Churches as providers of HIV/AIDS care: a normative and empirical study

by
Clive J Ferreira

Dissertation presented for the degree of Doctor of Philosophy
in the Faculty of Arts and Social Sciences at
Stellenbosch University

Supervisor:
Prof Cornie Groenewald
Department of Sociology & Social Anthropology
&
Co-supervisor:
Prof Ignatius Swart
Department of Theology

December 2012

Declaration

By submitting this dissertation electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Clive J Ferreira

Abstract

There is, as yet, no cure for HIV/AIDS, a disease that has affected South African society profoundly. While antiretrovirals (ARVs) are now available and have stemmed the tide of AIDS deaths, medicines alone cannot be seen as a long-term solution. Treatment costs, finite resources, limited health-care capacity, morbidity and the unpleasant side-effects of ARVs, make treatment an untenable solution.

The Christian church in South Africa continues to retain a powerful position; it has a significant affiliation; it is present in most geographic areas and inspires trust and confidence. Furthermore, in my view, the church, by its very nature and calling, is mandated not only to demonstrate and provide care, but also to inspire care-giving.

In the light of HIV/AIDS, what does care mean? Can it only mean rendering care that is welfarist in nature? Or does the church have the mandate to look beyond immediate suffering, to examine and address those issues that lie at the core of suffering? Research has demonstrated that issues such as poverty, injustice, stigma, discrimination, gender inequality and patriarchy fuel the pandemic. Ultimately, it is the "othering" of people; the failure not to recognise God in another person and our common humanity, that lie at the heart of the problem. These then, I suggest, are the very reasons why the church must address these areas.

But that is not all: if HIV/AIDS care is to be rendered in a developmental way, then there must be a thorough understanding of the disease: how is the virus transmitted, how can it be prevented and treated? It is also important to understand that there is not a single global epidemic but many local epidemics; the determinants and risk-factors of these need to be recognised, as must the cultural, economic, political and social contexts that fuel the spread of the disease. The changing nature of society, the effects of globalisation, the evolving nature of care owing to biomedical advances and even the "privatisation" of sex all need to be comprehended.

Furthermore, any meaningful rendering of care requires the churches to examine why they should be giving it and the values that underpin such care-giving. I make the case that the churches are required to do nothing less than drive social change in situations of suffering, injustice and abuse. An examination of the history of HIV/AIDS in South Africa illustrates that the churches have often failed to meet up to this calling.

iii

An empirical study was conducted as to how the churches render care at a more micro, grassroots level, using a framework propounded by David Korten, who suggests that authentic development must be people-centred, rather than growth-centred. Essentially, development must seek to increase personal and institutional capacities, guided by principles of justice, sustainability and inclusiveness. In these respects, I argue, it accords very strongly with the Christian message. Korten suggests that there are four orientations (or generations) of rendering help but it is only the fourth generation that is truly developmental.

Through the use of case study methodology, I sought to examine the manner in which the churches render care, in a region of the Western Cape, outside Cape Town, known as the Helderberg Basin. The area is representative of many peri-urban areas in the Cape: it is predominantly Christian, with a mix of different denominations and racial and socio-economic groupings. It allowed for an assessment of care initiatives afforded by mainline, charismatic and African Independent Churches and in particular, sought to answer the question of whether churches engage with HIV/AIDS in a way that Korten would identify as developmental.

From the research, it is clear that the church is hampered by its inability to talk of sex and sexuality; its knowledge of the issues surrounding HIV/AIDS is limited; it has not done a sufficient amount to conscientise its followers; the church has yet to learn to utilise its networks; it lacks technical know-how and is unwilling to engage in the political sphere.

Social change is only possible if the church embraces a new vision of how to create a better world. Additionally, I recommend that the church looks to the emerging church movement to achieve radical transformation.

Opsomming

MIV/VIGS is 'n siekte wat Suid-Afrika onmeetbaar beïnvloed en waarvoor daar tot op hede geen genesing is nie. Antiretrovirale middels (ARVs) is weliswaar beskikbaar en het die gety van VIGS sterftes gestuit maar medisyne kan nie alleen as die langtermyn oplossing gesien word nie. Behandelingskoste, beperkte hulpbronne en vermoë om gesondheidsorg te lewer, morbiditeit en die negatiewe newe-effekte van ARVs bring mee dat slegs mediese behandeling 'n onhoudbare oplossing is.

Die Christelike kerk in Suid-Afrika behou steeds 'n magsposisie; dit het 'n beduidende lidmaatskap asook 'n teenwoordigheid in meeste dele van die land en boesem vertroue en sekerheid in. Dié kerk is na my mening gemandateer deur haar besondere aard en roeping om nie alleen sorg te bewys en te voorsien nie maar ook om versorging aan te moedig.

Maar wat beteken sorg, gegewe die aard van MIV/VIGS? Kan dit slegs die lewering van welsyngerigte sorg beteken? Of sou die kerk die mandaat hê om verder as onmiddellike lyding te kyk en ondersoekend die kwessies wat aan die wortel van lyding lê, aan te spreek? Navorsing het aangetoon dat kwessies soos armoede, onreg, stigma, diskriminasie, geslagsongelykheid en patriargie die epidemie aanvuur. Uiteindelik is dit die objektivering ("othering") van mense - dit is die onvermoë om God nie in 'n ander persoon en ons gemeenskaplike mensheid te herken nie - wat die hart van die probleem is. Ek betoog dat hierdie die redes is waarom die kerk hierdie kwessies moet aanspreek.

Om ondersoek in te stel of en tot watter mate die kerk sorg verskaf in verband met MIV/VIGS het ek die raamwerk van David Korten gebruik. Dié raamwerk stel voor dat outentieke ontwikkeling mensgesentreerd eerder as groeigesentreed sal wees. Ontwikkeling moet essensieel streef na 'n toename van persoonlike en institusionele vermoë, gerig deur beginsels van geregtigheid, volhoubaarheid en inklusiwiteit. Ek toon aan dat hierdie beginsels baie sterk ooreenkom met die Christelike boodskap. Korten stel vier hulplewerende oriëntasies (ook genoem generasies) voor maar dit is eintlik slegs die vierde generasie van hulp wat werklik ontwikkelingsgerig is.

Maar dit is nie al nie. Indien MIV/VIGS versorging ontwikkelingsgerig gaan wees, moet dit gegrond wees op 'n diepgaande verstaan en kennis van die siekte soos onder

andere, hoe die virus versprei word en hoe die siekte voorkóm en behandel kan word? Dit is ook belangrik om te verstaan dat daar nie slegs 'n enkele globale epidemie is nie maar verskeie lokale epidemies. Die veroorsakende en risiko faktore van hierdie epidemies moet daarom geïdentifiseer word en so ook die kulturele, ekonomiese, politieke en sosiale konteks wat die verspreiding van hierdie siekte aanhelp. Die veranderende aard van gemeenskappe, die effek van globalisering, die ontwikkelende aard van gesondheidsorg vanweë die vooruitgang in die mediese wetenskap en die "privatisering" van seks moet alles in ag geneem word.

Betekenisvolle versorging vereis dat kerke ondersoek instel na waarom die versorging aangebied word en die waardes onderliggend daaraan. Ek stel die saak dat daar van kerke verwag word om sosiale verandering te stuur waar mense swaarkry, onregverdig behandel en misbruik word. 'n Ondersoek na die geskiedenis van MIV/VIGS in Suid-Afrika illustreer dat kerke dikwels misluk het om aan hierdie roeping gehoor te gee.

In opvolging van die bostaande argumente het ek navorsing uitgevoer oor hoe kerke sorg op 'n mikro of voetsool-vlak aanbied. Hiervoor het ek die genoemde mens-gesentreerde ontwikkelingsraamwerk van David Korten gebruik. 'n Gevalstudie benadering is gevolg in die Helderbergkom wat geleë is in 'n streek van Wes-Kaapland buite Kaapstad. Hierdie gebied is verteenwoordigend van baie buitestedelike gebiede van die Kaap: dit is oorwegend Christelik en sluit 'n verskeidenheid van denominasies, rasse en sosio-ekonomiese groeperings in. Die gebied maak 'n oorsig moontlik van die sorg-inisiatiewe van hoofstroom, charismatiese en Afrika onafhanklike Kerke, en in die besonder van 'n identifikasie daarvan of kerke betrokke by MIV/VIGS dit doen op 'n wyse wat Korten sou tipeer as ontwikkelingsgerig.

Uit hierdie navorsing het dit duidelik geword dat die kerk gekniehalter word deur 'n onvermoë om oor seks en seksualiteit te praat; die kerk se kennis beperk is wanneer dit kom by kwessies wat handel oor MIV/VIGS; dit nie genoeg doen om lidmate bewus te maak van VIGS kwessies nie; dit nog veel te leer het oor hoe om netwerke aan te wend; dit tegniese kennis kort en onwillig is om met sake van politieke belang om te gaan.

Sosiale verandering is alleen moontlik indien die kerk 'n nuwe visie voorhou oor hoe om 'n beter wêreld te skep. Ek beveel ten slotte aan dat die kerk let op die ontluikende kerkbeweging om radikale transformasie te verwesenlik.

Acknowledgements

When I embarked upon the PhD programme, my promoters, Professor Cornie Groenewald and Professor Ignatius Swart, warned me that this would possibly be one of the loneliest journeys that I would ever have to undertake. I was somewhat blasé and naïve, not fully appreciating the task upon which I would be embarking.

It is often said that with any journey, it is not so much the destination that is important, but rather the process. I learnt, through this endeavour, many things, not least the importance of companions and fellow travellers upon the journey. I am therefore particularly grateful to Professor Groenewald and Professor Swart for their support and care. They were by turns, kindly, stimulating, challenging, exacting, humorous and encouraging. Their keen minds, academic prowess and experience have been invaluable and without their constant support, the journey would have been less enjoyable and stimulating.

I am also grateful to all the staff and members of the Department of Sociology, and in particular, to Mrs Hendrine De Wet and Miss Cyrildine Fortune, who always provided a cheery word and encouragement when I faced difficulties or frustrations.

The Carnegie Research Commons at Stellenbosch University is a welcome addition to Stellenbosch University; it provided the quiet and space in which to write the dissertation. I could not have wished for a more helpful team, both in terms of staff and student assistants, who were always on hand.

My passion for the subject of HIV/AIDS was initially fuelled and sustained by Professor Jan Du Toit, who now heads the Africa Centre for HIV/AIDS Management at Stellenbosch University. His enthusiasm and commitment to fight the disease are inspirational.

The financial assistance of the National Research Foundation (NRF) towards this research is hereby acknowledged. Opinions expressed and conclusions arrived at are my own and are not necessarily to be attributed to the NRF.

I would also like to express my appreciation to the churches, FBOs, congregations and other religious organisations of the Helderberg Basin, who gave their time to talk

to me, despite the pressures that they face. I believe that they are, without exception, well intentioned but it is my hope that through the findings of this dissertation, they will be encouraged to do things differently so that the enormity of the pain and suffering that is caused by HIV/AIDS is alleviated more effectively and meaningfully.

I am indebted to Mrs Sheila Duckham too, whose love, friendship and encouragement have sustained me when I felt myself faltering. Her dedication to teaching has made me see more clearly than ever, the difference between a vocation and a profession. Her gift to me of Mark Tully's book (of which I make mention in the dissertation) and her careful reading of this work in its final stages, have been invaluable.

Finally, my heart brims over with joy and thankfulness to Ian Greer and my parents, for their love, steadfast support and faith in me; they have made the journey worthwhile and without them, life would not be as rich or as much fun!

Acronyms

ACT UP	AIDS Coalition to Unleash Power
AIDS	Acquired immunodeficiency syndrome
ANC	African National Congress
ARHAP	Africa Religious Health Assets Programme
ART	Antiretroviral therapy
ARVs	Antiretrovirals
BIG	Basic income grant
CABSA	Christian AIDS Bureau of Southern Africa
CBOs	Community based organisations
CD4	Cluster of Differentiation 4 positive T-lymphocytes
CDC	Centre for Disease Control
DfID	United Kingdom's Department for International Development
DOH	Department of Health (South Africa)
DSD	Department of Social Development (South Africa)
EFSA	Ecumenical Foundation of Southern Africa
ELISA	Enzyme-linked immunosorbent serum assay
FBOs	Faith-based organisations
GCS	Global civil society
GONGOs	Governmental Nongovernmental Organisations
HAART	Highly active antiretroviral therapy
HBC	Home-based care
HBCB	Home/community-based care
HIV	Human immunodeficiency virus
HDI	Human Development Index

IDUs	Intravenous Drug Users
KRCCC	KwaZulu-Natal Regional Christian Church Council
MTCT	Mother-to-child transmission
NRASD	National Religious Association for Social Development
NRLF	National Religious Leaders' Forum
NGOs	Non-governmental organisations
OECD	Organisation for Economic Cooperation and Development
PEPFAR	USA President's Emergency Plan for AIDS Relief
PLWHA	People living with HIV/AIDS
POs	People's Organisations
PSCs	Public Service Contractors
SABC	Southern African Bishops' Conference
SACC	South African Council of Churches
SAIRR	South African Institute of Race Relations
STI	Sexually transmitted infection
TAC	Treatment Action Campaign
TB	Tuberculosis
TRIPS	Trade Related aspects of Intellectual Property Rights
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on AIDS
UNICEF	United Nations Children's Fund (formerly United Nations International Children's Emergency Fund)
USA	United States of America

USD	United States dollars
VCT	Voluntary counselling and testing
VO	Voluntary Organisation
WCC	World Council of Churches
WHO	World Health Organisation
WTO	World Trade Organisation

Tables

Maps

Table of contents

Chapter 1

Orientation and research design

1.1   Introduction

In his book, *Getting to the 21st Century*, David Korten (1990) says that the critical issue of development is not growth but transformation: transformation of institutions, technology, values and behaviour, taking into account environmental concerns as well as the needs of society (1990:4). Korten therefore calls for a people-centred development vision that embraces the transformation agenda and that incorporates the core principles of justice, sustainability and inclusiveness. In many ways Korten's alternative vision of development is consistent with the Christian church's stance that the human person, rather than economic growth, should be at the core of development programmes. Both argue for "people-centred" development.

As Swart (2005:39) has noted, in the literature on social development the terms "people-centred development" and "social development" are often used interchangeably, as these words describe an alternative development paradigm and one that is distinct from the neoliberal approach to development, with its focus on the free market and free trade as the means to drive economic growth (which, it is then argued, eventually works for the benefit of all through a "trickle-down" effect). Patel (2005:30) concurs that social development is a people-centred approach that seeks to promote citizen participation, while also strengthening the voice of the poor in decision making and in building democratic, accountable institutions. In other words, human development rather than economic (or growth-centred) development is key in social development. Indeed, Midgley (1995:66) states that "human development is nothing more than a synonym for social development". This resonates strongly with the Christian message, which emphasises that it is not the market that should dictate our approach to development, but rather authentic human development which recognises God in every person and every person in God.

Midgley (1995:25) defines social development as "a process of planned social change designed to promote the well-being of the population as a whole in conjunction with a

1

dynamic process of economic development" and he makes the point that social development can only take place in tandem with economic development and, furthermore, that economic development is meaningless if it fails to improve the wellbeing of the population as a whole (1995:23).

According to the United Nations Development Programme (UNDP 1999), social development could create an environment in which people may enjoy healthy, productive and creative lives, while also creating wider choices for people by expanding their human capability and functioning. Health, education and income are therefore key aspects of social development. To this end, the UNDP has devised a Human Development Index (HDI) as an alternative measure of development, using longevity, educational attainment and income to assess human development and social progress. Patel (2005:50) comments:

> The human development framework addresses itself to the question of pervasive poverty in a manner that tilts development efforts in the direction of people …. Human development also involves a process of achieving these human capabilities in a way that is equitable, participatory, productive and sustainable…. The goals and targets focus on key human development issues such as income and poverty eradication, health, food and nutrition, education, children and women, and human security…. [However,] the goals are not considered to adequately address the structural causes of the social situation in many countries, including institutional constraints and complexities.

Korten (1990:34) recognises this and, while also arguing for just, sustainable and inclusive growth, goes further by calling for a "fundamental transformation of structures and values". He argues that serious development assistance to the poor demands that consideration be given to political and economic empowerment. This necessarily requires an acknowledgement that the problems are by and large "a result of the maldistribution of power and require major institutional change" (1990:142).

Health is a crucial aspect of social development, because it not only enhances the potential of people, but also their households and ultimately their nations; a healthy population places fewer demands on health systems and contributes to productivity. However, diseases such as tuberculosis (TB), malaria and HIV/AIDS[1] have the

---

[1] HIV stands for "human immunodeficiency virus". HIV is a virus which destroys or impairs the function of the immune system, leading to "immune deficiency", thereby making a person more susceptible to a wide range of infections. AIDS stands for "acquired immunodeficiency syndrome"

capacity to reverse socio-economic gains. It is estimated that the cost of caring for people with AIDS in Africa has been rising; to provide basic care and prevention programmes cost US$3 billion in 2002 (AIDS Review 2003:17). The pandemic is placing enormous pressure on care and support systems.

HIV/AIDS also affects vulnerable sectors of the population such as the youth, children, women, homosexual men, single men, migrants, the poor, etc. The fact that young people continue to be at the greatest risk of infection in sub-Saharan Africa has grave implications for society, households, communities and the workplace.

HIV/AIDS therefore has the potential to impede human development and social progress. The Joint United Nations programme on HIV/AIDS (UNAIDS 2010) estimates that there were 33.3 million people living with HIV at the end of 2009 (27% more than in 1999). The majority of new HIV infections continue to occur in sub-Saharan Africa, where although the rate of new HIV infections has decreased, the total number of people living with HIV continues to rise. In 2009 that number reached 22.5 million (or 68% of the global total). It is estimated that 1.3 million people died of HIV-related illnesses in sub-Saharan Africa in 2009, comprising 72% of the global total (UNAIDS 2010:25). An estimated 5.6 million people were living with HIV in 2009 in South Africa, making the country's epidemic the largest in the world (UNAIDS 2010:28). A fuller analysis of the figures is undertaken at Chapter 2, section 2.5.

Given these figures, it is not difficult to imagine the social and economic impact of HIV/AIDS on individuals, families and communities. The disease is a human tragedy and its impact is felt in many different ways, not least through reduced life expectancy, increased poverty, loss of experience and skills, the effect on children and families, and so on. Morbidity, as a consequence of HIV/AIDS, affects productivity in the workplace. Households are affected because savings that might be spent on production are spent on medical help or medication. Furthermore, people who are ill might not be able to engage in food production.

---

and the condition associated with it is the breakdown of the immune system from HIV infection, which results in a range of symptoms, cancers and infections.

While it can be argued that the church, religious bodies and faith-based organisations (FBOs) have no part to play in development, the fact is that they have delivered health care, along with education and other social services, for several hundred years. Development agencies, including donor and aid-receiving governments, are increasingly recognising the roles that FBOs can play in development (Narayan 2001; Belshaw *et al*. 2001; Marshall & Keough 2004). Belshaw (2006) outlines several advantages of FBOs working in development, including:

1.   Their long-term commitment to projects and the fact that their efforts can often be sustained in difficult times;

2.   In poor countries the majority of their membership is often the poorest and most marginalised;

3.   Many FBOs have in place separate intra-country and international links to sister organisations that might have funds and/or experience;

4.   Christianity and other faiths stress values such as loving your neighbour and treating others as you would wish to be treated, and this provides a guide to establishing and building social relationships;

5.   Spiritual and relational experiences can help to raise the esteem and confidence of people who have been marginalised or previously excluded.

Indeed, the South African government increasingly acknowledges the potential role of FBOs in development in general, but more particularly in the fight against HIV/AIDS. A former South African Minister for Social Development, Dr Zola Skweyiya, made the following comment at a conference of the National Religious Association for Social Development (NRASD) and Ecumenical Foundation of Southern Africa (EFSA) (2004):

> Faith-based organisations and their agencies possess extensive and effective networks throughout our country. They are committed and closest to the disempowered and most vulnerable members of our society. There is no way therefore that the government, business sector or local communities will succeed against HIV/AIDS acting on their own. The partnership against HIV/AIDS requires the resolute leadership and sustained involvement of the religious sector in all facets of the epidemic (Ministry of Social Development 2004).

4

Foster (2009) states that the Christian church in particular has always played a role in caring for populations most at risk by using available resources, skills and knowledge. Owing to the humanitarian principles that underpin faith initiatives, the church is well suited to providing care. Indeed, according to the Institute for Development Training (1998), religious health networks are the second largest entity of health care providers in the developing world, after government programmes.

In his book, *How Christianity Changed the World*, Schmidt (2004) outlines how the Christian church changed society and attitudes towards the sick and vulnerable by bringing qualities of compassionate care and services, regardless of the social status of those in need of help.

In relation to HIV/AIDS care, the church's response has been significant, particularly in terms of treatment, including the provision of home-based care to those who are sick, as well as the care of orphaned children. The church's response in terms of prevention may, however, have been less evident, owing to the fact that HIV is primarily transmitted sexually (particularly in sub-Saharan Africa) and for this reason the church may have found it a more difficult area to address. In this regard, a pertinent question may be asked: if the church is unable, or finds it difficult, to address a key element in HIV/AIDS care, namely the issue of prevention, can it be called upon to play a part or indeed put itself forward as a partner in development?

The aim of this dissertation is to examine whether the church can exercise HIV/AIDS care in a manner that Korten would describe as transformational, that is to say can the church contribute or indeed, initiate a people's movement for social change in relation to a disease that is largely sexually transmitted in sub-Saharan Africa, so that it tackles the social, economic, political and cultural aspects that lie at the heart of fuelling the pandemic.

In an endeavour to fulfil the aim of the dissertation an examination will be undertaken as to what factors enhance or impede the church's ability to render HIV/AIDS care. For example, although the church might be motivated by love, its inability to address the issue of condom use may impede its ability to act as an effective developmental agent. In such a scenario the church's work may well be confined to providing immediate relief rather than a more profound form of development assistance.

5

Furthermore, it is my contention that if the church is to spawn or catalyse a movement that is born out of the crisis, it needs to confront structural issues such as poverty, gender discrimination and inequality, which are the real impediments to development.

This necessarily entails asking whether the church has allowed itself to be transformed in terms of attitudes and practices that might have implications for the disease. Issues such as gender equality are a case in point (see, for example, Haddad 2003a; Mwaura 2007). Mwaura (2007:209) makes this pertinent point: the church is not what it is called upon by God to undertake, but what the church as a community is called upon to become, which includes breaking the barriers of gender, social status, race and even disability.

This dissertation – in accordance with Korten's Dissertation – attempts to answer the question: *Can or does the church play a role in HIV/AIDS care that can be described as developmental, as defined by Korten?*

The responsiveness of the church to one of the key social issues facing the country is in my view indicative of its desire to engage in the transformation of society. As such, this research falls between the fields of applied sociology and practical theology. The interdisciplinary study therefore comprises two parts:

a.   An attempt at a theological motivation and sociological analysis of HIV/AIDS;

b.   A consideration of empirical results following case studies, conducted through interviews and triangulated, and assessed through a theoretical framework provided by Korten.

At this point it would probably be helpful to very briefly summarise Korten's generations of development strategies. It should be noted, however, that a much fuller description will be provided in Chapter 4, section 4.4.3. The nature of an interdisciplinary study is then considered.

1.2   A framework against which to assess developmental care

As discussed above, Korten advocates an alternative development paradigm: one that is people- rather than growth-centred. In order to realise this objective, he outlines

that there are several "generations" or levels of action in which to pursue the goal. However, the strategies employed by non-governmental organisations (NGOs) will depend upon whether they are prepared to move from the provision of welfare and humanitarian relief (first-generation strategies) or local, community projects (second-generation strategies), to a more developmental approach of engagement (third- and fourth-generation strategies). The latter strategies require NGOs to engage in sustainable systems development and in the catalysing of people's movements; they necessarily involve an NGO looking to change values and institutions at regional, national and global levels. Korten's classification therefore provides a valuable framework to assess whether the church's work in relation to HIV/AIDS is developmental in nature, or whether such help as it provides is welfarist or local in orientation. According to Korten, it is the fourth-generation strategic orientation that is truly developmental, as it is motivated by a vision to transform values across boundaries, in order to bring about a more just, sustainable and inclusive society. Fourth-generation strategies look to create a new level of human consciousness in order to release social energies that can be utilised to reorder human behaviour and institutions for the greater good of society.

Much has been written about the church in relation to HIV/AIDS (see, for example, Dube 2002; West 2003; West & Zengele 2006; Richardson 2006; Phiri 2010). There has also been a fair amount of coverage on the church's response in terms of HIV/AIDS treatment (see Haddad 2005; Root 2009; Root & Van Wyngaard 2011), as well as discussion particularly on the Catholic Church's response to HIV prevention (see, for example, Bovens 2009; Eriksson *et al*. 2010; Ferrari 2011). The theological justification for responding to the HIV/AIDS crisis has also been well covered (see, for instance, Haddad 2005; Van Klinken 2008; Seffner *et al*. 2011). An area that has not received much attention, however, is whether the care that the church provides can be described as developmental (and particularly with reference to Korten's definition).

There is however an increasing interest in the role of religion in development (see, for example, Marshall & Keough 2004; Tyndale 2000) but the manner of the church's engagement in rendering HIV/AIDS care has received scant attention, in particular whether such care measures up to a people-centred, social developmental way of

engagement. The contribution of the church to the delivery of social services in South Africa has recently been examined (Swart *et al*. 2010). The various ways in which the church provides help has also to some extent been covered (also see Chapter 2, sections 2.3 and 2.8). However, there has been little critical examination as to whether the nature of the help that is given is developmental and transformative. Furthermore the contribution of local churches in the battle against HIV/AIDS has not received much attention. There is a need, moreover, to understand whether the church's role in relation to HIV/AIDS is limited because of its doctrines (or indeed the local culture of congregations, which might impede or constrain the provision of HIV/AIDS-related services) or whether it can in fact play a far greater role in social development, if it allows itself to transcend these constraints by keeping foremost its calling to meet the spiritual, health and social needs of the ill, needy and marginalised in society, because of its Christian obligation to love.

The interdisciplinary nature of this dissertation, straddling as it does, the fields of applied sociology and practical sociology, requires a brief explanation.

1.3   An interdisciplinary study

The National Science Foundation (2011) adopts the National Academies' Report (2004:2) definition of interdisciplinary research by stating that it is a manner of conducting research by teams or individuals that integrates information, data, techniques, tools, perspectives, concepts, and/or theories from two or more disciplines or bodies of specialised knowledge to advance fundamental understanding or to solve problems whose solutions are beyond the scope of a single discipline or area of research practice. There are however undoubtedly tensions in the process.

Thung (1978:18) sums up the tensions between the disciplines, by describing the differences in the way of thought of sociology and theology as follows:

> …explanation as against interpretation, analysis against synthesis, empirical against normative, sceptical against utopian. Or, in a brief definition, the sociologist attempts to *explain* [italics, author's emphasis] our experience of reality; he (sic) therefore analyses it into its component elements, formulating hypotheses concerning possible connection, which are in turn tested against the facts of reality, whereby he limits himself (sic) to one aspect (i.e. that of interpersonal relations and processes). The theologian, however, seems to be engaged in *interpreting* this same experience of reality, understanding its meaning in the context of a vision of what God wants from us in this reality and how He deals with it. In doing this, the theologian is concerned

> with the *whole* and not aspects that have been "anatomically" analysed. His (sic) interpretation carries a normative and utopian slant against which the reasoning of the sociologist can only show up as disillusioning…

However, a sociological analysis does not exclude a theological interpretation and by the same token, a theologian is given the tools to understand a social reality. In other words, each discipline can illuminate the other and it is for this reason that I believe an interdisciplinary study such as this is important.

Furthermore, Gruenwald (2005:145) outlines how twentieth century science reshaped and redefined an entire culture, so that "the scientific method" has become the standard for investigating man and nature, positing an impermeable divide between fact and value, knowledge and faith, science and religion, objectivity and subjectivity. He further outlines how the social sciences have adopted the "the cardinal rule of the scientific method by bracketing values" (2005:145), in the same way as the natural sciences have done. This has become the benchmark through which human interactions and decision-making in society have come to be assessed.

Gruenwald (2005) however takes the view that development cannot be achieved by capital transfers and scientific know-how alone. He contends that ideologies are an important aspect of development, as are interdisciplinary studies that include the social sciences, the humanities, arts, natural sciences and theology (2005:147):

> There is an emerging consensus among scientists, philosophers and theologians that ethics or the moral sense is what defines a human being. This is the Christian, Biblical, metaphysical concept of man being created in the image of God – *imago Dei* (Gen 1:26-27), which constitutes the wellspring of both human dignity and human rights.

HIV/AIDS is a complex disease and its complexities are pervasive not only at the level of the individual, but also regionally, nationally and globally. There are therefore no facile solutions. An integrated, multifaceted approach is called for that not only involves the medical, social science and political sectors, but also the religious sector. Essentially I seek to put forward the case that it is the church and religion that can provide the answer to what Farmer (2005:145) deems to be the problem of how to "act" and "how to change the world".

HIV/AIDS cannot simply be regarded as a biomedical problem with medical and pharmaceutical solutions. The disease is medically complex and no less complex

when heed is paid to the behavioural, structural and indeed social aspects of it. If the disease is to be effectively tackled, therefore, different perspectives have to be brought to bear on addressing the disease, and various lenses have to be used to arrive at solutions that have maximum impact upon curtailing its effects and consequences. I suggest that the church and religion have the power to bring about transformation. Essentially, therefore, I advocate an approach to HIV/AIDS that is more holistic and that straddles disciplinary boundaries.

Furthermore, I believe that it is important – and indeed, incumbent – upon a developing country's national institutions, such as churches, to bring their own perspectives to bear on how health problems can best be handled; the spiritual dimension of the disease cannot afford to be neglected. In a South African context it is also necessary, in my view, to ask questions about what part an institution as powerful as the church is playing in confronting the challenge of HIV/AIDS and whether it is rendering care in a manner that it is called upon to do, namely in a way that I would define as people-centred and ultimately transformative of values, society and institutions. There is evidence, as will be seen later, that churches have responded with compassionate care; I question whether that is sufficient.

The development of antiretroviral drugs (and their increasing accessibility) is having the effect of keeping people alive and giving them back an improved quality of life. However, efforts at prevention of the transmission of HIV are proving to have limited effect. It would appear that more fundamental changes need to be wrought, particularly aimed at structural issues, such as poverty, exclusion and inequality. The issue that needs to be addressed, then, is how best to bring about social and institutional change (and indeed individual change), particularly in relation to HIV/AIDS care. I argue that the church has a fundamental role to play in bringing about such transformation and, indeed, that it is one of the few institutions that is capable of bringing about such change. Furthermore, the church is not only well positioned to influence the way in which physical care is rendered, but also to tackle the often "unseen" consequences of HIV, such as fear of rejection on the part of those infected and a stigmatising attitude from those who feel that they should moralise about the issue.

In an increasingly pluralistic and globalised world, the church, I believe, has an important, if not a vital, role to play in contributing not only to specific issues in relation to HIV/AIDS, but crucially in developing a vision that is underpinned and motivated by Christian values, as well as mobilising volunteers around such a vision. I posit that the Christian value of love should galvanise the church into examining its ecclesial and pastoral practice to transform society and in this way make an impact upon the disease.

Conole *et al.* (2010) outline that the challenge to interdisciplinary work is one of communication and more specifically the importance of having a shared vision, and clear communication. Different meanings, theories and perspectives attach to different disciplines. For this reason therefore, it is important to define what is meant by "the church", as well as what is meant by the acronym, "HIV/AIDS".

1.4   An attempt at definitions

1.4.1   How can the church be defined?

It can be said the church falls under the umbrella of FBOs. According to the African Strategic Research Corporation (2002:3):

> Faith-based organisations is a general term used to refer to religious and religious-based organisations, places of religious worship or congregations, specialised religious institutions and registered and unregistered non-profit institutions that have a religious character or mission.

Wikipedia,[2] however, describes faith-based groups, particularly in an American context, as civic associations loosely connected with faith groups, especially Christianity. The development portal CiSocH[3] takes a more narrow view, defining FBOs as organisations founded by or affiliated to religious congregations (whether a church, mosque, synagogue or temple), or religiously motivated incorporators and board members that clearly state in their name, incorporation or mission statement that they are religiously motivated institutions.

---

[2] Wikipedia is a free web-based encyclopaedia. See: http://en.wikipedia.org/w/index.php?title=faith-based&printable=yes.

[3] CiSocH is a portal developed and used by those working in the development field, who have created an encyclopaedia of helpful terms. See https://webgate.ec.europa.eu/fpfis/mwikis/aidco/index.php?title=Faith_based_organisations.

In an OXFAM report Goodenough (2007:6) uses the Firelight Foundation definition of an FBO, namely groups with religious affiliations or established by communities of faith, which include "congregations, their coordinating bodies, mission hospitals and schools and faith-driven NGOs and CBOs". She goes on to say that FBOs play a significant but often under-recognised role in responding to the health, education and social welfare needs of children and families. Denis (2009) makes an important point in this regard:

> FBOs can be managed by the national headquarters of a church, by a local congregation or by a group of religious people with no formal link to a church. Unevenly spread, they are the visible face of the church's response to HIV/AIDS. In no way, however, can they claim to *represent* the church. In terms of behaviour and attitudes, members of local congregations can be completely at odds with the FBOs operating in the same territory even if they belong to the same church (2009:69).

In this dissertation references to FBOs will be used in the context outlined by Goodenough (2007).

If churches are seen as FBOs, then they can also be put into the broad category of NGOs, which as we will see later are described by Korten (1999:2) more particularly as voluntary organisations that pursue a social mission owing to their commitment to shared values.

In an interdisciplinary study such as this, it is important to define what is meant by the church as it is a complex phenomenon that takes different forms and can be used, experienced and understood in various ways. The church can primarily be distinguished from the secular world because of its transcendental, sacred nature that sets it apart from the secular world of the usual and the ordinary. In this sense, therefore, it is fundamentally different from FBOs, as generally defined above. Weber (1978) states that the concept of "church" primarily indicates a community that dispenses grace (Sacrament) under the leadership of a priestly caste and that functions as an institution that includes all members of a population.

What I seek to do in this study, however, is to look at the church as a collective expression of faith that can be studied through its structures, conventions and tasks. In theological terms (ecclesiology), the church can be described as the mystical body of Christ, "a divine-human organism, a sacramental fellowship, a fellowship of faith, a fellowship of experience and communicating, a fellowship of discipleship of Christ"

(Fahlbusch 1999:478). While the Christian church can be said to be united and universal through its faith in Jesus Christ, in reality, for historical reasons and in different socio-cultural contexts, there are many different Christian churches (known as denominations). These denominations (for example, the Lutheran Church, the Roman Catholic Church, the Reformed and Presbyterian Churches, the Dutch Reformed Church, the Anglican Church, the United and Uniting Churches, etc.) have their own histories, structures and organisations (Fahlbusch 1999:478). While they all advocate the Gospel of Jesus Christ, they have their own denominational identity and defend their understandings of the Gospel theologically and institutionally. They all promote the Christian faith, but often in competition and sometimes in conflict with each other (Fahlbusch 1999:478).

There is therefore, on the one hand, a normative (and theological) premise of the church which refers to statements of "faith and doctrine, as well as to the external appearances, to concepts and practices, to collective expressions of faith and their spirituality", and on the other, the empirical reality of the church, which involves a social corporation with its members, as well as "the fact of different churches with their divergent view of themselves and issues of social effectiveness and contextual factors" (Fahlbusch 1999:478). This study attempts to take a theological view of what the church really means and what should distinguish it and the functions that it discharges in relation to HIV/AIDS care from other secular organisations and institutions, while also studying the church in the empirical, sociological reality of its social forms (or denominational expressions) – by examining the structures, policies, actions and practices of churches in relation to HIV/AIDS care that they provide. Two levels of inquiry are therefore attempted: at a macrolevel, I seek to inquire what HIV/AIDS care might mean for the church, in a developmental sense, and at a microlevel I examine the social reality of the church (its empirically different social structures) and how it dispenses the function of care, through case studies.

In adopting this approach, I endeavour to understand something of the unique phenomenon of the church and the way in which it (ought to) render HIV/AIDS care, as well as how people of faith manifest or practice such care, through the social and institutional forms of the Christian religion, that is to say, through the various churches and denominations.

The word "church", then, can be used in many different ways and it can mean different things to different people. It can mean the building in which worship is undertaken, or it can refer to believers who worship in a particular building or in a particular area, or the whole company of believers in the world. According to Richards (1987:48), to understand the meaning of *church* it is necessary to understand the history of the church. The church originally meant a fellowship of men and women who shared a common faith and commitment of love to other believers. This original understanding of the word is what he defines as church (Richards 1987:49).

Fahlbusch (1999:478), however, defines church more broadly and says that the word embraces many aspects – the building, the services that are held there, the membership of a particular church, its representative figures or church membership as a whole. He also defines church as an agent of public action in the social, cultural and political spheres. In addition, he says that the word church can also be used to describe worldwide Christianity "in all its colourful variety" (1999:478).

Ritschl (1987:217-220) also reminds us that when we look for a definition of the church, we should ask ourselves: why have a church in the first place? In the New Testament salvation in Jesus Christ is manifested in the church of the Jews and the Gentiles. As the people of God's election, therefore, Christians must give expression to the will of God in concrete forms of co-existence.

The problem of defining what is meant by the church is further compounded by the fact that there are often internal disagreements – for example, between the so-called charismatic Christian church and the more traditional church, or between academic theology, church bureaucracy and the church hierarchy. This dissonance is also seen between personal religion and the institutionalised church, and between the ecclesiastical and social orientation of church members, "who may sense a distance between themselves and the official church establishment" (Fahlbusch 1999:479). Perhaps nowhere is this point more relevant in considering the issue of HIV/AIDS, and in particular sexual behaviour. Here we see that the specific actions and beliefs of an individual in relation to sexual behaviour may be in conflict with the church's teaching of sexual abstinence before marriage and then faithfulness to one's wife or husband thereafter. An individual's behaviour may therefore be guided by specific contexts and experiences that might be at odds with the collective, transcendent

confession of the church. In such circumstances, the church is often accused of being out of step with society.

In this dissertation references to "the church" will mean the Christian church and the word is used as a collective noun.

References to "churches" will mean denominations within the Christian church. The *World Christian Encyclopaedia* (WCE) (Barrett *et al.* 2001:824) defines denomination as "an organised Christian church or tradition or religious group or community of believers or aggregate of worship centres or congregations, usually within a specific country, whose component congregations and members are called by the same name, in different areas, regarding themselves as an autonomous Christian church, distinct from other denominations, churches and traditions".

Sometimes the word "confession" is also used to describe a denomination, meaning that it is a large family of distinct or different autonomous churches or denominations around the world, which are linked by similar ecclesiastical traditions, history, polity and name, and often by some informal or formal organisation (Barrett *et al.* 2001:85).

A denomination differs from the church in that it makes no universal claim.

In this paper, therefore, references to churches will mean different denominations or confessions, such as Anglicanism, Methodism, Roman Catholicism, and so on. This therefore points to the different empirical structures of "the church", as described above.

In considering the response of churches to HIV/AIDS, there are three further features that need to be noted (Denis 2009). First, most churches have a body or an authority that formulates policy on particularly issues. Such bodies usually prescribe the moral norms on matters such as condom use, but whether they influence behaviour is a moot point (Denis 2009:69). For example, the Anglican Church has a Synod, the Catholic Church the Southern African Bishops' Conference, etc. It is important to have regard to church policy (should it formally exist), as it sets the tone and ought to be reflected in the response and actions of churches within that particular denomination.

Secondly, it is important to have regard to the local church or congregation as these are operating on the ground and represent the visible face of the church in communities, working within them to change attitudes and behaviour. In the context of HIV/AIDS it is the local church and its congregation that normally provides care for those who are affected by or infected with the disease. A local church might also set up an FBO to respond to HIV/AIDS (Denis 2009:69). It is at this level that an empirical study has been undertaken.

A final point in relation to churches is that they may be categorised as being mainline or mission churches, Pentecostal or evangelical, and African Independent Churches (Denis 2009:69-70). Mainline or mission churches are those that were established by European or American missionary societies. They often maintain financial, organisational or doctrinal links with sister churches in the rest of the world and include, for example, the Anglican, Baptist, Congregationalist, Lutheran, Methodist, Presbyterian and Roman Catholic Churches. Pentecostal or evangelical churches are also known as charismatic or spirit-type churches and includes churches such as the Apostolic Faith Mission, the Assemblies of God and the Full Gospel Church. Such churches might also have international links and, rather like mainline churches, often have a national structure and function like a mainline church. However, according to Denis (2009:70), they impose stricter moral rules among their members and follow literal readings of the Bible.

African Independent Churches represent a fast-growing group of churches in Africa. They often do not have offices and maintain elements of traditional African religions (Denis 2009:70). Such churches operate autonomously from Western Pentecostal churches (Anderson 2001).

1.4.2   Are HIV and AIDS the same thing?

HIV and AIDS[4] are not the same thing. However, in this dissertation the term HIV/AIDS is used. The difference between HIV and AIDS is explained more fully in Chapter 2. However, for now it suffices to say that HIV is the virus that causes AIDS. The term AIDS is applied to the most advanced stage of HIV infection (WHO 2005; Centres of Disease Control 1999).

---

[4] See footnote 1.

The Joint United Nations Programme on HIV/AIDS (more usually referred to as UNAIDS) refers to the disease as HIV/AIDS, rather than HIV and AIDS, or HIV and Aids, as has become the convention in South Africa in recent years. The reason for using the latter terms, i.e. distinguishing HIV from AIDS, is largely because of the history of HIV/AIDS in South Africa and in particular the weight that was given to AIDS dissidents. This is explored more fully in Chapter 3, section 3.4.3 of the dissertation. In this dissertation the disease will be known as HIV/AIDS. References to HIV will be a reference to the virus and references to AIDS will mean the advanced stages of HIV infection.

1.5   A brief sketch of the church's involvement in relief and development work

Love for one's neighbour is a central teaching of the Christian faith. The Christian church's theological foundation is set out clearly in various biblical teachings and Christian acts of charity have a long history dating back to the beginning of the Christian church. For example, in Acts 2:44-45[5] we are told that "All believers were together and had everything in common. Selling their possessions and goods, they gave to anyone as he had need." Later we read (Acts 4:32): "All believers were one in heart and mind. No one claimed that any of his possessions was his own, but they shared everything they had." Paul tells the Corinthian church (2 Cor 8:13-14):

> Our desire is not that others might be relieved while you are hard pressed, but that there might be equality. At the present time your plenty will supply what they need, so that in turn their plenty will supply what you need. Then there will be equality.

In other words, members of the Christian church should give responsibly and generously out of what they have in order to meet the needs of others. They are not, however, required to give so that their own basic needs are not met. The point of this approach is to try and achieve justice, relieve suffering and avoid a situation in communities and society where one group of people has plenty, while others have little or nothing.

The church has a long tradition of care giving. Indeed, from the earliest days churches, congregations and church bodies developed institutions to care for the sick,

---

[5] All biblical quotations, except where otherwise stated, are taken from *Life Application Study Bible* (1997).

impoverished, orphaned, disabled and elderly. White (2002:305) outlines that diakonia, which is the "responsible service of the gospel by deeds and by words performed by Christians in response to the needs of people" forms the basis of care-giving. Furthermore White (2002:305) outlines that both priests and laity have become involved in care work owing to the injunction in Matthew's Gospel (Matt. 25:34-37):

> For I was hungry and you gave me something to eat, I was thirsty and you gave me something to drink, I was a stranger and you invited me in, I needed clothes and you clothed me, I was sick and you looked after me, I was in prison and you came to visit me.

The bubonic plague or Black Death in the mid-fourteenth century, however, greatly increased the need for care (and cost the lives of about half the care-givers). Some fifty million people are thought to have died, with North Africa, South West Asia and Europe particularly badly affected. Changes in lifestyle and the economy added to the difficulties (White 2002:306). In many senses the crisis that confronted the church then may be compared to the crisis that confronts the church now in the face of HIV/AIDS.

By the sixteenth century the diaconal system was no longer able to cope with the needs of congregations, resulting in the establishment of organisations such as the St Vincent de Paul Society in the Roman Catholic Church, which was remitted with looking after the poor (White 2002:306).

The Industrial Revolution of the eighteenth and nineteenth centuries saw increased social hardship, in response to which secular and Christian social reformers endeavoured to make people aware of the plight of their neighbours (White 2002:307). Public charities increased and secular movements produced a philanthropy not tied to any religion or denomination. The Red Cross is one such example. Although it used the symbol of the cross and was supported by the church and Christians, it was a secular organisation, whose purpose was to care for the victims of war and refugees (White 2002:307). Meanwhile, the idea of the professional social worker began to emerge (White 2002:307; Patel 2005:69).

In addition to diakonia, mission organisations aligned to the church began to grow, particularly during the colonial era. Missionaries not only saw themselves as having

18

to take the Christian message to others, but also established schools, medical care services and hospitals. Indeed, many such mission organisations may be regarded by some as the precursor to modern development agencies (Patel 2005:21; Potter & Matthey 2002:784).

The period between the First and Second World Wars saw the birth of the Ecumenical Movement. In the USA and in Europe mainline churches began to contribute to rehabilitation work, as well as to address the issues of hunger, disease, the care of refugees, etc. Churches also began advocating for peace, for example, during the Palestinian/Israeli crisis in 1948, when the state of Israel was formed (White 2002:307).

The fast pace of reconstruction in Europe following the World Wars set the tone for development aid to the so-called Third World in the 1960s (for example, through the establishment of organisations such as Christian Aid). Furthermore, as the decolonisation of Africa began, governments began setting aside funds for "development" (mainly economic and technical assistance). Church-related development agencies grew in response and became particularly involved in education and healthcare. Emergency situations as a consequence of natural disasters, such as droughts, floods, etc., gave rise to further involvement by churches and their agencies, which were able to raise considerable sums of money for emergency relief (White 2002:307-308).

However, from the 1960s to the 1980s, as governments in Western Europe tended to take on more responsibility for social security, some churches left diakonia in the hands of the social services and welfare agencies, and saw their diaconal role as one of only plugging the gaps (White 2002:308). The World Council of Churches (WCC) also began reflecting on the meaning of diakonia. In 1966 a global consultation on inter-church aid, refugee and world services convened by the WCC in Swanwick, UK, added the idea of social advancement or social action to the prevailing concept of social relief work and service. The WCC sought to broaden traditional understandings of diakonia and the ecumenical sharing of resources to go beyond a focus on material transfers from rich to poor, and to enable practical partnerships which involved people as well as funds. In 1986, following a global consultation on diakonia in Larnaca, Cyprus, the WCC noted that diakonia can exist on various levels – emergency, prevention,

rehabilitation, development and change – and that the form it takes should be shaped by local needs. It reaffirmed commitments to, inter alia, philanthropic diakonia, as well as diakonia and development for justice, human rights and dignity (White 2002:307).

By the late 1980s, for economic and practical reasons, governments began to look to voluntary agencies to take on new tasks. However, this came at a time when many churches were facing funding difficulties themselves and had fewer staff and fewer financial resources for diakonia. Government support for church-related diaconal endeavours often came with restrictions, conditions and complicated reporting requirements, requiring further professionalisation of diakonia (White 2002:308).

Churches and their agencies have also had to adapt to a new and more complex world. They have to decide whether to become a voice for the poor and oppressed, or whether this is a task best left to others. Globalisation and the use of modern communications have led to new forms of networking action. The issue of social justice, particularly in terms of relations between countries of the North and those of the South, has become pertinent. It has involved searching for answers to questions such as what is God's ultimate intention for his creation? How can human action be aligned with God's intent? What relationships will best serve as vehicles for change and peacekeeping? How can justice, peace and reconciliation be brought about? (Myers 2008:742). The issues of HIV/AIDS and the role that the church can and should play have now been introduced into this mix.

In other words, the church has to have regard to transformational development, which means transforming lives through peaceful, just relationships. Myers (2008:742) poses the question: what does this mean for churches, civil society, the private sector and government?

> As long as there is no Christian understanding of how this wide and varied range of social institutions can and should contribute to peace and justice, the Christian agency will tend to reduce its mission to that of a simple provider of charitable services to the poor – charity – to forgo the pursuit of a higher kingdom goal of transformation. Clarifying the roles of the church and Christian organisations in the mix of state and non-state actors, the private sector and civil society is an important theological task.

Myers (2008) says that we must arrive at a Christian understanding of poverty, which is crucial to understanding how we should respond to the phenomenon. Poverty is not merely the absence of material things and knowledge: it also means poverty of being

(where people think that they are less than human or God-forsaken), poverty of purpose (we are here to be fruitful stewards of God's creation) and poverty of relationships (where relationships are neither just nor fruitful). Myers therefore arrives at the following conclusion (2008:742):

> Doing development means engaging the social, cultural, economic and political systems in which poor communities are embedded. This requires two things. First there needs to be a willingness to call for truth, justice and righteousness amongst those in power – something that is seldom welcomed. Secondly there needs to be a willingness to help communities find a voice in political and policy processes. One of the goals of any good development programme is the emergence of citizens who are engaged in enabling and promoting good governance.

This resonates very strongly with the sort of development that is advocated by Korten. It is in the light of development in this sense that the churches' care in respect of HIV/AIDS will be assessed in this dissertation.

1.6   Rationale for the research

In a letter to the NRASD in 2000, the Minister for Social Development, Dr Zola Skweyiya stated (quoted in Louw & Koegelenberg 2003:108):

> The government values the contribution and role the religious sector has played in the past – the role that churches and the broad religious sector played in bringing education and medical services and support to neglected areas, as well as in the struggle against apartheid. Now we face a new struggle: we can only succeed to eradicate poverty in our country if we build effective partnerships between the state, the religious sector and other institutions of civil society. Apart from the large networks available to churches (and other religious networks), and the resources they have at their disposal, we also know that they play a crucial role in the formation of values and the moral fibre of our society. As the Department of Social Development, we have launched a national campaign to create "a caring society" in South Africa. How can we succeed with this effort without the support of our religious communities, which are known for their networks, reaching even into rural parts of South Africa?

Similarly, in an address to senior church and other religious leaders in Cape Town, in a consultative meeting to discuss State-Religious Sector cooperation, Minister Zola Skweyiya said:

> From a social development perspective the critical challenges to be addressed by the contract to the people are the issues of poverty, social exclusion, HIV and AIDS and other re-emerging diseases. Important in addressing these challenges is the religious sector as it commands a special place in the hearts and minds of our people, since it was through your unwavering comradeship that we obtained our cherished freedom (Ministry of Social Development 2004).

Erasmus and Hendriks (2003) point out that the Christian church is the strongest and most influential non-governmental organisation in South Africa (see below for the demographics). Furthermore, it has been argued that church communities have experience, expertise, networks, discipline, training, motivation and a focus on life that make them natural contributors on issues of health (De Gruchy 2006). De Gruchy further argues that religious communities are ideal contributors of care, compassion and love, but he warns that this should not merely suggest the provision of relief, welfare and charity: it should include much more, such as political pressure for universal treatment, a critique of patriarchy and agitation for the legal protection of people living with HIV/AIDS (PLWHA).

This call is echoed by many others, including Greyling (2003), who argues that churches should be in the frontline of the fight against AIDS, as the largest social institution in South Africa. He makes the point that the church has an ethic of sexual responsibility and caring for others and, furthermore, that it has a natural platform to demonstrate unconditional love, forgiveness and acceptance. Because churches are present in every small town and city, together with the fact that they have the infrastructure, well developed social programmes and motivated congregations, with gifts and talents, these should be used to bring hope both to people who are dying and also to those are infected and affected and facing the harsh realities of HIV/AIDS.

Indeed, it has been argued by bodies such as the NRASD, EFSA and the National Religious Leaders' Forum (NRLF) that because of the extent of religious social welfare networks throughout the country, churches and the faith-based sector are able to reach out extensively to those in need by utilising their social programmes (Koegelenberg 2001; Louw & Koegelenberg 2003). Furthermore, Koegelenberg (2001:103) points out that EFSA estimated that the religious sector contributed in the region of R1 billion towards welfare relief and development programmes in 1996/97.

In addition, Koegelenberg (2001:97-104) argues that the government ought to consider the religious sector as a special partner in the arenas of social welfare and development, because of the sector's networks, as well as the range of services offered by these networks, together with their ability to raise funds and their ethos of volunteerism. He also makes a case for the fact that as the sector is not burdened with infrastructure costs or intermediaries, the cost of utilising these networks is more

affordable, particularly in areas where infrastructure is weak. Importantly, he points to the uniqueness of religious communities and their networks in their ability to play a vital role in the formation of social values and morals.

In fact, a religious-state partnership is advocated (Louw & Koegelenberg 2003) as a key element to building a caring, democratic and equitable society. The use of inter-sectoral partnerships between government, business and civil society, including the religious sector, is advocated to promote social development.

Although Koegelenberg recognises the risk of partnering with the state (particularly the fact that churches might be co-opted and used by politicians who have their own agenda), he is in favour of the principle of subsidiarity – public/private partnerships – so as to better utilise funds and add value to services. Koegelenberg argues that because church involvement in social work is motivated by fundamental beliefs and because it contributes to the formation of values such as honesty, compassion, solidarity with the weak and poor, responsibility, tolerance for life, etc., the church is ideally suited to partner with the state in order to engage in development issues (Koegelenberg 2007).

Koegelenberg points out that the church is important in the building of "social capital". Social capital has been described by the World Bank (Collier 1998) as the "glue" that binds society together; it describes the social networks and relations between members of society, who build trust with one another, care and take responsibility for each other within the broader society. Putnam (1996:56) refers to social capital as the norms, networks and trust that enable people to act together to pursue shared objectives. While such networks can be positive or negative (for example, in the formation of gangs), it can also be used to build social trust and bridges. Koegelenberg points out that in South Africa the church is one of the more important institutions to build relationships of trust in society. For this reason parishes and congregations have support programmes in local communities, "reaching out to those in need, mobilising church membership to render services for the benefit of the broader community, forming partnerships between businesses and churches" (2007:35).

Hendriks *et al*. (2004:382) also articulate the role that churches can play in social development, arguing that:

> In South Africa the church is the strongest and most influential non-governmental organisation (NGO), reaching on average 63 per cent of the Christian population weekly (World Values Survey 2000). … In South Africa there are approximately 33 000 Christian faith communities and the infrastructure of the church reaches all corners of the country. Congregations are value-based organisations with an effective infrastructure that is in touch with the realities on the ground and that is able to reach out to every household in the community.

Indeed, according to the 2001 Census (Statistics South Africa 2001), 79.8% of South Africa's population affiliated themselves with the Christian faith and 83.6% with religion in general. Hendriks and Erasmus (2005) also point out that a Markinor World Values Survey undertaken in 2000 more or less confirms these figures, with 77% of the survey affiliating themselves with Christianity and 82.4% with religion. Research by Inglehart and Norris (2004) also shows that some 56% of the population of South Africa regularly attend religious services (and again that some 80% of the population identify themselves as Christian). These figures should be treated with a little caution, however, as religious identity might not translate into participation in a religious organisation (Albrecht *et al*. 1988).

As will be seen, churches and FBOs can shape a community's response to the epidemic. Many churches are at the centre of a community's life in South Africa and have extensive networks, sometimes extending internationally and even touching remote rural areas in the country. Churches are trusted and are able to use contacts with congregants and communities to exercise influence. Haddad, Olivier and De Gruchy (2008) therefore call upon governments to utilise and leverage the advantages offered by religious entities. At the same time, however, they urge churches and religious entities to increase their awareness of the factors that contribute to the spread of HIV/AIDS, including the social determinants of the disease such as poverty. They also call for a contextual theological response that seeks to avoid stigmatisation and the undermining of prevention efforts.

Erasmus (2005:139) concurs that the church is the strongest and most influential NGO. Accordingly, "(n)either the government nor any other NGO can reach and influence the public more regularly and consistently than FBOs". However, while acknowledging the potential of churches, Erasmus proceeds to sound a note of caution

24

by pointing out that religion also has the capacity to inhibit change and maintain the status quo (2005:139).

Swart (2005) approaches the issue from a different and interesting perspective, essentially arguing that the debate has lost sight of the authentic role of religion. He argues that for pragmatic reasons there is a preoccupation with the execution of development projects through networking between religious agencies and their projects or services, as well as a concern for partnership and funding with the state (Swart 2005:21). In adopting such an approach Swart essentially argues that the Christian church in South Africa has lost its way in defining its strategic role in development, which in previous debates had been defined as the development of human capacities through a people-centred development paradigm. He forcibly argues that the religious sector in South Africa must vigorously promote the social development paradigm not only by appealing to the public consciousness of society, but by also examining the way in which it renders welfare (Swart 2005:35).

Swart's plea for a re-examination of the authentic role of religion may be supported by comments made in a recent report by the Organisation for Economic Cooperation and Development (OECD) (2007). The report makes a strong case for a complete rethink of the prevailing paradigms of conventional development that encourage economic growth through the exploitation and use of natural resources, manpower, capital skills and technology. The report in fact makes a plea for sustainable development but, interestingly, it does so in the following terms (OECD 2007:28):

> [Development] must give civil society and the people a larger role in the decision-making process … These paradigm shifts require changes in values and orientations … It requires the use of moral persuasion by implementing the teaching of religions, spiritual beliefs, customs and cultures. "One does not live by bread alone" provides the basis for further elaboration towards a more sustainable immaterial life.

In other words, social development does not merely mean partnership with government. It means that the church needs to examine how it will achieve transformation by perhaps challenging government, its policies and those in power (which would be much more difficult to do in a partnership). It requires an acknowledgement that purposeful intervention by state and non-state actors and "the creation of organisational and institutional arrangements at national level that harmonise economic and social policies within a comprehensive commitment to

people-centred development" (Midgley & Tang 2001:246). Korten goes further and argues that civil society has to be strengthened so that people can mobilise and improve their own lives, while holding government to account. Korten adds that "[t]he people by right and by necessity must be the architects and engines of development", leaving government to assume an enabling role (1990:157). He sees civil society as the primary agent of development. In particular, he regards the role of religion and the church in society as one of building an alternative human consciousness. Such consciousness should be aimed at making people aware that they hold a position of stewardship, which should be utilised in service of the community, for the fulfilment of all people, especially the powerless (1990:168).

The crucial point is this: the Christian church and by and large, most religions, such as Judaism, Islam and Hinduism, etc. prescribe philanthropy and charitable giving, which may be in money or in kind. This has the effect of meeting needs. From this religious base many voluntary philanthropic organisations have been established that have become more secular in their approach. The nature of such programmes, however, has been to provide humanitarian aid and immediate social relief (for example, to victims of war, in situations of natural disasters and to provide welfare services to the poor). In Korten's view (1990:118) this does nothing to alleviate the symptoms of underdevelopment. Development thus requires more than partnerships with government and charitable giving. According to Korten, it requires engagement with institutional and policy issues, but even more crucially, a decentralised people-centred vision that mobilises voluntary action towards social transformation.

Swart (2005) calls for the religious sector to raise a moral, critical challenge to the current social trends in South Africa, including the increasing disparity between rich and poor in the country, the culture of self-enrichment and the exclusion of the mass of the poor from development (Swart 2005:33). Such exclusion and deprivation, he argues, is a question of equity and justice, which should be part of the agenda of the religious sector. But that is not all. Swart argues that if the religious sector is to become an exponent of the social development paradigm, then it has to critically examine the way in which it undertakes its welfare tasks, so that people are enabled and empowered.

Given that the church is described as powerful and influential, this would be a good juncture to look at the demographics.

1.7   The churches and demographics in South Africa

In an interesting analysis, based on the Population Census 2001 (Statistics South Africa 2001), Erasmus (2007) points out that black Africans constitute the majority of South Africans, constituting 79% of the population, and that they are the majority population group in seven of the nine South African provinces. Coloureds comprise the largest population group in the Western Cape (53.9%) and Northern Cape (51.6%).

In terms of age distribution, 31.2% of South Africans are under the age of 15 years, which besides having implications for the education system, has implications for HIV/AIDS (in South Africa, the highest prevalence is among young people, aged 15 to 24 years, especially women). An analysis of the main religious groups showed that 61.9% of the population belonged to mainline churches; 7.4% to Pentecostal/charismatic; 10.2% to "(o)ther [Christian] churches" and 7.4% to African Independent Churches. Other faiths accounted for 2.4% of the population and 10.7% of respondents stated that they had "no religion" (Erasmus 2007).

In terms of affiliation to churches, 7.4% belonged to the Methodist Church, 7.2% belonged to the Reformed Churches (Dutch Reformed Church, the Reformed Churches, Afrikaanse Protestante Kerk, Nederduits Hervormde); 7.1% to the Catholic Church; 3% to the Anglican Church (Anglican and Church of England in South Africa); 2.5%, to the Lutheran; 1.9% to the Presbyterian; and 1.1% to the Congregational Church. Pentecostal and charismatic churches (such as the Apostolic Faith Mission, Pinkster Protestante Kerk, New Apostolic, Assemblies of God) comprise 5.9% of the population. African Independent Churches (including the Zionist Christian Churches, Bandla Lama Nazaretha [Shembe Church], ethnic churches, Ethiopian Type Churches) had an affiliation of 32.6%. Other churches, which included the Salvation Army (with an affiliation of 0.1%) and Seventh Day Adventists (0.3%), as well as other Christian churches, had an affiliation of 9.5% of the population. Affiliation to the Jewish faith comprised 0.2% of the population, while 1.2% of the population subscribed to the Hindu faith and 1.5% to the Muslim faith (Erasmus 2007).

More recent research (Pew Research Centre Publications 2009; Religious Intelligence 2009) bears out the fact that by far the majority of South Africa's population identify themselves with the Christian faith. They, however, breakdown religious affiliation as follows: Protestant, 41%; African Independent Church, 27%; Catholic, 11%; Islam, between 1.6% and 3%.

A further interesting trend to draw from the figures (Erasmus 2007) is that the membership of the African Independent Churches (which are also known as African Indigenous Churches or African Initiated Churches) is 92% black African (only 69% of the mainline church membership is black). Furthermore, there is a decline in the membership of mainline denominational churches (Reformed, Methodist, Congregational, Presbyterian, Baptist, Lutheran and Roman Catholic), whereas the membership of African Independent Churches and Pentecostal/charismatic churches is growing. Research by Squire (2007) bears this out.

Hendriks and Erasmus (2005) also outline what they call an "intriguing double movement" in the religious trends in South Africa, namely a trend towards Christianity in South Africa (especially towards African Indigenous Churches and Pentecostal/charismatic/evangelical churches), as well as a move away from established mainline religion. Of those stating that they had no religious affiliation (according to the 2001 Census), 70.9% were younger than 35 years and a large proportion were from the province of KwaZulu-Natal.

The educational profile of those with no religion bears repeating, as it reveals interesting data that ought to guide, inter alia, HIV/AIDS-prevention education: 28.7% of black Africans had no education, whereas 35.1% of whites and 27.1% of Indians who had no religion had post-matric qualifications.

So what do these trends imply in terms of HIV/AIDS? Erasmus (2007:92) makes the point that because of the decline in the membership of mainline churches, this might have "serious implications for the services (inter alia welfare) that these churches render to communities". Resources will most probably decrease with declining membership. Similarly the pool base for volunteers will decrease. While there is a growth in the charismatic and Pentecostal churches, the point is made that many of these churches are decentralised and independent, and therefore may not be able to

provide the services that were hitherto provided by mainline churches. It is not known, however, whether or to what extent the volunteer pool will shrink; this is a factor yet to be tested by time. However, any decline in the number of volunteers will have serious consequences for change. As Korten (1990:215) explains, "a more dynamic vision of development as a people's movement gains energy from the voluntary commitment of its participants".

1.8   Methodology

1.8.1   *A qualitative approach conducted through case studies*

Methodology is said to be a system of explicit rules and procedures upon which research is based. It is also the way in which claims for knowledge are evaluated (Frankfort-Nachmias & Nachmias 1996:15). A methodology serves several purposes. First, it gives scientists and researchers an opportunity to replicate the same experiment, allowing them to learn from any mistakes that might have been made. Secondly, it allows inferences to be drawn from actual observations and, in so doing, promoting logical interpretations. Finally, methodology allows for inter-subjectivity, which can then be shared by the scientific community. However, it is only through a clear research design that a methodological process can be defined.

The issue of HIV/AIDS care by the churches was primarily conducted through an empirical qualitative study in the Helderberg Basin, a peri-urban area situated some 50 kilometres from Cape Town. Neuman (2000) postulates that apart from proceeding from different assumptions about social life and objectives, one of the main differences between qualitative and quantitative research is the nature of the data. Qualitative research deals with "soft data" including words, sentences, photographs, symbols, etc. Ethnographic research, such as participant observation studies and case studies are examples of studies that are usually qualitative in nature, as indeed are participatory action research (PAR) studies (where the subjects of the research are integral to the design). On the other hand, quantitative research deals with "hard data", such as numbers obtained from surveys, laboratory experiments, statistical modelling, etc.

In this study, a qualitative approach was considered to be the most appropriate method:

a. It provides an understanding of the way in which the churches' hierarchies view HIV/AIDS and how this is translated into action by the local churches;

b. It provides a context in which to assess the activities of local churches in relation to HIV/AIDS;

c. It provides an explanation as to why (or why not) a church has adopted a particular course of action.

Yin (1994:3) rejects the notion that research designs can be organised hierarchically, in other words that one type of research design is inherently inferior or superior to another. A research design should be selected depending on the issues or questions that are to be addressed, as well as the extent of existing knowledge and previous research, the resources and time available, and the availability of suitably experienced staff to implement the design (Hakim 2000:12). A qualitative approach was adopted because it provided an opportunity to assess whether local denominational churches had embraced and implemented the policies developed by their church's hierarchy at a local level, while also allowing an opportunity to elicit accounts of attitudes, motivations and behaviours of various church denominations in the Helderberg area. Although it is accepted that not all explanations can be reduced to accounts at the level of each local church, they do provide a definition of the situation in context, which is important in any social process. Although this might not provide a complete explanation, this approach provides an indication of how such attitudes and behaviour are justified.

In order to implement a qualitative approach, a methodology using case studies was employed, which enabled a better understanding of the different categories of action that were being undertaken by churches in relation to HIV/AIDS. This in turn facilitated an assessment to be made in relation to Korten's four generations of development.

Hakim (2000:59) states that case studies are "the most multi-purpose of all designs" and can be used to describe a phenomenon clearly, offering "the strengths of experimental research within natural settings". Furthermore, through the use of multiple sources of evidence, the case study can be one of the most powerful research designs. The case studies aimed at looking at the main denominations of the Christian church in the Helderberg area to ascertain in what care activities they were engaged.

Case studies also provide for flexibility and diversity. In this way multiple case study designs can be said to be capable of replication or, indeed, compared and contrasted to other case studies.

Hakim (2000) outlines that there are five types of case studies – individual case histories, community studies, case studies of social groups, case studies of organisations and institutions, and case studies of events, roles and relationships. The study undertaken in this dissertation is one of organisations and institutions.

1.8.2   Interviews

The case studies in this dissertation were conducted following a review of the literature and press articles, after which a list of subjects was prepared (rather than a questionnaire). In-depth interviews were conducted and the questions posed were semi-structured in that topics of interest were highlighted rather than specific questions asked (see Addendum A). This allowed for a freer and more unrestricted discussion, giving respondents an opportunity to provide any further information they felt necessary and also allowing for tangential matters to be introduced that were felt by the interviewee to be of importance to the subject. A further advantage is that it allowed for the question of why a certain action was or was not taken, and therefore allowed for circumstantial and contextual factors to be taken into account.

Interviews were conducted at churches and/or other places convenient for the interviewees. Extensive notes were taken during the interview process, after which they were transcribed (for an example of a transcript, see Addendum B).

The texts were then analysed.

In addition, data were collected by asking for HIV/AIDS policy documents of the churches (which I took to be indicative of the churches' leadership/stance on various issues), as well as printed material concerning HIV/AIDS, where available, from the local churches.

Visiting the sites, if possible, where HIV/AIDS work was being undertaken (for example, orphanages) provided a further source of data collection and another way to test the hypothesis. Through the use of various data sources, triangulation was possible, providing a better account of the social issues and processes at work.

1.8.3 Data analysis

Data analysis of qualitative (and quantitative) material allows for the following (Neuman 2000:418-419):

a.   Inferences may be drawn by the researcher, which allows for consideration of the information from which conclusions can be reached by reasoning and simplifying the volume and density of the data;

b.   The methods of data gathering used by the researcher means that the data is available for use by a large number of people;

c.   Data analysis allows for comparisons to be made;

d.   Data analysis minimises the risks of errors and false conclusions.

In contrast with quantitative data analysis, qualitative analysis is often inductive (Neuman 2000:418). This allows a researcher to discover specific data as the process of gathering information evolves. By contrast, quantitative data analysis can only be undertaken when the data have been collected. Qualitative data analysis can therefore be guided or redirected in other directions quite early on in the data-gathering process. Neuman (2000:418) states that quantitative analysis "manipulates numbers that represent empirical fact in order to test an abstract with variable constructs". Qualitative analysis can, however, lead to the construction of new concepts through the interpretation or generalisation of a theory. Finally, qualitative analysis is less abstract than statistical analysis and closer to raw data.

In order to analyse the data, Cresswell (1994:155) outlines eight steps, which were used in the case study that was conducted:

1.   Read through all the transcripts carefully with the purpose of getting a general sense of the whole and the underlying meaning of the transcripts;

2.   Pick the single shortest or most interesting transcript and go through it once again;

3.   Make a list of topics or clusters to get similar topics;

4.   Go back to the original and abbreviate the topics as quotes and write quotes next to appropriate segments of text;

5.   Develop the most descriptive wording for the topics and convert them into categories by grouping related topics;

6.   Make a final decision on abbreviation for each category and alphabetising existing data;

7.   Assemble the data material belonging to each category in one place and perform a preliminary analysis;

8.   Recode the existing data.

1.8.4   *Limitations of the study and difficulties encountered*

Although all efforts have been made to make this study defensible, like many other research studies, it suffers from weaknesses, not least the possible bias of the researcher. I am a Christian and, as such, it must be acknowledged that personal beliefs colour the research, however unconsciously. Indeed, Hakim (2000:63) states that the principal weakness of case studies is that "results can be shaped strongly by the interests and perspectives of the researcher".

Secondly, the study cannot be said to be representative of all the churches in the Helderberg area. There are so many churches in the area and even in specific geographical places within the area that it was impossible to cover all of them. The main weakness of qualitative research is that small numbers of respondents cannot said to be representative (Hakim 2000:36), even if great care is taken to choose a fair cross-section of the churches in the area. However, by conducting multiple case studies generalisation is possible, particularly where the subject matter is complex (Hakim 2000:62).

Nonetheless, as the field work has been limited to the Helderberg area, the study cannot be said to be generalisable to the rest of the Western Cape.

Finally, although time was spent on the interviews, many of these were conducted with local churches for the first time and some may have been wary of saying too

much. There may have been lack of candour too because insufficient time was set aside to build trust.

Ethical issues arose in the sense that a few respondents wished to express opinions on particular subjects on the basis of anonymity, as they were expressing their personal views or actions that might have been undertaken without the approval of – and sometimes in contradiction to – their church leadership. In such instances their anonymity has been protected. In fact, the names of all interviewees have been kept anonymous, not only to protect the source, but also because the objective of the case studies was to primarily examine what sort of HIV/AIDS care is being provided by local churches in the area and what differences, if any, there were between mainline, Pentecostal (or charismatic) and African Independent Churches. Of course, the point made by Hakim (2000:73) is important: one has to accept that "views offered by organisational and other role holders may not be coterminous with their private opinion".

However, even taking into account all of the above factors, I believe that the effects of the factors outlined above did not have had a significant impact upon the research that has been undertaken.

1.9   Dissertation outline

The role of the church as a social institution for caring for people infected, living with and affected by HIV/AIDS must be seen in the light of the global pandemic, which has its epicentre in Southern Africa. Bearing in mind the aim of the dissertation, namely *to examine whether the church can exercise HIV/AIDS care in a manner that Korten would describe as transformational,* I seek to make the case that if the church is to be more than just a provider of charitable relief, there has to be a thorough understanding of the pandemic globally, nationally and within the Western Cape Province. In addition it is important to know about the disease and how it can be prevented and treated as well as its main determinants; factors such as poverty, patriarchy and culture play a crucial role in the spread of the disease and these aspects are examined. A general overview of the churches' work in relation to HIV/AIDS, as well as a consideration of the churches' involvement in issues such as prevention, stigma and discrimination, gender inequality, etc is undertaken (Chapter 2), with a view to assessing the nature of the care that the church has rendered.

The dissertation proceeds to analyse and unpack the concept of care (Chapter 3) from theological and sociological perspectives. Without an understanding of care in these terms, I suggest that transformation in the sense articulated by Korten, would be impossible. An examination is undertaken of the church's motivation to care, which I believe arises from the core Christian imperative to demonstrate love of God and love of neighbour. The complexity of the care that is required is juxtaposed with various issues such as, for example, the rapid advances in treatment, the changing nature of health delivery, as well as societal changes and the need to take cultural factors into account. The issue of voluntary counselling and testing is examined as a possible area in which the church might demonstrate care. Utilising the concept of care that I suggest is required for transformation to occur, I then examine church action (or inaction) in relation to the history of the disease, as well as in relation to business and in the political spheres and question whether the church can be said to have discharged its duty of care. The analysis here is therefore inductive.

Chapter 4 outlines a developmental framework through which the initiatives of churches might be assessed. The theoretical framework that is employed is that proposed by David Korten (1990), namely the so-called four generations of development. By way of preliminary consideration, however, two issues are examined, namely whether the church, through its religious teachings, can contribute to social movements, and secondly, whether social movements can contribute to health-related matters. Particular consideration is given to the Treatment Action Campaign (TAC) as an example of a social health movement. Korten's (1990) generational framework as a tool for assessing care is then examined in greater detail, with a view gauging its resonance with the Christian message to care for one's fellow human beings. Finally, Korten's fourth generation of strategic orientation, namely the mobilisation of a social movement, is examined as a viable mode of engagement for the church.

In order to understand to what extent, degree and on what level churches are involved in providing care, an empirical investigation in the form of case studies in the Helderberg Basin, is undertaken. The empirical findings are then discussed and an assessment of the programmes and activities of the churches is made within the area studied, against the framework designed by Korten.

In the concluding chapter, Chapter 6, the research is briefly summarised. In addition, recommendations are made on the key areas in which I believe the church might be encouraged to act in a more people-centred developmental way. The research concludes with two suggestions as to how the church might become more effective in transforming the current epidemiological trends in HIV/AIDS, as well as the way in which care is undertaken.

Chapter 2

HIV/AIDS: challenges for the churches

2.1   Introduction

It will be recalled from Chapter 1 that the aim of this dissertation *is to examine whether the church can exercise HIV/AIDS care in a manner that Korten would describe as transformational, that is to say can the church contribute or indeed, initiate a people's movement for social change.* It is my contention if serious consideration is to be given to the issue, then there must be an understanding of the complexities of the context in which the disease is spread, as well as of the disease itself. Consideration must also be given to those factors that are fuelling the disease. It is suggested that only in this manner can the churches render care that will ultimately be transformational.

HIV/AIDS was identified some 30 years ago (see Chapter 3, section 3.4.1). The battle for treatment in South Africa has been hard and long. It now seems as though people are exhausted by the subject of HIV/AIDS, not least the Christian churches. With the availability of antiretroviral treatment (ARVs), it seems that everything that can be done has been done, and life can continue as normal, with the government proceeding with the roll-out of treatment and NGOs, including voluntary organisations such as churches, concentrating on other issues, not least the saving of souls.

However, a deeper examination of HIV/AIDS in a South African context in the second decade of the twenty-first century reveals a different picture. To look closely at the continuing rates of infection, the difficulties of treatment, the reasons for the spread of the disease, the catastrophes that it causes in its wake, requires a more fundamental rethink about how the disease is to be tackled. Witnessing the considerable changes that have been wrought (albeit in the political sphere) in North Africa and the Middle East ought to give us pause for thought as to what is possible and achievable through voluntary movements. The key question that needs to be posed is whether finding a cure for HIV is all that is required. By the same token, surely it cannot suffice to say that if enough funding is made available and people can

be kept alive, that will do. It seems to me that radical thought is required on this developmental issue and the unique role that the churches are able to play. This is, in my view, a proper matter for Christian churches to probe and discuss. There are, in addition, issues surrounding HIV/AIDS that need to be exposed to public discussion and argument, if an impact is to be made on halting the spread of the disease.

In recent public discussions[6] the question was posed, "Who will lead us?" That is to say, who has the vision to lead the country and its peoples? It was suggested that leadership could come from four centres of power: (1) Luthuli House (the official headquarters of the ruling governing party of the country, namely the African National Congress [ANC]); (2) the Union Buildings (in other words, the official seat of government); (3) the business sector; and finally (4) "the people". In what has been described as "[a]n age with a leaderless moral voice" (Dlanga 2011), it has been suggested that it should be the people, particularly young people, who should lead by using their social power, including social media such as Facebook and Twitter, to provide a vision. The report lamented that because there was no moral leadership, South Africa had not managed to achieve the great strides that had been hoped for, following the demise of apartheid. Veteran journalist Alistair Sparks added to the debate by also lamenting the poor leadership that the country experiences. He comments: "We need strong leadership to provide a vision of how to drive our new democracy from the phase of transformation [from apartheid to liberation] to the phase of development and maturity, of how to uplift all sectors of our society… We have lacked such leadership. Our vision has been blurred …" (Sparks 2011).

It is curious that in such discussions the Christian church is not mentioned and the moral codes provided by its teachings (and indeed by all religious faith beliefs) are not even considered. Surely it is in such a vacuum that the churches should be providing leadership, a vision and a moral code. Surely the Christian church has a vital role to play in contributing to values such as love and responsibility for oneself and for one another, tolerance, respect for life, honesty, compassion, etc.[7] The church

---

[6] Radio YFM Generation Y talk hosted by Nkosinathi Biko, June 2011. See also Dlanga K. 2011.

[7] In much of this dissertation, use is made of rhetorical questions. Aluwalia and Burnkrant (2004) describe the technique as follows: "Questions where the answer is implicit within the questions are termed rhetorical … The dominant explanation for the persuasive effects of rhetorical questions is

also has a vital role to play in building social capital, that is to say mutual social trust, and building bridges between people and communities. Furthermore, it has a yet unexplored role to play in building a movement that is ultimately aimed at defeating HIV/AIDS, as well as changing mindsets and attitudes, so that the issues of rights, responsibilities, justice and inclusion are brought to bear on the discussions, and care is extended to all who need it. This, in my view, is the ultimate challenge that the Christian church faces in relation to HIV/AIDS.

2.2   Background

2.2.1   *The need for contextualisation*

In its report *The First Steps to Healing the South African Family* (Holborn & Eddy 2011) the South African Institute of Race Relations (SAIRR) refers to a generation in crisis. The research points to a lack of stability in family life that is the cause of so many social ills presently affecting the country and its future. The report suggests that, as a consequence of the breakdown of families and the lack of parental role models, children are more likely to have poorer educational outcomes; it is also likely that they will be unemployed, practise risky sexual behaviour, indulge in criminal activity, and resort to drug and alcohol abuse. A typical family in South Africa is one where a child is raised by his or her mother in a single-parent household, where the norm is that the other adults of the family will be unemployed (only 34% of children aged 0-17 years live in households with an adult who is employed).

The statistics make for startling reading: they show that only a third of children aged 0-17 years live with both biological parents (Holborn & Eddy 2011). Some 9 million children (or 48% of the 18 771 000 children aged under 18 years) have fathers who are "absent" (an increase of 4% since 1996). This is a situation that affects all race groups in the country (in 2009 52% of African children had absent fathers, and the same was true of 41% of coloured families, 15% of whites and 12% of Indians). Nearly a million children have lost both parents, mainly through HIV/AIDS. Eight per cent of children live with their grandparents or great uncles or aunts. There are 98 000 child-headed households. In 2007 49 636 school girls fell pregnant. More than a third

---

the message elaboration view which suggests that questions focus the recipient's attention on the message arguments and thereby enhance persuasion when argument quality is strong" (2004:26).

of the country's prison population is made up of young people below the age of 25 years.

The absence of fathers is termed a "crisis of men", which serves to perpetuate patterns of abuse and desertion that are likely to permeate the behavioural patterns of the next generation. Furthermore, violence within families is said to influence youths in accepting violent behaviour as a norm and contributing to youth crime. Indeed, 51% of young people witnessed violence either in their families or communities.

The Holborn and Eddy report (2011) documents that in 2010 51% of young people aged 15-24 years old were unemployed and 3.3 million young people were neither in education nor employment nor receiving training. Without anything to occupy them, it is hardly surprising that youths resort to sexual activity, drug and alcohol abuse, and crime. Thirty-nine per cent of youths aged 12 to 22 years have had sex. Thirty-two per cent of sexually active people in this age group had four or more partners and 62% of them had failed to use a condom consistently. In 2008 HIV prevalence among 15-24 year olds was 8.7%. Thirty-one per cent of youths aged 12-22 years old had consumed alcohol and among 12 to 14 year olds 62% said that they had easy access to alcohol.

