking about genitals and sexual intercourse, there are others that should be avoided due to their rudeness. For example, instead of using words like *ibhentse, inyo,* and *isinene,* which are all terms referring to the female genitalia as a *hole* and all hold a very negative connotative meaning (Cain, 2007:62), it becomes preferable to use the *IsiXhosa* words for *vagina* that are selected in a respectful way to compare it to other things. Thus, "*itswele* and *iguava* are both terms that compare the female genitalia to food. *Itswele* is *IsiXhosa* for an onion. It is used to describe the female genitalia because 'it has a shape similar to an onion in that it is round,' and like the labium of the female genitalia 'it has a lot of layers.' The term *itswele* is a more respectful term than the direct anatomical word, *amalebe,* to describe the labium because it uses a euphemism. *Iguava* is the English term guava and compares the vagina to a 'delicious fruit'" (Cain, 2007:64). In the same way, the words for *penis* are more respectful. Words like *amasende, mthondo, umthondo, ipipi, ijwabi, incanca* are all difficult terms to mention because they directly describe the male genitalia or its anatomical features, and everyone knows what they refer to; each of them is a taboo word.

Therefore, words such as *ipitsholoza* (the snake that winds up), *iketile* (kettle), *ubhuti* (brother), *instimbi* (iron), *ngobudoda* (manhood) are used in a polite or euphemistic way (Cain, 2007:56-57; Mabeqa, 2005:62).

As for sexual intercourse, people may be comfortable with using terms like *ukusciyana* (slang), *ukubiya* (build a fence), *ufuna uku ayina* (I want to iron), *ufuna ukubeka instimbi* (I want to put some steel), *ukunkola* (bang), *saya ishlanu* (to bet five), *bhalana* (to write), *ukuqubha* (to swim), *ukudlala* (to play), *ebhayi* (let's go to PE), *Let's do it* (English), *Let's* go *to PE* (English), *isex* (English), *have sex* (English), *make love* (English), *ukwabelana ngesondo* (*IsiZulu*- share a cloth), *ukwenza ezothando* (make love), *ukuhaver* (to have), and *ukuphana* (you give, I give); however, there are other terms that people do not feel comfortable using, including *ukutyana* (eat each other), *ukutyiwa* (I am eating you), *ukudlwengulwa* (rape you), *ukuzumana* (sudden sex), *ukuzunywa* (sudden), *zumana* (sudden), *amanyala* (let's make a taboo), *ukutishinana* (slang), *ukulalana* (sleep together), *ukuhwelana* (to be on top), and *ukuzekana* (to take each other) (Cain, 2007:72-77; Mabeqa, 2005:62). Some expressions are in both English and Zulu which, according to Cain (2007:72-77), is due to the fact that people feel more comfortable mentioning sex in another language as it sounds less rude because it takes sex out of their culture.

The *amaXhosa* cultural practice of avoiding talking about sex and sexuality in a direct way may also explain the existing silence in talking about HIV and AIDS which is transmitted sexually. In Khayelitsha, the prevalence of the silence about HIV and AIDS could be due to the fact that the township is predominantly inhabited by *IsiXhosa*-speaking people.

The lack of openness in talking about sex is also seen in talking about HIV and AIDS. HIV and AIDS has become a disease which people do not want to talk about in the community, referring to it rather through the use of euphemisms. According to Haddad (2005:31) and Cloete et al., (2010:3), people do not usually mention HIV and AIDS by name. They habitually refer to it as "this thing" *(intoyakhe* in *IsiZulu; ulwazi in IsiXhosa),* and a series of euphemisms is normally used in which AIDS is referred to by replacing it with a more 'respectable' sickness such as TB, chest pains or pneumonia, or bewitchment through evil spirits. Furthermore, in her work with rural church women, Haddad (2005:32) points out that it is not easy for them to openly admit the existence of AIDS as a sickness killing their sons and daughters. The women continue to treat the topic of AIDS with secrecy and mystery, even though their view has been changing slowly due to awareness campaigns going on in

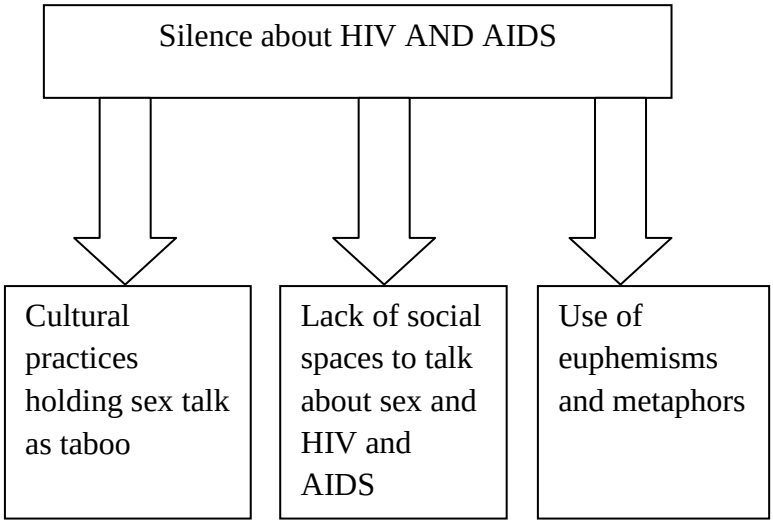
the communities. Church leaders have likewise been slow to talk about the subject of HIV and AIDS because of its association with sexuality.

The silence about HIV and AIDS results in stigma and defeats any kind of effort to fight the epidemic. Even in the Church, although not all have been quiet and unresponsive about HIV and AIDS, it can be said that the majority of church leaders and members have not spoken up about the disease as they should, and as a result, HIV and AIDS continues to afflict millions of people worldwide. It would therefore require church leaders breaking their 'silence' to mitigate the impact of HIV and AIDS stigma (Swann Jr., 2008:204). Talking about the silence surrounding the HIV and AIDS epidemic, Swann Jr. (2008:204) further describes two kinds of understanding of this silence which should be addressed in order to deal successfully with the destructive impact of the pandemic: absolute silence, and effective silence. He explains the two kinds of silence in the following way:

> Here it should be viewed from both the aspect of the speakers, in this instance, Christian Church leaders, and the hearers, those who receive their words. If we say nothing about HIV and AIDS, in effect, acting as if it is not there or it is not the Church's problem, then there is *'absolute silence.'* But if Christian Church leaders speak about HIV and AIDS and/or homosexuality and other activities leading to HIV exposure in theologically negative terms; then, for some portion of our hearers *'effective silence'* is promoted. Some hearers will not receive the message and choose to exist in *'effective silence.'* For a biblical example, God told Jonah to go to Nineveh, and '*cry against it.*' Because of his biases, Jonah chose to exist in *'effective silence'* with respect to God's command. In either case, whether the silence is *'absolute'* or *'effective,'* if breaking it has the effect of helping to alleviate the destructive impact of HIV and AIDS, it must be done.

In fact, these kinds of silence are manifested in the Church as will be seen later, and this needs to be addressed by church leaders. In order to deal with silence about HIV and AIDS, information about sex and HIV and AIDS is helpful in the sense that, if provided carefully, it can help in dealing with HIV and AIDS stigma. If there is a platform for people to access information and to discuss it with others, it can be a great tool to give knowledge to the people and make them aware of the disease. This indicates an urgent need for participatory initiatives to give opportunities for people to discuss HIV and AIDS-related matters with trusted peers in order to work collectively through their doubts about its truth and the relevance of the information they get, and to engage in dialogue about the possible impact which the information can have on their decisions to change their behaviour or attitudes. In this way, people can be helped to feel safe to discuss information about HIV and AIDS in

their families and communities (Campbell et al, 2007:409). The following diagram illustrates the silence that surrounds HIV and AIDS.



(Diagram 2.2: Silence about HIV and AIDS).

2.1.4 The Link between HIV, Sex, and Sexual Morality

Yet another cause of HIV and AIDS stigma is related to the link that exists between HIV, sex, and sexual morality. It is believed that those who contract HIV get it as a result of sexual behaviour. This is due to the fact that HIV is mainly spread through sexual intercourse and is mostly associated with behaviours that are socially 'unacceptable' or 'deviant', such as sex work, injecting drugs, same sex practices, sex outside of or before marriage, or sex with multiple partners. This has created stereotypes of PLWHA and the mistaken image that only immoral people are infected by the virus (Family Health International (FHI), 2003:1; UNAIDS, 2005:24; UNAIDS, 2007:8; Ullah, 2011:100).

In addition, the common belief that HIV is acquired as a result of sexual immorality reinforces stigma for PLWHA because it carries the assumption that anyone living with HIV and AIDS must have been involved in immoral sexual acts, and therefore, that person's moral integrity and values are questionable. As a result, the fact that HIV is mostly transmitted through sexual relationships makes people believe that PLWHA suffer as a result of their own wrong choices. It is held that they should have abstained from sex in order not to put their own lives in danger; so, the fact that they have been infected with HIV puts them in a position where they got what they deserve by choosing to engage in 'bad' behaviours that put

them at risk (ICRW, 2006:4, Ogden & Nyblade, 2005:21). It is no surprise, therefore, that the judgemental belief that HIV and AIDS is God's death penalty for sexual immorality is sometimes advocated in the Church and even by religious leaders (ICASA, 2003:1). Similarly, the fact that HIV-positive people get stigmatised as morally corrupt, irresponsible sinners supports the impression that AIDS is a plague sent by God to deal with the sexual immorality that has prevailed among people (Mlobeli, 2007:3).

This judgemental attitude sometimes becomes apparent when religious leaders are expected to deliver speeches of comfort to a community affected by HIV and AIDS; instead of delivering messages to build up those affected, they tend to give messages of confrontation rather than comfort. For example, "A religious leader in Zambia who discussed HIV-positive patients in a local clinic said, 'Those patients are promiscuous . . . careless with themselves. God is punishing them for disobedience . . . the diseases are not traditional in nature and those affected are examples of what God can do to those who disobey His commandments'"(ICRW, 2006:4; Ogden & Nyblade, 2005:21).

Moreover, the persistence of such beliefs is made evident by the influence of religious and moral beliefs and cultural norms that hold sex to be evil, with some religions continuing to teach that HIV is a punishment for a moral fault (O'Reilly, 2006:23).

Sometimes, as the ICASA (2003:2) posits, the stigma and discrimination against PLWHA are "perpetuated through the lack of a structure and policy to deal with people who are HIV+ in the Church". However, it is not only the lack of a structure and policy for PLWHA in the Church which promotes stigmatizing, but the exclusion of PLWHA from church services is ostracizing as well. This can be attested to by literature describing how PLWHA have at times been refused the same treatment as others in some churches, as well as by "'horror stories' of pastors refusing to anoint HIV infected people or forcing them to publicly confess the 'sins' that caused them to be infected" (UNAIDS, 2005:24). Such treatment of PLWHA in the Church can be so stigmatising that the targets lose the desire to attend church services.

Moreover, when HIV and AIDS is associated with promiscuity and immorality, PLWHA are viewed as having brought a curse on themselves and being therefore unworthy of family support. This results in rejection and hinders their interpersonal relationships within the family set-up (Roman, 2006:32). The reason why HIV and AIDS has been believed to be a punishment for sexual sin is the interpretation of the Bible in a manner that denigrates

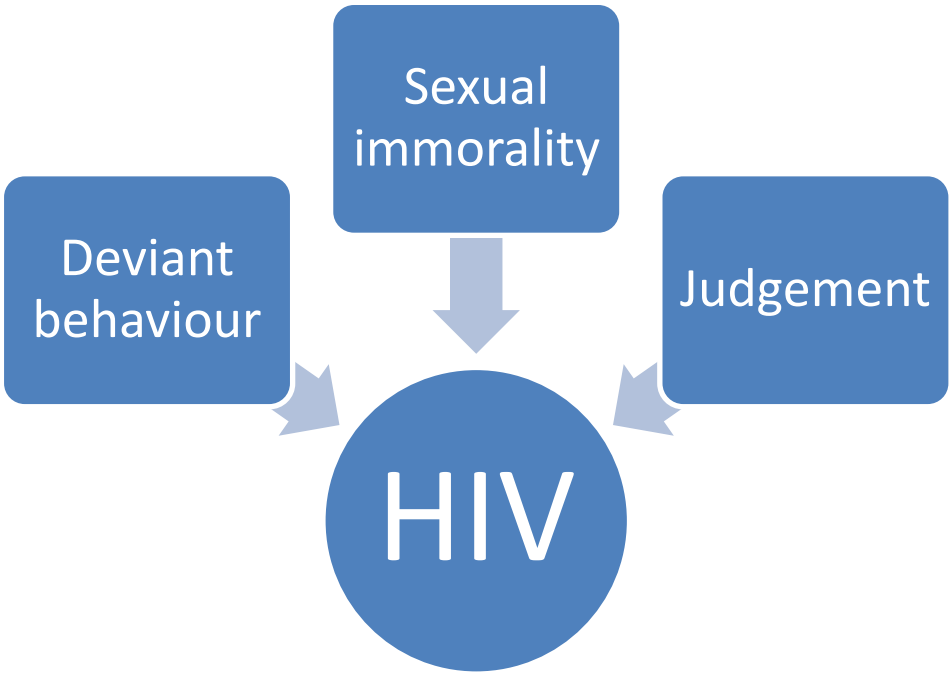
PLWHA, causing them to be victimised and ostracised in the church family (UNAIDS, 2005:10).

The theological understanding of HIV and AIDS as being the result of sexual sin also comes into play when some sins are regarded as worse than others, and people are led to think of sexual sin as a major sin deserving severe punishment. As the UNPAID (2003:12) observes, the stigmatization of PLWHA has grown out of the mistaken link in Christian thinking between sexuality and sin, including the widely held assumption that HIV is always contracted as the result of 'sinful' sexual relations, as well as the additional tendency to regard sexual sin as the gravest of all sins. Haddad (2008:49) confirms that HIV is often considered a punishment despite wide accessibility of anti-retroviral treatment. According to her, being HIV positive was for many years understood to be a death sentence, given the fact that access to ART was available only to a small, targeted group. This reality continued to fuel stigma and discrimination. Even now that ART is more readily available in most public health clinics, being HIV positive is still considered shameful.

However, careful thought must clearly be given to ways of stopping the association of HIV and AIDS or any other disaster with sin, which could be a way of running away from the responsibility of compassionate care. Evidence should be displayed of instances where wrong things happened to people, not necessarily after they committed sin.

> It is wrong to interpret HIV and AIDS (or other human catastrophes) as God's punishment for sin. This interpretation is damaging, because the judgmental attitudes that result are highly undermining to the Church's efforts at care and prevention. It is also theologically unsustainable, a fact that is demonstrated powerfully in the Book of Job, and also in many of the healing narratives of the gospels. In reflecting on the connections between HIV transmission and sin, it is important to remember that many people who become infected bear no responsibility for their condition: namely babies born with the virus, abused women and children and faithful partners of unfaithful spouses (UNAIDS, 2005:12).

The different types of theologies regarding the belief that HIV and AIDS is a result of God's punishment for sexual sin will be dealt with in detail in the third chapter of this research study which looks at the Biblical and theological refection of HIV and AIDS stigma. The link between HIV and AIDS, sex and sexual immorality is illustrated in the following diagram.



(Diagram 2.3: The Link between HIV, Sex, and Sexual Morality).

2.1.5 Poverty

HIV and AIDS have a strong impact on the ways health care and supports are offered to PLWHA in their homes and communities, and the disease is associated with extreme poverty in poor communities. To illustrate this point, Walker et al (2004:16) acknowledge that "Poverty and disease are widespread in Southern Africa and are major factors in the rapid spread of HIV and subsequent opportunistic infections. The disease mainly affects poor households in the region because breadwinners are ill or dying. The loss of income due to illness and medical and funeral expenses can be a devastating blow to an already desperate family. It can also pitch families that were just able to make ends meet into poverty". In South Africa, massive poverty is the harshest daily experience of the majority of citizens, since "large numbers of people are unemployed and many who find work are in low-wage, low-skill jobs. Significant numbers cannot find employment because of poor or no education and training and because they live in parts of the country that have little attraction for investors and human resource practitioners. The poor in rural communities also face the terrible plight of poor access to food and inadequate access to land that may be used for growing food" (Pandor, 2003:52).

In this regard, a research study done by Campbell et al. in two communities in Kwazulu-Natal indicated that some people live in such extreme poverty that they have difficulty accessing hospital facilities which are far away due to the fact that they cannot afford the high

cost of transport needed to take their loved ones suffering from HIV and AIDS for treatment. It also happens that even when they manage to find ways to take the HIV and AIDS patients to the hospital, proper treatment cannot be given because of lacking or limited facilities in hospitals, resulting in the fact that patients have to be sent home without treatment, even though they may be very sick (Campbell et al., 2007:411).

In poor communities, families struggle to find enough resources to support loved ones living with HIV. This is because of the special medical and nutritional needs of PLWHA which might enable them to live longer. Therefore, families that are already not managing in caring for themselves become even more crippled by the presence of a family member living with HIV and AIDS; the costs of caring for family members who are sick or dying of AIDS becomes devastating and unbearable for poor families, thereby causing these families to stigmatize and neglect afflicted family members (IRCW, 2006:6; Ogden & Nyblade, 2005:12-13; Zulu et al, 2004:169).

Furthermore, poverty in the context of HIV and AIDS is further aggravated by the issue of unemployment for PLWHA. It has been noted that PLWHA, once it is discovered that they are HIV positive, are refused employment opportunities, which makes them unable to care for themselves effectively and get the healthy nutrition needed for their ARV treatment, or to look after their dependants in terms of putting bread on the table, sending their children to school, and providing other types of care that is needed (Mashau, 2008:19). Even if they find jobs, PLWHA may become too weak to continue working, and may become so ill that their family members must spend time looking after them at home, thereby increasing the level of poverty. Unemployment thus puts PLWHA in a vulnerable situation where they have to be dependent on others. In such a situation, the burden of taking care of PLWHA becomes too heavy for the family members, with the result that they frequently experience burnout, particularly as the patient's HIV-disease progresses (IRCW, 2006:6). Burnout is characterized by lack of endurance to keep on helping family members suffering from HIV and AIDS, discouragement about the situation of having to care for a sick person for a long time with no prospect of recovery, and feelings of wanting to give up. Moreover, the situation of burnout and despair undermines the survival of PLWHA: families regard members living with HIV and AIDS as having no purpose in living. The more ill PLWHA become, the more unable they are to contribute to family life. Therefore, they are regarded as useless, subhuman beings that do not deserve to be taken care of because they are in the process of dying, so

there is no good reason for them to continue using up scarce resources if they are never going to recover (Maughan-Brown, 2007:22; Patient & Orr, 2003:18, 21).

Another issue contributing to burnout and stigma is the fact that children have to care for very ill people at home, and this takes a lot of hard physical work as "patients have to be lifted, washed and fed. Their bedding and clothing has to be kept as clean as possible. They need help with shopping and cooking. When patients are too ill to walk, they need someone to get their medication from the clinic. In many households children are left to do these tasks alone because neighbours reject families who are suffering from HIV/AIDS or are afraid to interfere" (Winkler, 2004:36).

Furthermore, the economic contribution of the member afflicted with HIV and AIDS is reduced or even ceases completely, which results in a double blow to the family and also causes this member to be blamed for the financial difficulties the family goes through (Maughan-Brown, 2007:22).When people get infected with HIV and develop full-blown AIDS, adults suffering from AIDS become less productive and experience loss of income, which causes families to become very poor, some even breaking up while others endure the burden of care for very sick relatives and orphans (Winkler, 2004:36). Consequently, there is a danger of PLWHA being isolated or even killed for uselessly consuming scarce resources (Church World Service, 2003:6).

In Khayelitsha, health facilities and social welfare services are widely available and accessible to the public, as mentioned earlier, but due to high unemployment rates, poverty continues to be a challenge to individual families, thereby creating an environment in which people cannot find enough resources to live on. Families may even withhold resources from members afflicted with HIV and AIDS, as was evident during the researcher's internship in Khayelitsha[3]. In addition, it has been discovered through research that in Khayelitsha, PLWHA have sometimes been cast out of their respective families and communities for being viewed as a burden to others (Mlobeli, 2007:2).

The discussion about the relationship between HIV and poverty will continue in Chapter Four, where the believers' devotion to *diakōnia* is discussed. The following diagram presents the relationship between poverty and HIV and AIDS stigma.

[3]As mentioned earlier, some of the information in this research is acquired from the researcher's experience during internship at Nolungile Youth Clinic in site C Khayelitsha HIV and AIDS youth clinic in 2010.

(Diagram 2.4: Poverty and HIV and AIDS stigma).

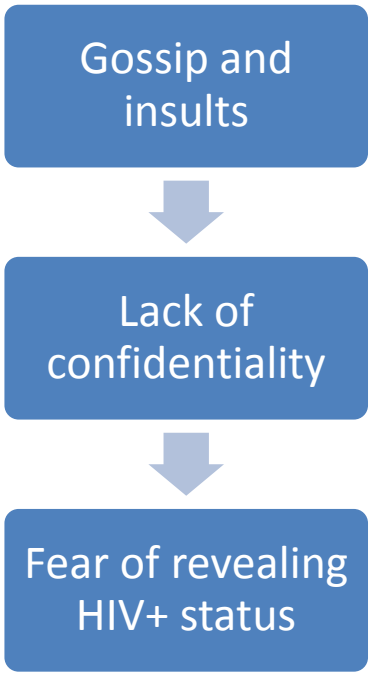
2.1.6 Gossip and Insults

Gossip and insults are yet other causal factors of HIV and AIDS stigma. In the community, PLWHA do not feel welcome due to prejudice, blame and bad language being aimed at them. According to O'Reilly (2006:23), "Prejudices regarding sex, gender and sexuality are difficult to change and despite the high HIV prevalence in some communities, blame and denial are common and continue to contribute to the stigmatisation of people living with HIV". This is once again due to the fact that HIV and AIDS are regarded as a shameful disease, making infected persons subject to public disgrace. As is often noted, the inappropriate and unfriendly language used to talk about PLWHA puts them in a position where they become targets of gossip, insults and other forms of verbal abuse characterized by taunts and name calling. When the community learns about the HIV positive status of a person, that person's health situation becomes a major topic of discussion among people surrounding him or her. There is speculation as to how the person contracted HIV, and this causes the person to face societal stigma. In this regard, gossip is reported to be one of the most significant sources of stigma (ICRW, 2006:5). Such stigmatising speech is linked to the nature of HIV and AIDS as a dangerous and deadly disease, and to the fact that it is transmitted through sex, as discussed above. All that people want to know is whether an individual was infected through sex or not. If sex was the means of transmission, it becomes

accepted that contracting HIV and AIDS was the person's own fault, and the stigmatizing language finds its ground.

As news about any HIV positive person spreads, there are often societal reactions of disgust, anger and fear toward people thought to be HIV positive, to such an extent that some even think of isolating PLWHA from the rest of society (Chavez, 2006:1). Thus, the language used causes PLWHA to be avoided and discriminated against in community life. They are considered to have brought a curse upon themselves, their family, and the community. For example, as UNAIDS (2003:3) discovered, some PLWHA in Cameroon were invited to the front of the congregation for special prayers because they were believed to have "sinned and would be punished up to the 5th generation".

In a context where gossip against PLWHA is evident, the victims fear to share information on their HIV status because it will not be kept confidential. According to Nyblade et al. (2009:2), HIV stigma manifests even among health workers who instead of keeping their clients' information confidential, gossip about them and harass them verbally, avoiding and isolating them, as well as referring them for testing without pre-counselling. Lack of confidentiality in HIV-related matters may result in the danger of a further spread of HIV, because if PLWHA are withholding information about their HIV status for fear of gossip, it may be very difficult to control the spread of the virus. This implies that if sensitive information like the patient's serostatus or symptoms are not kept confidential by doctors and counsellors, then the risk of transmission cannot be reduced since fear makes PLWHA avoid disclosing their status, and they thus silently continue to spread the virus (WCC, 1987:59). Furthermore, the gossip and insults associated with HIV and AIDS stigma are connected to the fact that language can be used to perpetrate stigma. Since the beginning of the HIV and AIDS pandemic, many powerful metaphors have been adopted regarding the disease, including describing it as death or horror, thus serving to reinforce and legitimise stigmatisation shame, punishment, crime, war and 'otherness' (Mlobeli, 2007:16). Moreover, the uttering of unkind words in the absence of a person because they are HIV positive contributes significantly to the spread of HIV stigma. In Khayelitsha, gossip has been identified as the most common and harmful reason for stigmatisation (Maughan-Brown, 2007:6). The role of gossip and insults is illustrated in the following diagram.



(Diagram 2.5: Gossip and Insult).

2.1.7 Gender Imbalance

In the effort to fight HIV and AIDS stigma, the imbalance of power in many societies is a significant factor contributing to family dysfunction, as the burden often rests more on the shoulders of women than of men. According to the WCC (1997:15) and Strebel et al. (2006:521), this imbalance of power is related to the failure of men to take responsibility for issues related to sexuality, reproduction and HIV and AIDS.

In fact, gender imbalance in the face of HIV and AIDS is enhanced by the patriarchal structure of certain societies, in which a man is superior to a woman as far as decision-making in sexual and reproductive matters is concerned. This is significant for South Africa which is a highly patriarchal society, and has the world's largest HIV burden, and where gender norms and disparities are considerable factors contributing to the spread of the HIV and AIDS epidemic in such a way that poverty has placed South African women and girls at higher risk of HIV infection. This higher risk is reflected, for example, in the fact that the HIV prevalence rate for females ages 20-24 is more than four times greater than that for males in the same age group (Ghanotakis et al., 2009:359; USAID, 2011:1). On the issue of patriarchy being a cultural factor contributing to women becoming vulnerable to HIV stigma, Mwaura (2006:35) observes, "Research has revealed that gender power imbalances in both the economic and social dimensions of life are a direct result of the patriarchal organization of most African societies, for patriarchy engenders a culture of male domination and female

subordination. In the sexual domain, women are rendered passive and silent". This puts women in an uncomfortable situation with limited power to decide on issues such as the control of their own bodies, the timing of sex and protective measures against HIV and other STIs. Furthermore, women are further disempowered by the fact that it does not matter how many sexual partners a man has, and that due to the pressure put on women by culture, they are forced to keep quiet and passively permit whatever a man does, regardless of the consequences.

It also became evident in the findings of the research done in two communities in Kwazulu-Natal that women become objects of abuse by men because of the heavy bride price paid before the women are given to the men in marriage, which is used by men as an excuse to treat women as they want. Campbell et al. (2007:409) present the cry of a rural woman thus; "We know our husbands have affairs, and some of us even suspect our husbands are HIV-positive, but we can't suggest a condom. Sometimes it feels like a living death to be a woman in this situation, we are dying whilst we are alive, we feel as if we commit suicide every time we have sex, yet we can't do anything because we are married". From this quotation, it is clear that women become vulnerable to such an extent as to feel that marriage is a living hell in which one is forced to be exploited without any objection. If marriage is like that, it would appear that it is not a pleasant situation for women. According to the report of the Department of Health in South Africa, women living with HIV and AIDS are more stigmatized than men and, as reported by a facilitator of a HIV and AIDS support group in Khayelitsha, those women encounter problems of violence or rejection by their husbands, family members and friends after disclosing their HIV and AIDS status, thereby making them opt to keep their HIV status secret rather than revealing it to anyone and facing a fearful or hostile reaction (Mlobeli, 2007:21; USAID, 2011:5).

The complaint of women when it comes to their vulnerability to HIV and AIDS can be understood in the sense that, as far as biological factors are concerned, women and girls are more susceptible to HIV infection than are men and boys (Kamaara, 2004:41, USAID, 2011:4; Ghanotakis et al., 2009:359). In addition to biological factors which appear to highlight the difference between men and women as far as HIV infection is concerned, there are further factors that underscore such a difference. As Farley (2004:137) asserts, the ritual initiation into sexual activity that takes place in rural areas, in which adolescent girls have to be initiated by older men who may already be infected, puts these girls in danger of contracting the virus. Meanwhile, in the cities, where countless girls lack the minimal

education given to boys, many girls are not able to find employment, and therefore turn to older men, exchanging sex for entertainment, security and even livelihood. In addition, women are driven to prostitution to support themselves and their children. There is also growing evidence that domestic violence plays a major role in the spread of HIV, and in settings of political instability and warfare, women and children are targeted for sexual abuse.

In the case of poverty, women are victimised by the fact that when they find themselves in financial difficulties, they may be forced to get involved in selling their bodies for sex in order to be able to care for themselves and their families for whom they are the breadwinners. Similarly, the burden of caring which falls on women forces them into deeper poverty and affects their self-esteem, thus increasing the pressure on them to opt for high risk transactional sex as a way out (Chirongoma 2006:49; Farley, 2004:137; WCC 1997:16; USAID, 2011:4). In South Africa, for example, "The HIV and AIDS-related stigma is particularly more severe for women than for men due to both gender and economic inequalities found in most cultures across the world. On average, Black South African women have a lower social status than men, have less access to safe housing, and are often dependent on their male partners as breadwinners for support. This may render some vulnerable to sexual abuse" (Simbayi, 2010:6). All these economic, social, and cultural factors contribute more to the escalating spread of HIV among women than is the case with men.

Also among the social factors causing women to be victimised more than men by HIV and AIDS stigma in South Africa is gender-based violence, which is so prevalent in the country that South Africa has one of the highest rates of violence against women globally, as well as one of the world's worst HIV and AIDS epidemics (Ghanotakis et al., 2009:359; Strebel et al., 2006:517). This gender-based violence is highlighted by the Treatment Action Campaign, a leading South African HIV and AIDS activist group, which states that "a woman is raped in South Africa every 26 seconds, and every 6 hours a South African woman is murdered by her partner" (USAID, 2011:4). Such violence, and the mere fear of it, aggravates HIV transmission by hindering women from insisting on consistent condom use by their partners, disclosing their HIV status, and adhering to treatment regimens (USAID, 2011:4; Strebel et al., 2006: 521).

Another aspect of gender imbalance in the world of HIV and AIDS is that women tend to more be affected psychologically and emotionally than men, and therefore, the burden of

HIV and AIDS-related care which is often disproportionately distributed between males and females makes women more vulnerable to the results of loss and grief than are men (Mwaura 2006:35; Chirongoma, 2006:49). This disproportion is due to the fact that it is the women who stay longer with a person suffering from HIV and AIDS. As they get more involved with the care of the sick and dying, they get more acquainted with the suffering of those who are ill, and this works on their emotions, making them bear the psychological and emotional burdens of the disease. This reinforces the aspect of women's victimisation in their role of caregivers in the family as well as in the community. Women are expected to care for everyone suffering in the family, which leaves them in a situation in which they do not have anyone to care for them in times of need, since they may not plead for help, and they may thus suffer burn out (Farley, 2004: 137; Kamaara, 2004:41;WCC, 1997:16).

In addition, women are subject to more suffering and vulnerability when their partners die. In certain cultures, the widow's life is open to HIV infection as she has to be 'inherited' by a brother-in-law in order to keep her late husband's property or else be forced off the property, which then means that she has to find other ways to earn a living, most of the time resorting to engaging in transactional sex for survival, which increases her chances of contracting HIV as she is not able to negotiate safe sex or to escape from the reality of multiple sexual partners (USAID, 2011:4; Mwaura, 2006: 37-38; Farley, 2004:137). Certainly, forcing a woman to marry her late husband's brother leads to her being regarded as an object, since objects can be inherited. She is thus not treated as a human being with dignity, and this further puts her at high risk of contracting HIV since she cannot object to marrying a brother-in-law, nor can she suggest any protective measures such as condom use.

While still on the issue of gender imbalance as a contributing factor to HIV and AIDS stigma, it is important to mention the way men and women are treated differently when they are both found to be infected with HIV. In communities where women are not viewed as equal to men, it appears to be more shameful for women to be diagnosed as HIV positive, as if women are not supposed to become infected. This is coupled with the fact that society puts a great deal of pressure on women infected with HIV by blaming them for the spread of the virus and seeing them as sexually promiscuous, loose, prostitutes, dirty and immoral, while men living with HIV are culturally free of blame for the high incidence of HIV infection and are actually praised at times for being male (Simbayi, 2010:6). It thus becomes accepted that when men are diagnosed as HIV positive, women have to take the responsibility of caring for them without raising any question as to where the virus came from (Mwaura, 2006:42; Farley

2004:137). This harsh treatment of women means that they generally bear the strongest brunt of HIV and AIDS stigma because in some settings women are expected to uphold the moral traditions of their societies, and when they become HIV positive, they are judged for failing to fulfil this important social expectation (Ogden & Nyblade 2005:24).

In Khayelitsha, the culture which is predominantly *amaXhosa*, contributes to the vulnerability of women in terms of power as far as HIV and AIDS is concerned. The *Laphumi'langa*[4] project found that the gendering of men and women in *amaXhosa* culture means that men see themselves as superior to women and women consider themselves as lower than men. As a document from that project puts it,

> The principal cultural context was the process of gendering women and men. Project participants saw this as the main factor that exacerbates notions of superiority by men. This was exemplified in reference to the initiation process for young men amongst the amaXhosa. This practice is known as *ulwaluko.* The participants argued that when boys are taught philosophies of manhood in the bush, the idea that men are heads of families and stronger than women are emphasised and internalised by young men. However, as part of social teachings for young women during *Ntonjane* (their own rite of passage), they are socialised to accept that a married woman must submit to the will of the man of the house. A married woman's – *umakoti's* – duty is to safeguard the problems of her home; she must place the family's needs before her own and must not question her husband's authority (2006:2).

In fact, the authority of men over women is taught even before initiation, as young people learn right from the beginning that man is superior to woman. That is why young men grow up with a mentality of authoritarianism while young women, in turn, grow up with a sense of blind submissiveness. As a result, it is becomes difficult to educate the youth to believe otherwise, because what culture has imparted to them speaks louder than any other voice that is then regarded as taboo.

Furthermore, in the study done by Arend in a faith-based organisation in Khayelitsha, it was found that men have the freedom to get involved with as many sexual partners as they want, even though women do not have that liberty. Arend (2008:265) quotes a fieldworker as saying, "*'It's not OK for a woman to have multiple partners, but for a man, it is appealing to society. You get labelled nice names like a player or a puncher if you have many partners. But if a woman has more than one partner, you have negative names like a slut, a bitch, a whore.'*"

[4]Laphumi'langa is a Xhosa word that means 'Sunrise'

It can also be noticed that the *amaXhosa* patriarchal culture puts more pressure on women when it comes to decision making in the home, which puts them in such a vulnerable position that they are not even allowed to say no to sex, or at least negotiate condom use in their sexual relationships. In a reflection on such a cultural practice, Nieuwmeyer (2002:40) explains,

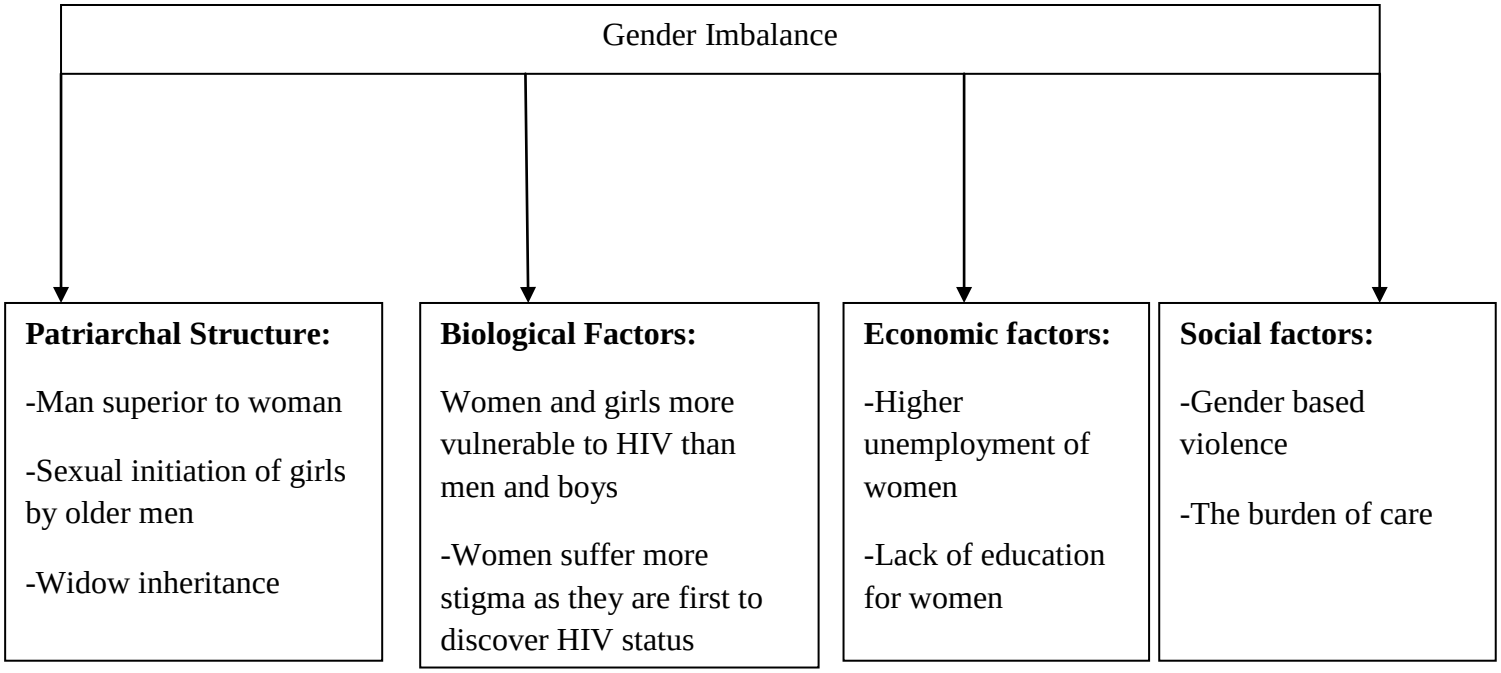
> Patriarchy in a society vests authority in the hands of men. Living under authority of men makes it hard for women to protect themselves sexually from human immune-deficiency virus, since they do not have the power to negotiate condom use. In terms of amaXhosa culture, the amaXhosa social body has developed certain normalized discourses, where women are inferior to men and therefore act as 'docile bodies' without much authority. This lack of power in sexual relations also means that women have little hope of influencing their partner to use a condom. At the same time, women are held unfairly by men to be responsible for the spread of AIDS and are thus stigmatized.

What is clear from this quotation is that women and girls are more susceptible to HIV than are men and boys, as the power to make decisions about the most crucial matters of life lies in the hands of men, and when they abuse such power, women suffer the consequences while men are culturally protected (UNAIDS, 2007:8).

When thinking about this situation, it may not make sense that women who hold no power whatsoever can be accused of responsibility for spreading HIV, while culture accords to men all the rights to initiate sex and have as many partners as they want to. However, as De Paoli (2010:27) suggests, women are caught in the trap of blame for HIV infection due to the fact that they may be first to be tested for HIV since if they are pregnant, they may go for testing during the antenatal care procedures in clinics. Then, when they come home with positive results, men find grounds to accuse them of bringing the virus into the family. Women thus encounter the consequences of HIV status disclosure because they face an obligation to make their status known before men do. As a result, women often delay going for HIV testing (Ullah, 2011:101; Simbayi, 2010:7).

The issue of gender imbalance as a cause of HIV and AIDS stigma is very serious and needs careful attention, as any effort to deal with HIV and AIDS will prove futile if the innocent keep carrying the blame. This section has dealt with the causes of HIV and AIDS stigma as applied to Khayelitsha. As one of the aims of this research study is to understand the causes and consequences of HIV and AIDS stigma in order to come up with a pastoral approach for church leaders to deal with HIV and AIDS stigma in Khayelitsha, it will be helpful for the

next section to discuss the effects of HIV and AIDS-related stigma. The following diagram summarises the issues related to gender imbalance as a cause of HIV and AIDS stigma.



(Diagram 2.6: Gender Imbalance and HIV AND AIDS stigma).

2.2 The Effects of HIV and AIDS Stigma

HIV and AIDS-related stigma has serious effects in the lives of PLWHA as well as those surrounding them. After discussing factors which could contribute to stigma, this research will now explore some of the effects of HIV and AIDS-related stigma.

The stigmatization of PLWHA clearly has many negative effects in their lives and communities. As Kamaara (2004:46) clarifies, "There are no known positive impacts of stigmatization on persons living with HIV and AIDS". On the other hand, as Kamaara (2004:46) further posits, "it may be argued that stigmatization instils fear in other individuals thereby influencing them to adopt positive behaviour to avoid HIV infection and the consequent stigma". However, using the fear of stigmatization as a tool to encourage behaviour change would not be a good option, since fear is not a good driver to a safe destination. Even if people adopt behaviour change to deal with HIV and AIDS stigma, it may not change the occurrence of infection through the infidelity of a partner or parent, or through contact with contaminated blood. Hence, expecting that the fear of stigma would give stigmatization a positive aspect may merely be solving one problem by creating another.

This is why another tool, namely, compassion, should be adopted. As De Vries et al. (2009:11) suggest, PLWHA are likely to take precautions in changing sexual behaviour as well as being more open about their HIV status if they are shown compassion.

The literature records various sources on the effects of HIV and AIDS stigma. Studies conducted in South Africa found that stigma continues to be the main barrier to effective HIV and AIDS prevention and treatment in South Africa (Meiberg et al. 2008:50; Guma et al. 2007:5) due to the fact that perceived or actual stigma perpetuates denial, thwarts risk reduction behaviour, inhibits HIV testing, invokes fear of disclosure, or deters PLWHA from seeking treatment. De Vries et al. (2009:11) and Ullah (2011:97) identify similar consequences of HIV and AIDS stigma, except that their list includes further effects such as health workers' fear of infection, poor adherence to ART by PLWHA, collective public denial of HIV and AIDS, the stress PLWHA live under, as well as hindrance to any access to social support networks. Interestingly, though, Kamaara (2004:46), proposing two categories of the effects of HIV and AIDS stigma, mentions the isolation of PLWHA as individuals, and the impact HIV and AIDS stigma has on the wider society. Even though there are numerous effects of HIV and AIDS stigma, it is not the aim of this research study to deal with all of them. Therefore, due to the limited size of this research, its focus will be on three of the effects, namely the fear of HIV and AIDS status disclosure, difficulties faced in care and prevention programmes, and acceleration of death for PLWHA which, according to the literature, are the leading factors in HIV and AIDS stigma in South Africa generally (Meiberg et al., 2008:51; Avert, 2011:4) and in Khayelitsha particularly (Cloete et al., 2010:3). Each of these three effects of HIV and AIDS stigma are discussed in this section because they are directly connected with Khayelitsha as the main effects of HIV and AIDS stigma (Almeleh, 2006:140).

2.2.1 Fear of HIV and AIDS Status Disclosure

The disclosure of HIV positive status is very important for the management of the HIV and AIDS disease (Almeleh, 2006:140). In a research study done on the disclosure of HIV positive status to sexual partners among women attending an ART clinic at Hawassa University Referral Hospital in Ethiopia, Gari et al. (2010:9) discovered that such disclosure has a number of effects: "It may motivate partners for Voluntary Counselling and Testing (VCT), reduce risk behaviours, and increase receiving support and adherence to ART". This is true in the sense that even when PLWHA decide to disclose their status, they expect others to respond with care and support for them. On the same note, a research study that was

carried out on *Coping with HIV and AIDS Stigma in Five African Countries* revealed that HIV positive status disclosure was one of the strategies used by PLWHA to cope with the disease. According to the findings of that research, "Some participants disclosed their HIV status to reduce gossip and rumours, while others disclosed their HIV status seeking to solicit support from loved ones and community members" (Makoae et al., 2008:6). These findings agree with those of a research study conducted in Khayelitsha among women living with HIV, which discovered that "the disclosure of a HIV status can be beneficial for PLWHA as well as their households, sexual partners and public-health in general. As the psychology literature shows, disclosure usually has a positive relationship with psychological wellbeing, as disclosure is thought to lower stress levels, which leads to better psychological health and quality of life" (Almeleh, 2006:138).

While PLWHA hope that disclosure of their HIV status will help them to gain acceptance and support, however, what they get is totally different, as the people they disclose to react otherwise. Even though Gari et al. (2010:10) identify some benefits of HIV positive status disclosure, they add that "On the other hand, it may cause blame, discrimination, abandonment, anger, violence, depression, loss of economic support and disruption of family relationship. Due to fear of these risks patients may not disclose their HIV positive status". In a study conducted among women in Khayelitsha on disclosure of HIV status, it was established that the negative aspects of disclosure of HIV status include fear of ostracism by the community or household, moral judgement and blame, relationship termination, discrimination, and in some cases verbal and physical abuse (Almeleh, 2006:145). For this reason, this study has included the fear of HIV positive status disclosure as one of the effects of HIV and AIDS stigma.

A further effect is a reluctance to go for testing. As HIV and AIDS stigma increases in the community, PLWHA become very reluctant to find out their HIV status for fear of becoming objects of stigma and discrimination (Norman et al., 2007:3; Parker & Birdsall, 2005:7). As a result, people refrain from going for HIV testing. According to the ICRW (2006:4) and HSRC (2009:4), qualitative data suggest that the number of those seeking HIV testing is likely to decrease because they fear a positive test result which they know is linked to the stigma and social repercussions that they would face if they were known to be HIV positive. Moreover, even those who take the step of going for HIV testing might not return for their results as they are afraid that being seen at a clinic known to test for HIV could raise suspicions about their health (Norman et al., 2007:3).

Furthermore, a study done in South Africa revealed that PLWHA face strong stigmatization from their communities, and this makes the fear of stigmatization a major obstacle hindering people's willingness to go for HIV testing and their efforts to find out their HIV status (Meiberg et al. 2008:53). The study identified several benefits of HIV Voluntary Counselling and Testing (VCT), such as knowing one's HIV status in order to protect oneself and others, being able to cope with stress caused by the uncertainty of not being aware of one's HIV status, receiving care and support, and promoting safer sex (HSRC, 2009:48; Meiberg et al., 2008:49). However, several studies show a different side of the story, indicating that many people are often discouraged from going for VCT because they are worried about lack of confidentiality, and they fear stigmatization, and the consequences of knowing that they are living with HIV, as well as fearing how people in the family and society will react if the result is positive. For that reason, many people refrain from going for testing so that they can simply continue with their lives without any awareness of their HIV status (Ullah, 2011:101; HSRC, 2009:4; Meiberg et al., 2008:52; Maughan-Brown, 2007:4).

In the churches, leaders also are reluctant either to go for HIV testing or to disclose their HIV status for fear of stigma. In support of this, the ICASA (2003:4) points out that stigma has led to individual clergy refusing to go for HIV test for fear of testing positive, while those who test HIV positive refuse to speak of their status for fear of a negative reaction from the church. Such an attitude may be due to the fact that church leaders, held as superhuman, are often expected to have high morals, which makes it very difficult for people to understand should a church leader contract HIV and AIDS. This is further worsened by the popular association of HIV with sexual sin. The USAID's report on *Mobilizing Religious Leader Response to HIV in Tanzania* states that as a result of societal beliefs that associate HIV with sin, religious leaders living with HIV often face even greater stigma than others, in that disclosing their HIV status makes them risk losing their jobs and being rejected by the community. The fear of stigma and discrimination has thus kept HIV positive religious leaders in Tanzania isolated (USAID, 2008:1).

In fact, evidence of the stigma which church leaders living with HIV and AIDS face can be found in the stories of some of them. In an article on clergy living with HIV, Rev. Gideon Byamugisha, who became the first religious leader in Africa to publicly announce that he was HIV-positive, writes about an instance when he was stigmatised by a fellow clergyman after he had delivered a sermon in which he disclosed his HIV status to the audience. As he recalls, "I still remember vividly the anger of a priest who confronted me after worship in a church

where I had been invited to preach. Congregants shook my hand and congratulated me for a sermon well-delivered. The priest couldn't bear shaking my hand when his turn came. Instead, he asked in rage: 'Who invited you into our cathedral to defile our pulpit! … And you even had the audacity to touch and preach from our Bible? Have you ever repented about your sin? You told us you were HIV-positive, but I didn't hear you repent the sin that gave you the infection!'" (Byamugisha, 2011:2).

Another example to illustrate stigmatization following HIV status disclosure by a member of the clergy is what happened to Rev. Amin Sandewa, the first church leader to make public his HIV status in Tanzania, and the founder of the Tanzania Network of Religious Leaders Living with or Personally Affected by HIV and AIDS (TANERELA). It is reported that he and his wife discovered they were HIV positive, and sometime after this, his wife and daughter died, leading to rumours in the community about his health. Rev. Sandewa, who was working as a chaplain at a university in Morogoro, decided to leave the university to go back to the parish where he used to serve as a pastor. His return to the parish raised a lot of questions from his bishop, from whom he expected to get comfort, but who offered more questions than answers: "Will a parish accept an HIV-positive pastor? Can an HIV-positive pastor manage the work of the parish? Can the parish afford the treatment and care of an HIV-positive pastor?" (USAID, 2008:3). In the case of Rev. Byamugisha, the concern of the priest was that Byamugishahad defiled the church and the pulpit by preaching without confessing the sin he had allegedly committed when he contracted HIV, while Rev. Sandewa's bishop was concerned about the parish's acceptance of an HIV-positive pastor, and whether the parish could afford to care for him; in other words, there was a feeling that he would become a burden to the church. These two examples prove that it is even more difficult for the clergy to disclose their HIV-positive status than for other people.

In addition, families fear the risk of announcing the cause of the death of a deceased family member if it was HIV and AIDS, as this may spark heavy stigmatization from the public. According to ICASA (2003:4), the issue of families giving notification of the death of a family member afflicted with HIV and AIDS has become a real dilemma confronting clergy in their work with the disease. On the one hand, families perceive the need to publicly announce the cause of death, but on the other, they have to consider the implications which this would have for the family of the deceased who would be stigmatized and ostracized by the community.

The consequences of disclosure of HIV status have been the motivation for people to decide rather to do without the knowledge of their HIV status, and thus avoid being tested, because the knowledge of such status, if positive, would be a source of more suffering. As Visser, (2007:8) says, research has found that due to the fact that lack of confidentiality and forced disclosure have resulted in prejudice, discrimination, the loss of a job and even broken relationships or even violence[5], not knowing one's HIV status is far preferable for some than being tested. Consequently, the fear of HIV status disclosure makes the spread of HIV and AIDS very difficult to control. PLWHA who refuse to make their status known can receive neither treatment nor assistance, and the fact that no one is aware of their status can result in their spreading HIV and AIDS through unprotected sex (De Vries, 2009:11; Zaccagnini, 2010:23).

Because people react differently upon learning about the HIV status of others, the disclosure of status is very difficult, and people therefore find it is better to give the matter careful thought before disclosure. The right time, the right place and the right people are needed in order for disclosure to be safe. People have suffered serious consequences, even death, for disclosing their HIV status at the wrong time and in the wrong place (Ntsimane, 2006:8; Panos, 2006:21).

In Khayelitsha, there was an incident involving a young lady who was killed by her rapists after revealing to them that she was HIV positive; in 2003, a TAC activist, Lorna Mlofana, was gang-raped in the toilet of a Khayelitsha shebeen in Cape Town, and beaten to death when she informed her attackers of her HIV positive status (Maughan-Brown, 2007:7; Boesten 2007:17).

Most PLWHA in Khayelitsha thus battle with the issue of how to handle and control the process of disclosure, and this situation presents a challenge in that if nothing is done to encourage disclosure and acceptance in the community, the fear of rejection and discrimination will result in the fact that PLWHA hide their HIV status, which means that people will continue indulging in unsafe sex (Mlobeli, 2007:22). As a field worker reported in Khayelitsha, the problem is not so much lack of medication as it is fear of stigmatization, rejection by family members and discrimination from communities which makes PLWHA feel lonely and empty (Mlobeli, 2007:21).

[5] http://www.psycology.ucdavis.edu/rainbow/html/aids.html

2.2.2 Difficulties in Care and Prevention Programmes

Since the discovery of HIV and AIDS, efforts to prevent the virus as well as to provide care for PLWHA have been underway, but they are undermined by the fact that stigma discourages the beneficiaries from accessing them (ICRW, 2006:4). Therefore, the health services available for PLWHA are not being freely accessed because such people do not feel free to use them. This is mostly due to the fact that PLWHA, because of what they go through due to the burden imposed by the virus or by stigma and discrimination, lose all courage to access the health facilities which are in place (O'Reilly, 2006:23). Clearly, prevention and management efforts are affected by the reluctance of individuals to seek voluntary testing to determine their HIV status (Gari et al., 2010:9; De Vries et al., 2009:11; Kamaara, 2004:48; Family Health International (FHI), 2003:1). In addition, people are hindered from making use of VCT services due to the fear of being seen at a health care centre for VCT, as well as by concerns about confidentiality at the VCT (HSRC, 2009:4). A study by Meiberg et al. (2008:53) established that "AIDS-related stigma is deeply rooted in South Africa and people are very afraid to become stigmatized", and that fear of stigmatization is a significant barrier to HIV testing and a source of negative consequences regarding AIDS prevention and treatment.

Those findings agree with the report of a research study commissioned by Family Health International (FHI) in Nepal in 2003 which also indicated that stigma and discrimination are among the key barriers to combating the AIDS epidemic. According to the findings of the Nepal study, stigma and discrimination "result in individuals denying they are HIV-positive, shying away from preventive behaviours and being inhibited in seeking medical treatment out of fear that their health status will be discovered" (FHI, 2003:1). These findings are similar to those of Nyblade et al. (2009:2) who likewise found that stigma and discrimination in the health care setting and elsewhere hinder people's willingness to adopt HIV preventive behaviours and to access the care and treatment which they need. Normally, as established by a research study conducted by the HSRC (2009: 48), voluntary counselling and testing are important as an entry strategy for prevention and access to treatment, as well as to care and support services, while increasing knowledge of one's HIV status is important in that it encourages an increase in prevention behaviours among those who test positive through VCT. However, the fear of being identified as being HIV positive makes PLWHA reluctant to go for VCT or to disclose their status to health care workers and family members, and this

hinders the willingness of these PLWHA to seek treatment and care, thereby endangering their health and wellbeing (Nyblade et al. 2009:2).

While some PLWHA decide to stay away totally from health facilities for fear of stigmatization, for others who start treatment it becomes difficult to continue with it, and hence, stigma influences the PLWHA's adherence to ART, which then affects their quality of life and increases health complications (Nyblade et al., 2009:2; De Vries et al., 2009:11;Panos, 2006:21). Nyblade et al. (2009:3) further discuss this poor adherence, using the example of a study done in South Africa which found that some PLWHA prefer to cover up the use of ARVs by grinding the drugs into powder, and by not taking medication in front of others, with the result that they are inconsistent in their doses. To make matters worse, cases have been reported where health care practitioners themselves become a hindrance to PLWHA benefitting from their services. As was established in the section on the causes of HIV and AIDS stigma, this is mostly noticed when health workers are afraid of being infected with HIV (De Vries et al., 2009:11). This fear of contagion may bring about the mistreatment of PLWHA by health professionals, thereby causing these PLWHA to experience a lack of commitment to going on with their treatment (FHI, 2009:11).

HIV and AIDS stigma and discrimination have thus been widely identified as key barriers to the delivery of quality services by health workers and to the access of such facilities by the public (Mahendra et al., 2007:619; Nyblade et al., 2009:1). Nyblade et al. (2009:2) found in a study that in Indian hospitals, for example, stigma and discrimination were manifested in the fact that health workers broke confidentiality by informing family members of PLWHA about their status without their consent, and when PLWHA were discharged after being hospitalized, their bedding was burned, they were charged for the infection control supplies, and gloves were used whether there was physical contact or not. Similarly, a research study done by Mahendra et al. (2007:620) on *Understanding and measuring AIDS-related stigma in health care settings* revealed four ways in which health care practitioners manifested HIV stigma in hospital environments. These four ways included "testing patients for HIV without their consent, disclosing test results to relatives and other health care workers without the consent of patients, labelling of HIV-infected patients' belongings or files, and unwarranted use of precautions to prevent transmission". A study by Naidoo (2006:55) likewise points out four common barriers preventing doctors from helping PLWHA. Those barriers are fear of contagion, unwillingness to care, fear of losing patients who are not living with HIV and lack of adequate knowledge or training about how to treat PLWHA. Moreover, Nyblade et al.

(2009:3) found in a study done in South Africa and Botswana that health care workers were reluctant to help PLWHA as they struggled with fear of stigmatization by their colleagues at work. Furthermore, they themselves had not sought HIV testing and early treatment when they were in need of it.

According to Mlobeli (2007:3), this stigmatization in the health care sector is a reality in Khayelitsha, where a support group member was quoted as saying that a health care worker at a clinic took her file, and before calling her name, shouted in front of other patients that she was tired of these AIDS people and then asked, "What do you want us to do because you know that you've got AIDS so you are sick".

Still on the issue of difficulty in accessing health care services, it is worth mentioning the material and moral support which PLWHA need in order to survive the scourge of HIV and AIDS. Stigma and discrimination may, in fact, also be a barrier preventing PLWHA from benefitting from welfare services available for their use, thus causing infected people to lose social and economic support networks either from the government, their communities, or their own families (De Vries et al., 2009:11; Panos, 2006:21;FHI,2003:1).

As mentioned earlier, lack of information is one of the contributing factors to HIV and AIDS stigma. This factor can be countered by awareness campaigns in which information needed for prevention and HIV and AIDS management is disseminated. However, when stigma is present, "It hampers HIV-prevention and promotional efforts as people may not be willing to attend the educational programmes aimed at reducing the spread of HIV and AIDS" (De Vries et al., 2009:11).

In the discussion of gender imbalance as one of the causes of HIV and AIDS stigma, it was noted that women suffer more stigmatization than do men. Even regarding the issue of difficulty in accessing health care services, women are more affected than men. This is evident in the fact that, since women are often the first ones to know about their HIV positive status, they are the ones who mostly face stigma. A study done by De Paoli et al. (2010:21) revealed that "The blame for contracting HIV is apportioned to the first one to disclose in a relationship... The fact that many pregnant women are invited to participate in PMTCT (prevention of mother-to-child-transmission of HIV) programmes when going for antenatal care means that many women learn of their own status before their sexual partners learn of theirs". This situation forces women to bear the pressure of being the first ones to disclose their HIV status in the home and consequently face accusations of bringing the virus into the

home. Hence, after learning about their HIV positive status through antenatal care, women are reluctant to disclose it to their partners for fear of dire consequences. "Reasons for non-disclosure reported in various studies were fear of accusations of infidelity or being considered unfaithful, fear of divorce, fear of embarrassment, fear of being abandoned, fear of blame, fear of rejection, discrimination, verbal abuse and concerns about public ignorance of the disease" (Gari et al.; 2010:9; De Paoli et al., 2010:21).

In addition, women who test positive in the course of antenatal care are told not to breastfeed. This again becomes an issue because when they give birth, everyone in the community may expect them to breastfeed, so failure to do so would create the impression that the mother is HIV positive, and she is then stigmatized in the society. To avoid such stigmatization, as Kamaara (2006:48) and Maughan-Brown (2007:4) put it, some mothers insist on breastfeeding their children even when they have been advised not to. As a result, stigmatization puts babies in danger of becoming HIV positive, which would decrease their life expectancy.

In Khayelitsha, as has already been mentioned, it is reported that stigma is also a significant barrier hindering the accessing of healthcare facilities by PLWHA. In fact, the importance of AIDS stigma as a barrier to AIDS care and HIV prevention in Cape Town was confirmed in a formative research study done by Kalichman et al. on *The Development of a Brief Scale to Measure AIDS-Related Stigma in South Africa*. As Kalichman et al. (2005:137) put it,

> In a formative discussion with 24 community health workers in a large Cape Town township, we found that AIDS stigma was a serious concern for HIV and AIDS services and prevention. Health workers informed us that AIDS-related stigma is the most important reason why people in their community do not get tested for HIV. Specifically, fears of rejection and harm resulting from an HIV positive test result are a significant problem. Also, stigmatising beliefs serve to distance people from HIV and AIDS, supporting the idea that 'AIDS is something that only happens to other people.' AIDS related stigma was viewed as the most pressing social aspect of HIV and AIDS.

If this situation occurs in Khayelitsha where there are many health care facilities, then it is clear that HIV and AIDS stigma is really a serious issue to be dealt with in that area.

Finally, from the discussion in this section, it can be seen that discrimination against people living with HIV and AIDS unfortunately occurs in all societies and communities, and has become a significant obstacle to effective measures in combating the further spread of the pandemic. Discrimination makes the whole community – both those who discriminate and

those discriminated against— more vulnerable to the spread of HIV. In a situation of stigmatization, prejudice and gossip, both groups are less likely to accept the presence of HIV in the community and to co-operate in the prevention of factors which lead to increased vulnerability to HIV. Dealing with resistance and discrimination against people affected by HIV is thus an integral part of prevention.

2.2.3 Acceleration of Death for PLWHA

As noted in the previous sub-section, when PLWHA are reluctant to access health facilities because of fear of stigmatization, this can result in acceleration of the devastation of the virus in their bodies to the point of causing early death (Chavez, 2006:1). To be more specific, the HIV and AIDS disease places a burden upon a person, while its stigma adds to that burden to inflict suffering in such a way as to interfere with any attempt to fight the HIV and AIDS epidemic (Visser, 2007:2).

Another aspect of HIV and AIDS-related stigma is that it weakens the person to such an extent that he or she feels that life is no longer worth living. This may also push the person to consider suicide as an escape from the world of suffering where nobody seems to care. It has been found that suicide is a common reaction among people living with HIV, especially when they learn about their HIV status; they lose hope as they face uncertainty, and they become stressed and afraid of the terrible suffering HIV may bring. Suicide is also considered when HIV has developed into AIDS and people prefer to die in order to escape the pain which they are going through (Schlebusch, 2008:2). To further illustrate this point, Chavez (2006:3) reports:

People stigmatized with HIV and AIDS could experience severe psychological damage. Often these persons experience many negative emotions such as fear, depression, hostility, and anxiety. Being isolated or rejected by other people is a very difficult experience for PLWHA, and this rejection intensifies their feelings of loneliness and alienation. Sometimes PLWHA also feel anger when they experience other peoples' ignorance about their medical condition. Stigma could also build up "inside" PLWHA to the point that some people interiorize stigma, and start feeling 'contaminated' or worthless. In some cases, stigma has intensified the stress of PLWHA to the point that it may have led them to commit suicide.

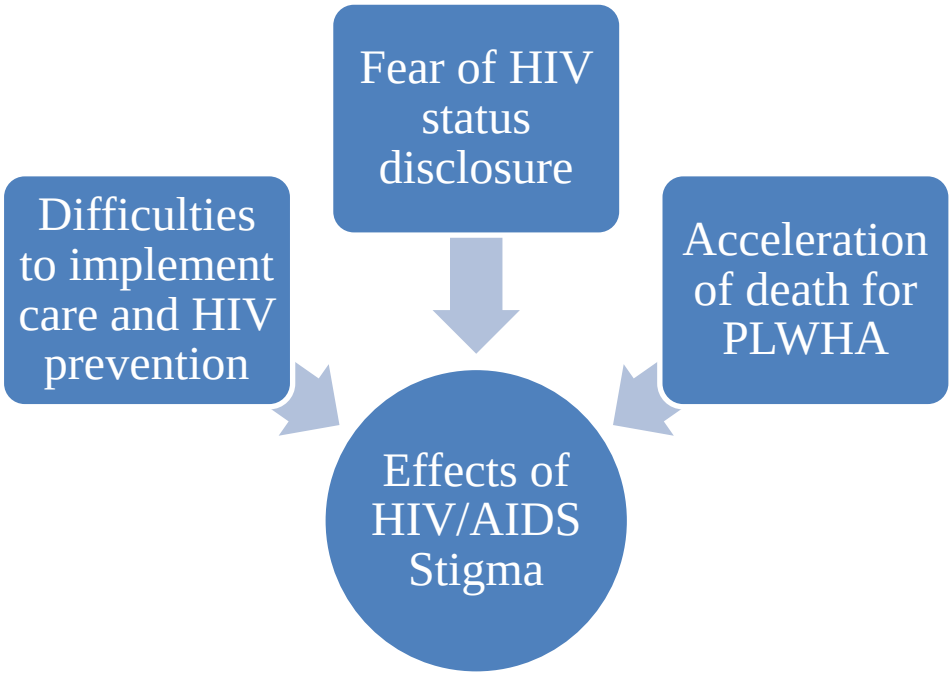
Similarly, due to stigma, an infected person can be so isolated from society that he/she may end up feeling devalued and neglected, and suffer emotionally to the extent of losing the desire to live. Such self-stigma results in low quality of life, depression, anxiety, social

withdrawal and even suicide, even to the point of feeling that it is not worth taking medication (Maughan-Brown, 2007:3), which is another form of suicide that PLWHA may use to speed up the dying process and escape from the burden of social stigma. It also happens that PLWHA stop their ART for fear of being stigmatized, thereby undermining the effectiveness of HAART (Maughan-Brown, 2007:15).

Social isolation is a serious issue for PLWHA. According to Kamaara (2004:46), the main cause of a miserable, early death is depression characterized by loss of self-love, self-value and dignity, resulting in feelings of rejection, self-hate, regret, blame and bitterness. The impact of these feelings is that the person's physical, psychological, emotional and spiritual health becomes jeopardized, and in that instance, the person's chance of survival is limited. Early death that is caused by the social neglect of PLWHA is unnecessary and can be prevented by the community through acceptance and care for the people who are infected. In Khayelitsha, qualitative research amongst HIV positive people supports the notion that non-disclosure may result from the fear of stigmatising behaviour, which causes PLWHA to avoid accessing medication, therefore dying early as there is no way to make sure that they are treated (Maughan-Brown 2007:15).

In this regard, the kind of stigma which can be referred to as 'self-stigma' or 'internal stigma' makes PLWHA feel worthless, and imposes an emotional burden on them to the point where they feel that life is no longer worth living. Internal stigma influences a person's perception of him/herself and his/her beliefs about how the public perceives him/her. This may make PLWHA impose stigmatizing beliefs and actions on themselves to the point of forcing themselves to be silent about their status, which on its own is burdensome and can accelerate their death (De Vries et al., 2009:11; Zaccagnini, 2010:24).

Furthermore, in Africa, where group or community life is meaningful, the stigma and discrimination directed towards PLWHA become even more dangerous because they cause PLWHA to live in total isolation. As Louw (2008:154) observes, "The African paradigm is … about life and human events of interconnectedness and relatedness. Life never stands on its own but is embedded in the dialectics between life events and death". In such a setting, when PLWHA are discriminated against, it means that they now have to be on their own after depending for their whole lives on the community. Consequently, they become progressively weaker, and die sooner, because they were not prepared to face a lonely life while living with the disease. The following diagram summarises the consequences of HIV and AIDS stigma.



(Diagram 2.7: Effects of HIV and AIDS Stigma)

2.3 Conclusion

In conclusion, this chapter has described several causes and consequences of HIV and AIDS stigma. As far as the causes of stigma are concerned, this chapter has discussed the notion that fear of HIV and AIDS is one root of stigma in the sense that people are afraid to associate with PLWHA because HIV and AIDS is a dangerous, infectious and incurable disease. With regard to lack of information about HIV and AIDS transmission being another cause of stigma, people may be well-informed about HIV and AIDS, but fail to put theory into practice due to their cultural beliefs about sex and disease. In addition, silence about HIV and AIDS is a cause of HIV and AIDS stigma in that the disease is connected to issues such as sex which are not usually spoken about, being regarded as taboo in many communities. The link between HIV, sex, and sexual morality is also a significant cause of HIV and AIDS stigma; the fact that HIV is mainly transmitted through sexual intercourse becomes grounds for implying that PLWHA are sinners who get what they deserve. With regard to poverty, resources may be so scarce that PLWHA cannot get enough to support them. Another aspect of HIV and AIDS causing stigma is that PLWHA are subjected to gossip and insults because HIV and AIDS is viewed as a shameful disease for one to have. As for gender imbalance, women face more stigma than men because of the patriarchal system that gives too much power to men. In addition, biological factors add to the burden of stigma which women face

because they are more vulnerable to the virus than men, and in cases of pregnancy, they are forced to disclose their HIV status during prenatal care.