One of the report's researchers, Katherine Hall, sounds a note of caution saying that we ought not to assume that poor families are not acting in the best interests of their children. The fact is that poor families had to make "trade offs" as a survival strategy such as, for example, leaving children in the care of relatives so that they could find employment elsewhere.

The National Planning Commission Diagnostic Report (2011) outlines that South Africa's human development remains relatively low for a middle-income country. The report sets out nine challenges that need to be addressed to eliminate poverty and reduce income inequality: (1) reducing unemployment; (2) improving the "substandard" quality of children's education, particularly that of black children; (3) improving infrastructure limiting social inclusion and economic growth; (4) meeting spatial challenges that marginalise the poor; (5) reducing South Africa's dependence on unsustainable resource-intensive goods; (6) reducing South Africa's "massive disease burden" impacting upon an already ailing public health system; (7) achieving better performance in the public services; (8) dealing more effectively with corruption

that undermines state legitimacy and service delivery; and (9) dealing with the continuing divisions within South African society. The challenges are immense indeed.

It is in this scenario that the churches seek to operate in South Africa and it is in this context that I seek to examine the care that the churches render in relation to HIV/AIDS. The complexities of the social situation in which the churches operate cannot be ignored. By the same token, the point that I wish to make is that HIV/AIDS has to be seen in context: in the context of poverty, unemployment, fractured families, violence, lack of fathers or indeed parents as role models. Furthermore, the history of apartheid and the migrant labour system have also had an impact and the effect of these policies continues to be seen today.

It must not be forgotten that HIV/AIDS too has had a profound effect on family life. In South Africa in 2008 there were 859 000 orphans, both of whose parents had died, in addition to 2 468 000 paternal orphans and 624 000 maternal orphans (UNAIDS 2008a:22). In such a situation it is not difficult to imagine orphaned children missing out on education, suffering from a lack of food security, being exposed to HIV infection and suffering from anxiety.

2.2.2   *Questions that require critical introspection*

Korten cautions: "Rather than acting on underlying causes, we prefer to deny their existence – at least where this might force us to question fundamental assumptions and challenge existing interest" (1990:23). In this chapter, as well as in Chapter 3, an attempt is made at uncovering the underlying issues that lie at the heart of the spread of HIV/AIDS.

In so doing, it is pertinent and relevant to ask whether the churches have critically examined their effectiveness in the manner in which they have rendered help; while the churches have undertaken many charitable works on behalf of those who are affected or infected with the disease, have they critically examined whether a charitable response is the right one in such circumstances? Have the churches advocated for and spoken on behalf of those who are voiceless and suffering? Have the churches taken the time to examine the issues that are driving the pandemic and how best to address them? Have the churches spoken up and pressurised the

41

government and other bodies for an appropriate response? Have the churches inspired and mobilised volunteers to rally to the human need arising out of the HIV/AIDS epidemic?

A kindly, paternalistic, charitable response is all very well but there is another way that is also theologically based, namely rendering help in a manner that builds a sustainable, just and more inclusive society. In so doing, those who are helped are able to help others, as well as enabled to shoulder greater responsibility.

According to my interpretation of Korten's Dissertation, churches should be asking how they can equip a person or a group to become included and engaged. They ought to ask questions such as the extent to which a certain policy builds the capacity or resources of the person who is being helped. The churches should also ask how a particular policy impacts upon the wellbeing of others in society. In this way limited resources might be better utilised to meet the needs and aspirations of others and oneself. This would strongly resonate with the African concept of *ubuntu*.[8]

As seen above, the churches have to address the fundamental issue of the disintegration in South Africa of the family as a social institution. The implications of the breakdown of the family are enormous, raising as it does the issues of where children will learn moral values, how they will learn to honour and respect parents, elders, teachers and others in authority, from what source they will learn to care and take responsibility for others? Parents have traditionally had the first responsibility for educating a child, for creating a home and teaching values. In circumstances where there are no parents, how are children to learn about these matters? Where does government responsibility end and what role do the churches have to play?

Patel outlines that the social development approach "requires purposeful intervention from state and non-state actors" (Patel 2005:29). In my view this should include the churches. Broader questions also need to be considered, for example, the extent to which the churches are bringing the government to account in guaranteeing certain "absolutes" in terms of treatment and care. Furthermore, what is being done about

---

[8] The word "*ubuntu*" has no direct translation, but is generally taken to mean communal awareness, responsibility for one another, compassion, cooperation and the sharing of abundant life.

what many see as the root causes of HIV/AIDS, such as poverty, illiteracy, poor education, a crumbling public health system and so on – and what role is the church playing in this? Have the churches asked the question as to what are the most important matters that cannot be left to development-orientated voluntary organisations and that must be undertaken by the government? Have the churches ventured to ask the question of where it is in agreement and can cooperate with the government and where there are areas of disagreement? While grassroots and local church initiatives abound, the churches need to examine whether this is sufficient as a response to a national crisis.

The churches also need to study other issues, for example, the language that they consciously or unconsciously use which results in labelling people who are deemed either "deserving" or "undeserving" of help, because of the way that they contracted the disease. How and in what manner have the churches contributed to the stigmatisation of those who have contracted the disease? If the churches are serious about really empowering people to make the right choices, then how have they addressed the issue of education – and not merely education about the disease and how it is contracted or prevented – but also about the critical tool of active democratic involvement on both the national and international stages, in order to relieve the human suffering that is caused by the disease and its consequences.

In discussing the issue of Christian care, Richardson (2006) makes what I believe to be an important point. Referring to Moila (2000), he says that we need to be mindful of the concept of "the holism of African care" (2006:49), which challenges the Christian church to look beyond just the care of individuals and the families. He says that

> (t)here are also political and economic battles to be fought because the context of HIV/AIDS is wider than the suffering of the individual PLWHA and their families, and wider than the boundaries of the Christian church. As an integral, responsible and caring part of the body politic, the Christian community must operate proactively and collaboratively in seeking improved structural provision for people living with HIV and AIDS.

2.3   An overview of HIV/AIDS care provided by churches

The response of the churches to the HIV/AIDS epidemic in sub-Saharan Africa has been varied in breadth and scope. Some initiatives by churches have been large and

43

organised. However, many programmes have been small and unacknowledged, for they have been geared to benefit individuals or local communities. Initiatives such as support groups, home-based care, helping orphaned and vulnerable children, provision of food, clothing and medication, provision of economic and social support are some of the ways in which the church has rendered help (ARHAP 2006). These measures have undoubtedly alleviated the suffering of many. However, the question that needs to be asked is whether such help been "people-centred", that is to say, has it increased the personal and institutional capacities of people to enable them to improve the quality of their own lives (Korten 1990:67)?

Seventy per cent of the world's people identify themselves as members of a faith community (UNAIDS 2008d). These communities of faith play a significant role in influencing people's behaviour and attitudes, and in providing care and support for people affected by or infected with HIV/AIDS. Religious communities, churches, mosques and temples have all reached out to provide support and their leadership has had a powerful impact, often for good, but also sometimes for bad.

UNAIDS (2008b) points out that faith-based-organisations (FBOs) are involved at all levels of the response, including prevention, education, home-based care, care for orphans and vulnerable children, hospital and clinic care, advocacy, the support of religious leaders living with HIV (INERELA+), training of health care workers, etc. Indeed, the World Health Organisation (WHO) (2007b) estimates that between 30% and 70% of the health infrastructure in Africa is owned by FBOs. The UK's Department for International Development (2006) makes the comment that faith groups (in this context, they mean congregations or denominations) play an essential role in providing services and relief to poor people, particularly in terms of health and education to rural people in sub-Saharan Africa, where they provide 50% of such services.

Goodenough (2007) outlines several areas in which FBOs offer care and treatment in relation to HIV and AIDS. She makes the point that many Africans employ health strategies that incorporate health, religious and cultural norms (a similar point is made by Mcfarland (2007), namely that religion shapes the way in which people engage in the search for health and wellbeing). As a consequence, it is important for health policy makers to understand the overarching influence of religion. Furthermore,

44

because Christian institutions are places where moral values are formed and strengthened, as well as the place where "self-esteem is cultivated and life's lessons are taught using the Bible" (2007:6), Goodenough advocates that this could be used to develop health behaviours in the youth.

A study conducted by the African Religious Health Assets Programme (ARHAP) (2006) outlined how FBOs, particularly local churches, adopted a holistic approach to illness and disease by incorporating a comprehensive range of responses to prevention, care and support that went beyond bio-medical help. For example, in a rural area of the Eastern Cape, known as Masangane, physical healing was addressed through the provision of ARVs. However, FBOs also worked with the government to ensure treatment literacy and to establish support groups to monitor adherence. In addition, FBOs provided psycho-social support through the reintegration and reacceptance of a person with HIV/AIDS into the community. In terms of Korten's (1990) generational approach for development strategies, these actions would surely be classified as people-centred. An ARHAP/WHO report (2006) also makes the point that religion often brings overlooked but intangible benefits to communities; for example, where information is given to communities by a church or FBO, it is often regarded as having great integrity and as a result is given some degree of weight and then often disseminated to workplaces and communities.

Certainly FBOs can be used to make changes that are more fundamental and more developmental. A report by Taylor (2006), on behalf of Tearfund, outlines that FBOs should be better used to shape attitudes and influence the powerful (2006:7-8). He advocates that faith leaders be used to shape the attitudes of society and community, as well as inculcate values of personal responsibility and sexual morality. In terms of influencing the powerful, he recommends that this be undertaken by empowering the poor and civil society to bring about social and political reforms. If indeed FBOs engaged with communities in this way, it would very much be along the lines that Korten envisages, namely the political empowerment of the poor, which he classifies as "serious development assistance" (Korten 1990:142).

Referring specifically to the church, Chitando states that it was initially slow to respond to the disease because of "theological rigidity", which interpreted HIV as a "manifestation of humanity's sinfulness" (2007:21-22). The church failed to take into

account the fact that unjust systems and circumstances lead to increased vulnerability. The churches and FBOs, however, have come a long way since the initial stages of the disease. Authors such as Nicholson (1994) and Saayman and Kriel (1992) have attempted to change mindsets by putting forward a new theology of sin and redemption, drawing attention to the socio-economic factors that fuel the pandemic. Munro (2003:32) sums up the challenge for the church as follows:

> [HIV/AIDS] is a sign of crisis, and also of opportunity, a sign of desperation, and also of hope. It is very easy to get caught up in the negativity and hopelessness of the HIV and AIDS pandemic as it manifests itself around us and yet the challenge to us as church and society is profound. We, the people of God, the suffering body of Christ, are being called and invited, challenged and urged, to live our common humanity, to be wounded proclaimers of the kingdom of God among a people that is struggling with its identity, its beliefs, and its values.

There has been limited analysis in terms of the nature of the work provided by churches and FBOs in relation to HIV/AIDS. Research by Birdsall (2005) in South Africa, however, gives an indication of the size of the contribution made by FBOs. The research demonstrates that there has been a 50% growth in the number of faith-based projects working in rural areas since 2000. The growth of faith-based projects in urban areas has increased by 32%. The services provided are in the areas of prevention, care and support, and treatment (medical support). In this section I will look at some of the areas in which the churches/FBOs are rendering help.

(i) Treatment

Churches and FBOs have not been particularly active in relation to treatment, although research by Stevens *et al.* (2007) has shown that community treatment programmes (including programmes delivered by FBOs, such as the Southern African Catholic Bishops' Conference, as well as organisations such as Right to Care and the TAC) were treating approximately 11 600 patients with Highly Active Antiretroviral Therapy (HAART).

(ii) Political engagement

Goodenough (2007:21) explains that church leaders "may be reluctant to focus on societies' challenges and to play a role in addressing problems relating to violence, abuse and human rights issues … church leaders regard many social issues as politics and argue that the church and politics should not mix. Some churches also perpetuate

gender discrimination". Such a stance would run contrary to Korten's view (1990:142) that if serious development is to take place, then the political dimension of problems cannot be ignored.

An example of a church engaging politically – and on the international stage – is the intervention by Pope John Paul II (2001), the late head of the Catholic Church. In 2001 he wrote to the then Secretary-General of the United Nations, Mr Kofi Annan, ahead of the Special Session of the General Assembly, urging that an AIDS fund be set up by the international community as a matter of moral responsibility for the sacredness of human life. He called for action to address the issues of the transmission of HIV from mother to child, orphans and access to medical care through the provision of ARVs. He raised the issue of intellectual property rights and urged that laws be changed to allow poorer countries access to treatment. This accords with Korten's view (1990:201) that NGOs should become increasingly involved in international forums, such as the United Nations (UN), so that they can give expression to the people's voice in the processes "by which governments shape their global agenda".

(iii) Care of orphaned and vulnerable children

Perhaps the area in which the churches have been visibly active in rendering care is in relation to orphans. UNAIDS (2010) (see later, section 2.5.2) estimates that there are at present 2.5 million children who have been orphaned (of these 1.5 million children under the age of 18 live in Africa and were maternal orphans (i.e. had lost a mother), and 66% of these children have been orphaned as a result of HIV/AIDS. Analysis of National Demographic and Health Surveys in sub-Saharan Africa empirically confirm an upward trend in the number of AIDS orphans (Gregson *et al.* 1994).

The implications of being an orphan are enormous, not least because it is very often grandparents, extended families or community members that take on the responsibility of caring for children. Being orphaned, however, makes children vulnerable to exploitation and perhaps makes it more likely that they will lose their rights to shelter, education, food, etc. (UNAIDS 2008c). Their emotional, physical and social needs may be neglected. In order to be socialised, family, friends, church and school are all important for the growth and development of a child, but all of these may fall away as the parent becomes more ill. Where children lose their parents,

47

they may also lose their sense of connectedness, which comes from belonging to a family and having roots in a community. Children losing one or both parents are deprived of their nurturing and loving influence; in such circumstances it may be that a child will lose his or her sense of identity and belonging (Kluckow 2004).

The suffering of orphaned children might, however, begin much earlier than the death of their parent(s). Kluckow (2004) explains that several changes may occur: the child may become a primary health giver (or even take on the parental role of caring for siblings). The child may also have to drop out of school, as the parent becomes ill, in order to look after him or her. Of course, there are also the obvious issues of dealing with the emotional aspect of confronting the illness and death of a parent. All of this may have emotional and behavioural consequences for a child.

Churches, such as the Anglican Church, have active policies for the support of orphans which include paying crèche fees (to allow older children to stay at school instead of having to be at home to look after younger siblings), paying school fees, providing stationery, books, etc., as well as offering volunteer programmes for bereavement counselling (Kareithi *et al*. 2005). Care is encouraged by linking the church with an orphanage or children's hospital, or twinning with a church in an area with a high HIV prevalence. Practical care includes visiting children, providing food packs, starting a support group, church-based orphan care and providing home-based care (Kareithi *et al*. 2005:107).

In a similar way the Catholic Church also provides support to orphans and has established homes in Cape Town, known as Nazareth House and Montana House. The former was the first institution to provide paediatric ARVs to HIV-positive orphans. It has also established day-care centres throughout the country for orphaned and vulnerable children and has a scheme for fostering or adopting orphans by family and community members (Toefy 2009).

From Faith to Action (Firelight Foundation 2007) is a publication for FBOs that is aimed at helping children and families affected by HIV/AIDS in a humane and theologically sound manner. It sets out a detailed strategy to help orphaned and vulnerable children, and it urges churches to integrate HIV and AIDS into all aspects of the life and ministry of the church, as well as establishing specific HIV and AIDS

projects. It says that the most important thing that FBOs can do is to help to ensure that every child has a family that is able to nurture and care for a child's needs; this necessarily entails strengthening the capacity of families and communities to care for them, a task to which the church is well suited.

Foster's research (2004) indicates that there are more than 9 000 volunteers working in over 650 FBOs which support in excess of 150 000 orphans and vulnerable children, through community-based initiatives that are aimed at providing spiritual, material, educational and psychosocial support.

(iv) Home-based care

Home-based care has been an important component of the churches' response to HIV/AIDS. Goodenough (2007) outlines the work undertaken by the Methodist Church in Hillcrest, KwaZulu-Natal, where volunteers are trained in home-based care as well as voluntary counselling and testing, and run a feeding scheme. It is the quality of the care that is brought to the community that is significant. Goodenough (2007:10) points out that one of the volunteers stated that working for a FBO was different: "(s)he regards herself as being 'employed' by two people – her employer and God" – and she had to be accountable to both. Faith therefore brings a quality and commitment to care that differs from that of an ordinary work environment.

Magezi and Louw (2006:67) label the home-based care that is offered by churches as "congregational home-based pastoral care that draws on the concepts of ubuntu and koinonia", to work with families and the community to support people with HIV/AIDS. Church networks are utilised to support existing care-giving structures to give both patient and his or her family the help that they require

An interesting example described by Goodenough (2007) is work conducted by the KwaZulu-Natal Regional Christian Church Council (KRCCC), an off-shoot of the South African Council of Churches. Although its work is similar to that performed by other organisations, it works for and through the church and with Oxfam to bring together 30 different ministers' fraternals, comprising more than 19 different denominations and 300 senior church leaders, as well as 20 ecumenical leaders' groups. It is one of the few examples of an FBO seeking to focus on notions of masculinity, gender and HIV. Its aim is to address inequalities in a context where

power relationships between men and women are unequal, where women are poor and do not have the means for production and in circumstances where women are politically and culturally marginalised. The programme therefore seeks to focus on gender socialisation within both Christian religious and African traditional contexts, by mobilising the clergy to transform church communities. In establishing such linkages and through addressing harmful actions, such as the abuse of human rights and the discrimination of women, it can be seen that the KRCCC is seeking to engender new and more positive institutions and transformation that is consistent with a people-centred development vision.

Another example of home-based care is that offered by the Catholic Church which, under the umbrella of the Southern African Bishops' Conference, provides care, treatment and support to infected and affected people. The church has particularly been involved with the care of the chronically ill by establishing hospices, arranging for respite care, spiritual counselling and support to the dying, their families and carers (Spokesperson AA 2002).

National data taken from an audit of home-/community-based care (HCBC) by the Departments of Health (DOH) and Social Development (DSD) examined FBOs in terms of the services and support that they rendered to persons affected by or infected with HIV/AIDS, during the period 2002-2003. The results are interesting and can be summarised as follows:[9]

- A total of 892 HCBC-related projects were identified around the country. Most of these were NGOs (50.4%) and community-based organisations (CBOs) (36%) (DOH/DSD 2003:10). Only 31 of these were run by FBOs (DOH/DSD 2003:23);

- HCBC projects network with other types of organisations. NGOs demonstrated a significant ability to network. For example, 61.5% networked with the corporate sector and 59.7% with international organisations. NGOs also networked with other NGOs (55.5%), hospices (53.7%) and public health facilities (52.7%) (DOH/DSD 2003:11);

---

[9] The remainder of this section has been adapted from a chapter that was written by Ferreira and Groenewald (2010).

- CBOs also demonstrated an ability to network. For example, 50.5% networked with women's organisations, 43.3% with other CBOs, 39.7% with schools and 38.8% with FBOs (DOH/DSD 2003:11);

- Of all the projects, only a little over a third (34.4%) networked with FBOs (DOH/DSD 2003:44);

- FBOs did not network much. For example, only 3.3% networked with NGOs, 3.8% with CBOs and 6.5% with other FBOs. NGOs (43.6%) and CBOs (38.8%) on the other hand, initiated networking with FBOs to a greater extent (DOH/DSD 2003:45);

- Generally, HCBC projects networked most often with reference to HIV and AIDS activities (84.9%) (DOH/DSD 2003:46).

The HCBC projects received most of their funding (in excess of R276 million) from the government (64.3%) (amounting to more than R178 million). During the audit period churches provided a total of R2 824 813 to HCBC projects, amounting to about 1% the total funding (DOH/DSD 2003:47-48). Korten states that networking, on the basis of shared interests, is conducive to the flow of information/communication; it encourages creative voluntary energies to assist in social learning processes, helps organisations to adapt and is conducive to sustaining social movements. He states that "[networking] unlocks the barriers to change imposed by hierarchy" (Korten 1990:106). And yet from the above survey, it can be clearly seen that although HIV/AIDS generates the most networking activity among home-/community-based care projects, FBOs are the least likely voluntary group to network, or indeed, to be networked with.

In order to formulate a response to HIV/AIDS, I seek to make the case that a critical knowledge is required about the disease, along with the manner in which it is transmitted and its local, national and globally contexts. Additionally, Denis (2003) urges us to pay heed to the sociological realities of HIV/AIDS: in circumstances where family relationships have broken down, where traditional marriage requirements have failed, where conditions of unemployment and poverty exist, can we talk about the ideals of sex within monogamous faithful marital relationships without also acknowledging that there is a need to talk about condoms? Furthermore, there is a need to understand global issues and structures that have an impact upon the

disease. As Korten argues that, for change to be transformative, there is a need to catalyse a change of institutions, policies and values, but this can only be achieved through an understanding of the issues, creating a global consciousness, advocating for policy change, linking up with people and exchanging ideas, engaging politically and encouraging people to take voluntary action (Korten 1990:186).

Some of these issues are explored in an endeavour not only to provide an indication of how the churches have responded, but also to shed some light as to how the churches have acted/might be encouraged to act in a people-centred developmental way.

2.4 The churches' potential to influence HIV/AIDS care

In Chapter 1 brief mention was made of the churches' influence in health care and its ability to use its influence, membership and voice to bring about considerable changes. This would suggest that churches themselves recognise the power that they possess to effect change through advocacy and action. In fact, churches and faith-based groups have often filled the gaps in areas where the state has failed to adequately provide in terms of welfare, health care or education to communities.

As seen above and in Chapter 1, the churches have been able to effect changes in attitudes and opinions by bringing a different values dimension to the issue of caring for the sick, the orphaned and the widowed that no other institution is able to provide.

The churches are also able to exercise influence at various levels and in different ways. For instance, according to a recent study (Ironson *et al*. 2011), people who are HIV positive have been found to have a much slower rate of disease progression in cases where they hold a view of God as benevolent and forgiving (as opposed to those with a view of God who is punishing and judgmental). Researchers used several measures, including adherence to medication, sexual risk behaviour and other drug use. They also examined psychological measures to determine whether depression, church attendance, social engagement/isolation, or optimism contributed to disease progression. After four years they concluded that there was a significant correlation between having a positive view of God and having a slower rate of disease progression.

The influence of church leaders, clergy and congregation is also seen in research conducted by Fakoya (2009) among 66 faith leaders (the majority of whom described themselves as Pentecostal – a movement within Christianity that emphasises a direct personal experience with God, through the power of the Holy Spirit). The majority (80%) took a compassionate view of HIV/AIDS sufferers, stating that they did not believe that the disease was punishment from God. More interestingly, however, three quarters of those interviewed believed that HIV could be cured through the power of prayer alone. This means, therefore, that it might be possible for a church leader to encourage people who are on antiretroviral medication to stop treatment.

The author concludes: "The belief that there are people who have been cured of HIV might become problematic, especially for people whose adherence to antiretroviral therapy leads to an undetectable viral load which is subsequently interpreted as a cure" (Fakoya 2009:16). Indeed, there have been cases of people dying after stopping their antiretrovirals, believing they have been cured by prayer. This illustrates not only the enormous influence that the churches exercise within communities, but also the need for faith leaders of all denominations to know about and understand HIV, its prevention and treatment.

The point is also made by Aguwa (2010) that in Nigeria faith healing has become popular, particularly in Pentecostal and charismatic Christian churches, but that such practices may not be helpful as, firstly, they detract attention from "real" health solutions, and secondly, such practices may strengthen the tendency to blame the sufferer.

A study by Noden *et al*. (2010), which looked at religious affiliation in Mozambique, specifically among youths aged 12 to 28 years, and its impact on knowledge and behaviour, would seem to indicate that where there is religious affiliation, there is increased knowledge about HIV transmission and prevention, possibly because of HIV/AIDS education initiatives, particularly in religiously affiliated schools. However, the increase in knowledge does not necessarily translate into different sexual behaviour: sexual activity, condom use and the utilisation of other prevention strategies and having multiple sexual partners all seemed to be the same compared with non-religiously affiliated youths.

Research by Garner (2000) would also appear to bear out the finding that, in general, church affiliation does not appear to have a bearing on sexual behaviour, albeit Pentecostal Churches seem to have a formula for reducing risky sexual practices, and there appears to be an association between belonging to a mainline church and youths delaying the age at which they have their first sexual encounter. Among the four Christian denominations that he examined in Pietermartizburg (Mainline, Pentecostal, Apostolic and Zionist), it was only the Pentecostal church that appeared to have an impact on sexual behavioural change. This was achieved through several means, namely indoctrination, religious experience, socialisation and exclusion. Indoctrination focused on education about pre- and extra-marital sex; religious experience related to meetings and activities of the congregation, which enhanced moral conformity; socialisation meant a much greater involvement and commitment to the church and its activities; and finally, exclusion referred to a fear of being excluded for engaging in sex outside marriage. It therefore seems that churches are able to influence sexual behaviour, but apparently this requires these four elements. The results of this research and that undertaken by Noden *et al.* (2010) suggests that the provision of information alone does not change behaviour, nor it seems does church affiliation, unless it is a church such as the Pentecostals.

According to research conducted by the Human Sciences Research Council (HSRC 2000), the church commands the highest level of trust (74%), compared to all other institutions and therefore has considerable influence. This leads Erasmus and Mans (2005:28) to comment that "(t)he wellbeing of communities depends largely on the harnessing of their citizens' contributions".

The churches can play a vital role in transforming society: they claim that they are a powerful body, with a presence in almost every area of South Africa (see Chapter 1 sections 1.6 and 1.7); they therefore have access to social networks throughout the country and these could be used to mobilise people to act in response to health and social issues that impact upon the HIV/AIDS epidemic. Castells (1997:75-86) speaks of the use of the internet during the Zapatista uprising in the 1990s, and more recently the use of mobile phones in the People Power II protests in the Philippines (Castells *et al.* 2007). Indeed, the political changes in Egypt and Tunisia in 2011 would not have been achieved without the use of cell phone and internet systems, which were used to

organise dissent against authoritarian governments in these countries. In fact, there are already calls for the use of social media such as Facebook, Twitter and MXit to be used to spread the word about AIDS prevention in Africa. In a recent newspaper article (Du Toit 2011), it was pointed out that Africa has 333 million cell phone users and 77 million internet users (5 million of the latter group are in South Africa). A plea was therefore made to use these tools to "fuel the revolution" and to talk about subjects such as HIV-prevention and other taboo subjects and issues. In this sense, what is being suggested by Du Toit (2011) corresponds very much with the views of Korten (1990:123-125), who advocates social energy and ideas, rather than money or structures, being the driving force behind social movements. However, although technology has played an important role in creating social movements, there is no reason why the churches cannot use their own networks to activate and mobilise people around a common cause, for example, the issue of access to treatment.

In her recently published and appropriately entitled book *Alone Together: Why We Expect More from Technology and Less from Each Other*, Sherry Turkle (2011) argues that social networks such as mobile phones, the internet, Facebook and Twitter have all succeeded in making us less human because we fail to interact properly with family and friends. While technology has given us a sense of greater connectedness, these are pseudo-techno relationships rather than human connections. She cites the example of a mother who, instead of watching and listening to her children at play, has her mobile phone in one hand and her attention absorbed by texting, rather than by the child with whom she is supposed to be interacting. While this is a subject in itself, what I wish to draw from this is that the churches are uniquely placed to utilise their own networks, which are not necessarily technological in nature, to bring a transformative, yet human, empathetic response to the disease. This is not to suggest that technology should not be used to communicate more easily and quickly, but rather to emphasise the fact that human connections need to be more than superficial engagements if development is to be people-centred or geared towards human development.

The social network site Twitter had as its objective, "(i)nstantly connect[ing] people everywhere to what's most meaningful to them". In a similar way, the church aims to connect people to the issues that have meaning for their lives. It need not do so

through technology, because the issue is one of engagement and the use of social media is but a tool in the process. The churches therefore have to use the best available platform to harness the power of its congregants and networks.

It must not be forgotten that the churches can also have a negative impact on the care of those who are HIV infected. If they impose strict moral codes and imply that AIDS is a disease caused by promiscuity, for example, the churches can contribute towards the stigmatisation of people. The double-edged sword is evident: on the one hand, by teaching moral values, they may be able influence sexual behaviour and thereby prevent the spread of HIV/AIDS and, on the other hand, a moralistic tone could contribute towards stigmatisation and discrimination, which prevents people from seeking help and support (and in turn leads to the further spreading of the disease).

Having advocated for a better understanding of the HIV/AIDS and why the churches are well placed to exercise an influence, I propose to now undertake a brief examination of the HIV/AIDS situation globally, regionally and in South Africa. I shall then look at the way in which HIV is spread and finally, consider some of the factors that contribute to its spread, including some underlying "burning" issues that I believe need to be addressed by the churches.

2.5   HIV/AIDS: a global, regional and national snapshot

In Chapter 1, section 1.1, brief mention was made of HIV/AIDS statistics. In this section I shall endeavour to make some sense of the figures, before examining the situation more closely in South Africa.

2.5.1   A global overview

What is clear is that globally the overall growth of the HIV/AIDS epidemic appears to have stabilised. The numbers of people newly infected with HIV have been declining for more than a decade and there are fewer deaths that can be directly attributed to AIDS, owing the availability of antiretroviral therapy (ART), as well as the care and support provided to people living with HIV. Accordingly, there are greater numbers of people living with HIV (UNAIDS 2010).

However, in Central, Western and Eastern Europe, as well as in Central Asia and the United States, HIV incidence increased by 25% despite having been stable for the past

56

five years, particularly among men who have sex with men, and injecting drug users and their families (UNAIDS 2010:17).

On the other hand, in the European Union some 26 000 people were diagnosed with HIV in 2009 (Likatavicius & Van de Laar 2010). Seventy-two per cent of those diagnosed were men and it was found that rates of infection in gay and bisexual men are on the rise, but are falling in the heterosexual population. Interestingly, unlike the situation in sub-Saharan Africa, the rates of infection for men per year for every 100 000 people in the population is much higher than that for women (8.3 per 100 000 for men, compared to 3.2 per 100 000 for women). However, even within Europe the rates vary considerably. While the average rate of HIV infection is 5.7 per 100 000 of the population in the European Union, in Estonia it is 30.7, Latvia 12.2, the United Kingdom 10.7 and Belgium 10.3 (Likatavicius & Van de Laar 2010).

What we need to draw from the global picture is the fact that there is not a single global epidemic, but many local epidemics that are driven by various factors and circumstances. For example, in the countries of Eastern Europe and Central Asia 89% of national government funding for HIV-prevention goes on programmes for the general population. Most of these countries' epidemics, however, are dominated by injecting drug use. But an analysis of government spending reveals that only 8% of spending on prevention is devoted to injecting drug users, 2% to work with sex workers and their clients, and 1% on programmes on men who have sex with men (Schonning 2010). This points to the fact that prevention campaigns have to be targeted at the groups that are most at risk and stigmatised. And even then campaigns directed at particular groups need to be undertaken sensitively, so as to ensure that these groups are not further marginalised.

2.5.2   Sub-Saharan Africa

In sub-Saharan Africa HIV incidence has fallen by as much as 25%. UNAIDS (2010:16) attributes this to HIV-prevention efforts and "the natural course of HIV epidemics". That said, 1.8 million people were newly infected in the region. Sub-Saharan Africa constitutes 11% of the world's population, but comprises more than two thirds of the population living with HIV/AIDS in the world. According to the Henry J Kaiser Family Foundation (2007), the region also accounts for 76% of AIDS

deaths. Average life expectancy in the region is 47 years, whereas it is estimated that it would have been 62 years in the absence of AIDS.

Using national surveys, UNAIDS (2010:16) concludes that there is a significant decline in HIV prevalence among young men and women, including in Botswana, South Africa, Tanzania, Zambia and Zimbabwe. Nonetheless, with 22.5 million people living with HIV, sub-Saharan Africa continues to bear the brunt of the burden of the disease (68% of the global total).

The HIV trends in sub-Saharan Africa make for interesting analysis. Southern Africa is particularly severely affected, with some 11.3 million people who were living with HIV/AIDS in 2009. Globally 34% of people living with HIV in 2009 reside in ten countries in Southern Africa (UNAIDS 2010:25).

With 5.6 million people living with HIV in 2009, the epidemic in South Africa remains the most severe in the world. However, the annual incidence of HIV shows a decline among 18 year olds (from 1.8% in 2005 to 0.8% in 2008). In Zimbabwe too there has been a decline in the incidence of HIV; UNAIDS (2010:13) attributes this to the fact that men have begun to have fewer casual partners and use condoms with their non-regular partners.

The number of children living with HIV increased to 2.5 million worldwide. However, the incidence of children younger than 15 years infected with HIV in Southern Africa has decreased significantly, by 32% in 2009 compared to 2004. Child AIDS-related deaths too have fallen from 120 000 in 2004 to 90 000 in 2009. However, drawing on a study by Shisana *et al*. (2010), UNAIDS (2010:28) documents research conducted by the Every Death Counts Writing Group (2008), (published in the *Lancet*[10]), that the exception to this is South Africa, where child and maternal mortality have risen since the 1990s. AIDS is the greatest cause of maternal mortality in South Africa and 35% of children who die under the age of 5 years die of AIDS-related diseases (Shisana *et al.* 2010).

---

[10] According to James, A. *et al*. (2005), the Lancet is a peer reviewed medical journal that seeks to "inform and reform medical thought and practice" (2005:115). As such, it reports on randomised trials, advances in disease knowledge and their treatment and it aims to be a leading voice of global health issues and research. The publication was founded in the UK some 190 years ago.

.

The total number of children aged 0–17 years who have lost a parent or parents as a result of HIV has increased from 14.6 million in 2005 to 16.6 million in 2009. Almost 90% live in sub-Saharan Africa, predominantly in Kenya, Nigeria, South Africa, Tanzania, Uganda and Zimbabwe (UNAIDS 2010:112). In the region more than 10% of all children aged 0–17 years have lost one or both parents to AIDS. The figures are, however, higher in Zimbabwe (16%), Lesotho (13%), and Botswana and Swaziland (12%). The tragedy of young children losing their parent(s) to AIDS has evoked an exceptional response, causing UNAIDS (2010:112) to comment: "Among the most remarkable contributions to the global response to HIV are the systems and networks, both formal and informal, that have been established to support children orphaned by the epidemic." As we have seen above, churches have been at the forefront of efforts to care for children who have been affected by HIV/AIDS.

The scaling up of treatment through the provision of ARVs is profoundly affecting the figures of AIDS-related deaths in sub-Saharan Africa. Accordingly, AIDS-related deaths decreased by 18% in 2009 compared to 2004 in Southern Africa (610 000 deaths in 2009, as opposed to 740 000 in 2004) (UNAIDS 2010:108).

In contrast to Europe, there are more women than men who are HIV positive in sub-Saharan Africa. The number of women living with the virus in sub-Saharan Africa, however, has remained stable at around 52% of the global total (UNAIDS 2010:130).

According to UNAIDS (2010:95), at the end of 2009 36% (about 5.2 million) of the 15 million people in need of antiretroviral therapy in low- and middle-income countries were receiving treatment. Nonetheless, as a result of the roll-out of ARVs, fewer people were dying from AIDS-related causes.

Prevention of mother-to-child transmission of HIV has seen extraordinary advances. Without ARV intervention, some 30-40% of mothers can transmit HIV to their babies during pregnancy, in labour or after birth, or through breastfeeding. According to UNAIDS (2010:64), infection rates among children born to mothers living with HIV have dropped significantly from 500 000 in 2001 to 370 000 in 2009. Several countries have made enormous strides in preventing the mother-to-child transmission of HIV: Botswana, Namibia, South Africa and Swaziland have achieved more than

80% coverage of antiretroviral prophylaxis to prevent mother-to-child transmission (UNAIDS 2010:78).

However, the WHO (2010a) documents that the efficacy of antiretroviral drugs in preventing mother-to-child transmission of HIV varies with the type of regimen used and the duration over which it is given. Combination regimens which include different types of antiretroviral drugs are more effective than a single or mono therapy. Furthermore, mono therapy is also more likely to build resistance to the virus, which may limit future treatment options.

In South Africa, for example, a single dose of nevirapine was given to mother and baby to prevent the transmission of the virus, which at the very best, reduced the HIV transmission rate to 8.8%. In 2008 the South African Department of Health estimated that 70 000 babies a year were still being born with HIV. Since 2010, however, the protocol has been changed, with HIV pregnant women being given the antiretroviral drug AZT for 14 weeks of pregnancy and three ARVs (nevirapine, tenofovir and 3TC) during labour. In addition, new born babies are given nevirapine syrup for as long as their mothers breastfeed them, or for six weeks after their birth, if they are not breastfed. This is in accordance WHO (2010a) guidelines and has the potential for dramatically reducing the transmission of HIV from pregnant mothers to their babies.

The UNAIDS report (2010:122) highlights various factors that are still fuelling the pandemic in sub-Saharan Africa – and indeed in South Africa – not least, issues relating to human rights and gender equality. The report (2010:64) documents that major successes in HIV-prevention have been achieved in concentrated epidemic countries that have devoted substantial programming and funds to prevention efforts among people at higher risk of exposure to HIV. However, prevention responses often do not focus on key populations. Some of the areas where prevention responses have been lacking are discussed further below, with a particular view to highlighting issues that perhaps the churches need to address.

2.5.3 A snapshot of South Africa

In relation to South Africa, it is important to take account of the Department of Health's National Antenatal Sentinel HIV and Syphilis Prevalence Survey that is

conducted each year. The 2010 antenatal sentinel surveillance report (for the year 2009) provides a good indicator of HIV prevalence and incidence in the population.

The DOH (2010b) report estimates HIV prevalence among females in the 15-49-year-old age group at 17.8% (DOH 2010b:4). This translates into 5.62 million adults and children who were living with HIV/AIDS, of which 5.3 million were adults, aged 15 years and older (DOH 2010b:56). It is estimated that of the adults, 1.54 million South Africans are in need of antiretroviral therapy (UNAIDS 2010:111). Women in South Africa continue to bear the greatest burden of the disease (3.3 million women) (UNAIDS 2010:130; DOH 2010b:2). There were estimated to be 334 000 children living with HIV, of whom 158 000 children needed ARVs (DOH 2010b:2). The number of orphans as a result of AIDS is estimated at 1.95 million (DOH 2010:2).

UNAIDS (2008b) estimated that the disease claimed 350 000 lives in 2007, which translates into nearly 1 000 AIDS-related deaths each day (amounting to a cumulative death total of over 2 million people). In 2009 it was estimated that 314 000 South Africans died of AIDS (DOH 2010b:2), of whom 284 000 were adults. The disease is therefore a major challenge to the country's socio-economic development. Consequently, the DOH report urges that government, civil society, non-governmental organisations and international partners help fight the scourge of HIV/AIDS (DOH 2010b:2).

The overall national HIV prevalence among pregnant women aged 15-49 years in the survey is estimated at 29.4% (almost unchanged from 2008, when it was estimated at 29.3%) (DOH 2010b:3).

In 2009 HIV prevalence among the 15-24-year-olds remained unchanged from the 2008 estimate of 21.7% (DOH 2010b:3). This is a blow to reaching the Millennium Development Goal[11] (MDG) 6, Target 7, indicator 18, which states that countries should aim to halve the prevalence of HIV among pregnant women in the 15-24 year age group (as well as reduce mother-to-child transmission to 5% and provide

---

[11] United Nations Millennium Development Goals: In 2000, at the UN Millennium Summit, 189 world leaders from North and South, rich and poor countries, agreed upon eight time-bound goals, ultimately aimed at ending extreme poverty, namely: ending hunger, universal access to education, gender equity, child health, maternal health, combating HIV/AIDS, environmental sustainability and global partnership. Available at www.un.org/*millenniumgoals.*

universal access to treatment for HIV/AIDS to all those who need it by 2010 (Schneider *et al*. 2010)). There was a marginal decrease in HIV prevalence among young women in the 15-19 age band (13.7% in 2009) (DOH 2010b:3).

Nationally, HIV prevalence among women in the age group 30-34 years (comprising 14.5% of those in the survey) remains the highest. Prevalence rose from 40.4% in 2008, to 41.5% in 2009 (DOH 2010b:3). Some of the increase in prevalence might be attributable to the increase in survival rates because of ARVs.

It is interesting to note that there are substantial differences in the rates of prevalence among the provinces in South Africa. According to UNAIDS, in 2009 estimated national and provincial HIV prevalence in the general population, including children and those above 49 years, was 17.8% (DOH 2010b:4). The provincial HIV prevalence in the general population for 2009 was estimated as follows (see Table 1):

Table 1: National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa, 2009

Province	HIV prevalence
Eastern Cape	18.5%
Free State	19.5%
Gauteng	16.6%
KwaZulu-Natal	25.0%
Limpopo	13.8%
Mpumalanga	21.8%
North West	19.27%
Northern Cape	09.3%
Western Cape	06.2%

Source: UNAIDS (2009), Department of Health (2010b)

The results show that the highest HIV prevalence continues to be located in the north-eastern part of South Africa, while the lowest prevalence is in the western part of the country. KwaZulu-Natal has the highest HIV prevalence followed by Mpumalanga and Free State. North West, Limpopo, Gauteng and the Eastern Cape also have high prevalence and the Northern Cape and Western Cape have lower rates of HIV prevalence (DOH 2010b:30).

Interestingly, the Department of Health antenatal survey (2010b:54) notes that the Western Cape provincial HIV prevalence among 15-49-year-old antenatal women was 16.9%, an increase from 15.3% in 2007. The Cape Metropole carries the heaviest burden of HIV in the Western Cape, with more than 70% of the HIV-infected pregnant women in the province (DOH 2010b:54).

The City of Cape Town had a prevalence of 18.2%. Prevalence on the West Coast has remained at or below 10% for the past three years. The Central Karoo district showed a 3.0% decrease from 14.8% in 2008 to 11.8% in 2009. In the Eden and Overberg districts there were slight increases of 5.2% (to 18.2%) and 4.9% (to 20.8%) respectively from 2008 to 2009. The Cape Winelands showed prevalence of 13.2% (DOH 2010:55). The district-level HIV epidemic is heterogeneous throughout the country, with different health districts recording variable rates of HIV prevalence. The only reasonable explanation for this is that there are different HIV determinants or risk factors that drive the epidemic in the different parts of the country (DOH 2010b:62-63). There has yet to be research conducted as to the potential risk factors that play a role in the HIV infection rates in different areas.

The Department of Health report (2010b) found that 1.9% of pregnant women presenting at public antenatal care clinics were infected with syphilis (unchanged from 2008). Syphilis prevalence among attendees of antenatal clinics has continued to fall from a high of 11.3% in 1997 to levels below 3% in 2003 (DOH 2010b:59).

Curiously, although the Northern Cape recorded the highest prevalence of syphilis (5.6% in 2009), KwaZulu-Natal (which has the highest HIV prevalence in the country) had the second lowest syphilis prevalence (0.8%) (DOH 2010b:59). There was a slight decrease in syphilis prevalence in the Western Cape, from 3.8% in 2008 to 2.0% in 2009 and in the Northern Cape from 6.8% in 2008 to 5.6% in 2009 (DOH 2010b:60).

In contrast with HIV, the prevalence of syphilis appears to be largely independent of age with the exception of lower prevalence in the youngest age group (15-19 year olds) (DOH 2010b:61).

In early 2005 DOH figures showed that some 42 000 people were receiving ART from more than 100 designated HIV service points throughout the country (DOH

2007). By the end of September 2005 this figure had more than doubled to around 86 000. The Department of Health Information Evaluation and Research report (2007) documented that in September 2006 over 230 000 people had started on antiretroviral therapy (ART) throughout the country and that there were 273 public health facilities providing it. During that period, however, there were no accurate figures as the Department of Health still did not have a monitoring system in place! According to a Department of Health (2008) report to the United Nations General Assembly Special Session on AIDS (UNGASS), it would appear that for the period January 2006 to December 2007 a total of 488 739 people were enrolled on ART treatment (estimated to be 55% of the 889 000 people in need of treatment) (DOH 2008:28). The accuracy of these figures can be questioned, however, as it is not clear how these statistics were collated by the government (see the DOH report to UNGASS, where the Department states that it "faces the greatest challenge as regards establishing adequate monitoring systems" (DOH 2006:29)). It did not include, for example, people who were receiving treatment within the non-governmental sector (for example, through medical aid schemes, workplace treatment programmes, donor-funded non-profit organisations, etc.) (DOH 2006:29-30). Estimates by the Joint Civil Society Monitoring Forum in 2007 put this figure at around 100 000 people.

The 2010 DOH report to UNGASS documents that South Africa is rolling out the largest ARV programme in the world. By the end of November 2009 833 653 adults (55% of adults who were in need of treatment) and 86 270 children (81% of children who were in need of treatment) were on ART (DOH 2010a:43-44). However, the exact figures are still not known and "remain a challenge" (DOH 2010a:45).

As there is no accurate estimate of the number of people receiving treatment, it is difficult to put a figure on the numbers still needing treatment. The best available estimate comes from the Actuarial Society of South Africa (ASSA) model (ASSA 2008). Assuming that by June 2008 495 000 people were receiving ART, the model estimated that 520 000 still required treatment. In other words ART rollout was reaching less than 50% of the people urgently requiring such treatment to stay alive. It has been estimated that a further 1.2 million people were in need of ART by 2011.

According to ART-LINC (2010), most people start treatment programmes too late, which limits the effectiveness of health outcomes. For instance, in South Africa until

2011 ART treatment only commenced when the CD4 count fell below 200 cell/mm3, by which time a person's immune system had already been compromised and as a result it may not have been as effective compared to a situation where treatment had commenced earlier. The WHO (2010b) has in fact issued revised treatment guidelines recommending earlier initiation of antiretroviral therapy, at a CD4 count of 350 cells/mm3, which the South African government has accepted. However, the implication of the implementation of this recommendation is that it puts pressure on an already strained health budget, as well as human resources and public health facilities, at a time when international donors are tightening their purse strings.

Having gleaned something about the extent of HIV/AIDS and, in particular, its effect and impact upon sub-Saharan Africa in terms of numbers, we shall now consider how the disease is transmitted and the treatment that is currently available. The reason for examining these areas is that I believe that the church cannot begin to have a vision of transformation without knowing about the disease and the many facets that have to be addressed, if it is to have an impact on halting the progress of the epidemic.

2.6   Modes of HIV transmission

In an HIV-infected person, the virus is present in the blood (including menstrual blood), semen, vaginal fluid and breast milk. However, the virus can only be passed on to another person if any one of these fluids gets into the body of another person. It is thought that the level of virus in the saliva or in the tears of an infected person is too low to be infectious. HIV is not present in urine, faeces, vomit or sweat.

The main ways in which the virus can be transmitted are indicated below (Levy 2007):

- through unprotected vaginal or anal sex (HIV is unable to pass through condoms, where these are used properly);

- through blood-to-blood contact, i.e. through blood transfusion (as was the case prior to the screening of blood products), sharing of injecting equipment (especially where injecting drug users share their needles) or through occupational accidents (for example, a needle-stick injury);

- perinatally or vertically, from mother to baby, during the course of pregnancy, childbirth or breastfeeding (often referred to as mother-to-child-transmission or MTCT, although there is some controversy about the term, as it implies that some element of blame attaches to the mother).[12]

For HIV to be transmitted, besides the live virus being present, there have to be two further conditions: first, there has to be a sufficient amount of the virus present, and secondly, the virus has to get into the body of the uninfected person through a route where there are susceptible receptor cells and inadequate host defences (i.e. where there is a plentiful supply of vulnerable cells, such as the vagina).

In addition, physical co-factors make transmission more likely. For example, having a sexually transmitted infection (such as herpes, gonorrhoea, chlamydia and syphilis) or where a person is at his or her most infectious stage (i.e. when there has been primary infection, before antibodies are made by the immune system) or during the symptomatic phase of the disease (Anzala *et al*. 2000; Wiley *et al*. 2000).

For people infected with HIV, safer sex is highly recommended as, apart from the need to avoid infecting others, there is a danger of re-infection with HIV or super-infection with drug-resistant strains of HIV. There are many different strains of HIV and if one is infected with one particular strain, there is the possibility of being infected with another HIV strain. The implication of this is that a person's immune system might then find it difficult to cope, leading to more rapid disease progression.

Studies suggest that men who are not circumcised stand a greater chance of HIV infection, because of the vulnerability of cells in the tissue of the foreskin. Recent research in South Africa (Auvert *et al*. 2005), in Kenya (Bailey *et al*. 2007) and Uganda (Gray *et al*. 2007) have demonstrated that male circumcision reduces the risk of male-to-female HIV transmission by about 60%. Male circumcision in sub-Saharan Africa varies according to religion, ethnicity, cultural practices, etc. In South Africa it is estimated that 35% of males are circumcised (Shisana *et al*. 2005) and it is therefore not a universal cultural practice.

---

[12] See, for example, a document issued by Pathfinder International (2005) which makes it clear that "[i]t is important to recognise that the use of the phrase MTCT in no way is intended to place blame on the mother, who may or may not know her HIV status, who transmits the virus to her child" (2005:2).

Auvert *et al.* (2005) sound a note of caution in relation to male circumcision: where performed under poor hygienic conditions, it can lead to HIV infections, permanent injury and even death. Furthermore, during the healing period, sexually active men are at a higher risk of HIV infection. There is also a danger that male circumcision could be perceived as offering full protection, resulting in men not taking safer sex precautions, such as using a condom, or even engaging in riskier sex practices. Finally, the researchers point out that there is a danger of confusing male circumcision with female circumcision.

Secondly, non-infectious co-factors, such as age, also increase the possibility of HIV transmission. For example, research in Europe has shown that progression to AIDS is faster the older one gets and particularly when infection occurs after the age of 40 years (Darby 1996; Collaborative Group 2000). Disease progression is also faster among young children. Malnutrition too can play a role in worsening immune function. Furthermore, factors such as malabsorption, diarrhoea and a deficiency in calorie intake or protein also hamper chances of survival (Sinyinza *et al*. 2004).

I shall now attempt to set out how the disease progresses following its transmission.

2.7   HIV and disease progression to AIDS

In Chapter 1 the point was made that HIV is not the same thing as AIDS. In simple terms, HIV is a retrovirus, which means that the virus copies itself into the human cell that it has infected. It then hijacks and attacks the most important cells of the human immune system, namely the CD4 or T helper cells. In so doing, it reduces the number of healthy CD4 cells in the body, progressively weakening a person's immune system. The immune system enables the body to defend itself against infectious agents, abnormal cells (such as cancer cells) and alien cells. If the immune system is not able to fulfil this function, the body is rendered defenceless.

The response to HIV infection differs from person to person. Some people remain healthy and active for 8 to 13 years with little sign of immune suppression (Babiker *et al*. 2000:1131). Others deteriorate rapidly and develop full-blown AIDS within a much shorter period of time. Before the advent of ARVs, once a person had progressed to AIDS, they died on average within 9 to 24 months (Babiker *et al*. 2000).

Evian (2000) outlines progression of HIV may be a result of various factors including:

- The strain or sub-type[13] of HIV with which one was infected (of which HIV-1 subtype C is the most prevalent [and most virulent] in southern Africa);

- Whether, when a person was infected, there was a higher or lower viral count in the blood or semen of the person who was HIV positive;

- The general health of the person during the course of the disease.

People who are ill owing to poverty, malnutrition, infections, repeated pregnancies or anaemia experience a much more rapid deterioration in health, compared to a healthy individual. Furthermore, disease progression is more rapid where people are suffering from chronic illnesses such as malaria and TB, as their immune system is already compromised.

While considerable progress has been made to prevent the rapid progression of HIV (through the use of ARVs), there has been no success in devising a vaccine to make the body immune to the virus.[14] Once in the body, the virus is impossible to eliminate completely. Thus, the only way to stop AIDS is to prevent HIV transmission.

The health of an HIV-infected or HIV-positive person depends on the condition of his or her immune system. Because HIV mainly kills the CD4 cells, the measure of CD4 cells provides a good indication of the status of a person's immune system and therefore of how vulnerable a person might be to an opportunistic infection. The status of a person's immune system can also be assessed by measuring their viral load: a higher viral load invariably means a lower CD4 count (although it should also

---

[13] HIV strains are classified into three groups (M, N & O). M viruses are then further subdivided into subtypes or clades, by using the letters A to K. The epidemics in Southern Africa, India and China are predominantly HIV-1 subtype C, while in Europe, North America, Australia and Japan the predominant strain is HIV-1, subtype B. HIV-2 is classified into genetic subtypes A to G. These differences in strains and clades pose significant challenges for the development of a vaccine.

[14] Vaccines act to prevent or control infection by an infective agent or pathogen. A preventative vaccine would therefore be given to prevent someone who is uninfected from becoming infected with HIV or, at the very least, to prevent the disease from being transmitted. A vaccine could also be developed as a therapy for those living with HIV in order to prevent disease progression. However despite nearly 25 years of research, a preventative vaccine has still not been developed. In September 2009 it was reported that in a trial involving some 16 000 people in Thailand a combination of two vaccines lowered the risk of contracting the disease by 31.2%. Although this particular vaccine is not viable for use globally to prevent HIV, it does give cause for hope (Laurance 2009).

be noted that a lower CD4 count could also be as a result of stress, influenza, etc.) and therefore a greater probability of being susceptible to infections.

In examining the issue of care, it is important to have regard to the stages of HIV infection, although these are not in reality clearly defined or delineated phases. An opportunistic infection[15] could strike where the body's immune system is depressed (because of a higher viral load and a lower CD4 count). On the other hand, a person may be clinically defined as having reached the final AIDS stage, but with antiretroviral treatment, they may be pulled back to an early stage of the disease.

The WHO (2005) classifies the disease into four phases. However, before these phases, there must first be the infection.

Normally, six weeks after infection with the HI virus, a person's HIV status changes from HIV negative to HIV positive. This phase of seroconversion is accompanied by influenza-like (or 'flu-like') symptoms (Schoub 1999).

In the weeks following infection, the HIV viral load is normally very high (as the immune system has not had time to build any defence or responses) and as a result the HIV positive person is highly infectious. Furthermore, because a person's immune system has not had the time to produce antibodies in response to the attack by the HI virus, an HIV test (which is usually an antibody test) will not be able to pick up the virus. Accordingly, the HIV status of a person may not be known during this stage of infection. This is called the window period, because although the virus is present in the body, it cannot be detected.

The viral load in the body then decreases some 16-24 weeks after infection, as the immune system has had time to develop a response to the HI virus. The CD4 cell count rises, but the HI virus nonetheless continues its attack on the immune system. Thus, although the viral load may be "undetectable", it should be noted that the virus is still present in the body.

---

[15] In a healthy person organisms do not cause a person to become sick (in other words, the organisms are not pathogenic). However, where the immune system is unable to defend the body, such organisms take the opportunity to attack the body, hence the term "opportunistic infections".

The disease then progresses to what the WHO (2005:5) defines as the asymptomatic latent stage or Clinical Stage I (however, the virus is never really latent (Evian 2003)). At this stage a person who is HIV positive displays no symptoms and they feel perfectly well but it is possible to infect sexual partners unknowingly, unless one has taken the HIV antibody test and safer sex precautions.

When symptoms of HIV disease begin to manifest themselves, this is known as Clinical Stage II. The symptoms may be minor (such as swollen lymph nodes or fevers) – or more serious (and painful), such as herpes zoster and upper respiratory tract infections. Weight loss of up to 10% of normal body weight and general fatigue may also occur (WHO 2005:5, 20-21).

As the immune system begins to deteriorate, the symptoms begin to worsen and opportunistic infections take hold; this is known as Clinical Stage III (WHO 2005:22-23). The virus may attack immune cells in the brain, causing HIV-associated dementia, or it may result in tumours or the so-called "wasting syndrome".[16] Old infections may also recur, such as malaria, TB and herpes. In other words, the symptoms signal advanced immune deficiency. According to WHO (2005), a person who has reached this stage of HIV disease will usually be bedridden for up to 50% of the day in the course of a month. At this stage the CD4 cell count normally drops between 200 and 350 cells/mm3 (WHO 2005:8).

When a person progresses to the severe symptomatic stage, they are said to have AIDS. In the final stages the symptoms of HIV become acute, as the immune system is unable to respond. Rare, persistent or untreatable conditions begin to manifest themselves such as severe diarrhoea, oral infections such as thrush, skin infections, respiratory infections (particularly PCP or pneumocystis carinii, a fungal infection of the lungs), wasting of the body and weight loss, nerve diseases (such as peripheral neuropathy), skin cancers such as Kaposi Sarcoma, etc. (WHO 2005:24-28; Mandell

---

[16] Involuntary weight loss is one of the most common symptoms of HIV and it is usually caused through malabsorption, diarrhoea, etc. It usually indicates that the disease has progressed. If weight loss is also caused by malnutrition, the likelihood of immune suppression increases. "Wasting syndrome" is a technical term that indicates weight loss of 10% or more of body weight in the absence of any other explanation.

et al. 2009).[17] At this stage, therefore, there is much need for practical help in terms of patient care and care for the family/caregivers. The CD4 count in such patients tends to be below 200cells/mm3. Correspondingly, the viral load is very high and a person is highly infectious.

While infections and diseases such as vaginal thrush, herpes, TB, etc. can occur in all people, such infections in HIV positive people tend to be more severe and common (Mbuagbaw *et al*. 2006; Mandell *et al*. 2009; Sanyaolu *et al*. 2011).

There is no single test for AIDS. Normally a doctor would look for an AIDS-defining illness such as PCP, together with underlying immune deficiency. However, countries such as the USA have developed their own definitions of AIDS: the Centres for Disease Control, for example, defines a person as having AIDS if he or she develops pulmonary TB, recurrent bacterial pneumonia, invasive cervical cancer or a CD count of less than 200 cell/mm3 (WHO 2005:8). In developing countries, however, the WHO definitions are used, as they comprise clear clinical markers and do not therefore require complex – and expensive – diagnostic tools (WHO 2005:7).

As opportunistic infections are likely in persons with a depleted immune system, it is better to try and prevent the infections from occurring by initiating prophylactic treatment (or preventative treatment). Where therefore a person has experienced TB, but as yet there is no sign of active TB, prophylaxis should be commenced, especially where the CD4 count is low (Martinson *et al*. 2011). The use of prophylaxis and ARVs can increase survival rates among people with HIV.

Similarly, oral and vaginal thrush are common when the CD4 count drops below 350 cells/mm3 and they can be prevented from occurring through medication. Diseases such as influenza and hepatitis B can also be prevented through immunisation. Indeed, the South African (SA) HIV Clinicians Society (2005) recommends prophylactic treatment to prevent PCP, bacterial infections and diarrhoea.

---

[17] For a fuller and detailed explanation of the clinical manifestations of HIV, see in particular Mandell *et al*. (2009).

2.8   Treatment

Once a person is infected with HIV, there is no cure for the disease and the virus remains latent in the body until the conditions are ripe for it to be reactivated. There have, however, been enormous strides made in keeping the virus under control through the use of antiretroviral therapy, and in particular highly active antiretroviral therapy (HAART) the purpose of which is to slow down the development of the disease by lowering the viral load in the body (Volberding & Deeks 2010). As a result of medical advances, HIV infection can now be considered to be a chronic but manageable disease. Combination drug therapies are said to have a "Lazarus" effect as people dying of AIDS can stage a remarkable recovery (Brashers *et al*. 1999:215).

Since 1996 the use of triple-drug therapy or HAART has been available to adequately manage HIV. The SA HIV Clinicians Society (2000) makes the point that ARV therapy not only suppresses viral replication, but also reduces morbidity and mortality. Triple combination therapy (using three antiretroviral drugs) is recommended as the optimal standard of care, as it not only results in viral suppression, but it also reduces the possibility of drug-resistant viruses.

HAART can be said to play a role in the prevention of HIV, because it may reduce the risks of the virus being transmitted between infected and uninfected sexual partners when engaging in unprotected sex. This view is contentious, however, as there is some evidence that HAART might encourage risky or unsafe behaviours (Quinn *et al*. 2000). However, the results of the most recent study funded by the National Institutes of Health (NIH) has confirmed that treating HIV-positive people with ARV drugs reduces the risk of transmitting the virus to HIV-negative sexual partners by 96% among heterosexual couples. The study, called HPTN 052,[18] enrolled 1 763 HIV-serodiscordant couples (in which one partner is infected with HIV and the other is not) in Africa, Asia, North and South America (HIV Prevention Trials Network 2011). The study also demonstrated that early ARV treatment reduced by 40% the incidence of TB in HIV-infected patients. Furthermore, it evidenced that HIV-infected patients benefit from taking ARVs when their CD levels are between 350 and 550,

---

[18] The report was presented to the IAS Conference on HIV Pathogenesis, Treatment and Prevention, 17-20 July 2011, Rome, Italy.

thereby protecting their partners, while improving their own health (Cohen *et al*., 2011). This of course raises the issues of costs, funding, sustainability and the capacity of the public health system.

The results of two studies (the TDF2 and University of Washington studies),[19] released mid-2011, also illustrate that a daily oral dose of antiretroviral drugs, used to treat HIV, can reduce HIV infection among uninfected individuals exposed to HIV through heterosexual sex. The Botswana study found that the risk of transmitting HIV through the once-daily drug was reduced by 63%. The strategy of providing ARVs to uninfected individuals prior to HIV exposure is called pre-exposure prophylaxis or PrEP. In a similar study, conducted in Uganda and Kenya by the University of Washington, it was found that the provision of antiretroviral drugs to serodiscordant couples significantly reduced HIV transmission. ARVs are therefore a powerful tool in a prevention strategy.

ARV therapy can also be utilised to prevent infection with HIV in other ways, for example, where there has been exposure to the virus as a result of a needle-stick injury. Additionally, ARVs can be used to try and prevent HIV infection in a case where someone has been raped or sexually assaulted (Linden 2011). In such cases post-exposure prophylaxis (PEP) must commence within 72 hours, for a period of 28 days (rather than for life, as is the case in the treatment of HIV).

Women with a high viral load and who are pregnant are likely to transmit HIV to their children (transmission rates range from 30% to 45% two years after delivery, with 15% to 25% of transmissions occurring during pregnancy, especially during delivery). Accordingly, treatment with antiretroviral prophylaxis during pregnancy, aims to reduce the viral load in the mother (Ellington *et al*. 2011). A drug such as AZT, taken during pregnancy can, reduce the risk of transmission from mother to baby by two thirds (Laher *et al*. 2012). Planned caesarean delivery can also reduce the risks of transmission in women who do not take any treatment.

---

[19] The results of these studies were announced at the International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention (www.ias2011.org). The TDF2 study was conducted by the Centre of Disease Control (CDC) and the University of Washington study may be found at http://www.uwicrc.org.

As noted earlier, in the developed world the preferred choice of treatment during pregnancy is triple combination antiretroviral therapy. Because of the costs involved, however, in resource-limited settings shorter treatment regimens have been used, such as a single dose of nevirapine, comprising one dose to the mother at delivery and one to the baby within 72 hours of birth. This intervention is simple, effective and the costs are minimal.

ARV therapy, however, is not a panacea for being restored to good health. It has side effects ranging from diarrhoea, nausea, vomiting, fatigue, headaches and skin rashes to more serious reactions, such as peripheral neuropathy (tingling in the hands and feet, which could lead to nerve damage). Experiencing side effects is one of the most common reasons for low adherence (Chisholm 2009).

ARV medication has to be taken every day for life to ensure that the virus is kept depressed and in order to avoid drug failure and the risk of mutation. The drug regimens may vary from once a day to four or more times a day. The absorption of the drugs is affected by either the presence or the absence of food in the stomach and it is therefore important that some drugs are taken with food and others without. The total number of tablets to be taken each day can increase from one (containing three different drugs) taken twice a day to more than 20 taken at different times of the day. If a drug dose is missed, the virus may develop ways of resisting the drug and so adherence is a vital aspect of treatment. Accordingly, a patient must not only be committed to keeping to a strict medication regimen, but also be prepared to deal with side effects, as well as ensure that they will commit to monitoring their CD4 counts and viral load. It goes without saying that they require the necessary support mechanisms to ensure that they adhere to the treatment regimen. Adherence can prove to be an insurmountable challenge for some people (Walsch *et al.* 2001).

Research demonstrates that an adherence of 95% is critical to achieve viral suppression and to delay the onset of treatment failure and drug resistance (Paterson *et al.* 2000; de Olalla *et al.* 2002). It is also vital to stick to the prescribed dose and regularity as taking too little of the drug (by missing or reducing a dose), allows the drug levels in the blood to fall to sub-optimal levels, thereby allowing viral replication to occur and increasing the risk of resistance. This dimension of care is also important to bear in mind.

74

2.9   Some burning issues

Despite knowing a great deal about HIV/AIDS and acknowledging the fact that there is still a great deal that yet needs to be learned, there are many issues that churches need to address if they are to render care in a meaningful, people-centred developmental manner that is aimed not only at stemming the tide of the disease but also transforming hearts, minds and actions. Churches need to examine and speak out on issues that can be used to motivate people and bring them together around a vision of defeating the scourge of HIV/AIDS, rather than hedging around – or indeed, not even discussing – issues that are relevant, pertinent and important.

The transmission of HIV also takes place in a context – not least the context of cultural, social and political situations. Churches need to take account of these if they are to offer a vision that is transforming and meaningful, rather than charitable.

HIV in Africa, and certainly in South Africa, is largely sexually transmitted. It therefore touches upon an intimate aspect of life and one that needs to be spoken about. Making moral judgements are not helpful in such discussions, because they only lead to people not talking about the issue and hiding the reality of their behaviour or situations. The heterosexual population is particularly badly affected. Babies have also been affected through MTCT. AIDS has also affected the homosexual community. Transmission through injecting drug use has been relatively uncommon in South Africa, but is becoming increasingly widespread.

There are then key population groups that are at a higher risk of contracting HIV. However, it is these very groups that have been neglected (for example, men or women who have a number of sexual partners, sex workers, men who have sex with men, and people who inject drugs). A question that needs to be asked, therefore, is what resources have been directed by the churches towards addressing the needs of these populations, including providing support for them? Moreover, how have the churches sought to protect their rights where there has been discrimination, stigmatisation, abuse and vilification? Although South Africa has laws protecting the rights of marginalised groups and/or those who are HIV positive, the question is whether the laws that are meant to protect them are being effectively enforced.

It must be made clear, however, that what I am not suggesting here is that there should be different standards of care or treatment according to the circumstances under which a person contracts HIV. There must, in other words, be no distinction between the care of people who have contracted the disease "innocently" (for example, through blood transfusion) and those who are alleged to have contracted the disease through "guilty or morally questionable conduct", that is to say through sexual intercourse, for example, outside marriage.

Below I set out some of the issues that the churches need to confront and address, if they are to meaningfully engage in HIV/AIDS as a developmental issue.

2.9.1   *Prevention*

In relation to HIV/AIDS, the churches have provided or motivated their congregations to give practical help in relation to treatment. However, with regard to their efforts in relation to prevention and education, their role has been questionable.

Sustaining a robust prevention response is identified by UNAIDS (2008) as a major problem and challenge for countries. It therefore urges them to "nurture a prevention movement" (UNAIDS 2008a:17) and to build human and technical capacity to sustain prevention efforts. Community mobilisation is seen as critical to the success of prevention initiatives. However, the report goes on to point out that where prevention has succeeded, a popular movement has endeavoured to make risk prevention a norm, generating a strong demand for prevention services. It is acknowledged that such a movement requires strong leadership to make national government and other stakeholders accountable for their HIV strategies (UNAIDS 2008a:29). In this context the question must be asked as to whether the churches have provided such leadership either through their own initiatives or by demanding accountability on such prevention strategies that have been adopted by government.

HIV-prevention investments are about 22% of all spending in 106 low- and middle-income countries. In responding to the epidemic however, planners and implementers have failed to focus prevention efforts where they have maximum impact; HIV-prevention investments do not always follow epidemic patterns (HIV Prevention Resource Gap 2003).

In relation to HIV-prevention, the churches have focused on abstinence from sex until marriage and then marital faithfulness to one partner. As an example of the effectiveness of the churches' message, Uganda is often hailed as a success story, as the HIV prevalence rate fell from 15% in 1991, to 5% in 2001. Religious organisations are credited with having played a part in the fall of HIV prevalence because of their emphasis on abstinence and monogamy, which had some effect on reducing sexual partners and delaying the age at which young men and women engaged in premarital sex (Green 2003) (but see section 2.9.3 below).

The success of the Ugandan campaign is also attributed to the fact that the churches, along with Islamic religious organisations, other traditional religious groups, non-governmental organisations and the state, all joined together to work on AIDS prevention. In fact, 4 500 church personnel received AIDS-prevention training (Green 2001:4). This is not to say, however, that condoms too have not played their part in HIV-prevention in Uganda (indeed, some 14 million condoms were estimated to have been distributed in 1997 (Green 2001:3)).

However, a document by Strategies for Hope Trust (Williams 2007:1) states that despite the fact that HIV transmission in most countries occurs sexually, "it is rarely discussed in church circles in an open, non-judgmental way". The organisation therefore calls for the silence to be broken, not only in relation to HIV/AIDS, but also in relation to sex, sexual behaviour and the unequal relationships between men and women. Indeed, a ARHAP report (2006:7), pleads for religious organisations to advocate for non-discrimination and for the church to declare that HIV is not necessarily "an immorality disease and to accept HIV/AIDS like any other illness". Birdsall's research (2005) confirms the fact that the churches' prevention work rarely extends to the distribution of condoms (or it is speculated, to advocacy on circumcision or voluntary counselling and testing).

Cherian (2004) also explains that religion even influences the teaching of HIV "life skills" in schools, as it restricts what can and cannot be taught. Of course, the fact that HIV/AIDS is predominantly sexually transmitted in South Africa has made the support of sex education more problematic for the churches. However, as has been pointed out by Padayatchi *et al.* (2010) school-based interventions to promote knowledge of HIV status and to incentivise young people to remain uninfected is

crucial and so church attitudes on the matter may be taken as an example of change being inhibited.

According to Department of Health figures (2007), young people between the ages of 15 and 24 years are vulnerable to HIV infection, particularly young women, who are three times more likely to be infected (12.7%, compared to 4% among males of that age group). Pettifor *et al*. (2004) state that 28% of young women report that they did not want their first sexual encounter. Churches however, avoid discussing matters of a sexual nature and therefore contribute, in part, to the stigmatisation of people who engage in sex, whether voluntarily or involuntarily (Messer 2004).

Eriksson *et al*. (2010) sought to examine: how the attitudes of Christian leaders in Durban, KwaZulu-Natal, had changed in relation to sexuality, in what ways the leaders addressed young people through preventative messages and how the church leaders addressed the issue of stigma. They found that the churches they examined faced three dilemmas: breaking the silence around HIV/AIDS, ambivalent messages on prevention to young people, and gender differences in prevention messages.

In relation to breaking the silence on HIV/AIDS, church leaders faced two problems: first, they felt a lack of freedom in being able to talk about the issue, and secondly, they faced a potential conflict with their congregations and church hierarchies. With regard to ambivalent HIV-prevention messages from church leaders to young people, the churches recognised that while they preached a message of sexual abstinence, young people were sexually active. However, they felt that it should be the parents who talked to their children about sex and they were reluctant to talk about condom use. With regard to gender inequalities, Eriksson *et al.* (2010:111) concluded that church leaders were inconsistent when speaking about equality of treatment; "their messages were shaped by patriarchal norms".

At the Fifth International Aids Society Conference on HIV Pathogenesis, Treatment and Prevention it was pointed out that, of the young women attending a clinic in KwaZulu-Natal aged 15 years, none were HIV positive. At the age of 16 years, however, 10% tested positive and at the age of 22 years 66% tested positive. The effectiveness and value of the abstinence campaign was therefore brought under the spotlight and questioned in terms of preventing HIV infection (Thom 2009a).

It is also rare for the churches to talk about other related issues that also have an impact on prevention, such as delaying the age at which first the sexual encounter occurs, or the fact that anal sex or sex during menstruation pose greater risks. Sexual practices such as "dry sex", where substances (usually herbs) are used in the vagina to dry it, in order to give greater pleasure to the man, are also hardly ever mentioned (Morar *et al*. 2003; Saethre & Stadler 2009).

Furthermore churches continue to struggle with the issue of condoms as a mode of HIV-prevention, although this is one of the key ways in which transmission of the disease can be prevented. While it is agreed that it is better to avoid the risk of transmission rather than to try and prevent it, we are faced with the reality that people do engage in pre- and extra-marital sex.

Churches, such as the Catholic Church, condemn the use of condoms on the basis that it is a contraceptive and therefore immoral (Catechism of the Catholic Church 1995: 2370). The rationale being that it renders procreation impossible and, furthermore, it turns the act of love into a selfish search for pleasure. The Catholic Church has also questioned the protection that condoms offer. It has therefore reiterated time and again that abstinence and marital fidelity are the only moral choices open to Christians. However, even in the Catholic Church there is confusion in the Church's message (or in the interpretation of the Church's message): for example, during a visit to Botswana in 2009 the leader of the Catholic Church, Pope Benedict XVI, said that condoms were not a solution to the AIDS epidemic. His comments were generally interpreted as the church being against the use of condoms under any circumstances. In a book interview, however, the Pope said that in some specific cases (for example, where a prostitute seeks to diminish the risk of spreading infection), the use of a condom would be a first step towards taking moral responsibility for one's actions (Seewald & Pope Benedict XVI 2010).

Other denominations condemn the promotion of condoms on the basis that it promotes the early initiation of sex among young people and/or it encourages extra-marital relationships. This also puts churches on a collision course with the government and secular agencies, which advocate the use of condoms as a tool in the prevention of the spread of HIV.

By way of contrast, the South African Council of Churches (SACC) has issued a strong statement in support of the continued public distribution of condoms to control HIV transmission. In their press release of 4 February 2005, Rev. Dr Molefe Tsele, the General Secretary of SACC, expressed "shock and dismay at continuing assertions that condoms 'don't work' as a means of preventing the spread of HIV" (Aidsmap News 2005). Nonetheless he acknowledged that there were "continuing disagreements" among the Council's 26 member denominations about "the moral implications of condoms" (Aidsmap News 2005).

Churches have, moreover, been happy to accept funds from PEPFAR,[20] the United States' US$15 billion anti-AIDS plan. Under the PEPFAR terms, however, recipients of funds are obliged to commit at least one third of their resources to programmes that stress "abstinence-until-marriage" as the primary prescription for halting the spread of HIV (PEPFAR 2005:18). While this may salve the churches' conscience, the question must be asked whether it is right that an important preventative measure should be side-lined. Furthermore, condom distribution is limited to groups that engage in "risky behaviour" – mainly sex workers and couples where one partner is HIV positive and the other is not. This could well be considered as a form of labelling of groups that already feel marginalised and alienated.

Interestingly, Christian churches have not responded, as far as I am aware, to a proposal made by two leading HIV researchers, namely Professor Alan Whiteside and Dr Justin Parkhurst (2010) that countries worst affected by HIV should promote a national month of sexual abstinence. The authors say that sexual abstinence could slow the spread of HIV by interrupting the chain of transmission during the primary, highly infectious stage of HIV infection (see section 2.7 above), which they believe accounts for anywhere between 10% and 45% of new HIV infections.

The above-mentioned researchers believe that community mobilisation could work in the implementation of this suggestion and, furthermore, it would provide a one-off, short-term, cost-effective plan that would be easy to monitor and would not lead to stigmatisation. A month of "safe sex/no sex" could also produce easily verifiable data

---

[20] PEPFAR is the acronym for the President's Emergency Plan for AIDS Relief.

with regards to adherence, as evidenced by the number of births occurring nine months after the campaign.

This sort of initiative, which would seem to conform to the churches' teachings on abstinence, is one that could be promoted among church communities. Thus far, however, it would appear that the churches have chosen not to respond. One could speculate that this is because they continue to feel uncomfortable talking about sexual matters.

Access to treatment, or rather the lack of access, is also a determinant in the spread of HIV. In countries such as the United States, Europe, Australia, New Zealand and Japan HAART has become the normal standard of care, but the picture of treatment elsewhere in a world is rather more fragmented. In South Africa, for example, gaining access to treatment has been a prolonged battle and research by Wood *et al*. (2000) has demonstrated that triple antiretroviral therapy for a quarter of HIV-infected South Africans would have prevented an estimated 431 000 new AIDS cases between 2000 and 2005, besides having a knock-on effect on the rate of HIV transmission.

However, the cost of antiretroviral treatment is such that the drugs remain out of reach of the vast majority of the population. A large part of the costs of the drugs derives from patent legislation, which entitles pharmaceutical manufacturers to retain exclusive rights over their drugs for 20 years (for a detailed discussion see Chapter 3, section 3.4.3). Individual countries can, however, over-ride the exclusive rights of a patent holder and issue a licence to another manufacturer, in circumstances where the government considers it to be necessary (for example, in a national emergency situation). This has been done in India, where the costs of the drugs have been reduced by a fifth. However, the United States government and pharmaceutical companies have been very strongly opposed to compulsory licensing, making access to health problematic (Waning *et al*. 2010). It is in areas such as this, where the international trading system produces injustice and hardship for the sick and the poor, that the churches might have been expected to advocate, but it appears that they largely chose to opt out of the debate.

Since ART has been provided through public health facilities in South Africa, the challenge has been one of delivery: the accreditation of ART public health facility

sites has proved to be fraught, along with the supply of appropriately trained health personnel and the registration of antiretroviral drugs. As a consequence, South Africa has fallen woefully short of the targets it set out in the 2007 National Strategic Plan (NSP) which committed the government to: reducing the rate of new HIV infections by 50% by 2011; expanding access to treatment, care and support to 80% of all HIV-positive people and their families by 2011; and reducing mother-to-child transmission of HIV to less than 5%. In terms of treatment, in 2008, only 40% of the new need was met, owing to a shortfall of funds (Cleary & McIntyre 2010).

The issue of prevention may therefore be seen as problematic for the churches. In addition however, it is relevant to ask to what extent, if at all, they have held government to account in respect of the targets that it has not met.

2.9.2 *Gender imbalance*

The issue of power relations between genders, particularly the lack of power of women to enable them to make the right choices, is important in the fight against HIV/AIDS. The majority of the churches' complicity in allowing men to dominate women, through the patriarchal way in which they are structured and their interpretation of the Bible, is relevant in this debate. As Dube argues (2004:202), biblical interpretations support the patriarchal nature of African culture in ways that "increase the likelihood that women will become HIV positive".

AIDS raises complex issues, such as sexual ethics, patriarchy and stigmatisation. And as Steve de Gruchy so rightly states, the disease also raises key issues that "that go beyond just the question of morality – to the issue of power relations between men and women" (De Gruchy with De Gruchy 2004:236). De Gruchy calls for the church to listen to the insights of women Christians, pastors and theologians so that it is influenced and guided by them in relation to matters of patriarchy and gender justice. He makes a persuasive case for the church to look at the issues of injustice, exclusion and violence that women in South Africa face for no other reason than "*because they are women*" (2004:239, emphasis in original). He says that the roots of gender justice are to be found in the Bible, which speaks of human rights and the provision of justice for all. However, he speculates whether the church is up to the task, because it is incapable of dealing with "human sexuality in anything other than a patriarchal mindset … and by a wilfully selective reading of the Bible" (2004:239).

The social context in which relationships and interactions between men and women are formed needs to be taken into account. As Jacobs (2003) points out, for patriarchal domestic relations to be transformed, there is an urgent need to educate men. Furthermore, where gender equality becomes normalised and accepted, there is a greater chance of addressing the issues of domestic violence and HIV/AIDS. This is particularly relevant in sub-Saharan Africa, where women are more likely to become infected with HIV than men (UNAIDS 2010:130).

The role of women, however, is more fundamental in development. Korten (1990:168-169) in fact calls for an alternative human consciousness, one that brings more feminine consciousness to bear on development. He argues that in this way feminine values of "a nurturing family and community, place, continuity, conserving, reconciliation, caring and reverence for nature and the continuous regeneration of life" will be brought to bear on transformation. Surely these are the very qualities that are important in rendering care and therefore crucial in this regard. To what extent, however, have the churches been active in promoting these qualities?

According to Korten (1990:200-201), it is important for attitudes towards women to change. He says that we must recognise women as a "development force" and key to bringing about economic and political change. However, research by Marshall and Taylor (2006) that was conducted in South Africa, Zimbabwe and Burkina Faso, showed that the opposite was the case in relation to churches. Their research, which focused on the evangelical church, demonstrated that they were often complicit in reinforcing African cultural attitudes about women through the interpretation of biblical texts that refer to the submission of women. They further state in this regard:

> …in sections of the evangelical churches, conservative attitudes towards sex and women are more entrenched than in society as a whole. Church leaders and members believe, in some cases, that sex is to be endured rather than enjoyed as a gift from God, that it is inappropriate, within culture, to speak about sex, and that the Bible requires women to be submissive. These views are mutually reinforcing. The reluctance to speak about sexual issues means that the church is perceived to agree with traditional values (Marshall and Taylor 2006:366).