The chapter also points out further causes and effects of HIV and AIDS stigma. Very often, stigma results in the fear of HIV and AIDS status disclosure, thus hampering any initiative to implement care and prevention programmes. Moreover, stigma is a major factor responsible for the acceleration of death for PLWHA. It is very important for this research study to examine these causes and effects of HIV and AIDS stigma before exploring ways of engaging in any battle against it. In addition, it is one of the aims of this research study to understand the causes and effects of HIV and AIDS-related stigma in order to be able to work out a pastoral approach for church leaders in addressing HIV and AIDS stigma in Khayelitsha. According to the research methodology of this research study, an understanding of the causes and effects of HIV and AIDS stigma serves as the second step of research in Practical Theology, consisting of interpreting the world as it is through understanding the causes and consequences of HIV and AIDS stigma. As the research study continues with the process of putting together the information needed to come up with a pastoral approach for addressing HIV and AIDS in Khayelitsha, the next chapter discusses the biblical and theological reflection of HIV and AIDS stigma.

CHAPTER THREE

BIBLICAL AND THEOLOGICAL REFLECTION ON HIV AND AIDS STIGMA

3.0 Introduction

The second chapter of this research study discussed various causes and consequences of HIV and AIDS stigma. The third chapter concentrates on providing a biblical and theological reflection on HIV and AIDS stigma. This chapter seeks to follow the third step of Practical Theological research methodology adopted for this research study by interpreting the world as it should be through a study of passages of scripture in order to suggest a theology useful for dealing with HIV and AIDS stigma. Since this research study uses literature as its only source of information, the methodology used to interpret Scripture in this chapter is also that of identifying passages from the Old and New Testaments that are relevant to disease and stigma, studying them with the help of commentaries written by Bible scholars on those passages, and applying them to the situation of HIV and AIDS stigma. In this process, this chapter discusses disease-related stigma according to the Bible, as well as a theology of judgement in times of HIV and AIDS stigma, and how God has already dealt with sin.

3.1 The Bible and Disease-Related Stigma

In constructing an approach usefulfor a pastor to be able to lead a church to combat HIV and AIDS stigma successfully, it is helpful to reflect on the theology surrounding stigma in the Bible. Apparently, there is no mention of HIV and AIDS in the Bible, but the biblical disease often associated with modern HIV and AIDS is *leprosy*, the most feared disease of biblical times (Alberts, 1990:200; Louw, 2008:427).

In biblical times, leprosy was feared in the same way as HIV and AIDS is today as far as the danger of transmission was concerned. Thus, just as people with leprosy were stigmatised and isolated in biblical times, so PLWHA can be stigmatised today. Concerning the comparison of leprosy and HIV and AIDS, Alberts (1990:201) suggests, “It also appears that the fear of AIDS today is similar to the fear of leprosy felt by those living in Jesus’ day. Just as leprosy deadens the sensations of the nerves, so the fear of AIDS has deadened the sensitivity of the heart, creating an unfeeling numbness toward those with AIDS. Like the masses of people in the time of Christ, many today desire to separate AIDS victims as far away as possible, placing them in ‘colonies’ to suffer with others of like ‘sin’”. This quote

makes it clear that the two diseases (leprosy and AIDS) are both dangerous, and people suffering from those diseases are sometimes avoided because it is feared that they carry infectious diseases as a result of sin.

It would be useful at this juncture to gain a biblical understanding of leprosy. There are two types of leprosy, namely the *lepromatous type* that begins with brownish-red spots on the face, ears, forearms, thighs and buttocks, and the *tuberculoid type* characterised by numbness of an affected area of skin and deformity such as fingers like claws resulting from paralysis and atrophy (Tenney, 1963:218). The biblical condition known as leprosy suits the description of the *lepromatous type*, indicating that leprosy was a general description of various skin conditions that characterised infectious diseases and should not to be confused with today's type of leprosy, the Hansen's disease, with symptoms similar to those of the *tuberculoid type* (Sakenfeld, 2008:636; Freedman, 2000:801; Achtemeier, 1996:600; Lindsey, 2000:192).

In biblical times, leprosy was regarded as a disease of uncleanness. In Old Testament (OT) times, a person with leprosy was declared 'ceremonially unclean' (Lev. 13:2, 8, 11, 44), and put 'in isolation' by the priest after a thorough examination of primary symptoms (Lev. 13:3-8). Consequently, due to the aspect of uncleanness associated with leprosy, a person suffering from the disease was not allowed to serve in the priesthood, as indicated in this verse: "If a descendant of Aaron has an infectious skin disease or a bodily discharge, he may not eat the sacred offerings until he is cleansed" (Lev. 22:4). This verse makes it clear that ceremonial uncleanness was so severe that it prevented a priest from either offering or eating a sacred offering, and disqualified him from appearing in God's presence (Lindsey, 2000:204). This reality is similar to what this research study has shown about relieving PLWHA from the duties and responsibilities they hold in churches and communities.

In addition, disease in the OT was also associated with sin, just as today HIV and AIDS is held to be related to sin. When Job lost all that he had and got sick, his three friends came to see him (Job 2:11-13), and one of them, Eliphaz the Temanite, accused him of having sinned and having thus brought all his problems on himself (Job 4:7-8). Considering the statement of Eliphaz the Temanite, "It is worth reflecting on the theological position that people or individuals reap what they sow. This idea is crucial to our understanding of the dispute that flares up between Job and his friends and to the doctrine of rewards and punishments that is encountered throughout the Scriptures" (Habtu, 2006:575). The concept of rewarding good

and punishing evil is common in a moral universe with a moral order where retribution is expected and where theology is to be replaced with simplistic logic (MacArthur, 1997:701). Moreover, in his article on *Elihu's Theology and his view of suffering,* Waters(1999:149) refers to the idea that the theology of retribution was popular in the OT, a belief which was influenced by the fact that most ancient peoples believed that God (or the gods) had the ultimate sovereignty to intervene in human history to reward the good and punish the wicked.It can thus be seen that the notion of reaping what one has sown is a reality that cannot be ignored; in fact, Paul warned the Galatians that "A man reaps what he sows" (Gal. 6:7). As MacArthur (1997:1799) observes, this is an agricultural principle applied metaphorically to the moral and spiritual realm which is universally true.

However, what happens in everyday life shows that the principle of sowing and reaping is not always applicable, due to the fact that the innocent often suffer while the wicked have no problems (Zuck, 2000:725; Waters, 1999:147). In Job's case, for example, it was not true to say that he suffered as a result of reaping what he had sown, because he was known and declared by God to be a blameless and upright man who feared God and shunned evil (Job 1:1). The characteristics of Job's life are described by Habtu (2006:572) in the following way: "Blameless implies that he was a man of integrity; upright implies that he was completely fair and honest in his dealings; that he feared God implies that he was committed to obeying the will of God above all else; while the fact that he shunned evil showed he took trouble to avoid anything which God would disapprove". Looking at all these characteristics of Job as a man approved of by God, it is fair to say that if suffering was necessarily connected to being wicked, Job had every good reason for not suffering. From this viewpoint, one can agree with Campbell (2010: 154,159) in his article on *God and Suffering* where he suggests that because human suffering obviously comes to people regardless of their righteousness or wickedness, it is better to move from the *moral context* which holds that human suffering depends on moral behaviour to the *amoral context* where the reality of human success or failure, joy or sorrow, 'just happens' to anyone, without being associated with the moral quality of human living, or with goodness or badness.

As it has been mentioned above, communicable diseases such as leprosy were stigmatized in the OT. For example, according to Lev. 13:40-46,

> When a man has lost his hair and is bald, he is clean. If he has lost hair from the front of his scalp and has a bald forehead, he is clean. But if he has a reddish-white sore on his bald head or forehead, it is an infectious disease breaking out on his head or forehead. The priest is to examine him, and if the swollen sore on his head or forehead is reddish-white like an infectious skin disease, the man is diseased and is unclean. The priest shall pronounce him unclean because of the sore on his head. The person with such an infectious disease must wear torn clothes, let his hair be unkempt, cover the lower part of his face and cry out, 'Unclean! Unclean!' As long as he has the infection he remains unclean. He must live alone; he must live outside the camp.

This passage indicates that people found to be suffering from infectious diseases were not supposed to be with others. The priest was given power to examine (diagnose) the sick person and determine whether he or she was clean or unclean, and then either isolate the person or allow him or her space in the camp. The isolation of the suffering person was primarily used to separate the unclean from the holy camp where God dwelt, which means it was useful in protecting religious and public worship, even though it also served to prevent contagion of the public (Carson et al., 1994:140; Lindsey, 2000:193; Buttrick, 1981:66). Furthermore, the uncleanness of the person considered as a leper was not taken as a personal sin, even though in the OT concept disease was associated with sin. Together with other kinds of plagues, diseases were generally taken as part of the consequences of God's judgment on His people for unfaithfully breaking the covenant, and exceptional cases were reported where God used diseases to punish individuals. The isolation of the person suffering from infectious skin diseases was thus not based on sin but on ceremonial uncleanness, since individuals with other kinds of diseases were not quarantined. Hence, it is not biblical to make homiletic use of leprosy as a type for sin (Gehman, Undated: 556; Carson et al., 1994:140).

If the admonitions in Lev. 13 were to be applied to the context of HIV and AIDS, it would imply that PLWHA today should be quarantined. However, it would be unwise to literally apply that text to HIV and AIDS without looking at the New Testament (NT) example of dealing with transmissible diseases. In the NT narratives, although the attitude towards people with leprosy and other physical defects was still characterised by discrimination and isolation, when Jesus came, He accepted them and healed them. In Mark 1:40-42 for example, "A man with leprosy came to him and begged him on his knees, 'If you are willing, you can make me clean.' Filled with compassion, Jesus reached out his hand and touched the man. 'I am willing', he said. 'Be clean!' Immediately the leprosy left him and he was cured". This passage is different from Lev. 13:40-46 in the sense that here, people who are diseased are free to come to Jesus and beg Him for healing. In His response, Jesus neither declares the

man *unclean* (the man is, in any case, already aware of his uncleanness), nor isolates him, but is willing to make him *clean with* immediate effect (Cole, 2006:1175).

The Greek word *lepra* used in Mark 1:40 for *leprosy* is the same as the Hebrew word *tsara'ath* used in Lev. 13-14 (Sakenfeld, 2008:635), and they both indicate a set of skin diseases as well as leprosy itself. In fact, both of the conditions cut the sufferer off from association with other community members, since lepers were held as ceremonially unclean. Actually, the attitude of the community towards lepers then was almost exactly the same as that towards PLWHA today, a combination of terror and hatred. Just as some people may view HIV and AIDS today, leprosy was often regarded as God's punishment for sin, so it took a bold move by the leper to approach Jesus for healing. Having faith that Jesus was able to heal him, he still came humbly to Him to beg for His willingness to heal him (Cole, 2006:1175; Grassmick, 2000:111; Carson et al., 1994:953). According to the rabbinic rule, since a leper was unclean, he was untouchable, and there seemed to be no hope for him to be healed in any other way than coming to Jesus. Consequently, by touching the leper, Jesus risked both infection and ceremonial uncleanness which could result in isolation, but His compassion was so amazing that He touched the untouchable and healed the incurable (Grassmick, 2000:111; Carson et al., 1994:953).

Reflection on the two passages reveals that there are two models in responding to HIV and AIDS: the OT isolation model and the NT acceptance model. Louw (2008:427) suggests a shift from the OT isolation model to the NT model of compassionate acceptance. As a matter of fact, while the OT way of dealing with people suffering from infectious and dangerous diseases was to expel them from the community, it is obvious that in the NT, with the coming of Jesus, such patients were embraced with love and care, as Jesus was willing to approach them, touch them, and heal them. Church leaders today need to learn from the kindness and compassion of Jesus in order to accept PLWHA. In order to explore a means of helping church leaders to understand that they need to accept PLWHA, the following section discusses a theology of judgement in times of HIV and AIDS stigma.

3.2 A Theology of Judgement in Times of HIV and AIDS Stigma

As has been mentioned from the beginning of this research study, HIV and AIDS create a lot of issues that contribute to the spread of the disease and hinder any effort to fight against the disease. Among such issues, stigma is known to be the most devastating and powerful obstruction to successful prevention, management and care for PLWHA (UNAIDS 2005:9).

In the midst of the HIV and AIDS crisis, just as in any other crisis in the community, church leaders, who are expected to intervene in the lives of those who are suffering, have a significant role to play. This is due to the fact that in the fight against HIV and AIDS, perhaps more than in any other challenge of our day, church leaders and other faith group leaders "have an irreplaceable role to play — through their moral leadership, community education and service, and capacity to reach into the hearts and huts of even the most remote communities" (Church World Service, 2003:3).

It can be further noted that while church leaders are expected to take action in relieving HIV and AIDS stigma, they cannot escape from their responsibility, no matter how hard they may try to do so. This can be explained by the fact that,

> No matter how lamely church leaders may be handling HIV and AIDS; they are nonetheless at the very epicentre of the storm. As one of the few institutions that have direct connection with families and individuals, and being, by conviction, aspiring to be a caring community, the Church is often obliged to visit the sick, counsel people living with and affected by HIV and AIDS, bury the dead, run orphans' projects, hospices and home-based care etc. (UNAIDS, 2005:57).

For that reason, church leaders need to stand up and take action in order to alleviate stigma caused by HIV and AIDS, if they are going to do anything about the disease. However, as Chitando (2007:21) posits, theological rigidity feeds HIV and AIDS stigma, and "stigma continues to hinder the Church efforts to counter HIV and AIDS. This has been worsened by theological rigidity". Therefore, due to this theological rigidity, as mentioned previously, church leaders have sometimes been judgmental towards PLWHA, holding the view that HIV and AIDS is a punishment from God for promiscuity. It has also been noted that the judgmental attitude of the Church has nurtured stigma in the lives of PLWHA. For this reason, it would be difficult for church leaders to implement action against HIV and AIDS stigma without revisiting the theology of judgement in times of HIV and AIDS in order to adopt an inclusive culture for PLWHA in their churches. This section therefore discusses the theological notions that support the idea that HIV and AIDS is acquired as a result of God's punishment for sexual sin.

3.2.1 God Portrayed as a Judge

Looking at a God portrayed as a judge, the stigmatization of PLWHA is boosted by the fact that the HIV and AIDS pandemic is depicted as God's punishment for sexual immorality. In her article on *HIV and AIDS and Church mission in Africa*, Isabel Apawo Phiri (2004:424) emphasises that due to the sexual transmission of HIV, the concept of HIV and AIDS being

God's punishment has dominated the theological stance of the African church leaders since the discovery of that disease. This has discouraged church leaders from getting involved with ministry for PLWHA because they did not want to reach out to people whom God was supposedly punishing for their sin.

Such an approach is to be addressed and altered in the light of God's unconditional love if Christians are to fulfil their duties of care and compassion. As the WCC (1997: 28-29) points out, "The terminology of punishment should be rejected in favour of an understanding of God in an omnipresent, constant, loving relationship, no matter how much some of the actions of every one of us may grieve God. A moralistic approach can easily distort life within the Christian community, hampering the sharing of information and open discussion which are so important in facing the reality of HIV and AIDS and in inhibiting its spread".

In addition, the way the Bible is sometimes interpreted in the Church has encouraged the stigmatisation of PLWHA (UNAIDS, 2005:10). In this way, the Church has taken over God's role of judgment, forgetting that any kind of judgment against another person can count against oneself (Mash et al., 2009:24). With regard to this, it can be understood that stigmatisation is even more sinful than what the other person is accused of, because in judging others, one brings judgement on him/herself. In Matt. 7:1-2 Jesus commands, "Do not judge, or you too will be judged. For in the same way as you judge others, you will be judged, and with the measure you use, it will be measured to you". In this passage, the term 'judge' is used in the sense of 'condemn' (France, 1994:142). Furthermore, Jesus emphasised that a sinful person cannot judge his fellow sinner since they both have shortcomings, having in mind that the Pharisees did not accept Him. They judged Him as inadequate because He did not lead the kind of righteous life they expected from Him, so he warned His disciples against such a hypocritical judgment (Barbieri, Jr., 2000:33). In actual fact, only God, who is sinless and faultless, is allowed to execute judgment (Kapolyo, 2006:1124). This implies that whenever one feels that another person has not done enough to deserve appreciation, one should be careful not to be judgmental because there might also be areas in which one could be negatively judged.

To better illustrate this point, Jesus told the parable of the Pharisee and the tax collector (Luke 18:9-14). Interestingly, the intended recipients of this parable were those "who were confident of their own righteousness and looked down on everybody else" (v9). This was simply to illustrate that one should not be so confident in himself to the point of despising

others (Martin, 2000: 250). In the parable, Jesus talked about two men who went up to the temple to pray, one being a Pharisee and the other a tax collector (v10). In his prayer, the Pharisee stood up and prayed about himself, thanking God that he was not like other men such as robbers, evildoers, or adulterers, or even like the tax collector he had gone up to the temple with (v11). In other words, he compared himself with other people, not only boasting about being a good man himself, but also congratulating himself for observing the law of fasting and tithing, using other people as his standard for measuring uprightness (Martin, 2000:250). He boasted of fasting twice a week and regular payment of a tithe (v12). However, the tax collector, standing at a distance, was too humble even to look up to heaven. He instead beat his breast saying, 'God, Have mercy on me, a sinner' (v13). In his prayer, the tax collector prayed about God, making Him his standard for measuring his uprightness and realising that being a sinner, he only had to let himself fall into God's merciful hands for the forgiveness of his sins (Martin, 2000:250). Jesus' conclusion to the parable was that the tax collector was the one who went home justified because anyone who exalts himself will be humbled and he who humbles himself will be exalted (v14). This story raises the matter of unrighteousness and righteousness. While people easily identify themselves with the tax collector who was willing to admit his sins before God, their actions often show the pharisaic character who commended himself for his outstanding spirituality and religious dedication (Isaak, 2006:1239). In fact, the big difference between these two prayers is that the Pharisee prayed 'to himself' whereas the tax collector prayed to God. Praying to oneself thus results in being humbled, while praying to God brings God-given exaltation. As a public worshipper, the Pharisee thought he was better than the tax collector who was a public sinner, but he found himself on the wrong side because of self-exaltation and criticising others. Using these verses (9-14) from Luke 18, Craddock (1990:210) shows the theological parabolic form presented in such a way that the central doctrine of God's justification of sinners goes with the ultimate failure of self-righteousness.

In fact, the sinful attitudes most frequently identified by Jesus as being incompatible with His Kingdom were pride, self-righteousness, exclusivity, hypocrisy and the misuse of power, all of them ingredients in the deadly cocktail that causes stigma (UNAIDS, 2005:13).For that reason, it is helpful to realise that when passing judgement on PLWHA, one brings judgement onto him/herself, and that the sin which PLWHA are thought to have committed in order to get HIV is no greater than that committed by those who stigmatise them.

The misunderstanding of God and misinterpretation of the Bible can be used to challenge church leaders to lead their churches to revisit their theology of judgement. If members of the Church agree that man was created by God in His image, they should also realize that any form of stigmatisation directed at man is even more sinful than most of the so-called 'misdeeds' on which HIV infection is often blamed, because it undermines God's image. Such stigmatisation is in fact not directed at one's neighbour but at God Himself, whose image is being undermined through the stigmatisation of His people (UNAIDS, 2005:12). Even if the person has acquired the HIV virus in a sinful way, it is not for human beings to pass judgement. God is still sovereign and His place as a judge should not be taken by sinful human beings. In this regard, Marshall (2005:137) contends, "The on-going unwillingness of humanity to recognise God's right to define human behaviour limits our ability to deal effectively with what is essentially a preventable disease. At the same time we must not attribute sinful behaviour to the person with HIV. The stigmatisation and discrimination which accompany HIV and AIDS are sinful in that they usurp God's role of Judge".

In addition, when a God-image is used to paint a picture of a God who is only there to punish, it supports the idea that HIV and AIDS is a 'sinner's disease' and robs PLWHA of their worth, implying that they have to be disqualified by God and discarded by the Church (Louw, 2006:102). It can thus be said that this view of God does not help PLWHA, apart from increasing the agony already imposed on them by the virus. In order to be helpful in dealing with the challenge of HIV and AIDS stigma, church leaders will have to lead their churches to change the view of a punishing God by looking at other God-images that make the acceptance of PLWHA easier. On this point, Louw (2006:102-103) suggests two paradigms for looking at a God who is concerned with caring for His people rather than just being there to lift a rod of punishment upon them: the *creational paradigm* and the *theopaschitic paradigm.*

About the *creational paradigm,* Louw (2006:102), emphasising God's providence, argues that God is seen as a *relational creator* who accepts His creation and is involved in its life. In this way, God is not only present when His creation is peaceful, but He continues to be with it even in times of trouble. This idea goes hand in hand with that of the *process model,* in which the process theologians depict a compassionate God who is in solidarity with His creation, sustaining and striving for it instead of standing against it (Kommonchack et al., 1988:255). While talking about the relationship between God and His creation, it is also very important to avoid pantheism and dualism, which exaggerate the matter by going as far as equating God

with what He created. Instead, it is essential to note that God, in His transcendence, is different from creation and, in His immanence, is present in His creation (Dyrness & Karkkainen, 2008:212). On the other hand, the *creational paradigm* completely disagrees with the secularisation of the nineteenth century that sees a dead God who is no longer involved with His people. They do not need Him any longer because they can sustain themselves through science and technology (Dyrness & Karkkainen, 2008:226-227).

Belief in the fact that God is present even in the suffering of His people will help church leaders to see PLWHA as God's valued creation in whom He delights, and who are thus worthy of acceptance instead of rejection (Louw, 2006:102).

As for the *theopaschitic paradigm*, Louw (2006:103) advances the idea that God is seen as the compassionate and suffering one. This denotes the notion of a God who is with His people wherever they are, hence the theology of incarnation.

The word *incarnation*, which means "to enter into or become flesh", is a Christian doctrine according to which Jesus pre-existed as God the Son before becoming man, without ceasing to be God. There is no appearance of the term itself in the Bible, but the doctrine emanated from some biblical accounts (e.g. John 1:1-3, 14) (Elwell, 2001:600; Achtemeier, 1966:452). In addition, the fact that Jesus became flesh presents Him as the living Word, the *Logos*, which was depicted in the Hebrew Scriptures as "the medium of God's creative involvement with the universe" (Kommonchack et al., 1988:535).

For people tormented by the HIV virus, the *theopaschitic paradigm* is certainly most supportive in that it makes them feel the presence of One who cares. Stated another way, those two paradigms are in line with two other models of dealing with people, namely the *kerygmatic model* which consists of proclamation of the gospel for salvation, and the *empirical model* which goes with experience (Louw, 1998:25-27). These two models will be discussed in more detail in Section 3.2.2.1 in an argument about PLWHA being created in God's image. Adopting these two paradigms is very helpful in that it encourages church leaders to create an environment of care and compassion for PLWHA, but it does not mean that the idea of God's punishment is ignored. In fact, God's punishment of sin is still to be taken into account, since ignoring it would be the same as ignoring man's sinfulness and God's grace. Indeed, one cannot escape the fact that there are certain instances where HIV is, in fact, contracted through irresponsible behaviour. As Louw (2006:103) points out, "Within creation and incarnation the reality of suffering and the vulnerability of our being human

cannot be ignored. It is indeed true that in some cases HIV is related to irresponsible and sinful behaviour. One can understand that the notion of punishment cannot be ignored as if it is totally irrelevant. Grace, as revealed in the cross of Christ, can never ignore, in a theological approach, the reality of sin. The cross is indeed about punishment and sin".

Therefore, in view of a God who punishes sin, it can be very helpful to look at scripture and theology to find adequate reflection about sickness, sin, and God's punishment.

First of all, the Bible makes it clear that God punishes sin. For example, after Adam had sinned, he was banished from the Garden of Eden to work the ground from which he had been taken (Gen. 3:23). According to Mathews (1996:156), while he enjoyed looking after a specially prepared habitat, Adam's eviction also meant that in order to sustain his life, he had to work hard to make a garden by tilling the ground that was under God's curse. This indicates that God's punishment for sin is inescapable. Arguing from a general theological perspective, Rae (2006:152) sees a generic connection between the entrance of sin into the world and the advent of death, decay, and disease. According to him, in Gen. 1–3, death is introduced as one of the consequences of sin, and with that, some of the primary means by which death occurs, namely disease. As a result of the entrance of sin, death and illness have become a normal part of human experience, though the Biblical account seems to make it clear that that is not the way it was supposed to be according to God's original design. Since man is a sinful being by nature, his failure to live up to God's righteous standards means that "condemnation hangs over his head like a sword of Damocles" (Elwell, 2001:638). In fact, God's punishment indicates that "the wages of sin is death" (Rom. 6:23). This means that obedience to the impulses of sin makes one reap death for himself as a reward, and eternal separation from God who alone gives life (Mounce, 1995:159). This verse, however, as will be discussed later, must not be used as a tool to stigmatise PLWHA by saying that they got what they deserve.

3.2.1.1 The God who Punishes Sin

In His character as a holy being, God hates sin and punishes it. As Lindsey (2000:201) and Marshall (2005:133) observe, this statement brings ethics and theology together in that human morality must absolutely depend on the unchanging nature of God (as a holy God) so that every biblical statement about God comes with a demand that men imitate Him in their everyday living. In punishing sin, God uses various means, including diseases. Moses warned the children of Israel that as a result of disobedience to God's commandments, "The

Lord will plague you with diseases until he has destroyed you from the land you are entering to possess. The Lord will strike you with wasting disease, with fever and inflammation, with scorching heat and drought, with blight and mildew, which will plague you until you perish" (Deut. 28:21-22). The diseases to which this passage refers are physical, and they would devastate the land and the people from time to time. Being also wasting diseases, they would be inflammatory and consuming, producing "a malady of the body matched by the scorching heat of drought" (Merrill, 1994:358-359). This punishment presented in a form of disease shows that "From earliest times, God has permitted sickness to be a judgment on sin. God sometimes uses physical infirmity as an instrument to punish sin and to chasten His children" (Martin, 2011:2). It is clear that in His endeavour to protect His holiness, God punishes sin and any other form of disobeying His commands. On this point, Schipper (2009:22) compares Deut. 24:5 and 1 Kings 15:23b. In Deut. 24:5, it is mentioned that a newly married man should not go to battle or get involved in the service of the country, but should stay home and make his wife happy. 1Kings 15:23b tells how King Asa was punished by God with a foot disease for violating God's command, given in Deut. 24:5, by undertaking building projects in his country which involved everyone, whether they were newly married or not.

Furthermore, the diseases mentioned in Deut. 28:21-22 were not the only ones inflicted on disobedient Israelites; towards the end of the chapter, the warning goes further to mention that "The LORD will also bring on you every kind of sickness and disaster not recorded in this Book of the Law, until you are destroyed" (v61). This meant that the Lord's punishment would be more severe, to the point of including diseases that the Israelites had not heard of in the Book of the Law which they had disobeyed. Henceforth, the diseases would be of two kinds, namely those they were already aware of, and those they had never even heard of, since they were not mentioned in the book of Deuteronomy (i.e. the *Book of the Law*).

Possibly, the diseases unknown to the Israelites might have been those the Lord had used to punish the Egyptians in the form of plagues (Exodus 15:26), even though the Lord reminded the Israelites about the plagues that afflicted the Egyptians and vowed that He would not punish them that way (MacArthur, 1997:118). In any case, these afflictions are still to be seen as literal even though the OT does not clearly state the contribution of the Egyptians plagues to Israel's demise.

It would also be fair to keep in mind the spiritual nature of the diseases which afflicted the nation of Israel as a way of describing their pain as people of the judgment (Merrill, 1994:370). Actually, if Deut. 28:21-22 is read with HIV and AIDS in mind, it can be assumed that HIV and AIDS is among the diseases not mentioned in the Book of the Law since there is no mention of it anywhere in Scripture. The danger of this assumption, however, would be that since HIV and AIDS is not mentioned in the Bible, it was inflicted as God's punishment when people became more and more promiscuous.

Furthermore, it is said in the NT that "whoever eats the bread or drinks the cup of the Lord in an unworthy manner will be guilty of sinning against the body and blood of the Lord" (1Cor. 11:27); and "That is why many among you are weak and sick, and a number of you have fallen asleep" (v.30). Clearly, judgement has been carried out already since some of the people who partake of Holy Communion in an unworthy manner "are spiritually weak because of their actions, others are suffering illness and some have been removed by death. This points to the enormous importance which God attaches to His Church and reflects the same activity in the OT on his part in judging and removing those who disregard their commitment to the unity and the needs of the believing community" (Carson et al., 1994:1179-1180). In addition, partaking in Holy Communion in an "unworthy manner" involves taking communion as a mere ritual, or taking it indifferently and with an unrepentant heart full of bitterness against fellow believers. Therefore, clinging to sin will be dishonouring both the communion and the Lord's body and blood, discrediting His sacrifice for us; hence the need to examine oneself before coming to the communion table or else facing the punishment that ends in death due to the fact that, instead of taking communion seriously, they use it for the purpose of feasting and creating factions which result in guilt of the blood of the Lord that is supposed to be washing them (MacArthur, 1997:1746).

After Jesus had healed the man who was an invalid for thirty eight years at the pool of Bethesda, upon finding him at the temple, he told him, "See, you are well again. Stop sinning or something worse may happen to you" (John 5:14). Though this implies that something bad comes from sin, the author of this research study does not agree with the idea that the man's disease was definitely the consequence of sin, since Jesus did not accuse him of committing any sin. Instead, this verse is more about the way Jesus dealt with both spiritual and physical healing. As Blum (2000: 290) observes, Jesus did not warn the man by implying that his previous paralysis would return if he sinned again, because Jesus was more interested in healing the soul. That is why after Jesus had healed the lame man of his physical lameness,

He gave him a warning because He saw that the man also needed spiritual healing. After all, it was Jesus' habit to heal both physically and spiritually as can be seen in Mark 2:5, in the healing of a paralytic.

On the other hand, this is not to deny the possibility that the man was lame due to sin, otherwise it would be refuting the sinfulness of human beings. However, this research study agrees with the idea that whether Jesus' words suggest that the man was ill as a result of a specific sin does not matter. Even if it was so, this does not imply that all physical illness is a result of moral causes. Nonetheless, it is possible that Jesus was warning the man about a moral lameness that could be worse than the physical lameness he had been delivered from (Carson et al., 1994:1036; MacArthur, 1997:1586).

From the passages of scripture discussed above, it is clear that sickness can possibly be seen as a sign of God's punishment for sin. This could also be the origin of the assumption that HIV and AIDS is God's punishment for sexual sin. However, it would be misleading to consider that assumption since in the Bible there were other situations where sickness was not a tool of God's punishment for sin. For example, as was observed earlier, when "Satan went out from the presence of the LORD and afflicted Job with painful sores from the soles of his feet to the top of his head" (Job 2:7), it was not because Job had sinned; as he was known to be "blameless and upright", fearing God and shunning evil (Job 1:1). The same situation is found in the example of Paul who states, "There was given me a thorn in my flesh, a messenger of Satan, to torment me" (1Cor. 12:7). In both cases, Satan was the agent that brought illness, but God was identified as the one who allowed it. For that reason, Carson et al. (1994:1204) rightly suggest that it is important to be aware that in both the OT and NT Satan has no power other than that permitted him by God, and that even his evil plans are meant to serve God's purposes in manifesting His glory.

In addition, when Jesus came across a man born blind, His disciples' concern was whether the blindness was the result of the sin of either the man's parents or his own, but Jesus assured them, "Neither this man nor his parents sinned, but this happened so that the work of God might be displayed in his life" (John 9:3). Jesus' answer did not focus on sin, but on God's glory. It was difficult to believe that suffering could be used for the glory of God, even though it is inherent in the Christian approach to the problem (Carson et al., 1994:1045). The fact that Jesus here mentioned that blindness was not the result of sin is contrary to His statement in John 5:14 where He told the person healed of lameness to go and stop sinning. In

contrast to the blind man in Chapter 9, the sick man in John 5:14 is portrayed in a rather negative way (Barton & Muddiman, 2000:970).

The contrast between these two passages should be a good example of not viewing HIV and AIDS as always being the result of God's punishment for sexual sin. It also helps one not to deny the possibility of cases in which HIV and AIDS has indeed come as God's punishment. From these passages, it is clear that sickness may not only be used as God's means of punishment, but can be also utilised as a means of justice to bring glory to Him.

In the case of HIV and AIDS as God's punishment for sexual sin, it becomes difficult to find where to draw the line to determine whether the disease can really be held as God's punishment or not, because some people get infected as a result of sexual sin, while others get infected without any such involvement (like unborn babies and faithful sexual or marriage partners). Yet others get involved in adultery but never get HIV and AIDS. In the Torah, a statement about the prohibition of idol worship in the second commandment says, "You shall not bow down to them or worship them; for I, the LORD your God, am a jealous God, punishing the children for the sins of the fathers to the third and fourth generation of those who hate me" (Exodus 20:5). According to this verse, children can be punished because of their fathers' sins. As Hannah (2000:139) purports, God in His uniqueness is concerned about an exclusive devotion to Him so that the parents' failure to dedicate themselves to God means that the sin affects future generations. This is also possible because it was believed that the father who rebelled against the Lord could easily influence his descendants to do the same, as obedience or disobedience depended on how parents raised their children (Deere, 2000:306).

In the same way, it can be assumed that those who get infected with HIV through an unfaithful spouse or parent are suffering because of the sins of a family member (a parent or spouse), but this assumption can be deconstructed by other verses which present God's punishment as being specifically directed at the sinful individual. According to the second law given by God through Moses, "Fathers shall not be put to death for their children, nor children put to death for their fathers; each is to die for his own sin" (Deut. 24:16). According to this verse, there is no way a child can be punished for his parents' sin and vice versa. Deere (2000:306) also comments that though personal responsibility is emphasised, it was common in the law codes of the Near East that in some cases a son was permitted to die in the place of his father. However, this came to an end, and from that time on, punishment for a criminal was to be for the offender him/herself (MacArthur, 1997:284).

Even through the prophets, God discouraged people from believing that He would punish children for the sins of their parents and vice versa. Jeremiah was told by God to prophesy to the people of Israel that on the day of judgement, everyone was to suffer for their own sins as no one would be asked to give account on behalf of another person's sins. Jeremiah says: "In those days people will no longer say, 'The fathers have eaten sour grapes, and the children's teeth are set on edge'" (v.30). Instead, everyone will die for his/her own sin, as "whoever eats sour grapes- his own teeth will be set on edge" (Jer. 31:29-30). In addition, Ezekiel was instructed to prophesy and say, "What do you mean by quoting this proverb about the land of Israel: 'The fathers eat sour grapes, and the children's teeth are set on edge'? "As surely as I live, declares the Sovereign Lord, you will no longer quote this proverb in Israel. For every living soul belongs to me. The father as well as the son—both alike belong to me. The soul who sins is the one who will die" (Ezek 18:2-4). Here it is clear that the sin of an individual is to be carried by himself/herself, eliminating the thought that someone has to be punished because of sins committed by others. This clearly calls for individual responsibility for the punishment of individual sin.

Ezekiel made a bold statement about each person's accountability to God in judgment. In other words, each person was to be answerable for his/her own sins, meaning that the idea that children could be punished for their parents' sins had become invalid because otherwise people could easily excuse themselves by saying that they had been unfairly punished by God for the sins of others (Cooper, Sr., 1994:188).

From the verses discussed above, it is fair to conclude that HIV and AIDS is not generally God's punishment for sexual sin, even though there can be cases where an individual gets infected as a result of adultery and the consequences of that sinful behaviour get extended to family members. This idea accords with Van der Ven et al. (2003:137) who state that "Not everyone who has HIV/AIDS is promiscuous, not everyone who is promiscuous gets HIV/AIDS". Since HIV is a virus that attacks people regardless of their involvement in sexual sin, it is possible to argue that it is not God's absolute agent for punishment. At the same time, one cannot reject the idea that God can still use illness for His purposes. In view of God's punishment through disease, as Van Zyl & Murray (2003:23) suggest, "This means that when one meets with sickness or trouble, you have to humble yourself before God to see if he is calling you back to him through punishment. When you have sinned, you must confess your sins and accept God's full forgiveness in the Name of Jesus our Saviour". However, due to the fact that sickness does not necessarily come as a result of sin, it is not

the aim of this research study to support this idea. After all, a sinful person should not wait to be afflicted by disease in order to confess his or her sins. Everyone is supposed to admit their sinfulness even without the presence of sickness, as denying one's sin makes God out to be a liar (1John 1:8-9). About these verses, Hodges (2000:885) observes that, instead of claiming that they have no sin, Christians need to be prepared at any time to acknowledge any failure exposed by God's light. However, sin is no longer a problem because God has already dealt with it, as the next sub-section clarifies.

3.2.1.2 How God Dealt with Sin

In a further discussion of God's punishment of sin, it is helpful to come back to the *creational paradigm* and the *theopaschitic paradigm.* These paradigms suggest God's involvement in His creation and His presence in the suffering of His people. These paradigms are supported by the fact that the Trinity came to live among God's people through God the Son, who was eventually crucified for the total punishment of sin. In other words, God dealt with sin by sending His Son Jesus so that through faith in Him, sinful human beings would no longer face a death penalty but would have eternal life instead (John 3:16). Regarding this verse, Blum (2000:282) points out that God's love is the motivation for the giving of His unique Son, His most priceless gift in whose death and resurrection the forgiveness of sin is granted in order to ensure that a believer enjoys eternal life, a new quality of life which he/she now has as a present possession and will possess forever. In the light of this, in order to support the argument that HIV and AIDS is not always to be viewed as God's punishment for sexual sin, this research study discusses the doctrines that are in line with the process of God's dealing with sin, namely the incarnation, the cross, the resurrection and the hope for the future.

a) Incarnation

As discussed earlier, the incarnation of God is seen in the coming of Jesus into the world. John 1:1-3 talks about the *Word* that was with God from the beginning. Jesus is identified as the *Word*, namely the *logos* in Greek, and the fact that the word was with God and was God from the beginning explains the pre-existence of Jesus, God the Son, who was there before the creation of the universe and was involved in the work of bringing the universe into being (Mare, 2004:118; Okure, 1988:1459). The term "the Word" thus depicts divine speech and its effectiveness in putting things into being (Gen. 1:1-3; Ps 19:1-4) (Beale & Carson, 2007:421). In a further statement about the incarnation of Jesus, John testifies that "The Word became flesh and made His dwelling among us. We have seen His glory, the glory of the One

and Only, who came from the Father, full of grace and truth" (John 1:14). In this verse, it is clear that Jesus became man and lived with other human beings where they were. They could interact with Him as John says in 1John 1:1-4 and His presence reflected the glory of God among His people. Before the incarnation, the Word had already revealed God in creation, and then the Word became a human being in the person of Jesus Christ in whom God took up His dwelling among humanity in a bodily and visible form, in the same way that in the OT He dwelt among His people through the tabernacle housed in the tent of meeting where Yahweh was consulted through Moses.

While the presence of the Lord in a tent made with human hands was temporal, God's glory with humans in Jesus' bodily form is permanent (Okure, 1988:1461). In addition, the incarnation also conveys the idea that by coming to dwell among His people, Jesus "made himself nothing, taking the very nature of a servant" (Phil. 2:7). Making Himself nothing means that Jesus, instead of using equality with God for His own benefit, emptied Himself for the sake of human beings (Bruce, 1989:69-70). The willingness of Jesus to make Himself nothing shows that He humbled Himself and became a servant who offered Himself for others, and indeed that is what He had come for (Mark 10:45). To emphasize this point, Ortiz (1988:1690) argues that the word 'servant, also translated as 'slave', as used in Phil. 2:7, brings out the way Jesus concretely became human and totally renounced every kind of honour, power or riches by accepting the ultimate humiliation that led Him to a most ignominious death.

Eventually, the purpose for the incarnation of Jesus was to identify with His brothers and sisters 'in every way', "in order that He might become a merciful and faithful high priest in service to God, and that He might make atonement for the sins of the people" (Heb. 2:17). Here, it is clear that a close relationship with human beings was necessary for Jesus in order for Him to be a high priest, as the mediatory function of priesthood required that He have a relationship with the two parties. Therefore, since Jesus already has a relationship with God, He needed a relationship with man whom He came to benefit, in order to mediate between man and God. So then, He had to be like human beings in every way except, of course, sinful ways, in order to accomplish His priestly service to God (Gordon, 2000:54; Hagner, 1990:53; Vanhoye, 1998:1774).

Even in the case of HIV and AIDS, God is present, in that He is "seen supremely in Jesus of Nazareth, the incarnate Word of God and the Lord of creation and history, who trod the dusty

roads of Palestine" (Marshall, 2005:135). In the light of this, one can rightly say that because Jesus came to dwell with human beings on earth, He is able to sympathise with PLWHA to the point that He is able to be where they are and to walk with them in their suffering.

b) The Death of Jesus on the Cross

At the end of Jesus' ministry on earth, He was condemned to die on the cross, as told in Matt. 27:22-24. In these verses, Jesus appeared in front of Pontius Pilate the governor, so that His case might be decided upon. When Pilate asked the Jews what he should do about Jesus, they replied that He should be crucified, without even knowing what 'evil' He had done. Pilate gave in to the decision of the crowd that he saw breaking into tumult as they insisted that Jesus should be crucified, even though it meant crucifying Jesus who was innocent and freeing Barabbas who was guilty (Leske, 1988:1326). When He was on the cross before He died, "Jesus cried out in a loud voice, '*Eloi, Eloi, lama sabachthani?*' which means 'My God, my God, why have You forsaken me?'" (Matt. 27:46; Ps 22:1). On the cross, Jesus hung forsaken by God and "smitten by him" (Isa. 53:4). This means that God was involved in the death of Jesus who, at that time, was going through abandonment and despair resulting from the outpouring of divine wrath on Him as a criminal (MacArthur, 1997:1449). Jesus had to go through a separation which He had never before experienced, because at that time it was judicially practical for God the Father to desert Him as He had become sin (Barbieri, Jr., 2000:89).

However, Jesus knew that He must go through this kind of suffering, as He had predicted in Matt. 20:17-19. Leske (1988:1326) suggests that for that reason, "Jesus' exclamation does not then express despair or a lack of faith but instead confirms His understanding of the role of the suffering servant who will triumph in his death by accomplishing the forgiveness of sins". Death on the cross was assigned to criminals, and was very painful and shameful to face. Carson et al. (1994:938) emphasise this by stating how most of the Jews detested crucifixion, which they held as a barbaric Roman method of execution. Nonetheless, they insisted that Jesus, as a supposed rebel, must officially and publicly suffer that death.

Even though the crucifixion of Jesus was shameful, it served as the means to redeem sinful human beings. In Gal. 3:13, Paul talks about the redemption we got from Christ's death on the cross. We were cursed and deserved death on the cross because of our sins, but Christ redeemed us from that curse by becoming a curse on our behalf. The word 'redemption' is used in the slave market to mean that a slave could be paid for so that he might be free. In the

same way, the death of Jesus was a death of substitution for our sins, and it moreover satisfied God's justice by exhausting the wrath He had against us in order to buy us back from the slavery of sin and from the sentence of eternal death through His precious blood (MacArthur, 1997:1793).

Additionally, the death of Christ brought about the sinner's justification by faith. In Rom. 3:23-26, it is clear that because of sin, no one can see God's glory without being "justified through the redemption that came by Jesus Christ" whom God offered "as a sacrifice of atonement". The reason why Jesus became an atoning sacrifice is that God, in His matchless justice, does not leave any sin unpunished. Therefore, a sinner cannot justify himself; hence, the need for the intervention of a sinless redeemer to act as a mediator between a just God and a guilty sinner. As Witmer (2000:452) puts it, "God's divine dilemma was how to satisfy His own righteousness and its demands against sinful people and at the same time how to demonstrate His grace, love, and mercy to restore rebellious, alienated creatures to Himself. The solution was the sacrifice of Jesus Christ, God's incarnate Son, and the acceptance by faith of that provision by individual sinners. Christ's death vindicated God's own righteousness (He is just because sin was 'paid for') and enables God to declare every believing sinner righteous".

In this sense, the death of Jesus on the cross satisfied the wrath of God by reconciling Him with sinful mankind so that the sinner is saved by Jesus' blood and thus escapes any kind of punishment. Put another way, the death of Jesus on the cross was the fulfilment of God's promise of salvation. Through that death, Jesus became the substitute for sinners by cancelling the guilt of sin and breaking the curse by which God had condemned mankind to death and transience in order to facilitate a new covenant through the blood of the Mediator (Louw, 2000:149). This implies that without the sacrificial death of one who acts as a substitute for the guilty, there would be no forgiveness of sin. This substitution is therefore useful for dealing effectively with sin and suffering. It reveals the character of God and the frailty of man.

To illustrate the point better, Louw (2000:74-75) points out that the suffering which Jesus faced on the cross has two significant meanings: the *existential dimension* and the *ontic dimension*. In these two dimensions of Jesus' suffering, Louw (2000:74-75) follows Luther's *'theologia crucis'* (theology of the cross) andMoltmann's *'theologia crucis'* to explain both human nature and God's nature in terms of suffering. On the one hand, Luther's *'theologia*

crucis', (Louw, 2000:74) posits that the cross has an existential meaning where God is seen in His intervention to get involved in human suffering, afflictions, and crises. On the other hand, Louw (2000:75) uses Moltmann's *'theologia crucis'* to shed light on the '*theo*-logical' impact and consequence of God's identification with human suffering on the cross. In other words, "a theology of the cross relates to both the existential dimension (our being human) and the essential dimension (the identity and characteristics of God's Being); it affects our human misery as well as the mode of God's existence.

Taking these two options into consideration, one could say that, in the theological debate about the pastoral significance of a theology of the cross, Martin Luther's *theologia crucis* tends to be a more existential model (posing the epistemological question: How do we know and understand ourselves as well as God in terms of Christ's suffering?), while Moltmann's *theologia crucis* tends to be a more '*theo*-logical' model (posing the ontological question: Who is the Triune God in terms of Christ's suffering?)". Following these two dimensions of the cross, it is fair to say that Christ's suffering on the cross reveals human vulnerability and helplessness, and God's sovereignty and His intervention in relieving human suffering. In this sense, knowing that man needs God's help in his frailty is helpful in establishing that the cross of Jesus was God's way of dealing with human suffering; therefore, the cross brings hope that human suffering has been dealt with. This leads to the notion of resurrection.

c) *The Resurrection*

After His death on the cross of Calvary, Jesus was buried, and on the third day, when the women went to visit the tomb where He was buried, the angel who was there told them, "Do not be afraid, He is not here; He has risen, just as He said" (Matt. 28:6). The resurrection of Jesus was very beneficial because it served as a means to destroy the devil, who holds the power of death, and Jesus' victory over the devil meant freedom for His people who were enslaved by the fear of death (Heb. 2:14-15). The effect of Jesus' death and resurrection is thus that Jesus holds authority over death, so that those who put their trust in Him are once and for all delivered from the devil's power and from the fear of death (Kassa, 2006:1493).

Certainly, the resurrection of Jesus offers hope for the future. This hope is based on the truth that, in the same way as Jesus Christ has risen from the dead, those who die in Him will also be raised by God with Jesus, and this is a message of encouragement (1Thess. 4:14,18). On the hope of resurrection stated by Paul, Koudougueret (2006:1463) stipulates that "Paul reaffirms that the real hope is based on the return of Jesus Christ. Christians already possess

salvation, but one day they will enjoy its benefits forever in Jesus' presence. Those who die before this grand finale brings great happiness are sleeping, and they will awaken on resurrection day". In this hope of resurrection, the notion of eschatology is also made evident. Reflecting on Jürgen Moltmann's theology of hope; Louw (2000:152) points out that "the resurrection plays a crucial role in revealing the meaning and gospel of the cross. Within Moltmann's *eschatologia crucis*, the cross is not limited to Christ's reconciliatory work, but becomes a symbol for the *eschaton* of Christ: the resurrection. The resurrection opens up a future perspective in such a way that the resurrection obtains an eschatological primacy over the cross. Eschatology, derived from the resurrection, reveals the hope principle embedded in the cross. Hope is actually resurrection hope".

Furthermore, resurrection hope brings forth the idea that those who die in Christ as "perishable" are clothed with the "imperishable", and the "mortal" with "immortality", so that death may be swallowed up in victory (1Cor. 15:53-54). This destruction of death is similar to the one mentioned in Rev. 20:14 whereby "death and Hades were thrown into the lake of fire" thereby indicating the 'death of death', because the cross has rendered death a conquered enemy (Rae, 2006:152).

d) Hope for the Future

In addition, according to Louw, one does not look at human beings only as sinners or as the ones having all the necessary potential within themselves in order to cope with suffering and to triumph over HIV and AIDS, but the focus is drawn to the cross, where God identifies with the suffering of human beings in Christ, and to the resurrection of Christ where God triumphed over sin and all other forms of suffering including HIV and all its related issues. For this reason, PLWHA must no longer be viewed judgmentally as sinners who must be punished, but as God's redeemed people whose sin has been dealt with on the cross and who are now subject to the living hope of resurrection. As Louw (2006:104) asserts, "In this regard one can view the resurrection of Christ as the final critique of God on death, suffering and stigmatising. Resurrection hope is about the death of death, about the fact that every form of rejection, stigmatisation and isolation has been finally deleted by God. People suffering from HIV should therefore be empowered to start to live life despite the reality of the virus". Similarly, the resurrection is both a promise and a foretaste of what God can and will do for the faithful when they confront despair or doubts about the One in whom they have put their trust. It gives an assurance that the same God who raised Jesus from the dead will be with

them when they feel overwhelmed by the dangers they face, the burdens they bear or the fears concerning the future that sometimes rob them of their hope (McMickle, 2006:22).

The theology of the cross and resurrection thus results in the idea that another way of looking at life has to be developed, whereby life is viewed not negatively or positively, but realistically, meaning that healing has to take place so that PLWHA are helped to live life despite the threat of the virus, or in other words, to accept what cannot be changed. "Wholeness in God's creation and in human existence now implies the following: a reassessment and refraining of life. Life is not necessarily negative (pessimistic stance); life is not necessarily positive (optimistic stance). Life is realistic: full of contradictions and paradoxes. But it can be lived through the Spirit of the resurrection in hope" (Louw, 2006:104). This is also to agree with Lamborn (2005:21) who hypothesises that if the resurrection is to mean anything here and now, people must attend to the totality of their human experience, including the aggressive, dark, negative parts, because new life must happen despite all the hopeless places and circumstances.

Furthermore, the theology of the resurrection can be used to give an assurance to PLWHA that life does not end when one suffers or dies, but that there is a better life at the end. Louw (2006:110) mentions three benefits that Christ's resurrection brings in the life of PLWHA, as follows:

Firstly, through His resurrection, Christ overcame death so that we could become participators in His righteousness, which he won for us through His death. Resurrection establishes an identity beyond the stigma paradigm.

Secondly, through His power we are now also awakened and empowered to a new life. Resurrection empowers people to live life as HIV positive persons despite their status.

Thirdly, the resurrection of Christ is a trustworthy guarantee of God's final punishment, in Christ, of every mode of sin and therefore of our new freedom to life beyond labelling and stigmatisation. The notion of stigma is exchanged for charisma: life defined by the Spirit of God.

As a result, the theology of the cross and resurrection can be used to work out some practical implications helpful in caring for PLWHA in terms of assisting them to understand and interpret their suffering in the view of resurrection hope. This means that instead of looking at

PLWHA in terms of their sinfulness, they now have to be seen as redeemed by Christ; therefore, they are no longer stigmatic but charismatic beings.

Louw (2006:111-112) identifies some indicators that can be used in pastoral care as means to encourage PLWHA and minister to them:

• *Transformation:* the new reality within the reality of pain and destruction, transformation then means that the power of the resurrection, due to the indwelling presence of the Holy Spirit, compels us to combat the destructive powers in our reality. In terms of our topic, the stigma should be transformed into what we call *charisma*. People are then perceived from the perspective of the fruit of the Spirit and not from the perspective of failure and sin.

• *Freedom and liberation:* the experience of forgiveness and reconciliation. This kind of liberation deals with failure and sin from the perspective of salvation, i.e. all our wrongdoing and sin (even in case of irresponsible behaviour) is already deleted in the cross of Christ. Resurrection is the proof of the fact of salvation: the past has been dealt with by God and been wiped out totally. Sin does not exist anymore and does not count at all. We are therefore not victims but instruments of the grace of God.

• *Vision, imagination and future:* the motivating and driving force behind anticipation and expectation. We are now motivated by resurrection hope. Hope is then an indication, not of wishful thinking, but of a new stance in life, a new mode of being, i.e. of who we already are in Christ.

• *Witness:* the intention to reach out to others in their suffering and pain. The intention of our witness is not, in the first place, to convert all people, but to reveal to them the presence of the resurrected Christ by living the fruit of the Spirit, and to convince them that God is indeed present in their situation of pain and suffering, and that their stigma is now part of His stigma.

• *Faithfulness:* the guarantee of trust despite disorientation and disintegration. Although people will still be exposed to suffering, faith means that we can rely on the faithfulness of God. The resurrection is the proof of the fact that God will never ever ‘drop’ us.

• *Support:* edification within the fellowship *(koinōnia)* of believers. The basic confession of the Church is the resurrection formula: Jesus Christ is Lord. One can even say: the resurrection constitutes the Church and not our perceptions and prejudices. In the fellowship,

we receive our brothers and sisters. We do not select them according to our phenomenological and empirical perceptions (stigma).

• *Comfort:* the courage to be, to endure and to accept. The courage to be, to go on with life, is no longer determined by our achievements, but by the knowledge that our new identity in Christ is through baptism into His death, so that due to the fact that Christ was raised from the dead, we too may live a new life. (Rom. 5:4).

• *Truth:* divine confirmation and a guarantee, promise for Life. The truth we are living by is related to all the fulfilled promises of God. In Him we have already received everything we need to live meaningfully. We inherited the same power which raised Christ from the dead (Eph. 1:18-19).

In addition to the above-mentioned indicators to be used as tools in pastoral care in order to encourage a positive view of God in the midst of the HIV epidemic, there are also some virtues highlighted by Cimperman (2005:45-58) which are helpful in the response to the AIDS challenge, and they can be summarised as follows:

- ♥ *Hope*: Hope not only gives vision, it sanctions and sustains the vision. Christian hope tells us what type of vision we have. Hope is also a prime Christian resource of the imagination. Hope points to the *telos* of Christianity and offers a horizon for our expectations in both tangible and non-tangible ways. Hope is the vision that allows us to reshape our reality in a particular way. It has a paschal imagination and a fundamentally eschatological dimension.
- ♥ *Fidelity*: fidelity requires that we treat with special care those who are closer to us. It is rooted in love and is characterised by active receptivity in a loving relationship. It is also marked by mutual, honest communication, embodied expressions, and consistency.
- ♥ *Self-care*: it addresses the unique relationship each has with his or her self as moral agent. It is about unique responsibility to care for ourselves, affectively, mentally, physically, and spiritually, and is attentive to the person as imago Dei, self-awareness, relationship with others, and self-acceptance (being at peace with yourself).
- ♥ *Justice*: reminds us that we belong to humanity, and are expected to respond to all its members in general, equally and impartially. In the time of AIDS, justice is marked

by a critical knowledge of global structures and issues, attentiveness to the needs of persons on the margins, interior discipline, and active, creative engagement.

- *Prudence*: is about 'good life' and is marked by tasks to pursue the ends to which the person is naturally inclined; to integrate the other cardinal virtues; to engage the moral imagination; and to establish a moral agenda for a person growing in virtue.

In discussing the link between Louw's tools of encouragement for PLWHA and Cimperman's virtues as a useful response to the HIV and AIDS challenge, the relationship between the two can be described as follows:

First of all, the point of departure towards acquiring the qualities necessary to respond to HIV and AIDS in a way that encourages PLWHA is found in what happens in the life of a believer, namely, the transformation brought about by the power of resurrection through the indwelling of the Spirit, which produces freedom and liberation from sin and other related wrongdoing. This enables believers to live prudent lives that are motivated by the hope they have in Christ, influencing their relationships with themselves and others. With this in mind, the hope which Cimperman refers to is related to Louw's point concerning vision, imagination and future. They both mean that a believer in Christ has a sure orientation of life in such a way that life is no longer determined by difficult circumstances but by the eschatological expectation of glory embedded in resurrection. The basis of this hope is the character of God as a God of faithfulness and truth who gives assurance that He will fulfil His promises and will never drop His people intoa vacuum.

This kind of resurrection hope produces comfort in the believers' lives so that even in the midst of pain and suffering, they are encouraged to keep on with life in the hope that pain will end some day. Consequently, believers have to respond to God's favour by sharing it with others who suffer. Here, Louw's points regarding witness and support match Cimperman's virtues of fidelity and justice in the sense that hope encourages believers to live a life that reflects Christ's resurrection and the fruit of the Spirit in their relationships and dealings with others, either outside or within the fellowship of believers, renouncing prejudices and treating everyone equally and with justice. In achieving this, Cimperman's point of self-care is of great importance. In fact, people may be concentrating on caring for others and forget to care for themselves. However, as Cimperman states, self-awareness, acceptance and care are essential to caring for others, especially when practised in a positive

way and not out of self-centredness. Even when Jesus commands His disciples to "Love your neighbour as yourself" (Matt. 22:39), He clearly does not promote self-love in a negative way, but He "prompts believers to measure their love for others by what they wish for themselves" (MacArthur, 1997:1435).

Moreover, in an endeavour to emphasise the hope that people can experience in the midst of suffering, Louw (2000:182), arguing from a pastoral-theological perspective, confirms that life in fellowship with the risen Christ gives a believer hope and anticipation through which he is established within the eschatological tension between the already (resurrection) and the not yet (parousia of Christ).

In this sense, pastoral care to those who are suffering means giving encouragement embedded in hope for the future and based on what has already been accomplished on the cross. This encouragement is better understood in Paul's prayer for the Romans in which he said, "May the God who gives endurance and encouragement give you a spirit of unity among yourselves as you follow Christ" (Rom. 15:5). In this verse, God is the one who gives the endurance and encouragement which believers need as they follow Christ. This implies that any encouragement given by pastoral caregivers derives from God Himself. Moreover, this endurance and encouragement emanate from the character of God as the God of hope according to the following words of Paul in his benediction to the Romans: "May the God of hope fill you with all joy and peace as you trust in Him, so that you may overflow with hope by the power of the Holy Spirit" (Rom. 15:13). In these two verses, God is seen as giving hope, endurance, encouragement, joy and peace, and He does this for those who follow Christ and live by the power of the Holy Spirit. In the light of this, MacArthur (1997: 1722) comments that God is the source of eternal hope, life, and salvation, and He is the object of hope for every believer... The believer's hope comes through Scripture which was written and is applied to every believing heart by the Holy Spirit."

Giving a detailed explanation of what the *joy* and *peace* mentioned by Paul entail, Witmer (2000:496) explains that while joy relates to the pleasure of anticipation in seeing one's hopes fulfilled, peace is the product of the guarantee of God's fulfilment of those hopes. Furthermore, this hope found in the resurrection of Christ is the work of God the Father. This is clear in Peter's first letter when he praises God, saying, "Praise be to the God and Father of our Lord Jesus Christ! In His great mercy He has given us new birth into a living hope through the resurrection of Jesus from the dead" (1Peter 1:3). Likewise, Raymer (2000:840)

sees God as the "Author of salvation and the Source of hope" who bestows His unmerited favour on sinners in their hopeless situation.

The hope that God offers is so significant that even those suffering from terminal diseases such as HIV and AIDS are encouraged to endure in the hope that their condition is not final, and to look beyond the disease as they celebrate what God has accomplished in Christ for their ultimate eternity because the death that the disease brings has already been defeated. In addition, the hope God brings makes people strong enough to face suffering with joy. This means that suffering is not avoided but embraced. According to Louw (2000:184), "The idea that suffering should not be avoided and resisted, but can be accepted, certainly does sound strange to contemporary humans who, driven by their obsession with success, are determined to eliminate all forms of suffering". In other words, instead of denying or avoiding suffering, it is better to accept it and look for a way of living with it if one can do nothing to escape from it, and in that way, coping is embracing suffering with joy.

In a further observation about joy in the midst of suffering, Louw (2000:184ff), referring to the fact God's creation is 'good' (Gen.1:31) and celebrates the joy of God (Ps. 19:2; 145:16), states that "God maintains this joy in his creation, despite suffering and evil. Whenever evil causes a break in the playful festivity between God and humans, God bridges the gap by a covenantal encounter" in which God identifies with His creation. This kind of joy emanates from God's salvific work in the history of His covenant people and is made concrete in the pastoral orientation of a believer towards the Lord's presence through the sacraments of baptism and the Eucharist which allow him/her to participate in the celebration of Christ's death and resurrection. True joy in suffering is thus not about cheap optimism or self-glorification. It is not eroded by artificial pleasure and mere entertainment, but is characterised in faith, hope and love just like the way Christ agreed to suffer for His people. Therefore, "Christian joy is means to glory in the cross and to sing a song of praise to the resurrection".

For PLWHA then, this joy in suffering means that they can live a better life full of peace and hope, knowing that the virus does not determine their future. It is the work of pastoral care to make sure that PLWHA are not overwhelmed by the despair which the virus may impose on them, but that their lives are driven by the victory which Jesus achieved over death on the cross. This can be used to bring about the healing that theologically involves "being transformed from a condition of death into a condition of life. This new condition is an

indication of a new state of being: being accepted unconditionally by grace and being restored into a new relationship with God; i.e. a relationship of peace, reconcilation and forgiveness" (Louw, 2003:213).

This can also be useful in encouraging other people not to view PLWHA as victims of stigmatisation, but rather as those for whom Jesus died and who are worthy of acceptance and are not subjects of rejection on the basis of the virus they are living with.

3.2.2 A Pastoral Anthropology for PLWHA

While it is very important for the Church to understand God images, an understanding of people in general and PLWHA in particular is also another factor to be considered in order for church leaders to be successful in their ultimate efforts to mitigate HIV and AIDS-related stigma. It would be difficult to engage in the fight against HIV and AIDS stigma without any understanding of pastoral anthropology. Therefore, in an attempt to establish an idea for dealing with HIV stigma, this research study addresses two aspects of PLWHA, namely PLWHA as beings created in God's image, and PLWHA as sexual beings.

3.2.2.1 PLWHA as Created in God's Image

According to Louw (1998:123), "Pastoral ministry is ministering to people. Thus any model and strategy must ultimately be determined by our view of who and what a person is". Therefore, this research study takes into consideration the fact that PLWHA, just like other human beings, are created in God's image, even before considering that they are infected by HIV. For that reason, there is a need for Christians as followers of Christ to go to extra lengths in acknowledging the primary characteristic of people as having been made in the image of God. They should do this by affirming the right and dignity of people who are being diminished by the stigmatisation of others (Burke & Burke, 2006:9). After all, the fact that human beings are created in God's image supports the idea that all human beings share the same value and dignity and therefore, whether small, vulnerable or sick, everyone deserves care and protection (Van Drunen, 2011:2). This truth can serve as a challenge to emphasise the fact that the Church needs to understand that PLWHA are just like others, with the same dignity and deserving of equal treatment.

Similarly, such a way of thinking can be helpful for the Church in the process of revisiting their anthropology in the face of HIV and AIDS. Cimperman (2005:15) argues that "the situation of AIDS today demands an exploration of our theological anthropology, for how we understand what it means to be human, and what humans need to survive and thrive, will

determine how we understand and respond to this pandemic." From this quote, one can presume that the way human beings are perceived will affect reactions towards PLWHA. Put another way, if humans are considered as sinful and bad, the result will be a tendency to cast off PLWHA as sinful beings with the assumption that they got infected as a result of their sinful behaviour. In contrast, if humans are believed to carry God's image, then PLWHA will not be judged according to the virus in their bodies and how they acquired it but according to the image of God which they are carrying, and this will result in care and acceptance.

A further explanation of pastoral anthropology that can be useful in dealing with PLWHA is developed by Louw, who discusses two models of looking at pastoral anthropology, namely the *kerygmatic* approach and *empirical* approach. As far as the kerygmatic model is concerned, it is a way of looking at a human being as "dominated by the reformed view of the human being: *simul justus et pecator*. Guilt before God and the reality of sin make a person a sinner who is subject to God's punishment and wrath" (Louw, 1998:129). In the kerygmatic approach, human beings are viewed as bad and fallible until God sends Jesus Christ to rescue them from death through His own death. This perspective can be used to strengthen the theology associating HIV and AIDS with human sin. On the other hand, Louw (1998:131) also talks about the phenomenological model of pastoral anthropology, a client-centred (empirical) approach which views human beings as having inner potential allowing them to be good. However, the kerygmatic approach and empirical approach both present problems for pastoral anthropology. While the kerygmatic approach presents the danger of elevating the fall, the empirical approach presents the danger of viewing a human being as holding the potential of self-sufficiency. Therefore, another approach, the hermeneutical theory[6], is proposed (Louw, 1998:132). For Louw, the hermeneutical theory is preferable to the other two approaches because it analyses human experience as a source of knowledge for a pastoral anthropology.

In order to design a pastoral anthropology, as Louw (1998:140) suggests, two questions need to be asked, one regarding the real nature of the human as having been created in God's image, with the emphasis on a relationship with God and dependence on Him, and another regarding the goal, direction, destination and meaning of human existence. On the concept of being created in God's image, Louw (1998:148-149) summarises four points suggesting that the 'image of God' for a pastoral anthropology means qualitative dissimilarity. These four

[6] See details about hermeneutical theory in Chapter one under 1.5

points include the following: the notion that human existence is unique; a relational interpretation which explains the destiny of human beings in terms of their dependence on God; purposefulness and dimension of the ultimate which explain the responsibilities and respondability of human beings; a Christological dimension according to which Jesus is the image of God, and human beings can acquire a new status in Christ.

In the context of HIV and AIDS, the understanding of a human being as a relational being helps in establishing the fact that one can be in a relationship with God, oneself, and others. The fact that man has a body can be useful in explaining the concept of suffering and frailty. This confirms Cimperman's observation that "A theological anthropology in this time of HIV and AIDS calls for an understanding of the human person as a relational, embodied agent in a context of suffering and historical realism" (2005:19). After considering the fact that PLWHA carry the image of God, it is also necessary to discuss the fact that they are sexual beings, because HIV and AIDS stigma is enhanced by the idea that HIV is mostly transmitted through sexual intercourse.

3.2.2.2 PLWHA as Sexual Beings

In the midst of the devastating HIV and AIDS pandemic, sex has been misinterpreted to be evil because it is the main channel of HIV transmission. This belief leads to the stigmatising conclusion that one needs to be involved in promiscuity in order to catch HIV. As Amanze (2007:36) observes, the stigmatisation of PLWHA is usually based on the assumption that they contracted the disease because of their promiscuous behaviour. That conclusion goes with the negative theology of sex and human sexuality that has characterised Christian ethics for a long time. In addition, the fact that HIV is transmissible through sex has led to the view that sex is bad, a view which puts a great deal of moral and ethical pressure on PLWHA.

As Amanze (2007:39) further notes, PLWHA who have been raised in an environment where the official teaching of the Church is that sex is inherently evil are often faced with a number of moral problems. They go through a strong sense of self-blame accompanied with feelings of rejection, isolation, loneliness, guilt, denial, depression, fear, suspicion, anger, resignation, pessimism, hopelessness, low self-esteem and even suicidal tendencies.