Phiri (2004) and Haddad (2006b) confirm the view that the church's stance on fidelity and abstinence would seem to suggest that contraction of HIV is a result of non-adherence to moral codes and as a consequence results in the stigmatisation of people. Unfortunately, it is women who have had to bear the brunt of stigmatisation.

Furthermore, UNAIDS (2001) notes that violence against women is deeply rooted in patriarchal stereotypes and gender roles. Often this results in the abuse of women being seen as "normal" or legitimate within domestic relationships. Violence or the threat of it, together with a fear of abandonment, prevent women from discussing issues such as safer sex, condom use or fidelity. It may also prevent women from terminating relationships that put them at risk of HIV infection (Weiss & Rao Gupta 2000). A study by Jewkes *et al.* (2010) in South Africa verified the link between violence and HIV infection. Power imbalances within relationships and intimate partner violence increase the incidence risk of HIV infection among young South African women.

An earlier study by Jewkes *et al.* (2009) on behalf of the Medical Research Council found that 28% of men admitted to having forced a woman or a child to have sex with them. Astonishingly, some of those interviewed had not realised that they had done anything wrong. In addition, 42.4% of men had been physically violent to an intimate partner (2009:2). The authors conclude that one of the reasons for the high prevalence of rape is "deeply embedded in ideas about South African manhood". The study therefore recommends that issues such as ideas of masculinity, which flow from notions of gender hierarchy and the sexual entitlement of men, be addressed (2009:2).

South Africa has in fact been labelled the rape capital of the world. A South African girl born today is more likely to be raped than she is to learn to read. Research by Seedat *et al.* (2009) has illustrated that deaths from violence and injuries in South Africa are almost double the global average, while the death rate of women killed by their intimate partners is six times the world norm. Indeed, 40% of men admitted to being physically violent toward their partners and some 27.6% of men admitted to having committed rape. While rates of other violent crimes have dropped, rates of rape have hardly fallen: in 2005–06, the rate was 117 per 100 000 – a decrease of only 6% from 1996. Since 1996 almost four in ten girls reported experiencing sexual violence before the age of 18, most of which went unreported (Seedat *et al.* 2009). In addition, some 35-40% of children have witnessed their mothers being beaten which, authors suggest, has implications for the way in which they will treat their own wives/partners. Seedat *et al.* (2009) conclude that various aspects of social dynamics support violence, including poverty, unemployment, income inequality, crammed

settlements, patriarchal notions of masculinity that valorise toughness (62% of boys over 11 years believe that forcing someone to have sex is not an act of violence), male disenfranchisement, risk taking, exposure to abuse in childhood, weak parenting, alcohol abuse, community acceptance, lax sentencing and poor law enforcement.

Watts and Garcia-Moreno (2000) also explain that power differentials within domestic relationships render women subordinate to their male partners, which again manifests itself in domestic violence, including rape and sexual abuse. Sexual and cultural norms also make it acceptable for men to have multiple sexual partners, whereas women are expected to be virtuous, which puts women at risk of contracting HIV from their partners. Research by Greig *et al*. (2008) demonstrate that all too often women do not have the capacity to negotiate safer sex or, indeed, access the health services that they require and therefore women need to be empowered.

Women are also expected to be seen to be "good" and therefore ignorant of sex. This may result in their being unable (or finding it difficult) to access information on preventative measures or appropriate medical advice on treatment and care (Carovano 1992; Weiss & Rao Gupta 2000; Rao Gupta 2002). The disempowerment of women (Campbell 2003) is therefore an important factor to which heed must be paid.

Additionally, other factors make women susceptible to infection. For example, in terms of physiology, women have a larger mucosal reproductive surface, which means that there is a greater risk of exposure to semen that is HIV infected. So too women have a higher risk of sexually transmitted infections (STIs) and therefore a greater vulnerability to contracting the HI virus (UNAIDS 2001).

The economically subordinate position of women may also result in their adopting survival strategies to ensure that they have access to food, shelter and other resources (Heise & Elias 1995; Weiss & Rao Gupta 1998). Gysels *et al*. (2002) has showed that such factors drive women into commercial sex work. Indeed, girls and young women may seek sexual relationships with older men, as a means to provide them with protection, money or goods. Demographic and health surveys in certain countries in Africa show that young women are at particularly high risk of HIV infection: women in the 20-24-year-old age bracket have much greater infection rates compared to women in the 15-19-year-old age group (Dunkle *et al*. 2004a; 2004b; 2007; Chatterji

et al. 2005). Research by Gouws *et al.* (2008) suggests that this is not only because young women are biologically more susceptible to HIV but also because they often have older male sexual partners, who are more likely than younger men to be infected with HIV. This is also borne out by research conducted by Dunkle *et al.* (2004a) and Wamoyi *et al.* (2008). According to them, while levels of HIV infection among men rise slowly and peak at a lower level than female infection rates when men are in their mid- to late thirties, prevalence among women rises rapidly at a young age, with higher peaks when women are in their late twenties.

Women who are poor are also likely to have restricted access to proper nutrition and sanitation, which increases their likelihood of contracting infections and succumbing to opportunistic infections. Haddad's research (2002; 2006a) confirms that poverty, racism and gender injustice have contributed to the burden that poor African women carry, making them more vulnerable to AIDS, as well as driving them into deeper poverty and marginalisation.

It is also important to address the traditional roles and societal values related to masculinity. Social conditioning results in masculine norms which influences sexual behaviour (Delius & Glaser 2002). Such roles and values may encourage boys and men to adopt risky behaviours. Men and boys are often encouraged to find it acceptable to indulge in heavy alcohol consumption, as well as engaging in concurrent sexual relationships, which increases their risk of acquiring and transmitting HIV. Norms relating to masculinity and femininity also stigmatise men who have sex with men.

Baral *et al.* (2008) have demonstrated that when men and boys receive education in HIV, sexual and reproductive health and gender issues, their behaviour can be changed for the better. However, do churches either run such programmes or promote greater involvement of men in such programmes, with a view to encouraging them to access HIV information, testing and treatment?

Haddad (in Phiri, Haddad & Masenya 2003:55) comments:

> The church can no longer assert to be the moral watchdog of society without challenging men to take responsibility for their sexual behaviour. Issues of gender violence, HIV/AIDS and the links between the two cannot be dealt with without addressing men's abuse of power relating to women and dare I suggest without

addressing the abuse of power within the structures of the church. One cannot theologise nor moralise while patriarchy continues unabated. And it is here that women need to take up the challenge. Women need to begin to take greater responsibility for breaking the silence of their oppression, abuse and disenfranchisement within the church.

The churches are well placed to address some of these issues, highlight them and speak out against practices that are harmful to relationships. To speak out, for example, about rape and sexual violence is an imperative, given the situation outlined above. The churches, however, seem to have avoided dealing directly and clearly on issues concerning gender roles and gender violence. Where state and legal authorities fail to protect the rights of women, surely we should expect churches to call for a society in which women and men are treated and treat each other with equality, dignity and respect. Whether – and to what extent – the churches have done so, however, is debatable.

2.9.3   *Discordant couples*

In sub-Saharan Africa by far the most common route of HIV transmission is through unprotected heterosexual intercourse. According to research by Cleland *et al*. (2004), there has been a rise in the number of discordant couples (i.e. where only one partner is infected), with the result that the risk of HIV transmission within long-term relationships increases. The problem is that such patterns of HIV transmission are hardly ever addressed in prevention education exercises and such serodiscordant couples rarely receive appropriate support. Do the churches acknowledge, let alone address, this issue? If prevention is to be effective, then I would suggest that the churches have to address key areas that are responsible for driving the disease.

Research has shown that it is not so-called "African promiscuity" that accounts for multiple partners, but rather the socio-economic circumstances peculiar to South Africa and, indeed, other parts of Africa (Saayman 1992; Whiteside & Sunter 2000). The South African economy depended on a system of migrant labour for its mines, which caused a breakdown in conjugal and parental ties. Today a different economic scenario may account for multiple partners: a man may leave his rural home to find work in the towns or cities. With high unemployment, he may find only temporary, poorly paid work, which would prevent him from marrying, because he is not able to

pay the bride's family *lobola* (a form of a dowry). He may therefore engage in a number of short-lived, multiple sexual relationships (Denis 2003:68-69).

Research conducted by Shelton *et al*. (2004) demonstrates that partner reduction has been key to controlling the HIV epidemics in Uganda and Thailand. As we have seen earlier (section 2.9.1) in Uganda, HIV prevalence fell from 15% to 5% in the space of a decade. Shelton *et al.* (2004) stress that each component of the ABC approach [abstinence, be faithful, use a condom] played an important role. However, the authors make the point that "the least recognised element, partner reduction, was probably key" (2004:891). Although surveys in Uganda conducted in the late 1980s and mid-1990s showed that young people initiated sexual activity at a slightly older age, and that condom use increased, these changes were not in themselves sufficient to result in the reduction of HIV prevalence seen in the country over the same period. However, further surveys showed that the proportion of men and women reporting multiple casual sexual partners fell substantially, and modelling suggests that partner reduction was sufficient to have a marked impact on HIV incidence. Moreover, evidence from the HIV epidemics among gay men in California, factory workers in Ethiopia and from men visiting sex workers in the Dominican Republic all show that partner reduction can play a key role in HIV-prevention (Shelton *et al*. 2004:892).[21]

The authors add that it is feasible to promote monogamy or partner reduction at the same time as either abstinence or condom use. They comment that "people seem generally able to grasp that the root problem with HIV transmission is risky sex and adopt the behaviour that best fits their circumstances" (Shelton *et al*. 2004:893). Although abstinence has a role in HIV-prevention for young people, the authors suggest that "it may be an unrealistic expectation" for others. Similarly, although condoms are highly effective at preventing HIV transmission, "in real life they are often used incorrectly or inconsistently" (2004:893).

Community leadership for all three elements of ABC are, however, needed to alter behavioural norms, the authors note. Again they cite evidence from Thailand and Uganda, where presidential announcements, the commitment of faith-based

---

[21] Here Shelton *et al*. (2004) cite Rotello (1997) and Low-Beer and Stoneburner (2003).

organisations, health service involvement and community mobilisation achieved a "tipping point" where "avoiding risky sex became the community norm" (2004:893).

As with the issue of condom use, are churches willing to confront and talk about issues such as discordant couples? Acknowledging the issue and talking about it would help not only to create awareness, but could also promote behaviour change.

2.9.4 *Same-sex relationships*

The issue of men who have sex with men (MSM) in sub-Saharan Africa has not received much attention. According to research by Smith *et al*. (2009), in 2007, the prevalence of male same-sex behaviour in the general population was estimated at between 0.03-0.9% in Kenya, 0.06-3.6% in South Africa, and 2.3% in Tanzania. HIV prevalence among African MSM was estimated to range from 7.8% in Sudan to 34.3% in Cape Town. Research by Lane *et al*. (2009), conducted in Soweto, shows prevalence of 13.2% among men who have sex with men. Furthermore, research indicates that the majority of men who have sex with men in sub-Saharan Africa also have sex with women, with all the implications of this for the spread of the disease. This is another issue that the churches are reluctant to discuss and rarely speak about. Homophobia and discrimination associated with MSM are rarely, if ever, addressed and thereby rendered invisible in the church's discourse on HIV/AIDS.

As documented by Stockman *et al*. (2010), recent attempts to criminalise homosexuality in Uganda and Kenya are likely to drive MSM behaviour underground rather than end it. This will impact upon public health efforts in HIV-prevention. Anti-gay or hostile sentiments that have been expressed by leading political figures in South Africa will not have helped either.[22] Such policies and sentiments subvert the health and human rights of sexual minorities and only help to fuel the HIV epidemic. While it is acknowledged that the conservative faction of the church sees

---

[22] For example, President Zuma is on record as saying that when he was growing up, "an *ungqingili* [a derogatory term for a gay person] would not have stood in front of me. I would knock him out." He is also said to have described same-sex marriages as "a disgrace to the nation and to God" (comments alleged to have been made at a public meeting to celebrate Heritage Day, KwaZulu-Natal, September 2006). Subsequently, Minister of Arts and Culture, Mrs Lulu Xingwana walked out of an art exhibition because of a photograph of two black lesbians kissing, which she described as "immoral, offensive and against nation building" (Xingwana 2009). Subsequently, Mr Jon Qwelane was appointed South African Ambassador to Uganda. He was recently found by the Equality Court to have made homophobic comments defined as hate speech by making derogatory statements about gays and equating same-sex relationships with bestiality (Chauke 2010; Etheridge 2011).

homosexuality as a moral issue and therefore non-negotiable and impermissible, there is still the issue of human rights and the equality and treatment of all human beings, irrespective of their sexual orientation.

South Africa has a progressive, liberal Constitution which offers protection to all peoples, regardless of race, colour, belief, gender and sexual orientation. However, the Constitution is at odds with the more conservative elements of the South African population, who are more inclined to support the prevailing patriarchal nature of society. The church has either condemned same-sex relationships or been ambivalent about them, causing alienation and/or hurt to many people. It has, moreover, failed to take a stand on a very visible form of social intolerance, namely homophobia.

"Corrective rape" is an issue that has been highlighted in recent months.[23] It concerns the rape of lesbian women, based on the notion that a woman's sexual preferences can be changed if she is forced to have sex with a man. Many of the victims of such crimes tend to be black, poor, lesbian women, who are already marginalised.

It is pertinent to ask what role, if any, the churches have played in transforming attitudes towards homophobia, rape, the trans-gendered population and people with different sexual orientations. Have the churches stood by or stood up when witnessing unjust and entrenched attitudes, practices and norms that have resulted in deep hurt and even death? Aside from the moral aspects (which the churches may find difficult to deal with), there are questions of human rights and legal activism. Have the churches become complacent? Is it the case that activism in relation to this issue is being left to professional and specialist bodies, without a recognition that the churches too have a role to play, if they are to transform society?

The churches need to act in solidarity with those who are marginalised if they are to realise a vision of a society that acknowledges that each person, irrespective of sexual orientation, is made in the image and likeness of God[24] and therefore is entitled to be treated with dignity and respect.

---

[23] In 2008 a lesbian woman called Eudy Simelane was raped and murdered. She was a well-regarded player for the South Africa women's national football team. Her rapists were convicted in 2011 of murder and sentenced to life imprisonment.

[24] Genesis 1:26.

Traditional religious teaching may interpret homosexuality as a personal choice of lifestyle that is sinful. AIDS would therefore become an expression of God's wrath on a particular people. While some argue that this is an incorrect interpretation of scientific information and a narrow interpretation of religious scripture or holy text, others cite selected passages from sacred texts to stigmatise and discriminate against individuals or certain groups of people, such as homosexuals infected with HIV/AIDS. The churches have an important part to play in relation to this issue, as its religious leaders are responsible for interpreting Scripture and shaping the minds of congregations. Religious communities and church members are also inspired by church leadership to care for those infected or affected, and involve themselves in the fight against HIV/AIDS. Religious leaders therefore bear a heavy responsibility in shaping the discourse and stamping out discrimination and stigmatisation.

A seemingly lone voice crying out against the injustice to people of homosexual orientation is the Anglican Archbishop Emeritus of Cape Town, the Most Rev. Desmond Tutu, who in a video message to the UN Human Rights Council said:

> I am proud that in South Africa, when we finally won the chance to build a new Constitution, we included sexual orientation in our laws, because we knew from our bitter experience that an injury to one is an injury to all … Sexual orientation, like skin colour, is a feature of our diversity. How sad it is that when God's children are facing massive problems – poverty, disease, corruption, conflict – we are so often obsessed with human sexuality … Gay, lesbian, bisexuals, transgender people are part of so many families. They are part of the human family. They are part of God's family. And of course they are part of the African family (Tutu 2010).

It would appear that there are very few churches and church leaders who are prepared to provide moral leadership in situations that are controversial or sensitive. Ultimately the question is whether moral principles such as basic human rights should be allowed to transcend cultural practice, religious dogma and discriminatory laws. It would be well to remember that in the not-so-distant-past racism, the oppression of women and meting out inhumane punishments were considered to be cultural practices or were justified on religious grounds. So while some may object to regarding sexual orientation and gender identity as cultural issues or as being against religious beliefs, they are also human rights issues, and as Korten states (1990:172): "(h)uman rights are universal, and acting to protect these rights for those to whom they are denied is a universal human obligation that knows no nationality."

91

2.9.5   *Drug use and drug dependence*

According to UNAIDS (2010:31), injecting drug use is a relatively new phenomenon in sub-Saharan Africa. However, there is a high HIV prevalence rate among injection drug users (estimated at 12% in South Africa) (Mathers *et al*. 2008).

Few studies, however, have examined potential linkages between the HIV epidemic and the epidemic of drug abuse in Africa. Among drug-using men who have sex with men (MSM) in Cape Town, Durban and Pretoria, South Africa, a considerable overlap was found between drug use and sexual risk behaviours. Crack cocaine and heroin use was associated with risky sexual behaviour and a higher risk of HIV transmission (Parry *et al*. 2008). Their research indicates that in the cities of Durban and Pretoria HIV prevalence stands at around 25% of men who have sex with men, particularly among drug-users aged 15 to 49 years old. In Cape Town the figure rises to over 40%.

How often, if at all, do the churches address the issue of drug abuse (and indeed, alcohol abuse) and, in particular, its association with HIV/AIDS? Or is this again an issue that the churches find hard to confront and talk about? Do the churches talk about whether they regard drug and alcohol abuse as a sin rather than as a sickness, and therefore whether these sorts of attitudes influence its response?

Injecting drug users are particularly at risk of HIV, where they share needles because clean injecting equipment is unavailable (Gostin *et al*. 1997; Stimson *et al*. 1985). The availability of sterile injecting equipment is therefore an important prevention strategy, but one that the churches may also find difficult to talk about. The education of injecting drug users in terms of how to inject safely, where to obtain sterile injecting equipment, etc. are subjects that the church leaders may avoid speaking about for several reasons, including the fact that they feel uncomfortable talking about an issue about which they know little, as well as because of concerns about encouraging people to use injecting equipment.

It is nonetheless important to address the issue of drug use. Drug users are sexually active and they are at risk of HIV through unsafe sex. In South Africa drugs such as "tik" and cannabis are widely available (Peltzer *et al*. 2010). In addition, it has been recently reported that a new drug ("woomba") is being manufactured, comprising a

mixture of ARVs and rat poison. The implications of the use of this drug are all too easy to imagine. There is therefore a need for churches and other agencies to engage drug users in services to reduce the possible harm or risks related to drug use. HIV/AIDS has brought to the fore the importance of harm-reduction policies.

2.9.6   *Poverty and social issues*

Poverty is a determinant for the spread of AIDS. While sex, gender and drugs are the key factors in the spread of HIV, poverty heightens the risk of contracting HIV. Although poverty is not the cause of AIDS, poverty does limit access to public health care. Poverty is also associated with diseases that compromise the immune system; people living with HIV are at a much greater risk of developing TB (WHO 2007a), which is a leading cause of death among people living with HIV (in 2009 an estimated 380 000 died from TB, who were also HIV infected). In sub-Saharan Africa, the incidence of TB is as high as 80% in some countries (UNAIDS 2010:103).

In South Africa it is estimated that 50-80% of TB patients are also HIV positive (Sonnenberg *et al*. 2005). Gandhi *et al*. (2006) document how quickly drug-resistant and multi-drug resistant TB can spread in communities of people living with HIV, resulting in death. In South Africa TB incidence rates have increased dramatically, from 169 per 100 000 people in 1998 to 645 per 100 000 people in 2005, thereby placing an additional burden on an over-stretched healthcare system.

Poverty also has a link with illiteracy and as HIV-prevention messages are largely reliant upon a literate population, the poor might not be able to access information necessary to reduce their risks. Research by Kalichman *et al*. (2006) has demonstrated that higher income groups are likely to be educated, literate and therefore able to access HIV-prevention information; where people are poor, this is unlikely.

To obtain some perspective on the issue of education, it is as well to have regard to the National Planning Commission Report (Diagnostic Overview) (2011:14), which states that although the matric examination pass rate was 67.8% in 2010, this masks the fact that only 15% achieved an average pass mark of 40% or more. In South Africa, literacy and numeracy test scores are low by African and global standards; the quality of education for black learners is poor. This has implications not only for

employment and social mobility, but development in general. In such a scenario, we can question whether AIDS education is making an impact.

Poverty is also at the root of forcing workers to go to other areas and even other countries in search of work so that they are able to support their families. Research conducted in Botswana has illustrated that mobile workers (those who work far from their permanent place of residence and are not able to return home at the end of the working day) often have sexual relations with local women as well as sex workers, and sometimes even have "parallel families" at their place of work; this has significant implications for the spread of HIV (Hope 2000).

South Africa has the distinction of being one of 12 countries in the world that has failed to reduce its child-death rate over the past 20 years (Harrison 2009:6). According to the South African Child Gauge 2009/2010, more than 80% of all deaths in children in South Africa are among those younger than 5 years and, shockingly, mortality in this age group has increased from 56 per 1 000 live births in 1990 to 67 per 1 000 live births in 2008 (Kibel *et al*. 2010:111). HIV, as well as childhood infections (such as diarrhoea and lower respiratory infections), are the leading causes of death. The report also highlights that social factors contribute to avoidable deaths, such as poor diets, poor living conditions and a deteriorating healthcare system (Kibel *et al*. 2010:111, 120, 129). Children born into poverty are more likely to be born underweight, undernourished or HIV infected, all of which reduces their resistance to fighting childhood infections. Kibel *et al*. (2010:37) call for South Africa's proud experience of advocacy to improve the country's performance; where are the churches to be heard in the debate?

In theory the churches could speak out on social issues such as inequality and living conditions, which are also part of the cause of the spread of HIV. However, they have not been as vocal on these matters as they have on "safe" subjects such as family life, conjugal roles, reproduction and the regulation of sexuality. The elimination of inequality, unemployment and poverty, however, are all part of a new vision for transformation of society.

The National Planning Commission's Report (2011) shows that, using an indicator of US$2 per day to live on (or R524 per month) as a guide, 48% of South Africa's

94

population was living in poverty in 2008, some 61% of whom were women and 31% of them living in destitution. The report further explains that there are linkages between poverty and a wide range of socio-economic indicators, such as life expectancy, mental illness, obesity, educational performance, teenage births, imprisonment rates, murders, levels of trust and social mobility, as well as violence and crime. By way of illustration of the income gap: the poorest 20% of the population earns about 2.3% of national income, while the richest 20% earn 70% of the income (National Planning Commission 2011:2-3). Although there has been a growth of a black middle class and elite, the proportion of the impoverished and destitute remains the same, if not worse, which means that the poor continue to be excluded from participation in the labour market and are forced to subsist on social grants (if they are entitled to one). The human development implications are clear.

Unemployment is, of course, a major cause of poverty (and it may perpetuate inequality by excluding people who are already marginalised from economic participation and indeed, from participation in other spheres of life). The National Planning Commission estimates that only 41% of the adult population of South Africa are in employment. Female rates of unemployment are higher compared to men and unemployment differences are also seen in races (30% for African men and 38.7% for African women, compared to 4% for white men and 6.2% for white women). The worst unemployment figures are for young people below the age of 35 years, two thirds of whom are unemployed. The Report concludes that unless things change "South Africa risks having 60% of an entire generation of young people … not having ever held a formal job. This time bomb is the single greatest risk to social stability in South Africa" (National Planning Commission 2011:4).

Any examination of the poverty situation in South Africa must, as has been illustrated above, have regard to the human development disparities in the country, which are largely attributable to the legacy of the racially discriminatory economic and social policies of apartheid (Gilson & McIntyre 2002). Gilson and McIntyre (2002) also found significant differences in the incidence of ill health between different race groups and geographic areas, as well as between groups of different socio-economic status. Indeed, research by May (1998) and May and Meth (2007) demonstrates that

many of the distortions and dynamics introduced by apartheid continue to reproduce poverty and perpetuate inequality.

Therefore, it is important to take cognisance of the social and economic drivers of HIV risk and vulnerability, as these factors significantly influence the epidemic. Lack of economic opportunities for the poor and illiteracy force people into the sex industry (Miller & Robert 2009; Dunkle *et al*. 2004b; Fenton 2004). Exchanging sex for money or goods may put sex workers and others at risk of contracting HIV, especially where they are not in a position to negotiate safer sex. Weiser *et al*. (2007) showed that in Botswana and Swaziland, owing to food insecurity, many people are forced use various types of coping behaviour, such as engaging in unprotected sex and sexual risk-taking to procure food, money or resources for themselves and their children. The link between poverty and transactional sex / multiple sexual partners has also been shown by Nattrass (2004) and Gillespie *et al*. (2007).

The fundamental issue that needs to be addressed has been expressed by Amartya Sen (1992:69): "When we assess inequalities across the world in being able to avoid preventable morbidity, or escapable hunger, or premature mortality, we are not merely examining differences in well-being, but also in the basic freedoms that we know and cherish." A critical exercise has to be undertaken: can it be right that by far the majority of South Africa's population are at risk of ill health, and more particularly of contracting HIV, by virtue of the fact that they are poor and/or marginalised?

In his book *Infections and Inequalities* Paul Farmer (2001:4-17) makes a persuasive case for investigating the reasons why "such inequalities have powerfully sculpted not only the distribution of infectious diseases but also the course of health outcomes among the afflicted". Farmer argues that extending antiretroviral treatment to all who are living with HIV/AIDS is not only a human rights imperative, but it also produces positive consequences both in terms of the epidemic and in an economic sense.

In addition, De Waal (2003:250) makes the point that:

> [Farmer's] approach has yielded some important results, for example in bringing down drug prices. But the demands of massively scaled up public health interventions across sub-Saharan Africa, in the context of very weak and declining public service capacities, demand something more. A campaign to roll back HIV/AIDS in Africa will simultaneously have to be a campaign for rebuilding a public service infrastructure and maintaining governing institutions and the social fabric.

Here then is another area where the churches need to consider, namely, what they can contribute to the debate. Calling for better health services and a system for protecting the most vulnerable in society is one aspect but an altogether more important one is how the churches can contribute to building the social fabric of the country. The National Planning Commission Report (2011) explains, inequalities in access to health care mean that relatively more is spent on the diseases of affluence, rather than the diseases of poverty; the churches' voices need to be heard in relation to this issue.

Farmer also urges that we examine social writing on HIV/AIDS analytically. He says that often such writing looks at sexual practices, where the concentration is on "the exotic reflections of cultural difference, animal sacrifices, zoophilia, ritualised homosexuality, scarification and ritual beliefs" (Farmer 2001:9). If however, HIV/AIDS is studied anthropologically then it is possible to discern that AIDS outcomes are linked to poverty. Furthermore, he says that the social sciences have failed to take into account that individual agency is very often constrained by poverty and inequality, and therefore talk of behaviour change is too simplistic a response.

He calls for an examination of the social forces and processes that manifest themselves in biological events. For example, TB is primarily a problem of poor countries, as well as of poor people in industrialised countries, because the poor live in close, ill-ventilated, crowded conditions. Furthermore, progress to active disease can be rapid because a poor person's immune system may be compromised, due to poor nutrition or because of drug or alcohol dependency. Poverty also increases the likelihood of poor treatment outcomes because of restricted access to therapy, or the ability of patients to adhere to lengthy, complex regimens.

Essentially, therefore, although HIV/AIDS might be regarded as a medical or a biological matter, we have to look at it sociologically as well, for it is fundamentally a disease of social origin or, as Farmer puts it, "biosocial". For these reasons, then, it is important for the churches to take into account the social factors that are fuelling the HIV/AIDS pandemic, as well as examining the best way in which it can help to bring about change. To merely offer charitable relief is insufficient. An alternative development paradigm is required. To this end, Korten advocates the power of a people's movement to bring about social change (1990:124) and in many ways, this would appear to align with the church's vision of bringing about a better world.

2.9.7   *Stigma and discrimination*

Stigma and discrimination prevent people from coming forward to undertake an HIV test. They may also prevent people from accessing advice on sexual health or antiretroviral medication. Stigma and discrimination may prevent a mother from feeding her baby with formulae feed, instead of breast milk, because she is afraid of what family members or the community will say about her. Stigma and discrimination may prevent people from changing high-risk behaviour, such as failure to access condoms, where there is a fear of being labelled as promiscuous. This further marginalises those groups who already suffer from discrimination, such as sex workers, injecting drug users and men who have sex with men.

Prevention strategies are far more likely to succeed where HIV is treated like any other disease and people feel able to disclose their HIV status. Often people create in their own minds stereotypes of who is likely to be infected with HIV. To counter this, concern and care has to be extended to everyone, irrespective of how they contracted the disease. UNAIDS (2002:67) suggests a number of measures, including the encouragement of leaders at all levels and walks of life, who should be urged to challenge HIV-related discrimination. In addition, it recommends the involvement of people living with HIV/AIDS (PLWHA), along with a supportive legal environment and safeguards to protect the rights of women and children. Furthermore, prevention, treatment, care and support should be accessible to all.

Squire (2007:156) however explains, HIV has had a "contested relation to religion across all countries and faiths affected by it". The churches' discourse on HIV has often been stigmatising. It will be seen in Chapter 3 (section 3.4.1) that because AIDS was first labelled as a gay disease, gay people were categorised as sinners and the virus was seen as divine punishment for their lifestyle (Iliffe 2006:94-97). When AIDS began to affect the heterosexual population, it was labelled a disease of sexual transgressors. And as the disease began to affect increasing numbers of women, it was associated "with the abjection of sexual rule breaking" (Squire 2007:156). Largely owing to the Catholic Church's response to the use of condoms, their use has been seen by certain sectors of the population as irreligious. Abstinence until marriage and faithfulness during marriage are therefore seen as the only acceptable prevention methods and not conforming to these God-given sexual norms results in punishment.

Research conducted by Keikelame *et al.* (2010) specifically looked at FBO leadership, collaboration and contribution in responding to stigma and discrimination experienced by people living with or affected by HIV/AIDS in South Africa. Most people surveyed, both secular and within FBOs, believed that there was a moral and ethical responsibility on the part of FBOs to fight stigma. FBOs were also perceived to be in the best position to tackle stigma and discrimination, because of their "revered position in society" and because of the fact that they could use channels of social mobilisation "to influence the social norms of their congregations" (2010:66).

However, the research also illustrated that the churches' "actions and mis-actions" (2010:67) contributed to stigmatisation: taking a moral stance suggested that HIV infection is punishment for immoral behaviour. Inadequate knowledge and a lack of social skills among clergy were said to contribute to the preaching of contradictory and confusing messages, resulting in discrimination. FBOs were also thought to be able to influence norms so that the vulnerability of women and girls to HIV infection was reduced. However, by failing to combat negative views and actions, FBOs "were perceived as passively perpetuating stigma" (Keikelame *et al*. 2010:69). In order to counteract stigmatisation surrounding the issue of testing, it was suggested that FBO leaders participate in voluntary counselling and testing (VCT).

Chitando (2007) suggests that it was because of inability of churches to deal with sexual issues that their initial response was weak and slow. In fact, the churches fuelled stigma and discrimination by reducing HIV/AIDS to a question of individual and personal morality (2007:19). Paterson (2005:9) summarises this view by saying that "HIV and AIDS are linked in people's minds with sex, sexuality and sexual orientation: all of which are associated in the Christian tradition with sin." As a result, there has been "a culture of silence, denial, stigma and discrimination" (Parry 2003:11). Haddad (2005:34) also makes the point that the church has traditionally regarded sexuality as dangerous, "thus rendering it a taboo subject confined to the dark secret corners of our lives".

At another level, the churches' response to someone who has been diagnosed as HIV positive also needs to be examined and considered. A person diagnosed with HIV will have fears of being isolated and rejected. Spiritual and religious concerns are bound to arise. However, because HIV/AIDS in Southern Africa is largely sexually transmitted,

people may feel reluctant to reveal their HIV status (Sunderland & Shelp 1987) and therefore seek religious and spiritual counselling (Van Arkel 1991).

HIV/AIDS raises difficult theological questions, for example, "Is HIV/AIDS punishment for sin?"; "Is suffering part of God's plan?"; "Will behaviour that has gone against church teaching result in condemnation and hell?" It is in this area that there is an obvious role for churches and religious leaders. Their reaction and response can enable people to grow spiritually at a time when they are most in need.

Spiritual comfort through a belief in life after death may also help to bring comfort and give meaning to death (Van Arkel 1991).

2.10   Conclusion

HIV/AIDS is not just a matter for the medical profession or sociologists, nor for that matter epidemiologists, statisticians, business, government, those affected or infected by the disease, or indeed any other number of a group of people. Because of the church's call to love, it too has a role to play. However, as has been illustrated above, HIV/AIDS is a complex disease, requiring not only an understanding of its pathogenesis, but also the social, economic, political and other factors that fuel it.

The churches in South Africa have social authority and can wield significant power. They can, moreover, forge alliances (for example, with women's rights and human rights movements) both nationally and transnationally to bring about change. Indeed, Korten advocates that "(a)lliances must be built across classes and sectors … with natural allies who share the vision or can be enlisted to its cause" (1990:220). Nonetheless, it is important also to acknowledge that there will be occasions when linking up with movements, for example, the feminist movement, may bring the churches into conflict with such movements (on the issues such as abortion, sexuality or reproduction). Such alliances therefore, should not be formed merely for pragmatic purposes: if the churches are serious about authentic people-centred development then they have to accept that transformation must occur both in society and in the church.

Korten (1990:214) states that "[w]e must recognise and come to terms with the essential values dimension of development … This transformation depends on overcoming the conditioning of our history, culture and institutions – and acting on a

new awareness". This, he says, is the most fundamental issue of development and from whom better to seek guidance than religious teachers? It is in this regard that the churches have their greatest role to play. Thus far however can it be said that the churches have succeeded in imbuing their congregations and members of the necessity for transformation? Have they been able to mobilise and inspire people to take action?

Often churches inspire the creation of faith-based organisations and motivate individuals to act in response to HIV/AIDS. It is this realm, of creating consciousness or conscientisation, that it would seem that the churches have the greatest role to play. Information provided by churches can shape people's beliefs, attitudes and actions in relation to the issue of HIV/AIDS. But the churches can do more – they can bring to people's consciousness the things that they have not seen or would prefer not to see: the hardships and circumstances, for example, that drive people to engage in risky sexual behaviour. The churches can also create a political consciousness: one that questions why, for example, in the face of a disease of such magnitude that is impacting so greatly upon the country, more is not spent on health rather than defence. Dirk Smit comments that there has been "a remarkable silence on the part of the church" in two spheres of public life that are critical for the formation of public opinion, namely the public media and education, leaving the overwhelming impression that "that the church has either retreated or has shifted to the margins" (2007:69).

The role that the church should be playing has, in my view, been summarised best by Ackermann (2006:188):

> The praxis of Jesus discloses the critical and transforming vision of what it would mean if the fullness of God's presence were to be known on earth. It calls us, like Jesus, to a radical activity of love, to a way of being in the world that deepens relation, embodies and extends community and passes on the gift of life. This challenge to live by mutuality and reciprocity is never free from risk … (The Christian faith) … demands the practical realisation of justice, love, freedom, peace and wholeness. As such it is a very public affair.

Chapter 3

Care and the churches

3.1   Introduction

In much of this chapter a theological or normative view of the church is taken, as described in Chapter 1, section 1.4.1. A critical issue that I believe needs to be addressed with respect to care and the church is: "Why should the church be involved in HIV/AIDS care?" This is a question with which I have struggled. When I asked church leaders/ministers whom I interviewed (in the area in which the empirical part of this research was undertaken, namely the Helderberg Basin) what they thought the primary role of the church was, invariably the response came back: "to evangelise", "to spread the Good News", "to let the world know about Christ and the message of redemption and salvation", etc. When I asked the question whether the church should be involved in HIV/AIDS care, the response was, without exception, affirmative. Various reasons were given: "we have to follow in Christ's footsteps and show compassion and love", "although Christ said that the poor will always be with us, he sent us to give the Good News to the poor and to set the downtrodden free", "the church should demonstrate solidarity with the trials that people are undergoing", etc.

However, for me, the issue of why the church should get involved with HIV/AIDS care became clear only when I attended a church service at the Holy Trinity Church (a Protestant church) in Sloane Square, London. The Gospel reading that day was taken from Chapter 20 of Matthew's Gospel,[25] which recounts the parable of the workers in

---

[25] Matthew 20:1 (as printed in the Order of Service for The Holy Trinity Church, Sloane Square, London SW1, for Sunday, 21 September 2008, 11 am) read: "For the kingdom of heaven is like a landowner who went out early in the morning to hire men to work in his vineyard. After agreeing with the labourers for the usual daily wage, he sent them out into his vineyard. When he went out at about nine o'clock, he saw others standing idle in the marketplace; and he said to them, 'You also go into the vineyard and I will pay you whatever is right.' So they went. When he went out again at about noon and about three o'clock, he did the same. And about five o'clock he went out and found others standing around; and he said to them, 'What are you standing here idle all day?' They said to him, 'Because no one has hired us.' He said to them, 'You also go into the vineyard.' When evening came, the owner of the vineyard said to his manager, 'Call the labourers and give them their pay, beginning with the last and then going to the first.' When those hired about five o'clock came, each of them received the usual daily wage. Now when the first came, they thought that they would receive more; but each of them also received the usual daily wage. And when they received it, they grumbled against the landowner, saying, 'These last only worked one hour, and you have made them

102

the vineyard. Here a landlord agrees, early in the morning, to hire labourers for the usual daily wage. However, at 9.00 am, at noon, at 3.00 pm and at 5.00 pm he continues to hire men. At the end of the day, however, when he comes to pay their wages, he calls for the employees who were hired last, to come forward to be paid first. He then pays all the other labourers in reverse order. But irrespective of the time at which they joined the workforce, the same wage is paid to each group, causing the workers who joined first and who therefore worked the longest to complain.

In explaining this parable Reverend Nadim Nassar made the following points, which struck me deeply: in Christianity it is taught that a person does not get what he or she deserves, but what he or she is *worth* in God's eyes. In God's eyes a person is worth so much, loved so greatly, that God gave up His only begotten Son so that humankind could be saved. The message of the parable is clear: God's ways of dealing with people is not our way. God does not say because you have worked longer, you deserve more, but rather, in His eyes, a person is worth every bit as much as the next person and is therefore just as deserving as the next person. Rev. Nassar also made the following point: of all the great religious traditions, such as Islam or Judaism, Christianity is the only religion where one does not get what one deserves.

For me, the sermon was profound: if God values the worth of every individual, surely the church too should value every person and has an obligation to care for him or her. This surely must be the fundamental reason for extending care to those who are HIV infected or affected. This surely is the reason why it is unimportant how people contracted the disease. This is surely the reason why it does not matter whether care is extended to fellow Christians or to non-Christians; in the words of the theologian and the former Archbishop of Canterbury, Rt. Rev. William Temple:[26] "The Christian church is the one organisation in the world that must exist purely for the benefit of non-members." The love of God, then, which extends to the whole human family,

---

equal to us who have borne the burden of the day and the scorching heat.' But he replied to one of them, 'Friend, I am doing you no wrong; did you not agree with me to work for the usual daily wage? Take that that belongs to you and go; I choose to give to this last the same as I give to you. Am I not allowed to do what I choose with what belongs to me? Or are you envious because I am generous?' So the last will be first and the first will be last."

[26] William Temple (1881-1944) has been described variously as a theologian, philosopher, social reformer and a leader of the ecumenical movement. He was appointed the 98th Archbishop of Canterbury and therefore the Primate of the Church of England in 1942. These words are quoted in Ozrovech (2002).

means that members of the Christian faith are required to look beyond themselves and to their neighbours because they are part of the network of human relationships that is also loved by God.

In this chapter I shall therefore endeavour to address in greater depth the issue of why the church is called to care: what is its rationale and motivation to care? I shall then attempt to unpack the concept of care: what does it mean in the context of HIV/AIDS and in relation to poorly resourced countries, such as South Africa? Care is not simply a question of attending to physical or spiritual needs; it requires, in my view, a thorough analysis if the Christian church is to respond in a way that addresses the core issues, obstacles and challenges, or in other words, if members of the church are to render care in a people-centred developmental manner. There also needs to be an awareness of multiple factors that might impact on care and I examine a few of these briefly, such as medical advances, changes in the nature of care delivery, societal changes and cultural factors. I shall then take Voluntary Counselling and Testing (VCT) as an example of an area in which the church could also demonstrate care.

Finally, I propose to examine certain aspects of the history of HIV/AIDS in South Africa to see whether the church has responded, or missed the opportunities, to demonstrate care. I shall do this with reference to Korten's (1990) explanation of why voluntary organisations are supposed to be different; because of their integrative power, their commitment to a vision of a better world, as well as their value commitment, they are able to play a role and meet a need that neither government nor market forces are able to fulfil. The question is whether the church has fulfilled its role in this respect. I believe that it is only through adopting a historical perspective that the church can appreciate the breadth of the task of care that it is called upon to exercise and measure whether it is able to live up to that calling.

3.2 What is the rationale and motivation for the church to care?

Korten (1990:113-114) makes the point that it is not possible to undertake development without a theory that directs action towards addressing the underlying causes of under-development. Without such a theory, any agency seeking to undertake development work risks addressing only visible symptoms through relief and welfare measures, rather than removing the conditions that prevent the sufferer from meeting needs through his or her own efforts. A theory, moreover, allows for

any assumptions that are made in rendering help to be made explicit. Importantly, a development theory allows for a development strategy to evolve and resources to be allocated, targeted at addressing the problem.

Given that there is no cure for HIV/AIDS and the fact that the development of a vaccine is still several years away (Rosales-Mendoza *et al*. 2012), care is a crucial aspect in dealing with the disease. In Chapters 1 and 2 above, we have seen that the Christian church is well placed to render care. In the introduction to this chapter I endeavoured to outline why I believe it is incumbent upon the church to render care. However, as indicated by Richardson (2006:39), churches and church-related agencies themselves require "an explicit, robust theological rationale" for what they are doing. What I am arguing here is that while the church is not a development agency, if it wishes to engage in a people-centred developmental way by putting the human person at the heart of development (rather than profits), then it must have a theological or biblical basis for doing so. Richardson (2006) is helpful in this regard. He says that it is important to "find points of resonance between the care [that Christians] are giving and … the motives for that care" (2006:39). Richardson emphasises a specifically Christian response to the pandemic, because he argues that care should be understood by those giving it and seen by others "as an expression and embodiment of their Christian convictions" (2006:40). Central to the issue of care are the teachings of Jesus Christ, the issue of worship (and the understanding of suffering and death) and the meaning and the importance of recognising that Christians belong to a community that must be shaped by discipleship to Christ. He makes the point that care, in a Christian sense, should not merely be "what good people do" or a question of human dignity and human rights, but be based on the theological principle that we are all "created in the image of God" (2006:40-41).

In Pope John Paul II's Encyclical Letter (1988: Chapter 4, para. 28) *Sollicitudo Rei Socialis,* he comments that true development cannot be limited to the "multiplication" of goods and service – to what one possesses – but must contribute to the fullness of the "being" of the human person. In this way the moral nature of real development is meant to be shown clearly. He took the view that authentic human development could only take place if members of the Christian faith recognised God in every person and

every person in God (1988: Chapter 4, para. 29). This view appears to summarise why most, if not all, Christian churches believe that it is important to provide care.

According to biblical belief (see for example, Scaer 1977), the human person has been made "in the image and likeness of God"[27] and as such carries the divine imprint. Furthermore, members of a believing Christian community are exhorted in the Gospel of Matthew:[28] "So in everything, do to others what you would have them do to you, for this sums up the Law and the Prophets." In this way, therefore, dignity is to be accorded to each person and it appears to be implicit that relationships and networks with others are required.

Richardson (2006), however, goes further in explaining that being created in the image of God is a good theological principle upon which to render care but it is a reason that is shared by Judaism too. For a distinctly Christian response, it is important to examine what the church is and what the church does (2006:45). Richardson also makes the point that looking at a distinctly Christian response does not in any way imply that other faith traditions are weak or unable to respond. Indeed, many of their responses put the Christian church to shame and, where this is the case, Christian churches should look to support and collaborate with their efforts.

In terms of what the church is, Richardson uses Nicholson's (1995:18) definition that human beings are all bound up in a relationship of mutual responsibility and interdependence:

> We need to rediscover the church as the family of God's people, and to rediscover the human race as one family. The pain of one affects us all … We are co-dependent; people with AIDS need the love, support and very often the practical assistance from the rest of the community (Richardson 2006:42).

Importantly, it is the broken body of Jesus Christ that is celebrated in the worship that is the ultimate meaning of what the church is: through the suffering and death of Christ, humans have been made whole and are healed.

In terms of what the church does, Richardson (2006:45-46) says that this is to be found in the principle of "*diakonia*" or "service" or "ministry", which is action of a

---

[27] Genesis 1:26-27

[28] Matthew 7:12

particular kind, carried out with a particular intention. Here he uses Nordstokke's[29] (2000) definition from the Church of Norway, which is that the intention of service should be "to promote fellowship" and be "directed towards people in distress" (2006:46). Richardson states that a church without *diakonia* is not a church – or at least not fully so. Furthermore, he claims that *diakonia* is not social action of the type advocated by secular development aid agencies, but more of a response to "the cry of their neighbour" by "small dynamic groups of Christians" (2006:47). It is in this last respect that I part company with Richardson, because I believe that if transformation of society is to take place, then it will occur only through the sort of movement advocated by Korten (1990), where voluntary action is mobilised nationally and globally through the creation of an alternative vision, rather than by a small group simply responding to the cry of a neighbour.

Richardson (2006:47) goes on to ask why, in ethical terms, the church should be involved in HIV/AIDS care. On an *individual* level, he says that members of a church must get involved if they are to be true to following the example of Jesus. Jesus touched and cared for the lepers and so in the same way Christians are called upon to care for people living with HIV/AIDS (PLWHA) and their families. On a *communal* level there is an obligation to care for those in need, because of our communal identity to care for the suffering and disadvantaged in our midst. Richardson makes the point that Christians do not operate as autonomous moral individuals, but are "shaped as moral agents by the communities in which … [they] belong and have … [their] identity … Christian ethics is rooted in a community which remembers the crucified Christ, and that those who make up that community are shaped by their discipleship to Christ and their belonging in his community" (2006:49). For this reason, Christian ethics must be different from other ethics.

What is put forward in this section[30] is that "care" in a religious sense, and more particularly in a Christian sense, entails something more not only in terms of the

---

[29] Dr Kjell Nordstokke was Director, School of Theology and Diaconal Ministry, Diaconia College Centre, Oslo, Norway. He lived in Brazil, where he worked as an urban pastor and then as a theology lecturer (1974-1981; 1994-1996 respectively). He served the Lutheran Federation as Director of Development 2005 – 2009.

[30] The remainder of this section has been adapted from a chapter that was written by Ferreira, C. & Groenewald, C. 2010. Churches as providers of HIV and AIDS care. In Swart, I., Rocher, H., Green,

rationale for the church rendering care, but also in terms of its motivation for doing so. The Christian church must be motivated by love – love on the part of congregants and love on the part of the church as an institution, as "the body of Christ". The issue of care, emanating and motivated by love, is therefore considered in the context of what has been said above (see Chapter 2) in relation to the practicalities and the issues involved in HIV/AIDS care.

The centrality of love in the Christian faith is beyond doubt and therefore has to be the motivation for care giving. In the Old Testament the Book of Deuteronomy states: "Love the Lord your God with all your heart and with all your soul and with all your strength. These commandments that I give you today are to be upon your hearts" (6:4-6). And in the Book of Leviticus we read of the commandment to "love your neighbour as yourself" (19:18). In the New Testament, in Mark's Gospel, we read, "There is no commandment greater than these" (Mark 12:29-31). And in John's Gospel, the nature of this love is made explicit: love means putting others first; it means demonstrating care, not just saying the words. "God is love. Whoever lives in love lives in God, and God in him. In this way, love is made complete among us…" (1 John 4:6).

In Erich Fromm's book *The Art of Loving* (1976) love is described as follows: "Love is an activity, not a passive affect; it is "standing in", not a "falling for". In the most general way, the active character of love can be described by stating that love is primarily giving, not receiving" (Fromm 1976:25). However, Fromm also makes it clear that giving does not mean "giving up" or sacrificing, nor does it mean giving something in anticipation of receiving something in return. Furthermore, giving should neither be viewed as an impoverishment nor as virtue (because it is seen as something of a sacrifice). Giving in the sense described by Fromm is the highest expression of potency, as it is an expression of "aliveness" (Fromm 1976:26), by which one experiences strength, wealth and power and therefore draws joy. It is not the one who *has* much who is rich, but the one who *gives* much (Fromm 1976:26).

Fromm goes a step further by stating that the most important aspect of giving lies in the "specifically human realm", rather than material things. It is in the giving of one's

---

S. & Erasmus, J. (eds.) 2010. *Religion and Social Development in Post-apartheid South Africa: Perspectives for Critical Engagement*, 175-201. Stellenbosch: SUN Press.

life – not necessarily in the literal sense – but in the sense of giving "that which is alive" in the person who gives which is the most important aspect of giving (Fromm 1976:27). The giving of joy, interest, understanding, knowledge, sadness are all aspects of giving of life, which enriches the life of another person, enhancing their sense of aliveness, while also receiving something back from that person. In other words, the giving of love results in the receiving of love or, as Fromm puts it "love is a power which produces love" (Fromm 1976:27).

Fromm describes love as having an "active character" that has four common elements, namely care, responsibility, respect and knowledge (Fromm 1976:28). He describes love as "the active concern for the life and growth of that which we love". In other words, one must labour for that which one loves and love that for which one labours: love and labour are inseparable. Love also entails responsibility, which is distinct from "duty", as it is a voluntary act stemming from a response to the needs of another human being. In other words, one must feel as responsible for one's fellow human being as one does for oneself. However, to avoid dominating or possessing another person, such responsibility must be acted upon with respect – in other words, recognising a person's individuality without a desire to exploit that person. Respect implies wanting a person to develop and grow for their own sake and in their own way, not for the purpose of serving one's own ends. However, Fromm argues that respect is only possible if one knows a person at his or her "core", rather than at a peripheral level, that is to say, when one can transcend concern for oneself and see the other person in their terms. This does not mean exercising power over another person, but by using love as the tool with which to penetrate the other person, one not only discovers the other person but also oneself (Fromm 1976:28-32).

Fromm makes the point that love is not primarily a relationship to a specific person, but rather an attitude or orientation of character that is not directed at one "object" of love (Fromm 1976:43). In saying this, however, he distinguishes between various types of love, including motherly love, erotic love, self-love, etc. He adds that the fundamental kind of love is the sense of responsibility, care, respect and knowledge of any other human being, in short, the wish to further the life of that person (Fromm 1976:44). He goes on to say that this is the kind of love that the Bible speaks of when it says love thy neighbour as thyself, for it is "the experience of union with all [human

109

beings], of human solidarity, of human at-onement". Essentially, therefore, if we look upon another person at a peripheral level, we perceive the differences between us. If we penetrate a person to the core, however, we perceive the identity common to all men, our brother- and sisterhood (Fromm 1976:43-45). Nouwen (1977:13) expresses it as "the profoundly felt experience of human sameness".

This resonates in a very real way with the central message of the Bible, namely that union with Christ also means union with all Christians and, indeed, all fellow human beings. As Paul's letter to the Corinthians states, "Because there is one loaf, we, who are many, are one body, for we all partake of the one loaf" (1 Corinthians 10:17). Furthermore, we are commanded to love because we have received love in the first place: "This is love: not that we loved God, but that he loved us and sent his Son as an atoning sacrifice for our sins" (1 John 4:9). This biblical passage goes on to state: "If anyone says 'I love God' yet hates his brother (sic), he is a liar. For anyone who does not love his brother (sic), whom he has seen, cannot love God, whom he has not seen." In short, because of the love that we have freely received, we are called upon to respond with love to our neighbour (Nouwen 1998; Tutu 1985).

This leads us to consider the meaning of "neighbour". In the parable of the Good Samaritan a neighbour is not necessarily someone from one's own community or even one's own countryman – or indeed, even a foreigner who adopts one's country as their own. The concept of neighbour is extended to all mankind and the love that is demanded entails practical action. In the Good Samaritan parable we learn that love means acting to meet a person's need, irrespective of race, creed or social status (Russell 2002).[31]

Furthermore, the Bible states that love is the definitive criterion by which we will be judged. It is our response to those in need, to the hungry, the thirsty, the stranger, the naked, the sick and those in prison, which is crucial because "whatever you did for

---

[31] In Luke's Gospel (10:25-37) Jesus is asked what is meant by the commandment "Love your neighbour" and in particular to clarify who is one's neighbour. He answers with a parable, telling the story of a man who, while travelling from Jerusalem to Jericho, is robbed, stripped of his clothing and badly beaten. A priest happens to come upon him, but passes by on the other side of the road. A Levite sees him and does the same. However, when a Samaritan sees him, he attends to the man's wounds, takes him to an inn to be cared for and pays for his care there. *Life Study Application Bible, New International Version* (1997).

one of the least of these brothers (sic) of mine, you did for me" (Matthew 25:31-46).[32] Love of God and love of neighbour are therefore one: in the least of God's people we find Jesus and in Jesus we find God (Nouwen 1977). This then is the church's motivation to care. It means going beyond exterior appearances to what Fromm refers to as the "core" of a person and recognising the common humanity that we share. If we therefore look at people, seeing them as the other, rather than as the image of God, and if we respond out of a sense of "duty", then we are not acting in love.

Love of neighbour is not only to be practised by individual members of the church, but also by the church. In the Acts of the Apostles we are told that the early church "had everything in common. Selling their possessions and goods, they gave to anyone as had need" (Acts 2:44-45). Indeed, in Ecumenical Documents (1981:194), church is described as "a community of God's love in and to the world [which] thus becomes an agent for mission". The church's responsibility is thus manifold and includes not only the proclamation of the Word of God, but also the demonstration of the love of God through works.

The church is the instrument of the love of God and members of its body are required to act in love. In Paul's letter to the Corinthians, we read, "If I give all I possess to the poor and surrender my body to the flames, but have not love, I gain nothing." In other words, love is more important than all the spiritual gifts that the church is able to exercise: more important than sacrifice, prophecy, knowledge or even faith "to move mountains" (1 Corinthians 13) (Klein 1959; Kroner 1948). Moreover, being in a position of being able to help others should not make us feel powerful over them for, as Fromm argues, compassion implies that we know and identify with the needs of others. This is nothing less than: "love between equals: but indeed, even as equals we are not always 'equal'; in as much as we are human, we are all in need of help" (Fromm 1976:45).

Following on from this consideration of care, in the context of love, we can see not only why the church should be a provider of care to people living with HIV and

---

[32] Matthew 25:31-46, where we are taught in a parable to treat all people whom we encounter as though they were Jesus. "For when I was hungry, you gave me something to eat. I was thirsty and you gave me something to drink, I was a stranger and you invited me in, I needed clothes and you clothed me, I was sick and you looked after me, I was in prison and you came to visit me". *Life Study Application Bible, New International Version* (1997)*.*

AIDS, but also why it is incumbent upon the church to do so. Religion brings a dimension – let us call it a value – to the concept of care that perhaps very few other institutions, disciplines or professions can provide and herein lies its strength.

Fromm says that in order to provide love, one needs knowledge of a person's 'core". However, in order to effectively respond to the needs of those affected by the disease, what is also required is knowledge of the disease, in all its complexities, including the social factors that contribute to its spread (see Chapter 2). I will now endeavour to unpack the issue of care by looking beyond the disease itself to other factors which we need to be aware of when rendering care. I will then look at a few areas in which the church has rendered care, before examining how Voluntary Counselling and Testing might be an issue where the church could demonstrate care-giving in a manner that Korten (1990) would define as developmental.

3.3 Care

3.3.1 *An attempt at unpacking the concept of care, in the context of HIV/AIDS*

We have seen in Chapters 1 (section 1.6) and 2 (see in particular section 2.4) the Christian church has an enormous influence in South Africa and that it is regarded as one of the most trusted institutions in the country. While some churches in South Africa supported apartheid and employed a racially-based structure, others provided leadership in the struggle against apartheid; churches can therefore be seen as a source of social networking, providers of spiritual comfort and a source of information. Importantly, the church can provide a vision for change and transformation. The church can therefore use its position to promote HIV/AIDS awareness, fight stigmatisation and discrimination, and exercise compassionate care. Korten goes further: the church (Korten says religion, but also refers to the role of the church in society) can drive social change towards people's development by creating a people's movement through the vision of a better world. The church should therefore rise to the challenge of helping the powerless to discover the sources of their own strength, as well as raise the consciousness of power holders that they hold a position of stewardship, whereby their wealth and resources should be used in service to the community and for the human and spiritual fulfilment of all people, especially the powerless (Korten 1990:168). The perception that HIV/AIDS is a sexually transmitted

infection, however, would appear to inhibit or prevent the church from rendering care in a more comprehensive, developmental manner.

In my view, it is a key responsibility of the church to draw attention to the fact that human beings are cared for and loved by God, and that as a consequence our love and care should not only extend to God, but also to our neighbours, whether they be poor, sick, orphaned, widowed, foreign, and so on.

HIV/AIDS is not some obscure disease that is suffered by a handful of people. It is a pandemic that affects people the world over, not only physically, emotionally and psychologically, but also their families and communities. It is a disease that affects people deeply. The Christian church, by its very calling, has the remit of creating the kingdom of God on earth. This means that it is called to care and love, to make people recognise the importance of sharing relationships with one another, and of our dependence upon each other for a fuller life (Simundson 1982).

MacMaster (2008:5) makes the point that the church, as part of its pastoral care, cannot be politically neutral; while the church and its leaders should not become involved in party politics, it cannot remain politically neutral in terms of politics in general. There is also a role in encouraging lay people to become involved in party politics, thereby working towards strengthening civil society. Indeed, this is seen in the role that the church played in the struggle for liberation in South Africa.

The church played a role both in sustaining and in protesting against apartheid by creating a movement that involved not only different denominations of the church, but also other faith traditions and organisations, as well as church leaders. The churches, moreover, encouraged many church congregants and members to become involved in the fight for liberation (MacMaster 2008:6-7).

Following the fall of apartheid, however, there has been a questioning as to whether the church has a continuing prophetic role of social criticism, or whether it should concentrate "on its pastoral, caring, affirming and non-critical role" (MacMaster 2008:8). MacMaster advocates that given the challenges that the country faces, including that of HIV/AIDS, it is important for the church to be prophetic and decry those factors, such as injustice, sexism, racism, etc., that give rise to problems.

MacMaster also acknowledges the important pastoral role that the church must play, given the enormity of the scale of human suffering.

MacMaster concludes as follows:

> Whatever view one has of the role of the church or religion in South Africa today, it is clear that there are definite challenges facing pastoral care, making it impossible to withdraw into denominational or privatised zones, attending only to our own 'flock'. Many of the challenges or problems that our flock has to face are of a systemic nature and cannot be addressed by ourselves alone, but need collective human efforts. This brings it into the public sphere or space. Public pastoral care subscribes to a holistic view of human beings – that they cannot be understood without their social context. (2008:15)

The church has a unique platform of appeal. In South Africa, in the church's struggle against apartheid it dealt with issues of social justice, equality and freedom. The issues of transcending individualism through social responsibility, promoting peace and holding the gifts of nature in trust for future generations are part of its mission. The meaning of life and death, the search for fullness of life and finding life in death are all subjects that the church is able to use in tackling the subject of HIV/AIDS. Christianity, moreover, is not all about the good news of salvation. It involves dealing with the difficult-to-talk-about subjects of sin and suffering, both of which are very important topics when confronting the issue of HIV/AIDS. The late Pope, John Paul II (1984: Chapter 2, para. 8), acknowledged that suffering has its own world and that it is a place of solitude, "as each experiences what no one else can share". However, he also called for human suffering "to become a place of community, where a special bond can be forged with those that suffer".

The church has a crucial role to play in explaining, rather than shying away from, subjects such as pain and suffering, the acceptance of the will of God, and the hope of the Resurrection (Foster 2006).[33] Not dealing with or confronting these issues (or indeed, adopting a pacifying tone that seeks to ignore these issues) does the church a disservice, if care is to be offered in a manner that is meaningful and true. Merry (2004:82) says that faced with the challenges of suffering and its causes, we can only say as Christians, that "there is mystery in suffering that bespeaks of a higher purpose to living than health and prosperity. Relationships often do take on a more profound

---

[33] Foster (2006:162) says that "[t]he physical appearance and experience of disease and death do not need to be seen as avoidable evils but part of the divine pattern of the cosmic covenant in which death – which is a pre-requisite for resurrection – play a part."

meaning when suffering is involved. In a word, suffering may have a humbling effect, if for no other reason than its inscrutability".

Although it is beyond the scope of this dissertation to examine the Christian doctrine and belief that people are called to repentance and faith in Jesus Christ as Redeemer, if they are to have eternal life, and why dealing with this issue is important for the church in terms of the care that it affords, they are nonetheless very relevant. How often however does the church deal with these issues, difficult though they might be?

The church also has a vital role to play in the linking of faith, worship and prayer to the way in which its members lead everyday life, otherwise it would seem that Christianity is meaningless. The translation of worship and prayer should be expressed – or at least endeavour to be expressed – in the way in which we try and live life. Almen (1984:131-132) describes it thus: "The Problem: relating Sunday to Monday … the issue is that Christians do not see the relationship between their work, other daily activities and their faith". This is of course critical when looking at the issue of HIV/AIDS and care.

In the Gospel of Luke[34] Jesus sets out his messianic prophecy:

> The spirit of the Lord is upon me, because he has anointed me to preach good news to the poor. He has sent me to proclaim release to the captives and recovering of sight to the blind, to set at liberty those who are oppressed.

Later, we read that Jesus relieved human suffering of both a mental and physical nature.[35] Jesus was demonstrating love to those in need and to the suffering. Providing comfort, demonstrating care, acting against unjust practices are then what care comprises. But, as discussed above, the church also needs to speak out and act where social structures result in oppression and injustice in society (Conradie 2005).

In an English dictionary sense of the word, "care" means giving serious attention to or heeding. In a Christian sense, in my interpretation, as discussed above, it means demonstrating the love of Christ by being of service. I have made the point in Chapter 2, however, that HIV/AIDS is a complex disease and therefore to really appreciate what practical care is required, it is important to have some understanding of the

---

[34] Luke 4:18.
[35] Matthew 4:23: "healing every disease and every infirmity".

disease and the course that it follows (its pathogenesis). Surely, therefore, it must be questioned whether, more than 30 years into the epidemic, on a continent where HIV/AIDS is rife, it is acceptable for any church to plead ignorance or lack of awareness about the disease?

The progression of HIV to AIDS may take many years (see Chapter 2, section 2.7) and therefore it is not only as a person approaches death that there is a need or desire for church involvement; palliative care (the control of symptoms) and terminal care (making death as comfortable or painless as possible) should also have church involvement.

As Alan Brandt (1988:168) prophetically commented:

> In the years ahead we will, no doubt, learn a great deal more about AIDS and how to control it. We will also learn a great deal about the nature of our society from the manner in which we address the disease. AIDS will be a standard by which we measure not only our medical and scientific skill but also our capacity for justice and compassion.

Chapter 2 indicated that a broad range of factors need to be taken into consideration, so that the church's response in relation to HIV/AIDS care is informed. Factors such as social circumstances, social attitudes, social needs, structural or delay barriers, government leadership (or the lack thereof) and policies all constrain the care that can potentially be provided, as well as affect matters such as adherence to therapy. In this regard, Brandt (1988:415) makes an important point:

> [HIV, like most other diseases,] is not merely a biological phenomenon; it is shaped by powerful behavioural, social and political forces. Social values affect both the way we come to see and understand a particular disease and the interventions we undertake … disease is socially constructed.

It is also important to take account of an individual's circumstances. In writing about medical clinical care, Dr Chris Wood says that clinicians working in the field of HIV/AIDS in its early days had little training, let alone preparation for dealing with the disease (Wood & Ellison 2003:111). He poignantly comments:

> HIV clinical specialists have had to learn how to listen carefully to the challenging personal circumstances that their patients face, and to be sensitive to both their medical *and* social needs… Ultimately they have come to realize that the principal barrier to therapeutic success lies outside the medical context, in the views, attitudes and beliefs of all concerned, and in the social, economic and cultural factors … that

> prevent disclosure and undermine the ability of those infected to cope with the disease [author's emphasis].

In other words, HIV/AIDS has caused the medical profession to look anew at their perspectives and practices and to broaden these beyond the clinical, so that heed is also paid to the social factors that fuel the epidemic and prevent access to treatment. Similarly, MacPhail and Campbell (1999) call for an interdisciplinary approach, so that we are better able to understand the role played by individual circumstances, culture and structural factors in the spread of HIV/AIDS. It is as well to question whether – and the extent to which – the church has also taken these factors into account in arriving at its response.

If, however, care is to be rendered in a way that has been described by Korten (1990:24) as an "Alternative Development Paradigm", then it is important for the church also to incorporate the vital element of conscientisation, where the church strives to bring an understanding of the role that factors such as poverty play in the spread of HIV/AIDS. Let us take another example: the issue of fear: the fear of disclosure of a person's HIV-positive status may be such that it prevents him or her from attending to urgent medical needs. Fear of rejection by one's partner or family, fear of being ostracised by one's church or community, fear of being thrown out of one's home are all factors that have been shown prevent individuals who are HIV positive from seeking medical care (Burns *et al.* 2001; Fenton *et al.* 2002). This is an area in which the church could play a larger role in changing societal attitudes that are stigmatising. Ultimately, the church must drive people "by ideas, by a vision of a better world" (Korten 1990:124), so that they are motivated and mobilised to make social changes. Swart (2006:48) goes further: "This [also] means bringing rich Christians and churches to the point of critically self-examining their own power base and ideological self-interest from which they render development aid."

The concept of care is then broader than it would appear at first sight and in relation to HIV/AIDS; it is a concept that continues to evolve, because of biomedical advances and other research. A cursory examination of a few issues in relation to HIV/AIDS perhaps illustrates this point best:

(i)   Medical advances

In the last few years there have been extraordinary advances in medical treatment available to people who are HIV positive. The availability of HAART (see Chapter 2, section 2.8) has transformed the disease from a death sentence into a chronic illness for many. For those who have access to treatment, or who can afford it, this means a good possibility of a prolonged and productive life. If medical interventions such as ARVs work, then it can be argued that a concept of care should include the provision of treatment options that produce the best outcomes. But then, how far should this extend? In South Africa, ARVs are now provided when a person's CD4 count is 350 cell/mm3 or less. Furthermore, recent research has shown that ARVs can be used to prevent infection in those people who are uninfected with the virus, but who have a sexual relationship with someone who is HIV positive. The issue here is how far should care extend? Does it mean exercising pressure to have the optimal treatment made available to all, whatever the cost implications? And is reliance upon medical treatment enough?

(ii)   The changing nature of care delivery

The impact of HIV/AIDS is such that it has meant that hospitals and hospices have not been able to cope. In rural areas or in areas without easy access to medical doctors very often the only help available has been through nurses, who have had to acquire an expertise and knowledge that would not otherwise have been available. In addition, in poor-resource countries and for the poor, home care has been the only option available for the care of those who are sick with AIDS. Palliative and terminal care for patients, as well as care for the family, are important issues to consider in all circumstances, but possibly especially so in situations where resources are limited. Furthermore, the burdens of the treatment regimen on the part of those who are receiving ARVs, as well as the burden of care on care givers, are also relevant.

In broader terms we have seen that increasingly scaled-up access to ART is changing the way in which health care is organised and delivered. Given the shortage of professional health care workers (particularly, but not exclusively, in South Africa), there has been a growth in the number of lay health workers (Ogden *et al*. 2006). Households and community members have sought to help meet the shortage of professional care workers and there has been a blurring of the lines between volunteers, household carers and health care workers. What is clear, however, is that

lay health care workers are utilised to deliver essential health care. Many such lay health workers are from the churches and a study on orphaned and vulnerable children showed that it would have been difficult for them to have been cared for without the intervention and care of the church (Foster 2004). In 2009 the Department of Health (DOH) estimated that there were some 65 000 carers, apart from 48 000 public health care nurses and 10 700 doctors (Day & Gray 2008).

In this regard, Schneider and Lehmann (2010:65) make an important point:

> The ability to be a successful home and community-based carer, in fact, is partly premised on moving beyond a stereotypical caring function and possessing sufficient 'systems knowledge' and moral authority to broker access to services such as health care or social grants. There is also anecdotal evidence of the role of lay workers, individually or in collectives, extracting greater accountability from local health services… It is through such actions that lay workers may reclaim their roles as advocates and mobilisers for communities.

Empowerment here is seen in the way that local and community capacities are increased in order to transform local institutions; it is therefore much more along the lines of people-centred development than would at first give the impression.

(iii)   Societal changes

Care has to be seen in the context of a society (both in South Africa and elsewhere in the world) that has changed: the extended family has given way to the nuclear family and even the nuclear family has broken down (see Chapter 2, section 2.2.1). The responsibility for care may therefore no longer lie where one would ordinarily look to find it – namely, the traditional family support structure. It may be that in urban areas, in circumstances where there are no family members available, decisions about health care are taken autonomously, on a self-determined basis, without regard to tradition, religious teachings or, indeed, family wishes. The issue of an individual's right to autonomy to make their own decisions about the way that they behave also raises wider issues about care, in particular about rights and responsibilities, particularly as has been discussed above in the terms defined by Fromm (1976), namely taking responsibility for another human being. The issue of care here necessarily entails consideration of whether an individual should be allowed to determine the options that they will avail themselves of, according to their circumstances, without reference to anyone or, indeed, to what the church has to say about the sanctity of life and responsibility for others. This of course impacts upon issues such as whether a person

who is infected with HIV can do what he or she wishes in terms of risky sexual conduct, without regard to the consequences.

De Gruchy (2004:236-241) also makes the point that over the past several years South Africa has seen, inter alia, the collapse of the sexual ethical system of traditional African culture, as well as the break up of "dour Dutch Calvinism, British missionary piety and up-right Victorianism" (2004:236). All this came at a time when apartheid came to an end and South Africa re-entered the global world, where sex is evident in every aspect, from advertising, television, pop songs, magazines, etc. De Gruchy takes the view that because churches are uncertain of their contribution on this matter, they have not been able to speak critically and coherently, as they did in the struggle against apartheid. Care in the context of these changes demands consideration of the issue of sex and sexuality.

Germond (2004:48) states that the church faces a "crisis of sexuality", where its message, for example, with regard to abstinence, is perceived as irrelevant. Germond further notes that society has changed remarkably over the past few years, so that "(t)he overwhelming legitimacy of the new sexual world is the urge to sexual freedom and fulfilment, with a corresponding rejection of any validity in the necessity of self-denial or control" (2004:60). Furthermore, globalisation has produced "wholesale commodification of sex and sexuality". The internet, phone sex, cyber sex, etc. have of course also contributed to the growth of pornography and the privatisation of sex, so that sexual acts are seen to exist in their own right, for self-gratification, irrespective of marriage, family, social relationships, etc.

It is in such a situation that the church faces the challenge of talking about sex and sexuality. The issues of conscience, moral agency, responsibility are, it seems to me, very relevant. Accepting that the church's stance of abstinence before marriage and faithfulness during marriage are sound in terms of halting the spread of HIV/AIDS, what is to be done when society has changed so significantly as to make the church's message irrelevant? Germond (2006:66) suggests that the Christian message needs to be helpful if it is be relevant, and this is the hard task that the church faces: equipping people to live faithfully according to an ethic of sexuality. Alternatively, the church will need to come to a decision to celebrate sexuality and to elucidate what kind of sexual activity is healthy and holy, and what kinds of sexual behaviour are not

120

(Cloutier 2004:73). Emphasising qualities such as justice, non-exploitation and relationships will therefore be important (Keenan 2007). The latter approach, however, will require a break with the church's traditional stance, which it may find hard to do.

Denis (2003) also makes the case that sexual behaviour cannot be addressed without also looking at social, cultural and economic factors that influence behaviour. He also makes the point that sexual behaviour and relationships between men and women

> will only change for the better when sexual questions are discussed freely in an atmosphere of respect for each other and with an understanding of the local culture (2003:75).

If therefore the church is to demonstrate care, these issues need to be addressed.

(iv)   Factoring in cultural issues

In his book *African Religions and Philosophy* Mbiti (1969:106) makes the following statement about the importance of community in African traditional life:

> When he suffers, he does not suffer alone but with the corporate group; when he rejoices, he rejoices not alone but with his kinsmen, neighbour and his relatives, whether dead or living. Whatever happens to the individual happens to the whole group, and whatever happens to the whole group happens to the individual. The individual can only say: 'I am because we are; and since we are therefore I am.' This is the cardinal point in the understanding of the African view of man.

This collective sense, which gives rise to norms and values, can be harnessed to great effect in the planning and implementation of HIV programmes. The influence of traditional community should not be underestimated in any programme, as according to Van Dyk (2008:211), there is an external health locus of control with regard to black South Africans. In other words, "other people" determine health and sexual behaviour. Accordingly, Van Dyk advocates for the involvement of community leaders, such as elders, traditional healers and peer counsellors in the fight against HIV transmission. The issue at stake here is how open the church is to culture and tradition. While colonisers and missionaries rejected these traditions, Knox (2008:19) argues for reconciliation: in Christ we are reconciled and made one (2 Corinthians 5:14-20); Christian faith therefore does not require a separation from tradition and culture, as Christ is capable of bringing all of these into himself.

121

As explained by Heald (2003), in Africa there are often two and perhaps more health care sectors side by side. On the one hand, there is the modern health care system, based on biomedicine and, on the other, traditional healers that incorporate a wide range of specialists, ranging from diviners to herbalists. In addition, Heald says that there are "the prophets of new schismatic Christian-based sects who find their vocation in healing" (2003:221). It is to traditional healers that many in rural and urban Africa regularly turn when they encounter a problem and because they work in the same idiom and language as their clients (Dilger 2001; Livingston 2002), it is important that their role in the battle against AIDS is recognised and enlisted.

Heald (2003) makes the point that HIV/AIDS is not simply a question of public health: it is a disease that involves politics, the community, the nature of belief and worldviews. These two worldviews (biomedical and traditional healing) are not necessarily in conflict, but their "interpretative schema are based on different principles and not on the 'authority of science'" (2003:230). In this sense, therefore, she argues that it is not just a question of modern science versus traditional healing, but it must also necessarily include "the current religious fervor in Africa with its plethora of new churches promising new forms of spiritual healing" (2003:231).

Here Heald is probably making reference to the African Independent Churches (including African Pentecostal churches) which often engage in "faith healing". Such churches, although rejecting the "spirit world" and its link to sickness, "give hope of deliverance and protection from evil in all its present forms including evil spirits and sorcery, misfortune, natural disasters, disease, poverty and socio-economic deprivation and oppression" (Anderson 2001:233). Anderson (2001) outlines that in these churches prophet-healers have taken the place of diviner-healers.

Heald (2003:231) adapts John Peel's (1977) questions in the following interesting way, providing food for thought:

> Do Africans, for example, convert to Christianity, with the assumption that old beliefs are displaced? Or do they alternatively convert Christianity, assimilating it to more familiar modes of belief? Under what conditions, and to what extent, is there a merging, syncretic response and under what conditions does opposition develop between the different beliefs and their adherents? What role are the churches, of all sizes and kinds, playing in the pandemic and how are their worldviews changing to adapt it?

122

In this regard, Knox (2008) makes a strong case for the inclusion of the cult of the ancestors into Christianity in the fight against AIDS. Knox explains that for Africans death does not mean an abrupt end to life: the dead proceed to the world of the ancestors, where they may still have contact with the living and are able to influence their lives. They are not worshipped so much as venerated. In times of crisis this traditional discourse helps to make sense and to give meaning to a situation. Ancestors are believed to be responsible for the wellbeing of their descendants; they deal with misfortune and restore blessing. Knox (2008:175) therefore argues that they should be seen as "agents of salvation" in restoring health and harmony to a family affected by AIDS. Salvation here does not have to do with a future life, but with the present reality of a community's life. It is, moreover, not so much aimed at restoring physical health, but rather relationships, the sense of belonging and the personhood of the patient (Knox 2008:177). Furthermore the cult of the ancestors has a transcendent dimension: the person who dies faces the prospect of being reunited with deceased family members and being remembered by surviving ones.

Van Dyk (2008) too strongly stresses the importance of respecting positive traditional beliefs and practices. Accordingly, initiation rites such as circumcision should not be discouraged, but rather made safer through the introduction of sterilised equipment. At the same time, however, attempts should be made to counter negative cultural behaviours that have a role to play in fuelling the HIV/AIDS pandemic, such as female circumcision or the practice of dry sex to heighten the sexual sensation for men or to "cleanse" women (Runganga & Kasule 1995).

I believe that in unpacking the concept of care and by briefly examining the four areas above, it can be seen that care is a complex issue. Furthermore, if it is to be rendered in a people-centred manner, various factors need to be taken into consideration. Indeed, unless we are able to move to an understanding of the multifaceted nature of care, the church will not know what capacities need to be strengthened and utilised.

The rendering of care by the church also requires consideration of certain other issues that might impede its ability to respond. First, for example, there is the attitude of clergy or church ministers, pastors, etc.: when confronted with the issue of HIV/AIDS, or a person infected with the disease, do they respond with love and spiritual sensitivity? The objectification of the "other", whereby socio-cultural

divisions and values are attributed to race, ethnicity, religion, class, sexuality, etc. may be responsible for a response that is less than adequate (Devine *et al*. 1999). In other words, where the disease is predominantly concentrated among a particular socio-cultural group (for example, men who have sex with men), the church might respond in a way that does not perhaps give full support or resources. Such stigmatisation leads to social exclusion and constrains efforts to fight the disease (Kopelman & Van Niekerk 2002).

Another issue to which I believe the church needs to pay heed is this: in view of the changes that have been wrought in society (for example, the migration of people from rural areas to the cities, or the changes in information technology), has the church examined its organisational structures, so that it is still able to communicate and provide effective help to its congregations and members?

In addition, church denominations need to grapple with the problem of the extent to which they have conscientised wealthier congregations about the problems and needs confronting poorer communities.

I shall now examine the issue of HIV Voluntary Counselling and Testing (VCT) as an example of an issue where the church could demonstrate care in a people-centred developmental manner by catalysing a movement that has the potential of being global in scale. The church could do so, in my view, by transforming values and attitudes that emphasise the importance of knowing one's HIV status. This would be very much in keeping with the developmental vision outlined by Korten (1990) and others, as it would seek to increase the personal and institutional capacities of society to make choices that could improve the quality of their lives. Such an initiative, moreover, is value-orientated: sovereignty would rest in the people, allowing them to make decisions about their lives in the knowledge that, while they exercise the right of whether or not to test, they also carry the responsibilities following on from their decisions. Korten (1990:185) stresses that individual voluntary action is as important as the action of a voluntary organisation (such as a church) in contributing towards the larger synergy of a movement. Furthermore, that transformation occurs through the efforts of millions of citizen volunteers all working toward a broadly shared vision, which in this case would be to try and halt the spread of the disease.

124

3.3.2   An example of the potential exercise of care within the domain of the church: Voluntary Counselling and Testing

As we have seen in Chapter 2 (section 2.6), HIV is not spread through the air, by water or even insects. It is a blood-borne disease, transmitted through commingling of certain body fluids. Furthermore once a person is infected, there is no cure for HIV (see Chapter 2, section 2.7). There are no visible signs of the disease and a person may look and feel healthy for several years before the disease manifests itself (see Chapter 2, section 2.6). For this reason, therefore, testing for HIV is vitally important.

Voluntary counselling and testing (VCT) is an important prevention strategy, as it is believed that if people know their HIV status and they are seronegative, they can be encouraged to continue to remain negative. Where people are seropositive, then the WHO (2000:1-4) recommends that people should be motivated to:

- Live positively;

- Use care and support services at an earlier stage;

- Learn to prevent transmission to sexual partners;

- Plan for their own and their family's future.

HIV tests are usually antibody tests (i.e. they test for antibodies that have reacted to infection with the HI virus) or tests that detect the virus in the blood. HIV antibody test are usually performed on blood, but saliva and urine could also be used. The two main tests for HIV antibodies are ELISA and Western Blot. Once information has been provided on HIV, its prevention and treatment, it is recommended that people be encouraged to have an HIV test, particularly in circumstances where they or their sexual partners might have been at risk. Such tests should be undertaken only after full counselling has been undertaken and where a person consents voluntarily. Privacy and confidentiality are vital. Counselling after the test is also recommended, so that advice can be provided to those who are HIV negative to remain negative, and support is given to those who are HIV positive.

There are two matters to bear in mind with testing. First, following exposure to the virus there is an initial period during which specific antibodies will not have been produced. A test for HIV will therefore not show any sign of infection (see Chapter 2,

section 2.7). This is known as the window period and may last for eight to ten weeks. A person may not know therefore that he or she is infected and could unknowingly pass the virus on. Secondly, it is not possible to determine HIV infection in a newly born child, as an HIV positive mother will pass large amounts of antibody to her newborn. An HIV test on a child is therefore usually performed only after 15 months (Corbitt 1999; Grundmann *et al*. 2011).

In an interesting study by Van Dyk and Van Dyk (2003a) in South Africa, it was demonstrated that while most people thought it important to know their HIV status, only 51% had been tested for HIV. Those who would not go for VCT gave various reasons, including the fact that they perceived a lack of treatment options and support following diagnosis, together with the fact that they feared prejudice and rejection. Furthermore, they believed that knowing their HIV status would lead to depression and early death. Logistical problems, lack of privacy, long queues at clinics, etc. were all barriers to undergoing VCT (Van Dyk & Van Dyk 2003b).

Those who said that they would go for VCT stated that they would do so only in an area where no one knew them. Moreover, they did not trust the health care system and feared prejudice by health care workers. Also of interest is the fact that both men and women feared rejection by their partners if they disclosed their HIV status. Women feared disclosure would mean a loss of security and the possibility of violence, while men feared loss of sexuality and sex appeal, along with a fear that no one would look after them when they were ill.

With regard to changing sexual behaviour if the HIV result proved to be positive, the majority said that they would (Van Dyk & Van Dyk 2003b). However, about a quarter of the survey said that they would not change their behaviours for various reasons, including a sense of fatalism or because they felt that they would somehow escape death. Where people knew of someone who had died of AIDS, they were much more likely to change their behaviour. Importantly, if people tested negative, they said that they would be prepared to change their behaviour.

The area of VCT is one in which, in my view, the church is able to make an enormous difference. If all Christian churches, irrespective of denomination, were to work together to promote VCT, they could potentially transform attitudes and values by

making responsibility for one's own health and the health of others their key consideration. Such an initiative also has the potential for halting the spread of HIV. By creating an accepting, supportive, confidential environment, where people would not fear rejection, discrimination and stigmatisation, the church would be able to encourage people to come forward to be tested. During a recent lecture at Stellenbosch University, Professor Manuel Castells[36] commented that in social movements it was the message that was important. Following on from the message, the media were important to amplify, spread and disperse the message. The other issue to which he made reference was the importance of inspiring the youth, as they generally were able to allow a movement to gather momentum, because they used social networks as a means of mass social communication. In my view, there is no reason for the church not being able to inspire such a movement with regard to testing commencing with the youth.

Many churches, however, have chosen not to use VCT as a strategy to combat HIV/AIDS. We can speculate that churches do not do so because if they did, they would be acknowledging the fact that relationships are broken, that some people do not abstain from sex before marriage, or that they do not confine themselves to sex within marriage, despite church teachings. In many ways, it is easier for the churches to repeat their mantra that the best way to prevent AIDS is to avoid engaging in any risky sex behaviours. Castells (see footnote 36) mentions another reason: fear is the biggest factor in preventing people and organisations from acting. However, although the church may not know the final outcome of this initiative, it is important to take this leap.

Campbell (2000) has demonstrated that conscious individual control over sexual and other health-related behaviour is constrained by many factors over which an individual may have very little control. Furthermore, the need for trust and intimacy is a powerful driving force in sexual behaviour. Social and economic factors also play a role, including poverty and migrant labour. The whole issue of gender imbalances (see Chapter 2, section 2.9.2) points to the fact that safer sex behaviours are not always under the control of the individual.

---

[36] Personal notes: Professor Manuel Castells gave a STIAS Lecture on 16 August 2011 at Stellenbosch University, entitled "Socio-political movements in the Internet Age: from Cairo to Barcelona".

Furthermore, any HIV programme that seeks to simply target vulnerable groups (for example, young people) has little chance of success unless it takes into account other factors and groups that also affect behaviour, such as power relations within communities, social stigma and conflicts of interest. A local community and its dynamics, along with macro-social relations will also have an important bearing on prevention. Accordingly, because health-related behaviours are not solely determined by conscious rational choice by individuals, but also by community and societal contexts that support and enable behaviours, the community too ought to be targeted (Gillies 1998; Sumartojo 2000; Campbell & Cornish 2003) and the church, being situated in communities, is in a good position to do so.

With these factors in mind, VCT could potentially be an area in which the church could act. Of course, it could be argued that because there is no cure for the disease and because individuals in the early stages of the disease can be healthy, there is no reason to call for mass voluntary testing, as nothing medically can be done. There is also the fact that knowledge of one's positivity could cause those infected to become depressed and even in some circumstances, suicidal. However, Erin (1999:240-266) puts forward a strong moral argument for testing: where a person is not prepared to act as if he or she were HIV positive, and where one cannot predict that one's actions would put another person at risk, then one is under a moral obligation to discover one's HIV status and cannot claim a "right" to remain in ignorance.

So too, the church makes a strong case for acting "responsibly". Bate (2003:x) defines responsibility as follows: "Responsibility, however, is not principally the apportioning of blame but rather the empowerment of people to take charge of their lives in an ethical human response to this crisis which affects us all." Empowerment of people goes to the heart of what Korten advocates: by urging people to test and creating a supportive environment, people are able to take control of their lives and their health.

But how could the church go about successfully embarking upon an AIDS – or more specifically – a testing programme? The short answer, it would seem, is that activism is required that is aimed at personal transformation and the creation of new relationships. Such a programme, if grounded in the church's motivation to act and respond with love and care, could meet with enormous success. Issues such as stigmatisation, privacy, confidentiality and social exclusion would need to be

addressed. However, it is not simply a question of activism within the church. The church would also need to engage with the government, medical authorities and HIV/AIDS NGOs to ensure that those in need of medical, psychological and other help are able to access assistance: testing cannot be undertaken without also ensuring that the right support mechanisms and help are in place. Networking with doctors, social service organisations, support groups and others will be necessary. Working with the government and other organisations on such issues would not mean political co-opting, but rather a way of acknowledging that on some issues it is important to work with other organisations, bodies and people. Both wealthy and poorer churches would have to be targeted, as HIV/AIDS is present in all socioeconomic spheres and it might be that wealthier churches would have to subsidise the efforts of poorer churches, thereby giving witness to the principle of stewardship in Christianity.

Bearing in mind the church's calling to respond with love, and given the broad definition that I have outlined in relation to care, I now propose to highlight certain issues in relation to the history of HIV/AIDS in South Africa in order to discern the circumstances where the church might have been expected to do more towards mobilising voluntary social energy in tackling HIV/AIDS in a people-centred developmental manner. I have entitled this section "Opportunities missed" and the purpose of examining this area is to suggest some of the issues that the church needs to confront if it is to engage in people-centred development, as defined by Korten (1990) (and briefly discussed in Chapter 1).

In looking at the history of HIV/AIDS we will also be able to assess whether the church has mobilised the considerable people power that it has at its disposal; we will be able to see whether it has engaged, inspired and given hope to people; whether it has confronted, where necessary, the prevailing political and economic powers; whether it has taken into account the new and changing nature of society both in South Africa and globally. I believe that it is only by studying the history of the disease and in trying to analyse the significance of certain events that the church can actually move forward and make a greater, more effective contribution to the fight against the disease.

3.4   Opportunities missed

Korten (1990:95-108) takes the view that development is not the task of government. While government has a role to play, so do business and voluntary organisations. The legitimacy of each is based on the belief that they all serve an essential function by meeting the needs of third parties: the legitimacy of government is premised on the belief that it serves the interests of its people; business exists to serve the needs of its customers, and voluntary organisations exist to serve those needs that have been neglected or left unmet by government and business.

It will be recalled that the *aim of this dissertation is to examine whether the church can exercise HIV/AIDS care in a manner that Korten would describe as transformational.* In this section a retrospective, historical, inductive analysis is undertaken to see what action the church, as a voluntary organisation, has undertaken in order to fulfil its function of care in situations where needs have not been met.

3.4.1   Possible causes for the church's initial inaction: fear and/or prejudice

Korten (1990:97) defines voluntary organisations, such as churches, as specialising in "integrative power" that is to say they are able to utilise shared values in order to mobilise human and financial resources to create a better world. The pertinent question posed in this section is whether the church used this value commitment to mobilise and render care.

In examining the early years of the identification of the HI virus, I believe that it is possible to discern the possible reasons that prevented the church from acting in a manner that was people-centred.

Research from low- to middle-income countries such as Uganda (Parkhurst 2002; Gow 2002) and Thailand (Ford & Koetsawang 1999) has demonstrated that where governments have shown leadership in the fight against HIV/AIDS, they have had some success in containing the epidemic. Some high-income countries have also achieved success, but as will be seen below, such success was largely driven because a vocal group of people from the homosexual (gay) community, worked hard to ensure that the rights of those infected or affected by HIV/AIDS were recognised and addressed, particularly in the United States of America (USA) and Western Europe (Epstein 1996). By and large, however, in low-income countries those affected by HIV/AIDS have not had the economic muscle or the political influence to encourage

their governments to take more urgent action. Herein lies the gap in which the church might have been expected to act.

In 1981 a rare cancer associated with immune suppression, called Kaposi's sarcoma, began to manifest itself among gay men in the USA and was known at first as Gay-Related Immune Deficiency (GRID) or gay cancer. Immune disorders also began becoming apparent among injecting drug users, Haitians living in the United States, along with haemophiliacs. These groups of people therefore became known as the "4 H's – homosexuals, heroin addicts, haemophiliacs and Haitians" (Gilman 1988:245). It was not until 1982 that the disorder was named Acquired Immune Deficiency Syndrome (AIDS). Such "cultural othering" was counter-productive in the long run as it led to stigmatisation, blame and marginalisation (Schiller *et al*. 1994:1338), as well as giving a false sense of security to those who did not fall within these categories. Soon after the identification of the disease in North America, AIDS was also identified in Africa.

In 1983 the retrovirus responsible for the transmission of the disease was identified by Luc Montagnier of the Pasteur Institute, France, and by Robert Gallo of the United States in 1984.

During 1984 a hospital in New York sparked alarm after speculating that AIDS could be spread from casual contact. This triggered panic and clearly health educators were left struggling with these very same fears many years later (Shilts 1987), despite the fact that they were unfounded. This was however to have a lasting impact on the disease by increasing prejudice and discrimination against people with AIDS.

In Simon Watney's book (1987) *Policing Desire* it is instructive to observe the harm that was caused by a consistent misrepresentation of AIDS. Media coverage gave the impression that gay lifestyles and the gay movement were responsible for AIDS, rather than a virus. Haemophiliacs and those infected through blood transfusions began to be represented as "innocent" victims. Comments, such as those by Rabbi Julia Neuberger,[37] seemed to carry little weight in the face of such prejudice. She remarked that it was a strange God who chose to punish male homosexuals and not

---

[37] Rabbi Julia Neuberger is Britain's second female Jewish rabbi. She is a social reformer and the first woman to have her own synagogue.

females, and who was angry with drug takers who inject intravenously, but not with those who sniff.

Another factor that ought to be taken into account is the fact that AIDS appeared at the time when the so-called Christian right became prominent and vocal in the USA, having fought high-profile campaigns against gay rights in Florida and California, during the time of President Ronald Reagan's election. AIDS was characterised as the wrath of God and the wages of sin against homosexuals. This not only contributed to the prejudice around HIV, but more importantly it influenced health education as well as research funding (Shilts 1987).

This then was the background against which AIDS was first identified in South Africa.

The National Party government of the day calmed public fears by saying that the general population was not in danger, the implication being that it was a disease confined to the gay community. Little attempt was made at prevention at this stage and this attitude was typified by the then Director General of Health, Coen Slabber, who remarked to the press: "Homosexuality is not accepted by the majority of the population and certainly not by the Afrikaans-speaking population. To advocate that homosexuals use the condom is therefore very difficult" (Lawson 2008).[38] It should be noted that at that time homosexual acts were illegal in South Africa. In such circumstances, therefore, the virus began to take hold.

Although African men and women had been showing symptoms of AIDS in the early 1980s, it wasn't until the mid-1980s that it began to be appreciated that AIDS could threaten the heterosexual population. In 1986, therefore, major public education campaigns were launched in the UK and the USA. The message was that AIDS was a potential risk for everyone. But as Mageto (2005:297) explains, a major barrier for the church, particularly in Africa, in engaging with the issue was the association of HIV/AIDS with homosexuality. De Gruchy (2004:235) expresses it as follows: "[t]he link between AIDS and sex, alongside the longstanding Christian link between sex and sin, has bedevilled the response of the church and Christians to the pandemic."

---

[38] Quoted in Lawson (2008:22).

The early years of the disease were also marred by confusion and ignorance: rumours abounded that mosquitoes and kissing could spread the disease. It was also assumed that those diagnosed with HIV would develop AIDS within a year of being infected (whereas in fact, in the absence of ARVs, people infected with HIV take 8 to 13 years before developing AIDS (see Chapter 2, section 2.7)). The consequences of such confusion resulted in people questioning the link between HIV and AIDS.

Further confusion resulted from the suggestion at the first international AIDS conference, in 1985, that the disease could have emanated from African primates. Somehow, because it was known that HIV could be sexually transmitted, there was an association in people's minds that HIV had been transmitted from animals to humans through sex. The spread of the disease in Africa was further attributed to the promiscuous, "exotic" behaviour of Africans or to cultural practices undertaken by traditional doctors, such as circumcision and scarification; the media were implicitly racist in their portrayal of the disease (Packard & Epstein 1991). Speculation about the differences in sexual behaviour between the peoples of Africa and those of the West abounded. However, research since has shown that there are no dramatically different patterns of behaviour and that most people, whether in the West or in sub-Saharan Africa, have a limited number of sexual partners (Auvert *et al*. 2001; Ferry *et al*. 2001). In fact, recent studies indicate that the difference in sexual behaviour does not lie in the number of sexual partners that a person has, but rather in the sexual networks to which a person is connected (see Chapter 2, section 2.9.3 and also Jolly *et al*. 2001). Moreover, in population groups where concurrent sexual partnerships are common, there is a particularly high vulnerability to HIV infection (Morris & Kretzschmar 1995).

Nonetheless, such speculation was to result in prejudices that were to influence the HIV/AIDS debate for many years: blame for the spread of the disease was assigned to gays and to Africans, and the result was stigmatisation and misunderstanding. The fact that infectious diseases such as SARS, avian flu and more recently swine flu have also crossed the species barrier[39] without sexual contact seemed to have escaped

---

[39] Diseases that can be transmitted from animals to humans are called zoonoses and they have always posed a threat to the human population, e.g. Ebola, Marburg, SARS.

notice in the heated atmosphere of the time. This in no small measure contributed to a suspicion about science.

Lawson (2008:28-31) charts how a racist ideology began to permeate the AIDS debate, with black people being blamed for the origin of the disease and its transmission. Not surprisingly, African scientists and commentators reacted with anger and defensiveness, sowing further seeds of doubt that were to result in the birth of AIDS denialism and the idea that immune deficiency (resulting from poverty) was the cause of the disease that was being seen in Africa. On the other hand, however, the disease among gay Americans was attributed to liberal attitudes towards sex, together with factors such as drug abuse. Labelling of groups of people and highlighting their differences became the norm, whether in the form of homophobia and misogyny, or racism and xenophobia.

Research by Caldwell *et al*. (1989) which sought to highlight the differences in sexual behaviour between Eurasians and Africans merely added to the prejudice, because of their over-simplistic analysis of a complex issue. Scientific evidence is, however, able to demonstrate that there were in fact two separate epidemics: the first, subtype B (linked to sexual networks in the gay community particularly in the USA and Europe) and the second, subtype C (linked to sexual networks in Central, East and Southern Africa). There is therefore no "gay" virus or "black" virus: the type of virus that a person gets depends on the sexual networks to which a person is exposed.

In 1987, however, AIDS had still not made a significant impact upon the heterosexual population of South Africa (Shoub 1987), probably owing the fact that South Africa's borders were largely sealed to neighbouring countries and South Africa was isolated because of its policy of apartheid. Yet South African mines employed a large number of migrant workers. Under apartheid's system of influx control these migrant miners were contracted to the mines for a year and lived in single-sex hostel accommodation located close to the mines. Away from their families, many of these workers established partners/families in South Africa, or they used the services of local sex workers. The social, economic, political and living conditions of the time set the scene for the spread of disease among workers in mining communities. Research was later to demonstrate that mining conditions also bred notions of masculinity that drove people to engage in risky sexual practices, despite being aware of the disease

(Campbell 2003). Such notions, along with sex and gender roles were factors that contributed to the spread of HIV (see Chapter 2, section 2.9.2). Dr Hoosen "Jerry" Coovadia, a scientist and AIDS expert goes further: he attributes the present culture of "macho male" in South Africa to the breakdown of black culture and traditions which has its roots in South Africa's colonial past (Davies 2009).

Although by the late 1980s it was known that the epidemic had taken hold in the heterosexual population, the South African government did not react as boldly as it might have done. As South Africa's borders began to become more porous and a large number of refugees and migrants poured into the country, the disease gained a foothold. Increasing trade with South Africa's northern neighbours by truckers and traders, along with the return of members of the South African Defence Force (SADF), as well as African National Congress (ANC) guerrillas, allowed the virus to penetrate the country (Lawson 2008). The abolition of influx control also resulted in a mass movement of people from rural to urban areas, providing the virus with what Lawson (2008:47) accurately describes as "unfettered movement across the land".

In 1988 the National Party government began an awareness campaign that was largely moralistic in character; for example, one of the messages urged people not to "sleep around" (Lawson 2008:65); the implicit message was therefore that promiscuity was causing the spread of the disease and this led to people who had contracted HIV being stigmatised. What the education campaign failed to take into account was, for example, the case of babies born to HIV-positive mothers or married women who were faithful to their husbands, but whose husbands were not in fact monogamous.

But the South African government was not the only government to respond slowly. In the USA and the UK it was only in the late 1980s that information campaigns began to be targeted at those most at risk. Clearly the allocation of resources to socially unpopular groups was a predominant factor in such decisions (Altman 1986). Voluntary organisations in the UK and the USA therefore had to respond to the crisis in order to close this gap. Initially such organisations merely provided information and voluntary support, and it was only later that they were to develop sufficient skills to provide services and policy advocacy (Altman 1994). Such voluntary groups were among the first to work with vulnerable groups, such as gay men, drug users, prisoners, women and children. Faith communities and families became involved and

135

churches, while emphasising Christian family values, did not at this stage engage with the issue of prevention, but rather concentrated on the practical care of those who were infected. This did, however, enable such voluntary groups to develop a wealth of experience. Epstein (1996) has documented how the gay community in the USA mobilised and educated themselves, in the face of marginalisation, so that they were able to enter into a discourse with the medical profession. Having gained credibility with the medical profession, they were able to enter the political sphere, where they lobbied for comprehensive AIDS education initiatives, further research and funding, and contributed to the formulation of policies on a whole range of issues, from human rights to public health policy. The birth of gay activism entailed not only becoming experts, but networking among experts. The church, however, appears to have taken a much more back-seat approach. Support groups also arose in response to the disease, many of which were initiated and supported by church members. But it appears that the church itself did little to demand state action and appropriate state policies.

By 1990 the South African government, realising the potential consequences of the disease, also began to distribute condoms and set up AIDS Training, Information and Counselling Centres (ATICC) to provide free HIV testing and counselling. These centres operated largely independently of government and did an excellent educational job, but the black population initially shunned them, as they feared that this was a population control measure (Lawson 2008:68). At this time NGOs began to proliferate in South Africa to fill in the gaps left by the government's prevention initiatives, thus mirroring the experience in the USA and the UK.

De Gruchy (2004:234) explains that it is difficult to get an overall picture of the church's response to the crisis in South Africa. While many Christians and local congregations steered away from the crisis, some local churches and Christian organisations responded in an inspiring manner. They established care centres, clinics, home-based care programmes, and interventions for orphans and vulnerable children.

In summary, I am suggesting that during the early years of HIV/AIDS the church did not respond with love and care because it did not know what to do, as the disease raises issues of sex, sexuality and sexual ethics. Its inaction or sluggish response can be said to be indicative of the church's lack of a vision and an inability to exercise its integrative powers.

3.4.2   Possible reasons for the church not tackling business and economic powers: reluctance and/or lack of know-how

In this section I propose to examine the battle between the South African government and others against pharmaceutical giants to reduce the price of life-saving HIV/AIDS drugs. I highlight the fact that the church was not evident in this battle and question why that was the case, particularly in an issue as important as life and death. Could it be that churches have not yet learnt new capabilities to enable them to engage with business? Has the church yet to learn how to bring economic powers to account? Here again I use Korten's definition of business (1990:97). Businesses specialise in economic power and their role is to create new wealth through value-added activities. They are naturally orientated towards market forces and accordingly have to be responsive to those who have purchasing power in the market, including the government. We have seen in recent years that ordinary citizens can bring businesses to account, particularly on issues of ethical practices and corporate social responsibility, for example, regarding the environmental impact of a company's operations. I am suggesting that the church can in a similar way potentially exercise its influence in bringing authorities, economic powers and business to account.

When the ANC government came to power in 1994, after the fall of apartheid, it faced many problems. Within the health sphere itself there was the issue of a dual health system, where the private health sector catered for a fifth of the population but consumed half of the health budget, while the bulk of the population had to make do with an under-resourced public health sector (Singh *et al*. 2005). Despite earlier promises, HIV/AIDS consequently took a backseat on the government's list of priorities.

The Health Minister, appointed by the then President Nelson Mandela, Dr Dlamini-Zuma, embarked upon restructuring the health system, including the provision of free public health for children under six and pregnant women. She also set about establishing a district health system, with the provision of primary health care at minimal cost (Lawson 2008).

However, it was the reform of the tobacco industry and the pharmaceutical sector that were the most controversial matters that she set out to tackle, which were to consume her and make her powerful enemies, as she sought to challenge vested interests

137

(Lawson 2008:89-92). Furthermore, in introducing abortion on demand (Lawson 2008:90), she was to cause outrage among religious groups and churches. This could therefore be a reason why the church felt alienated from the Health Minister rather than supportive of her and her other objectives.

In the tobacco industry Dr Dlamini-Zuma introduced health warnings on cigarette packets and proposed anti-smoking legislation in public places (Lawson 2008:90). In the pharmaceutical industry she proposed bringing down the price of drugs and introducing a more coherent national drugs procurement policy. With the blessing of the WHO, she embarked on a strategy to develop an essential drugs list and standard treatment for use in the public health system. Where South African companies were unable to manufacture drugs cheaply, she proposed importing medicines from other countries. She also proposed measures to introduce generic drugs, which earned her the ire of multinational companies who wanted to continue to have a monopoly on the market (Lawson 2008; Lisk 2009).

In 1996 considerable strides were made regarding HIV treatment. At the XI International AIDS Conference in Vancouver, it was demonstrated that a cocktail of three different drugs, known as antiretroviral therapy (ART), could suppress the virus (Lawson 2008:107). However, the regimen was complex, requiring some 20 different drugs to be taken at different times and the costs were prohibitive. At the Conference it was also demonstrated that a single drug, AZT, could reduce the risks of transmission of HIV from mother to child. The provision of such drugs to the general population seemed out of the question for South Africa, because of their costs.

In 1997 a battle commenced between the Health Minister and pharmaceutical companies (Lawson 2008:121-130). South Africa reputedly had one of the highest prices for medicines in the world and Dr Dlamini-Zuma therefore proposed changing the way in which drugs were procured, selected, distributed, priced and used. Besides encouraging the use of generic drugs, a clause was inserted in the Medicines and Related Substances Amendment Bill permitting the parallel importation of drugs. In other words, where branded medicines were more cheaply manufactured in another country, the South African government would have the power to import drugs from those countries (as was the norm in countries such as Japan and the European Union). Dr Dlamini-Zuma argued that public health interests should prevail over commercial

interests and, furthermore, that medicine prices should be lowered to benefit the poor. Lisk (2009:119) summarises the battle aptly by labelling it a "patient's rights versus patent rights" confrontation.

Local pharmaceutical companies and their parent companies in the USA and Europe reacted strongly against such proposals (Lisk 2009:119-122). Furthermore, they argued that a clause in the draft Bill would enable manufacturers to copy drugs that were still under patent. Such compulsory licensing was, they argued, illegal under the WTO's patent agreement, known as TRIPS (Trade Related Aspects of Intellectual Property Rights). However, they failed to acknowledge that there were provisions in TRIPS to allow for compulsory licensing in certain situations. The USA pharmaceutical companies were particularly alarmed and in 1998 succeeded in placing South Africa on a watch list of countries that allegedly did not provide adequate intellectual property protection (Lawson 2008:141-142). As a result, the USA began to withhold trading benefits from South African companies.

At this time medical advances in treatment were moving at a pace: a study in Thailand demonstrated that a short treatment course of the drug AZT, when given to an HIV-positive mother after her 36th week of pregnancy, halved the likelihood of the transmission of HIV from mother to child (Kumphitak *et al*. 1999). But there were problems, one of which was the cost aspect (at the time, it cost over US$200 per woman). Other issues included HIV testing, counselling, making formulae feed available for mothers, the capacity of the health sector to cope, etc. Furthermore, it was estimated that the programme would cost some R80 million per annum (Lawson 2008:151-156). The government therefore opted for HIV prevention as the basis of its HIV programme, rather than provision of the drug. In the meantime HIV prevalence among pregnant women rose from 17% in 1997 to 23% in 1998, as evidenced by the antenatal surveys.

In June 1998, at the XII International AIDS Conference in Geneva, the plight of low-income countries was highlighted (Lawson 2008:155). Until then, those who were HIV positive in both northern and southern hemisphere countries faced the same fate. Now, however, with the advent of triple therapy, people in the North were able to live longer and have more productive lives, whereas those in the South had to content themselves with preventative measures. It was argued, with some truth, that the cost

of ART was prohibitive for developing counties. Furthermore, the point was made that developing countries lacked the health infrastructure and necessary medical equipment/know-how for the rollout of such a complex regimen. Nonetheless, the injustice of treatment options for the poor was responsible for the Conference slogan "Bridge the Gap" (UPI 1998).

On World AIDS Day 1998, Peter Piot, Executive Director of UNAIDS was to comment:

> Whether measured against the yardstick of falling life expectancy, deteriorating household income, overburdened health systems, child deaths, orphanhood or bottom line losses to business, AIDS has never posed a bigger threat to development (HRI: 1998).

The church does not seem to have been evident in this debate. It was up to an activist called Zackie Achmat and Mark Heywood from the AIDS Law Project to join forces and create an organisation dedicated to advocating for treatment. This organisation came to be known as the Treatment Action Campaign or TAC. Lawson (2008:183) notes how the organisation was "canny in its use of struggle language, strategy and tactics. It chose the familiar language of street politics for its slogans, and launched their campaigns on days of historical significance." Thus Human Rights Day, 21 March 1999, was used to launch the campaign for mother-to-child prevention and it garnered the support of some government officials, as well as religious bodies, trade unions, workers in the health sector, etc. (Lawson 2008:183).

At this stage the TAC and the Health Minister were in agreement: pressure had to be brought to bear on pharmaceutical companies to reduce the price of drugs in order to make them accessible to the poor. Abroad, similar debates were being conducted. At the WTO meeting in Geneva in early 1999 the WTO agreed with the activist interpretation that poor countries ought to be allowed to manufacture and import cheap generic drugs (Lawson 2008:192; Lisk 2009:120). Indeed, they said that parallel imports and compulsory licensing were permitted under the TRIPS agreement (which was incidentally the view that had been adopted by Dr Dlamini-Zuma). The pharmaceutical industry and the USA government, however, disputed this interpretation and in so doing created a coalition of health professionals and activists against them both in South Africa and, indeed, in the USA. For the first time the issue of intellectual property rights and AIDS became linked in the public's mind. In the

USA organisations such as the Consumer Project on Technology and the AIDS Coalition to Unleash Power (ACT UP) joined activists in South Africa to demand more affordable medicine for the South. In December 1999 the USA government conceded that the TRIPS agreement permitted countries to respond to public health crises by accessing affordable medicines. The case was not settled, however, and awaited trial (Lawson 2008:199-200).

In setting out the battle to secure access to life-saving medicines, I am suggesting that this is an area in which so much more could have been done by the churches to exercise pressure on both the pharmaceutical companies and the US government.

In 2000 the United Nations Security Council acknowledged that HIV/AIDS was a threat to peace and stability (UN Security Council 2000:2; McInnes 2006). Also in 2000 a new drug to reduce HIV transmission from mother to child was introduced, namely nevirapine. Not only was it much cheaper than AZT, at a cost of R25, but it was also effective in reducing transmission by more than 50% and it was easy to administer, requiring only a single dose to both mother and child at the time of birth (Skordis & Nattrass 2002). But the Minister of Health at that time, Dr Manto Tshabalala-Msimang, questioned its safety and said it should not be used until further trials had been undertaken (Lawson 2008:215). In the Western Cape, however, the health department ignored the national minister's advice and began to administer AZT and nevirapine to HIV-positive mothers to prevent vertical transmission.

At that time an Indian pharmaceutical company, Cipla, announced that it would be able to provide a generic version of the triple cocktail of ART drugs at a cost of US$800 per annum per person, compared to the branded drugs, which cost more than US$9000. Moreover, Cipla expected that it would be able to reduce its prices still further in the years to come. This was to induce the three main international pharmaceutical companies, Glaxo, Merck and Bristol Meyers Squibb, to reduce their prices by as much as 90% by March 2001 (Lawson 2008:241).

The case by the US pharmaceuticals against the South Africa government's Medicines Act commenced in March 2001, with the former arguing that patents were necessary to protect profits, which could then be utilised for further research and the development of life-saving drugs. However, in court it was demonstrated that cost of

research and development was not as high as was suggested, as academic research and government funding reduced the costs to drug companies. Clearly therefore, the rationale for the case was the protection of pharmaceutical profits. With drug companies being accused of exploitation of health conditions in poor countries, such as South Africa, they faced a public relations disaster and as a consequence withdrew their case (Lawson 2008:243-247; Grebe 2011).

Although there is some evidence that the church lent its support to the TAC's movement for greater access to treatment (church leaders, members of congregations, religiously affiliated non-governmental organisations participated in events such as protest marches against pharmaceutical companies),[40] the interesting question is why did the church not take the initiative when it saw that pharmaceutical companies were not meeting the needs of the majority of people requiring treatment? The church did not speak out against the greed of pharmaceutical companies, or against the unfair world trading system. The church in South Africa did not use its networks and affiliations to exercise pressure on USA pharmaceuticals. It appears to have failed to conscientise business about their corporate social responsibilities. It appears to have failed to have recognised that it has a watchdog role to play in relation to public interest issues and in bringing economic powers to account. Reluctance and/or a lack of know-how may be proffered as reasons for the church's failure to engage.

3.4.3   *Possible causes for the church's failure to negotiate the political landscape: inability and/or unwillingness*

In this section I shall look in closer detail at the South African government's handling of the HIV/AIDS crisis. Bearing in mind that certain churches (especially members of the South African Council of Churches, the evangelical and Pentecostal denominations), church leaders and Christians played a role in opposing the apartheid government, it could be expected that they would play a role in opposing the injustice of another system, namely one that deprived people of life-saving treatment. Korten (1990:97) defines government as the sole power that is able to exercise legitimate coercion, as well as command resources, for various purposes (including the provision of health services) for its citizens. In the allocation of such resources, Korten

---

[40] See www.tac.org.za

comments: "it [government] tends to be most responsive to the perceived needs of those who possess political power, irrespective of the lip service it may give to populist rhetoric" (1990:97). It is this respect that we shall look at the South African government's response to the unfolding epidemic of HIV/AIDS and what role, if any, the church has played in articulating the needs of its people, bringing government to account or educating citizens about democratic citizenship. In other words, has the church demonstrated the political clout that it is able to exercise in bringing the government to heel and urging it to act in the interests of the people?

In February 1990, when Nelson Mandela was released from prison and the ANC was unbanned, AIDS was placed as a priority on the health desks of both the ANC and the ruling government. A National AIDS Plan was drawn up, dealing with issues such as education, prevention, counselling, health care, human rights, confidentiality, etc. (Nattrass 2004:41-43). The timing of the report however came at a time of sensitive political negotiations in South Africa and when the WHO's response to the epidemic was faltering too (Lawson 2008:73-77). At a time therefore when HIV was spreading rapidly, there was no coherent, comprehensive strategy in place.

Following the election of President Nelson Mandela in May 1994, Dr Dlamini-Zuma was appointed health minister and Cabinet adopted the National AIDS Plan. Unfortunately, the AIDS programme was not placed within the president's office but with the Department of Health (Nattrass 2004:43). President Mandela therefore failed to give it the stamp of leadership that it required. Furthermore, the new government was faced with many issues, not least dismantling apartheid structures, as well as dealing with the thorny issues of redistribution of resources and services. AIDS was therefore only one of many national priorities. The health system was also haemorrhaging through loss of staff and the National AIDS Plan failed to make the progress that had been expected (Nattrass 2004:44). The Health Minister also faced a number of other issues (see above). The church too seems to have been paralysed and failed to bring government to account. De Gruchy (2004:223) attributes this to the increasing role that the church played in the struggle against apartheid, so that when that dispensation came to an end, a "denominational myopia" occurred, together with a preoccupation with internal ecclesial concerns, as well as a number of emerging issues in the public arena.

143

In June 1999 the political landscape changed with the election of Thabo Mbeki as president of South Africa. He appointed Dr Manto Tshabalala Msimang as his health minister. It was hoped that there would be a new beginning with regard to the relationship between civil society groups and the government in relation to HIV/AIDS. However, President Mbeki cast doubt on the safety of AZT during an address to the National Council of Provinces,[41] urging caution in the roll out of AIDS drugs in the public health system. Furthermore, he urged Members of Parliament to undertake their own research on the issue. This pitted government against the scientific community which, while it acknowledged that AZT had side effects, maintained that the benefits outweighed the risks. AIDS NGOs, including the TAC, therefore continued to demand that AZT be made available to reduce mother-to-child transmission of the virus (Vandormael 2007).

It became apparent in early 2000 that President Mbeki had been questioning whether HIV was in fact the cause of AIDS. In this regard, he was influenced by AIDS denialists (or AIDS dissidents), who claimed that the HIV test was unreliable and furthermore that HIV was not a harmful virus that could be sexually transmitted (Vandormael 2007:220). The denialist camp argued that AIDS was caused through factors unrelated to HIV, such as poverty, malnutrition, parasitic disease, etc. In other words, AIDS was being conflated with immune deficiency. When the President convened a panel of experts (the President's Advisory Panel on AIDS) to look at the issue of AIDS in Africa, it comprised some well-known personalities from the denialist camp, such as Dr Peter Duesberg.[42]

Against this background, at the XIII International AIDS Conference held in Durban in 2000 the TAC, along with the US organisations ACTUP and Health Gap, organised a Global March for Treatment. Protesters from 230 organisations and 33 countries were represented and were addressed by political and religious leaders,[43] who demanded

---

[41] President Mbeki's address to the National Council of Provinces (Mbeki 1999).

[42] Professor Peter Duesberg, is a prominent retro-virologist, and together with Matthias Rath, a German physician, they questioned the scientific basis of the belief that HIV causes AIDS and the use of AZT in its treatment. Professor Duesberg hypothesised that American/European AIDS diseases came about through the use of recreational drugs or AZT itself, and in Africa the epidemic was the result of poor nutrition/the environment (Duesberg 2000).

[43] See footnote 40, which also refers to: www.tac.org.za.

affordable drugs and a national programme to prevent mother-to-child transmission (Lawson 227-229).

But despite the US government conceding that the TRIPS agreement permitted the importation of affordable drugs, and despite research which demonstrated the efficacy of nevirapine, the Health Minister made it clear that antiretrovirals were still not affordable enough for South Africa to be introduced into the public health system. Furthermore, the drugs would also not be made available as a post-exposure prophylaxis for rape survivors, or to prevent mother-to-child transmission.

As a consequence, in August 2001 the TAC brought an action against the government, arguing that the right to health was guaranteed by the Constitution and asking the High Court to order the government to make nevirapine available to the public health system. Evidence was produced that the drugs were affordable and, furthermore, that there was sufficient capacity within the public health sector to allow the drug to be practically administered. It was argued that the government had an ethical obligation to provide the drug, given its availability and affordability. The TAC in effect argued that there was "a moral contract to ensure the protection of life" (Vandormael 2007:226). The court concurred. The Health Minister, however, did not accept the High Court ruling and appealed to the Constitutional Court, leading the TAC to label her a "murderer" (Vandormael 2007:226).

A couple of months later, at Fort Hare University, President Mbeki gave a speech[44] that perhaps affords us a glimpse into how greatly the HIV/AIDS debate was tainted and influenced by race, and it gives us a clue as to why President Mbeki adopted the stance that he did. He said that some people

> demand that because we are germ carriers, and human beings of a lower order that cannot subject its passions to reason, we must perforce adopt strange opinions, to save a depraved and diseased people from perishing from self-inflicted disease. … Convinced that we are but natural-born, promiscuous carriers of germs, unique in the world, they proclaim that our continent is doomed to an inevitable mortal end because of our unconquerable devotion to the sin of lust (Mbeki 2001).

As an aside, the President's comments should have also caused the church to reflect on its failure to imbue the sense in people of all races and socio-economic stations

---

[44] President Mbeki's address to Fort Hare University (Mbeki 2001).

that they are all loved by God and that they are made in His image and likeness. Such was the legacy of apartheid, however, that it left deep scars and indeed the issue of race, as we have seen above (section 3.4.1), permeated the HIV/AIDS debate.

In April 2002 the Constitutional Court ruled that the government had an obligation to roll out a national nevirapine programme. The government agreed to abide by the ruling, but maintained that a general roll out of antiretroviral drugs was still unaffordable. It did, however, concede to provide prophylaxis for rape victims. As Lawson (2008:267) points out, the case had wider significance: "It confirmed that the social and economic rights outlined in the Constitution are legal rights that can be enforced by courts of law." The issue then became not only one of moral compulsion, but constitutional obligation too (Vandormael 2007:226).

This ruling laid the foundation for the TAC's next line of attack: although mother-to-child transmission could now be prevented, babies needed mothers and therefore mothers too should have access to treatment (Nattrass 2004:66-67). A campaign for a general treatment programme in the public health system was therefore commenced. The Minister of Health argued that nutrition and vitamins along with beetroot, garlic and olive oil could be used to improve the health of a person who was HIV positive, earning her the name of "Dr Beetroot"(Kapp 2006).

But times were changing. The Department of Health antenatal surveys continued to show that HIV prevalence was increasing and that young adults were the worst affected group. Economic consequences apart, the health sector was feeling the pressure and as a UNICEF/UNAIDS/USAID (2004) report, *Children on the Brink*, pointed out, one million children were orphaned who would grow up without the structures of family and parents, education or social skills.

The economic cost-benefit of treatment therefore began to be debated. Nicoli Nattrass (2004:13-19) criticised what she called the government's "triage economy", whereby resources were rationed. She instead argued for a "moral economy", which called for taking action in cases where lives were at risk. Lawson (2008:274) adds:

> Since the beginning of the new millennium, international thinking about HIV and AIDS had turned increasingly around the broader developmental impacts of the epidemic. It was now understood that security, governance and sustainable development would be weakened by the impact of AIDS deaths. And with this

146

knowledge came the understanding that expanding access to antiretroviral treatment was not just a moral obligation, but a necessity for the future of countries worst affected by HIV.

The church again seems to have been largely absent (or perhaps invisible?) during this debate. The moral argument for treatment is surely an obvious one in which the church ought to have engaged?

With such pressure, the government was to some considerable extent forced to look again at funding for antiretroviral treatment in the public health sector, and the Department of Health was given the remit to devise an operational treatment plan. In November 2003 the treatment plan was agreed upon ("Operational Plan on Comprehensive HIV and AIDS Care, Management and Treatment") (Abdool Karim 2004). The Department broadly committed itself to providing ART to over a million people with AIDS by early 2008, along with nutritional assistance and a continuum of care within the public health system to people living with HIV and AIDS.

Since then, there have been further challenges, as highlighted in a speech by Stephen Lewis, Co-director of AIDS-Free World (and former UN Special Envoy on HIV/AIDS in Africa)[45] at the opening of International Aids Society Conference held in Cape Town in July 2009 (Lewis 2009). He argued passionately that at a time when funding for AIDS was under threat as a result of the current world economic climate and when the G8 group of countries was unwilling to renew its commitment to universal access to treatment which was made in 2005,[46] it was time for the scientific medical community to respond with activism: "Along with science, we need activism. They are inseparable" (in Thom 2009b).

He concluded that "we have to create such energy that the tide of intervention is irreversible, and neither the financial downturns nor the caterwauling of critics of AIDS funding will compromise our goal" (Thom 2009b).

---

[45] An edited version of a speech by Stephen Lewis at the opening of the International Aids Society Conference on Pathogenesis, Treatment and Prevention in Cape Town, as reported in the *Cape Times*, July 2009.

[46] It was reported that Stephen Lewis explained that at the meeting of the G8 group of countries in Italy in July 2009 there was a failure to renew the commitment to universal access to treatment and in fact, HIV/AIDS was not even placed as a priority on the Heads of State agenda (Thom 2009b).

Korten (1990:99) emphasises that the strength of voluntary organisations is the fact that they have diverse constituencies and a capacity for independent action. They are therefore able to form alliances and coalitions. They are also able to exercise a political role in enabling citizens to articulate their interests and needs and make demands upon government. They also perform a training role in teaching their constituencies about political participation, educating them about public interest issues and performing a watchdog role on government action (or inaction).

Given the political battles involved in gaining access to HIV/AIDS drugs, to what extent can it be said that the church exercised its function of care? If government legitimacy is grounded in the theory that it is there to serve the interests of the people, then it could have been expected that the church would have brought government to account. It could, moreover, have done so in a manner that would have had both a national and a global impact, through the use of its networks and affiliations with other churches across the world. Had the church undertaken this role, it might have brought about developmental transformation in relation to HIV/AIDS of the sort envisaged by Korten.

3.5   Conclusion

In this chapter I have endeavoured to illustrate that the Christian church, by its very nature, is called to care. Furthermore, it has a theological basis on which to do so and this basis must serve as the springboard for action. Such care must, moreover, be motivated by love. I have also attempted to illustrate that thought needs to be given to the concept of care and that care in the context of HIV/AIDS is not simply a question of talking about abstinence from sex until marriage and faithfulness during marriage. Critical thought needs to be given to a whole host of issues, not least the reasons that have prevented the churches from engaging with HIV/AIDS in a more transformational manner. Furthermore, although access to treatment may not be the topical issue today that it was a mere four years ago, it is still an important one. How, for example, do rural communities access treatment? Further afield, what about other countries that also face issues of lack of access to treatment?

I have endeavoured to look at the church as a voluntary organisation, which Korten (1990:108) defines as "the instrument through which citizen volunteers establish an identity and legal recognition for their collective endeavours". For this reason, as I

have argued above, the church is able to utilise its integrative power to produce a more just, sustainable and inclusive society by pressurising government and business to meet the needs of people in relation to HIV/AIDS.

I shall now go on to examine a framework for care, particularly to assess whether the care the churches provide can be classified as developmental, that is to say ultimately geared towards human wellbeing. For this purpose, David Korten's (1990) theoretical framework of "four generations" of development is utilised.

Chapter 4

A framework for assessing care

4.1.   Introduction

Korten (1990:124) makes the point that over several decades, it is the power of social movements that has driven social change, transforming the way we think about and act on issues ranging from the environment to human rights. Korten uses the terms "social movements" and "people's movements" interchangeably and ascribes to them a social energy that mobilises countless of people and organisations, across boundaries, to make changes because the participants have ideas of a better world. He says that the power of social movements has been ignored in development, but yet it is this power, rather than money, that can drive transformation and development that is orientated towards the wellbeing of humankind.

Castells (1997:3) defines social movements as being "purposive collective actions whose outcome, in victory, as in defeat, transforms the values and institutions of society". He also makes the point (2000:367-371) that social change is not simply the result of technological or economic transformation or indeed, institutional crises. In examining cultural movements of the 1960s and 1970s, he takes the view that these were movements that sought to "change life, rather than seizing power" (Castells 2000:370). These movements were a reaction to arbitrary authority, a revolt against injustice and a search for personal experimentation. Although such movements were often propelled by students, they were in fact not student movements but permeated throughout society. While many of the movements of that time were defeated politically, they did not die and, in fact, their ideas were to generate other movements, such as the environmental, feminist, human rights, sexual liberation, ethnic equality and grassroots democracy movements. These movements were not the result of economic crises, nor did they rely on information technology, but they did have an impact on the economy, technology and the capitalist restructuring process.

In a similar way, this is what I seek to suggest: that the church is potentially able to provide the leadership to mobilise people in the fight against HIV/AIDS and thus

150

effect social change in a much more transformational manner. It is able to imbue people with what Korten (1990:168) terms an "alternative human consciousness", so that people have a greater awareness of their interdependence and the resources that they hold in stewardship for future generations.

There is, of course, a further issue: in this age, which is described by Castells (1997:69) as one in which the influences of globalisation and informationalisation are transforming our world, there are aspects against which society is rebelling. For example, the information technology revolution has meant that there is very little control that can be exercised over the pervasive influence of sex, sexuality and the sex industry in our lives. The church does not appear to be dealing with these issues (or at least not effectually), nor in my view can it ignore them, given the impact of HIV/AIDS. The church in fact can do very little to control the many aspects of technology or media that have brought sex very much to the fore. A great deal therefore depends on building a society that is responsible, or as Castells (2000:385) puts it: "(w)hich way we go will depend on society's institutions, on people's values, and on the consciousness and determination of new social actors to shape and control their own destiny". It is here that I believe that the church should be playing a more decisive role.

Castells (1997:69-71) ascribes certain characteristics to social movements. First, they are what they say they are, by which he means that they are defined by their practices, including their discursive practices. Secondly, social movements may be socially conservative, socially revolutionary, "or both or none" (1997:70). In other words, they are all symptoms of society and their directionality cannot be predetermined. They are, however, all signs of social conflict and embryonic social resistance that in some cases can produce social change. Finally, movements have three characteristic principles: they have an identity (what it is and on whose behalf it speaks), an adversary (the enemy) and a societal goal (a vision of what it would like to achieve).

It is a sign of our times that many organisations have grown, responded or adapted in order to deal with the problems and challenges associated with the AIDS crisis. One of these is the Treatment Action Campaign (TAC), which would seem to reflect the characteristics outlined by Korten above (the TAC is discussed in greater detail below – see section 4.3.2). For those affected by the disease, there are a variety of welfare

and relief measures that have been introduced to try and alleviate the worst of the suffering ranging from home-based care to assisting grandparents who are looking after orphaned grandchildren, from the extension of the disability grant in South Africa to those whose CD4 count has dropped below 350, to support groups for men and women infected or affected by the disease.

In looking at the history of AIDS in Chapter 3 (sections 3.4.1 and 3.4.2) we saw that many non-governmental organisations were formed in response to the disease, both in the Northern and Southern hemispheres, to fill the need stemming from inadequate – or indeed a lack of – action on the part of government. It is these NGOs which have had to try and understand, cope and respond to the challenges that HIV/AIDS has produced for individuals, families and communities. The church has also responded to the crisis and the purpose of this chapter is to look at a theoretical framework in order to better understand the nature of the church's help and, in particular, to assess whether such help has been developmental in nature.

Before examining the framework in detail, however, I believe that it is pertinent to ask whether the church, through its religious teachings, has a role to play in contributing to social movements. I then propose to look at the issue of whether social movements can contribute towards addressing health-related issues. Finally, I shall examine Korten's vision for social transformation by assessing social movements in a people-centred developmental manner, that is to say development which has as its core human wellbeing. Development is viewed through the lens of Korten's four generations of voluntary development action. Essentially Korten says that there are various ways in which to tackle development, from addressing the symptoms rather than the causes of the problem, at one end of the spectrum, to addressing the fundamental issues that give rise to the problem, at the other. It is through using Korten's framework that I seek to examine the care that the church affords to those who are infected with or affected by HIV/AIDS.

4.2   Can religion contribute to social movements?

In Chapter 3 (section 3.2) I asked the question: what is the rationale and motivation for the church to render care in relation to HIV/AIDS? In this section I propose to look briefly at the issue of whether the church, through its religious teachings, can contribute anything towards social movements and, if so, what it can bring to them. I

do not, however, propose to dwell on this aspect to any great extent or to recite the critical discussions around each viewpoint, but merely seek to highlight the debates around this issue (in particular about the social gospel), as it is relevant, in my view, to ask whether social movements need religion at all. It seems to me that the debates on this subject largely revolve around philosophical and ethical issues, and for this reason I have chosen to summarise the situation rather than deal with it in depth.

Lasch (1990:7) in particular draws attention to the debates by asking the question about what social movements can learn from religion. He states that "(r)eligious contributions to social movements might be variously characterised as inspirational and inflammatory, disciplinary and morally self-correcting, politically sobering and cautionary, emotionally healing and hope giving". This summary, by way of adjectives, is used by Lasch (1990:7) to condense the different viewpoints in the debate. First, implicit in the social gospel is the fact that religion mobilises the indignant, otherwise they would not have the energy or the inclination to resist injustice. A second view questions the social value of moral indignation and sees religion as a check on it. A third stance is that religion relativises the good that can be achieved through political action, as it rescues us from making the mistake that the Kingdom of God can be aligned too closely with any particular form of human society. The final insight is that we need to have a trusting attitude towards our fellow humans and to social progress that is borne out of hopefulness. It is having hopefulness in this sense that is more enduring.

The first proposition, then, is that religion alone can provide the basis for righteous indignation about injustice. Religion therefore stimulates what Lasch (1990:8) describes as a sense of ethical solidarity, a willingness to sacrifice selfish interests for the common good and to help those in need. It therefore brings a special quality to movements – a sense of responsibility, a moral responsibility for one's fellow human beings – rather than vague concepts such as humanitarianism or social justice.

According to Lasch, Rauschenbusch (1917) had put forward another point of view, namely that we must appreciate the power of guilt, sin, evil and ethics as being the core of Christianity. These are key to understanding the social gospel. Rauschenbusch believed that, without the doctrine of sin and without understanding the power of evil, the concept of redemption would become superficial and individuals would shift

153

moral responsibility for their actions onto society, rather than taking responsibility for their actions themselves. This was not to say, however, that he did not also acknowledge "questions of public morality" (1917:34-36). He called on Christians to embrace the social mission and to attend to both social and individual sins, bearing in mind that humankind is sacred and humans share solidarity with one another. According to Lasch, however, Rauschenbusch sought in essence to answer the question of why social movements needed religion and his answer to this was that in order to achieve a more just society, there needed to be a spirit of Christian forgiveness so that future injustices could be avoided. In other words, movements such as movements for social justice might not need religious reinforcement or support, but without religion and the spirit of forgiveness, the desire for social justice could lead to resentment and revenge.

Niebuhr (1932) contributed to the debate (although he effectively criticised Rauschenbusch) through a series of questions (quoted in Lasch 1990:12): "If social cohesion is impossible without coercion, and coercion is impossible without the creation of social injustice, and the destruction of injustice is impossible without the use of further coercion, are we not in an endless cycle of social conflict?" Niebuhr therefore argued that only a politics of "nonviolent coercion" (1932:231-232) that guarded against resentment, along with the recognition of an adversary's humanity and the fact that we are ultimately bound together by common ties, could break this cycle. Unfortunately Niebuhr's stance on politics and violence came at a time of social unrest and the main thrust of his arguments was lost at that time. Lasch (1998:16) concludes, however, that Niebuhr's thesis offers us a third answer to the question of what religion has to offer social movements, namely "a chastening critique of utopian illusions" (Lasch 1990:16). Progress, as defined in secular terms, was not to be equated with providence: providence implied something altogether different – what you do matters because ultimately it is subject to divine judgement. The Kingdom of God is therefore not to be regarded as the end of the world or an ideal for the future of society, but rather as a community of the faithful, subject to judgement.

The final contribution of religion to social movements is that of bringing a quality of hopefulness that is beyond the hope we might associate with social progress. Lasch (1990:20) beautifully and cogently summarises this sort of hopefulness as follows:

> The hope that heals depends less on the expectation of social improvement in the future than on an underlying conviction of the goodness of being. The first is easily shattered by untoward events, reverses, defeats; the second endures. It cannot be shaken by the discovery that the rain falls alike on the just and the unjust; precisely this impartiality of life-giving force, for the truly hopeful, constitutes the most important imitation of its benevolent character. An appreciation of the beauty and rightness of the created order of things transforms envy and resentment into gratitude; and a grateful disposition, far from issuing in political resignation and passivity, often provides the spiritual energy for movements that challenge injustice without losing sight of the solidarity of mankind (sic).

This, of course, has been so evident in South Africa's fight for liberation from apartheid. The peaceful transition to democracy and the fact that resentment and revenge failed to emerge in the aftermath can be taken as an example of a grateful disposition that leaves the question of judgment to God.

In essence, therefore, Lasch makes a plea for recognition that the crucial quality that religion brings to social movements is the fact that God's standards, higher standards, prevail when a person looks at injustices in the world and that this should give hope to the hopeless, or enable people to see that they are not merely victims but moral agents.

In examining the "new social movements" of antinuclear and environmental movements, the peace movement, and the minorities' movements (the elderly, gay people, the handicapped, etc.), Melucci (1989:222) concurs with this point of view, stating that "movements cannot survive on rational calculation alone". He goes on to say that movements need a set of ethical principles which can motivate them into action and, although he does not specifically state that religion can provide this ethic, clearly it is able to do so.

In my view, ultimately it matters not what quality religion brings to social movements. It is, however, important to acknowledge that religion does bring a special, unique quality to them and for this reason it is important that a movement is animated – and indeed, motivated – by religion.

155

4.3   Can social movements contribute to health-related issues?

4.3.1   Examples of health social movements across the globe

Much has been written about social movements and their impact on various matters ranging from patriarchy to the environment. In current times the world is witnessing the "Arab Spring" revolutions that are affecting Tunisia, Egypt, Libya, the Yemen, Syria, Bahrain and Israel, all of which will transform the geopolitical landscape of the Middle East certainly, but also in all likelihood Middle Eastern societies too; the roles of democracy, women and religion have yet to be determined. The feminist movement, along with the transformation of women's work and, importantly, the transformation of women's consciousness is, according to Castells (1997:134-140), one of the most significant social movements of our time because it is eroding patriarchy, which is "a founding structure of all societies" (1997:134). Similarly, the environmental movement, despite its diverse composition and forms of expression, is transforming the way in which individuals, communities, organisations and governments approach the environment (Castells 1997:67-133). The issue that I propose to examine in this section, however, is whether social movements can impact upon health-related issues.

In examining the issue of health-oriented social movements, I should add a caveat: I accept that health is only one indicator of the quality of life. But it is an important one. Korten (1995:5) reminds us that we are well advised not to measure progress in terms of financial indicators alone and that the true quality of our living should be measured by "the extent to which all people are meeting their basic needs for shelter and sustenance, the health and vitality of our natural systems, the strength of our social fabric, and the opportunities available for all people for social, cultural, intellectual and spiritual growth". It is therefore not only in terms of health that the church's contribution to transformation may be assessed, but in all of these respects.

There have been many movements that have arisen out of particular health or environmental concerns, particularly in Northern countries. For example, in Britain a movement arose out of the threat of foot and mouth disease, in the Ukraine it was the Chernobyl nuclear disaster, and no doubt the recent damage to the nuclear facility in Japan (Fukushima) following the tsunami will also result in a movement that is intent

on addressing the gaps that neither the government nor the scientific community are perceived to be dealing with in relation to health-safety issues. As Colvin and Robins (2009:156) state: "social movements … are important for the ways they channel individual and community energies, motivate for change at all levels, challenge key meanings, values and practices, and in general, reshape the imaginative conditions of possibility for those struggling to understand and respond".

De Olivera (1988) describes how a particular neighbourhood in Brazil is blighted by social problems, which have produced many social movements aimed at addressing various issues, ranging from access to clean, unpolluted water supplies to better wages. These popular movements differ in organisation, expression, locality, location and linkages from other movements, political parties and the church.

De Oliveira points out that in the mid-1970s health discussion in Brazil was restricted to a biomedical approach. However, social scientists began discussing health as a political issue, particularly the commercialising of medical care, the diversification of disease and the unequal distribution of health services among the population. Conditions of life and work became part of the debate. It was into this scenario that the church (the Catholic Church) "(g)uided by the Theology of Liberation … sided with the oppressed people in their struggle for better conditions of life and for transformation of society" (De Oliveira 1988:50). It did this through the formation of Church Pastoral Action, which set out an agenda each year through a "Fraternal Campaign", whose aim was to "create a critical conscience on social problems" (1988:51). The strategies that the church employed were, inter alia, providing courses in political conscientisation, literacy courses, encouragement of the participation of the community in healthcare, nutrition and setting up other forums for discussion. In addition, the church worked with other institutions engaged in popular education. It engaged in debates and highlighted recommendations made by the World Health Organisation and other bodies. As we shall see later, the work of the social movement as outlined by De Oliveira was carried out much more along the lines advocated by Korten in terms of achieving people-centred development whereby people are empowered to drive social change. Korten (1990:123) calls this a "fourth-generation" approach to development.

The church also sought to understand the problems and needs of the community by going to the dwelling places of the poor and listening to them, as well as by talking to the Dweller's Association (an organisation set up to represent dwellers' concerns to public authorities). De Oliveira is of the view that this movement to gain better access to health was achieved only because "it introduced a political meaning to the education for health" (1988:58) and penetrated public institutions.

There have, of course, been other health-based social movements, but there are few studies that have examined their effectiveness and how their actions changed policy. Keefe *et al*. (2006), however, describe how four health-based social movements influenced health and social policy legislation in the USA, namely the woman's health movement, the AIDS Coalition to Unleash Power (ACT UP), breast cancer activism and needle-exchange programmes. The research outlines how activists involved in these movements engaged in various tactics to acquire knowledge that belonged to so-called "experts" so as to empower ordinary citizens with medical knowledge, promote self-help, engage in civil disobedience and thus influence health and social policy.

Keefe *et al*. (2006:57) state that "the actual process of creating health policy is often a power struggle, in which divergent interests, values and financial concerns compete with and at times trump epidemiological evidence. In this contentious environment highly motivated grassroots activists have succeeded in influencing key policy decisions and creating changes in policies".

In all the cases considered by Keefe *et al.* (2006) it is clear that the activists gained knowledge of science. As I have argued in Chapters 2 and 3, if the church wishes to transform HIV/AIDS and if it is serious about rendering care in a developmental fashion, then it is important that it also understands the many facets of the disease, along with the language and the social, cultural and other factors that could influence the trajectory of the disease. Secondly, Keefe *et al*. (2006) illustrate that the activists had to learn the processes through which policy was made. Finally, they had to draw on the personal experiences of people affected by the disease (in a similar way to that outlined by De Oliveira 1988).

The impact of health social movements on health and social policy is outlined by Keefe *et al*. (2006:58-59), who also discuss six strategies that are employed:

i.   The empowerment of people living with a health condition to gain greater control of their health and greater control of their health decisions (rather than leaving these entirely to the medical establishment);

ii.   Enabling a greater control "of the terms of discourse by shaping the words and phrases used to speak about the health and social condition" (for example, women with breast cancer were referred to as "survivors" rather than "victims") (2006:58-59);

iii.   Working to truncate lengthy research protocols to make life-sustaining drugs available more quickly (for example, in the case of HIV/AIDS, ACT UP persuaded federal authorities to speed up its drug-approval process);

iv.   Lobbying for the approval of pilot projects to provide direct services to those individuals with the condition (for example, needle-exchange programmes);

v.   Seeking alternative clinical and preventative services for individuals whose needs were not adequately addressed in traditional health-care facilities (again, needle-exchange programmes provide an example);

vi.   Looking either to change laws or enforce them, often through a combination of civil disobedience, legal challenges and lobbying.

I now propose to briefly look at the health social movements outlined by Keefe *et al*. (2006) as I believe that, although they relate to the USA, they hold valuable lessons as to the key elements that produce social change in terms of laws, policy, societal attitudes, etc. I shall then look specifically at an example of a health social movement in South Africa, namely that of the Treatment Action Campaign (TAC) in relation to HIV/AIDS.

In relation to the Woman's Health Movement, Keefe *et al*. (2006:65) describe how women in the late 1960s in the USA began to share their experience about reproductive health/contraception, child birth and abortion, and how they taught themselves and then translated medical literature into more accessible language. They

159

subsequently wrote books aimed at empowering women to take control of, and actively participate in, their own health and care. In so doing, this movement produced a generation of women who took charge of their own health.

ACT UP arose as a response to HIV/AIDS in the late 1980s and because existing gay agencies of the time had become wealthy and professionalised and were only "capable of managing AIDS, not ending it" (2006:60). In 1987, therefore, a gay actor and activist, Larry Kramer, called for direct and radical action aimed at shaking the federal government out of its state of inertia and in order to obtain more research funding. A decentralised structure was set up. The organisation fought the "expertism" of medical language and was committed to speeding up the drugs approval procedure through non-violent but militant disruption. They were also committed to making the drug AZT more affordable, as well as challenging discrimination and stigmatisation. They were instrumental in maintaining insurance cover for people infected with HIV and produced a cultural change in society in relation to attitudes towards gay sexuality. They were also global in their activities, even lobbying that pharmaceutical companies should not be allowed to use their patents to prevent South Africa from producing its own drugs at a lower cost (2006:62). ACT UP was also vocal in advocating that a needle-exchange programme was a "medical necessity".

Breast cancer activists pursued three goals: a change in collective identity by removing the stigma and loss of femininity (by losing a breast), empowerment through education and advocacy, and changes in the treatment of breast cancer. Keefe *et al.* (2006) identified one of the problems of earlier breast cancer organisations as being that, while they provided education, prevention and fundraising, "most did not engage in political advocacy" until the early 1990s (2006:63).

The needle exchange programme in the USA emerged in the mid-/late 1980s as an explicit act of civil disobedience. Their aim was to publicly test prescription laws and to draw attention to the issue of transmission of HIV among Intravenous Drug Users (IDUs). The distribution of clean needles to IDUs was often illegal. In addition, the communities that were hardest hit by injecting drug users often opposed the needle-exchange programme. The authors (2006:64-65) believe that the impassioned urgency of activists, along with their taking the risk of being arrested, the telling of personal

stories, etc. eventually resulted in the success of the movement, in spite of a lack of community consensus or legal sanction.

Keefe *et al.* (2006) caution, however, that not all health-oriented social movements have a positive impact on the health of a population. They cite the abstinence-only programme to reduce teenage pregnancy and sexually transmitted infections as examples. This policy was adopted on a federal basis "despite evaluations demonstrating their failure to reduce teen sexual risk taking" (2006:66). Nonetheless they conclude that if viewed "from the bottom up … when average people organise, they can have a considerable impact" (2006:66).

From the above examples it is clear that health social movements have been successful where participants have understood the problems giving rise to the condition, learnt the language of the experts, taken the time to learn about the policy processes and involved themselves in the political aspects.

4.3.2   *A home-grown health social movement: the Treatment Action Campaign (TAC)*

In Chapter 3 (section 3.4.2) I outlined the history of HIV/AIDS in South Africa and mentioned the activities of the TAC. In this section I propose to examine the strategy employed by the TAC to build a health-oriented social movement. This necessarily entails some overlap with the previous chapter, but the focus will be on how the TAC achieved its goals. The purpose in so doing is to try and discern the factors that contribute to a successful social movement.

In a South African context the health-oriented social movement is very different compared to the health movements of Northern countries. Robins (2008:102-107) makes some very pertinent points in this regard. First, how can a social movement be globalised in a context where scientific knowledge and institutions are limited (Robins 2008:105)? "Citizen science" (Irwin 1995), which was a tactic deployed in the health movements in the USA, for example, is much more difficult in a context where there is a contestation between a public's form of knowledge, particularly where it appears to undermine bioscientific authority. What happens in a situation where local and lay interpretations of HIV/AIDS challenge the scientific truths of biomedicine? For example, in a situation where AIDS is blamed on witchcraft or on

certain sections of the white population who, it is alleged, wish to stem the population growth of blacks, or where it is believed that pharmaceutical companies are using blacks to test out their drugs or that having sex with a virgin – even a child – provides a cure for AIDS, how can a social movement mediate between science and citizenship in a globalising world (Robins 2008:104-5)?

Secondly, as we have seen from Chapter 3 (section 3.4.3) the issue of HIV/AIDS in South Africa became highly politicised, with President Mbeki siding with the denialists, who questioned the link between HIV and AIDS. Furthermore he believed that AIDS activists and scientists were being racist in their portrayal of the disease. The denialists accused pharmaceutical companies ("Big Pharma") of being in a conspiracy with the TAC to use Africans as guinea pigs to experiment with their toxic drugs. They further held out that poverty was the real cause of AIDS, rather than HIV. There was also a view that HIV/AIDS was an implicit attack on the African family for failing to live up to the ideal of the Western nuclear family (Robins 2008:109). In a situation where scientific authority was brought into question by the country's leadership, how did the movement take hold?

Finally, there was the situation where people responded with violence and denial of the disease in certain instances. For example, when an AIDS counsellor, Gugu Dlamini, revealed her HIV status, she was stoned to death for having brought shame on her community. How can such positions be reconciled with building a social movement?

The interesting aspect here is how, despite the constraints, social movement actors mediated and negotiated their way with the government, experts and the global community. In spite of – or perhaps because of – the obstacles, the movement gathered momentum, publicity and strength.

The remarkable aspect of the TAC's approach in respect of meeting the challenges posed by HIV/AIDS is that it most resembled Korten's concept of a developmental social movement that sought to transform institutions and values through a "global-scale social learning process that engages the creative energies of … people in a process of creative experimentation towards the creation of our institutions to serve the needs of life" (1990:106). For this reason, if for no other, a closer examination of

162

Steven Robins's (2008) analysis is helpful, for in his book *From Revolution to Rights in South Africa* he assesses the making of a social movement through AIDS activism and biomedical citizenship.

The TAC employed social mobilisation on a local, national and global scale. At a local level, as indicated by Robins (2008), TAC membership comprises young, urban Africans. However it also has the support of health professionals and university students. In addition, the majority of its volunteers are young, employed, black women (Robins 2008:116). In this way, the organisation also managed to avoid accusations of being "anti-black" by the Mbeki government (Robins 2008:119). Furthermore, it managed to cut through the racial, class, ethnic, occupational and education divide by garnering support from all sides. Nonetheless, the TAC says that the key to its success is the fact that it was able to engender grassroots mobilisation. It achieved this through AIDS awareness and treatment literacy campaigns in schools, factories, community centres, churches, shebeens (informal drinking outlets) and through door-to-door campaigns in African townships (Robins 2008:118). Drawing on research by Wasserman (2007), Robins documents that volunteers were engaged in activities ranging from dissemination of reports and scientific studies, to media briefings rebutting the government's claims that ARVs were toxic or too costly or could not be provided because of logistical problems (Robins 2008:117). By exerting pressure through the mobilisation of poor, working-class communities, and by taking legal action (for example, to compel the Department of Health to provide ARVs at public health facilities), it achieved considerable progress and, more enduringly, "created the political space for the articulation of new forms of health/biological citizenship linked to attempts to democratise science in post-apartheid South Africa" (Robins 2008:117).

When a TAC activist, Lorna Mlofana, was gang raped and then beaten to death when she told her attackers that she was HIV positive, the organisation took the bold step of holding a protest outside Khayelitsha magistrate's court. It then organised educational initiatives at trains and clinics. It went on door-to-door visits to talk to households about AIDS (Robins 2008:120). Essentially, the TAC demonstrated courage in tackling the sociocultural obstacles that impede HIV/AIDS prevention.

At a more fundamental level the TAC played a significant role in encouraging people to take up ARV treatment and has contributed to the establishment of "therapeutic citizenship that draws on liberal individualist conceptions of self-fashioning, 'responsibilised citizenship' and 'caring of the self'" (Robins 2008:121).

At a national level too, the TAC was unafraid of challenging the government, the Department of Health or the dissident camp. HIV/AIDS has life and death consequences and the TAC did not therefore engage with issues of cultural or scientific relativism. It instead resorted to legal challenges and utilised scientific evidence ruthlessly. It therefore took the government to court for failing to provide mother-to-child-transmission (MTCT) programmes in public health facilities.

In 2001 the TAC took the government to the High Court, arguing that the state has a constitutional obligation to provide basic rights, which include health care, along with water and housing. It therefore argued that the provision of AIDS drugs was part of that right. In 2003 the battle to have the right to ARV treatment was won. Robins (2008:119) makes the comment that the TAC manage to straddle the difficult tasks of both managing to cooperate with the government where necessary, but also opposing the government in certain situations. In so doing, the TAC revealed "a clear understanding of the politics of contingency in contrast to an inflexible antagonistic politics of binaries: us and them" (Robins 2008:119).

The TAC was also unafraid of tackling the social movement led by the HIV/AIDS dissident, Matthias Rath. Colvin and Robins (2009:162-164) say that it would be wrong to ignore Rath and his supporters as a social movement; in spite of the fact that they had the support of President Mbeki and the Minister of Health, this movement should not be regarded as an extension of state orthodoxy for it had significant support among local political structures in townships and was therefore able to work closely with organisations such as the South African National Civics Organisation (SANCO). The Rath Foundation, moreover, had considerable success in promoting vitamin and micronutrient supplements as an alternative to "toxic" ARVs. Through education, the use of medical science and the media, however, the TAC was able to win the day.

In relation to global action, the TAC linked up with organisations such as Oxfam, *Médecines Sans Frontières,* the European Coalition of Positive People, Health Gap, the US's Ralph Nader Consumer Technology Project, etc. (Robins 2008:118). Robins comments that "it seemed as if this was indeed a glimpse into what a progressive global civil society could look like" (2008:118), thus echoing what Korten himself advocates in terms of a transformation agenda. Such links were to prove very useful. For example, in July 2000 a TAC volunteer, Christopher Moraka, died, suffering from severe thrush. The TAC claimed that his life would have been saved had he had access to a drug known as fluconazole. It was, however, unavailable in South Africa at public health facilities, because it was claimed to be too expensive. As a result the TAC's founder, Zachie Achmat, in a publicity stunt, flew to Thailand, where he bought 5 000 capsules of the generic drug cheaply and brought them into South Africa, challenging the government to arrest him. This was announced at a press conference and resulted in an international public outcry. When it became clear that the price of the drug was grossly inflated, the pharmaceutical company, Pfizer, was forced to relent on its pricing policy and shortly afterwards made the drug freely available at state clinics. Subsequently, the TAC was to challenge the intellectual property regime and pricing protocols imposed by pharmaceutical companies. It drew attention to the unfairness of international pharmaceuticals preventing developing countries from importing and manufacturing generic antiretroviral drugs. An inadvertent consequence of the TAC's action was to bring into question the widely held view that science is apolitical, technical and objective. It was demonstrated in fact to be "highly politicised and ideological" (Robins 2008:112).

The TAC utilised the courts, the internet and the media. It networked nationally and internationally with other civil society organisations. Its acts of "civil disobedience" gave it a platform and publicity. It sided with the working class and the poor, and thus won the support of trade unions, such as COSATU. It did not confine itself to tackling the issue of access to drugs, but also addressed, where necessary, issues such as the discrimination against people who are HIV positive, women, gays and lesbians. Indeed, in recent years it has moved beyond health-related concerns to demand a basic income grant (BIG) for the poor, as well as responding to the violence that was perpetrated against foreign refugees in May 2008 (Robins 2008:118-119).

It would appear that there were several reasons for the HIV/AIDS social movement to be so successful. These reasons hold lessons for the church. First, the TAC was able to engage both on a global basis with scientists, lawyers, medical professionals and other NGOs, while also engaging with its grassroots constituencies (Robins 2008:107). Secondly the TAC was concerned with larger issues than simply medical treatment. It set out to empower citizens to understand the science of AIDS, while also alerting members to the interplay of politics both nationally and globally.

Thirdly, the TAC was able to create conditions of social belonging and solidarity for those people living at the margins of the state and the formal economy. The TAC deployed a rights-based approach that included people who had been previously stigmatised and shamed by the disease, such as homosexuals, bisexuals, blacks, sex workers and drug users.

Importantly, Robins (2008:115) states that the TAC was able to create an "experiential dimension of belonging" and citizenship, both to a local and global politicised activist community. Many HIV-positive people, once they reveal their HIV status, are exposed to stigma and rejection from their families, friends and communities; the TAC was able to provide them with a home, dignity and acceptance. Robins (2008:120) attributes the success of the TAC's grassroots mobilisation to the fact that it provided poor and unemployed HIV-positive black South Africans "with a biomedical and a psychological lifeline". Finally, Robins (2008:127-143) examines the issue of "responsibilised citizenship".[47] This occurs where people who have experienced near-death are restored to "new life" (2008:129) through ARVs. It is here that the complex mix of religious, communal, biomedical and activist activity elements come into play, allowing people to make sense of their illness and social

---

[47] Robins (2008) analyses "responsibilised citizenship" (a phrase attributed to Rose (2007)), which he says is produced when someone who is HIV positive proceeds to full-blown AIDS. Robins uses Victor Turner's (1969) work on the ritual process as a tool to analyse this transformative experience. Essentially, three stages of rites of passage are identified: separation, liminality/communitas and reintegration. Where a person experiences "near death", together with the stigma and "social death" associated with the later stage of the disease, the experience is profoundly traumatic. Illness is often accompanied by the isolation that the illness itself produces (for example, you are not able to work). This stage may be labelled the separation stage. With ARVs, however, a person may be restored to health, but one's health status may still not be certain as the drugs may not work or there may be side effects. This stage may be classified as the liminal stage. Finally, there is a recovery stage, when physical and psychological health is restored, a state that Robins terms, "new life". It is in this last phase that people are able to make sense of their lives and the experience that they have been through.

suffering. The TAC provides the space for people to recount their experiences – it allows people to declare their HIV status on T-shirts, to attend demonstrations, protests, workshops, etc. Robins (2008:132) comments that it is through these "activist mediations" that "the social reintegration and revitalisation of large numbers of isolated and stigmatised AIDS sufferers into a social movement and caring community" becomes possible. This can empower people to talk about their illness and turn it into a life-affirming experience. Reintegration is therefore achieved.

In this sense, Robins says that the theories of social movements may be extended: activist commitments go beyond "instrumental rationality, rational choice, education and conscientisation" to produce "a quasi-religious commitment to 'new life' and social activism" (Robins 2008:138). Turner (1969) calls this phase "reincorporation". This sense of responsibility for oneself and for others, an ethical solidarity, the spirit of forgiveness, a sense of hopefulness may indeed be the qualities that religion brings to social movements, as discussed above (see section 4.2). This would ultimately mean reincorporation in a fuller sense. When people are faced with HIV/AIDS, they have to confront a disease that has no cure, which produces a wide range of illnesses and which is profoundly stigmatising. Robins (2008) therefore argues that the movement has to be understood in a more comprehensive way. The TAC is not merely a right-based movement, but rather works "at the level of the body, subjectivity and identity" (Robins 2008:140), wherein lies its appeal and strength. Furthermore, it provides a way of understanding how activists with HIV/AIDS make meaning of their journey from near death, suffering and exclusion to new life.

What is clear from the section above is that social movements can contribute to health-related issues, but probably in a way that is much more complex than would first appear to be the case. Furthermore, it would appear that religion (and the church) can contribute in a very special way towards such movements. The question that I now want to examine is whether the church can contribute to a movement in a manner that is developmental. I propose to do this by looking at Korten's (1990) framework of stages (which Korten (1990:115) refers to as "generations") of strategic orientation, which determine whether action undertaken by an NGO tackles merely the symptoms of a problem or its causes.

4.4   A framework for assessing care

4.4.1 Overview

In his book, *Getting to the 21st Century: Voluntary Action and the Global Agenda*, David Korten (1990:124-125) states that in order to achieve people-centred development, a social movement is called for, but on a scale that is global. Its purpose would be to "reshape thought and action" on a whole host of issues. Such work must, he says, come from voluntary organisations, which will become facilitators of a global people's development movement.

He describes an epiphany moment when he realised that the qualities that allow an organisation to be effective in development work and in changing social processes is not its ability to provide or raise funds, but the fact that it is an "independent, nonpolitical private agency able to field highly qualified staff backed by modest but adequate financial resources to work closely and flexibly with local colleagues on shared commitments" (1990:xii). In other words, it is those organisations that are not overly constrained by bureaucracy, procedures and legislation which are best able to respond to any crisis. From years of working with NGOs, it was Korten's experience that organisations working in the field of development impose constraints upon themselves that result in a limitation of their role – or confining it to the alleviation of the *consequences* of poverty rather than having "the courage to embrace a more expansive vision of their role and potential" (1990:xiii). It is his view that many NGOs do not make the impact that they could because they lack a strategic focus and/or technical capability and/or they are reluctant to work with other organisations (1990:xiii). The next chapter will examine these very issues by looking at church action in relation to HIV/AIDS in the Helderberg Basin in order to assess whether the church is having an impact on the fight against HIV/AIDS and, if so, whether the impact is such that it can be identified as developmental.

Korten believes that NGOs and their voluntary action can play a pivotal role in generating social and institutional change. Moreover, he does not limit voluntary action to the work that NGOs do. He argues that voluntary action includes the work that numerous people undertake in a voluntary capacity, for the public good, as global citizens, although they might in fact be employed in government or by business. He

168

says that it is these citizen volunteers who are crucial to the transformation of society. Clearly Korten could envisage that congregants of churches too could be used to transform society, as well as various ministry groups and charitable arms of churches.

Korten argues for a different, alternative vision of development that will provide the guiding light to individuals and organisations. Such a vision then goes beyond a particular organisation's vision, recognising that we share a common future. In a world of globalisation, where North and South are increasingly dependent upon each other, Korten calls for change that is motivated by this different vision of development. Indeed, Castells (1997:1-3) draws attention to the fact that various movements have arisen to challenge the trends of globalisation, the technological revolution, the transformation of capitalism and the demise of statism. The movements have ranged from the proactive (such as feminism and environmental) to the reactive, which "seek to build trenches on behalf of God, nationalism, ethnicity, family, locality", etc. and finally, to transformative social movements. It will be recalled that *the aim of this dissertation is to examine whether the church can contribute or indeed, initiate a people's movement for social change in relation to HIV/AIDS care.* Evidence is therefore sought as to whether actions by the churches can be described as transformative.

Korten (1990:2) defines NGOs broadly to include a wide range of organisations, from voluntary organisations that "pursue a social mission driven by a commitment to shared values" (1990:2), public service contractors (non-profit, market-orientated businesses serving a public purpose), people's organisations (which are largely self-reliant and represent their members' interests and have accountable leadership), and finally governmental non-governmental organisations (GONGOs), which are created by government to serve as instruments of government policy. Churches or faith-based organisations (FBOs), such as development-orientated NGOs, are voluntary, civil society structures that have a similar moral conscience about meeting the needs of the poor and suffering (Turok 1995).

Korten argues that transformation is the goal of development – transformation of institutions, technology, values and behaviour so that they meet three basic needs of global society, namely:

169

i. Justice to ensure each person receives a decent minimum livelihood to exist;

ii. Sustainability to ensure that we recognise that we hold the stewardship of the earth's resources and its ecosystem on behalf of future generations;

ii. Inclusiveness to ensure that the wellbeing of society is dependent upon recognising that everyone can contribute in their own way to society, their communities and families.

In many ways, therefore, Korten's stance coincides with the Christian view that the human person should be at the heart of development, rather than profitability; this aspect is explored further below.

4.4.2 Congruence between Christian faith beliefs and Korten's views

From the section above it is clear that Korten advocates a new vision of development that leads to improvements in human wellbeing: he proposes people-centred development and an equity-led sustainable growth strategy, rather than growth-centred development. In this respect, Korten's alternative vision of people-centred development resonates strongly with the Christian message of the dignity of the human person (see Chapter 3, section 3.2), as well as his or her obligation to respect the moral imperative to ensure that the life of one's neighbour, as well as that of future generations, is not compromised by the over-exploitation of mineral, vegetable or animal resources (Climenhaga 2009; Tucker 1997:6). In Genesis we read that God created the world "and God saw it was good …very good".[48] According to a Christian viewpoint, every plant, tree, beast and bird should be regarded as a gift to humankind and an inheritance that has been entrusted and which therefore has to be treated with respect – and in trust – for future generations (Hiers 1984:45). The responsibility is clear: the world's resources should be used responsibly to satisfy legitimate needs, material or otherwise, while respecting the intrinsic balance of creation. Thought therefore needs to be given to the consequences of actions and heed needs to be paid to abuse of the earth, since neither attitude is consonant with the Christian vision of nature as the fruit of God's creation (Tucker 1997:8; Benedict XVI 2009: Chapter 4, para. 48).