In talking about the belief that sex is evil because it is a channel of HIV transmission, it should also be mentioned that some cultures view the topic of sex as taboo, thinking that by talking about it, people will be encouraged to get involved in promiscuity. However, it has

been proven that sex education does not result in promiscuous behaviour per se, which is why the Church needs to make sure to address such myths (WCC, 1997:60).

Actually, no one can escape the fact that human beings are created as sexual beings, with sexuality being their primary biological phenomenon, and gender their primary social phenomenon (Marshall, 2005:138). Hence, by making human sexuality subject to secrecy and taboo, the Church has not been acting openly and honestly, thereby obscuring the truth that sexuality is inherently given by God as a reality to be cherished and enjoyed. As Haddad (2004:34-35) alleges,

> For too long, the Church has pronounced judgment over people's sexual activity, without simultaneously celebrating human sexuality as a gift from God. The traditions of the Church notoriously have seen sexuality as "dangerous," thus rendering it a taboo subject confined to the dark, secret corners of our lives. This secrecy and silence have made it difficult to engage in sex-education and HIV-prevention honestly. Prone to moralistic judgment over those who seemingly have led promiscuous lives, the Church has sponsored little analysis of patriarchy and gender injustice within society. The subordinate status of women often means that they are unable to negotiate safe sex with their partners. The Church itself has been a place where sexual abuse has been allowed to take place, without legal repercussions for the mainly male perpetrators.

It is time to change the belief that sex is bad. Louw (1998:163) argues that human sexuality has frequently been identified as the main 'culprit' in human sinfulness. He suggests that pastoral care should not dismiss sexuality as a problem area, especially when dealing with the notion of embodiment. This means revisiting the view that human sexuality was given by God as a gift to be enjoyed. In fact, God created sexual human beings to enjoy sex, and any view that makes sex out to be evil needs to be challenged with a positive theology of sex based on the fundamental biblical truth that God created human beings as sexual beings with the plan that man and woman must celebrate and enjoy the gift of sexuality, treating sex and human sexuality with the utmost responsibility (Amanze, 2007:39). In this regard, the Church, in order to fulfil its mission as a place of redemption, hope and healing, needs to promote the Christian teaching that emphasises the goodness of human sexuality while also highlighting the responsible use of sex in a way that does not bring death. After all, the HIV and AIDS crisis presents the Church with a great opportunity to teach people good sexual behaviour that comes from God's word in a positive way (Amanze, 2007:39; Haddad, 2004:34; Van Zyl & Murray, 2003:25).

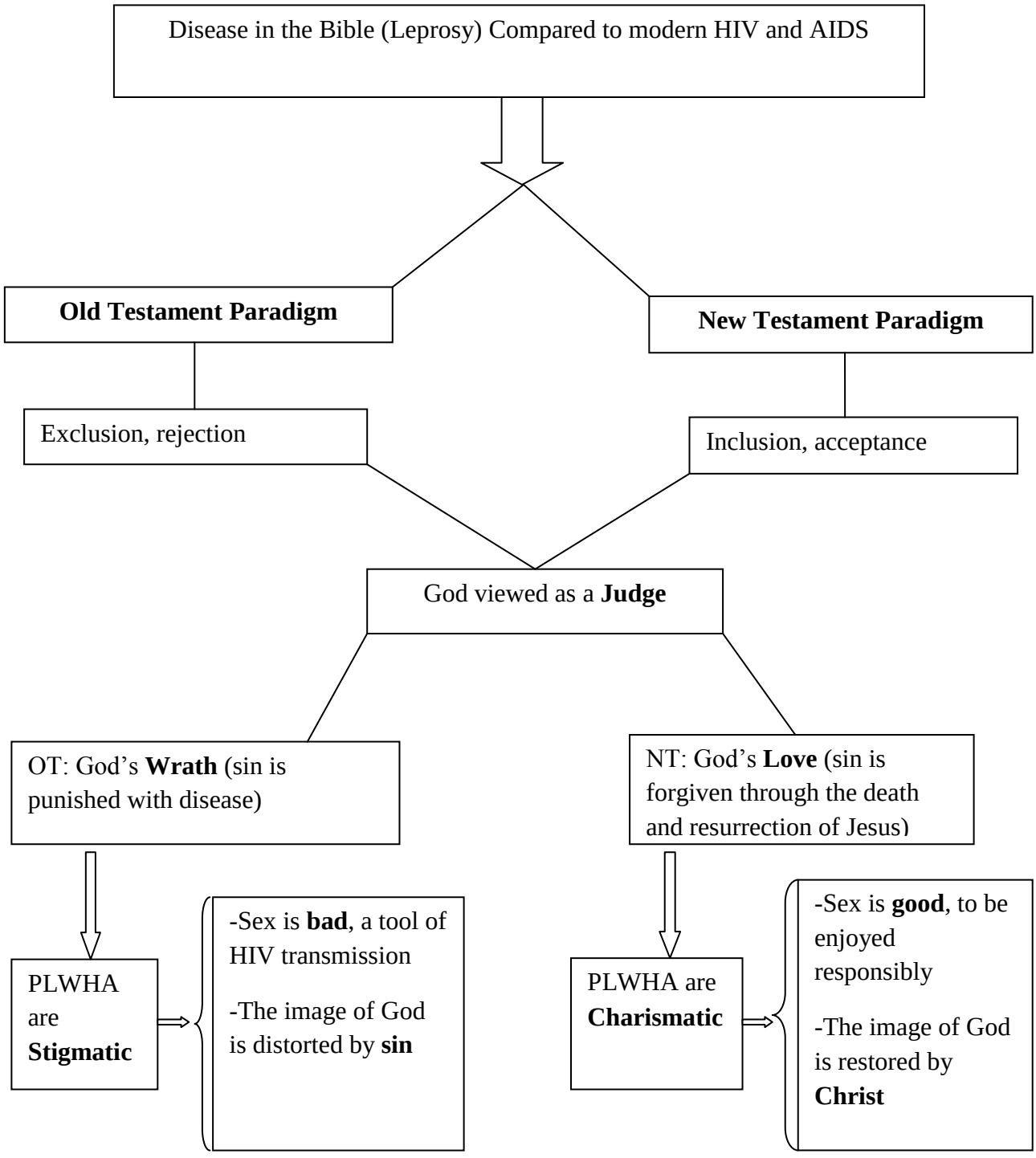
3.3 Conclusion

In conclusion, church leaders need to deal with HIV and AIDS related stigma by careful interpretation of biblical passages in a way that does not impose stigma on PLWHA. In this chapter, stigma in relation to disease has been explored. In fact, it has been established that some diseases in the Bible were stigmatised. A disease that has been identified as comparable to modern HIV and AIDS is leprosy. The OT reveals that anyone diagnosed with leprosy was to be declared unclean, and was to be marginalised from the community by the priest until he/she could be declared clean again. However, in the NT, the case is different in the sense that when Jesus came, He accepted lepers, touching them and healing them unconditionally. In the situation of HIV and AIDS, it is better to denounce the OT paradigm of rejection in favour of the NT paradigm of acceptance. Regarding the issue of punishment, it was obvious that God is a holy judge who must deal with sin, and that diseases are among His ways of punishing human sinful behaviour. However, this must never be used as an excuse to qualify HIV and AIDS as God's punishment of sin as has been widely believed in the Church; it is better to consider cases where innocent people have caught the virus, and the fact that God does not punish the innocent for the sins of the guilty ones.

Furthermore, the chapter has discussed the subject of how God dealt with sin by coming Himself to His people to show them love through Christ who became man, died on the cross and rose from death never to die again, thereby overcoming sin and giving salvation to man and an assurance of eternal life. Therefore, man's sin is borne by Jesus and the stigma of sin is extinguished to such an extent as to change man from a stigmatic stance to a charismatic one before God. Eventually, man is viewed not as a sinner but as one who is loved and redeemed by God. This truth is useful in challenging the theology of a God who is just there to punish people. As a judge, God deals fairly with His people in the sense that He took the judgment they deserved upon Himself when Jesus died on the cross. In this sense, the Church can deal with HIV and AIDS stigmatisation by renouncing the kind of theology that sees PLWHA as objects of God's judgment and replacing it with the theology of grace, hope and acceptance which God shows through the death of Jesus on the cross.

In this chapter, the issue of sex was also discussed. Actually, the fact that HIV is commonly transmitted through sex has created the idea that sex is bad. However, it is time to realise that sex is an integral part of being human and should be celebrated and enjoyed in a responsible way that is free from risk and stigmatisation. For the Church to be a place where PLWHA feel welcome, it is called to model and teach a responsible theology of sex that does not

continue to stigmatise PLWHA. In the light of this, the next chapter deals with the subject of the Church being a healing community for PLWHA. The Biblical and theological reflection on HIV and AIDS stigma is represented in the following diagram.



(Diagram 3.1: Biblical and Theological Reflection on HIV and AIDS Stigma).

CHAPTER FOUR

THE HEALING MISSION OF THE CHURCH IN TIMES OF HIV AND AIDS STIGMA

4.0 Introduction

In the previous chapter, this research study focused on the biblical and theological reflections on HIV and AIDS stigma. This chapter discusses the healing mission of the Church in times of HIV and AIDS stigma. This chapter is in line with the objective of examining the nature of the Church as a place of healing in relation to HIV and AIDS stigma, and the chapter follows the third step of the Practical Theological research methodology which involves interpreting the world as it should be. In this chapter, various church activities which can serve as means of healing will be explored after looking at the meaning of healing. The chapter takes Acts 2:42-46 as a point of departure in order to talk about *koinōnia* and *diakōnia* as channels of healing. This will be achieved by looking at the Church as a healing community, and at *baptism*, *koinōnia* and *diakōnia* as means of healing. The chapter will also include a discussion of the difference between healing and cure in order to come up with an idea of what healing really entails. In that way, even though not focusing as much on theology as the previous chapter, this chapter deals with traditional Christian religious practices in the Church and the way they can be used to address HIV and AIDS stigma.

4.1 The Church as a Healing Community

In the midst of suffering in the face of HIV and AIDS, church leaders are expected to help the Church to bring healing. In suggesting that the Church should be a healing community, a question can be posed as to what 'healing' is really about. According to Elwell (2001:539), "Healing is the restoration of health, the making whole or well whether physically, mentally, or spiritually". This definition paints a picture of healing as a multidimensional act. Marshall et al. (1996:452) and Douglas (1962:461) give a similar definition, but specify that healing includes recovery brought about by medical treatment or spontaneous remission of sickness. It also includes the improvement in a patient's outlook, even if there was no physical change, or a correction of the patient's misconception of the nature of illness. In addition, as Moore (1988:99) states, in its multiple dimensions, healing is basically about recreating a broken life, and demands the presence of a healer who participates in the healing process. Healing is also a mystery to be celebrated; therefore, it is not to be taken lightly, but to be regarded in

acknowledging and witnessing Christ as the living God, the physician and saviour of all mankind and creation.

The above explanation shows that healing should be *holistic*, since a human being is not made only of the body or the soul. In the endeavour to strive for holistic healing, it is helpful to once again look at the following components of a human being, as presented by Louw (1998:245):

* *The affective component*: the emotions and feelings which facilitate a human's immediate reactions and disposition.
* *The cognitive component*: the human *nous* about knowledge, standpoints, perspectives, opinions, and perceptions.
* *The conative component*: human passion and needs.
* *Normative component*: norms and values which make people qualify to be moral and ethical beings.
* *The physical component*: a body which is the centre through which God makes Himself known.
* *The koinonic component*: the capacity to fellowship with others, which facilitates ministry to each other.

The consideration of these components will be crucial in any healing process that claims to be holistic, since it has to do with various dimensions of a human being as a whole. In order to do justice to a discussion on healing in this research study, it is important to begin with the biblical and theological idea about healing.

The Bible mentions a great deal about healing, and there seems to be no difference between the Old Testament (OT) and New Testament (NT) in this regard. According to Renn (2005:473), "The semantic range of both the Hebrew and Greek vocabulary for 'healing' is much the same. Both Testaments emphasise the phenomenon of divine healing — at the hand of Yahweh in the OT, and by Jesus Christ in the NT. Both Testaments also attach great importance to the concept of spiritual renewal, lending a non-personal aspect to the Hebrew vocabulary for 'healing' in regard to the land". In the OT, the word often used for healing is *rāphā*, which occurs around seventy times, usually referring to physical healing (Renn, 2005:472), and refers to the healing of all kinds of diseases (Samadhanam, 2008:1). For example, in 2Kings 20:5, God sends the prophet Isaiah to tell King Hezekiah, "... I have heard your prayer and seen your tears; I will heal you". However, it is clear that the word

rāphā also refers to healing related to caring (Renn, 2005:472). In Ezek. 34:4, the Lord condemns the shepherds of Israel saying, "You have not strengthened the weak or healed the sick or bound up the injured". This refers to God's rebuking the leaders of Israel for their failure to look after the people under their care (Carson et al., 1994:738). In other words, the princes, judges, and ministers of the state did not fulfil their duty of caring for the sheep that were ill or injured, and which then went astray to look for shelter somewhere else (Habtu, 2006:972). In the OT then, it is found that healing can carry the meaning of spiritual restoration, or the caring for those who are experiencing great suffering.

Similarly, the NT word equivalent to *rāphā* is *therapeuō*, used approximately forty times in the synoptic gospels to refer to "heal" or "cure". The term *iaomai* is synonymous to *therapeuō* and refers to Jesus' healing ministry (Renn, 2005:473; Vine, 1997:533). Another word, *sōzō*, means healing in the sense of saving from a disease and its effects (Vine, 1997:533).

Healing was at the central mission of Jesus in the New Testament, and His miraculous healing is seen in many stories in the four gospels. For instance, in the story recorded in Matthew 9:1-8, Jesus, moved by the faith of some men, healed a paralytic whom they brought on a mat (v.2). In the process of healing, Jesus said to the paralytic, "Take heart, son; your sins are forgiven" (v.2). Then the response of "some of the teachers of the law" was that "This fellow is blaspheming!" (v.3). In vv4-6, Jesus knew the thoughts of the teachers of the law, and told them that it was easier for him to forgive sin than to command the paralytic to get up and walk, which He then did. After being healed, the paralytic went home, and the crowds that witnessed the miracle were filled with awe (vv.7-8).

In this passage, two main aspects characterise the healing that Jesus performed, namely the authority to forgive sins and the power to heal the sick. In fact, the men had brought the paralytic for physical healing, but Jesus identified another urgent need to be dealt with in addition to the healing that the paralytic was brought for, namely, the forgiveness of his sins. As Kapolyo (2006:1124) puts it, this passage demonstrates Jesus' authority over sin, which is the most intractable problem in human experience as there is nothing on earth man can do to eradicate it. For that reason, even when the men who brought the paralytic had faith, Jesus still saw the need to deal with the sins of the paralytic himself. Even though Barbieri, Jr. (2000:39) and MacArthur (2007:1522) suggest the possibility that the paralytic's sins were the cause of his sickness, Carson et al. (1994:916) do not see any mention of sickness being

linked to the sin of the sufferer in this passage. Hence, the author of this research agrees rather with Kapolyo (2006:1124) who says that the decision of Jesus to forgive the paralytic's sins does not imply that he had become paralysed as a result of sin. He was merely a sinner in need of forgiveness, like any other person. After pronouncing the forgiveness of sin for the paralytic, Jesus then told him to stand up and walk.

This act of healing which Jesus performed shows that He is not just concerned about physical healing, but He also wants to provide spiritual health for those who get healing from Him. In other words, one can say that Jesus offers *holistic* healing.

The healing work of Jesus was directed towards all those who had an encounter with Him while suffering. As a summary of the way Jesus intervened in the suffering of the people, Matthew 9:35-36 says, "Jesus went through all the towns and villages, teaching in their synagogues, preaching the good news of the kingdom and healing every disease and sickness. When he saw the crowds, he had compassion on them, because they were harassed and helpless, like sheep without a shepherd". In these verses, Jesus works hard for the kingdom of God. He finds Himself among people who are harassed and helpless, and in need of healing. Moved by compassion, He then teaches, preaches, and heals. Compassion is Christ's motivation to heal. As Olson (1982:357) perceives, the context of this passage argues that compassion is, after all, a features of Jesus' ministry. This is confirmed by the way He urges the twelve disciples to pray for labourers in His harvest. Although this seems to imply that the people had chosen to be harassed and helpless, that does not seem to be Jesus' observation, since He sees the problem as being the lack of a shepherd, someone to nurture the people. For that reason, this research study agrees with Carson et al. (1994:916) who posit that the basis of Jesus' compassion was more an emotional response resulting in caring action.

Consequently, Jesus then sent His disciples out to do the same work as He was doing. He said to them, "As you go, preach this message: 'The kingdom of heaven is near.' Heal the sick, raise the dead, cleanse those who have leprosy, drive out demons. Freely you have received, freely give" (Matt. 10:7-8). Here, the disciples are commissioned to proclaim the coming of the kingdom of God and to liberate people from the evil forces of sickness, death, and demons that oppressed them. This shows the interconnection between preaching and healing. As Luz (2001:75) comments, the healing mission and that of proclamation are essentially related, so as not to become mere ethical exhortation, but to provide concrete experiences of salvation and physical healing. Olson (1982:357) also suggests that the mission that Jesus

gave to His disciples is holistic because it takes care of different facets of a human being. That is why, when the sermon proclaims God's concern for the salvation of the soul, it must also go further to demonstrate God's concern for the whole person.

In their mission to care for their members, church leaders can lead their churches to follow Jesus' example in the work of healing. However, the Church also needs to be clear on how to carry out its programme for healing. In caring for PLWHA, church leaders can help the Church to take various approaches in order to become a healing community. This research therefore deals with two principles, namely *koinōnia* and *diakōnia*, which church leaders can use to encourage the Church to respond to the needs of PLWHA. In other words, *koinōnia* and *diakōnia* are means which the Church can use to bring about healing for PLWHA. However, before discussing the principles of *koinōnia* and *diakōnia*, it is worthwhile to discuss baptism, which is a channel through which an individual enters into the Church and benefits from its *koinōnia* and *diakōnia*.

4.2 Baptism

It is an undeniable fact that while living in the world, everyone needs to belong to a community in order to survive. In a community that cares, a human being experiences a sense of life in which acceptance takes place, making wellness possible. As Benn (2001:144) argues, because a human being is a social being and depends on interaction with fellow human beings, membership in a strong community promotes health. In fact, humans can only survive within a community. There is often a need for something to be done by an individual in order for him or her to belong to a certain community and be accepted, and this is often called initiation, whereby rituals have to be performed for the person to be accepted as a new member in the group.

In the same way, for someone to be accepted into the community of believers, certain rituals have to be performed and baptism constitutes such a ritual. Davies (1986:55) defines baptism as "The rite whereby a person is made a member of the Church". This statement implies that baptism is a very prominent way through which a person becomes a member of the Church. As Browden (2005: 620) says, because becoming a member of a religious group is an occasion normally marked by some kind of ritual which marks the initiation process, baptism in its many forms then becomes the most important element in Christian initiation. In addition, baptism, being the formal entrance rite into the covenant community, is in some sense to Christianity what circumcision was to Judaism (Achtemeier, 1996:102). In Col. 2:11,

Paul compares the Jewish circumcision to the one believers get in Christ, but the circumcision from Jesus is not performed by human hands. This shows that there is no power of any creature involved, but that it is only the power of the blessed Spirit of God who does the work. Jews thought they were made complete by observing their ceremonial law of circumcision, but believers today are complete in Christ through baptism. Paul talks further about baptism in Col. 2:12, saying that in baptism, believers are buried with Christ and raised with Him. Hence, just as Christ's burial set the seal upon His death, the believers' burial with him in baptism shows their true involvement in His death, being also laid in His grave. In this sense, not only are believers dead and risen with Christ, they have also been raised with Him in His resurrection (Carson et al., 1994:1270).

In fact, Paul's idea of the participation in the death and resurrection of Christ through baptism is also found in Rom. 6:3-4. Here, it is stated that the baptised person is in fact dead with the Lord, even though the person does not die physically. Instead, Paul uses this as an allegory for the death of Christ in the sense that it separates believers from sin because it puts them in a relationship with Christ as they participate in his state of separation from sin. This union with Christ thus serves as a 'forensic' relationship in which God views us in association with his Son, and thereby applies to us the benefits won by his Son. The Christian rite of initiation, water baptism, thus does not make sense unless it manifests what physical death represented for Jesus, that is, a total and definitive separation from the forces of evil (Aletti, 1998:1578-1579; Mounce, 1995:149; Carson et al. 1994:1135).

With regard to the way Christian initiation was carried out in the Early Church, Browden (2005:622) outlines four steps in the process, as taken from the *Didachē*, a late-first-century or early-second-century Greek document:

1. An instructional period: this period had no specified length;

2. Baptismal preparation: this period came immediately after receiving instruction and it was represented by one or two days of fasting by the candidates, baptismal ministers and the entire Church;

3. Water baptism: this was to be done either by immersion (a complete dunking in water) or by affusion (a pouring of water over the candidate), perhaps accompanied by a Trinitarian formula ('I baptise you in the name of the Father, and of the Son, and of the Holy Spirit), and

4. The beginning of participation in the Holy Communion.

This process of initiation was fundamental in order to allow an individual to take part in the life of the Church. After this process, the candidates for baptism could continue enjoying their lives in the midst of a community of faith.

Furthermore, baptism does not stand alone; it is, in a way, completed by 'confirmation' and the 'Eucharist'. Fahlbusch, et al. (2001: 705) support the argument that in ecumenical use, without the more general religious connotation, "initiation" denotes the acts associated with incorporation into the Church, namely baptism, confirmation, and the Eucharist (First Communion). In this sense, confirmation is often called a completion of baptism, and the candidate earns full acceptance into the Church through partaking in a first communion to consummate his/her membership into the community of believers.

The role played by baptism and the Eucharist is thus very important for the life of the Church. It is with this importance in mind that Crow, Jr. (1980:76) points out that "Initiation through baptism and participation in the Lord's Supper make visible the unity of the Body of Christ. Christ unites us to himself and to one another, embracing us in the love which he offered on the cross for the redemption of humankind". In fact, baptism was performed whenever a person wanted to join the Christian community as a full member. The Scriptures mention various reasons why this initiation rite was useful, and it is still useful today. Moreover, baptism allows candidates to take part in the church *koinōnia*, thereby being able to share the Eucharist with other church members as well as benefiting from the *diakōnia* that takes place in the body of Christ. While *koinōnia* will be discussed under an independent heading, the researcher prefers to discuss *diakōnia* under another sub-heading, namely the early believers' devotion to fellowship, because, as *diakōnia* is in line with the believers habit to minister to each other by sharing material possessions, it would be a repetition to deal with it both under a separate heading and under another sub-heading.

After the discussion on baptism, this research study proceeds with a discussion on *koinōnia* in which different elements of church fellowship are looked at, with Acts 2:42-47 being taken as a framework.

4.3 Koinōnia

In the care of PLWHA, *koinōnia*, expressed in forms of worshipping together and sharing, is a strong means to use in order to make PLWHA feel welcome in the Church. It means that

when they have fellowship with the whole church membership, it becomes easier for people to identify with one another because worship removes all barriers and stumbling blocks to fellowship. As the WCC (1997:79) puts it, "Worship calls the body in its totality to express moments of daily life and to recognize God's will and importance of God's commitment to care for people and creation. Worship can help churches to remove the barriers we create in the everyday life of our human communities by opening up our eyes, our ears and all our senses to the extraordinary significance of 'ordinary' experiences and to ways of expressing God's presence amidst the people and creation". This sense of togetherness among believers is what motivates *koinōnia* and makes it a tool for mutual care and acceptance which brings healing in the community of believers.

Basically, *koinōnia* is a Greek term that can be translated as 'participation', 'fellowship,' 'communion', 'community', 'association', and 'close relationship' (Elwell, 2001:445; Mounce, 1995:1513; Polhill, 1992:122). This word is often used in the New Testament to talk about the communal life the first believers enjoyed with one another in the church community. In Acts 2:42-47, Luke gives an outline of what was happening among believers in the Early Church in terms of being together and supporting one another. In v42, there are four outstanding practices which the first believers were committed to: first, the believers' devotion to the teaching of the apostles; second, their devotion to the fellowship; third, their devotion to the breaking of bread; and fourth, their devotion to prayer. Looked at another way, these four elements are similar to the four parts of the early Christian liturgy, made up of what can be called 'liturgy of the word,' 'the collection for the poor,' the 'liturgy of the Eucharist,' and 'prayers of thanksgiving.' Thus the celebration of the liturgy is the image in miniature of the whole life of the community (Taylor, 1998:1513). For the purposes of this research study, these four practices will be discussed in more detail in order to establish how church leaders today can learn from the practices of the Early Church as far as fellowship is concerned, as well as integrating such an example in the fight against HIV and AIDS stigma within the Church.

4.3.1 The Early Believers' Devotion to the Apostles' Teaching

After the ascension of Jesus, the work of teaching was given to the apostles. This is clear in the Great Commission in which Jesus charged His disciples to "go and make disciples of all nations, baptising them..., and teaching them..." (Matt. 28:19-20). For these first Christians, therefore, being new disciples of Jesus, the teaching of the apostles was very important since they had just been saved during Peter's sermon on the day of Pentecost. In fact, though the

apostles had to carry out the teaching that Jesus used to do (Mark 10:1), this teaching, according to Taylor (1998:1517), was different from the apostle's public proclamation of the gospel. It was rather the kind of private instruction and explanation of the Scriptures which was given to new converts in regard to Christian life. In writing about this in the Acts of the Apostles, Luke would also have had in mind the teaching of the leaders and the catechists in the Church of his own day. The Greek word used here is *didachē* which, according to Vine (1997:323), means 'that which is taught', or 'doctrine'. In addition, the reason why the apostles' teaching was so interesting to the audience might have been because it was about the Lord who had just ascended. Concerning the content of the teaching which the first Christians were devoted to, Polhill (1992:119) suggests that in keeping with Jesus' teaching to them in Chap1:1-8, the apostles' instruction would have included such subjects as the resurrection of Jesus, the Old Testament Scriptures, the Christian witness, and in all probability, their own memoirs of Jesus' earthly ministry and teachings.

After some time, the apostles did not have only the new Christians as recipients of their teaching. Instead, they also taught in the Jewish temple where they certainly encountered members of Judaism. In Acts 5:42, it is clear that "Day after day, in the temple courts and from house to house, they never stopped teaching and proclaiming the good news that Jesus is the Christ". In fact, even though they faced persecution and stern warnings from the Sanhedrin, the apostles were not discouraged from reaching out to the Jewish community with the Gospel (Kisau, 2006:1309). This verse (Acts 5:42) shows that along with teaching, there was also the preaching of the gospel. This means that, as the teaching about Christian life continued, the evangelistic mission which the disciples were given by Jesus in Matt. 10:7-8 also continued in order for more people to be converted. Therefore, it would be fair to say that while Acts 2:42 focuses on the teaching of the apostles as part of the first Christians' fellowship, Acts 5:42 includes both teaching and preaching in the temple. For that reason, this research study deals with teaching and preaching as two of the liturgical elements in a Christian Church. Although it is often difficult to notice the difference between teaching and preaching, in Acts 5:42, it is clear that, as Polhill (1992:174) puts it, teaching was often done in Christian fellowship while preaching was mostly a public task performed in the temple courts. This concept of preaching is the one depicted in this verse, as the Greek word used is *euangelizō* which carries the idea of evangelism (Pervo, 2009:150).

According to Renn (2005:750-751) the Greek word used is *kēryssō* which means *to preach*, and is used in the sense of making a proclamation as a 'herald'. The verb *kēryssō* is used

synonymously with another verb, *euangelizō* that conveys the same sense of bringing the good news. The noun that derives from *kēryssō* is *kērygma* which conveys the meaning of 'preaching' as well as that of being the content of the proclamation of the word of God, both in the OT and in the NT. With this meaning in mind, it is also good to note that the Christian ministry of preaching is grounded in the ministry of Jesus and the commissioning of the apostolic Church. In His preaching, Jesus proclaimed the kingdom of God and also announced the good news of salvation. In the same way, His disciples carried on with the same message, and their *kērygma* included the resurrection and the second coming of the Lord Jesus (Gehman, undated: 534; Komonchak et al. 1988:792).

However, preaching was not only directed at those outside the Church. It has always been part of the liturgy in the Church in order to serve as a tool for the growth of the Church. As Cross (2005:1326) and Browden (2005:974) state, since the first century, preaching has taken many forms and has been principally, though not exclusively, focused on the Church, with the aim of teaching, strengthening, and encouraging congregations by way of preparing them to become more effective witnesses to the Christian truth and manner of life. For this reason, *kērygma* has become part of the Church liturgical order. Just as proclamation outside the Church has been a tool to win new converts, preaching within the Church has also been used to encourage believers to carry on with their Christian living. This is what Komonchak et al. (1988:791) mean when they argue that "In addition to the to the liturgical homily (the preeminent form of Christian preaching), preaching in the broad sense includes catechesis (*didache/didascalia*), exhortation (*paranesis*), mystagogy (post-baptismal instruction in the mysteries of faith), and various forms of evangelisation (broadly, any ministry of the word; more specifically, the initial proclamation of the word of God in a non-Christian or non-religious environment). This argument can be used to show how in the Church, the ministry of the word can be used by church leaders to encourage PLWHA and to challenge church members to change their attitudes towards them. For that reason, what can be said here is that through preaching and teaching, people in the Church are instructed about how to live a holy life which is characterised by love for one's neighbour. The following discussion about the believers' devotion to fellowship enhances the fact that believers can work together in a community of worship in order to share what they have for the benefit of all its members, so that there is no one left behind.

4.3.2 The Early Believers' Devotion to Fellowship (*Diakōnia*)

The second part of what the early Christians did was represented by *koinōnia* in the form of sharing their material belongings. In Acts 2:44-46; 4:32-37, it is clear that the believers, being together and having everything in common, sold their possessions and goods and gave to the needy among them. Their sharing is obvious in the way they broke bread in their homes and ate together with glad and sincere hearts. This sense of sharing, which showed concern for one another and generosity in this new believers' community, is very similar to the secular Hellenistic ideal of friendship as expressed in the sharing of possessions, motivated by the communal concept that everything is held in common and should be shared equally (Pervo, 2009:127; Polhill, 1992:119; Holladay, 2000:991).

In addition, the apostle Paul used the same practice of collecting money for the poor in his ministry. In fact, Paul saw the need for intervention in helping the poor in the Early Church and, for that reason, urged the Church to intervene in that situation (Rom. 12:13). According to Mounce (1995:238), "The level of poverty and the need for help were relatively high in the Early Church. It was critical for believers who had enough and more to share their abundance with those who were in need (cf. 2 Cor. 8:13-14). And finally, Paul indicated the moral responsibility for showing hospitality". Paul's desire to encourage churches to care for the needy was not just a humanitarian concern, but the sense of sharing was to be viewed as a sign of commonality between the Jews and the Gentiles. It is in this light that in 1Cor. 16:1-4, Paul instructed the Corinthian church to see to it that they collected money on every first day of the week in order to send it as a gift to Jerusalem. Carson et al. (1994:1185) posit that "Paul attached great importance to money being collected for the needy Christians in Jerusalem. It had not only a philanthropic motivation, but it represented a unique gesture of solidarity by Gentiles to Jews. Normally, the Jews of the Dispersion sent gifts to fellow Jews in Jerusalem, but the fact that the Gentile churches collected money for Jewish Christians showed the nature of the Gospel which could break down the decisive racial barrier". As a result, "the Corinthians should realize that contributing to the fund for Jerusalem is an important sign of their obedience to the gospel of Christ and that the thanksgivings of the beneficiaries are not really for their human benefactors, but for the greater glory of God" (Furnish, 2000:1100).

While still talking about how believers shared their resources with the needy, it is also useful to have a look at the concept of *diakōnia*. Etymologically, *Diakōnia* comes from the Greek word *Diakoneō* which means 'to serve', and it has been explained as the accountable service

of the Gospel by deeds and by words carried out by Christians in reaction to the needs of other people (Fahlbusch et al., 1999:830). According to Marshall et al. (1996:769), the pattern for Christian ministry is provided by the life of Christ, who came not to receive service but to give it (Matt. 20:28; Mark. 10:45); the verb used in these texts is *diakonein* which suggests something like 'waiting at table', and recalls the occasion when Jesus washed the disciples' feet (John. 13:4). It is the same pattern of ministry which guides the Christian's service to neighbours as they serve Christ. In 2 Cor. 4:5, Paul talks about his ministry to the Corinthians because of his commitment to serve Christ. On this point, Lowery (2000:563) highlights the fact that in serving the Corinthians who may not even be worthy of his service, Paul clearly does it because of his love for Christ. In addition, Paul finds it necessary to urge believers to use the freedom they have in Christ by serving one another in love (Gal. 5:13).

To emphasise this truth, MacArthur (1997:1798) affirms that Christian freedom in Christ is not for selfish fulfilment, but for love and service to one's neighbour. Holding a similar view of Christian freedom, Ngewa (2006:1423) observes two sides to Christian freedom: having been set free from slavery to the law, believers are called to serve the Spirit and one another. Christian freedom is thus not a call to irresponsibility or self-indulgence, but to a new set of responsibilities towards others. Hence, as it has been mentioned before, the responsibilities of believers in service to others extend to taking care of the needy so that there are no needy found in their midst. *Diakōnia* thus dovetails with *koinōnia* to characterise the life and nature of the Church as well as to be relevant in the community. As Fahlbusch et al. (1999:830) stress, *diakōnia* is particularly useful in the context of the social breakdown in the Third World which faces problems of poverty, refugees, exploitation and hunger. In this sense, the Church's solidarity with the poor is of great value. This assertion agrees with Richardson's definition of *diakōnia* as action of a particular kind, carried out with a particular intention to promote fellowship, and directed towards people in distress (2002:46). Coupled with this definition is the idea that "Theologically, *diakōnia* starts in the local congregation and indeed may be defined as the social presence of the local worshiping community. The new ecumenical awareness of this service becomes a Christian challenge for church leaders leading churches that use a comprehensive *diakōnia* to secure for themselves a clear role in a society" (Fahlbusch et al. 1999:830).