---

[48] Genesis 1:29-31

Furthermore, while the church acknowledges that humankind has been instructed to "fill the earth … subdue it … [and] be masters of the sea…",[49] such gifts have to be used properly (Benedict XVI 2009: Chapter 4, para. 48). The parable of the king who went away and gave each of his servants a mina (or three months wages), with the instruction that the money had to be put to work, is illustrative of the instruction to use whatever resources have been given by God to build and expand God's kingdom. That is not all, however. That which has been entrusted to humanity has to be utilised with a concern for the welfare of others as well as their own, and such resources have to be used faithfully (Benedict XVI 2009: Chapter 4, para. 51).[50]

According to a Christian viewpoint, if nature is regarded as a gift from the Creator, then humankind has a responsibility "to till it and keep it",[51] in other words, to use it responsibly (Hiers 1984:48; Engel 1970). This accords very closely with what Korten expresses. He uses Kenneth Boulding's (1968) example of looking at nature and the economy either from the point of view of a cowboy, living on an open, vast frontier, or as an astronaut, living on a spaceship, with limited space and resources. Where one regards the economy as a cowboy, then one uses the earth's resources at will to satisfy wants and without regard to conservation or the disposal of items not regarded as useful. If, on the other hand, one regards oneself as living on a spaceship, then one regards resources differently: the meeting of needs takes priority over wants. The key test in looking at an economy is asking what increases human wellbeing – is it economic output at the cost of leaving the environment impoverished? In Korten's view, while growth-centred development leads to short-term gains in economic output, it leaves the world a poorer place because of the impact on the environment. He describes this as "de-development" (1990:37), because reckless exploitation does not increase collective human wellbeing, but rather benefits one party (usually Northern hemisphere countries) at the expense of the other party (usually Southern hemisphere countries). Integrated human development therefore necessarily involves environmental considerations, as it is linked in a very real way to our duties to others – the family and to society.

---

[49] Genesis 1:28.

[50] Luke 19:11-27. See also Matthew 25:14-30 and the parable of the talents, which again makes the point that each person has to use well what has been given to him or her by God; it does not matter how much a person has, but how the person uses it that matters.

[51] Genesis 2:15.

For this reason Korten advocates an alternative vision where the wellbeing of people and the ecology on which they depend come ahead of economic growth for its own sake. He calls such development people-centred development, which he defines as a process by which people increase their capabilities to improve the quality of their lives and work towards achieving their aspirations in a way that is just and sustainable (1990:67). He calls for the values of justice, sustainability and inclusiveness to transform our vision and our institutions. In a similar way, the Christian faith also advocates an economy that is people-centred and that focuses on authentic human welfare and justice. The fact that human beings are created "in the image of God"[52] gives an inviolable dignity to the human person, which requires a higher value of natural moral norms (Benedict XVI 2009: Chapter 4, para. 29; Vogels 1994:191, 195). Accordingly, the economy should not be exploitative of people, but rather used as an instrument to better meet their needs. In other words, the economy should be considered a human activity rather than simply a financial or wealth-creating instrument (Oslington 2011; Benedict XVI 2009: Chapter 4, para. 35).

If such a position is accepted as a Christian stance, then it follows that the centrality of human beings in development programmes is paramount, requiring them to be involved in the planning and implementation of such programmes. Korten quotes a statement from participants in the Inter-Regional Consultation People's Participation in Environmentally Sustainable Development,[53] in stating that one of the principles of people-centred development is that "Sovereignty resides with the people, the real social actors of positive change" (1990:218). Accordingly, it is not the donor that sets the agenda or projects, because authentic development is "community driven, community led and community owned" (1990:219). Good examples of this were seen in sections 4.3.1 and 4.3.2 above, which are illustrative of the commitment of voluntary organisation to serve the people rather than the donor.

Recognising that people often do not have the capacity to work for their own development and, furthermore, if it is accepted that it is not the government or international agencies that are the legitimate agents for making decisions on

---

[52] Genesis 1:27

[53] Korten draws extensively on this consultation, which was sponsored by the Asian NGO Coalition (ANGOC) and the Environmental Liaison Centre International (ELCI); it led to "The Manila Declaration on People's Participation and Sustainable Development".

development or the management of development resources, Korten makes a persuasive case that civil society has "an essential, if not central role in both" (Korten 1990:28). He goes on to advocate that NGOs provide leadership in relation to policy issues that will allow people to take the initiative and lead. The government's role is therefore seen as enabling people to develop themselves. If NGOs strengthen their capacities to take the lead in relation to policy issues, then Korten envisages a new development dynamic in which the poor will be able to engage in self-help to create their own employment and other opportunities. In a South African context the question then arises as to whether and to what extent NGOs, including voluntary organisation such as churches, have encouraged or provided leadership to civil society in relation to HIV/AIDS. Certainly the comment has been made that civil society has weakened substantially since 1994 (Van der Westhuizen 2010).

Churches and religious teachings bring a further and important dimension to authentic human development: a human being cannot be regarded simply as a "tool" for wealth creation, or as an equation in economic activity (Benedict XVI: Chapter 3, para. 36). In fact, as economic activity is a human activity, conducted within society, it is essential to bear in mind human and ethical dimensions. Economic and technological advancement do not necessarily equate with human advancement (Benedict XVI: Chapter 3, para. 40). For this reason the task of development cannot be merely delegated to institutions. It is only by recognising the image of God in another person and therefore the importance of the common good that development can be said to be authentic (Vogels 1994). Responsibility for our fellow human beings is therefore crucial (Benedict XVI: Chapter 4, para. 43). Korten expresses this in the following way: "Growth-centred development puts economic growth ahead of people and the ecology on which their well-being depends. We need an alternative vision in which the well-being of people and the living systems of the planet that is their home come first" (1990:67).

The economic aspect of Korten's stance is important for several reasons, not least the fact that it has been demonstrated that there is a link between poverty and HIV/AIDS (see Chapter 2, section 2.9.6).

If this should be the caring vision of the church, it should be manifest in the concrete actions of the churches in relation to the care that they extend towards those who are

173

affected by or infected with HIV. However, this is not always the case. As Korten points out, churches even inhibit positive change. Nonetheless, Korten admits that churches do have the capacity to be caring, and hence what is important is to use this capacity. Care is ultimately about having the vision to improve the socio-economic wellbeing of humankind through the power of ideas and values, and this ultimately needs to be motivated by love.

Care seen in the above terms can be seen to be part of development: development that is ultimately geared towards human wellbeing and which acknowledges that economic circumstances such as poverty make the provision of adequate care problematic. In this sense, care that is provided by the church can be examined by using David Korten's four generations of development as a framework.

At the root of a religious organisation is its spiritual and transcendent character, its values and ideas that can inspire followers to a caring, just and morally sound vision of our world. This view is at odds with a materialistic culture that pays little regard to consequences in the quest to satisfy immediate needs – and Korten would argue, with a neoliberal culture that encourages indulgence and consumption to satiate individual needs without concern for others or the impact of such actions, particularly on the environment. Korten sees that the prevailing economic system, based as it is on a striving for growth, to be responsible for cultivating a narrow self-interest and in the process absolving the individual of responsibility for his or her role to other people, society and nature.

In the relentless pursuit of growth, little heed paid to what is consumed or the unmet basic livelihood needs of many (Korten 1990:3). Conspicuous consumption is then a further issue that the church could address, as it can be argued that the quest to fill one's life through consumption is a search to find satisfaction and the meaning of life. Christian churches would argue that such meaning cannot be acquired through material things, but rather through a fundamental transformation in values.

4.4.3   *Korten's framework*

While the government, business and the voluntary sector all meet certain needs in society, voluntary organisations (VOs) specialise in "integrative power" (1990:97) for mobilising human, financial, time and other resources, and they are able to do this

174

because people believe in the work of the VO and its contribution to society. Thus people attending places of worship or belonging to a church believe in the vision that they will be able to make the world a better place through adherence to certain values and by their actions. The political machinations of the government and the economic demands of the market therefore do not impinge to any great extent on VOs, giving them a unique advantage and strength.

Korten points to the advantage of a healthy voluntary sector, which comprises a number of varied, independent VOs: because they are small in size, independent and have a focused value commitment, they are much more able than the government or business to innovate, adapt and respond. And because of their commitment to integrative values rather than political or economic values, they are much more sensitive to the perceived needs of those without political or economic power.

This is not, however, to suggest that either the government, the economy or the voluntary sector is more important than the other in terms of development. The government has the power to command resources, to meet needs and to set the parameters for social behaviour, and it therefore has an important part to play in development (although in an increasingly globalised world, it is accepted that the power of the nation-state is somewhat constrained). So too the economy and business are important to create wealth, encourage entrepreneurship and distribute goods and services according to the demands of the market. But they are also at the mercy of the influences of globalisation (see Castells 1997). However, as Korten points out, it is "the voluntary sector that has the advantage in mobilising voluntary social energy in the service of institutional and values innovation" (1990:98). If we take churches, their members and congregations as an example, it is evident that they, like other VOs, have the advantage of reaching consensus around certain values; for example, in the case of churches, it could be to demonstrate the love of Christ by caring for one's neighbour and in so defining their position, Korten says that they are better able look for innovative solutions and experiment in ways that a government would find difficult. He adds: "This ability gives VOs a distinctive role as catalysts of system change in defining, articulating and advocating positions that are not in the established political mainstream and therefore not supported by existing public policy" (1990:99).

The strength of the voluntary sector has been illustrated in section 4.3 above, in relation to the TAC; unlike government, it was not constrained by its size or the fact that it needed to find consensus among its political constituencies, power groups and other interest groups. The TAC was largely able to draw support from a variety of groups and organisations, forming coalitions and alliances, adapting the emphasis of its campaign, redefining issues (see Chapter 3, sections 3.4.2 and 3.4.3), agitating for protest action against the government, the Health Department, pharmaceuticals, the international trading regime, arranging acts of civil disobedience, bringing litigation before the courts, etc. It is therefore not difficult to see why the voluntary sector is able to "catalyse social innovation" (1990:99).

Korten also explains the importance of VOs in a democracy (1990:99): politically, they can supplement the work of political parties by articulating the interests of citizens, meeting needs and pressurising the government. In terms of education, VOs provide a space to learn about democratic citizenship and issues of public interest. Finally, VOs are able to exercise a watchdog role, along with the media, and in so doing can bring the state to account. In examining the churches as VOs in terms of their political, educational and watchdog role, one need look no further than the role that many of the churches played in the anti-apartheid struggle in South Africa. For example, the South African Council of Churches (SACC) and the Southern African Bishops' Conference (SABC) rejected what they called "state theology" and formed part of an important movement against apartheid by mobilising people both nationally and internationally (SACC 1985). In addition, they issued what became to be known as the Kairos Document, which was essentially a biblically and theologically based document, questioning the political system in the country and calling on the Christian church to stand with the poor and oppressed, and to join in the struggle for liberation. Interestingly, it called for "church theology" to acquire a better understanding of politics and political strategy, because it recognised that changing the structures of society and its institutions is a matter of politics. It also recognised the need for the church to acquire better skills in social analysis. It appreciated that the voluntary sector would be better able to access, experiment and evolve its services through the acquisition of such skills (Logan 1988).

Korten also examines another type of NGO, namely a people's organisation (PO). Such organisations have three defining characteristics: they are mutual benefit associations that serve their members' interests, they have a democratic structure, which gives members power over their leaders, and they are non-dependent on outside initiatives or funding. Co-operations, burial associations, labour unions, political interest groups, etc. may all fall under this category. They resemble the government in that they are able to exercise the power of threat (through fines and other sanctions); they resemble business as they exert economic power, and finally, they resemble the voluntary sector as they are able to exercise integrative power because they share values that lead them to cooperate. POs are important to people-centred development, because where people are charged with controlling organisations that supposedly exist to serve them, there is a much greater likelihood that they will fulfil their true function, namely distributing power within society, particularly to the previously marginalised, providing a training ground for democracy and being responsive to grassroots concerns (1990:100-102).

VOs differ from public service contractors (PSCs), because although they too may be NGOs and non-profit-making bodies, they are "driven by market considerations more than by values and therefore are more like businesses than VOs" (1990:102). Although PSCs also meet an important social need, they are unlikely to be social catalysts or to be as committed to certain values that are part of a VO's inherent nature. PSCs are also much more likely to follow the solutions suggested by a donor in relation to a certain problem (for example, a request to increase or reduce staff).

GONGOs, on the other hand, are invariably formed by the government and under government control, despite their outward appearance of being PSCs or VOs. They also tend to be ultimately accountable to the government rather than to an independent board or to their members (1990:104-5).

In examining NGOs, and VOs in particular, Korten classifies their orientations in terms of development by way of stages or "generations" of strategic orientation (Korten 114-115). Whereas some VOs have a strategic orientation to deliver relief and provide welfare services, others are involved in community development. Some go beyond these objectives and seek to make policy or institutional changes that are aimed at achieving results that are more sustainable and fair. Others are motivated by

177

a social vision, which causes them to drive a people's movement. These strategies of NGO engagement with development is illustrated in Table 2 below:

Table 2: Korten's framework of four generations of strategic NGO intervention in development

	Generations			
	First	**Second**	**Third**	**Fourth**
Defining features	relief and welfare	community development	sustainable systems development	people's movement
Year of reference	1945	1960	1973	1982
Problem definition	shortage	local inertia	institutional and policy constraints	inadequate mobilising vision
Time frame	immediate	project life	ten to twenty years	indefinite future
Scope	individual or family	neighbourhood or village	region or nation	national or global
Chief actors	NGO	NGO plus community	all relevant public and private institutions	loosely defined networks of people and organisations
NGO role	doer	mobiliser	catalyst	activist/educator
Management orientation	logistics	project management	strategic management	coalescing and energising self-managing networks
Development education	starving children	community self-help	constraining policies and institutions	spaceship earth

Source: Swart (2010:213), Korten (1990:117), Korten (1987:148), de Senillosa (1998:44-45)

The progression of developmental activity through the various generations will be examined below.

4.4.3.1 Generation one: charitable work

First-generation strategies are primarily aimed at providing immediate relief to those suffering from the effects of war or natural disasters, as well as meeting the welfare needs of the poor. Such services are designed to address immediate symptoms rather than the underlying causes of a particular problem. Immediate needs could therefore include help with matters such food, shelter, clothing or medical/health-care assistance. Korten classifies such help as humanitarian assistance rather than developmental assistance. While such efforts are important and appropriate for humanitarian reasons in certain circumstances, it cannot really be said that such efforts are directed towards tackling the problems of underdevelopment.

In such cases the NGO is the "doer" in terms of funding, resources, management of logistics, etc., while the beneficiaries are the passive recipients; they are not required to do anything to obtain help (1990:115). As Korten explains, many contemporary

178

international NGOs (such as Catholic Relief Services, CARE, OXFAM, etc.) were originally established to assist victims in World War II. It was only as Europe recovered from the effects of war and became more prosperous that such agencies turned their attention to assisting with problems in Southern countries. Many Southern country NGOs depended upon assistance from the North. For example, churches and missionary societies working in the South initially depended upon funding and goods from the North. Korten also makes the point that in Africa the colonial governments largely left basic education and health care to churches and missionary societies (Korten 1990:116). He adds that voluntary action to assist people affected by natural disasters and wars has frequently been undertaken by religious groups and in fact, very often, they have been "at the forefront of these efforts" (1990:115).

In the context of HIV/AIDS churches have been active in providing help to those affected by and infected with the disease. Such assistance encompasses a variety of activities, from providing nutritional meals to visiting those who are sick or dying. Care for children who have been orphaned, as well for families who have been bereaved, are examples of the churches' response to obvious and immediate needs.

Epstein (2007:xii) draws attention to the many initiatives that have been launched in response to HIV/AIDS which depend neither on finance nor technical know-how. Such responses are "something for which the public health field currently has no name or programme. It is best described as a sense of solidarity, compassion and mutual aid that brings people together to solve a common problem that individuals can't solve on their own."

While Korten (1990) recognises the necessity of meeting such immediate needs and the place of NGOs engaged in such work "within the NGO family" (1990:129, n. 5), he is of the view that because such actions rarely arise from theories of development but rather a desire to provide for an unmet need, such efforts "offer little more than a temporary alleviation of the symptoms of underdevelopment and should not be confused with development assistance" (1990:118). Korten makes an important point in this regard:

> There are constant pressures on the NGOs of both North and South to focus on humanitarian assistance rather than development. The former produces more immediate and visible (though less sustainable) benefits to the poor than does true

179

development assistance and is therefore easier to justify to donors, whether public or private. It is easier to administer and requires less technical expertise (1990:142).

In Chapter 3, section 3.2, the importance of a development strategy was discussed along with the necessity for an organisation to have a development theory; there must be logic to the way in which an organisation utilises its resources in implementing a particular development strategy. An organisation must therefore reach some conclusions as to the reason for the problem and why the intervention it is proposing or undertaking will result in an amelioration of conditions or circumstances that will enable the sufferer to take measures to meet his or her own needs, through his or her own efforts, in the future (1990:114).

Rutledge (2008) also makes the point that social action is not about a programme of "taking sandwiches to homeless people" and urges an interpretation of the gospel that is "big enough to motivate us to go beyond sympathy to action … to addressing the root causes". In so doing, a social movement will be animated by God (see Chapter 3, section 3.2).

4.4.3.2 Generation two: local empowerment

Where NGOs see that the assistance that they offer provides no more than temporary alleviation of the symptoms of a problem, they may look at other ways in which to assist by taking more of a developmental approach. In other words, such NGOs realise that although they have been able to meet immediate needs, these needs go beyond their capacity. NGOs therefore engage in strategies that focus on helping to develop the capacities of people to enable them to better meet their own needs. Such NGOs are often said to be engaged in community development strategies, commonly involving self-help activities at a village level. The theory behind this strategy is to encourage self-reliance, so that even after the NGO has rendered assistance and left, a community can continue the work (1990:118).

In the context of HIV/AIDS such help may include, for example, a church conducting educational classes, informing a community about HIV/AIDS, modes of infection, prevention, treatment options, care and support, etc. In empowering people with knowledge, it is hoped that they will then be able to help themselves. Thus, for example, armed with the knowledge that HIV transmission can be prevented by using a condom correctly and consistently, it is assumed that people will use a condom on

every occasion they have a sexual encounter, particularly where such sexual encounters are casual or outside a committed relationship.

In second-generation strategies the NGO is the mobiliser rather than the doer. This theory of self-advancement presumes that a village community can make progress. However, the community may also fail to do so because of a range of issues, from lack of health-care facilities to issues of tradition and isolation (1990:119). The NGO is the outside change agent that in theory is expected to assist the community to achieve its potential through measures such as education, the introduction of simple new technologies, raising consciousness, making small loans, etc. In other words, the idea is that with a little help from outsiders, the poor are able to get on their feet and meet their own needs through their own self-generated efforts. Korten (1990), however, takes issue with this view: by developing the resource value of a person through education, for example, it is assumed that the economic system will provide the opportunities for employment. This conforms to the oft-quoted proverb attributed to Lao Tzu: "Give a man (sic) a fish and you feed him (sic) for a day; teach him (sic) to fish, and you feed him (sic) for a lifetime."[54] In other words, giving people help and doing things for them all the time creates a relationship of reliance and dependence. However, Korten believes that such views are simplistic, for they fail to take into account that the problem is not just a question of a lack of development on the part of an individual, but also a consequence of exploitative relationships at a local level that prevent him or her from accessing the resources that would really make a fundamental difference. In the fishing quote above, therefore, it would also be a question of enabling a person to gain access to the fishing grounds or market places in which to sell the fish. Often, however, these resources are controlled by local elites who have no interest in sharing their privileges.

Foster (2002, 2004) outlines the kind of help that local faith-based organisations render in relation to orphan care, which is non-sensational and largely invisible. Such help is given without any large-scale funding or technical know-how, but relies instead on the spirit of voluntarism, local leadership and community cooperation. Such local-level activity is very effective in responding to the changing needs in orphan care, compared to what large external agencies can do. However, even

---

[54] Lao Tzu was a philosopher and is said to be the father of Taoism. He lived in the 6th century BC.

accepting the fact that such local-level and community initiatives are important in the care of orphaned and vulnerable children, Korten would say that such initiatives are constrained by the absence of a development theory, strategic focus and technical expertise to enable discussion or negotiation with national power structures. Furthermore, the nature of the care that is offered also needs to be examined: is it rendered in a manner that will eventually lead to orphaned and vulnerable children being able to live a life that is fulfilling, sustainable and enabling?

While second-generation strategies are developmental in concept, therefore, they often fail to take into account the political dimensions of poverty (1990:120), which in effect mean that the poor are unable to change local power structures, let alone the national and international systems that maintain them. Such strategies are very much focused on individual local communities, villages and groups of people, and are largely marketed by an NGO as a project for which funding is required. Korten describes them as a sophisticated guise for providing a hand-out, as although it may talk of self-reliance, it in fact builds a relationship of dependence (1990:119).

Let us take an example of an NGO carrying out an initiative to conduct an HIV/AIDS educational programme among women in a rural village. While it is all very well to talk about the use of condoms as a means of protection, it fails to take into account issues such as patriarchy, gender imbalances and sexual power dynamics within relationships that militate against the use of protection on the part of women. Perhaps a UNICEF (2006) report demonstrates this point more cogently:

> Women's vulnerability to HIV infection is particularly heightened by their economic dependence on men, lack of access to education, poverty, sexual exploitation, coercion and rape, as well as by their engagement in informal and commercial sex work. Women face additional and more acute discrimination when they are identified as being HIV positive. Because they are often first to test positive through prenatal testing, they are branded as the "spreaders" of the virus. Once their HIV-positive status is revealed or disclosed, women face being physically abused, losing access to important economic resources, and face the threat of being chased from their homes.

Given the sort of scenario above, it is not difficult to discern why attempts at local empowerment might not be effective.

4.4.3.3 Generation three – sustainable development

Third-generation strategies normally result from frustrations with second-generation strategies. With second-generation strategies there is invariably a continued reliance on NGO and donor funds; otherwise the benefits yielded by the intervention are likely to be short-lived. Furthermore, an NGO working in a particular village or with a specific community is unlikely to spread benefits further afield, unless supported by a national development system (Korten 1990:120).

Third-generation strategies therefore look beyond a specific community, to make an impact upon policies and institutions at local, national and international levels. This may require an NGO to work with national agencies in order to change the focus of policy and to strengthen control over local resources. Such actions could, of course, result in the creation of new institutions designed to provide essential local services on a sustainable, self-funding basis.

The theory underpinning third-generation strategies is that factors such as the control of resources prevent essential services from reaching the poor and, furthermore, existing systems are conducive to exploitation and corruption. Changing such circumstances therefore requires both building the capacity of people to challenge the existing system, while at the same time building networks and relationships with those in power, to make the system responsive to those demands (Korten 1990:121).

By embracing third-generation strategies, NGOs are able to work in a "catalytic, foundational-like role" (Korten 1990:121). An NGO with a third-generation strategy will focus on policy and institutional changes, which will require it not only to work with government but also with other NGOs and organisations from both the private and public sectors. Korten makes a perceptive comment with regard to NGOs working with each other, saying that this is often the most difficult barrier to overcome, as they allow rivalries and jealousies to prevent cooperation towards achieving a common purpose (1990:130-131).

Adopting third-generation strategies requires that an NGO cultivates a thorough knowledge of the system, as well as the necessary technical know-how. Not only that, it will have to develop relationships with the system's key-players and learn how to

183

adapt its position strategically in order to achieve the best possible results, with limited resources. An NGO may also have to raise public awareness of the necessity to transform particular critical institutions. Transformation of both human and institutional orientations is therefore required. The skills and capacities of peoples and communities need to be enhanced and at the same time, reform will be required of roles, relationships and values by people in positions of power and in government.

In an interesting analysis of Korten's third-generation of development, Swart (2006) makes the point that if an NGO aspires to act as a systems catalyst to reform micro policy, it "has to be guided by more than good intentions" (2006:120). Such an NGO has to professionalise its management techniques and technical competence, in keeping with the values of people-centred development. Its approach to development therefore ought to discourage central control and "actively support self-assessment, self-correction and a well-defined sense of mission in the institutional learning process on the basis of rich information flows" (2006:121). As Korten himself points out, development of professionalism requires not only basic skills in social analysis, but also skills in process facilitation and coalition building (1987:156). In other words, as the purpose of third-generation strategies is to restructure social institutions, an approach is required that develops organisational capacities in order to achieve these objectives.

Churches engaged in third-generation strategies in relation to HIV/AIDS at the time when universal access to antiretroviral drugs was not made available would therefore have understood the disease and also the many factors that were fuelling the pandemic, such as poverty, the position of women in society, mother-to-child transmission (MTCT), etc. They would have also understood the political landscape, including the influence of the denialist camp on the then President of South Africa, Thabo Mbeki, and the Minister of Health, the issue of costs and why patents on drugs were making the price of medicines prohibitive and access to health care for the majority of the HIV-infected population more difficult. The churches would have joined efforts with other churches working in the field, across the divide of denominations and indeed faith beliefs, as well as with organisations such as the TAC. Such churches might also have been eager to raise the awareness of their congregations of the problems that were being encountered by those in need of

treatment and the forces at play. In this way the churches might have been able to garner, galvanise and mobilise support, and work with – or indeed against – relevant government departments in an endeavour to change policy and challenge those in power and those with the ability to make a difference, including pharmaceutical companies, national and international bodies, etc. In other words, if churches wish to engage in a meaningful way as development actors in the field of HIV/AIDS, it is essential that they devote attention to their strategic orientation and to the values and ideas that guide them to action.

For any NGO the key to taking such action is whether they have a theory that underpins its intervention. In Korten's view, it is much more likely that a VO or PO will have such a theory, as they have a need of it, and they are much more likely to focus on the problems that people face. For the PSC it is the donor that defines the need and with GONGOs the government does so. Furthermore, governments and donors are generally more interested in supporting relief and welfare interventions of NGOs rather than engaging in fundamental structural change (1990:122). Although VOs may not intend to take controversial action or make structural changes, if their value commitment to help others and solve their problems is strong, then they are "more likely to move toward politically orientated empowerment interventions and to seek to build community capacity to stand up against local injustice" (1990:123). In fact, we have seen precisely this in the TAC's actions (see above, section 4.3.2).

A truly developmental approach therefore requires not the addressing of immediate needs, but rather addressing the conditions that give rise to the need, thereby enabling a person to meet his or her needs through their own efforts. A third-generation development approach requires social learning, which according to Korten is based on the following preconditions: "a focus on a problem or goal, an intervention theory, and a critical ongoing self assessment" (1990:124). In other words, development requires a more critical approach both in terms of conceptualisation of the problem and the way in which it is resolved.

In this way third-generation strategies can be distinguished from first- and second-generation strategies. In the case of first-generation strategies, as we have seen above, there is no real theory of development, whereas in the case of second-generation strategies, although they ultimately aim at self-reliance at a local level, they fail to

185

take into account the larger processes at work that prevent the actualisation of this objective.

It must be clarified that Korten does not dismiss first- and second-generation strategies. Indeed, he acknowledges that "each generation meets an important need and has its important place". Nonetheless, he adds that in his view "the future of development, perhaps even global society, depends on many more VOs engaging boldly and effectively in third and fourth generation type strategies" (1990:129, n. 5).

Swart (2006:127) summarises the difference between the first- and second-generation development strategies and the third- and fourth-generation strategies:

> Involved here [in third- and fourth-generation strategies] are also critical questions relating to ideology, power and the lack of more sophisticated social theoretical capacities, the need for critical self-examination and the quest to conceptualise new modes of strategic development action that might break through prevailing problematic modes of engagement.

The three generations, however, are not precise categories. As Korten states in his earlier work, such categorisations may apply to individual programmes rather than to the whole organisation. Accordingly, one programme may be third generational in its approach, while another maybe first or second, in order to meet specific needs (Korten 1987:149).

4.4.3.4 Generation four: creation of a social movement

The objective of third-generation strategies is to endeavour to make changes in policies and institutions. As we have seen, Korten advocates such changes in order to produce just, sustainable and inclusive development outcomes. However, rather like second-generation development strategies, in order to achieve social transformation, the process must be replicated "hundreds of thousands, even millions of times" (1990:123) in an environment that is hostile both politically and institutionally. In other words, the problems that second-generation strategies encounter at a micro level are encountered at a more macro level by third-generation strategies.

In reflecting on the problems and limitations of third-generation development strategies, Korten was eventually to come to the conclusion that only a social movement could achieve the sort of decentralised action that was required to achieve a global people-centred development vision that would produce the sort of social

change that was required. The transformative power of such movements could be seen in all sorts of actions, from environmental to women's rights movements and from peace movements to anti-globalisation demonstrations.

The appeal and quality of social movements as a generational strategy for development is summarised by Korten as follows:

> Social movements have a special quality; they are driven not by budgets or organisational structures, but rather by ideas, by a vision of a better world. They move on social energy more than on money. The vision mobilises independent action by countless individuals and organisations across national boundaries, all supporting a shared ideal. Participants in successful movements collaborate in continuously shifting networks and coalitions (1990:124).

As discussed in Chapter 1, section 1.2, this is termed an "alternative development paradigm" where the wellbeing of people and the environment of the planet take priority over profits and market share (Korten 1990:67-71).

Korten defines people-centred development as follows:

> Development is a process by which the members of a society increase their personal and institutional capacities to mobilise and manage resources to produce sustainable and justly distributed improvements in their quality of life consistent with their own aspirations (1990:67).

In other words, development is not about economic output; the definition firmly points to people being in charge of defining what they consider to be improvements in their lives.

Fourth-generation strategies of development therefore necessarily require NGO leaders to examine policy options and ensure that these are translated into national strategies, for only in so doing can a people-centred development vision be genuinely promoted and implemented. A national strategy therefore has to be what Korten refers to as an "equity-led sustainable growth strategy" rather than a conventional growth-centred strategy. Equity becomes the basis of growth. According to Korten, such growth should be "unimodal" rather than dualistic or bimodal (1990:73). That is to say, strategies should be employed to increase productivity and incomes of small family farms, with an emphasis on labour-using (as opposed to labour-saving) and capital-saving technologies (rather than concentrating on commercial farming, with its

emphasis on capital-using technologies). In this manner, the internal market for industrial goods and services is expanded.

For such growth to be sustainable, as well as environmentally sound and democratic, Korten suggests various stages in which equity-led sustainable economic transformation policy might be sequenced. I do not proposed to dwell on these steps here, save to say that the first step includes not only basic education, but also the development of the consciousness and skills related to what it means to be an active citizen and the responsibilities of stewardship (1990:78-81). The aim of the sequencing stages proposed by Korten is to achieve institutional transformation, so that a people-centred vision of a just, sustainable and inclusive society can be built.

The point that I wish to draw from Korten's stages to achieve an equity-led sustainable growth strategy is that it is essential that political will is built up to undertake the necessary reforms and, indeed, this is what is proposed in Stage 1. By increasing the political participation of those who stand to gain the most by the reforms, as well as by persuading the holders of power of the rationale for equity-led growth, sufficient political will is built up to carry out reforms. Thus, while it is acknowledged that NGOs, governments and donors have different perspectives on the nature of development, NGOs have to involve themselves in the political sphere if they are to influence and transform policy and institutions, and above all, their social vision. This holds an important lesson for the church if it is to engage in development that is transformational.

In Korten's view, "development must become a people's movement" (1990:83) or "a people's development movement" (1990:84), through the channelling of social energy that is geared towards the transformation (not the destruction) of institutions and values. People power therefore becomes the force for reform. The vision for development is consequently much broader than that of third-generation strategies, because it seeks to link domestic and international political forces in order to enable the movement to succeed. Accordingly, national VOs may undertake the primary role in education as well as for organising and advocacy within their own countries, but the support of international VOs is also required, thereby allowing alliances and networks to be formed to lobby Northern governments and international aid agencies (or at least the people who work within them, as they are more likely to be committed

to a people centred vision) to put political pressure on their own and other governments to bring about changes in their development vision.

As Korten states: "VOs, particularly those with broadly based constituencies, have increasing opportunities to reshape the agendas of governments and public international assistance agencies" (1990:84) and the purpose in so doing is to build public support to put political pressure on non-accountable governments to transform their vision of development through "the power of ideas, values and communication links" (1990:127).

Castells adds another dimension. In analysing the success of the environmental movement, he attributes much of its success on its ability to "adapt to the conditions of communication and mobilisation in the new technological paradigm" (1997:128). This means that new capabilities have to be learned, such as mobilising people through the use of the media, as well as utilising new communication technologies and mobilising tools, such as the internet, which allows for transnational sharing of information and the coordination of global initiatives.

In looking at fourth-generation strategies, Korten specifically assigns the role of transformation to VOs and POs (rather than PSCs or GONGOs, as these are largely establishment institutions and therefore keen to protect the status quo). The objective of VOs and POs is to "energise a critical mass of independent, decentralised initiatives in support of a social vision" (1990:127). However, it is not the individual VOs with paid staff that provide the real energy of the movement, but rather their volunteers. Korten attributes the failure of development "to an inadequate mobilising vision as the root cause" (1990:127). A fourth-generation strategy therefore requires the public to be conscientised with an alternative vision of social transformation, so that voluntary action can be harnessed and mobilised on a national and even a global scale. The communication of ideas and information is therefore key in order to enable people both within their formal organisation and outside it, to act.

Korten summarises the role of a VO with a fourth-generation development agenda as follows:

> …to coalesce and energise self-managing networks over which it has no control whatever. This must be achieved primarily through the power of ideas, values and

> communication links. To the extent that the VO is truly successful in these efforts, most of the resulting action will be beyond its range of vision. (1990:127)

VOs are essentially part of a broader movement of "social and political activists" (Korten 1990:127)). In other words, although VOs may be facilitators of a global people's development movement, there is recognition that they are also part of other social movements that are geared towards social change in diverse areas, ranging from the environment to peace movements and women's rights (1990:124). VOs therefore wishing to engage in fourth-generation strategies have to build alliances with other people's movements. Furthermore, it is not solely VOs or POs that are the main actors in fourth-generation development strategies. The citizen volunteer plays an integral part, whatever their background and wherever they come from. The citizen volunteers are the numerous individuals who bring their spirit and energy to their communities and workplaces, irrespective of the sector in which the organisation belongs (1990:106). In other words, it is the social energy of a people's movement that becomes the driving force or the "engine" of development and not money. Korten therefore concludes that "the surest way to kill a movement is to smother it with money" (1990:124). He remarks that serious development assistance to the poor demands attention to political and economic empowerment (1990:142). Furthermore, although important, the core of development is not money and technology, but institutions and politics (1990:144).

Korten advocates that transformation, not growth, should be the goal of global development. He calls for a transformation in our definition of the quality of life, so that rather than focusing on consumption, we emphasise the development of the social, mental and spiritual. Secondly, he calls for the transformation of technologies to ensure that they are environmentally sound, so that they are able to benefit human wellbeing, and finally, he calls for the transformation of institutions, so that we look to meet basic needs rather than wants (1990:133-134).

Korten makes the distinction between truly "natural" disasters, such as famine, earthquakes and the like, which are real short-term emergencies and "unnatural" disasters, which he refers to as "*human* disasters" (1990:143, his emphasis). The latter represent "chronic situations that are a direct result of human action – war, environmental destruction, lack of access to productive resources and employment, and political repression". In his view, these issues can only be resolved through

"difficult institutional and behavioural changes" (1990:143). In other words, the provision of humanitarian assistance in the latter instance does not remove the cause of the suffering nor indeed reduce the demand for humanitarian assistance.

Let us take, as an example, HIV infection among youths in South Africa. Shisana *et al*. (2005) note that in 2005 prevalence in the 15-24-year-old age bracket was 10.3%, with females having an infection rate of 16.9% and males 4.4%. UNAIDS (2008a) has subsequently reported a prevalence rate of 12.7% for females and 4% for males. HIV transmission among youths is therefore extremely high, translating to 192 000 new infections per year (Rehle *et al*. 2007) and while it is true that ARV treatment is available, it is unsustainable as a response to the crisis in financial terms, let alone in terms of the cost of human suffering and morbidity. This points to the fact that there needs to be a fundamental change in the way that the crisis is approached.

In order to achieve global transformation, Korten outlines an agenda to address several key areas in which change must occur. These include reconciliation and demilitarisation; a change in lifestyle and technology; political and economic democratisation; trade and investment relations reform and a re-examination of trade rules. He particularly cites the example of intellectual property rules, which work as a protectionist measure (1990:176), and serve to exploit non-renewable resources.

Clearly, there is an obvious role for the church to play in some of the above areas, for example, facilitating reconciliation. In my view, the church perhaps has a less obvious but nonetheless important role to play in the reform of trade rules (see Chapter 4, section 4.3.2, where unjust rules, prevented life-saving medication being made available to those infected with HIV in South Africa).

Korten also identifies two further areas that need to be examined in order to achieve social – if not global – transformation, namely spiritual development and the family. In both of these areas, the church has a crucial role to play.

Religious teaching, according to Korten, is an essential element in addressing poverty and injustice. Korten rightly points out that "(q)uestions relating to the issues of power, values, love, brotherhood, peace and the ability of people to live in harmony with one another are fundamental to religion and to the role of church in society" (1990:168). Churches, the religious community, religious missions and religiously

orientated voluntary development organisations are best placed to tackle greed and egotism, and consequently the unjust structures that result from them. Korten here speaks of the development of an "alternative human consciousness" (1990:168), where power is to be regarded as "a gift to be held in stewardship to the service of the community and the human and spiritual fulfilment of all people – especially the powerless" (1990:168). However, raising the consciousness of the holders of power about the nature of their power is not the only aspect of consciousness raising: the disempowered too have to be conscientised politically, so that they are able to bring power holders to account. Korten also suggests transformation in consciousness can be achieved by moving away from masculine aspects of growth-centred development, with all the implications of "competition, empire and conquest" to the more feminine ideals of "nurturing" that are integral to people-centred development (1990:169).

Korten states that ultimately, the wellbeing of women, children and men depends on their ability to function as members of a family and community. Family, as the most basic social unit of human society, "is the building block that is essential to the construction and maintenance of strong integrative social structures" (1990:169), providing psychological and economic security for an individual. In this context, therefore, the subordination of women and children has to be addressed through education and increasing the income-earning opportunities for women. However, Korten adds this caveat to his remarks: "it is essential to recognise that the goal is to transform family relationships, not to separate the woman from the family – with the disastrous consequences this brings for men, women and particularly children" (1990:170). Korten highlights in particular the role of women in African society, where he says that women are financially dependent upon men for reasons of financial necessity, while the men accept little or no financial responsibility for family maintenance (1990:170). He therefore makes a particular call for a more constructive role to be established for men within the family.

So too Korten makes an appeal for the welfare of children to be considered within the context of family and communities. By focusing solely on child-centred initiatives, it is the symptoms that are being treated rather than the problem; Korten therefore advocates that issues such as the disintegration of the family, along with enhancing the ability of parents to provide for themselves, be addressed.

Korten's views on family are important in the context of HIV/AIDS. However, it should also be borne in mind that changes to the nuclear family are being wrought in South Africa (see Chapter 2, particularly section 2.2.1). Such changes bring to mind Castells's view that "(t)he patriarchal family, the cornerstone of patriarchalism, is being challenged" (1997:135). So what is to be done? Castells points out that the transformation of the economy (in particular the labour market), along with a transformation of technology (which enables women to have greater control over child bearing), the feminist movement and the rapid diffusion of ideas in a globalised culture are all having an impact on the model of a family, "which regards the adult male as its head" (Castells 1997:138). Even accepting the view that South African society continues to be male-dominated (Qakisa 2002) and women have a "subordinate cultural status" (Haddad 2005), there are nonetheless changes occurring in what is regarded as a family comprising husband, wife and children, if only because HIV/AIDS is leaving homes without one or both parents. It is in this scenario that there is a role for the church, if it is only transforming the ways in which it regards household structures and responds to them.

The vision for transformation outlined above is people-centred rather than growth-centred, based on justice and peace. Human beings are accorded dignity and given the means and resources to meet their basic needs. With this vision, heed is paid to the environment, which is held in trust for future generations. Values and institutions are transformed to create a just, sustainable and an inclusive global society.

Swart (2006:148-149) explains that there is an overlap between third- and fourth-generation development strategies. Fourth-generation development strategies are more radical because they are value- and idea-centred, embracing democratic politics and the participatory principle of social movement theory. However, fourth-generation strategies also fully adopt the kind of people-centred development that determines third-generation development action. Third-generation strategies look to the transformation of societies through networking and coalition building in order to mobilise the actors of people-centred development. Fourth-generation strategies build on such mobilisation by including NGOs, POs and other social movements to enable changes to be wrought beyond national boundaries.

In order to achieve the transformation agenda, voluntary action is required on a scale hitherto unprecedented in four critical areas.

i.   *Catalysing the way in which people see their world, use its resources and relate to each other both as individuals and nations*

According to Korten, this agenda is best realised through "defining issues, creating a new global consciousness, facilitating people-to-people exchanges, advocating policy change, building political will and undertaking experimental initiatives" (1990:186). For the VO this means employing third- and fourth-generation strategies that are aimed at re-examining policies, transforming institutions and helping people "define, internalise and actualise" a people-centred development vision (1990:186). Although such action might include protests and monitoring, Korten says that the primary focus should be on advocacy to create positive change.

The other essential function of development-orientated NGOs is to focus on education for global citizenship. This does not mean fund-raising appeals for compassionate reasons, but rather a focus on the issues that give rise to the problem, such as unjust power relations.

ii.   *Systems monitoring and protest by citizens*

Systems monitoring and protest action is taken in order to ensure that abuse of power by government and business is kept in check. This is not something that can simply be left to the judiciary and press, but something in which citizens must be involved.

iii.   *Facilitating reconciliation with justice*

In situations of conflict, rather than close their eyes to the cause of suffering, Korten advocates that NGOs adopt a more proactive stance (1990:188-189), namely the rejection of violence and a commitment to reconciliation. However, such reconciliation has to take place in accordance with principles of justice.

Korten summarises the role of reconciliation as follows:

> The need for just reconciliation is one of the most fundamental development needs in our contemporary world. Religion, which commonly presumes to be society's primary arbiter of the values that govern human behaviour and relationships, must surely play a central role. While religion is all too often involved as the rallying cry of the intolerant and hateful in the cause of violence, the basic message of all the

194

> world's great religious teachers has been one of love, brotherhood and tolerance. Those who follow in the tradition of these great teachers are amongst the most important development workers of our day because they are attacking the root cause of human suffering (1990:189).

Korten draws attention to the importance of spiritual renewal, powerfully making the point that "spiritual poverty may well be the cause of more human suffering than economic poverty" (1990:190). Although Korten envisages reconciliation on a global scale, he first calls for reconciliation within families and communities.

Korten acknowledges that reconciliation presents a particular problem for religiously affiliated VOs, as their agendas are frequently indistinguishable from those of their secular counterparts, even when working through their local churches. Nor have VOs asked what the distinctive role of the church might be in addressing the issue of underdevelopment. Indeed, have churches asked themselves this question? In circumstances where churches have lost their mission, Korten suggests that religiously orientated development VOs take responsibility for teaching the central messages of love, brotherhood and reconciliation. Lest there be doubt, Korten makes it clear that the objective here is not to win religious converts, but to help people to discover the integrative teaching of their own faith (1990:190-191).

iv.   Implementing large- scale service programmes

An equity-led growth strategy must have the necessary service delivery systems to be able to deliver essential services (such as education) on a national scale. This cannot be left entirely to the government. While there is merit in providing such services and programmes on a decentralised basis through the use of NGOs, it must be borne in mind that such NGOs would then find it difficult to act as catalysts, advocates and monitors. Korten recommends that an examination be undertaken into how volunteer energy could be used for service delivery on a large yet decentralised scale (1990:192). This is not the same as temporary participation in, for example, the short-term delivery of relief supplies and services. Large-scale service delivery means that the VO, PSC, PO or governmental non-governmental organisation must institutionalise itself and its functions, which would requires sustained financing, rather than reliance upon foreign grants of a short-term nature. The NGO's structure would also have to be such that it can be held accountable by those using its services (1990:196).

There is clearly a role for the church in facilitating reconciliation and healing in relation to HIV/AIDS. But the church should also be mindful of the fact that it has a vital role to play in catalysing the way in which people see each other, as well as in exercising a watchdog role. Many churches were able to exercise all of these functions in relation to their contribution in the fight against apartheid and there is no reason for them not to exercise a similar function in relation to HIV/AIDS.

Transformation – and achieving the goals of the transformation agenda – also requires that VOs develop new competencies. VOs need a change of theory and, importantly, Korten points out that certain skills also need to be developed, namely social and policy analysis, political strategising, public education and communication skills to be able to convey policy issues to lay audiences (1990:192). Where it is unrealistic or expensive to develop formal policy analysis capabilities, Korten recommends linkages with organisations in both the North and the South to meet this need. In this manner, information is shared and Southern VO perspectives are incorporated.

In addition to strong North-South linkages, the value of an active and engaged grassroots constituency cannot be overlooked. A committed constituency can be mobilised to lobby parliament, obtain media publicity, talk to civic groups, demonstrate, organise meetings, etc. and thereby make their views known to decision makers. Korten says that "in the end it is voluntary action that is most likely to influence the policy process" (1990:195).

VOs also need to develop competencies in monitoring and this is best achieved through an extensive network of volunteers who are linked through an effective information system. The gathering of information in itself will not suffice. Where necessary, action must be taken and this necessarily requires the development of lobbying skills, legal know-how and the mobilisation of protest action (1990:195). In this regard, see Chapter 3, section 3.3.1, where it is seen that owing to the changing nature of care delivery, volunteer carers are having to develop new competencies. The enhancement of skills and the conscientisation of people to achieve more are very much along the lines envisaged by Korten.

In situations of conflict VOs can be used to play a role as mediators, conciliators and bridge builders. Such efforts need not entail direct engagement with the leaders of

contesting factions but with their citizen groups, thereby encouraging diplomacy at a citizen level.

The transformation agenda further requires development-orientated VOs to work with other individuals and organisations that are also people-centred and committed to the transformation agenda. In this regard, Korten makes a perceptive comment: "Development-orientated VOs have long been known for their exclusive preoccupation with their own development projects and beneficiaries. Sometimes it almost seems as though they are competing for the right to claim accessible groups of the poor as their own" (1990:197). Could the same accusation be levelled at churches both among different denominations but also within them?

Korten states that international NGOs are often (and sometimes unfairly) criticised for representing the interests of the establishment rather than the poor, and of lacking a development theory (1990:197). That said however, the provision of adequate food, school uniforms, education and health care are insufficient in themselves to provide people with the capacity for self-help. Inequitable local, national and international economic and political structures thwart the ability of the poor to make development progress.

Korten therefore calls for a North-South partnership (1990:198) in which long-term relationships are developed between Northern NGOs and Southern local partners which are aimed at providing linkages both nationally and internationally, especially where they share the same political and social commitments to change. Southern VOs may have a capacity and expertise that international Northern organisations lack. VOs in the South may lack skills in, for example, legislative lobbying, policy analysis, public relations and computer communications network technology, and may therefore benefit from establishing relations with NGOs from the North. International partnerships may also be helpful when lobbying against policies of a Northern agency. So too, where Southern VOs and POs require international pressure to be brought to bear upon their own governments, linkages with a Northern NGO might be very useful. The usefulness of forming linkages is very clearly illustrated in relation to the TAC campaign for access to ARV drugs, where the world's attention was brought to bear on the unfairness of the costs of drugs, which made them unaffordable for Southern countries (see above, Chapter 4, section 4.3.2).

The creation of linkages between Northern and Southern NGOs does not mean the creation of replicas, however, as this only leads to the commercialisation of national NGO sectors and their institutionalisation as an international system of welfare dependence (1990:199). Instead Korten recommends interventions to strengthen the NGO sector, but better still, promoting efforts aimed at strengthening voluntarism in the South. Korten makes the point that "(t)he voluntary dimension of development action needs much greater attention in future North-South partnerships among development-orientated NGOs than it has received to date" (1990:199). What body is better than the church to inspire and motivate people to volunteer their time, energy and services, for it is able to call on people to do so for the Glory of God, rather than for the church itself?

Working with other organisations also may require forming alliances across people's movements. Thus, a Southern VO working with, for example, disenfranchised rural women might join forces with international women's rights networks or indeed human rights groups, and in this way evolve a strategy to try and combat factors that contribute to a woman's vulnerability to contracting HIV/AIDS. The environmental, women's, peace, human and civil rights movements may indeed have more in common with a Southern development-orientated VO or PO than with international NGOs. Such movements have two elements: a reactive element that seeks to block harmful actions (such as discrimination) and a proactive element that seeks to create new and more positive social institutions in line with the people-centred development vision.

Another area that Korten calls to be strengthened is the use of international forums, such as the United Nations (UN), by NGOs, to make known the views of people. In so doing, Korten believes that national and global agendas will be better influenced (1990:202).

A change of competency, however, is not required only from Southern NGOs. Northern NGOs too have to change if they wish to become agents of transformation, rather than providers of humanitarian assistance. Northern NGOs need to consider what the consequence might be if they were to support a people's development movement, rather than function as a professionally staffed bureau, primarily involved with funding. It may require them to deal with the root causes of poverty, for

example, rather than rely upon the image of a starving child in order to raise funds, which could well alienate the organisation from its funders; is this a risk that they are willing to undertake? This aspect finds resonance with Northern NGOs that raise funds for combating HIV/AIDS in Africa by showing images of a person with full-blown AIDS in a Southern country, the body wasted, emaciated and sore-ridden. While such a campaign would draw sympathy, and possibly funding, it fails to address the issues that might have given rise to the disease, such as poverty, which might drive a woman, for example, to engage in risky sex behaviours in exchange for food or other favours as a survival strategy (Pettifor *et al*. 2004).

In order to become relevant to people-centred development, international NGOs need to have engaged constituencies – people who volunteer and do more than merely make financial donations. It requires them to understand the causes of human suffering and be prepared to disseminate information both within and outside the organisation, with the objective of reaching broader constituencies.

In relation to churches, Korten makes the point that many church-sponsored VOs have large natural constituencies within their affiliated churches. "The challenge is to reach out through human networks, study groups and forums where people can engage and dialogue on critical development issues. There is a need to seek more opportunities for true people-to-people linkages … to build a shared vision and put their efforts in global perspective" (1990:204). As the people-centred vision is envisaged as a global movement, international VOs can also assist by facilitating people-to-people linkages.

In short, Korten says that the dynamic energy of a people's movement must be used as a development resource and that the global citizen volunteer must play a crucial role in development, rather than a professionalised NGO:

> We must act on a recognition that the distinctive role of the voluntary sector is not to serve as a cheap contractor to implement government-defined programmes. Rather it is to mobilise and focus the social energies of a people's development movement driven by a commitment to self-help action and guided by a critical consciousness of the responsibilities of global citizenship (Korten 1990:207).

Korten attributes the fundamental problem of development to power and furthermore, that power issues can also be viewed as value issues (1990:214). We therefore need to apply integrative values, i.e. the essential values of development, and it is here that

199

"(t)he great religious teachers provide useful guidance through their insights into the values of humility, moderation, and love – the integrative values by which we must now learn to live" (1990:214). Korten speaks of "a new awareness" that needs to be instilled in humankind and possibly the greatest awareness that the church can bring to humankind is that we are all dependent on each other and share a common destiny.

In order to do this, there are powerful tools at our disposal, not least communication technology, which can be used to disseminate information and enable people-to-people linkages. So too, international NGOs can be used as a resource for learning and change, as well as to facilitate links between influential constituencies across the world. Many such NGOs started off as VOs, but need to acknowledge that things must change, not least their programmes and modes of operation. They also need to regain their vision and rediscover their core values. International NGOs also need to look closely at the underlying causes of problems before activating their natural constituencies to become engaged citizen-volunteers. I would add that some soul-searching - not least within the church - is also called for to discern the ways in which it has contributed towards the attitudes and mind-sets that have helped the spread of AIDS or that have resulted in stigmatisation and discrimination of PLWHAs.

4.4.4 Limitations of a fourth-generation (social movements) approach

Swart (2006) summarises the views expressed by Shaw (1994), Finger (1994) and Walker (1994) that although the social movements approach is important, it has its limitations, which can only be addressed through a global civil society approach to transformation, which "emphasises the fundamental need *for a more effective and deliberate coalition of progressive, alternative actors or forces to push forward the true global reach of the alternative agenda*" (Swart 2006:170, his emphasis). In order to challenge the establishment and to avoid being co-opted by the system, coalition politics is called for in order to make an impact on world politics.

Swart mentions that each of the above authors makes the point that social movements depend on other institutions of civil society, as well as formal political parties, to make an impact. In so doing, they are dependent upon them and this relationship of interdependence should be utilised to achieve common goals. This requires the purposeful building of relationships, networks and coalitions to enable global transformation to take place.

Swart (2006) refers to Shaw (1994) as identifying churches as one of the major emergent institutions (along with parties, unions, educational bodies, the media, etc.) that can facilitate global civil society, as a result of their global linkages, networks and collective organisations.

Theoretically, the church should be able to meet the challenge of building relationships and linkages, networks and coalitions, to enable it to exercise a more effective influence in the national and global sphere.

4.5   Conclusion

In a recent article the Anglican Archbishop of Cape Town, Most Rev. Dr Thabo Makgoba (Makgoba 2011) commented that South Africa, as a new democracy, was still learning where the church should act in solidarity with people, where it should be critical, how the church should respect diverse views, and how it should deliver and receive constructive criticism. He went on to say:

> I firmly believe it when God says that people matter. God cares that his beloved children should all have adequate food, shelter, clothing and so forth. God cares that everyone should be treated with complete respect by everyone else, with no one marginalised, excluded or voiceless in the ordering of our common lives … [The church should be] in solidarity with the needs of the poorest, the most vulnerable and the most marginalised; including the strangers, the foreigners in our midst.

The views expressed by the Archbishop perhaps summarise the centrality of the human person by the Christian church.

Mbembe (2011), in another article in the *Cape Times*, paints a picture that reflects how far removed the country is from putting the human person at the centre of development. Mbembe writes of the current dangers that South Africa faces: a gradual closing of life-chances for the bulk of the population, an increased polarisation along racial lines, a government that is indecisive, a "rebalkanisation" of the public square, a promise of liberation that has become privatised, and ideals of reciprocity and mutuality that are struggling to find a platform. He makes this cogent point:

> Despite the emergence of a solid black middle class, a rising superfluous population is becoming a permanent fixture of the social fabric with little possibility of ever being exploited by capital. Most black youth are barely holding on to the ledge. They are likely never to get full-time formal employment or to enter the proletarian economy. Stuck in a field of blighted possibilities, they scavenge to live or simply to get through the day … so much rage and almost no future.

In this mix we have HIV/AIDS, a disease that Robins (2010:127) refers to as bringing "profound stigma and 'social death'". And it is all very well to speak of the treatment options that are now available to those who have contracted the disease, but can this be the answer? Surely not. The question needs to be asked as to where the church is in emphasising the centrality of the human person in the government's (and business) policies and objectives.

In this chapter I have endeavoured to examine how health care might be transformed. But more still is required; it seems that nothing less than a transformation of society and values is required. Transformation that is people-centred in orientation and that incorporates a quality that only the church is capable of imparting is necessary.

Korten is of the view that social movements are the best way in which to bring about transformation that is global in scale, for they alone can impart the energy to mobilise people, as well as provide a vision of a better world. I have endeavoured to make the case that the church is in an excellent position to be able to provide such a vision, as well as the motivation and impetus to achieve these objectives – and in fact, a movement without the influence of the teachings of the church would fail to bring those qualities of solidarity, forgiveness, reconciliation and hopefulness that, in my view, are important aspects of transformation. As De Oliveira (1988) has demonstrated, in Brazil it was because the church sided with the poor and came to understand problems from their point of view that it was able to create a movement to bring better health care to the community.

But transformation cannot occur unless the church learns to negotiate its way in the political field, as well as to conscientise the population and teach them about the political process and how such change might be achieved. In examining health-oriented movements, it is clear that there are certain elements that are essential to their success, not least the provision and dissemination of information, learning the language of experts, negotiating the political landscape, forming alliances and networks, and being able to communicate concerns through various media, including making use of the internet and the latest communication technologies. Whether the church has risen to these challenges will be examined in the next chapter with regard to an empirical study that was conducted in the Helderberg Basin in the Western Cape.

Chapter 5

Churches in action: a case study

5.1   Introduction

In Chapter 1 I outlined that *the aim of this dissertation is to examine whether the church can exercise HIV/AIDS care in a manner that Korten (1990) would describe as transformational.* In the previous chapter we saw that, notwithstanding the help that is provided that can be described as first, second or even third generational, it is the fourth-generation approach, namely social movements, that can be described as developmental in the truest sense, because they seek to make changes in personal and institutional capacities that are ultimately transformational.

In order to answer the research question, I have used a qualitative approach. As outlined in Chapter 1, section 1.8, a qualitative approach allows for a deeper understanding of a complex social problem or phenomenon (Yin 2009:4). According to Feagin *et al.* (1991:13-15), if a process or population is sufficiently defined, it can be said to represent similar groups and therefore allows for a better understanding of a group, culture or organisation. I have worked on the assumption that a church belonging to a particular denomination represents a similar group and I have sought to understand the various denominational groups in relation to their stance and work in the field of HIV/AIDS. With one exception, all the groups examined are Christian and I did not therefore expect to find any fundamental differences in terms of their views on sex and sexuality. I sought to examine whether any particular denomination adopted a developmental approach in relation to HIV/AIDS and, if so, what were the factors that enabled this approach. Although a quantitative approach might have allowed inference to be drawn as to social causes that could be responsible for individual(s) or organisational behaviour (typically through statistical analysis), other complex factors that might affect behaviour would have been ignored (Feagin *et al.* 1991:38).

In undertaking the research, I endeavoured to find out what the church is doing in relation to HIV/AIDS; how it is rendering care – and if it is not doing so, why not.

203

What are the reasons preventing the church from engaging fully with the issue? In Chapter 1 I outlined more fully the reasons for utilising a case study methodology. Suffice to say here that one of the reasons is that, given the fact that I have very little control over what a church does or does not do in relation to the disease, I thought the case study method to be appropriate (Yin 2009:13). Several sources in collecting evidence were employed in order to make triangulation possible.

5.2   Scope and limitations of the study

Church leaders, where possible (or church pastors where the leaders were not available), were contacted from the main areas of the Helderberg Basin, which is situated 50 kilometres east of central Cape Town, in the Western Cape, South Africa (see Chapter 1, section 1.8.1, where the area is briefly described), across the different denominations thus hoping to capture diverse theological profiles and structures. Erasmus (2005:115) describes the Helderberg Basin as a community of approximately 150 000 people (this number can most certainly have expected to have grown in the nine years since Erasmus conducted his research in 2003). It is fair to say that the Helderberg Basin is not homogenous in terms of the different areas within it, for these differ in terms of wealth, racial population groups (black, white, coloured) living within them, formal and informal housing, employment, education level, etc. The main areas within the Helderberg Basin are Macassar, the Strand, Gordon's Bay, Broadlands, Lwandle, Nomzamo, Zola, Somerset West, Sir Lowry's Pass, Erinvale and Helderberg Village.

Erasmus documents that there has been a significant increase in the numbers of people moving to metropolitan areas as a consequence of apartheid laws, particularly those relating to influx control of the black population to "white" areas (2005:114) and because of urbanisation and the subsequent abolition of those laws. As a result of the scarcity of formal housing, therefore, several areas of informal housing have developed; the Helderberg Basin is no exception. Erasmus (2005:115) points out that 20.7% of dwelling places in the Basin are informal. Areas within the Basin with a high number of informal dwellings include Broadlands (98%), Lwandle/ Nomzamo/ Zola (88%) and Sir Lowry's Pass (41%). The Helderberg Basin also comprises areas with exclusively formal homes, such as Somerset West, and these tend to be

predominantly white owned and occupied. Map 1 below illustrates the different areas of the Helderberg Basin.

Map 1: Map of the Helderberg Basin, 2005[55]

---

[55] Figure reproduced by kind permission of the Unit for Religion and Development Research, University of Stellenbosch, from its report on the Helderberg Basin: Transformation Research Project 2005.

Despite the fall of apartheid, areas within the Helderberg Basin are still largely dominated by racial groups along lines of colour, albeit nowadays largely because of economic considerations. For instance, Erasmus (2005:145) documents that income among the black and coloured population groups within the Basin is lower than that of the white population group. Furthermore, unemployment is also higher among the black and coloured population groups. The coloured population group therefore tends to live in areas within the Helderberg Basin such as Sir Lowry's Pass, Macassar and Rustof, whereas the black population group tends to live in areas such as Lwandle, Nomzamo and Zola. These areas tend to have a higher proportion (and in some cases, an overwhelming proportion) of informal dwelling places. Areas of relative prosperity include Somerset West, Erinvale, the Strand and Gordon's Bay.

Churches were selected for interviews from the wide spectrum and cross-section of churches that are represented in the Helderberg Basin, from the established "mainline churches", to Pentecostal/evangelical/charismatic churches and, finally, an African Independent Church. Mainline churches that were formerly mission-established, such as the Anglican, Baptist, Dutch Reformed (including the Calvinist Protestant), Methodist, Presbyterian (now the United) and Roman Catholic Churches were chosen because they have operated in the community (and indeed in South Africa) for many years. They also have connections or links with their counterpart churches in the North and I presumed that because of their size and presence not only in the community, but also in many towns and villages throughout the country, they might have the resources to deal with HIV/AIDS. I was also interested in looking at the hierarchies of the church and the influence that these had on local church policy/ practices. For example, the Dutch Reformed, Anglican and Methodist Churches have a synodical structure; in the case of the Methodist and Anglican Churches, a bishop is elected as head of the church for a region, and in the case of the Dutch Reformed Church, regional synods represent the interests of presbyteries. In all these churches the regional bishops or synods meet from time to time (perhaps every few years) to form a General Synod, which then formulates and determines church policy for the whole denomination. Policy emanating from the General Synod is presumed to carry authority and is supposed to permeate the structures below. Similarly, in the Catholic Church the authority of the Pope and church policy derived through the Magisterium are supposed to carry through to the various church hierarchies and then, ultimately,

to the local parish level. I was interested in seeing, first, whether HIV/AIDS policies had been formulated and adopted in the hierarchies, and secondly, what effect these might have in terms of actions and attitudes at a local level.

Many of the mainline churches operate in several areas in the Helderberg Basin. According to Erasmus (2005:145), there are 244 places in the Helderberg Basin where people worship and there is one church for every 660 people, with a concentration of more churches per capita in areas of lower socio-economic status. This is borne out by demographic research undertaken by the Unit for Religion and Development Studies, Stellenbosch University (URDR) (2005:19) which found, for example, that whereas there were two churches in the relatively well-to-do area of Heldervue "meaning one church for every 1167" people, there were 65 churches in Macassar, which translated into one church for every 376 people, and 20 churches in Sir Lowry's Pass Village, meaning one church for every 110 people (URDR 2005:19). The URDR research led the authors to conclude that "areas of low income need more churches to serve the people effectively" (2005:19). I therefore took the opportunity of interviewing mainline (as well as other) churches in some of the areas in which they are located, primarily to see if there was a difference in the way in which they addressed the issue of HIV/AIDS. It was also a way in which to explore what resources, if any, were shared, whether there were differences in the understanding of the problems that different communities were facing, and how churches belonging to one denomination were coping in one area compared to another.

Churches that can be described (and would describe themselves) as charismatic, evangelical, Pentecostal or "Spirit-led" were also interviewed. These included churches such as Anointed Christian Ministries, Bethesda Evangelical Church, Bizweni Community Church, Every Nation, Helderberg Christian Church, Shofar and Rhema Good Hope Ministries. Many of the "house churches" operating in the Helderberg Basin that would also describe themselves as charismatic or Pentecostal, such as Kronieke Pinkster and Ephesians Faith Mission, were also interviewed. There is a plethora of such churches in poorer areas, running into many dozens.

Depending on their size, the Pentecostal/evangelical churches had some links with other churches in the area, as well as both nationally and internationally. Such churches by and large are connectional churches, accountable to each other through a

body of rules. Authority in Pentecostal churches, however, tends to be based on an individual congregation (usually through a board) and they are therefore more congregationalist in terms of their governance.

Congregational churches, such as the New Apostolic Church, were also interviewed and placed in this category. However, it should be noted that they have a hierarchical structure and although such churches were not mission-established, the church resembles a mainline church in terms of operation (Denis 2009).

I also interviewed the Seventh Day Adventist Church in the Helderberg Basin. Although it is problematic to put this church into a category, as it is generally regarded as outside of the mainstream of Christian churches, believing that salvation is uniquely accessible to members of this religious group (Kanter 1972) and adopting a much more proselytising stance, along with the Mormons (Church of Jesus Christ of Latter Day Saints) and Jehovah's Witness (Kanter 1972). However, as the Seventh Day Adventist Church is a presence in the Helderberg Basin, it was also interviewed.

African Independent Churches (or African Initiated Churches) are a more elusive category of churches. They have been described as "a major force in African Christianity today, one manifestation of the shifting centre of gravity of Christianity … from the North to the South" (Anderson 2001:107). I was, however, only able to interview one church in this category. Although I was told that they are prevalent in the largely black communities or areas of Nomzamo and Lwandle,[56] many attempts at making contact with them failed. For example, on two occasions when meetings were set up for me by community members to meet church members of the Ethiopian Church (an African Independent Church), I found that I was in fact meeting a church minister of an evangelical church and a lay minister of the Catholic Church respectively! For reasons that were later explained to me by a theologian of African religions (see Mazamisa 2009 below), they are more difficult to contact because they do not have the formal structures or offices of other churches. In such circumstances their policies on HIV/AIDS are rather more difficult to establish (and all the more so

---

[56] Nomzamo and Lwandle are examples of areas that grew as a result of the policies of apartheid and the subsequent effects of urbanisation, which have seen large numbers of people moving towards metropolitan areas in search of employment. The areas of Nomzamo and Lwandle have largely black populations and, according to Erasmus (2005:145) and the URDR (2005:15-30), they are characterised by informal dwellings, high unemployment, overcrowding and higher crime rates.

because they do not rely on written documentation); but it was important to interview this category of churches as they are an increasing presence and influence in South Africa (Denis 2009:70). It was also important to investigate what cognisance churches in this category had taken of the disease and whether they had put any programmes in place.

West (1975:16-17) describes this type of church as "a Pentecostal, apostolic movement, stressing the influence of the Holy Spirit and of divine healing, and combining both African and European cultural elements". In this sense, therefore, there is an overlap with the Pentecostal churches described earlier, "although they have moved in their own direction away from Western-orientated Pentecostalism in several respects … and may be regarded as Pentecostal only with important qualifications" (Anderson 2001:109).

Church leaders were selected from the different areas within the Helderberg Basin in such a way as to reflect the different population groups (white, coloured and black), as well as different economic groupings, from the prosperous to the very poor. This was relatively easily achieved with the mainline churches, but somewhat more difficult with "house churches", where the church pastor invariably held a full-time job, only concentrating on his[57] ministry on a Sunday or in the evenings on his return from work. Meeting with the leadership of the African Independent Churches also proved to be difficult, not least because the leaders of the main churches in this grouping, namely the Nazareth Baptist Church, Zionist Christian Church and Bantu Church of Christ are based outside the Western Cape in the provinces of KwaZulu-Natal, Limpopo and the Eastern Cape respectively. Requests for meetings failed to elicit a response, but I succeeded in meeting with a Minister of the Zionist Christian Church in Lwandle.

By and large the church leaders were male. House churches of a Pentecostal nature are led by men, but their elders tended to be women. In the mainline churches of the Helderberg area, the exceptions in terms of *leadership* were the Anglican and Methodist churches, where women lead their own churches/parishes. In common with

---

[57] In relation to "house churches", I did not come across any female pastors but in every case I found that the pastor's wife played an important supporting role for her husband and in fact was happy to talk about the ministry that her husband offered to the church. They often described themselves as "lay ministers".

virtually all churches in the Helderberg Basin, it seemed to be women who are involved with HIV/AIDS care work. Where such initiatives were led by women, I conducted interviews with them.

I also collected documents and other material, such as HIV/AIDS policies, relevant sermons, books, training material and other material such as church bulletins. In addition, I conducted interviews either in person or telephonically with organisations that I term "faith-based arms of the church", such as the Anglican's Fikelela project and its AIDS and Healthcare Trust and the Catholic Church's Catholic AIDS Network and the AIDS Office of the Southern African Catholic Bishops' Conference, whose remit is to address HIV/AIDS. Interviews were conducted with faith-based organisations, such as the Philippi Trust, the Christian AIDS Bureau of Southern Africa (CABSA), and social services such as BADISA (which is affiliated to the Dutch and Uniting Reformed Churches). While these organisations are not formally linked to a particular church, they regard themselves – and are regarded by others – as Christian organisations. I was interested in seeing to what extent the churches influenced their teachings and policies, and in turn, how these influenced their programmes. I also felt it important to see the extent to which churches worked with such organisations, as they too are tasked with dealing with HIV/AIDS.

I undertook visits to church projects, such as those supporting feeding schemes, as well as those caring for orphaned children and those who were either sick or requiring hospice care. I also visited the Hope Project in Cape Town, an initiative of the Catholic Church, which adopts a different mould of HIV/AIDS help, demonstrating much more of a leaning towards the sort of developmental transformation envisaged by Korten (1990). Many initiatives were located outside the Helderberg Basin, but they nonetheless enabled me to gain a broader insight into the activities of the churches.

Despite these initiatives, I acknowledge the critique directed against case studies – for example, they are criticised because they are said to be not generalisable. But as Yin argues (2009:15), case studies, like experiments, are generalisable to theoretical propositions and not to populations or universes. Another criticism levelled at case studies is that they are not "true experiments" in the way that randomised field trials might be (Yin 2009:15-16). In other words, they do not establish a causal relationship

– that is to say that a particular "treatment" has produced a particular "effect" (Jadad 1998:16). However, the advantage of case studies is that they do try to explain how or why a certain treatment worked. Yin, quoting Cook and Payne (2002:151), therefore states that "(c)ase studies may therefore be valued 'as adjuncts to experiments rather than as alternatives to them'".

The reason for wishing to employ a case study method is to try and understand a real-life contemporary phenomenon in depth (that is to say what actions the churches are undertaking) and such an appreciation can only be obtained by understanding the contextual conditions (what the factors are, in other words, that encourage or impede action in relation to HIV/AIDS).

The case study was conducted in the Helderberg Basin, for reasons of convenience as well as because the area represents a good cross-section of racial, age and socio-economic groups as well as faith beliefs. According to research conducted by the URDR (2005:11), the main faith tradition in the area is Christianity (85%), followed a very long way behind by Islam (4%). Those professing to have no religious affiliation amount to some 10% of the population of the area. Although I did not set out to look at Islam, some of my research led me to a local mosque and I therefore make mention of policy and attitudes in that faith tradition (although I make no claim that the attitudes and actions indicated at that mosque are representative of the Muslim faith).

All the interviews were conducted in English in a semi-structured manner so as to encourage probing, expansion and freer discussion. The interviewees were fully appraised of the nature of my research and none requested that their church's stance be disguised in any way. A couple of respondents did however express opinions on particular subjects on the basis of anonymity and these wishes have been respected. For ethical reasons, moreover, I have chosen to make the interviewees' comments anonymous and accordingly refer to them as Minster "A", Reverend "B", Spokesperson "C" etc As the research sought to examine, inter alia, whether there were differences in the various church denominations in relation to their approach to HIV/AIDS, in most instances I have named the church or denomination. For this reason I have not adhered strictly to a Harvard system of referencing in this chapter.

I accept that communicating with respondents in English might have inhibited communication.[58] I also accept that, as a Christian, my own views may have introduced some bias into the results.

The general scope and nature of the churches' work in relation to HIV/AIDS was discussed in Chapter 2, section 2.3. In this chapter, I shall examine what policies, if any, church denominations have in relation to HIV/AIDS. This may be taken as indicative of the direction that a particular denomination of the church would like its structures to follow at a local, parish or congregational level. I will then look to see how such policies are translated at a local level by setting out the findings of the research that I undertook in the Helderberg Basin. In this way the focus changes from looking at the Christian church in a theological, normative sense as one body, to looking at it in its empirical, sociological reality of denominations. The actions of churches are assessed by using Korten's measure of four generations (or stages) of development assistance.

5.3   The policies of churches on HIV/AIDS

It is important for the hierarchy of churches to adopt policy or policies in relation to HIV/AIDS, as this serves, first, to demonstrate that the church has taken cognisance of the disease and its implications. Secondly, it should serve to guide church action. Finally, it indicates to church members where church policy has been articulated and drafted sensitively, that the church recognises that AIDS is present within the church, and that it provides a welcoming place for all. In respect of the latter, an expression that is often used is that "the body of Christ has AIDS". Winfield (1995) explains the expression as follows: we are inseparable from Christ and from one another. We need one another to function and be whole; "[we] belong together and cannot come to healing and freedom without the other parts of the body: 'There is no life that is not in community'" (1995:365). Kelly (2009:17) explains the use of the same phrase by referring to Shuman (1999:89):

> [Through baptism and Eucharist] the body of the Christian person is no longer separate from Christ, but one and the same. When the word *body* is employed theologically …we cannot distinguish in an absolute way whether we mean our own

---

[58] Although all of the people whom I interviewed spoke English, many spoke Afrikaans or Xhosa as their first language, which might have had an inhibiting effect.

human bodies, Jesus' human body, Christ's bodily presence in the elements of the Eucharist, or the social body called "church".

Furthermore the use of the term "body" encompasses not only the Christian person, but his or her world, for this is what Paul means when he says in Corinthians (12:26): "If one member suffers, all suffer together with it; if one member is honoured, all rejoice together with it"[59] (Kelly 2009:18).

The evidence of HIV/AIDS policies in churches would appear to indicate that rather than looking for solutions and support mechanisms outside the church, the church acknowledges that it first needs to look to itself and examine whether it is responding in a Christ-like manner, lovingly and inclusively.

As Haddad (2005:33) expresses it:

> Perhaps the biggest challenge that HIV/AIDS poses to the Christian church is the call to become a true community where acceptance, love, and belonging flourish. The Christian vocation to build community becomes a clarion call, because those who are HIV positive experience the exact opposite. The church has become for them a place of stigma, discrimination, and rejection.

In an examination of *state* policy and HIV/AIDS and their impact on women, James (2011:202) makes the point that the women's movement in South Africa promoted legislation for women's equality in the new post-apartheid government. However, it did not focus on the situation of women with HIV/AIDS or at risk of contracting the disease. She makes the interesting point that, for example, the Rural Women's Movement spoke on behalf of poor rural women and other women's organisations to ensure that the South African Law Commission and Parliament developed equitable laws, while retaining traditional rights. However, it has been much less proactive in intervening in relation to HIV/AIDS. Such policies as have been adopted by government have been small and piecemeal, and lacking in resources, thereby having minimal impact on women's health. Their lack of power in sexual relations, lower educational status, domestic violence, stereotypical gender roles, cultural and religious practices, poverty and inequality, as well as their physiology, have all fuelled women's vulnerability to infection. James (2011) concludes that what is required is greater participation by women, the mainstreaming of gender concerns and the translation of policy into practice. The intriguing question that also needs to be

---

[59] 1 Corinthians 12:26

asked in the context of *churches* and their HIV/AIDS policies is the extent to which women have succeeded in putting gender issues on the agenda. Or indeed, whether they have endeavoured to do so? And perhaps an even more interesting question is the extent to which women have been allowed to contribute to policy-making within churches.

It is true to say that all of the mainline churches have policies on HIV/AIDS. For example, the Dutch Reformed Church has a comprehensive policy called the "Good Shepherd" (Dutch Reformed Church 2003). The church calls for involvement in addressing the issue of HIV/AIDS, acknowledging that the disease has been characterised by ignorance, prejudice and denial. It also recognises the presence of HIV within the church and calls for a response that is supportive and hopeful. It particularly calls for the care of children orphaned by the disease, the emotional and spiritual support of those affected, as well as their physical care and the provision of knowledge, work and facilities to alleviate the impact of the disease. Among the things that the church advocates are for (1) couples to remain faithful; (2) parents to provide sex education; and (3) people to abstain from sex until marriage.

In order to combat the spread of HIV/AIDS, the Dutch Reformed Church recommends several things, including the strengthening of family life, based on biblical values; the combating of poverty and violence against women and children; the provision of accurate information; support for VCT; an emphasis on abstinence and an explanation of "other protection methods"; and the combating of stigmatisation and discrimination. It calls for greater cooperation and partnership with "other role-players".

Another part of the Reformed Church family, the Uniting Reformed Church in Southern Africa (URCSA) (which was formerly the church for the coloured population group), also has an HIV/AIDS policy that calls on the church to be a caring and compassionate community that "stands with people living with HIV/AIDS and against discrimination, rejection, deprivation and prejudice". It particularly calls "on all people to do all we can to prevent the spread of HIV/AIDS … by abstaining from irresponsible sexual practices" (URCSA 2005:1). Nonetheless, it acknowledges that there are situations in society where there is an imbalance in power and where people have no control (URCSA 2005:1). Interestingly, URCSA acknowledges that

"many members of our own church and the broader Christian community are living with HIV/AIDS" (2005:1) and that "[we] the body of Christ (the church) has AIDS" (URCSA 2005:1).

The Anglican Church of Southern Africa also has a policy on HIV/AIDS, which was established in 2003, with a view to raising awareness and providing information on HIV, supporting and caring for those with HIV, advocating for the rights of those who are discriminated because of the disease, supporting children affected, and working with more advantaged communities to support those in need and empowering caregivers.

In order to give effect to these policies, the Anglican Church has set up an organisation known as Isiseko Sokomeleza ("Building a Foundation"), whose purpose it is to undertake a programme or projects to give effect to these objectives. However, recognising that no organisation can have a significant impact on the AIDS pandemic on its own, the Anglican Church has stated that it will make a concerted effort to work with the government, the faith-based sector, as well as NGOs such as Christian AID, with a view to mobilising each of the 23 dioceses in the province of Southern Africa (Anglican Church of Southern Africa [Isiseko Sokomeleza] 2003:1).[60] Each diocese was asked to appoint a Diocese HIV/AIDS Coordinator to build capacity at parish level and to implement projects such as home-based care, projects for the care of orphans, youth programmes, information drives on the prevention of HIV/AIDS, etc. (Anglican Church of Southern Africa 2003). In this sense, the Anglican Church's approach accords with Korten's view that networks are the best way in which to free the flow of creative and voluntary energy, and to unlock barriers to change (Korten 1990:106).

The Methodist Church of Southern Africa, through its Connexional Task Force (Methodist Church 2001), has also developed a policy on HIV/AIDS, which comprises eight elements: mobilisation, training, education and prevention, healthcare, counselling, welfare and support, project development and, finally,

---

[60] The reference given to this source in the bibliography is correct. However, the website details have since changed, as follows: http://www.anglicanaids.net/programmes.htm. Details of Isiseko Sokomeleza, as well as the second phase of the programme, namely "Siyakha" ("We are building"), may be found at this website address.

funding. The objectives of the church are: a) to prevent the spread of the disease; b) to care for those infected and affected; c) to reduce the personal and social impact of HIV/AIDS; and d) to mobilise national, international and local resources. The Methodist Church Conference in 2001 firmly stated that "HIV/AIDS is not the judgement of God on the infected. It is an opportunity for Methodists to love and care for those infected" (2001:2). In addition to many of the programmes outlined by the Anglican Church, the Methodist Church also calls for an open and frank discussion of sex and sexuality in church and in society, including imparting to youth "the vision of a lifestyle governed by informed choices, shared responsibility and healthy sexuality and the ideal of Christian marriage" (Methodist Church 2001:2). The Church also draws particular attention to gender issues, especially the empowerment of women and girls and sensitising men and boys to adopt a change in behaviour and to examine "social, customary and cultural roles" (Methodist Church 2005a:1). The Church also calls for closer cooperation with ecumenical and inter-religious partners, as well as government and societal structures (Methodist Church 2005b).

At its Conference in 2005 the Methodist Church resolved on further steps, including ensuring that each of its structures at District and Circuit level establishes an HIV/AIDS Action Group in order to put in place a programme aimed at achieving various things, not least fundraising, the empowerment of Church leadership to remove stigma and discrimination, as well as to establish ways of forming partnerships with other FBOs, NGOs, the government and other role players (Methodist Church 2005b).