In addition, in a world affected by the scourge of HIV and AIDS, *diakōnia* becomes very important because it can be used by the Church to respond to the needs of those infected and affected. This is because of the serious combination of HIV and AIDS and poverty which

makes the disease even more devastating. Concerning this dangerous combination of HIV and AIDS and poverty, Kamaara (2004:38) argues that they feed each other. She maintains that even though HIV does not affect only the poor, "poverty contributes enormously to the spread of HIV and to the development from HIV to AIDS. On the other hand, HIV and AIDS contribute enormously to poverty. This means that a vicious circle exists where poverty contributes to HIV and AIDS and vice versa, complicating the situation".

As to the reason why HIV and poverty have a strong link, Magezi (2007:65) gives an explanation of the two-way traffic between HIV and poverty. He points out the role of poverty in increasing poor people's vulnerability to HIV and AIDS through risk behaviour caused by the selling of sex to survive, acceleration of immunity depletion due to poor nutrition, lack of access to information and preventive interventions, and loss of access to care. The situation becomes even worse when HIV and AIDS enhance poverty, as a potentially productive person in the home becomes powerless and draws from savings, causing the household income to be eroded through high medical and funeral costs (Mulligan, 2010:5; Greyling, 2001:7). To elaborate further on the combination between poverty and HIV and AIDS, in a study done on the extent of households' experiences of HIV and AIDS in rural South Africa, Hosegood et al. (2007:1252-1257) discovered that increased expenditure on health care and funerals, while at the same time households lost the income from the patient or their caretaker, which exacerbated the financial constraints and resulted in inability to afford health care, education, or adequate food to sustain the health of patients. The MSF (2011:5) reports that in Khayelitsha, PLWHA face the challenge of spending a lot of time attending clinics as required as well as being hospitalised to get treatment, therefore finding it difficult to work in order to sustain themselves and their families.

Similarly, a report by the Merafong City Council (2011:6) confirms that the burden of care rests on the families and children of the one who is ill, and if he/she has been the sole breadwinner, it means that there will be no bread on the table. Furthermore, children will be unable to go to school because they have to care for the sick, and there is also not enough financial support to pay for their education. This hampers their future in that they may end up on the street and face a jobless future, sometimes even becoming criminals. As a result, young people who live in poverty often suffer from low self-esteem and crave the material things which their friends possess while they cannot afford them. This may cause them to become involved with "sugar daddies", taxi drivers, etc. who can give them the material things they wish for in exchange for sex, which may increase their risk of HIV infection. This

becomes even worse in cases where parents fall ill or die with AIDS and cannot be there to give attention and guidance to their children, who then indulge in risk behaviour leading them to unsafe sexual activity and, in turn, to HIV infection (Greyling, 2001:8-9). Indeed, poverty forces people to adopt 'survival strategies' such as prostitution, due to the fact that it is difficult for poor households to be financially able to cope with illness and disease. This causes the poor to adopt coping mechanisms which later expose them to infection with STDs such as HIV. In the case of unemployment, many poorer women in South Africa "migrate to areas with large-scale mining in the hope of finding a man with regular employment. Squatter camps are hastily erected in these locations, where inhabitants live in shacks with little or no facilities. Casual sex and prostitution is widespread in these camps and there is rapid spread of STDs including HIV/AIDS" (Mulligan, 2010:3).

Many South African men also adopt survival strategies due to high levels of unemployment and poverty forcing them to migrate in the search for work, finding themselves working in the mines far away from their families. They stay there for up to eleven months per year, engaging in casual sex or even beginning another relationship or family where they are working, and then infect their spouses with STDs such as HIV upon their return home once or twice a year (Mulligan, 2010:3).

In addition, the kind of poverty experienced by families with members living with HIV and AIDS also plunges several households into borrowing money, with no assurance of having the means to repay the debt. In the case of death, the situation becomes even worse for households that have multiple deaths of members within a short period, which further exhausts their already limited resources and reduces support from relatives and neighbours who also become either unable or unwilling to assist the stranded households. In this regard, government social grants that are meant to assist affected households to look after their HIV and AIDS patients and orphans are not easily accessible to them due to such problems as: the delay caused by the lengthy application process; their inability to meet the expense of transport to health and welfare offices, or even, in some cases, to pay the bribes demanded for finding documents or for processing applications; overloaded and unmotivated civil servants and social workers, as well as long queues and poor service in some government departments (Hosegood et al., 2007:1252-1257; Uys & Cameron, 2003:166).

Whatever it takes, the poverty situation caused by the HIV and AIDS scourge calls for church leaders to respond with *diakōnia* in order to care for PLWHA and their families and to

alleviate the poverty they face by taking care of their financial and material needs as far as possible. In this regard, religious institutions could lend a supportive hand by being in contact with affected persons and through devising workable strategies of support (Pandor, 2003:52). This kind of intervention by church leaders will be discussed further in Chapter five.

4.3.3 The Early Believers' Devotion to the Breaking of Bread (Eucharist)

The third element of worship which early believers were devoted to was the breaking of bread, which can also be referred to as the 'Eucharist', the 'Holy Communion' or the 'Lord's Supper'.

According to Cross (2005:570), the title 'Eucharist' is the Greek for 'thanksgiving', and this sacrament is so called because the central act of Christian worship is based on the fact that at its institution, Christ 'gave thanks' (1Cor. 11:24, Matt. 26:27), as well as on the belief that it is the supreme act of Christian thanksgiving. It is also important to note that the modern term 'Eucharist', used in 1Cor. 11:23-25 to denote the Lord's Supper, derives from the Greek *eucharisteō* which means to 'give thanks' (Sampley, 1995:934). According to Browden (2005:968), the Eucharistic prayer, which means 'prayer of thanksgiving', expresses gratitude and praise to the Lord for the salvation which He has performed and which was completed by the death and resurrection of Jesus.

Although in Acts 2:42 there is no mention of the cup that goes with the bread which is broken during the Lord's Supper, this is not a reason to deny the reference to the Lord's Supper in this passage. Komonchak et al. (1988:343) argue that this passage does, in fact, talk about the Lords Supper. As they further suggest, many exegetes find the same kind of gathering reflected already in the "breaking of bread" in Acts 2:42 and 46, even though the clearest picture of the early Eucharist emerges in the four versions of the Lord's Supper: Luke 22:19-20; 1Cor. 11:23-25; Mark 14:22-24; Matt. 26:26-28. The Eucharist is thus celebrated in a Christian community as the people observe the rituals of bread and cup to commemorate the key events from which their community draws its life, namely the death and resurrection of the Lord. The cup and bread, being the components of the Eucharist, symbolise the Body and the Blood of Jesus. According to Cross & Livingstone (2005), the belief that the Eucharist conveyed the Body and Blood of Christ to the believer was universally accepted from the beginning, and it was widely understood that the Eucharistic elements, i.e. the bread and the cup, were themselves the Body and the Blood. Even where the elements were referred to as

'symbols' or 'antitypes' there was no hint of denying the reality of the Lord's Presence at the occasion.

The reality of an occasion on which believers eat of the Body of Christ and drink of His Blood may be difficult to understand, but as Culpepper (1995:421) suggests, the challenge for the believers is not to grasp the full meaning of the Lord's Supper, but to open themselves to the full extent of its power to change them and create intimacy between them and outcasts. In other words, the Eucharist has the power to bring together all kinds of believers as they are united by Christ through partaking of His Body and Blood. This therefore shows that no matter what one may be going through, as long as he/she is a member of the body of believers who share the Eucharist together, there must be a sense of healing in a broken life.

In his commentary on the Lord's Supper as described in Luke 22:19-20, Culpepper (1995:421) suggests that the Supper relates the believers physically and spiritually to the Lord, who laid down His life that they might live. It is therefore a commemoration of the life and death of Jesus in the past, a celebration of His real and spiritual presence today, and an affirmation of the hope that believers will eat and drink with Him in the kingdom of God. This highlights the importance of the Lord's Supper in that it foreshadows a meal that believers expect to share with the Lord in heaven one day. This is the idea that Achtemeier (1996:622-623) and Browden (2005:968) convey when they argue that even in earliest Christianity, the Lord's Supper was pervaded by intense eschatological expectation, a strong expectation of a new age to be established by the risen and exalted Jesus upon his return to earth. This means that being in a fellowship where the Eucharist is administered assures a believer that he/she is in a place where he/she eagerly awaits the Lord's return, and that the Blood of Jesus which he/she shares with others has purified him/her from sin. In Matthew's account of the Lord's Supper, Jesus talks about "the blood of the covenant poured out for the forgiveness of sin" (Matt. 26:26-28). In this statement, as Powell (2000:897) puts it, Jesus "affirms that his death will indeed be a ransom by which his people will be saved from their sins."

Another important fact about partaking of the Body and the Blood of Jesus is the act of searching oneself before partaking, requiring that every time a believer eats of the Body of Christ and drinks of His Blood, there must be an element of penance, i.e. the person must purify him/herself of anything that may interfere in his/her relationship with the Lord and his/her fellow believers. This is what Paul refers to when he says that whoever partakes in the Eucharist must make sure of "recognising the body" (1Cor. 11:29). However, in Paul's view,

the Body of Christ can never be separated from the members who by God's grace are incorporated into it, which is Paul's way of talking about an individual's assessment of two distinguishable but inseparable matters, namely, how well one's life relates to Christ, and how well one's love ties one to others who, though many, are one Body in Christ.

In short, the Eucharist is essential for symbolising the on-going union which the believer has with Christ and the Church, which perpetuates hope for a future life to be enjoyed with the Lord. Furthermore, it helps the believer to stay connected to others who share the same faith, and also to Jesus who died for him/her. It is also important to mention that the Eucharist becomes a means of healing and acceptance for those who are broken and rejected. For that reason, the communion of believers becomes very significant in the context of HIV and AIDS stigma. If the Church marginalises PLWHA, it indicates that these people miss out on a very important chance of healing because they will not be able to eat of the Body of Christ and drink of His Blood. They will then grow away from the union with Christ and the Church that is supposed to be giving them hope.

4.3.4 The Believers' Devotion to Prayer

The fourth element that the first believers were devoted to is prayer. In fact, prayer had long been a significant characteristic of God's people. In the OT for example, as Fahlbusch, et al. (2005:325-326) mention, prayer was as varied as life itself. In this sense, prayer is seen in its two basic types, namely complaint and petition on the one side, and praise and thanksgiving on the other. These types of prayer articulate the two fundamental relations of believers to the reality around them, namely, assistance and submission. Prayer in this way is not to be considered as a mere religious act, but a self-evident way of dealing with life.

It is because of this background that believers in the Early Church continued to adhere to the hours of prayer as set in the Judaic worship system. For example, Acts 3:1says that "One day, Peter and John were going up to the temple at the time of prayer - at three in the afternoon". This exemplifies the believer's constant commitment to prayer. In the Jerusalem temple, the Jews were used to praying three times a day, that is, 9:00 a.m., 12:00 noon, and 3:00 p.m. (MacArthur, 1997:1639; Toussaint, 2000:360). If they were devoted to the apostles' teaching, as mentioned in the discussion above on the first component of their fellowship, it is possible that the apostles also taught the early believers about the Lord's prayer, and that they had to pray according to its pattern, which, according to Browden (2005: 96), encompasses the different forms of prayer, namely adoration, confession, thanksgiving, and supplication (also

represented by the acronym ACTS, which is a well-known *aide-memoire* for the elements of 'prayer').

Prayer is, in general, the communion of the human soul with God. Prayers were usually presented in the form of hymns and psalms, as illustrated in the Book of Psalms, which is often called a prayer book since it is full of prayers by the psalmists. Taylor (1998:1513) supports the notion that 'the prayers' to which believers were devoted would mean especially the singing of psalms, which were the great prayers in the Bible that Christianity inherited from Judaism. This is further supported by Paul's exhortation to believers to "Let the word of God of Christ dwell in you richly as you teach and admonish one another with all wisdom, and as you sing psalms, hymns and spiritual songs with gratitude in your hearts to God" (Col 3:16). With regard to singing psalms, hymns and spiritual songs in thanksgiving to the Lord, as MacArthur (1997:1812) comments, the Early Church sang psalms in the same form as those in the OT. They also sang hymns, which were songs of praise, as distinguished from psalms, but which exalted God in that they focused on the Lord Jesus Christ. Apart from psalms and hymns, they also sang spiritual songs, which were probably songs of personal testimony uttering the reality of the grace of salvation in Jesus Christ.

Furthermore, the fact that psalms and hymns were part of the worship in early Christianity is a reality. Reflecting on the Lord's Prayer (Matt. 6:9-13), Komonchak et al. (1988:788) point out that "The entire first part of the prayer is directed to reminding worshipers that all reality exists for the praise and glory of God and that his fatherly will is the guide and goal of all human striving. Only when his followers have oriented themselves to the transcendent Father does Jesus direct them to petitions for personal needs. And the needs that believers are to ask for are extravagant. They reflect simplicity of lifestyle and sincerity of heart: food that is necessary at the time; forgiveness that identifies them as followers of Jesus; and protection against the crafty powers of evil".

From that statement, it can be argued that in the Lord's Prayer, on the one hand, adoration, confession and thanksgiving form the first part of the prayer and have to do with the character of God as the One who is holy and transcendent, to whom all glory and honour should be directed. On the other hand, the second part of the prayer is about supplication, which carries the idea of praying for one's needs through petition, as well as praying for the needs of others, or in other words, intercession. Talking about the significance of intercession, Fahlbusch, et al. (2005:327) posit that in intercession, believers achieve solidarity with those

for whom they pray, because it brings awareness of the needs of others and openness to taking on responsibility for those needs. In this way, prayer serves to glorify God by liberating those who pray and making them proficient in action.

All in all, prayer is to be part and parcel of church life as believers come together to share the joys and sorrows that life holds. As Komonchak et al. (1988: 593) hypothesise, "The Church's daily prayer, the liturgy of the hours, presumes regular gatherings of the Christian people in households, monasteries, and local churches morning and evening for public praise, thanksgiving, lament, and intercession in Christ's name and in communion with him". This means that believers are to stay together and encourage each other as they carry each other's burdens through prayer.

Furthermore, the spirit of prayer in the Church allows for prayers to be offered for people who are sick in the congregation of believers. This is now the task given mostly to leaders in the Church. In his letter to the Church, James (5:14-15) urges anyone who is sick to call on the church elders for prayer with anointing of oil. James is convinced that prayer by faith will heal the sick person both physically and spiritually. Moreover, these verses highlight the task of church leaders in ministering to sick people in need of prayer. With regard to being 'sick', a lot of debate has taken place as to what James means by the word 'sick'. Some commentators have argued that James is talking about the general physical weakness which people face when their wellness is hindered, while others take the concept of being 'sick' literally to mean physical ailment. For example, MacArthur (1997:1934) proposes that James' word to the 'sick' is for those who are generally made weak by their suffering and are in need of the church elders' intervention to strengthen, support, and pray for them. With this idea in mind, MacArthur posits that the anointing with oil refers to "the medical treatment of believers physically bruised and battered by persecution". He then suggests that the anointing can thus be better understood as a metaphor for the role the elders play in encouraging, comforting, and strengthening the sick believer.

Blue (2000:834-835), holding a view similar to that of MacArthur, sees no reason to consider that James is referring to physical illness when he calls for the 'sick' to consult elders for prayer. Blue's argument is based on the Greek term for sickness, *asthenei*, which means 'to be weak'. Even though the same word is used in the Gospel for physical sickness, it was generally used in Acts to refer to 'weak faith' or 'weak conscience'. In Blue's view then, "James was not referring to the bedfast, the diseased, or the ill. Instead he wrote to those who

had grown weary, who had become weak both morally and spiritually in the midst of suffering". As for the act of anointing with oil suggested by James, Blue proposes that James's intention is not to suggest a ceremonial or ritual anointing as a means of divine healing, but instead refers to the regular tradition of using oil to grant honour, refreshment and grooming.

In their views of sickness in James 5:14-15, MacArthur and Blue seem to deny any reference to physical illness in that passage. However, a different position on this passage is held by Andria (2006:1516) who sees the Church as having the opportunity to care for the physically ill as a healing community. This task, in Andria's view, is the responsibility of the church leaders in the sense that they must fulfil their role of praying for the sick, while the whole Church then offers the support that the sick person needs. As for the anointing with oil, Andria purports that even if the sick person is anointed, what matters is not the power or the quality of the oil used, but the promise of God to heal through prayer.

After considering these different views of sickness in James 5:14-15; this research study takes sickness and anointing literally and therefore supports Andria's idea of illness being physical, with the task of church leaders being to anoint and pray for the sick person. Prayer by faith, as presented by church leaders in interceding for the sick, is significant in that it carries such great healing power. As Browden (2005:972) claims, "Intercession is a form of prayer that has much to do with the pastoral work of the Church and is closely allied with it. As such, it is important that, on the level of care and concern for people, visiting, giving advice, and conveying a sense of hope and belief in God, the prayer of intercession receives the attention it deserves and demands".

Furthermore, such prayer is not only useful for delivering people from their diseases; it also serves as a means of liberation from sin. That is what James communicates by pointing out that prayer by faith will heal the sick, and if the person has sinned, he or she will be forgiven (James 5:15). Consequently, the kind of physical healing that is accompanied by spiritual healing refers back to the nature of Jesus' holistic healing, as mentioned at the beginning of this chapter. Concerning this kind of holistic healing, it would be fair to agree with Michaelson (2001:135) that "The presence of pain and death in our world creates suffering that cannot be escaped. Yet, within these limitations, a healing ministry which focuses on all aspects of people's emotional, physical and spiritual wellbeing is understood to be in harmony with the mandate of Jesus to preach, teach and heal".

Indeed, prayer for the sick is a vital part of church life. This is because people who are sick come to church with an expectation of receiving healing through faith. According to Asamoah-Gyadu (2004:375), people often seek healing and deliverance in the Church, not only because they regard the Church as a healing place, but also because many of them learn that the ministry of Jesus was about the deliverance of the afflicted as a sign that God is in the business of restoration. However, the interpretation of faith healing or healing by faith has become a point of hot debate among different faith communities. Salzman (1957:147-148) distinguishes two extremes concerning faith healing: one is the '*Least faith'* paradigm, and the other is the '*Most faith'*. For the '*Least faith'* paradigm, the use of drugs and physical therapies that are scientifically approved are vital to the treatment of the disease. Hence, the techniques and specific agents derived from scientific sources play a major role, while the personal characteristics of the healer play a minimal role. In contrast, for the '*Most faith'* paradigm, a variety of healers and healing techniques, which are often irrational and mystical, are performed. In some instances, religious spiritual elements form part of the healing process, but healers in this category rely largely or exclusively on the development of faith based on established psychological techniques, rather than on spiritual experience.

In his article on *Whole Person Healing, Spiritual Realism and Social Disintegration*, Allen (2001:127) compares the way mainline churches and Pentecostal charismatic churches view the issue of faith healing. He points out that while the mainline churches focus more on the scientific facts of sickness and medical ways of healing, Pentecostals have come to appreciate the faith healing ministries that offer miraculous healing of diseases. Matching Allen's findings and Salzman's distinction of levels of faith, one may say that, in this regard, mainline churches fall into the category of '*Least faith'*, while Pentecostal churches may be classified under the '*Most faith'* category. Looking closely at these two paradigms, it is clear that they both have loopholes. For the mainline churches, on the one hand, their focus on scientific means of healing implies that they give little regard to faith healing, thereby falling into the danger of denying miracles. As Olson (1982:354) suggests, "Theological objections to miracles are those which find it inappropriate to think of a creator who occasionally makes small adjustments in a world normally allowed to run on its own. This conviction that God is merciful and just makes some people object to the seeming randomness of miracles and even more to the idea that sincere prayer or many prayers or special merit could convince God to do a miracle. The difficulty with both the logical and the theological objections to miracles is the inherent danger of divorcing God completely from the world". From this quote, it is

understood that God can still intervene in ways that human beings cannot understand or explain.

Another ambiguity is that people in the mainline churches who believe in miracles secretly attend services where miraculous healing takes place, and even hide their experiences from others (Allen 2001:127). On the other hand, for Pentecostal churches, their exaggerated consideration of miraculous healing can push them into overemphasising the gift of the person who prays for healing to such an extent that the gift of healing becomes a vital characteristic for anyone who wants to be a leader. Such people come to be regarded as wonder workers able to pray for the oil and apron in such a way as to make them powerful enough to heal anyone who comes into contact with them (Bergunder, 2001:106-108). Another danger which Bergunder (2001:111) sees in the Pentecostal's strong focus on healing, is that people then tend to come to Church just for healing. Then, after getting the healing they were looking for, they go back to their respective churches, and this makes church growth and discipleship difficult.

Yet another issue concerning overstressing the ministry of healing is that people tend to ignore medical intervention in dealing with sickness because of their tendency to spiritualise any kind of illness. This supports the view of Elwell (2001:540) who states that "Because of faith's integral part in divine healing, some supporters of the doctrine believe the use of medical means and the supernatural are mutually exclusive. Since the root cause of sickness is sin and the only cure of sin is spiritual, they believe the only cure for sickness is spiritual. Any medical attempt at helping would imply a lack of faith in God's healing power". In fact, this is the case in the debate between the Treatment Action Campaign (TAC) and Christ Embassy in which the TAC has been accusing the Christ Embassy Church of 'quackery' in promoting a view of faith healing that discourages PLWHA from adhering to ARVs (TAC, 2010:2).

Considering the fact that churches differ on whether healing should be sought mainly through medical care or through miracles, this research study sees weaknesses in both extremes. For those who advocate the prominence of healing through medical intervention, it would be difficult to deal with cases of incurable diseases such as HIV and AIDS. In fact, by focusing too much on medicine, some even go to the extent of believing that the gift of healing has ceased in the Church, a view contrary to what Dyrness&Karkkainen (2008:365) put forward when they claim that "The biblical data neither supports the view that the miracles of healing

and exorcism ceased after the apostolic age nor the view that they are expected to continue in the same manner and frequency at all times of Church history. Such miracles are to be expected, especially where there are new missionary inroads into new territories, but they are not to be expected to be the norm".

However, as Blomberg (1992:171) asserts, miraculous healings continued after Jesus' resurrection, and there is no exegetical support for views that see the ceasing of the gift of healing at the end of the apostolic age. Therefore, believers in all eras may still expect supernatural healing from time to time. However, for those who promote faith healing, it becomes difficult to bear the situation when the patient has not been healed, even after having been prayed for.

Also, one may not ignore the Church's involvement in the medical mission to see to it that health care facilities are available for people to access. According to Van Laar (2006:229), health care practice has its origin in mission, as it was mission organisations that initiated the building of clinics for the welfare of the people they reached, and since physical care and proclaiming the gospel were inextricably bound up with one other, medical activities were also regarded as the proclamation of the gospel through charitable deeds. In addition, as the bearer of a salvific healing mission, the Church has sought to provide or sponsor institutional frameworks in which Christian medical professionals can realise the charity they are called to (Hayes, 2001:120; Allen, 2001:128).

Therefore, this research study still supports the notion of a holistic type of healing, where both medicine and prayer have a role to play. In the case of HIV and AIDS, for example, the idea that the virus can never disappear from the body even through prayer would be to undermine God's power to heal. It is thus better to accept that "healings do occur which are difficult to explain by the scientific means at present available to us" (Bergunder, 2001:108). At the same time, the fact that God can heal does not mean that prayer should replace any medical intervention in dealing with sickness, and in the case of HIV and AIDS, one can still use the ARVs that are available to manage the virus. Holistic healing in this case, therefore, implies that church leaders can help the Church to offer many kinds of support to PLWHA in such a way that they experience acceptance in order to continue living, even when the virus has not disappeared from their bodies.

The elements of liturgy in a worship service brings excitement to people and can also serve as a means of physical involvement with others and with God, which sparks an attitude of

belonging and can thus contribute to healing. This supports the WCC (1997:78) in its idea that "Worship — a special moment for celebration — attempts to place daily life on the stage. The repetition of gestures, words, sounds and colours that form the moment of celebration re-creates a reality that in many respects is also lived in an unconscious way".

Furthermore, worship services should be planned in such a way that they include PLWHA. There are places where worship services have been used as tools to make PLWHA feel part of the Church, and where this has been done, PLWHA have enjoyed a feeling of inclusion through their involvement in the planning and developing of such services by creatively identifying and addressing the spiritual needs of those affected and infected by the disease (WCC, 1997:79). Where worship services have accommodated PLWHA, it has been noticed that they enjoyed a sense of being together with others, and felt accepted: "People living with HIV or AIDS have commented that the liturgies and rituals of the Church have been a great source of strength, particularly when they are combined with the support of the worshipping community" (UNAIDS, 2005:16).

The elements of liturgy in the Church should include the sacraments of the *Eucharist*, *preaching*, and *lament*. Since the Eucharist is about sharing broken bread and wine in remembrance of Christ's suffering, it is important that all in the Church come together to celebrate that moment in order for them to be united to Christ and to each other. Mash et al. (2009:115-116) emphasise that the fact that PLWHA are often marginalised "demands a re-evaluation of the importance of the Eucharist, the proclamation of the death and resurrection of Christ. The whole community gathers around the broken bread and the poured wine, and that includes the broken, damaged, abused and stigmatised bodies of individual sufferers and the broken body of the community. The invitation to draw near and receive is an invitation that will take all people up into the body of Christ".

As for the preaching of God's word, it should be realised that in the face of HIV and AIDS, preaching is part and parcel of liturgy in that it brings hope for the community. On this point, Mash et al. (2009: 116) argue that "AIDS reminds us that preaching and sacrament cannot and should not be separated, and it is in the liturgy where both have their rightful balance that lament can become hope, hope for a new community".

As far as lament is concerned, Louw (2000:21-22) sees it as "an example of the way the righteous struggle to express to God their experience of the injustice of suffering". He further refers to the book of Job and psalms of lament as example of OT lament documents. Lament

is different from complaint in that lament serves as a tool to celebrate God's faithfulness and show dependence on Him through petition in times of trouble, while complaint is connected to pessimism in that it implies that nothing can be done about the situation (2000:22). In the case of HIV and AIDS, lamenting becomes the voice to be heard in the liturgy by which the pain and sorrow of the sufferers are expressed, so that those suffering from HIV and AIDS feel that their suffering is acknowledged. Thus, "The Church and preachers must talk about the things that cause us pain. A language which talks about suffering gives dignity to the suffering" (Mash et al., 2009:81). For this reason, it is useful to use a language that can touch the lives of those who are suffering in order to help soothe their pain. While discussing healing, it is also necessary for this research study to distinguish the difference between healing and cure.

4.4 Healing Versus Cure

In an endeavour to point out the difference between healing and cure, Herselman (2007:62) specifies that while 'cure', on the one hand, has more to do with clinical biomedicine, where the physician focuses on pathological processes to deal with the symptoms of a disease in order to restore the body to its wellness and functioning ability, 'healing', on the other hand, is linked with the patient's health-belief system and has to do with emotional and somatic aspects of the patient. Healing is thus meant to deal with the problem by addressing social and cultural factors that influence the disease.

In the light of this definition, it can be said that, since HIV is a virus that is incurable, church leaders in their ministry to PLWHA need to understand the difference between 'healing' and 'cure' in order to take a stance of what to focus on in order to deal with HIV and AIDS stigma. The Church is a place where everyone wants to feel accepted and accommodated. As the UNAIDS (2005:16) claims, the Church is a community of Jesus Christ's disciples, and as such, should be a sanctuary, a safe place, a refuge, a shelter for all those who are stigmatised and excluded. This implies that the Church can only make a difference once it understands its calling and puts it into practice in the way it treats PLWHA. In this way, church leaders need to help the Church move away from its exclusive attitude and adopt a culture of inclusion. This will only be possible if church leaders learn from Jesus Christ who, being the Master of the Church was not so much concerned about moral codes and rules as about grace and unconditional love (Paterson, 2009:5).

Concerning some of the things church leaders can do to encourage the Church to become a healing community, Shorter & Onyancha (1998: 65) suggest that "Christians who treat AIDS people with compassion are involved in a variety of activities. These include patient care, providing relief, home visitation, washing clothes, consoling the bereaved, and assisting in funeral arrangements". On the same note, Chitando (2007:72), talking about a healing Church in the African context, defines a healing Church as one that is motivated by a spirit of hospitality and acceptance of PLWHA in order to restore them and their relationships: "In fulfilling its task as a healing community in the context of HIV and AIDS in Africa, church leaders must help the Church to recognize the need to become a welcoming and hospitable Church. It is one that is aware of the fact that it is a Church living with HIV. By offering safe and friendly space to people living with or affected by HIV, the Church goes a long way in healing persons and relationships".

However, there are different forms of healing as understood by different people: some understand healing as necessarily curing the disease so that it disappears from the body. Even though HIV and AIDS is regarded as an incurable disease, those who believe that it must be cured put a lot of pressure on PLWHA, and say that there is something wrong with them if the virus did not disappear from their bodies. This supports the findings of Shorter & Onyancha (1998:64) that some people feel that "If the disease is impervious to all healing, then the sufferer's lack of faith is obviously to blame. The incurable nature of AIDS is further proof, if proof is needed, of the sufferer's guilt. This type of belief is a wholesale condemnation of all people living with HIV and AIDS, as sexually promiscuous sinners".

Looking at this issue in a different way, there is another side of the story which encompasses the idea of holistic healing which will help the suffering person to feel loved and accepted in order to move on with life despite the disease. In this way, healing is presented through accepting what one cannot change. This is the kind of healing which Chitando (2007:64) advocates: "Healing can take place in the absence of cure. If we understand healing in terms of restoration and reintegration, we can imagine how it is possible to be healed even if one has not been cured. A good example is how healing occurs when those of us with HIV no longer have to experience exclusion, stigma and discrimination. When those among us with HIV receive love and acceptance, healing occurs. Healing entails overcoming alienation and brokenness. It entails the idea of recreating a sense of belonging and community". This idea of healing through restoration and reintegration into a community supports the idea that for a person to be healed, he/she needs soul care. In this sense, the soul is taken as a systemic

structure of interrelatedness and interconnectedness which indicates the quality of human life as well as the intentional directedness of being towards meaning and ultimate life goals. Thus, healing in the Church calls for the attention of pastoral care, and refers to pastoral actions and intentions which emanate from salvation (Louw, 2003:213).

As to pastoral actions to facilitate the healing of the soul, Louw (2003:217) suggests the following:

- *Seeing*: a perception and vision created by unconditional love.
- *Listening*: an attitude and aptitude of empathy, which lead to the creative act of replacement/substitution. To place oneself in the position of the other presupposes the sacrifice of love. Listening then becomes an act from below (the position of the victim) and not from above (the position of the benefactor).
- *Understanding*: the application emanating from a theology from below: the God-with-us (companionship, partnership).
- *Identification*: to shift your position from apathy (rejection) to acceptance; from frustration to accommodation.
- *Relating*: to become involved in the systemic network of interconnectedness and shared humanness.
- *Structuring:* to develop a policy of decision-making which incorporates the needs, dignity and creative imagination of the sufferer.
- *Acting*: the design of programmes and projects in which the sufferer is invited to take initiative and accept ownership.
- *Supporting*: to start with small support groups within caring communities and congregations.

These pastoral actions are so significant in the efforts of soul healing for PLWHA, and they correspond with what will be suggested as a pastoral approach for church leaders in dealing with HIV and AIDS in Khayelitsha.

In the light of these views, this research study supports the idea that despite the notion of incurability that surrounds HIV and AIDS, church leaders can still encourage the Church to create an environment in which healing takes place by focusing on holistic healing through inclusion and acceptance in the body of Christ, and not necessarily on the curing of the body which does not always imply wellness. In this sense, HIV and AIDS provide the Church with

a valuable chance to be a community where true healing is experienced in Christ. This healing is expressed in the fact that the sufferer is integrated into the body of Christ through acceptance, and the immune system that is decaying is assured of eternal life. In this way, pastoral healing is presented as faith care displayed as life care to facilitate salvation as healing and humanisation in order for a human being to be enabled to function fully in relation to him/herself, his/her society, and his/her environment.This implies that even in the case of severe physical disability or terminal illness, the person may still feel healthy due to the hope and human dignity through the meaning found in God's co-existence with human beings in Christ, an act which Anderson refers to as Christopraxis[7] (Louw, 2003:212, 213). This co-existence with His people shows that God is committed to human beings and identifies with them in order to liberate them so that they realise that they are created in His image no matter how fragile and vulnerable they may be (Van der Ven, 2003:139). For that reason, being a sinner, a person is saved by God's grace, irrespective of how the disease was transmitted. As God uses church leaders to practice pastoral healing, He blesses His people when the Church acts as Christ's agent of healing and hope, and in this way, healing is experienced holistically, i.e. physically, emotionally, relationally, and spiritually (Marshall, 2005:143-144).

Thus church leaders need to develop a sense of self-understanding of the healing mission given by God to the Church in order to become bearers of hope in the midst of the world's hopelessness created by the scourge of HIV and AIDS. Believers need to fulfil their God given role of standing with the poor, the oppressed and the suffering in order to bring God's acceptance, love, belonging, and hope, so that those who are dying as a result of shame for their HIV-positive status may experience the salvation that comes from God (Haddad, 2004:37).

While talking about healing in the context of the Church, it is also helpful for this research study to also look at healing in the *amaXhosa* culture which helps to get a picture of how the majority of people in Khayelitsha would understand healing.

[7]Louw (2003:212-213) refers to Anderson's theory of Christopraxis which is the ministry of Christ for the world, a revelation of God's being-with-us, is the service of God for the humanising of persons. 'This Christopraxis unites advocacy and diaconia so that actions of 'being there' are accompanied by actions of 'bringing there' tangible assistance and deliverance'.