Another mainline church, the Catholic Church, through the Symposium of Episcopal Conferences of Africa and Madagascar (SECAM), has also adopted a policy on HIV/AIDS, pledging to make available Church resources – educational, health-care institutions and social services – to fight the disease (Catholic Church [SECAM] 2003). The Catholic Church specifically outlines that education is an important tool and should be used to "promote those changes in attitude and behaviours which value abstinence and self-control before marriage and fidelity within marriage" (Catholic Church [SECAM] 2003:2-3). The Catholic Church stresses the importance of utilising lay men and women to talk about these moral principles. It makes special mention of poverty, recognising that it "goes hand in hand with HIV and AIDS" (Catholic

216

Church [SECAM] 2003:3). It is probably true to say that the Catholic Church's policy and programme on HIV/AIDS have got lost in the stance that it has taken on the use of condoms. It plan of action is outlined as follows:

a. To advocate for treatment, especially on behalf of those who are poor/suffering from structural injustices (2003:4);

b. Focus on the vulnerability of girls and the heavy burden borne by women (2003:4);

c. Ensure that church institutions and services respond appropriately (2003:4);

d. Advocate with government "at all levels and with intergovernmental institutions" to provide care and treatment; for adequate policies to support those affected by HIV/AIDS and for assurances that they will be treated with dignity (2003:5). It also commits itself to work with "those who are knowledgeable about traditional medicines and other natural remedies" (Catholic Church [SECAM] 2003:4).

It is also worth noting that the Catholic Church pledges to collaborate with other Christian confessions and "with people of other faiths", and calls for closer partnerships with "civil society, the business sector, governments, the United Nations, international and intergovernmental agencies and particularly with organisations of people living with HIV and AIDS, in order to increase the capacity for care and support" (Catholic Church [SECAM] 2003:5). In articulating this stance, the Catholic Church may be acknowledging what Korten (1990:160) terms "the principle of global interdependence", namely the fact that it is not sufficient to merely look to work with national governments, because so much of what happens in the world – including AIDS (of which Korten makes particular mention) – is affected by and has implications that go beyond national boundaries.

Charismatic churches such as the New Apostolic Church also have HIV/AIDS policies. They too urge acceptance and inclusion of people with HIV. While this church also emphasises the values of sexual abstinence until marriage and monogamous union after marriage, it acknowledges that where people are not prepared to align themselves to these principles, they "become responsible for the consequences" (n.d). While the New Apostolic Church does not agree with such actions, "it still feels responsible to recommend that such people adhere to safe sex

means by using a condom" (n.d). And it also makes reference to the avoidance of harmful traditional practices and intravenous drug use.

The General Council of the Assemblies of God (a charismatic church), as far back as 1989 called for the churches to reach out and minister with love and compassion to those infected with HIV. It makes particular mention of homosexuality and states that while Jesus faced those "guilty of sexual improprieties" with compassion, the church as a responsible Christian organisation must also "address their sin" (Assemblies of God 1989). The Assemblies of God adopts a strict reading of Scripture and states that, as a consequence, it is not possible to be both gay and Christian.
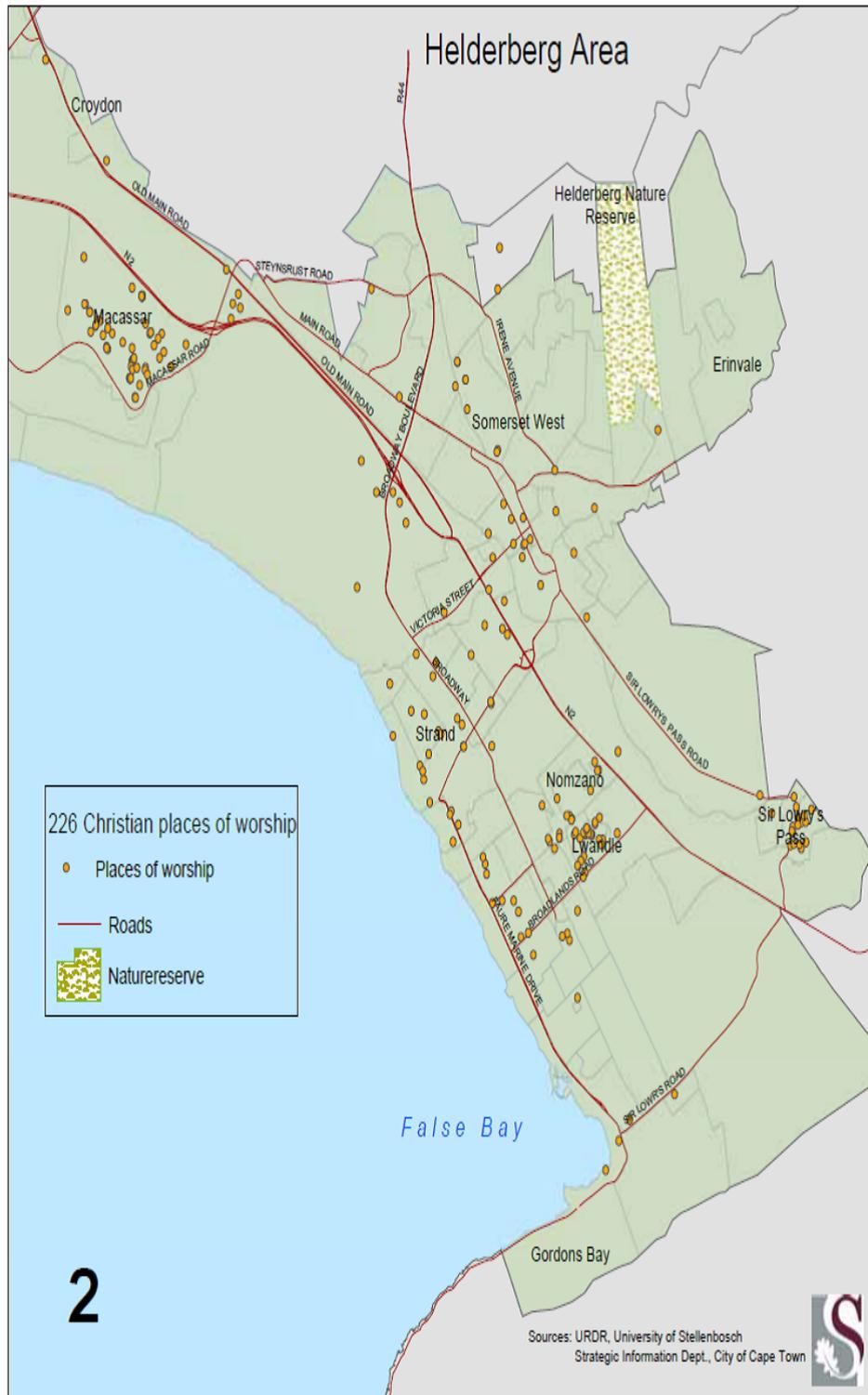
The African Independent Churches tend not to have written policies on HIV/AIDS. I endeavoured to elicit their approach in relation to the disease, as well as the help that they rendered and the nature of that help in terms of Korten's generations of development strategies.

5.4   The case study

I shall now consider whether the Christian church has influenced HIV/AIDS care in a way that is transformational or fourth generational by examining church action in the Helderberg Basin. A necessary aspect of such consideration is to see how far, in cases where churches have a policy on HIV/AIDS, such policies permeate and influence action at a local level.

5.4.1   *Church affiliation and a description of the Helderberg Basin*

As outlined above, the Helderberg Basin is extremely well served by churches (Erasmus 2005; URDR 2005:19). The map below (Map 2) identifies the churches in the area in 2005. There are many formal Christian church buildings. However, school buildings are often also used to conduct services. Worship also takes place in many instances, especially in areas of poorer socio-economic status, in people's homes. Less well-off areas have a significant proportion of churches in the area; this could be because people living in higher socio-economic areas have the means to travel to churches further away, or because churches in such areas have the means, resources and infrastructure to serve more people, obviating the need for physical proximity (URDR 2005:19).

Map 2 Church locations in the Helderberg Basin, 2005[61]

---

[61] Figure reproduced by kind permission of the Unit for Religion and Development Research, University of Stellenbosch, from its report on the Helderberg Basin: Transformation Research Project 2005.

The following are the main Christian church affiliations in the Helderberg Basin:

Table 3: Christian church affiliation in the Helderberg, 2001

Church	Affiliation (%)
Dutch Reformed Church	15.33%
Other Apostolic Churches	13.03%
Other Christian churches	10.21%
Pentecostal/charismatic Churches	09.23%
Anglican Church	08.57%
Methodist Church	06.86%
Catholic Church	05.55%

Source: URDR (2005:46)

Nearly 60% of the population of the Basin are married (either religious or traditional marriages); 7.58% of the population are categorised as living together and 21.4% as never having married.

Against this background, it is interesting to note that from figures extrapolated by the URDR (2005:32-34) (supplied by the South African Police Service [SAPS]), sexual crime is at its highest in Sir Lowry's Pass, Lwandle and Macassar. Sir Lowry's Pass also reported the highest occurrence of violent crime, followed by Nomzamo, Lwandle and Macassar. It should be noted that figures recently released show that nationally there has been a 3% decline in sexual crime year on year. However, the number of reported rapes remains extremely high at 55 097 (Jones 2011:6).

Looking at the latest crime figures (for the period April 2009 to March 2010) released by the South African Police Service for the Helderberg Basin, it can be seen that there is a fall in crime in most areas and across different categories of crime, from murder (49 murders in 2009/2010, compared to 50 the previous year), to assault with intent to cause grievous bodily harm (564 assaults in 2009/2010, compared to 660 the previous year), as well as slight falls in robberies, burglaries and motor-vehicle thefts. The

figures, however, do not provide an area-specific breakdown. In line with the rest of the Western Cape, there has been a rise in the numbers of people driving under the influence of alcohol or drugs (Crime in the Helderberg 2011:1). Much of the violent crime is said to be fuelled by alcohol and drugs, leading Dolley (2011:7) to label the Western Cape Province as "South Africa's drug capital". The figures relating to alcohol and drugs, however, probably need to be treated with caution, as they may be indicative of better policing and arrest rather than an indication of a worsening problem.

According to the URDR survey (2005:45), the largest population group in the Helderberg Basin is coloured (53.79%), followed by African/black (26.68%), then white (18.52%) and lastly, the Indian/Asian (1%). Afrikaans is the most widely spoken language (59.3% of the population), followed by isiXhosa (21.4%) and then English (16.2%).

The 0-19 year old age group comprises 34.4% of the population, followed by the 20- to 34-year-old bracket (26.67%). The 35-49 age bracket comprises 19.7% of the population in the area. The youngest population groups live in the areas of Macassar, Nomzamo, Lwandle and Sir Lowry's Pass Village, the middle-aged tend to live in Somerset West and Gordon's Bay, while older population groups live in the Strand and at Helderberg Village (URDR:12).

Most people in the area have had a basic education, although 5.8% have had no education. Those with a post-school education comprise 11.33% of the population. Most of those without schooling live in the area of Lwandle/Broadlands (which adjoin each other) (URDR 2005:14). The employed proportion of the population is said to be 48.44%, while 34.40% are not economically active and 17.15% are unemployed. Income levels are at their lowest in Macassar, Nomzamo, Lwandle and Sir Lowry's Pass and highest in Somerset West and the Strand (URDR 2005:13). Not surprisingly, unemployment is at its highest in Lwandle/Nomzamo, followed by Sir Lowry's Pass (URDR 2005:16).

Approximately 80% of the Helderberg Basin population live in formally built houses, flats or complexes, while 16.14% live in informal dwelling places. Nomzamo,

Lwandle and Sir Lowry's Pass Village have the highest proportions of informal dwelling places (URDR 2005:15).

According to the URDR (2005:53) survey, 0.89% of households were headed by a child in the 15-19-year-old age bracket. It was speculated that this was as a result of HIV/AIDS. The population groups most affected by child-headed households were those in the areas of Sir Lowry's Pass, Lwandle and the Strand.

Deaths as a result of HIV/AIDS as well as other diseases were highest in Nomzamo and Firgrove, followed by Lwandle and Macassar (URDR 2005:31).

5.4.2   *Analysis of churches' programmes and activities in relation to HIV/AIDS, using Korten's framework of generations of voluntary development action*

I have briefly examined a few of the Christian churches' HIV/AIDS policies above, some of which have elements that point towards a fourth-generation approach towards HIV/AIDS, in that they have a vision of a better world that can come about not only through change on a personal or at community levels, but also through changes across national boundaries. I now propose to look at the programmes and activities of local churches to see whether and to what extent they might embrace such policies and if the programmes that they implement can be classified as developmental.

Prior to doing so, it is worth making the following point: Korten (1990:123-124) highlights the fact that third-generation approaches (sustainable development) do not generally succeed because of hostile political and institutional contexts that are resistant and antagonistic to change. For this reason Korten advocates a fourth-generation approach, where people's power is used to drive social change. An interesting aspect of the research that I have undertaken was to discover that even with an issue such as HIV/AIDS, which is affecting some areas and population groups much more visibly than others, churches confront the following problem: community members (gatekeepers) – and even church members – have been unwilling to discuss the issue or to have it on the agenda, despite knowing the effect that it was having either in their communities or on their fellow human beings.

The recounting of a few conversations during personal interviews may help to make this point:

222

> Churches are run by community members and therefore community members are able to divide or unite people. Generally in poorer communities there is a spirit of helping one another. But at times of political activity, politics can divide the community. Political leaders say "You cannot talk to these people about HIV/AIDS, they are my people" (Mrs CC 2006, Lay Counsellor/Facilitator for the Philippi Trust).[62]

> In working with poorer communities, I have found that there are powerful figures within the community. They have a suspicion of outsiders and they want to determine what help is needed and how it should be channelled. They ultimately determine what happens in the community. Their agenda may be personal or political or both and you therefore need to reach a *modus vivendi* with such people if you are to achieve anything (Father C 2006, Catholic Church, Helderberg Basin).[63]

> In a community such as Sir Lowry's Pass Village, you need to be aware of the dynamics. Sir Lowry's Pass is made up of two communities – the "haves" and the "have-nots" and they each have their agendas and priorities. People who live on the mission ground tend to have their own properties and are better off. They do not see themselves as affected by AIDS and do not want to be preached to about it (Minister K 2006, Methodist Church, Helderberg Basin).

Where churches have not therefore been able to implement policies, this could well be because of resistance within communities and the local politics that are at play. Although we might regard churches as having some authority, it is worth bearing in mind that they too have to tread sensitively and negotiate with communities.

5.4.2.1 Generation-one activities: the provision of charity for immediate relief

It is true to say that virtually all of the church leaders whom I interviewed set aside some resources to meet immediate needs. Korten (1990:115) states that religious groups have been at the forefront of efforts to provide welfare services to the poor and this is evident in the Helderberg Basin. Interestingly, the Anglican (including the Church of England in Southern Africa [CESA]]), Baptist, Catholic, three Dutch Reformed churches and United (formerly Presbyterian) Churches in Somerset West have got together under the umbrella of the "Helderberg Street People's Centre" to provide food on a daily basis for all those in need, including those who are HIV positive in Somerset West and at Sir Lowry's Pass Village. In addition, they support the efforts of the volunteers to provide food to school children who are orphaned and live with their grandparents, family or community members in the area of Lwandle,

---

[62] For the reasons outlined in section 5.2 above, I have chosen to keep all the interviewees anonymous, but I have identified the churches or organisations in an endeavour to highlight possible differences in their approach.

[63] For the reasons outlined in section 5.2 above, I have not adhered strictly to the Harvard system of referencing, as I seek in this section to examine, among other things, whether there are differences in the way in which different church denominations approach the issue of HIV/AIDS.

and undertake child bereavement support classes for children who have recently lost their parent(s) at Sir Lowry's Pass Village. All the churches involved provide limited financial help to the Centre and make occasional appeals for help at their respective churches for volunteers, food, provisions, clothing and the like. It is true to say that the financial help and donations from local churches are far from adequate to meet the needs of the Centre and as a consequence the Helderberg Street People's Centre has to source funding from abroad. The remarkable feature of the Helderberg Street People's Centre is that it is run by volunteers from the churches in the area. Such volunteer action is critical to a people's movement. Whether or not the churches have conscientised volunteers sufficiently to embark on transformative actions, however, is another issue.

In addition, each of the churches also has its own food distribution and/or food parcel schemes to help those members of their congregation who are in need or, indeed, people outside their congregations who go to them for assistance. For example, the Helderberg Dutch Reformed Church has a distribution centre for food, clothing and household goods, which is well-stocked and supplied. This is in stark contrast with a Pentecostal church in a very poor area called Zola, where a Minister of the Anointed Christian Ministries remarked, "(t)he community is poor and so even establishing a feeding scheme is difficult" (Minister W 2008). The Baptist Church in Lwandle is also too poor to have a feeding scheme, according to one of its ministers (Rev. G 2008). House churches such as Kronieke Pinkster and Ephesians Faith Ministries, both in Sir Lowry's Pass Village, face similar problems because they are located in impoverished communities, where unemployment is rife and most people depend on social grants, such as disability payments to survive (Mrs EE 2006).

The Helderberg Street People's Centre also provides home-based care; volunteers from the community in Sir Lowry's Pass Village (*not* volunteers from the churches in Somerset West) take food to those who are ill and who live in informal dwelling places, bathe them, where necessary, and ensure that they have medication. The evangelical/charismatic church, Helderberg Christian Church, undertakes similar work at Chris Nissen Park, as does the Bethesda Evangelical Church in Rustof. Both churches have provided some training to carers and are therefore more "hands-on" compared to other churches in the area. The Helderberg Dutch Reformed Church has

a care group and, although no one has yet disclosed their HIV status, the care group – comprising a doctor, social worker, psychiatrist and other specialists – could in theory be dispatched to render help. The Seventh Day Adventist Church in Somerset West is unique in having established a "lifestyle centre", specifically devoted to the care of those who are sick. Care here is provided on a 14-day cycle and the facility is open to all in need, not just Adventists. Representatives of other churches, such as the New Apostolic Church in Sir Lowry's Pass Village commented: "There is a need for more practical caring and counselling structures but primarily the church would see its role as rendering spiritual care, through prayer and communion" (Minister T 2009 2008).

The point that I feel needs to be made in relation to home-based care is that volunteers rendering such care in poorer areas, such as Sir Lowry's Pass Village and in Lwandle and Nomzamo, are rarely drawn from churches in well-off areas. It seems that the volunteer sector has not been sufficiently mobilised by churches to act in areas of need. Korten (1990:105), however, states that "(i)f transformation is to come, it must come as a consequence of voluntary action, an act of human commitment to collective survival driven by a vision". In this respect it is questionable whether even with generation-one strategies, such as the provision of welfare or immediate relief, churches have been able to sufficiently tap into the enormous voluntary resources that they possess, because as yet there is a lack of vision.

Care is also provided for babies who are HIV infected. Such infants invariably require specialist care and this is provided at an organisation called "Cotlands" in Somerset West. Although Cotlands is not an FBO, churches support its initiatives and are often the source of its volunteers. Korten (1990:116) makes the point that pictures of starving children are sometimes used by NGOs to make appeals for donations and that while this is an appropriate response to an emergency situation, it does little more than temporarily alleviate symptoms of under-development. I venture to suggest that the reason that children's charities such as Cotlands receive such good support from churches is because of the irresistible appeal in meeting the needs of vulnerable children who are sick or hungry. The reasons why the child might be HIV positive, and issues such as the mother's vulnerability to infection, or why the child did not have access to optimal treatment are rarely raised. This is not in any way intended to deny the need for care for these children, particularly given the devastating impact of

225

the loss of a parent on these children's lives. However, in terms of assessing whether church work is developmental, it is a factor that needs to be examined.

Yet even in relation to providing for immediate welfare relief, it was interesting to hear the following views, which appeared to buck the trend of the church being automatically seen as a provider of welfare. First, the Minister of a charismatic church, Every Nation, commented:

> Charismatic churches are not necessarily very hands-on or practical: it is up to individuals within congregations. All churches do less than they are called to do because they are preoccupied by the "business" of the church (Minister O 2008).

The Baptist Minister of a church in the Strand also expressed the following view:

> The purpose of the church is primarily man's relationship with God. Meeting a human need may be important, but this is a 'horizontal' relationship. The 'vertical' relationship with God – reconciliation – is the purpose of the church (Minister N 2008).

In reflecting on the activities of churches with regard to the provision of immediate relief, it is probably fair to make three points. Firstly, most churches are committed to providing help to those most in need. Although a theory of development might not guide their actions, it is clear that they are responding to a cry for help and, given the levels of poverty, it is beyond question that there are cries for help. The churches, however, seem to accept poverty as part of the landscape, but do not appear to question why this is the case. It would seem as though the church accepts that the poor shall always be among us.[64] Secondly, there do not appear to be differences of any note in the way in which first-generation care is rendered by the churches, irrespective of whether they fall into the mainline, evangelical or African Independent Church categories. Finally, churches are by and large happy to confine themselves to working with their own congregations and in their own areas.

What is interesting is that churches in the wealthier areas, such as Somerset West, are able to give out of plenty, while those in the poorer areas struggle to give because they do not have the resources. The issues of meeting fundamental needs, the

---

[64] In the Gospel of John (12:8) Jesus remarked to the disciple, Judas Iscariot, "You will always have the poor among you, but you will not always have me". In Deuteronomy (15:10-11) Moses said: "There will always be poor people in your land", but he also went on to say "therefore I command you to be open-handed to your brothers and towards the poor and needy." Often the first part of the quotation is used as an excuse to do nothing.

expansion of vision beyond the narrow definition of self, family and close community, the issue of sufficiency (rather than abundance for a few), listening to the pleas from those without food, or the specific issue of our times where obese people now outnumber the hungry around the world (Sapa-AFP 2011:6)[65] are subjects that churches probably need to address more comprehensively, if transformation is to be achieved. Conscientisation is attempted by the churches from time to time during sermons at Sunday Services, but clearly a level of critical consciousness and awareness of the needs of neighbours have not been achieved. Could it be because this is an area in which the churches continue to "tread carefully" for fear of giving offence? Castells (2000:124) documents that in South Africa 10% of households receive nearly 50% of total income. What obligation is there for this minority sector of the population to care for those who have very little and who are infected with or affected by HIV/AIDS? To the question "How far have churches conscientised their congregations?" I would answer: to a limited extent and with poor effect.

5.4.2.2 Generation-two activities: local empowerment of people

Generation-two activities are those initiatives that Korten defines as enhancing the capabilities of people to enable them to better meet their needs. These are often referred to as community development initiatives (Korten 1990:118). In this respect HIV education and training programmes may be put into this category, because their purpose is to build capacities for self-reliance or empowerment.

Many of the churches in the Helderberg Basin conduct HIV/AIDS-awareness programmes. For example, the Calvinist Protestant Church operating in the area of Macassar has an HIV-awareness programme. In addition, it has undertaken the training of HIV/AIDS counsellors, whose remit it is to conduct workshops on the issue. Information is also provided during "Family Week" and prior to confirmation and at youth camps (Minister D 2006). Similarly, the Helderberg Christian Church ensures that at parents' meetings, which are held at least once a term, HIV/AIDS is on

---

[65] According to this source (Sapa-AFP 2011), obese people now outnumber the hungry around the world. The International Federation of the Red Cross (IFRC) issued a report (2011) indicating that the numbers of obese had surpassed the numbers of hungry (1.5 billion people are estimated to be obese and 925 million undernourished). According to the IFRC, the problem was not lack of food but poor distribution, wastage and rising prices that made food unaffordable for the poor.

the agenda and information is provided. The Methodist Churches too conduct HIV-awareness programmes prior to confirmation.

Perhaps the most comprehensive approach to HIV/AIDS education and training is that of the Anglican Church. Its Siyafundisa ("Teaching our Children") project is the prevention programme for the Anglican Church of Southern Africa, which incorporates South Africa, Namibia and Lesotho. The aim of the project is to provide information to youths between the ages of 10 and 24 years, with the objective of reducing the incidence of HIV by promoting abstinence before marriage and faithfulness within marriage. The Anglican Church, however, also has a wider approach to prevention that goes beyond the A (Abstinence) and B (Be faithful) approach. It incorporates safer sex practices, VCT, the empowerment of women, disease control (early detection of opportunistic infections, access to ARVs), etc. (Spokesperson Q, Siyafundisa, Anglican Church, 2008).

In addition, in the Archdiocese of Cape Town (which incorporates the Helderberg Basin) the Anglican Church has a programme called "Fikelela" ("We are reaching out"). This particular programme arose out of a survey that the Anglican Church conducted among 1 300 young people in its parishes, in the 10- to 24-year-old age bracket in 2004. They discovered that 30% of them were sexually active, of which 66% had more than one sexual partner (some children had begun experimenting sexually from the age of nine years) (Minister FF 2008). Although nearly three quarters of those surveyed had some form of sex education, as well as information provided on HIV/AIDS, this did not appear to have had any impact on their behaviour. As a result, the Anglican Church decided to embark upon sex education by using peer educators, providing information and empowering girls (Kareithi *et al*. 2005). Before confirmation every child has to attend a sexuality course, called "Survivor Africa" (Minister FF 2008). Acknowledging that youths are engaged in sexual activity, the Anglican Church's programme also includes education on preventative measures, including the use of condoms. However, the church has to exercise care in conducting such programmes, because donor funding from the United States President's Emergency Plan for AIDS Relief (PEPFAR) prescribes what can and cannot be taught, and the "C" aspect of prevention, namely condoms, is not

covered by the funding. The Anglican Church therefore has to find funding from other sources in order to tackle this aspect of prevention.

An HIV Task Group has also been established in the Anglican Church and they, in turn, have encouraged task teams to be established in churches at a parish level. The purpose of the task teams has been to get HIV/AIDS on the agendas of local churches, encourage church members to join in community projects, make churches HIV/AIDS friendly and celebrate World AIDS day. Interestingly Kareithi *et al*. (2005:108) say that "(t)ask teams in participating churches decide the what, who, how, when of all the needs and their associated responsibilities". Korten (1990) has described this type of transformation as process driven, building the personal and institutional capacities to mobilise and distribute resources by just and culturally appropriate means. While this is certainly true, Korten also envisages working beyond immediate communities to achieve transformation and building links with other organisations with similar aims. It is not clear to what extent the Anglican Church has achieved this. For example, a church minister from Macassar commented to me:[66]

> Churches that receive funding, for example, from PEPFAR, tend to use it for their own congregations and not for the wider community. For example, funding for education on HIV prevention is targeted at a church's own congregation and not the wider community. They are keen to have the publicity for the funding award but don't do anything for the community (Church Minister, Macassar, 2006).

The Anglican Church, along with churches such as the Bizweni Community Churches have also had people living with HIV/AIDS (PLWHA) talk to the church and this perhaps has helped to engender a better understanding of the disease. Such churches seem to be the exception rather than the rule. Interestingly, the Helderberg Dutch Reformed Church also had a PLWHA talk to the church and his impact was summarised as follows:

> People such as Christo Greyling[67] helped to break some of the stigma against people who are HIV positive. He contracted the disease in 1988 and in talking to the congregation he helped people understand that the disease is not contracted by people who are irresponsible or sinful (Minister DD 2006).

---

[66] It is not my intention to create tensions between church denominations and for this reason I have chosen not to give any indication of the church denomination.

[67] Christo Greyling contracted HIV during a blood transfusion and he has done much to break down barriers in relation to stigma. He has also been instrumental in demonstrating that it is possible to live with the disease and have a healthy family.

As an aside, it is speculated that the congregations' reaction might have been different – and possibly less sympathetic or accepting – if the PLWHA had contracted the disease sexually.

Initiatives such as encouraging people to know their HIV status by going for VCT can also be categorised as a generation-two strategy, because it might act as a spur for them to either seek medical help or to keep themselves HIV negative. Churches in the Helderberg Basin have handled the issue of VCT in various ways: there are those that have encouraged testing by church leaders "showing the way" by going for the test themselves (such as the Anglican, Calvinist Protestant and Helderberg Christian churches). Others encourage couples to undergo VCT before they marry, if they have been sexually active (such as the Helderberg Dutch Reformed Church and the Methodist Church in Sir Lowry's Pass), while others do not refer to the issue of testing (assuming that congregants have adhered to the church's teaching on abstinence and faithfulness?), such as the Catholic Church. In the Catholic Church, however, testing may be encouraged out of "pastoral solicitude, to encourage a couple preparing for marriage to voluntarily submit to HIV testing (and to receive the result of that testing as their own unique property)" (Czerny & Vitillo 2006:284).

Church approaches vary in relation to the provision of information on HIV/AIDS. Churches, such as the Anglican Church, believe in the provision of comprehensive information, informed by research it has conducted among its young congregants. Churches such as the Bethesda Evangelical Church, Strand, and the Bizweni Community Church, Somerset West, also take the view that the provision of information is important. This was expressed to me as follows:

> We try to be proactive, not reactive as a church and therefore address the issue of prevention (Minister H 2008, Bizweni Community Church, Somerset West).
>
> Sex education has to begin at an early age, as youths are experimenting earlier. After the age of 12 years it is too late. Education at an older age is useless as the youths are already exposed and they are bored with the subject of HIV/AIDS (Pastor SS 2008, Bethesda Evangelical Church, Rustof, Strand).

Other churches, however, take a very different view, believing (in relation to young people, in particular) that information on sex, sexuality and HIV prevention is not as important as inculcating the appropriate values. A sample of interview responses serves to illustrate the point:

> HIV is not talked about at services. Sex is not talked about either but abstinence is. The Bible says if you want sex you must find a husband and marry (Mrs R 2006, Kronieke Pinkster Gospel Church, Sir Lowry's Pass Village).

> Marriage is scriptural, and therefore sacred. The issue of condoms and protection before marriage is problematic. The family is under fierce attack these days and we need therefore to promote abstinence until marriage. "Thou shall not commit adultery" is a commandment and it is given so that we might have life in abundance. It is therefore important that we keep to these principles (Minister HH 2009, Seventh Day Adventist Church, Somerset West).

> We work with young people to give them values. Young people learn values from their fathers. But so many young people in poorer communities such as Kayamandi [a township on the outskirts of Stellenbosch] do not even know who their fathers are, so how can they learn values? (Spokesperson II 2009, Community Development Officer, Prochorus, Shofar [charismatic church], Stellenbosch, but which also established a church in Somerset West in 2009).

> The Strand Baptist Church has youth group meeting once a week, one of the purposes of which is to teach children about sexual ethics – not condoms, as that would be talking about protection, which is a concession. We need to talk about how young people should lead their lives (Minister N 2008, Strand Baptist Church, Strand).

> At the Anointed Christian Ministries [Pentecostal Church], there are two youth groups [16-23-year-olds and 23-29-year olds] who are encouraged to get involved in the life of the church. The church's role is to educate, train and empower youth, to teach them the values of life (Church Elder A 2008, Anointed Christian Ministries [Pentecostal] Church, Zola).

In general it can be said that the mainline churches are more open to discussion on HIV/AIDS and sex (except for the Catholic Church, which finds it more problematic). The difficulty lies in trying to reconcile the teachings of the churches in respect of abstinence and faithfulness, while also acknowledging that these teachings are not always adhered to. On the other hand, many of the evangelical/gospel/charismatic churches choose not to talk about sex, concentrating instead on the building of values.

The African Independent Church minister whom I interviewed, namely from the Zionist Christian Church, had a different problem altogether. It was open to discussion about sex and HIV, as long as discussions on the issue were kept separate between the men and women, for cultural reasons. The problem was explained to me as follows:

> HIV is talked about – sometimes men's services or men's groups are held to talk about it. But the problem is that not many men attend the services. They are drinking across the road and the women come to the Service. Mother's groups are left to talk about the issue (Minister I 2008, Zionist Christian Church, Lwandle).

The problem highlighted earlier by the Bethesda Evangelical Church in the Strand in relation to education was expressed by many churches and is probably best summarised by a member of the Ephesians Faith Mission Church in Sir Lowry's Pass Village, who said, "(w)e tell the young people don't get yourself into a position of being intimate. But the young people don't want to hear about abstinence and condoms" (Mrs EE 2006).

Support groups for those who are HIV infected or affected may also be put into the category of strategies that are aimed at the empowerment of individuals who are affected by or infected with HIV/AIDS, by allowing a person to know that they can share their problems, worries and fears in a supportive and confidential environment, and that it is a disease that can be managed. The Helderberg Street People's Centre runs a support group but because of the problem of stigmatisation such group meetings have to be arranged carefully. The problems of confidentiality and stigmatisation were also highlighted by the Community Day Care Centre in Macassar, which said that they used to run a support group for HIV-positive people at which the Calvinist Protestant Church used to provide soup. However, people did not want to go to it because they "feared being recognised" (Sister KK 2008). On the other hand, a home-care worker at the Methodist Church in Somerset West, who undertakes outreach work in less prosperous areas, took the view that support groups were not being well attended nowadays, because with the advent of ARVs people felt well and did not fear the illness as much as they used to (Homecare Volunteer B 2008). It thus becomes evident that undertaking generation-two strategies that are aimed at local empowerment is not as simple as might first appear. Sensitivity is required on the part of churches, as well as an ability to negotiate various interests and views. Illustrative of this point are these two views:

> We find it difficult to talk in our church about sex, because of tradition. The youth, however, are more open and receptive to talking about the issue (Minister M 2008, Methodist Church, Lwandle).

> We need to take into account the cultures of people when talking about sex. The Xhosa and Zulu cultures do not like talking about it openly and the church therefore has to respond in a culturally sensitive manner (Minister Z 2008, Methodist Church, Rustof, Strand).

The churches that appeared to have support groups are the Methodist Church in Lwandle (Minister M 2008) and the Anointed Christian Ministries in Zola (Church

Elder A 2008), both areas that are particularly affected by HIV/AIDS, as well as the Anglican Church. In an interesting comment about support groups, Minister FF of the Anglican Church (2008) said:

> Power dynamics [of support groups] need to be learned and there needs to be incentives provided for people to come to them, such as food or entertainment. The groups also need to be well managed otherwise they have no outcomes.

This perhaps serves to underscore the point made by Korten (1990:119-120) that such local empowerment efforts are too limited and face too many obstacles, not least in relation to confronting local power relationships. Issues such as stigmatisation and discrimination worsen the problem.

Clearly HIV/AIDS-related stigmatisation continues to remain a real difficulty in communities. The churches have a role to play in confronting the issue, but thus far appear to have had very little impact. In an honest appraisal a Minister of the Dutch Reformed Church in the Helderberg Basin said that "(t)here may be people who are HIV positive in this congregation but they would be reluctant to disclose their status" (Minister LL 2008). A lay minister of the Anglican Church in Macassar remarked that "(t)here is a lot of fear about how you will be treated if you are HIV positive. People are therefore more comfortable saying that they have TB" (Lay Minister V 2008).

All of the church leaders whom I interviewed said that they would adopt a compassionate approach, mainly using the analogy of the attitude and response of Jesus to the leper.[68] An Anglican Church spokesperson for the HIV/AIDS Fikelela Project made an interesting comment in this regard:

> Disclosure is difficult – perhaps people feel that it will embarrass their clergy if they were to tell them. People are also worried about issues of confidentiality. They worry about labelling – the church is good at paying lip service to the fact that we should not reject people but there are subtle ways of rejection that we need to also address (Minister FF 2008).

It would seem that by and large the church's leadership has not been able to convince its members and congregations that if they are infected with or affected by HIV, they will not be rejected. Time and again church ministers have said that no one in their

---

[68] For example, in Luke's Gospel (5: 12), the story is told of a leper approaching Jesus and asking to be cured. Jesus does not reject him but heals him.

church has come forward to disclose their status. Minister I (who is also known as Umfundizi)[69] of the Zionist Christian Church in Lwandle expressed this as follows:

> [In the Zionist Church, Lwandle] no one has yet come forward to reveal their status. They are afraid and when they have this thing, they leave the church. They fear that the congregation will criticise them. When you hear that people are sick in hospital, you don't know what disease they have. You guess it must be this thing… (Minister I 2008.)

Two further comments illustrate the point that perhaps it is the church leadership that has still an important role to play in creating awareness, an atmosphere and a vision in order to empower people, make them self-reliant and feel accepted:

> Church leaders still struggle to come to terms with the disease. They think that if they acknowledge it, then it reflects on them … "What does this say about me or my community?" Church leaders are also concerned about the financial impact of HIV – they are struggling to keep afloat... (Spokesperson GG 2008, Philippi Trust).

> The Anglican Church, as a church, is intent on embracing those people who are HIV infected or affected by AIDS. This, however, does not always translate to the local churches. Much depends on the individual priest and the training that they have received (Canon U 2008, Ecumenical & Public Relations & Training, Anglican AIDS & Healthcare Trust).

The fear of being labelled, rejected and stigmatised is acknowledged by most churches. Dreyer (2002:97) makes the point that moral or religious beliefs often imply that having HIV/AIDS is the result of moral failure and therefore the HIV/AIDS sufferer deserves his or her punishment; this view was indeed expressed in an interview with a representative of the Pentecostal Church, Shofar: "HIV/AIDS is a result of immoral and sinful living: this is the reason that it is spreading so fast in Africa. Cultural beliefs also contribute to its spread. There must be a change in living" (Spokesperson II 2009). In a later interview with Shofar, the following view was expressed in answer to the question, "What would the church's reaction be to disclosure?"

> The church would react with acceptance and it would give support. There would not be discrimination or stigmatisation, as the person would be treated as though they had any other disease, such as cancer. The heart of the church is to help people so there would be compassion. In the case where sexual immorality is the cause of the disease, there would have to be correction facilitated and a commitment from them to change their ways and align them to God's will. If there were no change, the church would have to act (Spokesperson X 2009).

---

[69] In isiXhosa the word "umfundisi" means minister of religion ("predikant" in Afrikaans would have an equivalent meaning) (Pharos Dictionary 2004:15).

234

Although I did not set out to look at Islam, during the course of my research the social welfare agency, BADISA, in the Helderberg Basin explained that they were experiencing a rise in the number of Muslim people within the community with HIV/AIDS seeking their help. As a consequence, I decided to interview an Imam of a local mosque, who commented as follows:

> From an Islamic point of view, HIV is regarded as a curse. The Prophet Mohamed, Peace be Upon Him, said that until promiscuity is confessed, diseases and plagues will spread. However, we also recognise that people need help and sympathy (Imam S 2008).[70]

An interview with another Imam in the Helderberg Basin revealed a somewhat different approach:

> Islam is very sympathetic towards people who get infected. We do, however, tell people that the Koran says that you must not do things that lead to fornication before marriage. But if people are infected, if they have a disease, we must be compassionate and tell people not to reject their family (Imam JJ 2008, mosque, Helderberg Basin).

Time and again the view was expressed by churches that disclosure was difficult because people feared being judged. For example, an Anglican lay minister commented: "Disclosure of your HIV status is difficult – people associate it with a sexual disease – they say it is due to 'sleg wees' [or bad sexual relations] and so they are embarrassed to disclose. No one mentions a word" (Lay Minister TT 2006). Similarly, a Methodist home-based care volunteer commented: "People have a soft heart for illnesses such as cancer. With HIV, they say 'It's their fault' and don't want to get involved" (Homecare volunteer B 2008).

It is not surprising then that disclosure is still problematic for those who are HIV infected. The Minister of the Baptist Church in Lwandle perhaps best summarised the consequences as follows:

> There is still silence about the subject of HIV. No one admits to having it, although we talk about the disease. People fear rejection. They fear the community and reactions in their workplace. Nowadays there is not so much confidence or trust in pastors. People do not see pastors as counsellors (Rev. G 2008).

---

[70] I should add that in a subsequent telephonic interview with Imam UU, a Spokesperson for the Muslim Judicial Council of the Islam Peace University of South Africa, he explained that in Islam, the wellbeing of both the individual and society are important. If a person is HIV infected, there are guidelines for the community. There is supposed to be no judgement. The individual's relationship with God is important.

The rationale behind second-generation strategies is to enable people and communities to better meet their needs by developing their capacities, so that their work and outcomes can be sustained beyond the period of NGO (or in our case, the church) assistance. To some extent, the churches have achieved this in relation to their HIV/AIDS education and training initiatives, although they are constrained by the doctrines relating to abstinence and faithfulness. Some churches – such as the Anglican Church – have taken the view that HIV/AIDS awareness and prevention programmes should be as comprehensive as possible. An Anglican Bishop explained the church's stance as follows: "The Church's policy on HIV/AIDS emanates from respect for human life; we are made in the image of God and all steps should be taken to protect life. In certain circumstances, if protecting life means using condoms, then that is what we must do" (Bishop VV 2006).

Kareithi *et al*. (2005:112) make the point that the laity is often closer than the clergy to the situation on the ground. He therefore advocates that they be re-educated to see that by involving themselves in the ministry, they are being equipped to better serve their own church community, particularly with regard to addressing issues such as youth sexuality and sexual activity.

It is a sad reflection, not only on the church but on society in general, that nearly thirty years into the pandemic little impact has been made on removing or indeed reducing the stigmatisation of people infected with or affected by HIV. I was deeply saddened to learn in an interview with a church minister[71] that he was HIV positive, but felt that he could not disclose his status for fear of the reaction of his congregation and the community in which he was living, as well as for his family, whom he felt would be treated differently – and perhaps even discriminated against. It appears that both within and beyond the church prejudice and discrimination prevent the acceptance of people who are infected and affected by HIV/AIDS, which sits at odds with the Christian message of love of God and love of your neighbour.

Second-generation strategies are meant to produce self-reliant communities. The theory behind second-generation strategies is that their benefits should be sustained beyond the period of NGO assistance. So often, however, they are not, because they

---

[71] I have chosen to keep the name and location of the church minister confidential, for obvious reasons.

are constrained by national systems that are not supportive of their survival (Korten 1990:118-119). In the case of HIV/AIDS, however, it could be that part of the reason why such strategies are unsuccessful is that the churches themselves shy away from addressing issues of a sexual nature in a comprehensive way and also because there still remains a judgemental approach. This suggests that change must come within the church itself before it can be both effective (that is to say successful) and effected (that is to say implemented) outside the church.

5.4.2.3 Generation-three activities: influencing policy and institutions locally and nationally to produce sustainable development

Generation-three strategies aim to effect changes of policy and institutions at a local, national and even at a global level, acknowledging the fact that existing systems tend to be hostile to such changes. Korten (1990:120) makes the point that "(b)ecause NGOs are often the only consistent advocates of such change, they must accept a substantial leadership role in catalysing them". In order to create the changes, the capacity of people must be increased so that they can "make demands on the system". In addition, alliances must be built to make the system more responsive to the people. This necessarily requires an in-depth knowledge of the system, as well as a resolve to build relations with key players and the building of technical competence (Korten 1990:120-121).

In this regard, it is true to say that by and large the churches in the Helderberg Basin have done little that can be described as third-generational in relation to HIV/AIDS. However, some views were expressed that perhaps point towards a glimmer of hope for a third-generation outlook (and indeed a people-centred approach), in that the churches speak of capacity building, engendering change, looking at the broader issues that need to be addressed and so on:

> The church has a bigger role to play in poverty but we have a paralysis of comfort. We must help people to have a mission in life – to take up their mat and walk. This means developing personal capacities (Minister QQ 2008, Helderberg Christian Church).

> Churches are not doing enough … we need to look beyond our own borders and walls and encourage congregations to be agents of change … but whether congregants respond is another matter (Minister H 2008, Bizweni Community Church).

> The promotion of condoms does not promote Christian values. It sends out the wrong message: "Use a condom and do as you wish". We need to address the fundamental

237

issue of the breakdown of moral fibre and cultural values of society. We also need to look at the issue more widely: what are the socio-economic reasons that make people vulnerable to the disease? What clinical factors, such as disease and malnutrition, make them more susceptible? (Spokesperson AA 2008, AIDS Desk, Southern African Catholic Bishops' Conference).

The church needs to be a voice to government, urging it to meets its responsibilities to its people. The church cannot be a substitute for government or its agencies. What the church must, however, do is to live out its love of God and neighbour by doing what it can, including acting as a catalyst for people to demand of government that it makes improvements in living conditions and health care (Father C 2006, Catholic Church, Helderberg Basin).

Church leaders have met and have given money for people to go out into the community to give help to those in need. But the issue should not be just about money. We must develop people. Transformation means a white church joining hands with another church in a poorer area to transform society, rather than just giving money. It means moving from your current place to a better place, both spiritually and in terms of society (Pastor SS 2008, Bethesda Evangelical Church, Rustof, Strand).

Third-generation strategies seek to make changes in policy and at an institutional level. In this regard, the former leadership of the Anglican Church by Archbishop Emeritus Desmond Tutu and recently retired Archbishop Njongonkulu Ndungane, has been notable. They have been vocal on the issue of HIV/AIDS and critical of the government. Kareithi *et al.* (2005:107) write of Archbishop Ndungane that "he continued the tradition of social activism [which his predecessor, Archbishop Tutu initiated] through his outspokenness and involvement with HIV/AIDS issues within and beyond South Africa. At a national level he has been very outspoken, even calling for the resignation of the minister of health, and publicly aligning himself with the Treatment Action Campaign". At present Archbishop Makoba chairs the care and support portfolio at the Lambeth Conference (the meeting of the Anglican Communion of Bishops, chaired by the Archbishop of Canterbury in the UK), which is aimed at highlighting and mobilising the Anglican community around the world on the issue of HIV/AIDS, including the issue of funding (Minister FF 2008).

In relation to the Catholic Church, Caritas International is a confederation of emergency relief, social service and welfare organisations, which operates in more than 200 countries in the world. Much of its action is focussed on advocacy and HIV/AIDS is a special priority. Regionally, the Southern African Catholic Bishops' Conference (covering the areas of South Africa, Botswana, Lesotho and Swaziland) has established an AIDS office (Spokesperson AA 2008). In 2002 there were 80

different pastoral projects ranging from orphanages, clinics and hospices to home-based care, counselling and youth education with full-time staff. In addition, there were community service projects, involving a few full-time staff and volunteers, as well as small-scale projects run entirely by volunteers. Bate (2003:199) notes that "(o)ther services include paralegal guidance to help people access benefits and state services, children's arts projects, abuse prevention, advocacy and lobbying for people living with HIV/AIDS (PLWHA) to government and society". In addition, socio-economic services are provided to help with poverty problems, along with the establishment of income-generating activities.

Interestingly, the Catholic Church's social arm in South Africa, a faith-based organisation (but not Catholic-specific), Catholic Welfare & Development, commented, "Catholic Welfare & Development are doing great work in the HIV/AIDS field, for example, by being the largest distributors of ARVs in South Africa, after Government. However because of the [Catholic] Church's stance on condoms, we are seen as lacking credibility in the fight against HIV/AIDS" (Spokesperson J 2008). The Catholic Church also has the Catholic AIDS Network, which is an advisory and coordinating body to share experience, expertise, information and resources, and to discuss moral/ethical issues (Father E 2006).

It is also interesting that despite the work being undertaken in the Catholic Church, there is what I regard as healthy critical introspection by those engaged in such programmes:

> The Catholic Church is not developmental enough in its approach. It is well meaning but with an issue such as HIV/AIDS, you need a public health – a specialist – approach. We need to ask why things are happening – and what is the effect of the help that we are giving, what interventions are succeeding and if not, why not? (Spokesperson J 2008, Catholic Welfare & Development).

On a much smaller and local level, churches appear to work best with organisations that they have established to handle social issues. The Dutch Reformed and Uniting Reformed Churches, for example, work closely with BADISA, which is a social welfare agency that was originally established by them (but which operates independently of them). The Bizweni Community Church in Somerset West also has its own FBO, the Institute for Social Concern (Minister H 2008), and the Bethesda Evangelical Church, Rustof, has the Phambile Community Development Trust, whose

remit is to deal with social issues such as HIV/AIDS, TB, poverty alleviation, parenting, teenage pregnancies and care for the aged. Churches such as the Seventh Day Adventists in turn utilise their Health and Family Ministries (Spokesperson BB 2009). Churches sometimes seek to work with other agencies, but by and large they do not appear to use existing structures or organisations effectively. There are, however, some examples to the contrary. For example, the Calvinist Protestant Church in Macassar is aligned with a local AIDS action group (Rev. OO 2006) and churches such as the New Apostolic Church say that they would make use of existing community structures, such as the welfare agency ACVV and Stellenbosch AIDS Action, in situations where it required support (Minister T 2009). Churches such as Every Nation work with MSAT (a government agency, the Multi-Sectoral Action Team).

Many churches, however, are too small and lacking in capacity as well as expertise and know-how to even begin to address issues such as initiating changes to policy or institutions. An exception in this regard is the Helderberg Dutch Reformed Church, which has a large membership. It was explained to me that:

> [The Helderberg Church] has no contact whatsoever with government. We may network with other churches on local projects but we avoid government (Spokesperson PP 2008, Helderberg Outreach, Helderberg Dutch Reformed Church).

One can speculate as to the reasons why the Helderberg Dutch Reformed Church does not liaise with the government or see the need for any political involvement. While the church has numerous projects and activities, ranging from the training of people for missionary work to the training of unskilled poverty-stricken people, it is clear that policy and institutional change are issues on which the Church would rather not engage. And yet Korten cautions that "no organisation can simply choose to ignore the political dimension of poverty", if it is serious about development (Korten 1990:142). This stance is also at odds with the fact that poverty (along with HIV/AIDS) remains one of the five "giants" that the Dutch Reformed Church has identified and committed itself to fighting (Spokesperson PP 2008).

Korten (1990:185) explains that, in order to achieve transformation, millions of volunteers will have to work towards a broadly shared vision. This necessarily requires that voluntary organisations need to develop various new competencies,

including that of working together with like-minded individuals and organisations "to create a critical mass of support for change" (Korten 1990:197). A people-centred developmental approach that is aimed at transforming institutions and values must therefore seek cooperation and partnerships. There is, however, scant evidence of churches working with each other in relation to HIV/AIDS in the Helderberg Basin.

A spokesperson for the Anglican AIDS Healthcare Trust commented that "(t)he Helderberg Basin is a socio-economically diverse area. There are large divisions in terms of resources, facilities, skills, etc. We therefore need to find a way to collaborate with other Christian faith traditions and NGOs and to share resources between communities" (Canon U 2009). However, I found little evidence of this. Even between churches of the same denomination there is limited contact, although they share the same traditions and are not geographically separated by any notable physical distance. A Methodist minister of a church in the relatively poor area of Lwandle summarised the situation as follows:

> We don't come together with other churches. We did so when there were the xenophobic attacks, but not since. From time to time, the Methodist Church in Somerset West does ask us to tell them where there is the need and they do supply food and blankets (Minister M 2008).

For reasons that are somewhat more understandable, churches such as the Seventh Day Adventists say that they do not work with other churches for historic reasons: they were formerly not regarded as a church, but as a sect. They do not therefore believe in an ecumenical system. Furthermore, they believe that "God has called a specific group to hear his message, as is revealed by the prophecy in Revelations 14:3"[72] (Minister HH 2009).

The Transformation Network, which is an informal organisation of churches that initially came together for prayer, meets on a weekly basis. It has evolved into an organisation that aims to mobilise churches in the area so that resources and strengths can be shared for the benefit of local communities. In this respect, therefore, the organisation gives the impression of being third generational in its approach. However, the issue of HIV/AIDS is only on the periphery of its agenda, because many

---

[72] Revelation 14:3 states that "(n)o one could learn that song except the hundred and forty-four thousand who had been redeemed from the earth. It is these who have not defiled themselves with women, for they are chaste; it is these who follow the Lamb wherever he goes; these have been redeemed from mankind as the first fruits for God and the Lamb" (New English Bible 1971:328).

of the churches belonging to the Network are situated in the prosperous parts of the Helderberg Basin, which do not see HIV/AIDS as a priority. Issues such as crime and drugs appear to be the issues that dominate its agenda. It does not, moreover, include all the churches nor is it representative of the main Christian denominations. The Transformation Network has not built any significant links with powers and organisations outside the churches and FBOs. It was explained to me that "churches don't function if they don't work together", but it was also acknowledged that "(d)octrinal issues prevent the churches from working together. The churches are also unable to give up their own kingdoms and this may be because of the fear of loss of finances" (Spokesperson RR 2006).

By way of contrast, the Catholic Hope Association project, which operates outside the Helderberg Basin, provides a good example of a third-generation approach. It works with provincial and municipal administration structures and health facilities in the Western Cape to provide care for HIV/AIDS sufferers. It has built excellent relationships with community health centres in Cape Town, as well as hospitals such as the Tygerberg Children's Hospital. The Hope Association project also works with role players (such as the provincial health ministry) and leaders within the community (such as traditional healers and sangomas, as well as medical professionals) and politicians in the fight against HIV/AIDS (Father P 2006). Because of the engagement of this project with policy makers and institutions and because it aims to produce sustainable, inclusive impacts at a local level, it is much more akin to a third-generation strategy.

Time and again it was mentioned that churches have not learned to network with each other (let alone with people and organisations outside the realm of FBOs). For example, there are numerous churches in Zola, Lwandle and Nomzamo that serve a population of approximately 100 000 people. Many churches are Pentecostal or Zionist in orientation. However, it was remarked to me that "one Pentecostal Church asking help from another Pentecostal in the area may be problematic. It is better to go for help to a church in Somerset West, as many pastors feel threatened and think that you are going to poach their members" (Church Elder A 2008, Anointed Christian Ministries [Pentecostal Church], Zola.) The following remarks serve to emphasise the point:

242

> The church spreads itself too thinly and does not work together with other churches (Minister WW 2008, United Church, Somerset West).

> Churches tend to be inward looking. They often tend to be competing with each other. In part, this may be because of the mission history of mainline churches. Apartheid has also played a role in preventing churches from crossing borders with each other. Theologically however, we need to understand the purpose of the churches – they are here for the kingdom of God, not for the churches themselves (Spokesperson F 2007, Christian AIDS Bureau of Southern Africa (CABSA)).

> Churches are keen to protect their own kingdoms so there is very little contact with other churches (Minister K 2006, Methodist Church, Helderberg Basin).

> Churches are in the community but they do not know the problems of the community. They only reach out to people when they are terminally ill. We have 25 churches in Macassar but they do not work together to do things for the community (Sister KK 2008, Community Day Care Centre, Macassar).

An interesting explanation for not "intentionally" working together with other churches was put forward by a Minister of the Baptist Church: "We have had no real exchange between the Baptist Church [situated in the prosperous area of the Helderberg] and the Baptist Church [situated in the poorest part of the Helderberg]. Exchange has however taken place with [another] Baptist Church [in the area], where we supported them and helped them to establish themselves. The danger of working with other communities is that we may be seen to be patronising them" (Minister N 2008). The question that I would like to pose is this: is seeking cooperation a risk worth taking, especially when a church of the same denomination in the same area is resource-poor and experiencing problems of significant magnitude in relation to HIV/AIDS and its sister church is relatively prosperous and has not yet had to deal with disclosure of the disease among its congregants?

Another explanation that was put forward for a lack of involvement in HIV-related issues was put forward by a Minister of Helderberg Dutch Reformed Church, Somerset West: "HIV/AIDS is a problem for South Africa. It is not a problem for this congregation. It has to be a problem for this Church if it is going to be addressed" (Minister DD 2006). While one can of course appreciate this standpoint and the many demands that the churches have on their time and resources (as well as their involvement in a great many issues besides HIV/AIDS), does this explanation suffice? Perhaps the view expressed by the Strand Dutch Reformed Minister is more to the point:

> The congregation know about HIV/AIDS but it does not personally affect them and so they may not feel the need to get involved in the issue. We need to try and understand the problems that communities that are affected with HIV are facing. Drugs, on the other hand, are a real problem for this church community but we also need to look at the surrounding communities and their problems (Minister LL 2008, Minister, Dutch Reformed Church, Helderberg Basin).

Another area in which churches have to learn new competencies in order to achieve transformation is in relation to "policy education and advocacy beyond lobbying to protect or increase foreign assistance levels" (Korten 1990:193). While Korten acknowledges that it might not be realistic or cost effective for every voluntary organisation to develop policy analysis capacity, he recommends that links be established between North and South organisations in order to meet this need. However, there still remains a need for advocacy and, in this regard, "an active and committed grassroots constituency can greatly add to the effectiveness of a VO as policy advocate and educator" (Korten 1990:194).

Advocacy would appear to be unfamiliar territory for those engaged in church ministry, particularly in relation to HIV/AIDS. The churches do, however, have crucial roles to play in relation to advocacy on a wide range of issues. These include combating stigmatisation and discrimination, as well as advocating for the inclusion of people living with or affected by HIV/AIDS in church-based and other services. Other obvious areas in which the church should be engaged are the call for equitable access to treatment and care for all, especially those living in developing and resource-poor countries. As Czerny and Vitillo (2006:275) comment:

> The responsibility [of the Church] to advocate for those who have no voice or who may benefit from the moral force of the Church's defence and teaching is not one to be rejected or taken lightly.

For this reason, the resolutions adopted by the hierarchy of the Catholic Church in relation to an action plan for HIV/AIDS is interesting (see section 5.3 above). However, these resolutions do not appear to have permeated to the level of the local church, where there is little evidence of advocacy on behalf of those infected with or affected by HIV/AIDS. In many instances churches in the prosperous parts of the Helderberg do not know what help is available locally, while those in the poorer part are much more likely to seek the help of the local public health clinic.

The Anglican Church too recognises the importance of advocacy. In writing about the Anglican Church's initiatives, Kareithi *et al*. (2005:111) make the following comment:

> Advocacy means amplifying voice, and transformational development should be aware of the legitimacy of such voices. Fikelela is concerned about the fundamental question facing activists: whose voice and for what purpose? Fikelela builds the capacity of its task groups to engage in dialogue with policy makers, as well as building alliances with other activists in order to amplify the voices coming from the congregational task groups. Partners at these higher levels include Government Departments of Health and of Social Services, both of which render aid in the form of funding.

These authors' comment on funding leads one back to Korten (1990:193) who, as we saw earlier, says that advocacy must move beyond the issue of lobbying for funding. The question posed, namely "whose voice and for what purpose" is, however, an important one.

The issue of advocacy is also highlighted in a UNICEF report (2008) concerning children. A survey conducted by UNICEF illustrates that only 12% of children receive basic external support in the eighteen countries that were surveyed. They conclude that this is because churches, families and community services provide the resources to care for the children, allowing government to relinquish its responsibilities. Foster (2008:17) in his paper, "HIV/AIDS Policy Initiatives for Family and Community Ministries" therefore makes the following statement:

> Christian influence, leadership and action in policy initiatives and advocacy concerning children affected by HIV/AIDS are every bit as important as service indicators. The modern church, currently entrenched in service provision, must advocate for the rights of children in institutional care … must look critically at how international non-governmental organisation funds … are being used to benefit impoverished families … must look at holistic, systemic policies and programmes that will improve the overall effectiveness of their work.

It is probably true to say that none of the local churches in the Helderberg Basin are engaged in advocacy in relation to HIV/AIDS. In part this may be the result of a lack of technical competence and in part because churches with a hierarchical structure rely on representative bodies to advocate on their behalf. It does not seem, however, as though the local churches make any input (or indeed choose to make an input) into the making of such representation and unless they actively seek to make known the problems that they are contending with, their problems cannot hope to be addressed.

Furthermore, those churches that are independent or loosely linked to a wider representative body do not appear to have formed linkages or partnerships with one another.

Third-generation strategies are aimed at changing structures that are unjust. Korten advocates that this is achieved through building the capacities of people, as well as building alliances, so that the NGO acts in a "catalytic, foundation-like role, rather as an operational service provider" (Korten 1990:121). Clearly, this is yet to be realised by churches in the Helderberg Basin. The need for churches to develop skills in the areas of social and policy analysis, political strategy and public education (Korten 1990:192) is evident, because unless they do so, they will be unable to engage in development in much more than a second-generation way.

5.4.2.4 Generation-four activities: a social movement approach

Third-generation strategies seek to change specific policies and institutions. However, to achieve just, sustainable and inclusive development, policies and institutions in every sector and in every nation need to be changed. Replication is therefore required "hundreds of thousands, even millions, of times" in order to achieve transformation (Korten 1990:123). For this reason, Korten advocates the power of a people's movement to achieve social change. Such movements are neither motivated by money nor organisational structures, but rather by the social energy of volunteers, who are driven by ideas and a vision of a better world (Korten 1990:124).

In theory, churches are in an excellent position to be able to imbue "public consciousness with an alternative vision adequate to mobilise voluntary action on a national or a global scale" (Korten 1990:127). According to my reading of Korten, if churches are to be effective in this regard, three things are required: first, that they "should work from a well articulated philosophy or vision"; secondly, they should build alliances with other people's movements (such as the women's, peace, human rights and environmental movements); and finally, they must relinquish control over networks, acknowledging that their job is primarily to "coalesce and energise self-managing networks" (Korten 1990:127). It is perhaps in these latter two areas that the churches face particular challenges.

The church's vision for humankind and its rationale and motivation to care for people infected or affected with HIV/AIDS was explored in Chapter 3. It is therefore of concern that the churches do not appear to have conveyed or articulated a vision of love, of hope, or indeed, of a more just and inclusive society. To illustrate this point, I set out two comments below which are, I believe, illustrative of the churches' failure in this regard:

> Teenage pregnancies are a real problem in Macassar. Some schools are now labelled "labour wards" because there are so many pregnancies: 72 in one year. Love Life ran a campaign. The Calvinist Church talks about HIV. But young people want to experiment. Others don't have a job. Some are addicted to tik and will do anything for it. Some just want the grant (Sister KK 2008, Nursing Sister, Community Day Care Centre, Macassar).

> Young girls have lost a vision for themselves. When teachers ask them what they want to do in life, they say that they want to have children. When Boland College [a higher education establishment] said that they were going to be offering bursaries in Hawston [a village near the town of Hermanus, in the Western Cape], only 5 girls out of a 120 said that they wanted the opportunity of a tertiary education. Young girls, who are mothers, when they are asked by whom they are loved unconditionally, they do not say that they are loved by God, but by their babies and young children. The church is failing them if it cannot demonstrate God's unconditional love for them and if the only way in which they feel they can get love is by having babies (Minister FF 2008, Fikelela Spokesperson, False Bay Diocese, Anglican Church of Southern Africa.)

As discussed in Chapter 2, section 2.3 and above (section 5.4.2.3), churches are poor at forming networks with their own denominational churches, let alone with other churches, organisations and movements. And yet they would benefit tremendously from forming relationships as there are so many issues upon which joint action could make greater impact. Let us take, for example, the issue of gender equality. Knowing that women are particularly badly affected by HIV/AIDS and the fact that part of the reason is because of the subordinate position that they are accorded in society, there is much that could be achieved towards changing attitudes and behaviour. This could well be through dialogue with each other and with their congregations, across the spectrum of church denominations, as well as through forming alliances with women's rights movements and organisations such as Sonke Gender Justice, an NGO that seeks to protect and promote gender equality. Denis (2003:71) comments: "Rape is part of the South African way of life. It is socially accepted. Generally speaking, government bodies, legal authorities, the churches and media fraternity respond

passively to the situation." Surely this issue therefore requires much more of a concerted effort on the part of churches to try and work together?

The situation with regard to women was summarised as follows by a spokesperson for the Southern Africa Bishops' Conference:

> Christianity is very patriarchal. But we must not forget that African society too is very patriarchal. The Church is not talking enough about such issues. We also need to bear in mind that women are disempowered; they fear losing their men or partners and so will not say no to sex. Intergenerational sex is occurring because women are disempowered economically. The Church needs to talk about such things (Spokesperson AA 2008, AIDS Desk, Southern African Catholic Bishops' Conference).

Furthermore, churches in the Helderberg reveal diverse views on women's rights. For example:

> A man's first ministry is to his family. If a woman is prophesying it is a disgrace to a man (1 Cor. 11:3).[73] The role of a woman is not to be a leader; they must be under the submission of a man (Church Elder A 2008, Anointed Christian Ministries (Pentecostal) Church, Zola).

> A strong family means a strong church and a strong community. Mothers and fathers have their own roles to play. A father is the head and the mother is there to teach a child manners (Pastor MM 2006, Rhema Good Hope Church, (charismatic/Pentecostal church), Macassar).

> Paul's teachings in Ephesians[74] are emphasised, with all its implications. But the ultimate question is "[w]ould Christ approve of behaviour that was not loving, giving or sharing?" (Rev. OO 2006, Calvinist Protestant Church, Macassar).

> The Bible tells us that men and women were created in the image and likeness of God. The marriage rite sees man and wife being a relationship of equals, one of sharing, one of mutual love, one that should try and receive complement, completeness or perfection. Pope John Paul II talked of the "dignity of women"; although their differentiation needs to be maintained, this does not entail discrimination. There is therefore no excuse for emotional or physical violence or abuse between a husband and wife (Father C 2006, Priest, Catholic Church, Helderberg Basin).

---

[73] My reading of Paul's letter to the Corinthians (1 Cor. 11:3) is somewhat different to the interpretation that has been given: "Now I want you to realise that the head of every man is Christ and the head of the woman is a man, and the head of Christ is God. Every man who prays or prophesise with his head covered dishonours his head. And every woman who prays and prophesise with her head uncovered dishonours her head … A man ought not to cover his head, since he is the image and glory of God, but the woman is the glory of man."

[74] Ephesians 5:23: "Wives submit to your husbands as to the Lord. For the husband is the head of the wife as Christ is the head of the church, his body of which he is the Saviour. Now as the church submits to Christ, so also wives should submit to their husbands in everything."

> Men and women are equal in the church's eyes but women would not be made elders. The leadership of the church is in the man's domain (Spokesperson L 2008, Outreach, Helderberg Christian Church, Somerset West).

As demonstrated by the last comment, within the church structures women are also not accorded equality of treatment; women are often not allowed to assume leadership roles as ordained priests or ministers of religion. For example, the mainline Catholic Church and the evangelical Helderberg Christian Church both prevent women from assuming such positions. This is in contrast to the mainline Anglican, Dutch Reformed and Methodist churches, as well as churches such as the Bizweni Community Church, which is described as having "a strong women's movement" (Minister H 2008). In the area of the Helderberg Basin, these churches would appear to demonstrate that they are living out their message of equality of treatment of the sexes.

At the same time churches also need to address issues relating to men and it is questionable to what extent, if any, they are doing so. It is rare for the churches to acknowledge, let alone address, issues relating to men, although the following comments by interviewees give cause for encouragement:

> We need to equip young women and widows. But it is men in the community who are behaving irresponsibly. We need a space to discuss men's issues (Minister W 2008, Anointed Christian Ministries (Pentecostal church), Zola).

> We have a weekly support group for men under the age of 40. Men play around. They indulge in alcohol and drugs. They cannot solve their problems – especially their financial problems. 68% of the population of the area are unemployed (Pastor SS 2008, Bethesda Evangelical Church, Rustof, Strand).

The development of critical consciousness is the cornerstone of people-centred development in order to allow "the responsible citizen to transcend institutional and cultural conditioning for the larger good of society" (Korten 1990:107). In not addressing gender issues comprehensively and purposefully, the churches are failing to deal with a social need and one of the primary causes for the spread of HIV/AIDS.

The chief actors in driving social change in fourth-generation strategies are "loosely defined networks of people and organisations". For this reason, social movements require networks and coalitions to be built within and beyond national boundaries (Korten 1990:124). However, even among Christian churches themselves within the Helderberg Basin they have failed to use their belief in Christ to try and understand

each other's positions. In part, this could be because of differences in doctrine, in part it could be the fear of losing members to other denominations (or indeed, losing their financial support) and, finally, it could be that churches are simply preoccupied with their "own business", areas and congregations, so that they fail to see the need beyond their own church or parish borders.

There is little, if any, contact with the African Independent Churches and no attempt to understand their needs. They are often categorised as practising "ancestor worship" and are therefore not engaged in dialogue. By the same token, churches such as the Zionist Christian Church are wary of providing access, because they "fear misrepresentation" (Mazamisa 2009 [personal interview]).

In relation to the issue of ancestor worship, it was explained to me in an interview with a lecturer and specialist in African theology that Zionists (from the Zionist Christian Church) are both a religious and cultural community. Ancestors play a role in the daily lives of people, but it is a misrepresentation to say that they are worshipped. Only God is worshipped. Ancestors, however, "provide an 'ancestors ethic' – a way in which you should lead your life. They therefore should not be wiped out from your memory" (Mazamisa 2009).

In explaining the care that is afforded by the Zionist Christian Church in relation to HIV/AIDS, it was explained that:

> Christianity is based on dualism: mind and body, spirit and matter, man and woman. Whereas African religions such as Zionism are based on collectivism: it is didactic and holistic. You cannot know me until you know my mind and my soul. In the same way, with HIV/AIDS – you cannot get healing through ARVs alone – the environment, the family, are all issues that need to be addressed. In the Zionist Christian Churches, HIV is handled differently. People are advised to go to clinics for their medication. However, they also have to attend spiritual healing sessions at church, where they are cleansed with water and the sacraments are used. The entire family also has to attend such services to be prayed for and healed. If I can express it this way: "I have to be attached to a religious body and a collective homestead for ARVs to work." Ancestors are also called upon to play their part (Mazamisa 2009, lecturer and specialist in African Theology, University of Cape Town).

In many ways this appears to accord with the Christian view of the importance of health not only in body and mind, but also in spirit. The intangible strengths that churches can bring to health, and which can be used to transform and empower people, are often ignored. But it is these qualities that are prevalent in all religions that

need to be shared, recognised and yes, even celebrated, for they bring a unique dimension to wellbeing. The church, above all, should recognise that clinical and biomedical interventions are not the sole answer to HIV/AIDS – other factors, such as faith, prayer, the support of family and community, all have a role to play. The point that I wish to make here is that if churches cannot work together where there are broad commonalities, how can they expected to work together when there are enormous differences?

An essential aspect of engendering a people's movement is "joining in the formation of networks and coalitions in support of joint action, advocacy and educational strategies on critical local, national and international issues" (Korten 1990:93). In this regard, I wish to introduce again an Islamic mosque, situated in the Helderberg Basin, which has some dealings with the Christian churches in the area. I was interested to learn from the mosque and from the Methodist and Dutch Reformed churches in the area that they had come together on certain issues that were affecting the community, such as drugs and the xenophobic attacks. The mosque also joined with Christian denominations in the area to march on Parliament when it was considering the issue of same-sex marriages. I found the latter extraordinary – that churches could come together with other faith beliefs, organisations and interest groups on the subject of people of the same sexual orientation wanting to make a commitment to one another, while they are not able to come together on the subject of HIV/AIDS, which is literally a matter of life and death.

I was particularly struck by the mosque's stance on certain issues that have resonance in some Christian denominations. For example, on the issue of homosexuality:

> Islam is against homosexuality. We objected to same sex marriage in South Africa. In cases of homosexuality, Islamic scholars agree that a homosexual should be killed. The only issue is how that person should be killed: thrown off a high wall, a wall pushed over a person or stoned to death. Sodomy is death offence. Mercy and love should be there, but homosexuality is an unnatural act which challenges God's decency (Imam S 2008, mosque in the Helderberg Basin).

This stance is similar to the one adopted by some Christian churches in the area:

> A man is a man and a woman is a woman. God does not make mistakes. Homosexuals must therefore be shown the error of their ways and they must change willingly. Change is possible through the truth (Pastor MM 2006, Good Hope Church (charismatic/Pentecostal church).

251

> Homosexuality is taboo. When the question was raised at Synod, many Ministers walked out and said that this is something for other communities, not for ours (Minister M 2008, Methodist Church, Lwandle).

> Homosexuality is not part of God's plan but we would reach out to anyone. There would not be a problem with belonging to the Church, but I am not sure what would happen if they were practising homosexuals (Spokesperson L 2008, Outreach, Helderberg Christian Church).

The consequences of hard-line positions taken in relation to certain issues are that people find it difficult to disclose their status and, indeed, do not come forward for VCT, as they fear the consequences. The social welfare agency, BADISA commented as follows:

> HIV/AIDS in the community is not talked about. People are afraid of revealing their status … people come to me for help when it is too late and they are sick and their immune system is down. If a person is gay, they are afraid to tell because they will be rejected by their family, the community, their church or the mosque (Spokesperson NN 2008, Social Worker, BADISA, Strand).

Most of the churches in the area, however, had a more accommodating approach, which is probably best summarised by the views expressed by a local religious minister:

> Religion should not be reduced to sexual morality. Christ spoke of the lived faith of the life of his people. We should not therefore over-emphasise sexual morality over other areas of morality. For example, the ill treatment of workers or the disregard of the rights of the poor are all sins too. Sexuality is a gift and it is a gift to be used with love and respect (Father C 2006, Priest, Catholic Church, Helderberg Basin).

In Chapter 2, we saw that there are many factors that are fuelling the HIV pandemic. One of these is the issue of multiple concurrent partners (section 2.9.3) that is causing HIV to spread among the heterosexual population. Yet this is an issue that the churches fail to address. So too the issue of poverty is addressed as a peripheral matter and the link to HIV is rarely made or demonstrated. If the churches are to engender critical conscientisation, which is the key to fourth-generation development, then surely these too are issues that need to be highlighted?

In relation to condoms, some of the Christian churches in the area share similar views with the Strand mosque.

> Islam says abstinence before marriage is the best way. We therefore do not even talk about the use of condoms, as that encourages promiscuity (Imam S 2008, mosque in the Helderberg Basin).

> Young people are having sex because of a lack of understanding of the consequences. Churches need to get out the message that it is important to listen to God's word and why. The reason why we are told to keep ourselves pure until marriage is for our protection – to prevent things such as sexually transmitted diseases, pregnancy, etc. God's law is a law of love and grace, giving protection in cases where our understanding of the consequences of our actions, is blurred (Spokesperson X 2009, "Voices in Africa", publishing arm of Shofar Church.)

This is in contrast to the nuanced approach taken by most other churches. For example:

> The Methodist Church is open to talking about protection – pastorally, it is an acceptable option. We need to promote responsible lifestyle choices, taking into account the social problems that people face (Minister Z 2008, Rustof Methodist Church).

Churches, then, can come together on certain issues; they can join forces and create alliances with other similarly minded bodies and organisations. The danger, of course, is that they may share a vision of a better world that runs contrary to what another party or religious grouping might believe to be a more balanced, compassionate and caring approach. In addition, deeply rooted prejudices and judgement, whether about gender, race, cultural or issues of sexual orientation, need to be confronted within the churches themselves before they are able to meet the challenges presented by HIV/AIDS in a developmental manner. It will be recalled that in Chapter 4, the reactive and proactive thrusts of people's movements, were discussed (Korten 1990:200). In my view, blocking attitudes that are stigmatising and encouraging attitudes that are more caring and nurturing would be a more effective way to confront the challenges posed by HIV/AIDS. Ultimately it is bringing the quality of love and a recognition of the image of God in one's fellow human being that should be the test.

If a voluntary organisation wishes to engage in transformation of institutions and values, then it will look at North-South partnerships on a whole range of matters (see Chapter 4, section 4.4.3.4) Many local churches, particularly the mainline churches, have powerful links, translocally and transnationally, to churches within and beyond South Africa's borders. For example, the Anglican Church is linked with the Anglican Communion throughout the world and the Catholic Church has strong ties with Rome and indeed the rest of the Catholic Church globally. These links, however, are not utilised to any effect. Churches such as the Bizweni Community Church have national links (for example, to the Juda Alliance in Southern Africa) and international links (Life Link), but they do not use these links either (Minister H 2008).

Korten (1990:197) makes the point that the more committed a voluntary organisation becomes to people-centred development, "the more it is likely to find a need to cooperate with like-minded individuals and organisations to create a critical mass of support for change". Utilising the natural links within denominations, let alone beyond, would seem to be an obvious way in which to have an impact on certain issues. For example, on the issue of drug patents, which makes access to ARVs prohibitively expensive for Southern countries, churches could have initiated a very effective campaign aimed at making the drugs more affordable. They seem, however, to have abdicated their responsibility in this regard to the TAC (with the exception of the leadership of the Anglican Church, which aligned itself with the movement) (see Kareithi *et al*. 2005, at Chapter 2, section 2.3). Certainly, the local churches of the Helderberg Basin have not engaged with the issue of HIV/AIDS in this way.

Korten also stresses the importance of NGOs using international forums, such as the United Nations (UN), to "articulate people's voices into the processes by which governments shape their global agendas" (1990:201). In this respect, local churches have not joined forces with other movements to make their voices heard. The only example of representation made at international forums in relation to HIV/AIDS is that made by the Catholic Church. Recognising that one of the most urgent ethical issues arising from the HIV/AIDS pandemic is the lack of distributive justice and that the poorest, most marginalised and oppressed members of society are also the most vulnerable to HIV/AIDS, the Catholic Permanent Observer of the Holy See to the UN insisted that "the poor and vulnerable people of the world be accorded, as a universally recognised human right, access to care and treatment, not just for HIV but also for the other two global 'killer' pandemics – tuberculosis and malaria" (United Nations Commission on Human Rights 2005:Item 10). In relation to fourth-generation strategies, it would appear that churches are some way off exercising care in a way that could be considered people-centred or developmental in the sense articulated by Korten (1990).

5.5   Conclusion

To create a new human society that is based on justice, peace and human dignity, and that is accommodating to life, transformation is required. Such transformation requires faith, however, because "the outcome is by no means certain" (Korten

1990:179). Herein, I believe, lies part of the reason for the churches' reluctance to engage with the issue of HIV/AIDS in a way that is more developmental. Engaging with other players, with other movements and like-minded NGOs, might require transformation of the churches themselves; it might require that they change their stance on a few issues; but it might also mean that some congregants or church members will leave the church and there will be a consequent loss of income; the implications could be enormous. This may account for the churches' reluctance to extend themselves beyond welfare and community development activities. In this sense, it would be somewhat ironic if people of faith cannot trust that the outcome of transformation will result in the world becoming a better place. The provision of social welfare and the meeting of immediate needs does not require much more than compassion and an ability to either do things on behalf of people, or to mobilise them to do something for themselves. It does not require a vision and perhaps it is in this regard that the churches need to play a much greater role.

In studying the work undertaken by churches in the Helderberg Basin, it is clear that all of them are well intentioned, and with limited resources and considerable demands, they are doing a wonderful job in generation one activities, namely alleviating the worst of the suffering caused by HIV/AIDS. Initiatives such as soup kitchens and other feeding schemes, home-care, support for orphaned and vulnerable children, etc. abound. Unfortunately however, churches are reluctant to move beyond the comfort zones of their own congregations to render help where it is most needed. It appears to be easier for them to hand out aid rather than involve themselves in questioning what caused the problems to arise in the first place. I believe that it is fair to say that churches are not sufficiently active in concientising their congregations or communities.

The churches in the case study area have also endeavoured to engage in second-generation strategies that are aimed at local empowerment and development of communities. In this respect, however, they encounter several obstacles, not least an inhibition in talking about sex and opposition from the church members themselves. Tradition, culture and the age of church members also play a part and are factors that need to be taken into account before criticising the churches too hastily, as they may impede discussion on matters of a sexual nature.

255

Church doctrine too might inhibit the churches from addressing educational matters in a more comprehensive way. Issues such as condom use and even VCT have the potential of being controversial. Addressing issues such as gender equality might also be problematic for churches, especially if their biblical interpretation is at odds with this view, or if churches are not themselves willing to transform. Far more influential, however, on whether a church is effective in empowering people and communities is whether it provides a safe, non-discriminatory, non-stigmatising environment, but in this respect churches have some way yet to go.

Moreover, the churches in the Helderberg Basin have not adequately built alliances and networks, nor become technically or politically adept at the skills, values and orientation that are required for third- and fourth-generation development strategies. While the leadership of some of the churches demonstrates a move towards such goals, this has not permeated churches at a local level. One of the reasons for this may again be the fact that the churches will have to accept that they will have "no control whatever" (Korten 1990:127) over such networks that are produced.

Importantly, the church has failed to build a vision in relation to HIV/AIDS. Such a vision is critical to "mobilise voluntary action on a national or global scale" (Korten 1990:127). This is not to decry the work that the churches are undertaking, which may be classified as first- or second-generation activities, but rather it is to make the point that it is only through the power of ideas and values, and by transforming relationships and communicating more effectively, that volunteers can be mobilised to form a movement that is aimed at changing and transforming the prevailing HIV/AIDS situation.

The need for a vision – and the churches' failure to provide that vision, particularly in relation to young people – is, I believe, evident from the remarks that were made by a Minister of the Zionist Christian Church:

> [In the Zionist Christian Church, Lwandle] we have many young people who are pregnant, even four of the pastor's children, all of whom are aged under 18 years. They do not go to school. They all attend church. They are involved in church activities, the choir and youth groups. I cannot understand why the youth do not listen. Some say that it is the grants (Minister I 2008).

These comments echo those made by the Anglican spokesperson of the Fikelela project. With high poverty levels, poor education and increasing unemployment

256

among the youth in particular, they see a future that is bleak and without prospects. It would appear that the only way in which they find fulfilment and meaning in their lives is through having children. The need for hope is evident and churches are well placed to give such hope and to inspire the youth to look to the future and beyond satisfying short-term needs.

Moreover, churches, wherever they are based in the Helderberg, are faced with many challenges, among which is the one that was expressed to me as follows:

> Television, news, cell phones, magazines are full of sex and nowadays, virtually all high school students experiment in sex. There is a change in ethos: if you have a relationship in high school, then sex is part of it. Sex is not something to enjoy within marriage itself. In high schools, boys and girls are taking indecent photographs of themselves and sending them to each other (Minister LL 2008, Dutch Reformed Church, Helderberg Basin).

The church's call to care requires an approach that appears to cry out for a vision that is transformational, rather than piecemeal or intended to provide a short-term solution to a problem that is more complex.