4.5 Illness and Healing in the AmaXhosa Culture

In a definition of 'illness', Louw (2008:105) points out that, while 'sickness' refers to 'the biological and physiological dimension of medical pathology and the total predicament of being a patient or being hospitalised, 'illness' is 'the patient's awareness of the sickness, his/her responsive behaviour, perceptions and emotional experience of pain. According to Herselman (2007:62), 'illness' in anthropological terms "refers to patients' subjective experiences and interpretations of sickness in line with their health-belief system rooted in culture; hence what is classified as 'illness' across cultures". From those two definitions, it is clear that illness is more than a set of physical symptoms. In the African context, in the second chapter of this research study (See sub-section 2.1.2), it has been established that just like in other African cultures, illness in the *amaXhosa* traditional beliefs is viewed as an evil caused by an external agent that could be either ancestors, sorcerers, or witches. Therefore, whenever sickness occurs, it is mostly blamed on witchcraft. However, according to the *amaXhosa* health-belief system, there are other causes of illness such as *impundulu* and a violation of a taboo for example. *Impundulu* or lightning bird is much feared among the IsiXhosa-speakers as it is associated with thunder, and lightning is believed to be the laying of its eggs. It can suck blood, cause miscarriages, blindness, long and wasting illnesses, and death to people and stock (Hammond-Tooke, 1989:75). In the case of illness as a result of breaking a taboo in the *amaXhosa* culture, it is held that sickness or misfortune can sometimes come as a consequence of an infringement of a prohibition that regulates people's behaviour in specific circumstances. For instance, when a woman breaches a taboo associated with a condition of ritual impurity or pollution known as *umlaza* that follows childbirth or occurs during menstruation, she will bring sickness to herself (Herselman, 2007:63).

Furthermore, in the African context, 'health' is measured by a balanced relationship between people, nature and the supernatural, and 'illness' as the disruption of the relationship produces physical or emotional symptoms (Louw, 2008:169, Herselman, 2007:63). In the same way, the *IsiXhosa* term *impilo* refers to physical health, but it also means 'fullness of life' with a religious connotation that implies harmonious relationships with the ancestor spirits. Destruction of *impilo* is caused by sickness, but also by some other misfortune such as losing a job, money or livestock. This understanding of misfortune explains why people consult an indigenous healer for medicine to strengthen and protect them against misfortune in general (Herselman, 2007:63).

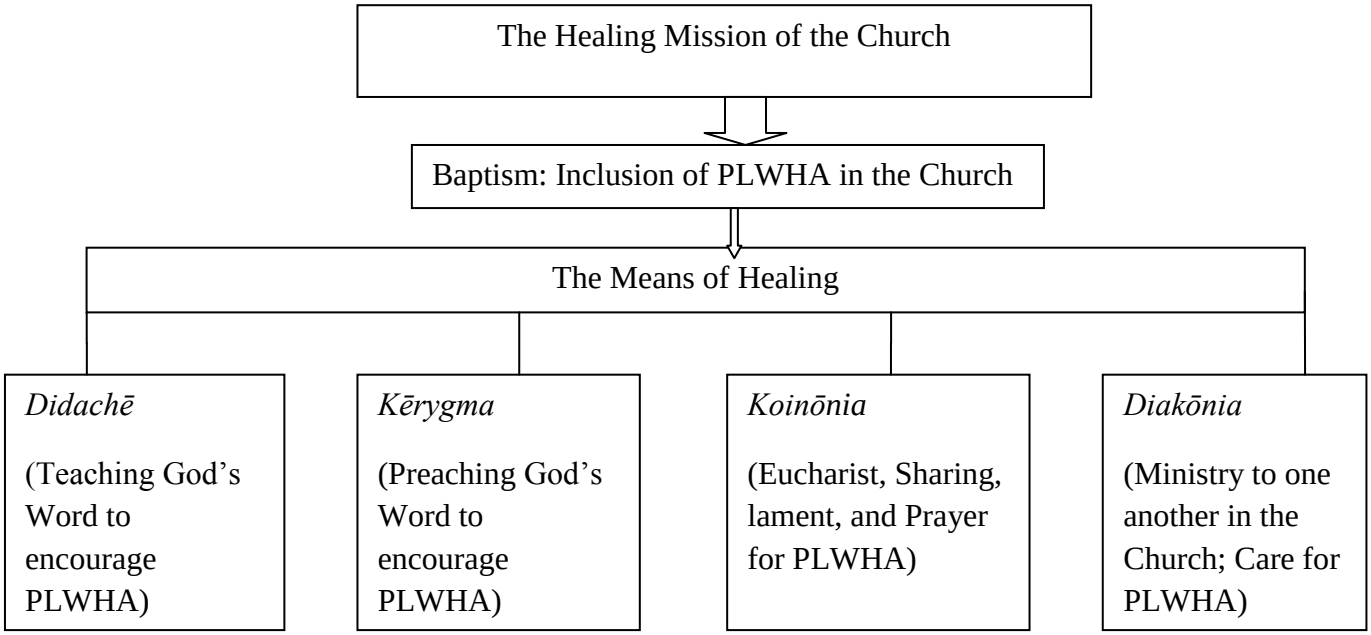
As a result, whenever *impilo* has been hindered, the intervention of a traditional healer referred to as *igqirha* (diviner) in *IsiXhosa*, is sought to determine the real cause of the disease or misfortune in order to get traditional medicine and/or perform rituals to cure the disease. Even in the case of HIV and AIDS, which is viewed as a mysterious and contagious disease with no cure, it does not matter whether people are aware of the ways through which it is transmitted. As long as they believe in witchcraft as the driving force behind any disease, they just cling to the idea that someone who was jealous with them bewitched them. Furthermore, as Mndende in Nieuwmeyer (2002:36) asserts, because sickness is viewed as multidimensional (physical, spiritual, and relational) in traditional *amaXhosa* beliefs, healing does not necessarily mean the absence of disease but involves "the balance within an individual, between the individual and the community, and between the individual and the spiritual world". As a result, when seeking for healing in traditional *amaXhosa* beliefs, western medicine is not enough because it cannot satisfy the need for the spiritual aspect of the disease. Therefore, most people going to the clinic for medical attention are also going to consult a traditional healer (Nieuwmeyer, 2002:36). However, others find it better to just consult a traditional healer because they feel that he is the one who can understand their sickness better, due to the fact that in the context of cosmology based on the cultural conception that human beings exist in a multidimensional world, "witchcraft beliefs and traditional healing become culturally acceptable means of making sense of both natural and supernatural phenomena" (Petrus & Bogopa, 2007:5). In that way there is a tendency to rely on the supernatural abilities of a traditional healer as the only one who can counter the effects of witchcraft and thereby provide holistic healing by dealing with both the physical (natural) and spiritual (supernatural) aspects of the disease, instead of consulting a western medical doctor who would only deal with the physical part of the disease because he/she does not know anything about witchcraft (Louw, 2008: 169; Petrus & Bogopa, 2007:7).

Linking the traditional *amaXhosa* beliefs about healing to the Christian view of healing, it is clear that the two are in conflict, because while the traditional *amaXhosa* people trust a traditional healer for the healing of sickness, Christians hold the biblical view that since the Bible forbids any consultation of diviners or traditional healing practices such as sorcery, charms and others, they are instead advised to honour God and trust Him for healing instead of consulting traditional healers (Knox, 2004:124). Moreover, this conflict becomes evident in that even when the traditional *amaXhosa* people repent and convert to Christianity, most of them never forsake their cultural values, and this makes them mix worshipping God with

ancestral worship as well as consulting traditional healers to provide the solution to their problems (Mlisa, 2009:277). As church leaders strive to help their churches become a place for healing, such a conflict is an issue that must be addressed with sensitivity.

4.6 Conclusion

In conclusion, the Church is indeed expected to be a healing community where PLWHA feel welcomed, accepted, and included. In fact, as this chapter has put forward, there are means of healing which the Church can use in its endeavour to become a healing community. The kind of healing which PLWHA need is holistic, taking care of the body, the soul and the spirit. In carrying out this kind of healing, the Church should make sure that its activities are characterised by healing. To achieve this, the Church should consider the example of what happened in the community of early believers who were committed to the teaching (*didachē*) and preaching (*kērygma*) of God's word, Holy Communion, sharing of belongings, and prayer. PLWHA are known to be vulnerable in the community and they need special care. In order to offer the care that PLWHA need, the Church should include them in the community of believers through baptism, which is a way of accepting people into the Body of Christ, then allow them to share fellowship (*koinōnia*) with others, and thereby benefit from the ministry (*diakōnia*) of the Church. In this way, the Church will be fulfilling its God-given healing mission. However, there must also be a sensitive consideration of the traditional beliefs of the people the Church reaches. The healing mission of the Church in times of HIV and AIDS stigma can be presented in a diagram as follows.



(Diagram 4.1: The Healing Mission of the Church in times HIV and AIDS stigma)

As this chapter has laid out, the healing task of the Church in times of HIV and AIDS stigma, the next chapter serves as a suggestion of a pastoral approach to how church leaders in Khayelitsha can deal with HIV and AIDS related stigma in their respective churches.

CHAPTER FIVE

HIV & AIDS STIGMA IN THE TOWNSHIP OF KHAYELITSHA: TOWARDS A MINISTERIAL AND PASTORAL APPROACH

5.0 Introduction

The previous chapter discussed the healing mission of the Church. The chapter emphasised the means of healing for PLWHA in church life, namely the teaching (*didachē*) and preaching (*kērygma*) of God's word, baptism, Holy Communion, fellowship (*koinōnia*) with others, sharing of belongings, the ministry (*diakōnia*) of the Church, and prayer. After exploring the situation of HIV and AIDS stigma in the Church, it is now time for this research study to suggest a practical way of dealing with HIV and AIDS stigma in Khayelitsha. In its endeavour to follow the final step of research in Practical Theology which is about interpreting contemporary obligations through providing a do-able remedy to the problem, this chapter starts with helping church leaders in Khayelitsha to perceive the need for engaging in the battle against HIV and AIDS stigma, then proceeds with other elements of the pastoral approach in dealing with HIV and AIDS stigma, such as a paradigm shift, breaking the silence, involving PLWHA in church life, leadership training in HIV and AIDS related matters, and providing care and counselling for PLWHA and their families.

5.1 The Way Forward for Action against HIV and AIDS Stigma

As has been established by this research study thus far, very little has been done to reduce HIV and AIDS-related stigma which has been recognized as a crucial barrier to managing HIV and AIDS (ICRW (2006:1). In his keynote address on reducing HIV and AIDS-related stigma, Dr Peter Piot, the UNAIDS executive coordinator, admitted, "We have not done a good job in proposing practical and realistic interventions on stigma, discrimination and gender inequalities" (UNAIDS, 2006:3). Even in the religious sector, PLWHA have faced rejection from religious people, congregations or institutions due to their reluctance to engage in the fight against HIV and AIDS for fear that it would imply dilution of their moral standards (Campbell & Rader, 2009:1).

Actually, with regard to the need for intervention in the area of combating HIV and AIDS stigma in the Church in Khayelitsha, it is church leaders who are mostly concerned, as their involvement means that they can then lead their congregations into action. This implies, on

the one hand, that if church leaders are reluctant in waging war against stigma, their congregations will not be involved. On the other hand, if church leaders stand against stigma, they will be able to motivate their congregations to join the fight.

There is, however, a mixture of church leaders' responses to the fight against HIV and AIDS stigma; even though many religious leaders have shown involvement in confronting the exclusion of PLWHA in their churches, some churches still display attitudes that reinforce stigma (ICRW, 2006:12). Some of the reasons for inaction could be denial, not seeing a reason to be involved, judgemental attitudes, and lack of skills to respond. According to Richardson (2006:39), "There are those many churches that are not yet responding - which continue ecclesiastical 'business as usual' as if there were no HIV and AIDS". He mentions that there may be many reasons for the churches' lack of response. One of these reasons may be denial, with some churches saying that there are no HIV and AIDS infected or affected people in their midst and that their own lives are not affected. This may be followed by moral denial in which they ask: 'Why should we be involved?' Third, they may adopt a judgmental mode, and their lack of action may be an expression of their prejudiced perception of HIV and AIDS. Fourth, they may be in paralyzed mode - willing to respond, but not knowing how. Similarly, the scourge of HIV and AIDS may cause confusion, to the point where people in the church are divided as to how to get involved. These reasons for the churches' lack of response are similar to what Louw (2003:215) refers to when he states that in poor townships, pastoral counselling methods may be ineffective at grass-roots level because pastoral caregivers often come across scepticism, hesitation and resistance. He mentions that the reasons for this resistance are: (1) distrust for the helping persons; (2) lack of patience; (3) need for imediate gratification; (4) educational background; (5) pessimism about the future, and (6) devaluation of goal-directed plans.

In a research study done by Haddad (2006:83) among church leaders in KwaZulu Natal, the question of whether HIV and AIDS is a punishment from God was answered differently by church leaders, a few of them saying "yes" and the rest saying "no". The disagreement that exists in the perception about HIV and AIDS as God's punishment thus creates 'theological confusion' within the church leadership.

Concerning judgemental attitude as one of the possible reasons why churches stigmatise PLWHA, Byamugisha et al. (2002:102-103) highlight judgement against PLWHA by other church members which contradicts the Christian ethic of unconditional love, yet is found in

many churches. This attitude, which is often based on a narrow interpretation of certain Biblical verses, drives people who know themselves to be HIV-positive to conceal their status because they fear rejection and discrimination. It also discourages those who do not know their HIV status from being tested. Therefore, churches are called to be 'AIDS competent' by adopting the understanding that there is no automatic link between HIV infection and sexual 'immorality'.

As for not seeing any reason to become involved, Byamugisha et al. (2002:104) state that there is a 'not my problem' attitude among believers which fosters unwillingness to get involved. The reason for passivity is that HIV is seen as being outside the person and the Church; that is to say, it affects people of different vulnerable groups and it is not for church people who are 'holy'. This agrees with the statement made by Van der Ven et al (2003:137) that "The congregations, as a rule, are not becoming involved in the issue. It is as if they say 'Those are not our people', 'They can't be Christians,' 'It's them, not us.' They pass over the whole catastrophe in silence. If they react at all, it is to express judgmental attitudes by saying or thinking 'Where do you get it?' or 'They brought it on themselves,' connecting HIV/AIDS to promiscuity, visiting female and male prostitutes and the like". Another reason is confusion and lack of self-confidence to take action. Byamugisha et al. (2002:104) suggest that many church people do not have the self-confidence to take action in response to HIV and AIDS. Given the sheer magnitude of the epidemic and the complexity of the problem it creates, church people are hindered by uncertainty as to how they can make a difference. This was the case for the church leaders in a study carried out by Haddad (2006:83), which showed that although these leaders wanted to be effective in curbing HIV and AIDS in their communities, they could not easily come up with successful strategies due to the stigma and discrimination, as well as the cultural silence, surrounding HIV and AIDS and sexuality in their communities. These factors caused any intervention from their side to be viewed as pastorally and culturally insensitive. Byamugisha et al. (2002:104) thus emphasise the importance of documenting and sharing whatever information is available about how local churches and communities can make a difference in the lives of people affected or infected by HIV and AIDS.

Lack of information about HIV and AIDS is another aspect contributing to lack of knowledge of the facts about the disease. Consequently, lack of education in HIV and AIDS matters forms another barrier to the fight against HIV and AIDS-related stigma. Even in the Church, this barrier affects church leaders' response to the epidemic and their responsibility to

educate church members. For that reason, it would be helpful to educate the clergy in order to empower them with the necessary skills to address HIV and AIDS stigma (Byamugisha et al., 2002:103). Lack of HIV and AIDS education in the Church is also coupled with lack of learning material about HIV and AIDS. This scarcity of material is due to the fact that it is often not available in the languages of the people, or even when it is available, there is an unfair distribution, as well as scarcity of theological material for educating people on the disease.The lack of material in local languages should be dealt with through translating such material, developing and documenting local experiences in local languages(Parry, 2008: 41). Despite the lack of education reported in the field of HIV and AIDS in the Church, the great importance of such education still needs to be emphasised. People need to be educated about how to find out their HIV status and how to live positively with the virus. Their families and neighbours also need to be aware of the facts about HIV and AIDS in order to know how to help them. With regard to the need for education in the area of HIV and AIDS, West & Zengele (2006: 54) identify two important aspects: first, HIV and AIDS education is a vital tool in the fight against stigma and discrimination, and second, such education provides the information needed for PLWHA to live positively.

Furthermore, in order to deal with HIV and AIDS stigma successfully, it is useful to consider motivating factors that encourage the Church to take action. In his book on *African Churches and HIV and AIDS*, Chitando (2007:14) points out at least two factors motivating the Church to get involved in the fight against HIV and AIDS. Firstly, he talks about the endurance and credibility of the Church in developing programmes that remain in the community. While other NGOs come and go, when the Church comes, its presence is permanent. Thus, when the Church gets involved in the fight against HIV and AIDS, there is an assurance that the projects undertaken by the Church will be more permanent, unlike those undertaken by organisations that stay only for a number of years. This is a major advantage that the Church enjoys over other social actors in the context of HIV and AIDS. The epidemic requires long term and sustainable responses. For this reason, the Church in Africa is seen as dependable and qualified to effectively fight the HIV and AIDS pandemic, and to convey necessary information about HIV and AIDS in order to raise awareness useful in prevention and care.

Secondly, the Church in Africa, as compared to other organisations, has prayer and spirituality as crucial resources to utilise in the struggle against HIV and AIDS stigma. This is another characteristic which is not found in secular NGOs, but which is useful in creating a sense of courage and strength for PLWHA (Chitando, 2007:17). If prayer and spirituality

become an integral part of church life, it means that the people whom the Church reaches will enjoy a relationship with God and experience the hope He offers. As Louw (2008:51) confirms, "Christian spirituality is an indication of hope. Spirituality is an indication of how faith is enfleshed within our daily existence".

The Church should respond to the needs of PLWHA by developing an attitude of care that is motivated by God's mercy as manifested through His people. If the Church is really going to bear the name of Christ, they have to live as He did. People are looking for a Church that really cares. Richardson (2006:42) poses an ecclesiological question: "Where can we find a caring Church?" This question comes with the assumption that it is contradictory to claim to be committed to Jesus Christ and yet not be actively caring, embodying compassion, for those in desperate need. The care that must be administered in the Church would not be possible without willingness to sacrifice oneself in the Christian faith community. This is what Richardson (2006:42-43) means in saying that it seems that any adequate response to the massive needs occasioned by HIV and AIDS must have about it an element of sacrifice. That being the case, the community of Christian faith should be well placed to respond.

Based on this approach, the following motivating factors for church leaders' involvement in the area of fighting HIV and AIDS stigma can be considered:

- Church leaders are expected by their communities to take action in the relief of HIV and AIDS stigma since they are in a position to reach the greater part of the community. Therefore, church leaders can play a significant role to ensure that HIV and AIDS stigma is fought against (Religions for Peace, 2008:21).
- The influence that church leaders have in the community allows them to be approached by individuals in times of trouble. They have the pulpit as a major and powerful tool for Christian education which allows them to reach out to a large number of their flock; the Church is thus an institution that addresses more people consistently, at least once a week, from the grass-root level to the international level. In this regard, the pulpit can be used to spread information about HIV and AIDS prevention and care for PLWHA. It appears, however, that the pulpit has been under-utilised as far as combating HIV and AIDS stigma is concerned. Instead of calling for acceptance, forgiveness and love for PLWHA, it has rather been used to reinforce stigma (Kamaara, 2004:52; Chitando, 2007:15).

- Church leaders, being key players in helping those who are struggling with illness, grief and fear, often have the opportunity to influence and educate large numbers of people because of their position in society (Baldwin, 2005:35).
- Since the Church is in the community, it has a chance of direct contact with people, and can thus more easily perceive what people are going through and take action accordingly. The fact that religious communities are usually intermingled with the community at large is a key asset and a strong tool for maximizing their efforts to promote mutual, healthy accountability for care, support and change among people in the community (Campbell & Raider, 2009:5).

All this leads to the suggestion that church leaders, facing the challenge of developing effective religious values and strategies to deal with stigma, must live up to God's commands and people's expectations in their work to protect PLWHA against the stigma and discrimination which they face (ICASA, 2003). This highlights the necessity for developing an effective pastoral approach for dealing with HIV and AIDS stigma in Khayelitsha, and, in this regard, a paradigm shift on certain issues is of great significance.

5.2 A Paradigm Shift

In an effort to pave the way towards dealing with HIV and AIDS in Khayelitsha, church leaders need to develop a paradigm shift away from the stigmatisation of PLWHA. As suggested by this research, the paradigm shift needed for church leaders in Khayelitsha would start with a confession in order to denounce any involvement in stigmatising attitudes. A point of departure towards addressing HIV and AIDS would then need to be established, followed by attention to areas which need change, such as theology and pastoral anthropology.

5.2.1 A Confession

As has been found by this research study, the theology that has been prevalent in the Church has not been helpful with regard to HIV and AIDS stigma. This is evident in the fact that since HIV is mainly transmitted through sexual intercourse, churches in general and church leaders in particular have often adopted a theology of judgment that has reinforced stigma and discrimination against PLWHA. It is time to change this kind of thinking in order to adopt a theology of acceptance that accommodates all people as being created in God's image, despite who they are and what they are going through. If the Church is to put a stop to

the theology of judgment and start embracing PLWHA with God's love, it has to begin by admitting, confessing and denouncing the sin of stigmatization. As an example of this kind of confession, the Pacific Island AIDS Foundation (PIAF) (2004:1) and Van Wyngaard (2006:13) refer to the declaration of church leaders during the African Religious Leaders Assembly on Children and HIV and AIDS held in Nairobi in 2002, in which they admitted that their silence, ignorance and passivity due to fear and denial in the fight against HIV and AIDS had greatly contributed to the spread of HIV and AIDS in their communities and congregations.

In addition to looking at how the Church has been doing in terms of not being fully involved in eradicating HIV and AIDS related stigma, Owen & Owen, (2005) argue that churches need to seek God's forgiveness for their failure to imitate Christ's teaching about accepting those who suffer, as He spent most of His time healing those who were sick and showing compassion to those who were suffering, treating them with dignity despite what they suffered from and how they had become infected.

Moreover, this confession must be accompanied by action through the development of what Chitando (2007:38) calls a 'welcoming community'. In this sense, "The least the churches can and should do is to open themselves to those who suffer physically, emotionally, socially and economically from HIV/AIDS" (Van der Ven et al, 2003:137). In order to become a welcoming community, the Church in Khayelitsha needs to open its doors for PLWHA and give them opportunities to share their stories and feel accepted. In achieving this, the Church in Khayelitsha needs a point of departure, a theological paradigm shift, a paradigm shift concerning its place in the community, and a paradigm shift concerning pastoral anthropology.

5.2.2 The Theological Paradigm Shift

In order to work towards HIV and AIDS stigma relief, church leaders in Khayelitsha need a point of departure, which in this case is the fact that the Church is an institution made up of people who have been called out of the world as they came to have faith in Jesus whom they have accepted as their Lord and Saviour. So, church leaders are looking after the flock that Jesus redeemed. Since Jesus Christ is the Lord of the Church, which is His body, church leaders need to learn from the way Jesus Christ loves His people and was willing to offer His life for them. For this reason, being 'imitators of Christ,' they will be encouraged to lead the Church in the love of Jesus Christ and God's people in the world. In other words, the

Lordship of Christ over the Church and the salvific work He has done for His people should provide considerable motivation in anything they do in order to be His instruments in this world. Thus, in the case of dealing with HIV and AIDS stigma, the mission of the Church will be fuelled by Christians' status in Christ. In addition to recognizing the identity of the Church as people who belong to Jesus Christ, it is important to realise the Church's position and function in the community. As this research study has established, the Church is recognised as an influential agent in the community, and thus has an opportunity to get involved in the lives of many people. Its marks of prayer and spirituality are useful tools for intervention in times of human need. The Church is viewed as an institution that offers care to the people, and the fact that it endures in terms of permanently dwelling in the community makes it possible for it to carry out its ministry.

For that reason, in any call for action, the Biblical point of view of stigma relief must be considered. It has been found that in OT times, people with diseases such as leprosy, which could be compared with HIV and AIDS, were discriminated against, but in the NT, Jesus Christ accepted them unconditionally, and the Church is thus supposed to model Christ in accommodating PLWHA (Emma, 2008:12). In the same way, church leaders in Khayelitsha should strive for the acceptance of PLWHA in their churches because, as Van der Ven et al. (2003:139) stipulate, "Perhaps the most frustrating aspect of living with HIV is the fear or, even worse, the experience of being rejected. There is no worse indication of being expelled, of being isolated from one's community, of being excommunicated, than to be told one is being punished for a 'sin' one once committed. HIV/AIDS could just as well be looked on as a contingent phenomenon, a random and unfortunate event that turns people's lives into a tragedy".

In this regard, in order to develop AIDS competence[8], the Church in Khayelitsha needs to stay away from theological rigidity by adopting a theology regarding HIV that affirms life, thereby coming from "the Egypt of theological rigidity into the Canaan of theological creativity as it seeks to respond to HIV" (Chitando, 2007:25-26).

[8] According to Parry (2008:15), an HIV competent church "is a church that has first developed an *inner competence* through internalization of the risks, impacts and consequences and has accepted the responsibility and imperative to respond appropriately and compassion-ately. In order to progress to outer competence, there is need for *leadership, knowledge and resources. Outer competence* involves building theological and institutional capacity in a socially relevant, inclusive, sustainable and collaborative way that reduces the spread of HIV, improves the lives of the infected and affected, mitigates the impact of HIV and ultimately restores hope and dignity".

If the Church adopts an appropriate theology, it will be easier for it to establish a framework of action. As has been discussed, the way in which God is viewed is very important for Church life and ministry. This brings us to the notion of perceptions of God. If the Church understands God only as a dictator who is there only to execute judgment, it will be difficult for them to come up with anything helpful for people who are suffering, because in the context of HIV, all that will be said is that God is punishing people for their promiscuity. What is needed is a look at other perceptions of God that are helpful in providing relief in the situation people are going through. The notion of a God who relates to His people by being there for them in times of suffering needs to be introduced to people in need. God should also be presented as a loving and caring Father who is willing to suffer with His people. With this comes the idea of Jesus' suffering, death and resurrection. In His suffering, Jesus bore the suffering and shame of PLWHA on the cross. The marks of the beating and piercing He endured on the cross, also referred to as the stigmata, are an indication that Jesus took the stigma of PLWHA and gave them the charisma (the gifts of the Spirit), so that they are no longer seen as stigmatic but as charismatic.

5.2.3 Paradigm Shift about Pastoral Anthropology

The pastoral understanding of man is helpful in understanding PLWHA and what they go through, and this will contribute to determining the action that is to be taken in order to deal with HIV and AIDS stigma. As discussed in Chapter Three, a human being is known to be created in God's image, and is able to relate to Him. Through the fallen nature of man, man gets separated from God, so God has provided a way of restoration through the death of Jesus Christ. Man has in him a natural aspect of doing good, but also of doing evil. Another aspect of man is his ability to respond to things, since he is made of body, soul, and spirit, therefore having cognitive, conative, and affective dimensions, the capacity for being moved by norms and values, and a spiritual dimension that facilitates his search for meaning. A human being is also open to physical vulnerability and suffering, and is thus in need of help in dealing with life issues. Therefore, any type of healing given to man must follow a holistic approach.

Another area of intervention is gender imbalance. As discussed earlier, stigma related to HIV and AIDS has been enhanced by the difference between men and women as far as power is concerned. Even in the Church, there has been a constant struggle to deal with the question of gender and the fact that women remain subject to men in a patriarchal, negative way. If the Church in Khayelitsha is to get involved in the fight against stigma successfully, the question of gender imbalance will need careful consideration in such a way that a theology that

victimises women is denounced in favour of a theology that promotes equality between man and woman in the sense that they are both created in God's image. Here, the vulnerability of women in terms of being susceptible to HIV infection due to biological factors and the fact that they suffer the burden of care and financial difficulties more than men, will also need attention on the part of the Church.

In short, the action of the Church in combating HIV and AIDS stigma will be based on the love of God as manifested in the life of Jesus Christ who is the head of the Church. This will be possible if the Church revisits their theology and anthropology, which will enable them to understand that God, out of grace and love, created man in His own image and accepts everyone, whether living with the disease or not. In order for this to happen, the Church needs to adopt a culture of inclusion. This could be possible if the Church adopts a language that does not reinforce stigma, but that accommodates PLWHA entirely in Church life, and that follows a careful interpretation of the Bible in a manner that does not erroneously bring judgment and confusion on people. This highlights another very important aspect of the pastoral approach in dealing with HIV and AIDS in Khayelitsha, namely, the training of church leaders.

5.3 Church Leadership Training in HIV and AIDS

One of the barriers in the fight against HIV and AIDS related stigma, as has been established by this research study, is lack of knowledge of the facts about HIV and AIDS. The 2009 report by the South African Council of Churches (SACC) stated that reports from some parts of South Africa showed that instead of taking education on HIV and AIDS seriously, the clergy were of the opinion that it did not concern them, and that such programmes should therefore be directed at the youth (SACC, 2009:9). This obstacle affects church leaders' responses to the epidemic and their responsibility to educate church members. For this reason, it would be helpful to educate the clergy in order to empower them with the necessary skills to address HIV and AIDS stigma.

As can be observed, many church leaders in Southern Africa have little or no education, and therefore cannot read or write, which make it even more difficult to reach them through seminars about HIV and AIDS. In addition, lack of HIV and AIDS education in the Church is accompanied by lack of learning material about HIV and AIDS due to the fact that it is either scarce, or not available in the language of the people, or is unfairly distributed. If church leaders are not trained in matters concerning HIV and AIDS, they will remain ignorant, and

even avoid talking about the pandemic because they do not know what they are talking about, or are ambivalent and apathetic about the disease. However, if they are well informed about HIV and AIDS, they will understand more and will have more authority in tackling issues such as HIV and AIDS-related stigma, as they will be talking of things they know about. Training is thus essential in alleviating people's fears and prejudices, expanding HIV and AIDS projects, enhancing effective awareness campaigns, giving care, treatment and counselling, and responding to the concerns of PLWHA. In a word, it is fair to say that training is an integral part of the Church's response to HIV and AIDS related stigma (Shorter & Onyancha, 1998:51; Byamugisha et al., 2002:103-104; ICASA, 2003:5; The St Maarten AIDS Foundation, 2006:6). With the right training, church leaders will be informed about how to take action against HIV and AIDS stigma in their churches as well as how to create a conducive environment to break the silence about HIV and AIDS, include PLWHA in the life of the Church, and organise activities such as providing care and counselling for PLWHA and their families.

5.4 Breaking the Silence about HIV and AIDS

As has already been observed, HIV and AIDS stigma has been surrounded by silence due to the fact that there has been lack of knowledge about HIV and AIDS issues as well as failure to take necessary action against the disease. According to Parry (2003: 11) there have been a number of factors feeding this silence:

> Problems faced by the clergy concerning HIV and AIDS have included a lack of knowledge on preventative measures, counselling, advocacy, community mobilization and networking, coupled with a deep cultural taboo about open discussions on sexual issues. Thus a culture of silence, denial, stigma and discrimination has largely been the response. There is a lack of Advocacy and Activism from those that can make a difference, with notable exceptions, the voice of the religious has been muted.

Therefore, there is an express need for religious leaders to encourage open talk about HIV and AIDS and support PLWHA in order to break the silence and thereby deal with the stigma surrounding HIV and AIDS (ICASA, 2003:6). Any efforts to break the silence surrounding HIV and AIDS should be characterised by raising awareness and giving a message of hope to PLWHA, as well as mobilizing churches to care for and support them.

Breaking the silence about HIV and AIDS is the task of church leaders who, after all, have the responsibility of setting a good example for others. For this reason, church leaders should deal with any kind of silence that hinders the fight against HIV and AIDS stigma through

compassion by following the example of Jesus in balancing the law and the gospel (Swann Jr, 2008:212).

In the Church in Khayelitsha, the following steps should be taken if church leaders are to deal with the silence associated with HIV and AIDS:

- Programmes should be organized where facts about HIV and AIDS are talked about respectfully, without making anyone with HIV and AIDS uncomfortable. Messages about HIV and AIDS, acceptance, care and prevention should be delivered in non-threatening language (ICRW, 2006:7).
- Since PLWHA are often insulted and gossiped about in the community, breaking the silence calls for compassionate language that will make PLWHA feel accepted, and it is church leaders who are qualified to offer such a language of love. In this regard, "Compassion is about suffering with those who suffer, but also working to transform the situation" (ICASA, 2003:6). Hence, the language that has been used to talk about HIV and AIDS and PLWHA has to be reconstructed, with theological language being re-visited so that it fits the HIV and AIDS context to foster compassion, dignity and love that is inclusive for PLWHA.
- In addition, religious leaders have to learn from each other, and be willing to share knowledge and experience about HIV and AIDS stigma relief in their communities. This process of encouraging church leaders to learn from each other means that they need also to create a kind of network through which they can share information and goals. There should be a certain understanding among different churches, despite their doctrinal diversity, to agree on major issues while still remaining unique in other ways (Shorter & Onyancha, 1998:53).

As long as church leaders in Khayelitsha lead their churches through changing the way they think about HIV and AIDS and PLWHA, it will prepare church members to be able to accept PLWHA to such an extent as to include them in the life of the church.

5.5 Involving PLWHA in the Life of the Church

This research study has established that PLWHA should be included in churches in order for them to feel accepted. Through baptism, they can enjoy membership in the Church as they share life with others, as well as enjoying the fellowship expressed through preaching,

prayers, and sharing of spiritual as well as material resources, in the same way that the Early Church believers were committed to the Apostles' teaching, the sharing of the Eucharist in their houses, and prayer. This inclusion serves as a means of healing. According to Parry (2008:76), churches can contribute to the prevention of HIV and AIDS by becoming "a home, an anchor, a place where there is a reinforcement of positive value systems and loving, compassionate peer support". Since the isolation of PLWHA may cause them to become involved in more risky behaviour, churches need to see to it that their programmes are inclusive, non-judgmental and marked by compassion. This means that PLWHA should be given the opportunity to get involved in church programmes, which would then encourage others in the same situation to break the silence and access testing, support, and care, thereby making the prevention strategy easier, and reducing the stigma and discrimination faced by PLWHA (Parry, 2008:76).