I did not seek to examine whether the initiatives undertaken by the different types of churches (mainline, Pentecostal/charismatic and African Independent) were more effective or not. Research by Garner (2000:61) (see Chapter 2, section 2.4), supports the view that Pentecostalism[75] produces "a change in sexual attitudes [and, allegedly behaviour] that follow on the heels of the 'born again' experience".

In a master's thesis on the Pentecostal/charismatic churches conducted in the Western Cape, Harvey (2010) reaches similar conclusions. He says that churches belonging to this family-type of Pentecostal/charismatic, have multiple, holistic responses that are strongly based on the Gospel of Jesus Christ. He concludes that such churches "tend to impart a sense of inner value and a set of moral values which are conjunctively likely to reduce the propensity to perpetrate or succumb to transactional polygamous or promiscuous sex" (2010:iii).

---

[75] "Pentecostal faiths are characterised by their emphasis on an individual's personal relationship with God. They believe that the gifts of the spirit, such as speaking in tongues, divine healing and prophesying are for today – not just for biblical times. God plays a direct role in everyday life and members commit themselves to following biblical commands and norms" (Pew Forum 2006:86).

Harvey (2010) further concludes that such churches are achieving considerable success, despite their limited resources, but that such success is contingent on "institutional flexibility and the establishment of credibility within the communities in which the ministries operate" (Harvey 2010:iv).

It is not possible to come to any firm conclusions on the matter from the research that I have undertaken. It is, however, fair to say that where Pentecostal churches are located in areas of poverty, HIV/AIDS is a problem. This is not to say that it is not a problem in more prosperous areas, but it may just be better disguised. Churches such as the Ephesians Faith Mission Church of South Africa, which describes itself as a "spiritual/Pentecostal church", employs the four elements described by Garner in his research, including that of exclusion:

> If some has done wrong within the church or has made a "mistake", they are not thrown out but they are expected to sit on one side of the church for three months. (Mrs EE (2006), Elder and Pastor's wife, Ephesians Faith Mission Church of South Africa, Sir Lowry's Pass.)

However, both within the church and in the surrounding community of Sir Lowry's Pass Village, they are faced with this problem: "We tell the young people don't get yourself into a position of being intimate. But the young people don't want to hear about abstinence and condoms" (Mrs EE 2006). Similar views were expressed by other Pentecostal/charismatic churches, such as the Bethesda Evangelical Church in Rustof and the Rhema Good Hope Church in Macassar. Shofar, a church that describes itself as a Pentecostal church "but less noisy" (Spokesperson II 2009), is situated in the areas of Stellenbosch and Somerset West. It is my understanding that the church's contact with HIV/AIDS is in relation to the work that it undertakes in the township of Kayamandi, which is situated on the outskirts of Stellenbosch, once again, an area that is poor.

It would also appear, however, that with a church such as Shofar an individual is socialised into the religious culture in a way that it is supposed to become deeply embedded in the individual. Consequently, as a member of the church, one would be expected to conform to the church's teaching or face exclusion. For some this might mean having to behave in a covert fashion, rather than risk sanction from the church, in whatever form.

Mainline churches in Somerset West also do not see HIV/AIDS as a problem within their own church communities. While inference can be drawn that this is attributable to their religious teachings (which has resulted in a lower rate of HIV/AIDS prevalence), this is unlikely, because their denominational churches within the same area, but geographically located in poorer areas of the Helderberg Basin, daily encounter people who are affected by or infected with HIV/AIDS and face the challenges that the disease poses. The Methodist Church or the Catholic Church in Somerset West may not therefore know of the problems that their sister churches face in Sir Lowry's Pass Village, Lwandle, Macassar or Rustof.

This point perhaps serves to underline the issue that was highlighted earlier: there is a need for churches in more prosperous areas to know and understand the problems that churches in poorer areas have to contend with – and with rather fewer resources.

Korten's framework is valuable in helping to allow us to assess the nature of the churches' HIV/AIDS care. It allows for a critical examination of how the churches are involved in rendering care. Korten (1990:142) states that "(s)erious development assistance to the poor … demands attention to political and economic empowerment". From the empirical study that was conducted in the Helderberg Basin it is clear that thus far the churches have yet to render assistance that can be classified as people-centred.

Chapter 6

Towards transformation of the role of the church in addressing HIV/AIDS

6.1   Introduction

In Chapter 1 I set out the research question as follows: *Can or does the church play a role in HIV/AIDS care that can be described as developmental, as defined by Korten?*

The first part of the research question can undoubtedly be answered with an emphatic "yes"; yes the church can exercise a role that is developmental owing to its rationale and motivation to care, which puts the human person ahead of economic advancement in development (see Chapter 1, section 1.6 and Chapter 3). However, I made the case that the church is only able to do so if it understands the disease in all its complexities and manifold aspects, including knowledge about the disease and the factors that drive the pandemic (see Chapter 2).

I sought to answer the second part of the question, namely does the church exercise care in a developmental way, by using a framework propounded by Korten (1990), namely a people-centred development paradigm, which I suggest finds strong resonance with the Christian view of the centrality of the human person in development (see Chapter 4). In this regard, I examined the work that the churches undertake in relation to HIV/AIDS (see Chapter 2, sections 2.3 and 2.9) and their historic involvement in HIV/AIDS issues (see Chapter 3, section 3.4). An empirical study was also conducted in the Helderberg Basin (see Chapter 5). As a result, it is fair to conclude that the church provides care that is charitable and welfarist in nature or aimed at developing capacities at a community level. Such care is not however transformational because the church has still not learnt to create a critical consciousness (or indeed, engage in the political sphere, build strategic alliances, utilise communications media etc), which are vital ingredients in creating a social movement that is aimed at changing values, policies and institutions at local, national and even global levels that lie at the heart of fuelling the disease.

In this chapter therefore, I put forward suggestions as to how transformation might be achieved.

6.2   Meeting the challenges

HIV/AIDS raises several issues, not least the one expressed to me by Mazamisa (2009), in an interview on African Independent Churches:

> In African culture, the older person is not supposed to outlive the young person. The young person is supposed to live to care for the older person. Also in African culture, there were no widows and orphans because the community was there to take care of them. HIV/AIDS has changed the situation. New solutions are called for and the African Independent Churches have to help find solutions. The cultural aspect is crucial.

I would suggest that solutions need to be found by the Christian church, rather than one particular denomination or category of church.

In Parry's (2005) mapping study of the responses of faith-based organisations to HIV and AIDS in sub-Saharan Africa, she makes the point that the HIV/AIDS policies of churches are on the increase (2005:15). However, these may not be translated into plans of action and implementation at a local level. While therefore the leadership of churches might outline policy, actions at local level may be quite different. The study conducted in this dissertation indeed evidences this (see Chapter 5).

Churches have not, moreover, asked themselves the fundamental question of what their mission might be. Attanasi (2008) (whose study was confined to Pentecostal churches) found that generally those churches that held the view that their work should be concerned with the spiritual realm also tended to classify sin as a matter of individual morality. However, churches with an integrated sense of church mission tended to regard HIV/AIDS more broadly, looking at the structural issues that fuel the pandemic and "(h)aving encountered the disease and seen its complexity, these individuals [of Pentecostal churches] found a dualistic worldview that focused on spiritual causes and effects inadequate. They saw HIV/AIDS as a problem embedded in institutional structures" (Attanasi 2008:204). As a result, such churches were keen to address the issue of prevention and to provide practical care.

There are other matters too that need to be addressed. Dube (2005) writes that the church has sometimes been the only source of help to those who are infected with or

affected by HIV/AIDS. Often it is the church that has visited and prayed with the sick, supported their families and when they have died, buried them. However, the care that the church has rendered has seldom had a prevention element; it has often dealt with symptoms rather than causes. Indeed, as we have seen in the empirical study conducted in the Helderberg Basin, scant regard has been paid to the complexities of the epidemic and the social factors that fuel it. The issue of gender and in particular, the effects of HIV/AIDS on women (see Chapter 2, section 2.9.2) is one such example.

Thomas (2008), acknowledging the important role that the churches can play, makes a plea for them to engage in a structured public discourse. While she lauds the efforts made by theologian Musa Dube (2004) and others to offer a gendered reading of biblical texts in order to expose the injustices that are suffered by women, she posits an altogether more radical proposition. Thomas in fact wonders whether, even with a more liberal reading of biblical text, "it is reasonable to place hope in the scriptures to reshape patriarchy when the Bible overwhelmingly buttresses it" (2008:282). As an ordained female church minister, Thomas asks the rather radical question: "Can the Christian Bible be seen as the authoritative and most life-giving text for women living with HIV? … Is it the best source for their survival?" (2008:283). It is not a question to which she is able to provide an answer, but it is certainly thought-provoking.

But that is not all: churches could also act to address male notions of masculinity, which have clear implications for male sexual health (including the fact that they are unlikely to seek help for health-related concerns) (Pearson & Makadzange 2008).

Churches should also examine the utilisation of the oft-used phrases: "the Body of Christ has AIDS" or "We have AIDS in this church". Do such phrases in fact induce a sense of complacency in that people are not in fact encouraged to ask questions such as why HIV/AIDS is particularly prevalent among the poor, injecting drug users, sex workers, etc., or why South Africa has one of the highest HIV prevalence rates in the world? By encouraging people to ask questions, they become conscientised on issues that fuel the pandemic.

It is my contention that churches also need to have regard to advances in treatment (Cullinan 2011; Test Drive 2011)[76] and examine whether this too is inducing a sense of complacency on their part. However, as outlined in Chapter 2, section 2.5.3, ARVs are as yet accessible only to a small proportion of people who need them (Department of Health 2010a; TAC 2008) and the prospect of a vaccine is still a number of years away, with trials only scheduled to commence in 2014.

There are a number of other areas however where I believe the church can make a more fundamental, meaningful contribution. Some of these may have implications for church dogma but, in my view, if addressed, would achieve transformation.

6.2.1 Tackling patriarchy within the church

The need to tackle certain issues is clear, not least the issue of gender inequality and the subordination of women. Mashau (2008), Kimani (2004), Dube (2004), Phiri (2003), Haddad (2002, 2003b) and Vetten and Bhana (2001) have all demonstrated that the highest risk factor for African women being exposed to HIV/AIDS arises within heterosexual marriage. Indeed, Dube labels marriage "one of the most deadly institutions" (2004:9). This is no surprise, particularly as UNAIDS (2006:88) documents that in sub-Saharan Africa women account for 58% of HIV infections, with some 90% of them only ever having had one sexual partner, namely their husband (also see Chapter 2, section 2.9.2).[77] Dube (2004) makes the point that patriarchy, both in church and society, limits the possibility of women being in charge of their lives and health. To talk of prevention without tackling the issues of gender injustices and patriarchy is therefore hollow, if the challenge of HIV/AIDS is to be met. Bjork (2006:312) rightly stresses that if the links between gender inequality and HIV/AIDS are not dealt with properly, then the battle against the pandemic will not be successful.

---

[76] At the International AIDS Vaccine Conference in Bangkok in September 2011 it was announced that that a vaccine known as RV144, which underwent a clinical trial in Thailand, offered protection to 31% of people who received it. A vaccine with an efficacy of 60% could prevent as many as 3 million HIV infections within 10 years.

[77] See also the case study at Chapter 5, section 5.4.2.4, where church attitudes towards women are discussed.

Dealing with gender issues requires the church to examine the interpretation of biblical passages that subordinate women.[78] This demands that the church looks at issues such as patriarchy and sexuality; and it requires the church to face the issues of lack of fidelity and violence perpetrated against women. In other words, what is required is a transformation of attitudes and behaviours.

Bjork summarises the challenge as follows:

> In order for the Church to become an effective and well-founded instrument in the struggle against HIV/AIDS it must let its patriarchal structures be scrutinised, challenged and rejected by feminist perspectives and in this way be ecclesiologically transformed. This entails something more than creating a women's only discourse for the Church … [but] a mainstreaming of feminist discourse in order to transform the practices and structures of Christian communities so that they can contribute to the liberation and healing of all human beings (2006:329).

Earlier, I alluded to Thomas's (2008) question as to whether the Bible could be relied upon as an authoritative guide to the social position of women (see section 6.2). Perhaps the time has come for the church to consider the issue seriously. The church, however, needs to address the issue with the involvement of women within churches, so that they can bring what Korten (1990:28) refers to as fresh and ethical perspectives to the problems of development.

6.2.2 Opening the debate on HIV/AIDS

In a newspaper article Robins (2011) explains that prior to the availability of ARVs (particularly HAART) and during the period that President Mbeki was in office as president of the country, there was limited scope for debate; the Treatment Action Campaign (TAC) was involved in a battle against AIDS denialists and therefore would not critically engage with or entertain any ideas other than those of traditional orthodox medical science (see Chapter 3, particularly section 3.4.3). Robins (2011:11) says that "(t)he mere mention of ARV side effects, nutrition, traditional healing or alternative medicine in relation to HIV, was likely to produce accusations of unscientific quackery from some of the more zealous AIDS activists." In the context of a president and a health minister who questioned the link between HIV and AIDS, as well as the efficacy of treatment, it is not surprising that the debate was limited.

---

[78] See chapter 5, section 5.4.2.4 of the case study of the Helderberg Basin, where several churches quoted biblical texts in relation to their stance on the position of women in the household and in society.

Robins asks whether the time has now come to open the debate and look at issues such as these. He (2011:11) also draws attention to the view of the sociologist, Michael Neocosmos, that the TAC's brand of AIDS activism has produced "a culture of patient passivity and dependency on the medical and scientific establishment". Neocosmos (2003:343) commented:

> In South Africa in particular, state fetishism is so pervasive within hegemonic political discourse that debate is structured by the apparently evident "common sense" notion that the post-apartheid state can "deliver" everything from jobs to empowerment, from development to human rights, from peace in Africa to a cure for HIV-AIDS. As a result, not only is the state deified, but social debate is foreclosed from the start; the idea becomes one of assessing policy or capacity. In other words the focus is on management not on politics.

He advocates for a new way of thinking about altering the relationship between the state and society, whereby the question is not so much one of taking power, but rather the dissolution of power (2003:354-355). This is what I interpret as being the empowerment of individuals and society to make decisions for themselves. However, this can only be achieved through dissemination of information and greater debate.

Robins (2011:11) says that perhaps the time has now come for a more open debate to allow people to question the medical establishment on the political logic of the neoliberal state. Critics allege that because the TAC concentrated on biomedical solutions, structural problems of poverty, inequality and the health system were ignored. While Robins does not agree with all the criticisms that have been levelled at the TAC, he says that by addressing some of these issues, the future of social movement activism would be enhanced (Robins 2011:11).

Here again I believe that the church could exercise much more of a developmental role. It seems that the church has a legitimate right to raise issues such as whether, as a society, South Africa wishes to create a dependence on medication and treatment as a solution to the HIV/AIDS crisis. It also poses a challenge for the church to begin to engage in politics and to ask questions in a manner that Korten would applaud as developmental, for this would require the churches to reach out to other constituencies, as well as to get involved in discussions as "social and political activists" (1990:127).

6.2.3 Branded drugs versus generic drugs

Buthelezi (2011), in a newspaper article, points out that in South Africa consumers pay 80% more for medication than they have to. This is because manufacturers of branded pharmaceuticals sign agreements with the makers of generic drugs not to launch their own generics onto the market until their patent period for the drug has come to an end. This, of course, delays the availability of the generic drug to the consumer. Authorised generic medicine is a branded drug maker's own generic version of its patented drug that is marketed either directly by the branded firm or by its licensee. Apparently, branded drug companies often release authorised generics when faced with entry by generic competitors. In effect therefore a generic drug is a lower cost, generic-label version of the branded-name drug. In this way generic manufacturers are being muscled out and branded drug makers continue to ensure a price advantage, to the detriment of consumers and health-care systems. Buthelezi (2011:5) reports that, according to the Generics and Biosimilar Initiative, costs of generic prescriptions and substitutes showed an average of 41.1% saving. A further 10% saving could be obtained if generic prescription and substitution were practised to the maximum in South Africa (Buthelezi 2011:5).

In my view, it is in relation to an issue such as this, where injustice results from the desire of pharmaceutical companies to maximise profits, that the church should be speaking out. Medicines such as ARVs are critical for mitigating the disease's impact. The treatment is for life and it is therefore imperative that there is access to essential medicines and that the medicines are affordable and their supply is sustainable.

The church might draw lessons in this regard from the TAC, which argued that the World Trade Organisation (WTO) members have an obligation to protect public health and promote public interest in areas that are essential for development. In an interesting analysis George (2011:196) points to the global South alliance of South Africa, India and Brazil,[79] which she advocates can be utilised to improve the living conditions of people living in the global South, through a better use of legal rights and

---

[79] Here George (2011) refers to the India-Brazil-South Africa Dialogue Forum (IBSA). IBSA is described by George as an internal institutional organisation for the partnership composed of the foreign ministers of the three countries. Its purpose was to increase South-South cooperation in areas such as defence, social development and environmental issues. IBSA is a South-South alliance and in that respect can be differentiated from BRICS, which is an alliance of the emerging economies of Brazil, Russia, India, China and South Africa.

political cooperation. She points out that in some instances human rights can be made to prevail over property rights because they have a greater moral claim. This therefore seems to me an area in which the church is able to act. However, she cautions that "(w)hile the success of social movement mobilisation and the South-South alliance is worth celebrating, without more, these movements may not ensure a sustainable reconciliation between rights of pharmaceutical companies and the obligations of developing countries with populations in need" (2011:193). Given that some medicines are essential for life and health, and therefore important in terms of human health and dignity, this is an issue that ought not, in my view, to be simply left to other civil society actors, but one with which the church should necessarily engage.

6.2.4 Monitoring and questioning of government and donors

As we saw in Chapter 3, the South African government's response in relation to HIV/AIDS was subject to particular scrutiny by the TAC in an atmosphere that was highly politicised in relation to treatment, particularly the affordability and sustainability of medicines. Johnson (2008), however, draws attention to what I believe to be another important issue: she says that South Africa has tried to negotiate a balance between self-help and dependence, and partnership and paternalism, particularly in relation to the assistance that the country receives from donor organisations. In this regard, although South Africa receives aid from a large number of organisations, the public sector anti-retroviral programme is largely funded by government resources rather than donor money or foreign aid (OECD/UNAIDS 2004; Guthrie & Hickey 2004; Tshabalala Msimang 2006).[80] South Africa has sought not to become reliant on foreign aid (Johnson 2008:502) and has endeavoured to evolve a response that is affordable and sustainable through the use of domestic resources.

This strikes me as an important issue to be examined in the context of Korten's people-centred development paradigm. Korten takes the view that development cannot come from an outside agent, but rather from people's own efforts. He also makes the point that the more money that is donated, the more an organisation's energies are involved in ensuring that the funds are committed according to some

---

[80] According to Johnson (2008), although donor funding for HIV/AIDS to South Africa has been increasing, through bilateral and multilateral aid to government, as well as to NGOs, it is not comparable to public sector funding, which has increased dramatically.

bureaucratic procedure, according to the mandate of the donor agency. He concludes that "this focus leaves little time to apply the money in ways that increase local capacities for sustainable, self-reliant development" (Korten 1990:140).

There is a fine line, however, for Korten also cautions that where financial assistance is placed in the hands of government, it tends to be used to serve the interests of power holders or special interest groups. In circumstances where donors provide funds through direct budget support to national governments, it is possible that direct funding to non-governmental organisations will be reduced, particularly in circumstances where the role of the churches in dealing with HIV/AIDS is not recognised. The issue of donor funding also raises other questions, such as whether countries which receive greater funding can adequately allocate new resources for HIV/AIDS, given their limited or declining public health capacity. The issue of sustainability of programmes was also highlighted recently by Piot *et al.* (2009). They drew attention to the fact that, as a consequence of the global recession, donors were threatening to cut down aid for HIV/AIDS, thereby potentially jeopardising the projects. Hanefeld (2010) furthermore draws attention to the fact that donor funding might also have a negative impact on coordination and could contribute to a disconnection between HIV prevention and treatment initiatives.

According to Johnson (2008), in 2004 South Africa was the third largest recipient of foreign aid for HIV/AIDS. At the same time, South Africa has increased its budget allocation for HIV/AIDS exponentially. The government nonetheless has been strategic in accepting and utilising foreign aid, especially where such aid does not correspond to the country's Comprehensive Plan[81] (Johnson 2008:499). Despite the fact that at the end of 2006 it was estimated that only one third of those in need of ARV therapy received it, the South African government has continued to insist that spending conforms to its national priorities. Accordingly, by mid-2009 only about half of those in need of treatment were estimated to be receiving ARVs (Kahn 2008). According to Johnson (2008), part of the reason for this is that the South African government does not want to become reliant on donor funding/resources that come from Western countries.

---

[81] A Comprehensive Plan for the Management, Care and Treatment of HIV/AIDS was adopted by the South African government for the period 2003-2007. In 2007 a new Strategic Plan for South Africa for HIV and AIDS and STIs was adopted and expired in 2011 (South African Government 2008).

It will be recalled that in Chapter 3 (section 3.4.3) and Chapter 4 (section 4.3.2) the conflict between the South African government and the Pharmaceutical Manufacturer's Association was discussed in relation to the accessibility of patented medicines for the treatment of HIV/AIDS. The conflict illustrated how Northern countries could use their financial muscle to protect their transnational interests, without regard for the difficulties that Southern countries faced in meeting the challenges posed by HIV/AIDS. "Big Pharma", for example, had little sympathy for the fact that South Africa was confronting a disease which had potentially devastating consequences, at a time when it was grappling with problems associated with dismantling the structures of apartheid. As Johnson states, at that time "no one in the international community raised the possibility of providing affordable antiretrovirals to HIV-positive people in Africa" (2008:503). It was only through pressure exercised by the global AIDS activist community that Western donor governments (who up until then had "shown relative indifference towards the global AIDS pandemic") (Johnson 2008:503), decided to provide funds for AIDS prevention. Johnson also makes this important point:

> In similar fashion, however, the advanced industrialised countries were all too willing to play the role of "missionary" and step in to "save" Africa. They proposed solutions for Africa that promote aid, handouts and Western knowledge and technology instead of removing the structural barriers, such as unfavourable international trade laws, that contribute to inhibiting African countries from "saving" themselves. But this approach reasserts global power imbalances and thus helps to explain much of the anger felt by African leaders struggling to avoid the pitfalls of African dependency and Western paternalism (2008:504).

It is through looking at the structural factors that fuel the HIV/AIDS pandemic, such as socio-economic conditions, rather than just behavioural issues, that the problem can really be understood and addressed. In this regard, the church has a vital role to play but one which it has, as yet, inadequately performed.

In addition, however, there is the issue of donor aid itself. In recent years the South African government has greatly increased the proportion of its health budget allocated to HIV/AIDS and has committed itself to expanding access to treatment, care and support, but it is still unlikely to meet the need or indeed the targets that it has set for itself (TAC 2008). Donor funding is therefore of some importance.

269

According to Johnson (2008:506), the USA, through its PEPFAR[82] fund, is the largest donor of HIV/AIDS funds, followed by the Global Fund to Fight AIDS, TB and Malaria, the European Union and the United Kingdom's Department for International Development (DfID). There are two issues in particular to which I wish to draw attention in relation to funding. First, drawing on Ndlovu (2005), Johnson makes the point that often donor funds are earmarked and come with strict conditions relating to spending that often do not take account of national or local government plans or priorities, resulting in decreased flexibility for implementers. The problem of conditions and lack of donor understanding, even when funds are disbursed to voluntary organisations such as churches, must also be noted.

Kareithi *et al*. (2005:112-113) draw particular attention to the issue of donor funding in relation to the Fikelela project, which is undertaken by the Anglican church in the diocese of Cape Town:[83]

> Inflexible donor policies can pose problems for the programmes being supported. At times, re-education of donors is an imperative in order to make them aware of the implications of some of their policies. Donors are very keen to support projects dealing with AIDS orphans in particular, and may request reports about the numbers of AIDS orphans being helped, or even limit the use of their funds to helping those who fall in this category. However, Fikelela has discovered that any programme on the ground must not distinguish between orphans, otherwise the children can become stigmatised … Another key lesson for donors is the view that faith-based initiatives are religiously sectarian. However, research has shown those faith-based organisations are strategically placed to address the issue of HIV/AIDS … yet these same FBOs are often overlooked for funding and other resources. More often than not, the capacity of FBOs has not been maximized because they have not received adequate levels of training or resources to address the impact of the disease.[84]

The second point that I wish to make is this: donor funding may not be effective, particularly in circumstances where there are weak health systems at a local level, along with a lack of capacity on the part of government to deliver on key programmes in the public health sector. Clearly, there is a need to strengthen both governmental

---

[82] Under the US President's Emergency Plan for AIDS Relief [PEPFAR], the budget for South Africa, in 2010, was USD550 million (Johnson 2008).

[83] See also Chapter 5, section 5.4.2.2, where in the case study, the Anglican Church's HIV/AIDS education and training programme is discussed. See also the criticism that is levelled against the church, namely that as a recipient of funds, resources are not shared more widely in the community, but rather confined to the Anglican congregation in the diocese.

[84] Chapter 5, section 5.4.2.1, generation-one activities, the help that is given to orphaned and vulnerable children in the case study area, were discussed. The point that was made there is that churches and church volunteers perhaps find it easier to respond more readily to appeals concerning children.

and non-governmental systems to ensure that HIV/AIDS funds are spent in the most efficient manner, particularly at a provincial government level in South Africa.

While the Global Fund and the European Union directly provide funds to the South African Government, PEPFAR does not. It instead partners with 300 non-governmental organisations in South Africa,[85] through which it provides treatment, prevention and care programmes. Johnson states that "PEPFAR's prime partners and the prime recipients of PEPFAR funding are largely northern non-governmental organisations and US government institutions such as the Centres for Disease Control as well as mainly faith-based community organisations who in turn administer HIV/AIDS programmes in South Africa" (2008:508). The concern that Johnson expresses is this: the United States administration may be tying aid to its strategic interests (for example, until recently PEPFAR funds could only be used to purchase ARVs that are approved by the US Food and Drug Administration, which meant purchasing branded drugs from US or European pharmaceutical companies) or pushing a politically loaded abstinence-based approach to AIDS prevention in Africa, rather than dealing with the ethical imperatives of alleviating poverty. In this respect, the church must not allow itself to become complicit or used as a tool in the power games that nations play. Furthermore, the church needs to speak out where, for example, it believes that donor money would be better spent on building institutional capacity or, indeed, on domestic initiatives and priorities. In this way the development agenda will become one of mutual empowerment that is aimed at transforming local, national and global institutions. Korten (1990:146) says that this can be best achieved through "people-to-people, government-to-government, and people-government cooperation" in solving the problems that people and nations face.

Indeed, Hanefeld's (2010:96-97) research also demonstrates that international funders, such as PEPFAR, often make decisions on funding without reference to or input from national ministries of health, which has implications for country ownership of activities and programmes. Furthermore, funding lines between treatment and prevention often means that there is little coordination between the two activities. As most funding through organisations such as PEPFAR are through civil society

---

[85] See, for example, Chapter 5, section 5.4.2.2, of the case study in the Helderberg Basin, where I explain the Anglican Church's HIV/AIDS programme, part of which is funded by PEPFAR.

organisations, including churches, there is I believe a need for the church (and indeed, those churches in receipt of funding) to be more critical about the funds that they receive. It is also important for them to consider the sustainability of programmes beyond the period of funding. The time-bound nature of funding and the requirement to demonstrate measurable impact may also lead churches to deflect the longer-term impact of programmes from consideration. Ultimately, in circumstances where funding bypasses the state, so that policy and its implementation are determined by an international donor agency, the church is challenged to question, monitor and examine the issue of funding more critically rather than be too eager to accept.

6.2.5 Addressing the issues of poverty, stigmatisation and discrimination

Dube (2003:7) writes that the church has failed to tackle issues of social injustice and stigmatisation because it has failed to see people as social beings, whose choices are dependent on their social relations and their power in society (or their lack of it).

Bjork (2006) also says that the church must become a prophetic community of hope, which means it must take seriously the social injustice found in the world and in the church:

> [When prophetic, the church] is characterised by its connectedness with and openness to the world and there is a more integrating view of the reality of the church and world. It is not a church that describes itself as holy and separate from the world or "above" the world but rather a church which gets out into the streets and confronts the unjust. It is a church which aims to criticise the dominant systems of power, as well as the effect of this ideology on thinking … This prophetic identity of the church takes notice of the structural sins found in society, rather than just focusing on an individual understanding of sin. They renew the doctrine of sin to denounce the structures of domination and injustice that human beings perpetrate against one another (2006:325-326).

I wish to posit, however, that the church has a far more fundamental role to play with respect to poverty. This was brought home to me during the case study that I conducted,[86] when the comment was made:

> We need to empower individuals and communities to be independent. We should not do things for people – we should motivate them to do things for themselves. That does not mean that the church does not have a role to play – when a person is HIV positive and before he gets AIDS, the person is living in fear. He will wonder "What people will say?" We, as the church, need to show them love, show them ubuntu. We must learn the walk to road with them. If Christ were around, would he not do this?

---

[86] See Chapter 5, section 5.4.

> We think about poverty too much – we push people into thinking that they are poor. But poverty does not mean only poverty of material things. People can be poor materially but they can be rich in spirit, in faith, in love (Rev G 2008. Personal interview with the Baptist Church minister, Lwandle).

The issue of poverty of being[87] is one that, I believe, runs counter to the basis of Christian faith, as I understand it. To believe that each human being is made in the image and likeness of God and to believe therefore that each person is to be accorded dignity and love, seems to me to pivotal; where people are therefore made to feel less than they are, for example, because they have contracted HIV or because they are materially poor, flies in the face of this basic tenet. I suggest that poverty of being contributes to a feeling of exclusion, which may be either perceived or real.

A reading of Archbishop Emeritus Desmond Tutu's autobiography (Sparks & Tutu 2011) serves to underscore the point, albeit that it refers in particular to apartheid. Sparks and Tutu (2011:61) draw attention to the insidious racism embedded in language:

> … people speak of having a black day, being in a black mood, of an unpopular relative being the black sheep of the family; while in children's stories, witches wear black, angels wear white, even the devil is invariably black. During the apartheid years, the identity of black people was expressed in negative terms, as non-Europeans, non-whites – ultimately … non-entities.

In other words, it is thinking of people as less than they are (in this instance, because of the colour of their skin) that contributes to poverty of being and this is an area in which I believe the church can play a far greater role and, in so doing, make some headway in eroding discrimination and stigmatisation. I further believe that it is right to pose this question: could it be that it is because some people do not value themselves or their own lives (because they have been made to feel less than they are), that despite all the information that they have about HIV/AIDS, they are willing to take risks they might otherwise refrain from taking? Poverty of being, I believe, is mutually linked to the concept of exclusion, each one impacting upon the other.

As Bjork (2006:315) puts it, "(t)he [HIV/AIDS] crisis challenges the church to re-examine the human conditions which in fact promote the pandemic, and to sharpen

---

[87] See Myers (2008), Chapter 1, section 1.4. Poverty is not only the absence of knowledge, information and material things, but also "poverty of being", that is to say where people are made to feel less than human and therefore ultimately, forsaken by God.

their awareness of people's humanity to one another, of broken relationships and unjust structures, and of their own complacency and complicity."

Gill-Austern (2007) asks how it is that with a pandemic killing some 4 million people a year, when there are affordable medicines to keep them alive, the issue of care is sometimes not on the agenda of churches. Certainly, we have seen that this is the case, particularly in the case study that has been undertaken, where churches situated in the relatively prosperous parts of the Helderberg Basin do not have HIV/AIDS as an issue on the agenda of their particular church.[88] The question is also raised as to why it is that so few in the church are speaking out about the disease. Gill-Austern argues:

> … the AIDS pandemic is in a large part the result of systemic practices of exclusion that proliferate when patterns of disconnection from those we consider "other" become the normal fabric of our lives. Practices of exclusion arise out of disconnections we create around perceived differences. The difference that most disconnects people from one and other in our world today is the growing separation of the "haves" from the "have-nots" and the greatest divide between people is where people are located on the economic spectrum (2007:38).

In a similar way, Ackermann (2005:104) notes that stigma too means exclusion or "othering": "Because HIV-related stigma intrudes into virtually every aspect of social, political and familial life, expressing itself in acts of discrimination, exclusion, condemnation and even banishment. Stigma presents a major impediment to decent care because it perpetuates the silence surrounding HIV/AIDS."

Gill-Austern (2007) makes the point that it is not poverty alone that is a risk factor for health, but economic inequality, that is to say the unjust distribution of resources. He says that exclusion is wrong, theologically, because we are both distinct and differentiated from everything else and meant to live in communion with one another, which means in relationships of interdependence, reciprocity and mutuality.

Exclusion is described by Volf (1996:75) as the unwillingness to see the other in their otherness, which ultimately means separation and the removal of mutual relationships of giving and receiving. Volf (1996) describes four forms of exclusion: the violence of expulsion (exiling another from community or saying that they don't belong, which

---

[88] See Chapter 5, sections 5.4.2.1 and 5.4.2.3 of the case study, where some instances are cited of churches in wealthier areas, which might have been expected to help churches in poorer areas. The churches themselves also acknowledge that they often do not work together on common issues, such as HIV/AIDS, that are affecting the community around them but not necessarily their own churches.

could lead to genocide in extreme form, or discrimination); violence of assimilation (incorporating others into our reality by obliterating their reality or subjugating their difference to what is normative for the dominant group).

Exclusion is also possible through the subjugation of the other (in other words designating the other as inferior or exploiting them or dominating them in some way; colonialism is an example of this form of subjugation). Finally, exclusion can be practised through "the indifference of abandonment". That is to say, pretending not to see, or choosing not to see or indeed pushing the issue from our consciousness. The other then becomes invisible or anonymous. Volf reminds us that indifference can be more destructive than hate (1996:77), because people become disconnected and therefore choose not to take responsibility.

Gill-Austern uses Volf's framework to look at HIV/AIDS as an exclusion issue of indifference of abandonment. By focusing on issues of promiscuity and loose morals, he says that the church is side-lining the issue of poverty, as well as issues such as those affecting women and children. Attention is particularly drawn to the fact that poverty is not a simple matter to assess. Hardest hit countries may have higher education levels and a larger gross domestic product, but this might hide the fact that they might also have the greatest income disparities and largest proportions of the population who live in poverty (as is the case in South Africa). He produces facts and figures demonstrating that the poor are largely excluded from education, health care, agricultural resources and trade subsidies, debt relief and even proper funding to fight HIV/AIDS. He also makes the point that countries choose to spend vast amounts on defence, instead of, for example, supporting efforts to combat HIV/AIDS in the poorest countries. As a result, he says, there is a profound sense of disconnection from the enormous suffering of the poor. From such disconnection come cycles of practices of exclusion resulting in greater poverty and economic inequality, rather than any means of addressing the factors that fuel the AIDS pandemic.

Gill-Austern therefore argues that the church has to give serious thought to practices of practical solidarity that remind Christians in particular, but indeed all of humankind that they are all members of one body.[89] This is achieved not only by walking with

---

[89] 1 Cor 12: 26: "If one member suffers we all suffer, when one rejoices, we all rejoice."

275

others suffering the impact of exclusion, but also by becoming involved with non-governmental organisations working in these areas. He says that the church can achieve this through several means including: raising its voice to advocate for those suffering from the impact of AIDS; holding the government accountable; seeking treatment for all who need it; and remembering in prayer and liturgy those on whom AIDS has had an impact (2007:50). Importantly, through walking in solidarity with others, we are also likely to erode poverty of being.

This also requires the church to address further issues: HIV/AIDS is predominantly a disease of heterosexuality, particularly in Africa. However it is also a disease that is affecting homosexuals in Africa. The church cannot afford to ignore or side-line this segment of the population in the care that it exercises, for in so doing the church would be equating gay people with the "other"; the church itself would therefore be complicit in perpetuating discrimination and stigmatisation by rendering invisible a part of the body of Christ.[90]

Furthermore, the church cannot simply deal with the issues of gender inequality as it affects women or the care of orphaned children. Men too need to be drawn into the church's ambit of care because in so doing it is also demonstrating the inclusive nature of such care.[91] Care for those who are sick, a commitment to community development, advocacy on behalf of the voiceless are actions that do not exempt the church from also engaging in activities that engender social change, for it is only in this way that transformation can be achieved in the fourth-generation developmental approach envisaged by Korten (1990).

6.3   Towards becoming a more effective church in responding to HIV/AIDS

The church undoubtedly faces enormous challenges, not only in relation to the issues outlined above, but more broadly: at a time when South Africa has become exposed to the world, following the fall of apartheid, and when the processes of globalisation and interconnectedness are playing a role in changing society, the church needs to address

---

[90] See Chapter 5, section 5.4.2.4 of the case study, on the issue of homosexuality and the impact that it has upon those who are affected. See also Chapter 2, section 2.8.4, where the issue of same-sex relationships is discussed, together with the effects of discrimination and stigmatisation.

[91] See Chapter 5, section 5.4.2.4, where in the case study some churches demonstrate an acknowledgement, if not a commitment, to addressing issues relating to men and masculinity, while most do not pay any heed to this aspect.

what Korten (1990:168) calls the questions "fundamental to religion", namely the use of power, values, love, brotherhood, peace and the ability of people to live in harmony with one another, as well as the essential relevance of religious teaching in addressing the issues of poverty and injustice. Enormous economic disparities, together with high levels of crime, violence and unemployment, prevail in South Africa and these too are issues with which the church must engage. The church also needs to reflect on how it responds to a situation which Archbishop Emeritus Desmond Tutu (2011) described as follows: "We all paid a very heavy price [for freedom]. And for what? So some of us can have three motor cars. There is something wrong that is happening in this country. That is not what we struggled for. There are levels of poverty in this country that are completely unacceptable" (Cape Times Special Supplement 2011:11).

However, globalisation and the demand for an ever greater secular space do not appear to have diminished church affiliation in South Africa (Erasmus & Hendriks 2003). Can the church meet the challenge of serving a unifying role for a diverse, pluralist world, particularly around the issue of HIV/AIDS? Religion has the power to legitimise a social movement of shared values, but the danger is also that it may polarise views, resulting in the exclusion rather than inclusion of some people.

In drawing attention to the enormity of the challenges that the church faces, I shall now endeavour to suggest two possible ways through which the church might respond with a view to making an impact that might be global in reach. Such a response, in my view, requires a fundamental re-think and ultimately a transformation of the church, if it is to remain relevant and a force in fighting the spread of HIV/AIDS.

6.3.1   Developing a vision

Helen Keller[92] was once asked "What is worse than being blind?" She replied "To have perfect eyesight and no vision." It seems to me that this is a vital point. The church appears to have rendered care in relation to HIV/AIDS at a time when the government and the international community were slow to help. However, organisations such as the TAC were at the forefront of efforts to disseminate information and to secure access to treatment. The church too has responded, often

---

[92] Helen Keller was born in 1880 and at a young age she suffered from what is now believed to be scarlet fever. The disease left her blind and deaf, but through these disabilities, she made an enormous contribution to our understanding of what it means not to have sight or hearing.

with love and compassion, but sometimes with prejudice and judgment. However, it has not given sufficient thought or attention to the nature of the help that it provides, nor to the developmental aspects of such help. In my view, the church has seen the impact of HIV/AIDS, but it has shown little vision as to how to handle the disease other than in an often ad hoc and piecemeal fashion. For people-centred development however, Korten (1990) makes a strong case for having a vision and the values that underpin it (1990:43) in order to address the causes that give rise to the condition (Korten 1990:114).

I believe that Cochrane (2006) provides a useful analysis on the need and importance of having a vision and in this section therefore, I propose to outline some of his thoughts. Cochrane (2006:26) calls for a movement for health, which if comprehensive and all-embracing, would be "a revolution". This challenge, Cochrane says, calls for "boundary leadership, a capacity to bridge boundaries and work in the interstices of them … and to mediate the relations that are necessary for a healing and healed world. It calls for solidarity … It calls for a model of ecclesial practice that draws on the strengths of faith and of congregations."

Cochrane (2006:12) makes the point that:

> … paying attention to the health of individuals, especially in caring for them, a common enough activity of Christians and Christian churches, is necessarily, simultaneously, to address the body politic. One needs only remember, in addition, that the body politic refers not to politics in the narrowest sense, but to the life of the *polis,* the sphere of our life together through which we make decisions jointly about how we might live well, together, in just institutions.

Illness, he argues, should therefore have a "corporate" meaning for the Christian church and therefore all the circumstances that surround it, including social determinants such as inequality and deprivation, must be taken into account.

Cochrane (2006:15) goes on to argue that the church should be the first to take up the challenge to care. Cochrane's perspective is not that the church is called to care for the sick or minister to the ill. He says that this fails the challenge pragmatically, because it invariably means one sort of action on the part of congregants and church leaders among many possible kinds of ministry, and this is inadequate to the reality of the health of the poor. He further argues that this sort of justification for care fails the challenge theologically too, because it is akin to the classic criticism of the commonly

adopted Good Samaritan model of caring for an injured person. While Cochrane does not dispute the fact that care in such circumstances is necessary, he says that it is insufficient, because it means that nothing is done about tackling the dangerous road along which many other people too may well suffer the same fate. In other words, therefore, we must look to resolving the underlying cause of a problem.

Cochrane (2006) argues that a comprehensive response to health and justice is required pragmatically, because the effects of inequality and deprivation are indicators of sin, which endanger life.[93] Theologically he says that the church is called upon to care because all human beings are God's people, the body of Christ. For this reason he argues that social justice is neither a secondary issue to the church's primary activities, nor is it redundant or misplaced: "the Body of Christ … cannot be separated from the bodies of people for whom the church exists". Similarly, George (2011), who in fact writes about the inclusion of disabled people in India, states that the mission and unity of the church depend on the inclusion and equal participation of those who are on the margins – including all those who are "suppressed, oppressed, marginalised, pushed-out, neglected, left-out, rejected, considered not-capable or not-normal, because of their social, financial or physical status" (2011:96); this is so because they too are part of the body of Christ and all members must therefore participate equally in maintaining the unity and "health" of the body.

Cochrane (2006:22) makes a particular plea that the church should take a "special, indeed a defining" interest in HIV/AIDS, because prevention and care, where undertaken comprehensively and in an integrated way, produces a marked improvement in other health indices. This therefore requires an examination of wider issues, including those of food security, nutrition, clean water, etc. As Nicoli Nattrass (2004:189) puts it: "AIDS is different because it is a public health crisis, which not only has deep social roots, but challenges the very notion of what it means to be a society." The church is therefore called upon to be a prophetic as well as a caring and pastoral institution. Using this perspective, clearly it is not possible for the church to continue to do things in the same way. Pushing the tenets of faithfulness and abstinence in relation to HIV/AIDS, without recognising, acknowledging and indeed

---

[93] This, I argue, goes to the heart of what Korten (1990) advocates in suggesting a fourth-generation developmental approach, namely one that is aimed at changing policies and institutions, and removing inequality and injustice. See Chapter 4, section 4.4.3.4.

working towards addressing socio-economic conditions that fuel the pandemic is meaningless.

Furthermore, the church must also be prepared to engage in the political sphere, however loath it might be to do so.[94] It is instructive once again to look at Sparks and Tutu (2011:56), who comment as follows on Archbishop Tutu:

> Many South Africans, including some of his admirers, believe to this day that Tutu was primarily a political activist who used his pulpit as a platform. The opposite is the truth. It was the depth of his spirituality that drove him to political activism. He was not a politician with a strategy but a churchman with a mission – a mission he believed had been given to him by God "to work for the realisation of something of his kingdom in this country".

Tutu's faith is summarised as follows: because God became human, human beings are not just important, but they are "God-carriers", created in the image of God and, consequently, not caring for a fellow human being is not simply a criminal act, but tantamount to a religious violation. It is not simply a question of encountering God in prayer; the love of God is expressed through love of your neighbour.

Cochrane (2006:25) also calls not just for care – but for "decent care", a notion that he says is intended to bring a sense of dignity, worth and respect to people; "it might be interpreted as a recall to uphold the values of personhood above commodities, of collective responsibility above individual gain, of stewardship and service for the sake of all and for the sake of the earth that sustains all, above entitlement and the maximisation of personal gain, authority or power".[95] Care in this sense is neither technical nor medical: it involves justice and human rights. Lankester (2008), in reviewing the book *Restoring Hope: Decent Care in the Midst of HIV/AIDS*, explains that decent care is a profound concept for it is an approach that is holistic and inclusive: individuals are afforded dignity and a destigmatised space to control their own destinies. The concept is also simple, as we have to imagine that we are the persons with HIV and ask ourselves what care and health services we would need, expect and want. Finally, decent care is comprehensive, for it incorporates the "care continuum": physical, preventative, therapeutic, economic, emotional and spiritual.

---

[94] Indeed, in the case study of the Helderberg Basin (Chapter 5, section 5.4.2.3), we have seen that by and large churches are very reluctant to engage in the political sphere.

[95] This of course recalls Korten's fourth-generation approach, which emphasises justice, sustainability and inclusiveness (see Chapter 4, section 4.4.1).

In this respect Cochrane's views accord closely with those of Korten and indeed with those that I have endeavoured to articulate in this dissertation, namely that the church should use its integrative powers, motivated by love, to exercise care for those affected by or infected with HIV/AIDS in a developmental, people-centred way that recognises the worth of every human being and by working to realise that worth, not in an exploitative way, but rather in terms of their value as human beings.

6.3.2 *The emerging church movement: lessons to mobilise volunteers towards a broadly shared vision*

In this section, I seek to utilise the concepts articulated by Korten (1990) and Castells (1996, 1997) (discussed in Chapter 4, section 4.1) to explore one way in which the church, might be mobilised to act in addressing the HIV/AIDS pandemic, despite the doctrine and histories of denominational churches that presently divide churches and prevent them from acting in a unified manner, as one body. The idea that I set out is closely linked to that of the above section, namely, the importance of having a vision. Korten asserts that "(i)t is the relationship among belief, perception and action that gives ideas revolutionary power". He goes on to say that ideas have the power to lift a veil from the eyes, bringing powerful new insights, which "can stimulate the release of massive social energies toward a reordering of human institutions and behaviour on a grand scale" (1990:35) – it is this transformative aspect that I wish to examine.

Without wishing to be prescriptive, the question that I wish to pose is the following: as outlined earlier, at a time when South Africa – and indeed, the world – is facing unprecedented change, how can the church meet the challenges presented by HIV/AIDS? In particular, is it possible for the church to utilise Korten's concept of a movement that is developmental in nature to transform people and institutions?

The first question that perhaps needs to be addressed is this: are the churches able to work together? From the case study that has been conducted in the Helderberg Basin, it would seem that churches have not learned to work with each other in meeting the challenge of HIV/AIDS, let alone work with other faith traditions, except in a peripheral way.[96] The Christian churches all profess one belief in Jesus Christ; they broadly agree on the tenets of abstinence and faithfulness; they all bring the same

---

[96] See in particular Chapter 5, section 5.4.2.3.

values to the table, albeit that some emphasise one quality over another. Why then are they not able to work together, cooperate and transcend their differences? Korten stresses that it is only through the creation of networks and alliances that transformation can be achieved; he states that a "global-scale social learning process" based on networks of shared interests and the application of integrative power is the way in which to achieve people-centred development (1990:106).

And yet there are examples of the churches coming together. De Gruchy (2004:223) explains that during the churches' struggle against apartheid, the ideology of apartness and exclusion provided the churches in South Africa with a sense of unity and cohesion. Because of the anti-Christian character and brutality of the apartheid regime, "(a) high degree of unity and purpose was forged between the churches, coalescing most visibly in the work and witness of the SACC [South African Council of Churches], but also in many other local ecumenical and fraternal networks and organisations".

In the recently published authorised autobiography of Archbishop Emeritus Desmond Tutu (Sparks and Tutu 2011), it is fascinating to read of the church's response to social change. Tutu, in particular, refers to the changes that were being wrought in Britain and throughout the world in the 1960s. It was a time when churches were called to change and when they responded to the challenge. What I am suggesting here is that we have reached such a time in South Africa (if not more widely) and that it is a time that cries out for a response from the church and which demands an approach that is able to transform lives and conditions.

I believe that it is worth quoting at some length from Archbishop Tutu's autobiography, as it provides an insight not only into social changes but also the church's response to such changes in Britain/the West in the 1960s. It seems to me that there are parallels to be drawn between that time and the present, when globalisation is changing the world socially, politically and economically. Indeed, Castells notes that we have entered the age of a "network society", which is global and geared towards financial, technological and information flows (1996:471-476). This has implications for society because the logic of market prevails, while "people, in the multiple space of places, made up of locales, are becoming increasingly segregated and disconnected from each other" (1996:476).

Desmond Tutu arrived in Britain in the 1960s to study for a divinity degree; this was:

> a decade of social and cultural revolution throughout the Western world … but especially in Britain. Not only were empires being dismantled and new nations being founded – thirty-two in Africa alone – but social norms were being turned upside down in everything from the arts to fashion to human relationships. The "Swinging Sixties" the decade was called, because of the fall of a whole range of social taboos, especially relating to sexism and racism…
>
> This counterculture of questioning all established mores reached into every sector of life, including theology … and an explosive new book by Bishop John Robinson of Woolwich called *Honest to God*[97] hit the headlines. In the book, Bishop Robinson argued that secular man needed a secular theology – that God's continuing revelation to humanity was brought about in culture at large and not merely within the confines of "religion" or "church". A review of Robinson's book in the *Observer* newspaper[98] carried the startling headline "Our Image of God must Go".
>
> This was also the decade of the Second Vatican Council, convened by Pope John XXIII because, he said, it was time to open the windows of the Catholic Church and let in some fresh air. The Pope invited other Christian denominations to send observers and all the main Protestant and Eastern Orthodox churches did so. Thus began a major new phase of theological liberalism and ecumenism, as the Catholic Church engaged for four years in serious dialogue not only with those other Christian denominations but, in time, with other non-Christian religions as well.
>
> Meanwhile, the Anglican Church [headed by the Archbishop of Canterbury, Michael Ramsey] … had a respect for honest agnosticism and atheism and believed they might not be barriers to salvation. He had respect for other faiths as well…" (Sparks & Tutu 2011:51).

It was in such an atmosphere that Desmond Tutu undertook his studies, commenting that his theological lecturers had "an allergy against dogmatism". It was a contrast to the didactic style that he had known in South Africa. In relation to HIV/AIDS, I ask whether it is not time for the churches also to come together and perhaps even give some consideration to the dogma that prevents them from working together and, more importantly, from exercising care in a people-centred, developmental manner.

The veteran journalist Mark Tully (2008), writing of his experiences in India, makes this point:

> Reason is not only an important tool that enables religious people to have discussions with non-believers; we should also be prepared to use reason as a test of the continuing validity of religious traditions. Doctrine has to develop in the light of new knowledge and the changing norms of society. If it flies in the face of reason it deteriorates into obscurantism, and nothing gives religion more of a bad name than

---

[97] Robinson, J. 1963. *Honest to God*. Philadelphia: Westminster: John Knox.

[98] *The Observer* is a UK newspaper and the article was covered in its issue of 17 March 1963 (Sparks & Tutu 2011:311[endnotes]).

283

that. Perhaps one way to put it would be to say there has to be a balance between reason and revelation.

In the light of various factors, discussed earlier in this dissertation, such as the changing nature of the family and parenthood, evidence relating to condom use and HIV prevention, the part that socio-economic factors play in fuelling the pandemic etc., I ask whether the time has not come for churches to examine those doctrines that inhibit them from engaging effectively on issues that impact upon HIV/AIDS.

What I would like to also propose is that all churches, whether mainline, Reformed, charismatic or indeed African Independent, draw lessons from the movements that we see all around us, for example, the feminist and peace movements. Korten (1990:36) makes particular reference to the women's movement, which he uses as an example of the power of an idea, which has released new forces into society, reshaping our world. That idea was that the subordination of women is political and social, and not biological. So too, if the churches were to examine the history of HIV/AIDS, particularly its evolution in the United States (see Chapter 3, section 3.4.1), they would see how the gay community galvanised support and changed the face of HIV/AIDS care by becoming knowledgeable about the disease and working with doctors, researchers, government and international bodies to generate solutions, funding and ideas on how to manage and contain the disease.

I believe that it would also be useful to take note of the emerging church movement, which could be unifying, workable and transformative in enabling the churches to work together on an issue such as HIV/AIDS.

Scott (2010:336) uses the following summary from *Next Wave* to define the emerging church:

> Our dream – To bring together Christians from all walks of life, including pastors, church planters and leaders, across national and denominational borders, who want to reach out to people in postmodern culture and who understand that, in order to do so, significant changes need to be made in the way we run and organise our churches.

Dager (2005), who in fact writes of the "Emergent Church" (which Barbour and Toews (2010) describe as a popular North American variety of postmodern emerging church communities and thus a sub-stream of the broader movement), says that the movement has grown because church leaders find that their traditional pastoral role is

284

too restrictive and not relevant enough for today's postmodern world. In the West, materialism has not fulfilled its promise of contentment and inner peace. Churches moreover, have themselves operated on a materialistic model, rather than try to "quench the spiritual thirst of seekers" (2005:2). Furthermore, Dager is of the view that modernity produced a spiritual vacuum by trying to produce rational explanations for supernatural events and by people paying lip service to the Gospel but living as though they are unaccountable to its tenets. According to him therefore, the malaise of materialism and greed has led to a hunger for spiritualism, which in turn has given rise to the emerging church.

Johnson (2008) agrees with this point of view, adding that the church is keen to offer a Christian response to a changing world; a world which is not only postmodern but also postcolonial, and where he acknowledges that biblical interpretations by white Western males may have been subjective. It is therefore into a world where not all answers are known that the emerging church has taken root.

Dager (2005:3) says that it is difficult to ascertain where and how the emerging church movement began; at first he says, it was not so much as a movement as a conversation among church leaders, who wanted to make their ministry relevant to today's culture and who sought a spiritual revival for those who had left the church. He goes on to state that "(t)o all outward appearances, the emergent church movement is a grassroots phenomenon."

Strimer (2006:1) writing for the Episcopal Church in Washington DC, says:

> A new church is emerging in cafes and coffee houses, pubs and bars, not only here in the United States but in England and Australia. In our own diocese, it is found at the Church of the Apostles … In England it is on the streets of East London, in the Anglican sponsored church, Moot. And in Australia it is found at the Café Church in downtown Sydney. But in each and every case, a new way of being church is erupting from the ground up. It is contextual as well as textual; Bible-based but rooted in the absolutely unique expression of the local setting.

McLaren (2006, 2007) is one of the foremost proponents of the emerging church movement. He says that all theological systems have a framing story: conventionally, they specialise in fulfilling spiritual needs to the exclusion of physical and social needs; the focus, in other words, tends to be on the afterlife. He questions, however,

what can be done about the societal and global injustices that people face during their life time. Systemic issues, such as injustice, poverty, the ecological crisis and other systemic dysfunctions of many kinds also need to be addressed. He concludes that by "the kingdom of God" Jesus meant changing this world, not escaping from it or retreating into churches.

The three crises that he outlines (McLaren 2006) are the prosperity system (unhindered economic growth), the security system (violence) and the equity system (the rich/poor conflict). All of these render life without meaning. He therefore calls for Christians to live authentically. Secondly, he calls for the rampant growth of individualism in culture to be halted in favour of a return to living in community.

McLaren therefore urges that the church gets involved with public matters in general, and politics in particular – including economics and aid, personal empowerment and choice, foreign policy and war.

> The radical revolutionary empire of God is here, advancing by reconciliation and peace, expanding by faith, hope and love – beginning with the poorest, the weakest, the meekest, and the least. It is time to change your thinking …It's time to change your life …be part of the revolution (McLaren 2006:32-33).

In many ways the sort of movement that McLaren is proposing can be viewed in terms of what Castells (1997:354-359) calls "resistance identities", the aim of which is to build defensive locales, in resistance to dominant global interests. Resistance identities may, however, eventually emerge as "project identities", the aim of which is to create a new civil society. In an age where people feel that they are being disenfranchised economically, culturally and politically, communal resistance is formed, with the aim of transforming society in order to resist the dominant interests imposed through global flows of capital, power and information.

There is some debate about what an emerging church movement means. Gibbs and Bolger (2005:44), however, provide a helpful definition in this regard:

> Emerging churches are communities that practice the way of Jesus within postmodern cultures. This definition encompasses nine practices. Emerging churches (1) identify with the life of Jesus (2) transform the secular realm and (3) live highly communal lives. Because of these three practices, they (4) welcome the stranger (5) serve with generosity, (6) participate as producers, (7) create as created beings, (8) lead as a body, (9) take part in spiritual activities.

There are many critics of the emerging church and I am not proposing that all churches conform to or adopt the emerging church's way of "being church", but rather suggest that it is a way for churches to come together to overcome the frustrations of dealing with HIV/AIDS in a way that not only addresses immediate concerns, but also responds to the crisis in a way that is transformational.

It is however perhaps relevant and important to focus on a few areas where the emerging church has been criticised. Scott (2010) outlines three areas of concern:

1. Cultural relevancy: While Scott (2010) lauds the emerging church's ambition to contextualise the gospel for today's generation, as well as its aim of "being about community and creating community", rather than reducing fellowship to "greetings and small talk" (2010:337), she questions the rather broad ambition of the church to be a welcoming place for all, including non-believers. Furthermore, Scott (2010) is of the view that in the emerging church's endeavours to provide a spiritual experience for the spiritual hungry "now", it may ignore the "not yet" of Christ's second coming. While she agrees that there must be respect for other religious traditions, the emerging church should not be too culturally accommodating. Gibbs and Bolger (2005:133) may however be helpful in this regard, urging that "emerging churches hold to Christian orthodoxy, affirming the uniqueness of Christ. This understanding however, rather than being a reason to exclude, empowers them to include those of other faiths, cultures and traditions".

2. The medium is the message: The emerging church insists that orthodoxy is meaningless without orthopraxy: practice must therefore flow from belief. Scott (2010) criticises this stance, as she says that relationships, rather than the written word, are given primacy. The Bible may therefore be interpreted as being insufficient for the church's life. Scott however takes some comfort in the fact that McLaren clearly states that if the gospel "changes to the point that it stops being about Jesus … it has stopped being the gospel" (McLaren 2003:218).

    In a similar vein, Johnson (2008) also urges caution, saying the message of the Bible must not be changed: the only way in which a person can relate to God

is through Jesus Christ and there is no other metanarrative. Furthermore, while the Bible can be open to interpretation, it does not change the fact that it is the authoritative book of the church. He also makes the point that the situational ethics of postmodernity does not change the fact that certain things are always wrong, such as murder, greed, theft etc.

In this regard, McLaren's stance in relation to feminism (2004) comes under stinging attack. McLaren endeavours to make the case that the emerging church movement must address the issue of male leadership, which is "patristic", "abusive" and "inadequate" (2005:74-75). He also apologises for the use of masculine pronouns. Dager (2005:17) takes issue with this, urging that heed be paid to the Scriptures:

> These were not "cultural" distinctives that have been abandoned. They are eternal truths: God made the man first; the woman sinned first; the woman was created for the man; the man was not created for the woman. None of these truths have changed just because mankind (created as male and female) has become more "enlightened."

In my view, by so condemning McLaren and in not paying heed to reason, tradition and experience, in addition to Scripture, some of the otherwise valid points that Dager makes, are in danger of being ignored. Dager (2005:18) says that

> Scripture must be the authority that holds sway over the other three [reason, tradition and experience]. Otherwise one ends up with a subjective religion … This explains why Anglicanism has embraced homosexuals in ministry, women in authority and teaching and the seeking of unity with the Vatican.

Roman Catholicism does not escape attack by Dager either (2005:19), as while "correctly stating that the Bible is the inspired Word of God, nevertheless says that it cannot stand alone. Equally authoritative are the Catholic Church's tradition and its teaching authority."

At this juncture, it would probably be helpful to remember that attitudes that are judgemental, discriminatory and stigmatising have done little to halt to spread of HIV/AIDS.

288

3.   Everything in mission: The emerging church describes itself as a "missional church", mission being the very nature of the church. Johnson (2008:167) sums up this position of the church well:

> Doing right (mission) is just as important as being right (doctrine), and sometimes more important. Rather than talking about mission, emerging churches make mission the primary purpose of their being … defining mission as sharing the gospel in word and deed.

Johnson (2008) takes issue with this stance, arguing that the mission of the church is to invite people to worship God in prayer and with their lives, stressing the importance of doctrine over practice. He also cautions the extensive use of technology by the emerging church, saying that it should not be used as a crutch for communication and certainly not as a substitution for prayer.

Despite these criticisms however, I believe that the emerging church movement holds lessons for the Christian church, all the while accepting that theology and doctrine should form the basis of action in relation to HIV/AIDS and that although it is important to take account of current culture in the way in which Christianity is practised, there must be a place for being critical of it too. I shall now proceed to consider aspects of the emerging church movement that I believe are helpful.

The "emerging" aspect denotes that it is a wider, informal, global, ecclesial (church-centred) movement (McKnight 2007:36). Essentially, it is a term that encapsulates "how to do church" in postmodern culture. The emerging church does not seek to fight postmodernity, but to take it seriously and to embody church practices within a particular culture. It has no central office and is as diverse as evangelicalism. In a very real sense, therefore, emerging churches represent a social movement that accords with Korten's definition: the movement is sustained by social energy rather than money, and it is "driven not by budgets or organisational structures, but rather by ideas, by a vision of a better world" (Korten 1990:124).

By identifying with Jesus and applying the message of the kingdom – that is to say that God's kingdom is here on earth – there is a requirement for people to join God's outward movement to humanity. In this way the values of love, justice, peace and forgiveness can be engendered. It will be recalled that Korten (1990:214) writes of the

process of conscientising people about the integrative values of humility, moderation and love. Secondly, Gibbs and Bolger (2005:66) say that far from undermining religion, secularisation has created a spiritual vacuum and a deep desire for integration. Gibbs and Bolger's (2005:47) views resonate with those expressed by Korten: they too advocate for a "new social order", which implies a radically new way of being and acting in the world, not only at a local level, but nationally and globally too, by identifying with Jesus and applying the message that God's kingdom is here and now, and not in the life hereafter or at some stage in the future. In the emerging church movement people are invited to take part in radical transformation that knows no boundaries; religion cannot be relegated to the private sphere or confined to a sacred space, for it is religion's task to define the purpose and meaning of life. Public space is not therefore a place without God, but rather a place in which God is already working.

Gibbs and Bolger's (2005:94) final core practice is that of living-in-community, by which they mean that it is not the individual's needs or desires that are prized, but rather relationships, mission and spiritual struggles. The church community should therefore be a network or connectedness of substantive relationships which work towards overcoming disagreements and disappointments. In a similar way, Korten (1990) not only writes of creating a "new awareness" of our profligate and individualistic lifestyles, but also of the need for global society to become inclusive, assuring everyone of an opportunity to be recognised and respected as a contributor to family, community and society (1990:4). He is also an ardent advocate of "people-to-people linkages" (1990:26-28), as well as alliances across broadly shaped constituencies (1990:84) to transform and reshape values and institutions.

The emerging church movement is therefore, to my mind helpful as it calls for social transformation, rather than seeking to comfort people as they confront dysfunctional aspects of society, or where they confront the seemingly intractable problem of how to meet the challenges of HIV/AIDS in all its manifold aspects.

But there is yet another issue that has to be addressed, namely that of incorporating or inculcating values into a vision. It will be recalled from the discussion earlier that Korten not only advocates a vision, but stresses the importance of the "values premises of the vision" (1990:43). It seems to me that if the church has a vision of

caring in a developmental manner in relation to HIV/AIDS, then it is important for it to take into account the values aspect of that vision. The question that is at stake is this: can the church instil values in the context of a globalised world?

In his study of the anti-apartheid movement, Thorn (2006) demonstrates how the movement developed networks and actions that connected and mobilised not only groups and organisations such as churches, unions and women's, youth and student organisations, but also global civil society in over 100 countries. The transnational networks of the anti-apartheid struggle form the basis of Thorn's research on transnational social movements and the emergence of global civil society. He argues that after the Second World War a transnational political culture emerged through the increasing internationalisation of old movements, such as churches and the labour movement, as well as through the emergence of new social movements (postcolonialism/anti-imperialism, the environment, peace and gender equality) to address global issues in different ways; the anti-apartheid movement was part of this process. Interestingly, he (Thorn 2006:295) says that what united these different actors was not the common goal of ending apartheid in South Africa, because "a common goal is not enough for a constellation of actors to compose a social movement". What was important was "a shared collective identity, and in the context of the transnational anti-apartheid movement 'solidarity' can be taken to constitute the central aspect". It is this concept of sharing a collective identity (in the case of the Christian church, for example, a belief in Jesus Christ) and solidarity, by virtue of believing that each person is made in the image and likeness of God and is therefore to be accorded love and dignity, that I believe the church can use effectively to meet the challenges in the fight against HIV/AIDS.

In a very interesting essay Stuvland (2010) examines how Christianity is influenced by postmodernism[99] to better inform normative thinking on global civil society. He argues that religion's role in the global values discourse is enhanced by a dynamic process of adaptation and transformation as part of the larger process of globalisation. He uses the emerging church to offer insights into how the church is changing and

---

[99] Postmodernism is a terms used to describe a state, condition or period subsequent to that which is modern, involving a conscious departure from modernism, especially when characterised by a rejection of ideology and theory in favour of a plurality of values and techniques. (*Oxford English Dictionary* 2006).

why it is able to influence the values discourse that is at the heart of global civil society (GCS). Thus, whereas Weber (1977:129-156) suggested that Enlightenment thinking would roll back superstition and mythology and thereby pave the way for rationality and progress, Stuvland makes the case for the return of religion from the throes of modernity (2010:210).

I do not propose to dwell at any length on a definition of GCS. For now, it may suffice to rely on Stuvland use of Keane's (2003:8-9) definition, namely: "a dynamic non-governmental system of interconnected socio-economic institutions that straddle the whole earth and have complex effects that are felt in its four corners". It comprises networks, pyramids, hubs, clusters, economic institutions and individuals who organise themselves across borders. In this sense, churches too can be classified as part of GCS, for in theory they are able to operate outside the nation state and transnationally. Globalisation helps this process by allowing a new global interconnectedness. Stuvland is of the view that actors operating within the GCS may be criticised for the fact that the values (or ethics – he uses the words interchangeably) that they bring are indistinct – non-violence, justice, peace – and because there is a multiplicity of actors, each of whom bring their own meaning to these terms, which have to be translated in locally-specific situations. Issues such as how these values can be operationalised or grounded substantively or communicated across competing moral communities are discussed infrequently, which is the basis of the criticism of the notion of a GCS. Furthermore the need to access common values across cultures means that ownership is multiple, competing and globalised.

Briefly, Stuvland (2010:205-209) analyses Keane's (2003:186-190) arguments of the values that are inherent in a GCS. Such values include those given by natural law, that is to say those values that are self-evident and imbued with sacredness (such as those that are espoused in human rights charters), as well as values that come through liberal consensus theory and the deontological imperative. According to Stuvland's interpretation, liberal consensus theory states that human beings broadly see the value of cooperating and generally will work towards that end. The deontological imperative is taken from Kant (1993:30); it fixes values in human reasoning that require those values to become a universal law. From this standard of rationality, all

292

moral requirements are derived. Stuvland, however, questions whether this is possible in today's globalised world, where information is the currency.

Stuvland (2010:209) takes the view that all the above theories emerge from the so-called first principles of human nature – the capacity to reason or transcend a moral law that is fixed and unalterable. He contends that such ethical frames are linked to the vision of a nation-state, which is untenable in a globalised world. The source for global values must therefore be found elsewhere. Stuvland suggests that religion provides a much more plausible locus of global values and in this regard he examines Christianity as a possible source.

There is some support for Stuvland's view. GCS is a complex, fluid idea and it is theoretically ill defined as a term for non-governmental organisations or social movements "of all shapes and sizes, operating in the international realm" (Taylor 2002). Taylor explains that increasingly NGOs are linking up with international governmental organisations (such as the United Nations) to form networks and coalitions to push nation-states, as well as major institutions such as the World Trade Organisation, the International Monetary Fund and the World Bank, and indeed, transnational corporations, to implement progressive reforms (2002:340) around issues of global concern. While a definition of GCS is difficult to formulate, Taylor explains that "the key motivating force of global civil society is its moral concern to create a better world through advocating a fairer, freer and more just global order" in relation to economic, political or social issues (2002:341). Any definition of GCS must therefore incorporate the moral aspects, because "what is distinctive to global civil society is its innovative network forms and transformative purpose" (2002:345). Religion and churches thus seem to be ideally positioned to provide global values and it is these values that need to be utilised in the fight against HIV/AIDS. However, given the fact that the churches thus far have not been able to act as one body in relation to the challenges posed by HIV/AIDS, the question then arises as to whether they are able to effect the possibility of providing global values. This is an issue to which I shall return later.

Stuvland acknowledges that religion can have "both civilising and polarising tendencies" (2010:211); through its shared values, it can also radicalise and parochialise, thereby being a force for social cohesion, as well at times creating

radicalised communities of belief that can crystallise along racial issues or gender lines. Stuvland suggests that this displays a normative shortcoming in the debate, namely that "religion can and should only contribute *to a certain extent*" (2010:211, Stuvland's emphasis). He says, however, that rather than looking at how religion transforms society or politics, a more valid question is how religion itself becomes transformed in the process both as a contingent process of, and antecedent to, new political ideas. To this end Stuvland focuses on one aspect of the Christian church, namely the emerging church, to see how it engages constructively in a postmodern world to provide a course of normative thinking for the GCS.

In analysing the emerging church, Stuvland documents how it grew as a movement from people who were disenchanted with how "the Christian church – Evangelical, Mainline and Orthodox – engaged culture". Apparently, the group coalesced "around the nagging question of being Christian and postmodern" (Stuvland 2010:213) and more specifically around the question of how Christianity functions or is relevant in the lives or communities and society at large in a postmodern world. The emerging church also "*grapples* with language as an approximation of God" (2010:219) as well as with trying to deconstruct concepts such as love, justice, hope, belief, "emphasising hermeneutics over propositions, interpretation over concretisation" (2010:219). It seeks to rethink "how church is *done* in a decidedly postmodern context" (Stuvland 2010:219). The emerging church movement affirms the universal human striving for spirituality.

In relation to the question of practical living, Stuvland turns to the research undertaken by Gibbs and Bolger (2005) on the emerging church. Such research indicates the emerging church's preference for talking about praxis rather than theory, and ecclesiology rather than epistemology. This necessarily entails asking questions relating to the mission of the church, the centrality of Jesus and what it means to live in community. As we have seen earlier, the emerging church is defined as "communities that practice the way of Jesus in postmodern cultures" (Gibbs & Bolger 2005:44). If, therefore, postmodern culture has relegated religion to the private sphere and it suggests that the secular sphere should be without God, then according to this theory, it is the secular space that is required to be transformed. As Stuvland (2010:221) states:

294

> The dualisms of modernity, especially the sacred/secular, public/private, transcendent/immanent variety, cripple the church and placate the transformative potency of the gospel … A hallmark of the emerging church is to eschew this false dualism from modernity and instead posit a more holistic and complex reality.

Public space therefore does not become a place without God because of legal coercion, but rather a place in which God is already working, in seen and unseen, overt and covert, simple and complex ways. Furthermore, the emerging church does not rely on a linear approach to worship or on a print culture/the written word; it seeks to move beyond the limiting effects of both. So too community is not confined to a Sunday morning corporate spiritual expression of the church, "but rather a practice that permeates space and time and bids people to make space continually for the kingdom of God in all aspects of life" (Stuvland 2010:222). As Gibbs and Bolger (2005:115) put it, emerging churches move away from individualism to people and community to find connectedness with other followers of Christ. By living in community, therefore, people practise the way of Jesus in all realms of culture.

A further aspect that I would suggest is helpful for the church in addressing HIV/AIDS is the fact that the emerging churches engage in politics. Although they are not strictly speaking overtly political, the life and message of Jesus are interpreted as being inherently political. While the church seeks not to be co-opted by a particular political party or demographically defined group, it does think in political terms – and not only about the nation-state but beyond it – to the global situation:

> the emerging church recognises the value of other narratives and other perspectives, especially those outside the confines of the nation state or given culture. This shift is emblematic of a more globalised social reality, a reality in which the church must operate and come to terms with in order to remain relevant … many in the church are calling for a new form of politics altogether – one that reaches outside the nation-state as an ineffective institution and instead relies on dense networks of religious, social and governance institutions (Stuvland 2010:226).

By engaging in the networks of GCS, the emerging church is becoming a dynamic player, linked as it is into issues such as economic globalisation, the global crises of poverty, terrorism, etc. The church is therefore uniquely positioned to take on new roles, provide new meaning and contribute more diversely to issues both of a local and global nature. Because the emerging church is decentralised and relational, it is better able to respond and, furthermore, it is not bound by race, class, nationality or economic status.

Religion too is changing under globalisation: by adapting and transforming, it is better able to serve as a source of global values, all the while taking into account the fact that we live in a pluralistic world, with a multiplicity of "voices and choices, races and places, cultures and religions … lifestyles and ways to be" (Stuvland 2010:230). Recognising this global reality "necessitates a system of values that is not derived of absolutes but rather maximizes its adaptability and fluidity as inherently relational, pluralistic and uncertain" (Stuvland 2010:230). The role of the global church is therefore to articulate *global values (or ethics) without absolutes* and in this way it is able to inform the global values discourse at the heart of GCS (Stuvland 2010:230). Korten expresses this in another way: he says that the focus of organised religion should not be to gain converts, but rather to help each individual discover the power of the integrative values of love, brotherhood and reconciliation as central to the mission of religious faith, whatever that faith might be (1990:191). If the church is therefore to transform values and institutions locally, nationally and internationally, I believe that the emerging church might offer a way of operating in the world that has the potential to make enormous impact in the fight against HIV/AIDS.

If churches are to act as a source for global values, then I would suggest that perhaps they need to rediscover what Pityana (1994:119) describes as "the excitement and charm of ecumenical witness [because it is] at the heart of the faith of the church" and because it has "liberating power [to free churches] from narrow and dogmatic denominationalism", in order to give effect to global values. Pityana goes on to explain that ecumenism is liberating because it frees churches from a sense of self-sufficiency, while also allowing them to recognise their need of others, as well as their own inadequacies.[100]

De Gruchy (1997), however, poses the question whether in the context of religious plurality and multi-culturalism in South Africa today, and particularly where issues do not have the same clear-cut character as they did during the struggle against apartheid, there can be church unity in a postmodern world. His answer is a resounding yes

---

[100] Rusch (2001:46), at the turn of the twenty-first century, defined "ecumenism" and the "ecumenical movement" primarily as referring to the multidimensional movement of churches and Christians "whose goal is both the visible unity of the churches and an integration of mission, service and renewal". He says that it is essentially a movement towards Christian unity, "although not a movement of ecclesiastical self-centeredness" (1997:48). Rusch goes on to explain that from its earliest days, it has been concerned with common service in response to war, poverty and social injustice and to common mission and service to God.

because he says that church unity then was not simply pragmatic, brought about through strategic necessity, but because:

> The unity which [the churches] discovered was rooted in a commitment to Jesus Christ, expressed in worship, as well as social action … It was a unity based on theological substance … that all human beings, irrespective of race, are created in the "image of God" and that God is God of the oppressed and of justice (1997:359).

This is not to say that church unity will not be difficult or problematic. However, just as apartheid was a moral issue, so too I posit that HIV/AIDS is also a moral issue for at its core also lie issues of injustice, such as poverty, unequal access to resources, gender inequality, stigmatisation and so on. The disease therefore presents churches with a theological challenge as to how to respond to it. De Gruchy (1997:363) says that the issue of church unity is not simply one of uniting denominations in common structures and institutions:

> (I)t is also, and even more importantly, about developing *koinonia.*[101]If the major sources of division are, as they have so often been, social, cultural, sexual and political, then church union has to deal with these divisive realities if it is to be an authentic expression of the unity we have in Jesus Christ.

Surely this should provide food for thought for churches so that rather than retreating into their denominational spaces, they unite to confront the further challenges facing South Africa. In this regard it might be helpful for the churches to take cognisance of De Gruchy (2004) who outlines several challenges that South Africa faces in the twenty-first century (including AIDS [2004:234]) and the steps that might be taken in order to address them. Briefly, he says that given the diversity of issues facing the church in South Africa, lessons need to be learned from the church's struggle with apartheid, by bearing in mind seven factors (2004:255-260):

1.   It is important for the church to bear witness in the public arena; "to translate its faith convictions into political praxis" (2004:255), by affirming the public role of theology and the church.

2.   The church must ask itself *how* it should bear witness. To this extent human rights should be regarded as a legitimate locus because it is "congruent with

---

[101] Tanner (1993) defines *koinonia* as communion – communion with God, in faith, sacramental life and in ministry.

the gospel; it draws on the legacy of the past; and it is a language that speaks directly to the public square" (2004:256).

3. We must not expect all church leaders to exercise a leadership role; just as with apartheid, there will only be a few who will exercise a prophetic role. However, church leaders must be expected to raise "a critical consciousness and an empowering spirituality" among (Christian) people (2004:257).

4. Public witness of the church must be ecumenical in nature and include ecumenical agencies, as well as "ecumenism of the streets" (2004:258), that is to say Christians of all denominations coming together to pray together, march, demonstrate, participate etc.

5. The church's witness must include written documents that bear witness to its struggle, clarifying its focus, educating people and coalescing support for the wider political and social struggle (2004:258).

6. Any theological reflection must be contextual, drawing on South Africa's history, the life experiences of the people of South Africa, as well as insights of feminists, African women theologians and also, I would add to De Gruchy, people living with HIV/AIDS (2004:259).

7. The church must finally, also make use of its wider church networks, particularly its international ecumenical links, as these provide an important role in stimulating dialogue and theological engagement.

It is in this manner that I would argue, the churches can come together, as one body, to fight the scourge of AIDS and to uphold global values that are developmental and people-centred in nature and therefore ultimately transformational.

6.4 Conclusion

In adopting a fourth-generation approach mode of engagement and through facilitating a people's movement, the church will have no control over the outcomes. Nonetheless it is possible, to offer a few suggestions as to the implications. In relinquishing its role as arbitrator, it does not mean that the church would avoid making decisions on thorny issues, nor does it mean that church authority would be

disempowered. It could, however, mean wider engagement with a greater number of people and, as a result, greater ownership of its vision of how to address the HIV/AIDS crisis. It will most certainly mean that the church will be approaching HIV/AIDS in a truly developmental, transformational manner that will also impact upon economic and political factors at local, national and international levels that lie at the heart of fuelling the pandemic. Instead of providing temporary, humanitarian relief, the church will be working to address core issues such as poverty, inequality and discrimination. It may also mean that the church is able to build engaged constituencies who are able to mobilise and energise a critical mass of volunteers and voluntary action, committed to addressing developmental issues and rendering care in a way that is people-centred. It will mean that the church will be able to build alliances and partnerships from North to South and East to West that will contribute towards a better understanding of each other's problems, as well as to a more meaningful exchange of information, resources and technology.

In order to do so effectively, however, the church needs, first, to embrace a vision that is broader than the one to which it has hitherto limited itself, and secondly, to accept the challenge to do things differently. Thereafter, the church will need to develop new competencies that not only incorporate, inter alia, advocacy and activism, but also include the use of new technologies that make global action possible, as well as enable social ties and networks to be built across NGOs and countries. In this way a global consciousness can be fostered focusing on our common humanity and dependence on one another. According to my understanding, it is incumbent upon followers of Christianity to not only espouse, but also to demonstrate, that all human beings are children of God, are part of God's family, one body; the scourge of HIV/AIDS demands that members of that body actively work to help, protect and support those of its members who are sick, weak, marginalised or in need.

Bibliography

ABDOOL KARIM, Q. 2004. HIV treatment in South Africa: overcoming impediments to get started. *Lancet* 363(9418):1394.

ACKERMANN, D. M. 2005. HIV and AIDS related stigma: implications for theological education, research, communication and community. *Stigma: implication for the theological agenda,* 46-50. In UNAIDS Report of a theological workshop focussing on HIV and AIDS related stigma. Geneva: UNAIDS (Joint United Nations Programme on HIV and AIDS).

ACKERMANN, D. M. 2006. Doers of the world: public theology as a feminist theology of praxis. A South African perspective. In McGaughey, D. R. & Crocker, C. C. (eds.), *From Biblical Interpretation to Human Transformation: Reopening the Past to Reactualise New Possibilities for the Future. Essays Honouring Herman C Waetjen*, 185-199. Salem, Or: Chora Strangers.

ACKERMANN, D. M. 2008. Ubi caritas? Care as faith in action. In Karpf, T., Ferguson, J. T., Swift, R. & Lazarus, J. V. (eds.), *Restoring Hope: Decent Care in the Midst of HIV/AIDS*, 102-109. Basingstoke, UK: Palgrave Macmillan.