It is also helpful for the Church in Khayelitsha to learn from the Early Church by making sure that PLWHA are really included in the life of the Church. This can be done by welcoming them to take part in fellowship with other believers. As far as baptism is concerned, PLWHA should be accorded the right to baptism without discrimination, because they can also contribute to the building up of the Body of Christ. Prayers can also be offered for the sick in general and for PLWHA in particular.

This study has so far revealed that PLWHA are often discriminated against, and that this has led to their exclusion from family, church, and community life. If church leaders in Khayelitsha are to be effective in fighting against HIV and AIDS-related stigma, they should consider PLWHA's role in their churches just like anyone else's. This means not merely showing that PLWHA are part of the Church, but going further to allow them to hold key, prominent roles in their programmes, which will add immense value to efforts to eradicate HIV and AIDS stigma. In fact, any fight against HIV and AIDS-related stigma which does not involve PLWHA will obviously prove futile, since these people have a wide range of experience and knowledge which the Church can use to design HIV and AIDS programmes, and furthermore, they can support each other in bearing the stigma and other challenges PLWHA go through. They should thus be included in HIV and AIDS prevention and care programmes, and spiritual outreach (ICRW, 2006:7; Religions for Peace, 2008:23).

In addition, the Church should consider including PLWHA in its function, since church membership includes people both with and without HIV and AIDS who need to be in a

mutual relationship of responsibility and interdependence. Therefore, everyone in the Church must be considered as valuable in the fight against the pandemic. The Church should thus not only be reliable as a body where PLWHA can experience love, but should also rely on them by involving them in efforts to care for and educate other members. The inclusion of PLWHA will confirm that the Church positively acknowledges them as being as valuable as other members, and this will mean that they are viewed as blessings to the Church in the contribution they make to the Body of Christ. The Church will, in turn, benefit from including PLWHA in its life, as they have a significant contribution to make towards the fight against HIV and AIDS. (Richardson, 2006:43-44).

PLWHA can also be useful in challenging HIV stigma by influencing people's attitudes, as well as by being a good example of perseverance in suffering. However, the basis for including PLWHA in the life of the Church should not be motivated by mere social and secular involvement, but by a spirit of generosity and acceptance, lest the Church fall into the danger of irony and contradiction (Richardson, 2006:45).

5.6 Provide Counselling to PLWHA and Their Families

PLWHA live in their homes and attend churches that are in their communities. For that reason, they need to feel that they are part of their communities. Since PLWHA are often marginalized in their homes, the Church in Khayelitsha should create an environment of inclusion and acceptance in such a way that other people in homes and communities learn from the Church how they should accept PLWHA. Hence, the task of church leaders in this regard will include counselling the families, church members, friends, and neighbours of PLWHA in order to stimulate a culture of inclusion. This will help in overcoming common doubts and fears about HIV and AIDS and the tendency to judge PLWHA (ICRW, 2006:7). The process of counselling PLWHA may involve the aspects discussed below.

5.6.1 Counselling as a Way of Giving Information

Counselling of families, church members, friends, and neighbours of PLWHA should include basic information about HIV and AIDS, messages about HIV and AIDS, open talks, and individual as well as group consultation. Church leaders in Khayelitsha should not hesitate to make use of the expertise of qualified facilitators to address their churches about HIV and AIDS in a manner that is less stigmatizing for PLWHA (ICRW, 2006:7).

The fight against HIV and AIDS stigma is not an easy task. However, church leaders should not give up. Despite difficulties and disappointments, their intervention will not be in vain. They have to strive to minister to both HIV-positive and HIV-negative people in order to ensure that the fight is well understood, and this will make HIV and AIDS stigma easier to overcome (Visser, 2007:4).

However, there is more involved in counselling than just educating people on facts about HIV and AIDS; there is also a need to go even further and deal with various areas of life affected by the disease. This calls for addressing different areas in the life of the individual and his or her family, which means that the counsellor must also think of dealing with the physical, practical, psychological, social and spiritual needs of PLWHA and their families (WCC, 1997:85)

Pastoral counselling for PLWHA is a significant tool to help them gain courage to live positively and grow in their relationship with God and others. Through counselling, PLWHA can discover God's will for their lives. They can grow strong in the midst of trouble upon learning about their HIV positive status, and can also be encouraged to share their condition with their loved ones in terms of disclosure. In this way, church leaders in Khayelitsha can encourage PLWHA to be strong despite their status, and to share their status with someone who can support them in order not to bear the burden alone (Shorter & Onyancha, 1998:76). This idea accords with the objectives of HIV and AIDS counselling and teaching as presented by Uys and Cameron (2003:7), which are to:

- Promote a positive acceptance of the diagnosis
- Promote disclosure, especially to sexual partners and FCGs
- Enhance understanding of the illness and a healthy lifestyle
- Assist with preparation for death and orphan care, and
- Assist the family to deal with loss.

Any church leader who wants to be successful in counselling by giving information to PLWHA and their families should make sure that those objectives are achieved.

5.6.2 Using Skilled Counsellors and Community Involvement in Counselling

In order for counselling to be effective, it is useful to consider carefully the quality of those to be involved in offering it. In fact, the Church in Khayelitsha should see to it that they use counsellors who are well informed, not only with regard to counselling skills, but also in HIV and AIDS issues and Christian faith. This will require providing thorough training before deploying people in the work of counselling (Shorter & Onyancha 1998:76).

To emphasize this point, the St Maarten AIDS Foundation (2006:6) confirms that pastoral care for PLWHA requires time, patience, and the development of a relationship. The church leaders' role is to support PLWHA through being with them. It is not to answer every question and give a solution for every problem, but to be patient as PLWHA work through the stages of grief and issues surrounding HIV. It is thus also useful to consider the grief process and the challenges PLWHA go through. As the St Maarten AIDS Foundation (2006:4) puts it:

> People who are infected or affected by HIV wrestle with the stages of grief. They deal with shock, denial, anger, bargaining, depression, and acceptance. People go through these stages in different ways and time periods and may bounce back and forth between stages. People will grieve over their HIV status, and AIDS diagnosis, the loss of a job, becoming symptomatic, the loss of their future, the death of their friends, and the anticipation of their own death.

In addition, counselling is even more helpful if the whole community is mobilised to set up support groups and group therapy for the emotional support of PLWHA. Where such a strategy has been used, PLWHA have found relative relief (Shorter & Onyancha, 1998:76-77).

Through pastoral counselling, the Church in Khayelitsha can fulfil the role of speaking for PLWHA, thus becoming a voice for the voiceless, actively countering stigma and discrimination, and sensitising the community to get involved in acts of care and compassion for PLWHA instead of marginalising them (Shorter & Onyancha, 1998:77).

A further aspect to be considered is that since everyone has his/her unique way of experiencing God, pastoral care needs to be sensitive in the way it deals with different types of spiritual practices (St Maarten AIDS Foundation, 2006:5).

It is also possible that in pastoral counselling, the counsellor may encounter obstacles. In that instance, it would be better to refer the client to another person who could offer more helpful support to the client (St Maarten AIDS Foundation, 2006:8).

Moreover, when a member of a family is diagnosed with HIV, the whole family becomes affected. For this reason, counselling should not be limited to HIV positive people, but should provide support and guidance which includes the whole family (Shorter & Onyancha, 1998:81).

5.6.3 Confidentiality

Another point to consider in the process of counselling PLWHA and their families is confidentiality. If people come for counselling, they may not be ready to disclose their status or information to the public, and therefore, anything that is shared has to be kept confidential. In the event that people who find out about their HIV positive status need to disclose it to their loved ones, careful attention needs to be paid so that it is done in the correct manner. On this point, Shorter & Onyancha (1998:68) point out that:

> One of the genuine concerns raised by those living with AIDS is the issue of confidentiality. Anonymity should be observed in HIV testing. While it is important to inform a spouse and members of the immediate family to avoid further infection, when a patient tests positive, this should only be done in the context of adequate counselling. Anonymity should be preserved beyond the level of the family. This will prevent those who are prejudiced from pointing accusing fingers at the person concerned.

In the case of HIV and AIDS, it is not always helpful to keep information confidential. There is still room for the community to be aware of an individual's status within a context of care and support. This is in line with what Campbell and Rader (2009: 3) mean when they refer to 'shared confidentiality', which is best done through support groups in which PLWHA get to know each other's stories in order to react in confidential, constructive, and supportive ways.

Counselling is clearly useful in helping PLWHA to accept their situation and to develop strategies for positive living. In fact, one characteristic of a church leader as counsellor is to be able to act as a shepherd who represents God in the lives of the people he/she leads. The fact that God is involved in the suffering of His people makes Him a God who is present among them (God with us), and, as Louw (1998:39-54) mentions, is willing to become their shepherd (the one who provides sensitive care), their servant (the one who is a wounded healer), their wise fool (the one who gets involved in their suffering in a paradoxical way), and their *paraclete* (the one who is willing to be their counsellor and comforter). These are the same functions that church leaders need to take on in dealing with HIV and AIDS stigma in Khayelitsha.

5.7 Provide care for PLWHA in the Church

With regard to caring for PLWHA, it is very important that the Church in Khayelitsha tries its best to initiate such care. As has been made clear in this research study, people in Khayelitsha live in terrible poverty, and this exposes them to higher vulnerability to HIV and AIDS. Church ministry, directed toward PLWHA in the form of *diakōnia,* is particularly useful in Khayelitsha, which faces the combination of HIV and AIDS and poverty. Since HIV and AIDS and poverty reinforce each other in afflicting the lives of people in Khayelitsha, it is very important to establish a pastoral care approach that equips the Church to deal with that challenge. In communities where HIV and AIDS prevalence is very high, hospitals and clinics are often overcrowded with HIV patients, and it is difficult for them to get admission into health facilities because wards and rooms are full (Slattery, 2008:35). In that situation, another strategy could be developed through which PLWHA could be given home-based care.

In this regard, Winkler (2004: 36) points out two good reasons why care and support in the home can be a very important part of the response to the HIV and AIDS epidemic. The first reason is that many health care practitioners feel that clinics and hospitals should focus on treating people in the early stages of HIV infection, but that when a person's condition has already developed into AIDS, and his/her immune system is no longer strong enough to fight infections and illnesses, it is better for that person to be cared for at home. The second reason is that there is increasing evidence that the care and support given to families living with HIV not only helps them to improve the quality of their lives, but also strengthens the HIV prevention services in the community, which then increases the capacity of families to care for patients. This is known as the 'positive prevention-care dynamic'.

In addition to Winkler's two good reasons why care and support should be given at home, Uys and Cameron (2003:6) also make the following points to emphasise the important benefits of home-based care:

- It allows the patient and the family time to come to grips with the illness and the impending death of the patient.
- It is less expensive for the family because problems such as transport to hospital, time spent on hospital visits, and other costs are reduced. Relatives can take care of the patient while attending to other chores.

- Care is more personalized, and the PLWHA feels less isolated from family and friends.

- People prefer to face ill health and death in familiar surroundings rather than in a hospital ward.

- The totality of care is less expensive for the country than institutional options, since periods of hospitalisation are reduced.

Van Dyk (2008:332) defines home-based care as the care given by a family member or friend (the primary caregiver), supported by a trained community caregiver, in the home of the person living with HIV and AIDS. According to Van Dyk (2008:333), home-based care is very important in the care of PLWHA, its goals being:

- To empower the community and the family to cope effectively with the physical, psycho-social, and spiritual needs of those living with HIV infection and AIDS;
- To educate the community about the prevention of HIV transmission;
- To support family members in their care-giving roles; and
- To reduce the social and personal impact that living with HIV infection and AIDS makes on all those concerned.

In this regard, the family can provide a safe place for care and disclosure. As has been noted, home-based care can be an effective tool to care for PLWHA in their homes, as individuals are more comfortable receiving care at home than in hospitals or hospices. Church leaders in Khayelitsha would then do well to establish pastoral home-based care in their churches according to the following principles, as pointed out by Magezi & Louw (2006:78-79):

- A congregational *(koinōnia)* systems approach, which does not view a believer in isolation, but within a network of relationships, should be encouraged. The sick and suffering HIV person that embraces Christian modes of healing and refuses African traditional modes, and is in conflict with the network of the extended family, should find a buffer or support base through fellow believers *(koinōnia).* Congregational (family) home-based care, therefore, should be ready to supplement or, where necessary in extreme cases of exploitation, replace traditional family care to facilitate the therapeutic process.

- Congregational members *(koinōnia)* should be patient with members who struggle to embrace Christian modes of healing. One must always keep in mind that it is a painful decision to distance oneself from the extended family. Jude's words are apt: "Be merciful to those who doubt" (Jude 22).
- In order to be sustainable, congregational systems of care should always try to assist affected members to keep connected to their blood relatives (family and community). When such members successfully overcome the crisis, they can exhibit and testify to God's victory and hope to the rest of the extended family, thereby becoming salt and light in this world (Matt. 5:14-15).
- Congregational *(koinōnia)* care in poor communities should generally be sensitive and be aware of the immense need of its people and those in the community. As an institution, it should stand between the informal home-based care providers and outside agencies that provide resources in order to holistically support its members and the community. Pastoral care cannot and should not ignore the plight of the needy.

As for the models of home-based care, Uys and Cameron (2003:6-7) distinguish between two types of home-based care: integrated home-based care links all the service providers (clinics, hospitals, support groups, social workers, non-governmental organizations, [NGOs] etc.) with patients and their families in on-going care; single home-based care, on the other hand, is about one service component (a hospital, an NGO or a church) organizing home-based care by recruiting volunteers, training them, and linking them with patients and their families at home. Informal home-based care is about families caring for their members at home without any form of training or external support, but with the informal assistance of their own social network. It is preferable that the Church strive to provide home-based care through an integrated model, since this approach ensures that the patient and family get all the help they need, from the day the diagnosis is made, through all the phases, to terminal care, even after the death of the patient.

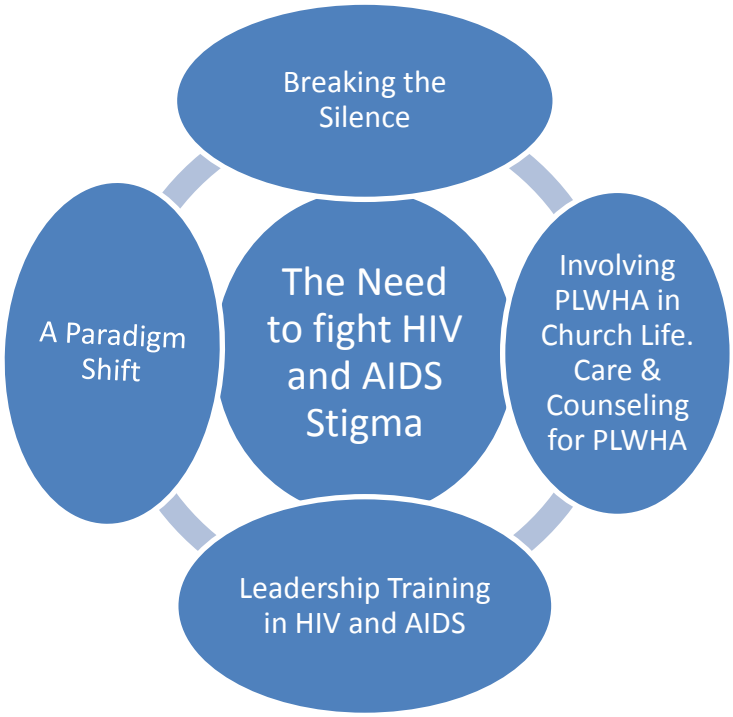
To further emphasise the design of a congregation's home-based care, Magezi & Louw (2006:67) make use of African communalism according to "*umunthu ngumunthu ngabanthu"* (an IsiXhosa proverb which means "a person is a person because of other people" or "a person is a person through other persons"). This concept is commonly called '*Ubuntu'* and means *'humanness'*. It embraces the values of non-discrimination, sharing, cooperation, cohesion, goodness and dignity in the daily interactions of the community. *Ubuntu* is

therefore the quality of being human through other human beings (Broodryk, 2006:22). For this reason, it is an invaluable building-block contributing to successful and effective congregational (*koinōnia*) home-based pastoral care (Magezi & Louw, 2006:67). The concept of *ubuntu* is common in Africa and even in Khayelitsha where people live with their relatives. Adopting such a system of care means that the Church does not just care for the individual, but also for the family, because an individual only exists in a family setting. This is to say that the individual also benefits, so everyone can share the care provided to them. In order for the Church to be effective in this, it should train families in caring for their members. This means that the efforts of the Church in providing an opportunity for the family to care for their own members who are suffering will include training to provide families with the skills to offer care to the loved ones who face suffering (WCC, 1997:81).This implies that when caring for individuals, it is important that the whole church be involved, each member having a part to play, rather than giving an opportunity only to those regarded as experts. It must be realised that each one in the congregation should have something to do, however small, to help PLWHA (Richardson, 2006:50).

5.8 Conclusion

In order for church leaders to be able to make a difference in alleviating HIV and AIDS stigma in Khayelitsha, they need to follow a pastoral approach which will guide them in their efforts to curb that kind of stigma. As it has been discussed in this chapter, there is a strong need for church leaders in Khayelitsha to engage in the fight against HIV and AIDS stigma. This will require a paradigm shift starting with a confession denouncing any involvement in stigmatising attitudes, as well as the establishment of a point of departure for addressing HIV and AIDS. Areas which need change, such as theology, pastoral anthropology, and the place of the church in the community, must also be addressed. To achieve all this, church leaders' need training in HIV and AIDS which will empower them to take action and educate church members, thus providing another tool for fighting HIV and AIDS stigma by raising awareness and dealing with the unnecessary fear of HIV and AIDS. In addition, such training would encourage church leaders to work towards breaking the silence about HIV and AIDS, and HIV and AIDS-related issues, which is common in communities. They will also see the need to create a platform allowing PLWHA to be accepted and involved in church programmes without being discriminated against. As a result, care and counselling will be provided to PLWHA, their families, friends and neighbours to reassure PLWHA that they can

survive longer with the virus. Families, friends and neighbours should realise that they still need to support their members, even in the presence of HIV and AIDS. A summary of the Pastoral Approach of dealing with HIV and AIDS stigma in Khayelitsha is presented in the following diagram.



(Diagram 5.1: HIV & AIDS stigma in the township of Khayelitsha: Towards a ministerial and Pastoral Approach).

CHAPTER SIX

CONCLUSION

6.0 Introduction

This thesis discussed the challenge of HIV and AIDS stigma in order to work out a pastoral approach for church leaders to address HIV and AIDS stigma in Khayelitsha. As HIV continues to spread all over the world and cause more deaths (Zaccagnini, 2010:1), this research study has identified stigma as one of the most powerful barriers in the fight against HIV and AIDS and care for PLWHA. The question this research study attempted to answer was, "How can church leaders assist PLWHA in addressing HIV and AIDS stigmatisation within their churches in Khayelitsha?"

A literature study was then carried out with the following aims:

- Understanding the causes and effects of HIV and AIDS stigma in relation to Khayelitsha;
- Examining the nature of the Church as a place of healing in relation to HIV and AIDS stigma in Khayelitsha;
- Constructing a pastoral, biblical, and theological basis in order to develop an approach which church leaders can use to address HIV and AIDS related stigmatisation in Khayelitsha; and
- Making recommendations useful for assisting the Church to address HIV and AIDS stigma.

In the research study process, the first chapter dealt with the background of the study, the conceptualisation, and a brief review of the HIV and AIDS situation in Khayelitsha, as well as a history of HIV and AIDS stigma from the beginning of the HIV and AIDS pandemic. The second chapter discussed the causes and effects of HIV and AIDS stigma, while the third chapter was about a biblical and theological reflection on HIV and AIDS-related stigma, and the fourth chapter addressed the question of the Church as a healing community in the context of HIV and AIDS stigma. The fifth chapter suggested a pastoral approach for dealing with HIV and AIDS stigma in Khayelitsha. Chapter Six serves as the conclusion of this research study, and its focus will be on discussing the objectives of the research study in

order to see if they were met or not. Some recommendations for pastors and suggestions for further studies will also be made at the end of the chapter.

6.1 Objectives for the Research Study

This section discusses the research study objectives one by one in order to check whether they were met or not.

6.1.1 Understanding the Causes and Effects of HIV and AIDS Stigma in Relation to Khayelitsha

In the second chapter, the causes and effects of HIV and AIDS stigma were dealt with, with the aim of understanding them and relating them to Khayelitsha. Various causes of HIV and AIDS stigma were identified in the literature as being prominent in Khayelitsha, including the fear of HIV and AIDS as a dangerous infectious disease with no cure. The fear of HIV and AIDS enhances HIV and AIDS stigma in that people are afraid to associate with PLWHA for fear that they might get infected by a disease which will afflict them to the point of taking their lives. In Khayelitsha, this fear is evidenced by the fact that in the *amaXhosa* culture, which is predominant in Khayelitsha, the concept of HIV and AIDS as a killer *'Gawulayo'* makes many people afraid of infection and of losing their lives. The second cause of HIV and AIDS stigma discussed in this research study was the fact that even though there is information about HIV and AIDS, there is still ignorance about ways through which HIV is or is not transmitted, due to the fact that some people may still hold beliefs that HIV is transmitted through condoms, witchcraft, or racism, despite the knowledge they have about HIV and AIDS infection. The third cause of HIV stigma discussed in this research study is the fact that due to poverty, PLWHA lack adequate support from their families. Community or family members may think that since PLWHA are dying anyway, they are uselessly consuming scarce resources, which are then withdrawn. This cause is particularly significant in Khayelitsha which, according to the literature, is a very poor township. The fourth cause of HIV and AIDS stigma, as discussed in this research study, is a common tendency to relate HIV and AIDS to sexual sin in a moralistic way so that HIV is viewed as God's punishment for sexual sin. The fifth cause, gossip and insults, is related to HIV and AIDS stigma in that when people are known to be HIV positive, they become a subject of talk in the community. Gossip and insults have been identified as being a common community response to PLWHA. In addition to those causes of HIV and AIDS stigma, there is a further factor which influences stigmatisation in Khayelitsha, namely gender imbalance. Since Khayelitsha is, in the main, a patriarchal community, men and women are not affected equally in terms of HIV

and AIDS stigmatisation; for example, when women are found to be HIV positive, they face more stigma than men. Furthermore, women are often first to disclose their HIV status due to the fact that when they are pregnant, they have to go for PMTCT. Women are also more vulnerable to HIV and AIDS stigma as they are more susceptible to the HIV virus than are men. In addition, they are more touched by poverty than men, have to be inherited by the siblings of their husbands if the husband dies, and are expected to carry the burden of care for the sick.

Along with the causes of HIV and AIDS stigma, the serious effects of such a stigma for both PLWHA and their communities in Khayelitsha were explored in this research. It was found that HIV and AIDS stigma is regarded as the key barrier to effective action against HIV and AIDS because it deters people from going for HIV testing or revealing their HIV status. There is also a reluctance to talk about the disease (silence) in churches and communities, which has caused HIV to spread more and more.

Furthermore, the negative effects of HIV and AIDS stigma are evident in the fact that if PLWHA know that they will be rejected in the community, they opt not to disclose their HIV and AIDS status, and therefore efforts in care and prevention programmes are hampered. This puts the whole community at risk, because it becomes very difficult to control new infections when a lot of 'silent killers' result from failure to disclose positive HIV and AIDS status. Stigma also results in a terrible acceleration of death for PLWHA because they stay isolated and neglected when they really need someone to care for them. In this regard, as Van Wyngaard (2006:12) posits, it is not the HIV and AIDS condition itself that causes most affliction, but the stigma and the possibility of rejection, discrimination, confusion and loss of trust which PLWHA have to endure.

In light of the above, the researcher is of the opinion that the objective of understanding the causes and effects of HIV and AIDS stigma in Khayelitsha was met by this research study, and that the understanding provided serves as a tool to suggest an approach for church leaders to deal with HIV and AIDS stigma in Khayelitsha.

6.1.2 A Pastoral, Biblical, and Theological ApproachAddressing HIV and AIDS Stigma in Khayelitsha

Concerning a biblical and theological reflection on HIV and AIDS stigma, this research study indicated in Chapter Three that church leaders have so far not done much in their efforts to motivate the Church to respond to the challenge of stigmatisation, even though they are

expected to take action. The stumbling block to taking action against HIV and AIDS stigmatisation has been the prevalent belief in the Church that HIV and AIDS is God's retribution for promiscuity, resulting in the fact that PLWHA are usually blamed for their situation, especially if they caught HIV as a result of sexual behaviour or injecting drugs.

However, an argument was also presented that the belief that HIV and AIDS is God's punishment for sexual immorality is not justified. There are people who become infected despite being faithful to their spouses. There are also instances where a child becomes infected through his/her mother, or where others are infected in different ways, not necessarily through promiscuous behaviour.

In fact, the stigmatisation of PLWHA, in itself, can also be viewed as sinful, due to its failure to consider the dignity of the human being who is made in God's image (Heymans, 2008:82). In addition, stigmatisation breaks down the essence of human worth. It is therefore sinful in the sense that it is a violation of human rights and a crime against humanity (Paterson, 2005:11).

Unfortunately, while some religious leaders are committed to making sure that HIV and AIDS stigma is addressed through their efforts to sensitise their congregations and get them to become involved, this study revealed that others continue to display attitudes that make PLWHA unwelcome on their doorsteps.

The research objective of constructing a pastoral, biblical, and theological basis in order to develop an approach which church leaders can use to address HIV and AIDS related stigmatisation in Khayelitsha was met through addressing faulty theology that reinforces stigmatisation of PLWHA, and suggesting a biblical theology of HIV and AIDS stigma which church leaders can follow in addressing such stigma in Khayelitsha. In addition, this objective was further dealt with in Chapter Five.

6.1.3 The Church as a Place of Healing

The objective of examining the nature of the Church as a place of healing in relation to HIV AND AIDS stigma in Khayelitsha was dealt with in the fourth chapter of this research study. It was established that the Church is a healing community in times of HIV and AIDS stigma. Taking the Early Church as an example of a healing community, it was suggested that inclusion in the Church can be a crucial element in healing for PLWHA. Baptism was identified as a tool of inclusion and acceptance into the family of believers, since after

baptism the new member is welcomed to take part in church fellowship and to enjoy the care of the Church along with other members. In the fellowship of believers, *koinōnia* is expressed in the sharing of spiritual and material blessings with others through worshipping together, and ministry is expressed through *diakōnia*. For the purpose of accomplishing the above objective, it was necessary to discuss the concept of healing from the *amaXhosa* perspective in order to apply it to Khayelitsha which is predominantly of *amaXhosa* culture. It was then established that in the *amaXhosa* culture, sickness is generally viewed as being the result of witchcraft, and that when it occurs, it affects both the individual and the whole community. In this sense, the objective was achieved, as the discussion in chapter four presented aspects in which the Church can be of help to PLWHA in terms of holistic healing, and this was a useful tool to suggest an approach for church leaders to deal with HIV and AIDS stigma in Khayelitsha.

6.1.4 Recommendations for Ministerial and Pastoral Approach

Chapter Five of this research study provided apastoral approach for a pastoral approach for dealing with HIV and AIDS stigma in Khayelitsha, including various suggestions as to how church leaders can address such stigma, while in Section 6.2 of Chapter Six, which also serves as the conclusion for this research study, further recommendations will be made, thus fulfilling the objective of making recommendations useful for assisting the Church in Khayelitsha to deal with HIV and AIDS stigma.

After determining that the objectives set for this research study have been met, the researcher finds it useful to reiterate some of the recommendations as part of the closure of the study. In this regard, recommendations for church leaders, recommendations for further research, and recommendations for theological seminaries will be presented.

6.2 Recommendations for Church Leaders

In order to deal with HIV and AIDS stigma successfully, church leaders in Khayelitsha should strive to:

- Understand the leading causes and effects of HIV and AIDS stigma in their communities in order to help their churches to understand them and deal with them;
- Work on information dissemination to ensure that people in their churches have access to accurate information about HIV and AIDS transmission, treatment, and prevention. This could be done through developing educational material in the Church and conducting workshops and campaigns where facts about HIV and AIDS are

taught. It would also be useful for churches to network with other organisations such as the City of Cape Town, TAC, MSF and others that are already involved in activities concerning HIV and AIDS in Khayelitsha in order to learn from them. Correct information about HIV and AIDS, especially from church leaders, if consistently and efficiently provided, would be useful in helping people to resist traditional beliefs about condoms, witchcraft, and racism being causes of HIV transmission. For this purpose, church leaders may need to go for training in HIV and AIDS facts in order to be well informed before they can pass information on to others;

- ♥ Encourage families of PLWHA to take care of their suffering members and be willing to share their resources no matter what, because PLWHA still have dignity and are worthy of support, despite the fact that their lives may be deteriorating. It would also be helpful if church leaders assisted families in taking care of members with HIV and AIDS by helping them to access support available in the community in the form of social grants, and by initiating schemes for home-based care and food parcels for PLWHA and their families. Church leaders should also strive to encourage churches to care for HIV and AIDS widows and widowers by creating church-based support groups and enabling them to find jobs or start self-support projects, while HIV and AIDS orphans could be assisted to continue with their education and stay in orphanages until they are self-reliant;
- ♥ Counter the moralistic belief that holds HIV and AIDS to be God's punishment for sexual immorality by promoting a correct interpretation of Scripture in order to inform churchgoers about God's judgement and forgiveness of sin. This would ensure that people are helped to focus on the image of God not as a judge, but as a God who is willing to identify with His people in their suffering and who dealt with their sin through sending His Son Jesus to die so that there is no longer condemnation for those who are in Him. This would help people to see PLWHA as no longer deserving of being stigmatised, but rather worthy of being accepted, since Jesus was stigmatised in their place when He died on the cross;
- ♥ Protect the dignity of PLWHA who disclose their HIV status, and encourage church members to treat with confidentiality any sensitive information disclosed to them by PLWHA. Church leaders in Khayelitsha should also encourage churchgoers to avoid bad language aimed at PLWHA. This would help to create a safe environment for

PLWHA to share their struggles and disclose their HIV status with no shame or fear of being stigmatised in the Church;

- ♥ Work on cultural issues such as gender imbalance by helping churchgoers to understand that man and woman are equally created in God's image, and that women should be protected against any unfair treatment rendering them more vulnerable to HIV and AIDS;
- ♥ Become instruments of holistic healing and hope by helping churches to become healing communities through accepting PLWHA and granting them an opportunity to be part of the Church and share in the fellowship (*koinōnia*), ministry (*diakōnia*), preaching (*kērygma*) and teaching (*didachē*), as well as the counselling and prayers, which other church members are enjoying. In this regard, willingness to learn from others such as the Early Church would be very helpful. In the effort to facilitate healing, church leaders in Khayelitsha need to bear in mind their people's cultural beliefs about sickness and healing in order to address them with sensitivity. They could also do better by leading people to replace traditional rituals such as rites of passage, cleansing or sacrifices with Christian practices such as baptism, Holy Communion, and prayers for healing.

6.3 Recommendations for Further Research

Due to the fact that this research study comprised only a literature review, it could not deal with the empirical aspect which is crucial for gathering up-to-date information from primary sources in Khayelitsha. Therefore, this research study recommends that any future research in this area should include consultation with people in Khayelitsha in order to see what is really going on in terms of the Church's response to the fight against HIV and AIDS stigma.

6.4 Recommendations for Theological Seminaries

As theological seminaries are the places where church leaders are often trained, it is recommended that they should be organised in such a way as to meet the academic needs of church leaders as far as their work in the community is concerned. In this regard, if church leaders are to be well trained in the area of HIV and AIDS, it would be very helpful for theological seminaries in Africa, South Africa and Khayelitsha to provide a strong foundation in their teaching about existential issues, especially HIV and AIDS, through including it in their curriculum to make sure that their graduates are well prepared to face such a challenge.

6.5 Conclusion

In the face of HIV and AIDS-related stigma, the Church is expected to be a safe haven for people infected and affected with HIV and AIDS because of its *diakōnia* and *koinōnia*. Even though it is clear from this research study that the Church in Khayelitsha has so far not been as effective in dealing with HIV and AIDS stigma as it should, there is still an opportunity for improvement if the Church really wishes to be God's representative in the world. Members of the Church need to realize that they are the followers of Christ, who was stigmatised on the cross in order to identify with His stigmatised people. According to the recommendations given in this chapter, the Church in Khayelitsha has a chance to play a role in combatting stigma related to HIV and AIDS. Due to the way in which some church leaders have responded by passing judgement on PLWHA, the Church in Khayelitsha has, up to now, generally been seen as not getting fully involved in efforts to deal with stigma. However, the time has come for all church leaders to stand together in order to fight against HIV and AIDS stigma which is identified as a major barrier in the fight against HIV and AIDS. In order to be successful in the fight against this stigma, church leaders in Khayelitsha needs to confess any passivity and then commit themselves to action. They should keep in mind that the Church still holds a prominent place in the community. In addition, they must work on paradigm shifts, i.e. instead of holding onto the view of a God who is there to punish His people; they should start thinking of a God who, by love, has forgiven His people through the death of Jesus. Moreover, instead of seeing HIV as being acquired through sexual sin, they should be considering that there are those who become infected innocently. It is time for church leaders in Khayelitsha to become more proactive in caring for PLWHA, regardless of how they got infected. This will be made possible by their relinquishing any judgemental spirit and focusing on the fact that people are created in the image of God, and that Jesus died for them, taking the stigma which they deserved and replacing it with charisma (the fruit of the Spirit). Church leaders in Khayelitsha should thus lead their churches into being transformed from communities of stigma into communities of healing by accepting PLWHA into membership in their midst, regardless of their status, and allowing them to enjoy *didachē, kērygma, koinōnia, diakōnia*, and prayer. It is only through such care that holistic healing (physical, spiritual, social, and psychological) will take place in the lives of PLWHA, and this will bring hope that even though they are afflicted by the virus, the Lord who died for them carried all their pain, and since He lives, they will live forevermore, even though their bodies are perishing. Leaders of the Church in Khayelitsha cannot run away from the reality of taking care of PLWHA who are in their midst.

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