AFRICAN STRATEGIC RESEARCH CORPORATION 2002. *Faith-Based Responses to HIV/AIDS in South Africa: Summary of Findings*. Centres for Disease Control and Prevention: United States Department of Health and Human Services, ASR.

AGUWA, J. C. U. 2010. Religion and HIV/AIDS prevention in Nigeria. *Cross Current* 2(2):208-223.

AIDS REVIEW 2003. Centre for the Study of AIDS. Pretoria: University of Pretoria.

AIDSMAP NEWS 2005. Condoms are an essential component of anti-AIDS strategy says South African Council of Churches. Available at: http://www.aidsmap.com/en/news/D865B4BC-3A99-4E1C-8881-C6D17157A1AO.asp?hp=1, accessed 16 June 2009.

ALBRECHT, S. L., CORNWALL, M. & CUNNINGHAM, P. H. 1988. Religious leave-taking. In Bromley, D. G. (ed.), *Falling from the Faith: Causes and*

Consequences of Religious Apostasy, 62-80. Beverley Hills: Sage Publications.

ALMEN, L. T. 1984. Vocation in a post vocation age. *Word & World* 4(2):131-140.

ALTMAN, D. 1986. *AIDS and the New Puritanism*. London: Pluto.

ALTMAN, D. 1994. *Power and Community: Organizational and Cultural Responses to AIDS*. London: Taylor & Francis.

ALUWALIA, R. & BURNKRANT, R. E. 2004. Answering questions about questions: a persuasion knowledge perspective for understanding the effects of rhetorical questions. *Journal of Consumer Research* 31(1):26-42.

ANDERSON, A. H. 2001. *African Reformation: African Initiated Christianity in the Twentieth Century*. Trenton, New Jersey: Asmara/Africa World Press.

ANDERSON, A. H. 2001. Types and butterflies: African Initiated Churches and European typologies. *International Bulletin of Missionary Research* 25(3):107-113.

ANGLICAN CHURCH OF SOUTHERN AFRICA 2003. Isiseko Sokomeleza. Was available at: http://www.anglicanaids.org, accessed 29 January 2011 (now available at: http://www.anglicanaids.net/programmes.htm).

ANZALA, A. O., SIMONSEN, J. N., KIMANI, J., BALL, T. B., BWAYO, J. J. & NAGELKERKE, N. 2000. Acute sexually transmitted infections increase human immunodeficiency virus type 1 plasma viremia, increase plasma type 2 cytokines and decrease CD4 cell loss. *Journal of Infectious Diseases* 182:459-466.

ARHAP (African Religious Health Assets Programme) 2006. *Appreciating Assets: The Contribution of Religion to Universal Access in Africa*. Report for the World Health Organisation. Available at: http://www.arhap.uct.ac.za/downloads/ARHAPWHO_entire.pdf, accessed 10 December 2010.

ARHAP (African Religious Health Assets Programme) 2006. Executive summaries of two recent research reports. *Journal of Theology for Southern Africa* 126:115-126.

ARHAP/WHO 2006. *Appreciating Assets: The Contribution of Religion to Universal Access in Africa*. Research report for the World Health Organisation. Cape Town: African Religious Assets Programme (ARHAP). Available at: http//www.arhap.uct.ac.za/downloads/ARHAPWHO_appenAtoL.pdf, accessed 10 December 2010.

ART-LINC (Antiretroviral Treatment in Lower Income Countries) 2010. Berne. Available at: http://www.art-linc.org/arv/adult2010/en/index.html, accessed 2 December 2010.

ASSA (ACTUARIAL SOCIETY OF SOUTH AFRICA) 2006. *Biennial Report on the State of the South African HIV/AIDS Epidemic*. Cape Town: Centre for Actuarial Research/Medical Research Council.

ASSEMBLIES OF GOD 1989. AIDS/HIV − Ministry to people with HIV/AIDS, resolution adopted at the 43rd General Council, 1989 (Commission on Doctrinal Purity and the Executive Presbytery). Available at: http://ag.org/top/Beliefs/topics/contempissues_16_aids_ministry.cfm, accessed 20 July 2010.

ATTANASI, K. 2008. Getting in step with the Spirit: applying Pentecostal commitments to HIV/AIDS in South Africa. *Political Theology* 9(2):193-208.

AUVERT, B., BUVE, A., FERRY, B., CARAEL, M., MORISON, L., LAGARDE, E., ROBINSON, N. J., KAHINDO, M., CHEGE, J., RUTENBERG, N., MUSONDA, R., LAOUROU, M. & AKAM, E. 2001. Ecological and individual level analysis of risk factors for HIV infection in four urban populations in sub-Saharan Africa with different levels of HIV infection. *AIDS* 15(4):S15-S30.

AUVERT, B., TALJAARD, D., LAGARDE, E., SOBNGWI-TAMBEKOU, J., SITTA, R. & PUREN, A. 2005. Randomised, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 trial. *PLoS Medicine* 2(11):1112-1122.

BABIKER, A., DARBY, S. & DE ANGELIS, D. 2000. Time from HIV-1 seroconversion to AIDS and death before widespread use of highly active antiretroviral therapy: a collaborative re-analysis. *Lancet* 355(9210):1131-1137.

302

BAILEY, R. C., MOSES, S., PARKER, C., AGOT, K., McCLEAN, I., KRIEGER, J. N., WILLIAMS, C., CAMPBELL, R. T. & NDINYA-ACHOLA, J. O. 2007. Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial. *Lancet* 369(9562):643-659.

BARAL, S., SIFAKIS, F., CLEGHORN, F. & BEYRER, C. 2007. Elevated risk for HIV infection among men who have sex with men in low and middle-income countries 2000–2006: a systematic review. *PLoS Medicine* 4(12):1911.

BARBOUR, T. & TOEWS, N. 2010. The Emergent Church: a methodological critique. *Direction* 39(1):32-40.

BARRETT, D. B., KURIAN, G. T. & JOHNSON, T. M. (eds.) 2001. *World Christian Encyclopaedia: A Comparative Survey of Churches and Religions in the Modern World,* second edition, vol. 2. Oxford: Oxford University Press.

BATE, S. 2003. Catholic pastoral care as a response to the HIV/AIDS pandemic in Southern Africa. *Journal of Pastoral Care and Counselling* 57(2):197-209.

BATE, S. C. (ed.) 2003. *Responsibility in a Time of AIDS: A Pastoral Response by Catholic Theologians and AIDS Activists in Southern Africa*. Johannesburg: St Augustine College of Southern Africa/SACBC AIDS Office.

BELSHAW, D. 2006. Enhancing the development capabilities of civil society organisations: with particular reference to faith-based organisations. *Transformation* 23(3):157-162.

BELSHAW, D., CALDERISI, R. & SUGDEN, C. (eds.) 2001. *Faith in Development: Partnership between the World Bank and the Churches of Africa*. Washington DC: World Bank/Oxford: Regnum Books International.

BENEDICT XVI 2009. Encyclical letter *Caritas in Veritate* (Charity in Truth). Holy See: Libreria Editrice Vaticana.

BIRDSALL, K. 2005. *Faith-Based Responses to HIV/AIDS in South Africa: An Analysis of the Activities of Faith Based Organisations (FBOs) in the National HIV/AIDS Database*. Johannesburg: Centre for AIDS Development, Research and Evaluation (CADRE).

BJORK, S. 2006. The unveiling of the patriarchal church: African women theologians in search of ecclesiological transformation in the struggle against HIV and

AIDS. *Swedish Missiological Themes (Svensk Missions Tidskrift [Uppsala])* 94(3):305-332.

BOULDING, K. E. 1968. The economics of the coming spaceship earth. In Jarrett, H. (ed.), *Environmental Quality in a Growing Economy*, 3-14. Baltimore, MD: Resources for the Future/Johns Hopkins University Press.

BOVENS, L. 2009. Can the Catholic Church agree to condom use by HIV discordant couples? *Journal of Medical Ethics* 35(12):743-746.

BRANDT, A. 1988. AIDS from social history to social policy. In Fee, E. & Fox, D. M. (eds.), *AIDS: The Burdens of History,* 129-138. Berkeley, CA: University of California Press.

BRASHERS, D. E., NEIDIG, J. L., CARDILLO, L. W., DOBBS, L. K., RUSSELL, J. A. & HAAS, S. M. 1999. "In an important way, I did die": uncertainty and revival in persons living with HIV or AIDS. *AIDS Care* 11(2):201-219.

BURNS, F. M., FAYOYA, A. O., COPAS, A. J. & FRENCH, P. D. 2001. Africans in London continue to present with advanced HIV disease in the year of highly active antiretroviral therapy. *AIDS* 15(18):2453-2455.

BUTHELEZI, L. 2011. Delay in generics robbing SA's sick: consumers pay 80% more. *Cape Times* 14 July.

CALDWELL, J. C., CALDWELL, P. & QUIGGIN, P. 1989. The social context of AIDS in sub-Saharan Africa. *Population and Development Review* 15(2):185-234.

CAMPBELL, C. & CORNISH, F. 2003. How has the HIV/AIDS pandemic contributed to our understanding of behaviour change and health promotion? In Ellison, G., Parker, M. & Campbell, C. (eds.), *Learning from HIV and AIDS* 148-177. Biosocial Society of Great Britain, Symposium 2001, Institute of Education. Cambridge, UK: Cambridge University Press.

CAMPBELL, C. 2000. Selling sex in the time of AIDS: the psychosocial context of condom use by Southern African sex workers. *Social Science and Medicine* 50:479-494.

CAMPBELL, C. 2003. *Letting Them Die. Why HIV/AIDS Intervention Programmes Fail*. Oxford: James Currey.

CAPE TIMES SPECIAL SUPPLEMENT 2011. The Arch: looking back on 80 years. *Cape Times* 7 October.

CAROVANO, K. 1992. More than mothers and whores: redefining the AIDS prevention needs of women. *International Journal of Health Services* 21(1):131.

CASTELLS, M. 1996. *The Information Age: Economy, Society and Culture. Volume 1. The Rise of the Network Society*. Oxford: Blackwell.

CASTELLS, M. 1997. *The Information Age: Economy, Society and Culture. Volume 2. The Power of Identity*. Oxford: Blackwell.

CASTELLS, M. 2000. *End of Millennium: The Information Age. Economy, Society and Culture.* Oxford: Blackwell.

CASTELLS, M. 2011. Socio-political movements in the internet age: from Cairo to Barcelona. Unpublished lecture notes. Stellenbosch: STIAS, Stellenbosch University.

CASTELLS, M., FERNANDEZ-ARDEVOL, M., QIU, J. L. & SEY, A. 2007. *Mobile Communication and Society: A Global Perspective*. Cambridge, MA: MIT Press.

CATECHISM OF THE CATHOLIC CHURCH 1995. Kenya: Paulines Publications Africa.

CATHOLIC CHURCH (Symposium of Episcopal Conferences of Africa and Madagascar [SECAM]) 2003. The Church in Africa in the face of the HIV/AIDS pandemic. Pastoral message issued by the Symposium of Episcopal Conferences of Africa and Madagascar (SECAM), World AIDS Day, 1 December 2003, Dakar. (Also available at: http://www.oikoumene.org/resources/documents/other-ecumenical-bodies/church-statements-on-hivaids/episcopal-conferences.html).

CENTRES FOR DISEASE CONTROL (CDC) 1999. *Human Immunodeficiency Virus Infection and Acquired Immunodeficiency Syndrome (AIDS): 1999 Case Definition.* Available at: http://www.cdc.gov/ncphi/disss/nndss/print/aidscurrent.htm, accessed 10 March 2009.

CHATTERJI, M., MURRAY, N., LONDON, D. & ANGELWICZ, P. 2005. The factors influencing transactional sex among young men and women in 12 sub-Saharan African countries. *Biodemography and Social Biology* 52(1/2):56-72.

CHAUKE, A. 2010. Zackie calls for Jon Qwelane protest. *Cape Times* 10 January.

CHERIAN, L. 2004. Influence of culture and religion in HIV/AIDS education in South Africa. Unpublished paper presented at the XV International AIDS Conference, Bangkok, 11 -16 July.

CHISHOLM, F. 2009. Willoughby gives "marvellous performance" at own finale. *Cape Times* 12 August.

CHITANDO, E. 2007. *African Churches and HIV/AIDS 1*. Geneva: World Council of Churches Publications/Risk Book Series.

CLEARY, S. & McINTYRE, D. 2010. Financing equitable access to antiretroviral treatment in South Africa. *BMC Health Services Research* 10(Suppl. 1):1-10.

CLELAND, J., BOERMA, J. T., CARAEL, M. & WEIR, S. S. 2004. Monitoring sexual behaviour in general populations: a synthesis of lessons of the past decade. *Sexually Transmitted Infections* 80(Suppl. 2):S1–S7.

CLIMENHAGA, D. R. 2009. Toward a theology of the environment. *Didaskalia* 20:79-96.

CLOUTIER, D. 2004. Composing love songs for the kingdom of God: creation and eschatology in Catholic sexual ethics. *Journal of the Society of Christian Ethics* 24(2):71-88.

COCHRANE, J. R. 2006. Of bodies, barriers, boundaries and bridges: ecclesial practice in the face of HIV and AIDS. *Journal of Theology for Southern Africa* 126:7-26.

COHEN, M., CHEN, Y., McCAULEY, M., BOLLINGER, R., BRYSON, Y., BURNS, D., CELENTANO D., CHARIYALERTSAK, S., CONRADIE, F., COTTLE, L., DE BRUYN, G., ELHARRAR, V., ESHELMAN, S., ESSEX, M., FILHO, E. C. J., GODBOLE, S., GRINSZTEJN, B., HAKIM, J. G., HOFFMAN, I. F., HOSSEINIPOUR, M., KUMWENDA, J., MAKHEMA, J., MARTINEZ, A., MAYER, K. H., MEHENDALE, S., MILLS, L. A., NIELSEN, K. A., PILOTTO, J. H. D. S., PIWOWAR-MANNING, E.,

SANNE, A., SANTOS, B. R., TAHA, T., WAND, L., SAFREN, S. & FLEMING, T. 2011. Antiretroviral treatment to prevent the sexual transmission of HIV-1: results from the HPNT 052 multinational randomised controlled trial. Paper presented at the IAS Conference on HIV Pathogenesis, Treatment and Prevention, Rome, Italy, 17-20 July.

COLLABORATIVE GROUP ON AIDS AND INCUBATION AND HIV SURVIVAL 2000. Time from HIV-1 seroconversion to AIDS and death before widespread use of highly active antiretroviral therapy: a collaborative re-analysis. *Lancet* 355(9210):1131-1137.

COLLIER, P. 1998. *Social Capital and Poverty*. Washington DC: World Bank.

COLVIN, C. J. & ROBINS, S. 2009. Social movements and HIV/AIDS in South Africa. In Rohleder, P., Swartz, L., Kalichman, S. & Simbayi, L. (eds.), *HIV/AIDS in South Africa 25 Years on: Psychosocial Perspectives,* 155-164. New York: Springer.

CONOLE, G., SCANLON, E., MUNDIN, P. & FARROW, R. 2010. *Interdisciplinary Research: Findings from the Technology Enhanced Learning Research Programme*. Available at: http://www.tlrp.org/docs/TELInterdisciplinarity.pdf, accessed 1 August 2012.

CONRADIE, E. M. 2005. HIV/AIDS and human suffering: where on earth is God? *Scriptura* 89:406-432.

COOK, T. D. & PAYNE, M. R. 2002. Objecting to the objections to using random assignment in educational research. In Mosteller, F. & Boruch, R. (eds.), *Evidence Matters: Randomised Trials in Educational Research,* 150-178. Washington DC: Brookings Institution Press.

CORBITT, G. 1999. HIV testing and screening: current practicalities and future possibilities. In Bennett, R. & Erin, C. A. (eds.), *HIV and AIDS: Testing, Screening and Confidentiality,* 21-38. Oxford: Oxford University Press.

CRESWELL, J. W. 1994. *Research Design: Qualitative and Quantitative Approaches*. London: Sage.

CRIME IN THE HELDERBERG. *The District Mail* 15 September 2011:1.

CULLINAN, K. 2011. Vaccine offering protection against HIV to be tested next in South Africa. *Cape Times* 13 September.

CZERNY, M. & VITILLO, R. J. 2006. The church's role and approaches in HIV/AIDS advocacy. *African Ecclesial Review (Afer)* 47(4/1):274-289.

DAGER, A. J. 2005. The Emergent Church: a new path to ancient religion. *Media Spotlight* (a biblical analysis of religious and secular media) 28(4):1-8.

DARBY, S., EWART, D. W., GIANGRANDE, P. L. F., SPOONER, R. J. D. & RIZZA, C. R. 1996. Importance of age at infection with HIV-1 for survival and development of AIDS in UK haemophilia population. *Lancet* 347(9015):1573-1579.

DAVIES, R. 2009. Long term effects of colonial past might account for scale of HIV pandemic in SA. *Cape Times* 22 July.

DAY, C. & GRAY, A. 2008. Health and related indicators. In Barron, P. & Roma-Reardon, J. (eds.), *South African Health Review,* 239-395. Durban: Health System Trust.

DE GRUCHY, J. W. 1997. Church unity and democratic transformation: perspectives on ecclesiology and ethics in South Africa. *Ecumenical Review* 49(3):356-365.

DE GRUCHY, J. W. with DE GRUCHY, S. 2004. *The Church Struggle in South Africa,* third edition. London: SCM Press.

DE GRUCHY, S. 2004. From church struggle to church struggles. In DE GRUCHY, J. W. with DE GRUCHY, S. *The Church Struggle in South Africa,* third edition, 223-260. London: SCM Press.

DE GRUCHY, S. 2006. Faith, hope and love in a time of AIDS. *Journal of Theology for Southern Africa* 126:2-6 (editorial).

DE OLALLA, P. G., KNOBEL, H., CARMONA, A., GUELARA, A., LOPEZ-COLOMES, J. L. & CAYLA, J. A. 2002. Impact of adherence and highly active antiretroviral therapy on survival in HIV-infected patients. *Journal of Acquired Immune Deficiency Syndromes* 30:105-110.

DE OLIVEIRA, E. R. 1988. The popular movement for health and the church's participation in Boqueirao. *Mission Studies* 5(1):49-63.

DE SENILLOSA, I. 1998. A new age of social movements: a fifth generation of non-governmental development organisations in the making? *Development in Practice* 8(1):44-45.

DE WAAL, A. 2003. A disaster with no name: the HIV/AIDS pandemic and the limits of governance. In Ellison, G., Parker, M. & Campbell, C. (eds.), *Learning from HIV and AIDS: from Multidisciplinary to Interdisciplinary*, 238–267. Biosocial Society of Great Britain, Symposium 2001, Institute of Education. Cambridge, UK: Cambridge University Press.

DELIUS, P. & GLASER, L. 2002. Sexual socialisation in South Africa: a historical perspective. *African Studies* 61(1):27-54.

DENIS, P. 2003. Sexuality and AIDS in South Africa. *Journal of Theology for Southern Africa* 115:63-77.

DENIS, P. 2009. The church's impact on HIV prevention and mitigation in South Africa: reflections of a historian. *Journal of Theology for Southern Africa* 134:66-81.

DEPARTMENT FOR INTERNATIONAL DEVELOPMENT (UNITED KINGDOM) (DfID) 2006. Faith in development. Unpublished position paper. London: Department for International Development (A DfID Practice Paper).

DEPARTMENT OF HEALTH & DEPARTMENT OF SOCIAL DEVELOPMENT (DOH/DSD), REPUBLIC OF SOUTH AFRICA 2003. *Appraisal of Home/Community-Based Care Projects in South Africa 2002-2003*. Pretoria: National Department of Health.

DEPARTMENT OF HEALTH, REPUBLIC OF SOUTH AFRICA 2000. *South African Tuberculosis Programme: Practical Guidelines*. Pretoria: National Department of Health.

DEPARTMENT OF HEALTH, REPUBLIC OF SOUTH AFRICA 2005. *National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa, 2005*. Pretoria: National Department of Health.

DEPARTMENT OF HEALTH, REPUBLIC OF SOUTH AFRICA 2006. *Country Progress Report on Declaration of Commitment on HIV and AIDS, 2006. Reporting period: January 2004 – December 2005*. Prepared for the United

Nations General Assembly Special Session (UNGASS) on HIV and AIDS. Pretoria: National Department of Health.

DEPARTMENT OF HEALTH, REPUBLIC OF SOUTH AFRICA 2006. Social sector cluster media briefing. Pretoria: Department of Health. Available at: http://www.doh.gov.za/docs/pr/2006, accessed on 10 December 2010.

DEPARTMENT OF HEALTH, REPUBLIC OF SOUTH AFRICA 2007. *Health Information Evaluation and Research Report.* November 2007 CCMT Monthly Statistics. Available at: http://www.healthlink.org.za/uploads/files/natDataARV1107.pdf, accessed September 2009.

DEPARTMENT OF HEALTH, REPUBLIC OF SOUTH AFRICA 2007. *HIV and AIDS and STI Strategic Plan for South Africa 2007-2011*. Pretoria: National Department of Health.

DEPARTMENT OF HEALTH, REPUBLIC OF SOUTH AFRICA 2008. *Country Progress Report on Declaration of Commitment on HIV and AIDS, 2008. Reporting period: January 2006 – December 2007.* Prepared for the United Nations General Assembly Special Session (UNGASS) on HIV and AIDS. Pretoria: National Department of Health. Available at: http://data.unaids.org/pub/Report/2008/south_africa_2008_country_progress_report_en.pdf, accessed 13 February 2011.

DEPARTMENT OF HEALTH, REPUBLIC OF SOUTH AFRICA 2010a. *Country Progress Report on Declaration of Commitment on HIV and AIDS, 2010. Reporting period: January 2008 – December 2009*. Prepared for the United Nations General Assembly Special Session (UNGASS) on HIV and AIDS. Pretoria: National Department of Health.

DEPARTMENT OF HEALTH, REPUBLIC OF SOUTH AFRICA 2010b. *National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa, 2009*. Pretoria: National Department of Health.

DEVINE, P. G., PLANT, E. A. & HARRISON, K. 1999. The problems of "us" versus "them" and AIDS stigma. *American Behavioural Scientist* 42:1212-1228.

DILGER, H. 2001. "Living positHIVely in Tanzania": the global dynamics of AIDS and the meaning of religion for international and local AIDS work. *Afrika Spectrum* 36:73-90.

DLANGA, D. 2011. Young people should take the lead. *Cape Times* 4 July.

DOLLEY, C. 2011. Province is South Africa's drug capital: 80% of violent crime fuelled by alcohol and drugs. *Cape Times* 9 September.

DOUGLAS, I. T. 2009. Equipping for God's mission: the missiological vision of the 2008 Lambeth Conference of Anglican Bishops. *International Bulletin of Missionary Research* 33(1):3-6.

DREYER, J. S. & VAN DER VEN, J. A. (eds.) 2002. *Divine Justice - Human Justice. Justice for the Oppressed: the HIV/AIDS Challenge*. Pretoria: Research Institute for Theology and Religious Studies.

DU TOIT, J. 2011. It's time social media started buzzing with HIV/AIDS prevention messages. *Cape Times* 1 June.

DUBE, M. & KANYORO, M. (ed.) 2004. *Grant Me Justice! HIV/AIDS and Gender Readings of the Bible*. Pietermaritzburg: Cluster Publications/Orbis Books.

DUBE, M. 2002. Theological challenges: proclaiming the fullness of life in the HIV/AIDS and global economic era. *International Review of Mission* 91(363):535-549.

DUBE, M. 2004. Grant me justice: towards gender sensitive multi-sectoral HIV/AIDS readings of the bible. In Dube M. & Kanyoro, M. (eds.), *Grant Me Justice! HIV/AIDS & Gender Readings of the Bible,* 3-27. Pietermaritzburg: Cluster Publications/Orbis Books.

DUBE, M. 2005. HIV and AIDS related stigma: responding to the challenge. In UNAIDS report of a theological workshop focusing on HIV and AIDS related stigma, *Stigma: Communicating the Message, Influencing Church Leaders and Members,* 51-62. Windhoek, Namibia: UNAIDS.

DUESBERG, P. 2000. The African AIDS epidemic: new and contagious – or – old under a new name? Available at: http://www.duesberg.com/subject/africa2.html, accessed: 12 February 2009.

DUNKLE, K. L., JEWKES, R. K., BROWN, H. C., GRAY, G. E., McINTYRE, J. A. & HARLOW, S. D. 2004b. Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *Lancet* 363(9419):1415-1421.

DUNKLE, K. L., JEWKES, R. K., BROWN, H., GRAY, G. E., McINTRYRE, J. A. & HARLOW, S. D. 2004a. Transactional sex amongst women in Soweto, South Africa: prevalence, risk factors and association with HIV infection. *Social Science and Medicine* 59(8):1581-1592.

DUNKLE, K. L., JEWKES, R. K., NDUNA, M., JAMA, N., LEVIN, J., SIKWEYIYA, Y. & KOSS, M. P. 2007. Transactional sex with casual and main partners among young South African men in the rural Eastern Cape: prevalence, predictors, and associations with gender-based violence. *Social Science and Medicine* 65(6):1235-1248.

DUTCH REFORMED CHURCH 2003. Statement and commitment of the Dutch Reformed Church in relation to HIV and AIDS. Accepted by the sitting of the General Synod of the Dutch Reformed Church, October 2003. Available at: http://www.kerkweb.org.za/index, accessed 14 November 2010.

ECUMENICAL DOCUMENTS 1981. *A World to the Church: 1980. Mid-Stream* 20(2):191-198.

ELLINGTON, S. R., KING, C. C. & KOURTIS, A. P. 2011. Host factors that influence mother-to-child transmission of HIV-1: genetics, coinfection, behaviour and nutrition. *Future Virology* 6:1451-1469.

ENGEL, D. E. 1970. Elements in a theology of environment. *Zygon* 5(3):216-228.

EPSTEIN, H. 2007. *The Invisible Cure: Africa, the West and the Fight Against AIDS*. London: Penguin Books.

EPSTEIN, S. 1996. *Impure Science: AIDS, Activism and the Politics of Knowledge*. California: University of California Press.

ERASMUS, J. C. & HENDRIKS, H. J. 2003. Religious affiliations in South Africa early in the new millennium: Markinor's World Values Survey. *Journal of Theology for Southern Africa* 117:80-96.

ERASMUS, J. C. & HENDRIKS, H. J. 2005. Religion in South Africa: the 2001 population census data. *Journal of Theology for Southern Africa* 121:88-111.

ERASMUS, J. C. & MANS, G. G. 2005. Churches as service providers for victims of sexual and/or violent crimes: a case from the Paarl community. *Acta Criminologica* 18(1):25.

ERASMUS, J. C. 2005. Religion and social transformation: a case study from South Africa. *Transformation* 22(3):139-148.

ERASMUS, J. C. 2007. Religious demographics in post apartheid South Africa. In Symington, J. (ed.), *South African Christian Handbook 2007-2008,* 81-93. Florida: Christian Info.

ERIKSSON, E., LINDMARK, G., AXEMO, P., HADDAD, B. & AHLBERG, B. M. 2010. Ambivalence, silence and gender differences in church leaders' HIV-prevention messages to young people in KwaZulu-Natal, South Africa. *Culture, Health and Sexuality* 12(1):103-114.

ERIN, C. A. 1999. Is there a right to remain in ignorance? In Bennett, R. & Erin, C. A. (eds.), *HIV and AIDS: Testing, Screening and Confidentiality,* 251-266. Oxford, UK: Oxford University Press.

ETHERIDGE, E. 2011. Hate speech ruling "a personal matter". *Cape Times* 1 June.

EVERY DEATH COUNTS WRITING GROUP 2008. Every death counts: use of mortality audit data for decision making to save the lives of mothers, babies, and children in South Africa. *Lancet* 371(9620):1294–1304.

EVIAN, C. 2000. *Primary AIDS Care,* second edition. Houghton: Jacana.

EVIAN, C. 2003. *Primary HIV/AIDS Care,* fourth edition. Houghton: Jacana.

FAHLBUSCH, E. 1999. Church. In Fahlbusch, E., Lochman, J. M., Mbiti, J., Pelikan, J. & Vischer, L. *The Encyclopaedia of Christianity*, 477-481, 499-502. Grand Rapids, Michigan/Cambridge, UK: Eerdmans/Brill.

FAKOYA, I. 2009. *Faith and HIV in Action – A Training Workshop for Christian Faith Communities: Evaluation Report.* London: UCL Centre for Sexual Health and HIV Research. Available at http://www.ucl.ac.uk/sexual-health/, accessed 08 June 2010.

313

FARMER, P. 1999. *Infections and Inequalities: The Modern Plaques*. Berkley, CA: University of California Press.

FARMER, P. 2005. *Pathologies of Power: Health, Human Rights and the New War on the Poor.* Berkeley, CA: University of California Press

FEAGIN, J. R., ORUM, A. M. & SJOBERG, G. (eds.) 1991. *A Case for the Case Study*. Chapel Hill: University of North Carolina Press.

FENTON, K. A., CHINOUYA, M., DAVIDSON, O. & COPAS, A. 2002. HIV testing and high-risk sexual behaviour among London's migrant African communities: a participatory research study. *Sexually Transmitted Infections* 78(4):241-245.

FENTON, L. 2004. Preventing HIV/AIDS through poverty reduction: the only sustainable solution? *Lancet* 364(9440):1186-1187.

FERRARI, L. L. 2011. Catholic and non-Catholic NGOs fighting HIV/AIDS in sub-Saharan Africa: issue framing and collaboration. *International Relations* 25(1):85-107.

FERREIRA, C. & GROENEWALD, C. 2010. Churches as providers of HIV and Aids care. In Swart, I., Rocher, H., Green, S. & Erasmus J. (eds.), *Religion and Social Development in Post-apartheid South Africa: Perspectives for Critical Engagement,* 175-201. Stellenbosch, South Africa: SUN Press.

FERRY, B., CARAEL, M., BUVE, A., AUVERT, B., LAOUROU, M., KANHONOU, L., DE LOENZIEN, M., AKAM, E., CHEGE, J. & KAONA, F. 2001. Comparison of key parameters of sexual behaviour in four urban populations in sub-Saharan Africa with different levels of HIV infection. *AIDS* 15(Suppl. 4):S41-S50.

FINGER, M. 1994. NGOs and transformation: beyond social movement theory. In Princen, T. & Finger, M. (eds.), *Environmental NGOs in World Politics: Linking the Local and the Global*, 48-66. London: Routledge.

FIRELIGHT FOUNDATION 2008. *From Faith to Action: Strengthening Family and Community care for Orphans and Vulnerable Children in Sub-Saharan Africa*. Available at: http://www.firelightfoundation.org/publication-from-faith-to-action.php, accessed 24 June 2011.

FORD, N. & KOETSAWANG, S. 1999. A pragmatic intervention to promote condom use by female sex workers in Thailand. *Bulletin of the World Health Organisation* 77:888-894.

FOSTER, C. 2006. Disease, suffering and sin: one Anglican's perspective. *Christian Bioethics* 12(2):157-163.

FOSTER, G. 2002. *Understanding Community Responses to the Situation of Children Affected by AIDS: Lessons for External Agencies*. Geneva: UNRISD.

FOSTER, G. 2004. *Study of the Response by Faith-Based Organisations to Orphans and Vulnerable Children*. New York/Nairobi: World Conference of Religions for Peace/UNICEF.

FOSTER, G. 2009. HIV/AIDS policy initiatives. *Family and Community Ministries* 23(2/3):8-19.

FRANKFORT-NACHMIAS, C. & NACHMIAS, D. 1996. *Research Methods in the Social Sciences*, fifth edition. London: St Martin's Press.

FROMM, E. 1976. *The Art of Loving*. London: Unwin.

GANDHI, N. R., MOLL, A., STURM, W., PAWINSKI, R., GOVENDER, T., LALLOO, U., ZELLER, K., ANDREWS, J. & FRIEDLAND, G. 2006. Extensively drug-resistant tuberculosis as a cause of death in patients co-infected with tuberculosis and HIV in a rural area of South Africa. *Lancet* 368(9547):1575–1580.

GARNER, R. 2000. Safe sects: dynamic religion and AIDS in South Africa. *Journal of Modern African Studies* 38(1):41-69.

GEORGE, E. 2011. Reframe global intellectual property principles and promote access to essential medicines. *Indiana Journal of Global Legal Studies* 18(1):167-197.

GEORGE, S. 2011. Voices and visions from the margins on mission and unity: a disability-informed reading of the Pauline metaphor of the church as the body of Christ. *International Review of Mission* 100(1):96-103.

GERMOND, P. 2004. Sex in a globalising world: the South African churches and the crisis of sexuality. *Journal of Theology for Southern Africa* 199:46-68.

GIBBS, E. & BOLGER, R. K. 2005. *Emerging churches: Creating Christian Churches in Postmodern Culture*. Grand Rapids: Baker Academic.

GILL-AUSTERN, BRITA L. 2007. Practices of exclusion fuel the global AIDS crisis. *Journal of Pastoral Theology* 17(1):36-53.

GILLESPIE, S., KADIYALA, S. & GREENER, R. 2007. Is poverty or wealth driving HIV transmission? *AIDS* 21(Suppl. 7):S5-S16.

GILLIES, P. 1998. Effectiveness of alliances and partnerships for health promotion. *Health Promotion International* 13:1-21.

GILMAN, S. L. 1988. *Disease and Representation: The Construction of Images of Illness from Madness to AIDS*. Ithaca: Cornell University Press.

GILSON, L. & MCINTYRE, D. 2002. Experiences from South Africa: dealing with a poor health legacy of apartheid. In Whitehead, M., Evans, T., Diderichsen, F., Bhuiya, A. & Wirth, M. (eds.), *Challenging Inequities in Health: From Ethics to Action*, 190-210. New York: Oxford University Press.

GOODENOUGH, C. 2007. *Faith Based Responses to HIV and AIDS: Examples from JOHAP*, *Case Study Number Seven*. Joint Oxfam HIV and AIDS Programme (JOHAP). Victoria, Australia: Oxfam International Australia.

GOSTIN, L. O., LAZZARINI, Z., JONES, S. & FLAHERTY, K. 1997. Prevention of HIV/AIDS and other blood borne diseases amongst injecting drug users: a national survey on the regulation of syringes and needles. *Journal of the American Medical Association (JAMA)* 277(1):53-62.

GOUWS, E., STANECKI, K. A., LYERLA, R. & GHYS, P. 2008. The epidemiology of HIV infection among young people aged 15–24 years in Southern Africa. *AIDS* 22(Suppl. 4):S5–S16.

GOW, J. 2002. The HIV/AIDS epidemic in Africa: implications of US policy. *Health Affairs* 21:57-69.

GRAY, R. H., KIGOZI, G., SERWADDA, D., MAKUMBI, F., WATYA, S., NALUGODA, F., KIWANUKA, N. & MOULTON, L. H. 2007. Male circumcision for HIV prevention in young men in Rakai, Uganda: a randomized trial. *Lancet* 369(9562):657–666.

GREBE, E. 2011. The Treatment Action Campaign's struggle for AIDS treatment in South Africa: coalition-building through networks. *Journal of Southern African Studies* 37(4):849-868.

GREEN, A. 2003. *Faith Based Organisations: Contributions to HIV Prevention*. Washington DC: United States Agency for International Development (USAID).

GREEN, E. C. 2001. The impact of religious organisations in promoting HIV/AIDS prevention. The Christian Connections for International Health (CCIH) Forum (11 October). Special Double Issue: *Challenges for the Church. AIDS, Malaria, Tuberculosis*. Available at: www.siteresources.worldbank.org, accessed 12 January 2009.

GREGSON, S., GARNETT, G. P. & ANDERSON, R. M. 1994. Assessing the potential impact of the HIV-1 epidemic on orphanhood and the demographic structure of populations in sub-Saharan Africa. *Population Studies* 48:435-458.

GREIG, A., PEACOCK, D., JEWKES, R. & MSIMANG, S. 2008. Gender and AIDS: time to act. *AIDS*, 22(Suppl. 2):S35–S43.

GREYLING, C. 2003. Poverty, HIV and AIDS: the challenge to the church in the new millennium. In Couture P. D. & Miller-McLemore, B. J. (eds.), *Poverty, Suffering and HIV/AIDS: International Practical Theological Perspectives*, 117-136. Cardiff: Cardiff Academic Press.

GRUENWALD, O. 2005. The third culture: an integral vision of the human condition. *Journal of Interdisciplinary Studies* 17(1/2):139-160.

GRUNDMANN, N., ILIFF, P., STRINGER, J. & WILFERT, C. 2011. Presumptive diagnosis of severe HIV infection to determine the need for antiretroviral therapy in children less than 18 months of age. *Bulletin of the World Health Organisation* 89(7):513-521.

GUTHRIE, T. & HICKEY, A. 2004. *Funding the Fight: Budgeting for HIV/AIDS in Developing Countries*. Johannesburg: Institute for Democracy in South Africa (IDASA).

GYSELS, M., POOL, R. & NNALUSIBA, B. 2002. Women who sell sex in a Ugandan trading town: life histories, survival strategies and risk. *Social Science and Medicine* 54:179-192.

HADDAD, B. 2002. Gender violence and HIV/AIDS: a deadly silence in the church. *Journal of Theology for Southern Africa* 114:93-106.

HADDAD, B. 2003a. Gender, development and faith: the church and women's struggle to survive. *Missionalia* 31(3):427-450.

HADDAD, B. 2003b. Choosing to remain silent: the links between gender violence, HIV/AIDS and the South African church. In Phiri, I. A., Haddad, B. & Masenya M. (eds.), *African Women, HIV/AIDS and Faith Communities,* 149-167. Pietermaritzburg: Cluster Publications.

HADDAD, B. 2005. Reflections on the church and HIV/AIDS: South Africa. *Theology Today* 62(1):29-37.

HADDAD, B. 2006a. Living it out: faith resources and sites as critical to participatory learning with rural South African women. *Journal of Feminist Studies in Religion* 22(1):135-154.

HADDAD, B. 2006b. We pray but cannot heal: theological challenges posed by the HIV/AIDS crisis. *Journal of Theology for Southern Africa* 125:80-90.

HADDAD, B., OLIVIER, J. & DE GRUCHY, S. 2008. *The Potential and Perils of Partnership: Christian Religious Entities and Collaborative Stakeholders Responding to HIV and AIDS in Kenya, Malawi and the DRC*. Interim Report of a study commissioned by Tearfund and UNAIDS. Cape Town, South Africa: African Religious Health Assets Programme (ARHAP).

HAKIM, C. 2000. *Research Design: Successful Designs for Social and Economic Research*, second edition. London/New York: Routledge.

HANEFELD, J. 2010. The impact of Global Health Initiatives at national and sub-national level – a policy analysis of their role in implementation processes of antiretroviral treatment (ART) roll-out in Zambia and South Africa. *AIDS Care* 22:93-103.

HARRISON, D. 2009. An overview of health and health care in South Africa 1994-2010: priorities, progress and prospects for new gains. A discussion document

commissioned by the Henry J Kaiser Family Foundation to help inform the National Health Leader's Retreat, Muldersdrift, 24-26 January 2010. Available at: http://www.doh.gov.za/docs/reports/2010/overview1994-2010.pdf, accessed 12 May 2010.

HARVEY, R. 2010. An exploration of "Pentecostal/charismatic" church responses to the HIV and AIDS pandemic in the Western Cape: a policy learning approach. Unpublished Masters dissertation. Cape Town: University of Cape Town.

HEALD, S. 2003. An absence of anthropology: critical reflections on anthropology and AIDS policy and practice in Africa. In Ellison, G., Parker, M. & Campbell, C. (eds.), *Learning from HIV and AIDS,* 210-237. Cambridge, UK: Cambridge University Press.

HEISE, I. & ELIAS, C. 1995. Transforming AIDS prevention to meet women's needs: a focus on developing countries. *Social Science and Medicine* 40(7):933-943.

HENDRIKS, H. J. & ERASMUS, J. C. 2005. Religion in South Africa: the 2001 population census data. *Journal of Theology for Southern Africa* 121:88-111.

HENDRIKS, H. J., ERASMUS, J. C. & MANS, G. G. 2004. Congregations as providers of social service and HIV/AIDS care. *Dutch Reformed Theological Journal (NGTT)* 45(Suppl. 2):380-402.

HENRY J KAISER FAMILY FOUNDATION 2007. *The Global HIV/AIDS Epidemic: HIV/AIDS Policy Fact Sheet.* November 2007.

HIERS, R. H. 1984. Ecology, biblical theology and methodology: biblical perspectives on the environment. *Zygon* 19(1):43-59.

HIV PREVENTION RESOURCE GAP 2003. *Foreign Affairs* 82(3):32-35.

HIV PREVENTION TRAILS NEWORK (HPTN) 2011. Available at: www.hptn.org/research_studies/hptn052.asp, accessed 20 September 2011. Report presented to IAS Conference on HIV Pathogenesis, Treatment and Prevention, Rome, Italy, 17-20 July.

HOLBORN, L. & EDDY, G. 2011. *The First Steps to Healing the South African Family*. Research Paper for the South African Institute of Race Relations.

Johannesburg, South Africa: South African Institute of Race Relations (SAIRR).

HOPE, K. R. 2000. Mobile workers and HIV/AIDS in Botswana. *AIDS Analysis Africa* 10(4):6-7.

HRI (Human Rights Internet) 1998. Speech by Dr Peter Piot. Available at: www.hri.org/news/world/undh/1998/98-12-01.undh.html, accessed 25 January 2011.

HUMAN SCIENCE RESEARCH COUNCIL (HRSC) 2000. Media release from the Human Sciences Research Council, 14 November. Available at: http://www.hsrc.ac.za/media/2000/11/20001114-1.html, accessed 13 January 2008.

ILIFFE, J. 2006. *The African AIDS Epidemic: A History*. Athens, Ohio: Ohio University Press.

INDIA-BRAZIL-SOUTH AFRICA DIALOGUE FORUM (IBSA) 2003. Brasilia Declaration, 6 June 2003. Available at: http://www.ibsa-trilateral.org/index.php?option=com_contentview=article&id=154&Itemid=86 accessed 16 February 2011.

INGLEHART, R. & NORRIS, P. 2004. *Sacred and Secular: Religion and Politics Worldwide*. Cambridge, UK: Cambridge University Press.

INSTITUTE FOR DEVELOPMENT TRAINING 1998. *Religious Health Networks Survey Report.* Los Altos, California: David and Lucille Packard Foundation.

INTERNATIONAL FEDERATION OF THE RED CROSS 2011. A World of Hunger Amid Plenty. Available at: http://www.ifrc.org/en/news-and-media/opinions-and-positions/opinion-pieces/2011/a-world-of-hunger-amid-plenty/, accessed 12 October 2011.

IRONSON, G., STUETZLE, R., IRONSON, D., BALBIN, E., KREMER, H., GEORGE, A., SCHNEIDERMAN, N. & FLETCHER, M. A. 2011. View of God as benevolent and forgiving or punishing and judgmental predicts HIV disease progression. *Journal of Behavioral Medicine 34(6):414-25.*

IRWIN, A. 1995. *Citizen Science: A Study of People, Expertise and Sustainable Development*. London/New York: Routledge.

JACOBS, T. 2003. *Domestic Violence and HIV/AIDS: An Area for Urgent Intervention*. Cape Town: Institute of Criminology, University of Cape Town.

JADAD, A. 1998. *Randomised Controlled Trials*. London: BMJ Books.

JAMES, A., McNAMEE, B. & HORTON, R. 2005. Rapid review in the Lancet and beyond. *Lancet* 366(9480):115.

JAMES, S. 2011. Lost in the fray: state HIV/AIDS policies in South Africa and their impact on women. *Canadian Journal of Development Studies* 27(2):195-210.

JEWKES, R., DUNKLE, K., NDUNA, M. & SHAI, N. 2010. Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study. *Lancet* 376(9734):41-48.

JEWKES, R., SIKWEYIYA, Y., MORRELL, R. & DUNKLE, K. 2009. *Understanding Men's Health and Use of Violence: Interface of Rape and HIV in South Africa.* Technical Report. Pretoria: Medical Research Council. Available at: http://www.mspsouthafrica.org/files/pag/264510/violence_hiv.pdf, accessed 11 October 2009.

JOHN PAUL II 1984. *On the Christian Meaning of Human Suffering*: *Salvifici Doloris (*Apostolic Letter). Holy See: Libreria Editrice Caticana.

JOHN PAUL II 1988. Encyclical Letter *Sollicitudo Rei Socialis. AAS* 80:513-586.

JOHNSON, D. H. 2008. Emerging churches: reflections from a traditionalist seminary dean. *Didaskalia (Otterburne, Man.)* 19(1):161-177.

JOHNSON, K. 2008. Between self-help and dependence: donor funding and the fight against HIV/AIDS in South Africa. *Africa* 78(4):496-539.

JOLLY, A. M., MUTH, S. Q., WYLIE, J. L. & POTTERAT, J. J. 2001. Sexual networks and sexually transmitted infections: a tale of two cities. *Journal of Urban Health* 78:433-445.

JONES, G. 2011. Figures show a steady decline in crime: murders down 6.5% but rape and ATM blasts "a worry". *Cape Times* 9 September.

KAHN, T. 2008. Aspen queries HIV treatment numbers. *Business Day* 26 February.

KALICHMAN, S. C., SIMBAYI, L., KAGEE, A., TOEFY, Y., JOOSTE, S., CAIN, D. & CHERRY, C. 2006. Associations of poverty, substance abuse, and HIV transmission risk behaviour in three South African communities. *Social Science and Medicine* 62(7):1641-1649.

KANT, I. 1993. *Grounding for the Metaphysics of Morals*, third edition, (*Grundlegung zur Metaphysik der Sitten* (1785), translated by Ellington, J. W.). Indianapolis: Hackett.

KANTER, R. M. 1972 *Commitment and Community: Communes and Utopias in Sociological Perspective*. Cambridge, MA: Harvard University Press.

KAPP, C. 2006. South African health minister must go, say scientists. *Lancet* 368(9542):1141-1142.

KAREITHI, S., ROGERS, J. & MARSH, R. 2005. Transformation within the HIV/AIDS context: lessons from the Fikelela initiative in the diocese of Cape Town. *Transformation* 22(2):106-114.

KEANE, J. 2003. *Global Civil Society?* Cambridge: Cambridge University Press.

KEEFE, R. H., LANE, S. D. & SWARTS, H. J. 2006. From the bottom up: tracing the impact of four health-based social movements on health and social policy. *Journal of Health and Social Policy* 21(3):55-69.

KEENAN, J. F. 2007. Can we talk? Theological ethics and sexuality. *Theological Studies* 68(1):113-131.

KEIKELAME, M. J., MURPHY, C. K., RINGHEIM, K. E. & WOLDEHANNA, A. 2010. Perceptions of HIV/AIDS leaders about faith-based organisations' influence on HIV/AIDS stigma in South Africa. *African Journal of AIDS Research* 9(1):63-70.

KELLY, A. 2009. The body of Christ has AIDS: the Catholic Church responding faithfully to HIV and AIDS in Papua New Guinea. *Journal of Religion and Health* 48(1):16-28.

KIBEL, M., LAKE, L., PENDLEBURY, S. & SMITH, C. (eds.) 2010. *South African Child Gauge 2009/2010*. Cape Town: Children's Institute/University of Cape Town. Available at: http://www.health-

e.org.za/documents/9a274e0aeb2e0aac13f9769547a4ebbb.pdf#page=132, accessed 14 September 2010.

KIMANI, V. N. 2004. Human sexuality: meaning and purpose in selected communities in contemporary Kenya. *Ecumenical Review* 56(4):404-421.

KLEIN, G. 1959. Christian love according to 1 Corinthians 13. *Concordia Theological Monthly* 30(6):432-445.

KLUCKOW, M. 2004. *Psychological Support for Orphans and Vulnerable Children. Study Guide for DYD218-4*. Pretoria: University of South Africa.

KNOX, P. 2008. *AIDS, Ancestors and Salvation: Local Beliefs in Christian Ministry to the Sick*. Kenya: Paulines Publications Africa.

KOEGELENBERG, R. A. 2001. Social development partnerships between religious communities and the state: perspectives from the National Religious Association for Social Development (NRASD). *Journal of Theology for Southern Africa* 110:97-109.

KOEGELENBERG, R. A. 2007. A creative church-state development partnership. In Symington, J. (ed.), *South African Christian Handbook 2007 -2008*, 31-38. Florida: Christian Info.

KOPELMAN, L. M. & VAN NIEKERK, A. A. 2002. AIDS and Africa. *Journal of Medicine and Philosophy* 27:139-142.

KORTEN, D. C. 1987. Third generation NGO strategies: a key to people-centred development. *World Development* 15 (Suppl.):145-159.

KORTEN, D. C. 1990. *Getting to the 21st Century: Voluntary Action and the Global Agenda*. West Hartford: Kumarian Press.

KORTEN, D. C. 1995. Building citizen agendas for the twenty-first century. *Conrad Grebel Review* 13(3):321-333.

KRONER, R. 1948. A meditation on 1 Cor XIII. *Anglican Theological Review* 30(4):216-210.

KUMPHITAK, A., CAWTHORNE, P., LAKHONPHOL, S., KASI-SEDAPAN, S., SANAEHA, S. & WILSON, D. 1999. Zidovudine to prevent mother-to-infant

HIV transmission in developing countries: a view from Thailand. *Tropical Medicine and International Health* 4(3):236-237.

LAHER, F., CESCON, A., LAZARUS, E., KAIDA, A. & MAKONGOZA, M. 2012. Conversations with mothers: exploring reasons for prevention of mother-to-child transmission (PMTCT) failures in the era of programmatic scale-up in Soweto, South Africa. *AIDS and Behavior* 16(1):91-98.

LANE, T., RAYMOND, H. F., DLADLA, S., RASETHE, J. & STRUTHERS, H. 2009. High HIV prevalence among men who have sex with men in Soweto, South Africa: results from the Soweto men's study. *AIDS and Behavior* 15(3):626-634.

LANKESTER, T. 2008. In Karpf, T., Ferguson, T., Swift, R. & Lazarus, V. (eds.), *Restoring Hope: Decent Care in the Midst of HIV/AIDS.* Basingstoke, UK: Palgrave Macmillan. *HIV Medicine* 9(Suppl. 2):27

LASCH, C. 1990. Religious contributions to social movements: Walter Rauschenbusch, the social Gospel and its critics. *Journal of Religious Ethics* 18(1):7-25.

LAURANCE, J. 2009. Vaccine heralds a new dawn in the fight against AIDS. *The Sunday Independent* 27 September.

LAWSON, L. 2008. *Side Effects: The Story of AIDS in South Africa.* Cape Town: Double Storey Books.

LEVY, J. A. 2007. *HIV and the Pathogenesis of AIDS,* third edition. Washington DC: ASM Press.

LEWIS, S. 2009. Science voice is key to breaking the chain of AIDS (an edited version of a speech by Stephen Lewis at the opening of the International Aids Society Conference on Pathogenesis, Treatment and Prevention in Cape Town). *Cape Times* 22 July.

LIFE APPLICATION STUDY BIBLE 1997. New International Version. Illinois: Tyndale House Publishers Inc.

LIKATAVICIUS, G. & VAN DE LAAR, M. J. 2010. HIV and AIDS in the European Union, 2009. *Euro Surveillance* 15(48):pii:19737. Available at:

http://www.eurosurveillance.org/ViewArtcile.aspx?ArtcileId=19737, accessed 12 December 2010.

LINDEN, J. A. 2011. Care of the adult patient after sexual assault. *New England Journal of Medicine* 365:834-841.

LISK, F. 2009. *Global Institutions and the HIV/AIDS Epidemic: Responding to an International Crisis*. Global Institutions Series. London/New York: Routledge/Taylor & Francis Group.

LIVINGSTON, J. 2002. Longing for the Queen of England: AIDS, nostalgia and epidemiological transition in Botswana. Paper presented at the conference on Anthropology and the Health of Populations, Brunel University: UK, June 2002.

LOGAN, W. (ed.) 1988. *The Kairos Covenant: Standing with South African Christians*. New York: Friendship.

LOUW, L. & KOEGELENBERG, R. A. 2003. Building a new South Africa: the building of a caring, democratic and equitable society through partnerships between the State and the National Religious Leaders' Forum (NRLF). Position paper prepared for the NRLF meeting with President Thabo Mbeki, 29-30 April 2003. A perspective from the National Religious Association for Social Development (NRASD. 11 July 2005). Available at: http://sarpn.org.za/documents/d0000557/index.php, accessed on 15 April 2008.

LOW-BEER, D. & STONEBURNER, R. L. 2003. Behaviour and communication change in reducing HIV: is Uganda unique? *African Journal of AIDS Research* 2:9-21.

MACMASTER, L. L. M. 2008. Where have all the pastors gone? A case for public pastoral care in a democratic South Africa experiencing growth pains. *Journal of Pastoral Theology for Southern Africa* 132:3-15.

MACPHAIL, C. & CAMPBELL, C. 1999. Evaluating HIV-prevention programmes: do current indicators do justice to advances in intervention? *South African Journal of Psychology* 29:149-165.

MAGETO, P. 2005. A silent church = death: a critical look at the church's response to HIV/AIDS. *Currents in Theology and Mission* 32(4):291-298.

MAGEZI, V. & LOUW, D. J. 2006. Congregational home-based pastoral care: merging the African family and the church family systems for effective HIV ministry. *Journal of Theology for Southern Afric*a 125:64-79.

MAKOBA, T. 2011. Corruption threatens our dream: red card campaign. *Cape Times* 26 August.

MANDELL, G. L., BENNETT, J. E. & DOLIN, E. (eds.) 2009. *Mandell, Douglas & Bennett's Principles and Practice of Infectious Diseases*. Philadelphia: Churchill Livingstone/Elsevier.

MARSH, R. & KAREITHI, R. 2005. *Fikelela AIDS Project: Youth and Sexuality Research, Ages 12-19, in the Diocese of Cape Town, South Africa*. Cape Town: Fikelela AIDS Project.

MARSHALL, K. & KEOUGH, L. 2004. *Mind, Heart & Soul in the Fight Against Poverty*. Washington DC: World Bank.

MARSHALL, M. & TAYLOR, N. 2006. Tackling HIV and AIDS with faith-based communities: learning from attitudes on gender relations and sexual rights within local evangelical churches in Burkina Faso, Zimbabwe and South Africa. *Gender and Development* 14(3):363-374.

MARTINSON, N. A., BARNES, G. L., MOULTON, L. H., MSANDIWA, R. & HAUSLER, H. 2011. New regimes to prevent tuberculosis in adults with HIV infection. *New England Journal of Medicine* 365(1):11-20.

MASHAU, T. D. 2008. Where and when it hurts most: the theology of hope and accompaniment in the context of HIV and AIDS in marriage and family life. *Exchange* 37(1):23-34.

MATHERS, B. M., DEGENHARDT, L., PHILLIPS, B., WIESSING, L., HICKMAN, M., STRATHDEE, S. A., WODAK, A., PANDA, S., TYNDALL, M., TOUFIK, A. & MATTICK, R. P. 2008. Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review. *Lancet* 372(9651):1733–1745.

MAY, J. & METH, C. 2007. Dualism or underdevelopment in South Africa: what does a quantitative assessment of poverty, inequality and employment reveal? *Development Southern Africa* 24(2):271-288.

MAY, J. (ed.) 1998. *Poverty and Inequality in South Africa*. Durban: Office of the Executive Deputy President.

MAZAMISA, W. 2009. Personal interview (lecturer and specialist in African Theology, Department of Religious Studies, University of Cape Town), 18 May.

MBEKI, T. 1999. Address to National Council of Provinces, 28 October. Available at: www.info.gov.za/speeches/1999/991028409p1004.htm, accessed 3 June 2008.

MBEKI, T. 2001. Speech at Fort Hare University, 21 October. Available at: www.info.gov.za/speeches/2001/011016442p1001.htm, accessed 25 June 2009.

MBEMBE, A. 2011. Malema makes promises youth hear: suspended revolution. *Cape Times* 27 August.

MBITI, J. S. 1969. *African Religions and Philosophy*. London: Heinemann.

MBUAGBAW, J., FOUDA, A., LOHOUE, J. & EKOBO, A. S. 2006. A comparative study of parasitic and fungal infections in HIV positive and negative subjects in the urban setting of Yaounde. *Internet Journal of Internal Medicine* 6(1):6.

MCFARLAND, D. A. 2007. Clanging symbols. *Religion and Theology* 14(1/2):84-93.

McGUIRE, M. B. 1997. *Religion – The Social Context*. Belmont: Wadsworth Publications.

McINNES, C. 2006. HIV/AIDS and security. *International Affairs* 82(2):315-327.

McKNIGHT, S. 2007. Five streams of the emerging church: key elements of the most controversial and misunderstood movement in the church today. *Christianity Today* 51(2):35-39.

McKNIGHT, S. 2008. McLaren emerging: in his last two books, Brian McLaren presents more clearly than ever his vision of the gospel. *Christianity Today* 52(9):58-63.

McLAREN, B. D. 2003. The method, the message and the ongoing story. In Sweet, L. (ed.), *The Church in Emerging Culture: Five Perspectives,* 191-234. Grand Rapids: Zondervan.

McLAREN, B. D. 2004. *A Generous Orthodoxy*. Grand Rapids, MI: Youth Specialty Books.

McLAREN, B. D. 2006. *The Secret Message of Jesus: Uncovering the Truth that Could Change Everything*. Nashville, Tenn: Nelson Thomas Inc.

McLAREN, B. D. 2007. *Everything Must Change: Jesus, Global Crisis and A Revolution of Hope*. Nashville, Tenn: Nelson Thomas Inc.

MELUCCI, A. 1989. *Nomads of the Present. Social Movements and Individual Needs in Contemporary Society.* Philadelphia: Temple University Press.

MERRY, M. S. 2004. On evil, sin and suffering: toward a hermeneutic of their relation. *Journal of Pastoral Care and Counselling* 58(1/2):75-82.

MESSER, D. E. 2004. *Breaking the Conspiracy of Silence: Christian Churches and the Global AIDS Crisis*. Minneapolis: Fortress Press.

METHODIST CHURCH CONNEXIONAL TASK FORCE ON HIV/AIDS 2001. Methodist response to HIV/AIDS in Southern Africa. Available at: http://www.methodist.co.za/aids_strategy.asp, accessed 20 January 2011.

METHODIST CHURCH OF SOUTHERN AFRICA 2005a. Programmatic Response to the HIV/AIDS Pandemic. Available at: http://www.methodist.co.za/aids_strategy.asp, accessed 22 January 2011.

METHODIST CHURCH OF SOUTHERN AFRICA 2005b. Resolution of the Methodist Church of Southern Africa National Conference (Aug-Sep 2005).

MIDGLEY, J. & TANG, K. 2001. Introduction: social policy, economic growth and developmental welfare. *International Journal of Social Welfare* 10(4):244-252.

MIDGLEY, J. 1995. *Social Development: The Developmental Perspective in Social Welfare*. London: Sage Publications.

MILLER, J. R. & ROBERT, L. 2009. A rock in a weary land: AIDS, South Africa and the Church. *Social Work in Public Health* 24(1/2):22-38.

MINISTRY OF SOCIAL DEVELOPMENT 2004. Minister Skweyiya and religious leaders agree on closer cooperation in tackling poverty, unemployment, crime and HIV/ADS. Media Release, 20 July 2004. Available at: www.socdev.gov.za, accessed on 20 April 2008.

MOILA, M. P. 2000. Caring in traditional African society. *Bulletin for Contextual Theology in Africa* 7(1):21.

MORAR, N. S., RAMJEE, G., GOUWS, E. & WILKINSON, D. 2003. Vaginal douching and vaginal substance use among sex workers in KwaZulu Natal, South Africa. *South African Journal of Scie*nce 99(7/8):371-374.

MORRIS, M. & KRETZSCHMAR, M. 1995. Concurrent partnerships and transmission dynamics in networks. *Social Networks* 17:299-318.

MUNRO, A. 2003. Responsibility: the prevention of HIV/AIDS. In Bate S. C. (ed.), *Responsibility in a Time of AIDS: A Pastoral Response by Catholic Theologians and AIDS Activists in Southern Africa,* 32-51. Linden, Johannesburg: St Augustine College of Southern Africa.

MUNROE, A. 2002. Belated but powerful: the response of the Catholic Church to HIV/AIDS in five Southern African countries. Unpublished paper presented at the XIV International AIDS Conference, Barcelona, 7-12 July.

MWAURA, P. N. 2007. Integrity of mission in the light of the gospel: bearing witness of the spirit among Africa's gospel bearers. *Mission Studies* 24(2):189-212.

MYERS, B. L. 2008. Relief and Development. In Dyrness, W. A. & Karkkainen, V. M. (eds.), *Global Dictionary of Theology*, 739-745. Downers Green, Illinois: Intervarsity Press.

NARAYAN, D. (ed.) 2001. *Voices of the Poor*. Washington DC: World Bank.

NATIONAL ACADEMIES REPORT (Committee on Facilitating Interdisciplinary Research, Committee on Science, Engineering, and Public Policy) 2004.

Facilitating Interdisciplinary Research. Washington: National Academy Press.

NATIONAL PLANNING COMMISSION 2011. *Diagnostic Report*. Office of the Presidency, South Africa, June 2011. Available at: http://www.npconline.co.za/ , accessed 14 September 2011.

NATIONAL SCIENCE RESEARCH FOUNDATION 2011. *Interdisciplinary Research.* Available at: http://www.nsf.gov/od/oia/additional_resources/interdisciplinary_research/definition.j sp, accessed 1 August 2012.

NATTRASS, N. 2004. *The Moral Economy of AIDS in South Africa*. Cambridge: Cambridge University Press.

NDLOVU, N. 2005. *Monitoring AIDS Treatment Rollout in South Africa: Lessons from the Joint Civil Society Monitoring Forum*. Budget Brief No. 161, IDASA Budget Information Service. Cape Town: Institute for Democracy in South Africa (IDASA).

NEOCOSMOS, M. 2003. Neoliberalism versus state nationalism: beyond state thinking in Southern Africa. *Journal of Contemporary African Studies* 21(2):341-358.

NEUMAN, L. W. 2000. *Social Research and Method: Qualitative and Quantitative Approaches*, fourth edition. Needham Heights: Allyn & Bacon.

NEW APOSTOLIC CHURCH n.d. Church policy on HIV and AIDS (by Chief Apostle, Wilhelm Leber). Unpublished document.

NEW ENGLISH BIBLE WITH APOCRYPHA 1971. New York: Oxford University Press.

NEXT WAVE. About Next Wave. Available at: http://www.the-next-wave.org/about, accessed 22 April 2012.

NICHOLSON, R. 1995. *AIDS: A Christian Response*. Pietermaritzburg: Cluster Publications.

NICOLSON, R. 1994. AIDS: the ethical issues. *Missionalia* 22(3):227-244.

NIEBUHR, R. 1932. *Moral Man and Immoral Society: A Study in Ethics and Politics*. New York: Scribner's.

NODEN, B. H., GOMES, A. & FERREIRA, A. 2010. Influence of religious affiliation and education on HIV knowledge and HIV-related sexual behaviour amongst unmarried rural youth in Central Mozambique. *AIDS Care* 22(10):1285-1294.

NORDSTOKKE, K. 2000. *Through the Mud: Reflections on Diakonia*. Oslo: Andre Publications.

NOUWEN, H. J. M. 1977. Compassion: the core of spiritual leadership. *Worship* 51(1):11-23.

NOUWEN, H. J. M. 1998. *Sabbatical Journey: The Journey of His Final Year*. New York: Crossroads.

OECD/UNAIDS 2004. *Measuring Aid in Support of HIV/AIDS Control*. Available at: www.oecd.org/stats/dac/crs/hivaids, accessed 11 October 2011.

OGDEN, J., ESIM, S. & GROWN, C. 2006. Expanding the care continuum for HIV/AIDS: bringing carers into focus. *Health Policy and Planning* 21(5):333-342.

ORGANISATION FOR ECONOMIC COOPERATION AND DEVELOPMENT (OECD) 2007. *Institutionalising Sustainable Development*. Stockholm, Sweden: OECD Publishing.

OSLINGTON, P. 2011. *Caritas in Veritate* and the market economy: how do we reconcile traditional Christian ethics with economic analysis of social systems? *Journal of Markets and Morality* 14(2):359-371.

OXFORD ENGLISH DICTIONARY (third edition) 2006. Online version, available at: http://www.oed.com/view/Entry/238214, accessed 1 November 2011.

OZROVECH, S. 2002. *Filled with the Holy Spirit*: *A Daily Devotional*. s.l., South Africa: Lux Verbi BM.

PACKARD, R. & EPSTEIN, P. 1991. Epidemologists, social scientists and the structure of medical research on AIDS in Africa. *Social Science and Medicine* 33:771-794.

PADAYATCHI, N., NAIDOO, K., DAWOOD, H., KHARSANY, A. & KARIM, Q. A. 2010. *A Review of Progress on HIV, AIDS and Tuberculosis.* Durban: Health Systems Trust.

PARKHURST, J. 2001. The crisis of AIDS and the politics of response: the case of Uganda. *International Relations* 15:69-87.

PARRY, C., PETERSEN, P., DEWING, S., CARNEY, T., NEEDLE, R., KROEGER, K. & TREGER, L. 2008. Rapid assessment of drug-related HIV risk among men who have sex with men in three South African cities. *Drug and Alcohol Dependence* 95(1/2):45–53.

PARRY, S. 2003 *Responses of the Faith-Based Organisations to HIV/AIDS in Southern Africa*. Geneva: World Council of Churches.

PARRY, S. 2005. Mapping study: responses of the churches to HIV and AIDS in South Africa. In *Resource Material for Churches and Communities: Ecumenical HIV/AIDS Initiative in Africa,* CD, section 3:1-20. Geneva: World Council of Churches.

PATEL, L. 2005. *Social Welfare and Social Development in South Africa*. Cape Town: Oxford University Press.

PATERSON, D. L., SWINDELLS, S., MOHR, J. & BRESTER, M. 2000. Adherence to protease inhibitor therapy and outcomes in patients with HIV infection. *Annals of Medicine* 133:21-30.

PATHFINDER INTERNATIONAL 2005. *Preventing Mother-to-Child Transmission of HIV in Kenya*. New York: Pathfinder Press.

PATTERSON, G. 2005. *AIDS-related Stigma: Thinking Outside the Box. The Theological Challenge*. Geneva: Ecumenical Advocacy Alliance.

PEARSON, S. & MAKADZANGE, P. 2008. Health-seeking behaviour for sexual-health concerns: a qualitative study of men in Zimbabwe. *Culture, Health and Sexuality* 10(4):361-376.

PEEL, J. 1977. Conversion and tradition in two African societies: Ijebu and Buganda. *Past and Present* 77:108-141.

PELTZER, K., RAMLAGAN, S., JOHNSON, B. D. & PHASWANA-MAFUYA, N. 2010. Illicit drug use and treatment in South Africa: a review. *Substance Use and Misuse* 45(13):2221-2243.

PEPFAR 2005. *Engendering Bold Leadership: The President's Emergency Plan for AIDS Relief*. First Annual Report to Congress. Available at: http://www.state.gov/s/gac/rl/cl4961.htm, accessed 25 April 2009.

PETTIFOR, A. E., MEASHAM, D. M., REES, H. V. & PADIAN, N. S. 2004. Sexual power and HIV risk, South Africa. *Emerging Infectious Diseases* 10(11):1996-2004.

PETTIFOR, A. E., REES, H. V., STEFFENSON, A., HLONGWA-MADIKIZELA, L., McPHALL, C., VERMAAK, K. & KLEINSCHMIDT, L. 2004. *HIV and Sexual Behaviour Among South Africans: A National Survey of 15 – 24 Year Olds*. Johannesburg: Reproductive Health Research Unit, University of Witwaterstrand.

PEW FORUM ON RELIGION AND PUBLIC LIFE 2006. *Spirit and Power: A 10-Country Survey of Pentecostals*. Washington DC: Pew Research Centre.

PEW RESEARCH CENTRE PUBLICATIONS 2009. *Pew Forum on Religion and Public Life: Religion in South Africa 15 Years After the End of Apartheid*. Available at: http://www.religiousintelligence.co.uk/country/?CountryID=158, accessed 18 January 2011.

PHAROS DICTIONARY ENGLISH-XHOSA, XHOSA-ENGLISH 2004. Cape Town: Pharos Dictionaries.

PHIRI, A. P., HADDAD, B. & MASENYA, M. 2003. *African Women, HIV/AIDS and Faith Communities*. Pietermaritzburg, South Africa: Cluster Publications.

PHIRI, I. A. 2003. African women of faith speak out in an HIV/AIDS era. In Phiri, I. A., Haddad, B. & Masenya, M. (eds.), *African Women, HIV/AIDS and Faith Communities*, 3-22. Pietermaritzburg, South Africa: Cluster Publications.

PHIRI, I. A. 2004. Theological response in mission. *Ecumenical Review* 56(4):422-431.

PHIRI, I. A. 2010. HIV/AIDS: an African theological response in mission. In Kwok, P. (ed.), *Hope Abundant*, 219-228. Maryknoll, NY: Orbis Books.

PIOT, P., KAZATCHKINE, M., DYBUL, M. & LOB-LEVYT, J. 2009. AIDS: lessons learnt and myths dispelled. *Lancet* 374(9685):260-263.

PITYANA, B. 1994. Christian witness and the unity of the churches. *International Review of Mission* 83(3):115-212.

POPE JOHN PAUL II 2001. *Message of John Paul II to the Secretary General of the United Nations Organisation, 25/06/2001*. Available at: http://www.cabsa.org.za/book/export/html/3689, accessed 30 January 2011.

POTTER, P. A. & MATTHEY, J. 2002. Mission. In Lossky, N., Bonino, J. M., Pobee, J., Stransky, T. F., Wainwright, G. & Webb, P. (eds.), *Dictionary of the Ecumenical Movement*, second edition, 783-790. Geneva/Grand Rapids, Michigan: World Council of Churches/Eerdmans.

PUTNAM, R. D. 1996. The strange disappearance of civic America. *The American Prospect* 7:24.

QAKISA, M. 2002. Let's talk about sex: reaching young people through the media in the age of AIDS. *Journal of Theology for Southern Africa* 114:79-92.

QUINN, T. C., WAWER, M. J., SEWANKAMBO, A. N. & SERWADDA, D. 2000. Viral load and heterosexual transmission of human immunodeficiency virus type 1. *New England Journal of Medicine* 342(13):921-929.

RAO GUPTA, G. 2002. Gender, sexuality, and HIV/AIDS: the what, the why, and the how. Paper presented at the Plenary Session of the XIII International AIDS Conference in Durban, South Africa, 9-14 July.

RAUSCHENBUSCH, W. 1917. *A Theology for the Social Gospel*. New York: Macmillan.

REHLE, T., SETSWE, G., PILLAY, V., METCALF, C., JOOSTE, S., RISPEL, L. & SEKHOBO, J. P. 2007. *Assessing the Impact of HIV and AIDS Prevention and Care Programmes in South Africa*. Report to the Department of Science & Technology. Cape Town, South Africa: HSRC.

RELIGIOUS INTELLIGENCE 2009. *South Africa: Country Profile*. Available at: http://www.religious_intelligence.co.uk/country/?CountryID=158, accessed 8 February 2011.

RICHARDS, L. 1987. Church. In Richards, L. (ed.), *The Zondervan Dictionary of Christian Literacy: Key Concepts of the Faith*, 48-52. Grand Rapids, Michigan: Zondervan.

RICHARDSON, N. 2006. A call for care: HIV/AIDS challenges in the church. *Journal of Theology for Southern Africa* 125:38-50.

RITSCHL, D. 1987. *The Logic of Theology: A Brief Account of the Relationship Between Basic Concepts in Theology*. Philadelphia, Pa: Fortress.

ROBINS, S. 2008. *From Revolution to Rights in South Africa: Social Movements, NGOs and Popular Politics after Apartheid*. Durban, South Africa/ Woodbridge, UK: University of KwaZulu-Natal Press/James Currey.

ROBINS, S. 2011. TAC film opens space for debate. *Cape Times* 18 October.

ROOT, R. & VAN WYNGAARD, A. 2011. Free love: a case study of church–run home-based caregivers in a high vulnerability setting. *Global Public Health* 6(Suppl. 2):S174-S191.

ROOT, R. 2009. Religious participation and HIV-disclosure rationales among people living with HIV in rural Swaziland. *African Journal of AIDS Research* 8(3):295-309.

ROSALES-MENDOZA, S., RUBIO-INFANTE, N., GOVEA-ALONSO, D. & FUORENO-FIERROS, L. 2012. Current status and perspectives of plant-based candidate vaccines against the human immunodeficiency virus (HIV). *Plant Cell Reports* 31(3):495-511.

ROSE, N. 2007. *The Politics of Life Itself: Biomedicine, Power and Subjectivity in the Twenty-First Century*. Princeton, NJ/Oxford: Princeton University Press.

ROTELLO, G. 1997. *Sexual Ecology: AIDS and the Destiny of Gay Men*. New York: Dutton.

RUNGANGA, A. & KASULE, J. 1995. The vaginal use of herbs/substances: an HIV transmission facilitatory factor? *AIDS Care* 7(5):639-645.

RUSCH, W. G. 2001. Ecumenism, ecumenical movement. In Fahlbusch, E., Lochman, J. M., Mbiti, J., Pelikan, J. & Vischer, L. *The Encyclopaedia of Christianity*, 46-60. Grand Rapids, Michigan/Cambridge, UK: Eerdmans/Brill.

RUSSELL, K. A. 2002. Neighbor. *Living Pulpit* 11(3):1-49.

RUTLEDGE, F. 2008. When God disturbs the peace. *Christianity Today* 52:30-33.

SAAYMAN, W. & KRIEL, J. 1992. *AIDS, The Leprosy of Our Time? Towards a Christian Response to AIDS in Southern and Central Africa*. Johannesburg: Orion.

SAAYMAN, W. 1992. AIDS, healing and culture in Africa: a Christian mission perspective. *Journal of Theology for Southern Africa* 78:41-56.

SACC (South African Council of Churches). 1985. *The Kairos Document. Challenge to the Church: A Theological Comment on the Political Crisis in South Africa*. Braamfontein: Skotaville.

SAETHRE, E. & STADLER, J. 2009. A tale of two "cultures": HIV risk narratives in South Africa. *Medical Anthropology* 28(3):268-284.

SANYAOLU, A. O., OYIBO, W. A., FEGBENRO-BEYIOKU, A., GBADEGESHIN, A. H. & IRIEMENAM, N. C. 2011. Comparative study of entero-parasitic infections amongst HIV sero-positive and sero-negative patients in Lagos, Nigeria. *Acta Tropica* 120(3):268-272.

SAPA-APF. 2011. Obese people now outnumber hungry around the world – survey. *Cape Times* 23 September.

SCAER, D. P. 1977. Man made in the image of God and its relationship to the first promise. *Concordia Theological Quarterly* 41(3):20-35.

SCHILLER, N. G., CRYSTAL, S. & LEWELLEN, D. 1994. Risky business: the cultural construction of AIDS risk groups. *Social Science and Medicine* 38(10):1337-1346.

SCHMIDT, A. J. 2004. *How Christianity Change the World*. Grand Rapids: Zondervan.

SCHNEIDER, H. & LEHMANN, U. 2010. Lay health workers and HIV programmes: implications for health systems. *AIDS Care* 22(Suppl. 1):60-67.

SCHNEIDER, H., COETZEE, D., VAN RENSBURG, D. & GILSON, L. 2010. Differences in antiretroviral scale-up in three South African provinces: the role

of implementation management. *BMC Health Services Research* 10(Suppl. 1): 1-10.

SCHNEIDER, H., HLOPHE, H. & VAN RENSBERG, D. 2008. Community health workers and the response to HIV/AIDS in South Africa: tensions and prospects. *Health Policy and Planning* 23(3):179-187.

SCHONNING, S. 2010. Is there enough political commitment and funding? Paper presented to the XVIII International AIDS Conference, Vienna, Presentation no: THSY0104, 18-23 July. Available at: http://www.aidsmap.com/Less-than-10-of-East-European-prevention-spending-is-for-vulnerable-groups/page/1497950/, accessed on 13 September 2010.

SCHOUB, B. D. 1999. *AIDS and HIV in Perspective: A Guide to Understanding the Virus and its Consequences,* second edition. Cambridge: Cambridge University Press.

SCOTT, E. L. 2010. A theological critique of the emerging, postmodern missional church/movement. *Evangelical Review of Theology* 34(4):335-346.

SEEDAT, M., VAN NIEKERK, A., JEWKES, R., SUFFLA, S. & RATELE, K. 2009. *Violence and Injuries in South Africa: Prioritising an Agenda for Prevention*. Available at: http://press.thelancet.com/saser5.pdf, accessed 26 August 2009.

SEEWALD, P. & POPE BENEDICT XVI 2010. *Light of the World: The Pope, the Church and the Sign of the Times*. Rome: Ignatius Press.

SEFFNER, F., GARCIA, J., MUNOZ-LABOY, M. & PARKER, R. 2011. A time for dogma, a time for the Bible, a time for condoms: building a Catholic theology of prevention in the face of public health policies at Casa Fonte Colombo in Porto Alegre, Brazil. *Global Public Health* 6(Suppl. 2):S271-S283.

SEN, A. 1992. *Inequalitiy Reexamined*. New York, NY: Russell Sage Foundation.

SHAW, M. 1994. Civil society and global politics: beyond a social movements approach. *Millennium* 23(3):647-667.

SHELTON, J., HALPERIN, D., NANTULYA, V., POTTS, M., GAYLE, H. & HOLMES, K. K. 2004. Partner reduction is crucial for balanced "ABC" approach to HIV prevention. *British Medical Journal (BMJ)* 328:891-893.

SHILTS, R. 1987. *And the Band Played On: Politics, People and the AIDS Epidemic*. London: Penguin.

SHISANA, O., PELTZER, K., ZUNGU-DIRWAYI, N. & LOUW, J. 2005b. *The Health of our Educators: A Focus on HIV/AIDS in South African Public Schools, 2004/5 Survey*. Cape Town: HSRC Press.

SHISANA, O., REHLE, T., SIMBAYI, L. C., PARKER, W., ZUMA, K., BHANA, A., CONNOLLY, C., JOOSTE, S. & PILLAY, V. 2005a. *South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005*. Cape Town: Human Sciences Research Council Press. Available at: http://www.hsrc.ac.za/media/2005/11/20051130_1.html, accessed 12 April 2009.

SHISANA, O., SIMBAYI, L. C., REHLE, T., ZUNGU, N. P., ZUMA, K., NGOGO, N., JOOSTE, S., PILLAY-VAN WYK, V., PARKER, W., PEZI, S., DAVIDS, A., NWANYANWU, O. & DINH, T. H. 2010. *South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2008: The Health of Our Children.* Cape Town: HSRC Press.

SHOUB, B. 1987. AIDS in South Africa – a time for action. *South African Medical Journal (SAMJ)* 6:677.

SHUMAN, J. 1999. *The Body of Compassion: Ethics, Medicine and the Church*. Colorado: Westview Press.

SIMUNDSON, D. J. 1982. Health and healing in the Bible. *Word & World* 2(4):330-339.

SINGH, J. A., GOVENDER, M. & REDDY, N. 2005. South Africa a decade after apartheid: realising health through human rights. *Georgetown Journal on Poverty, Law and Policy* 12(3):355-388.

SINYINZA, F., WALKER, A. S., MULENG, V., SINYINZA, F., LISHIMPI, K., NUNN, A., CHINTU, C. &, GIBB, D. 2004. Prognostic markers of survival in HIV-infected children in the CHAP trial, Zambia. Paper presented at the XI Conference on Retroviruses and Opportunistic Infections, San Francisco, abstract 154. (Also available in 2006 *Journal of Acquired Immune Deficiency Syndromes [JAIDS]* 42(5):637-645).

SKORDIS, J. & NATTRASS, N. 2002. Paying to waste lives: the affordability of reducing mother-to-child transmission of HIV in South Africa. *Journal of Health Economics* 21(3):405-421.

SMIT, D. J. 2007. On the impact of the church in South Africa after the collapse of the apartheid regime. In Smit, D. & Conradie, E. M. (ed.), *Essays in Public Theology: Collected Essays 1*, 57-74. Stellenbosch: SUN Press.

SMITH, A. D., TAPSOBA, P., PESHU, N., SANDERS, E. J. & JAFFE, H. W. 2009. Men who have sex with men and HIV/AIDS in sub-Saharan Africa. *Lancet* 374(9687):416-422.

SONNENBERG, P., GLYNN, J. R., FIELDING, K., MURRAY, J., GODFREY-FAUSSETT, P. & SHEARER, S. 2005. How soon after infection with HIV does the risk of tuberculosis start to increase? A retrospective cohort study in South African gold miners. *Journal of Infectious Diseases* 191(2):150–158.

SOUTH AFRICAN HIV CLINICIANS SOCIETY 2005. *Guidelines for Antiretroviral Therapy in Adults.* Available at: http://www.sahivsoc.org, accessed on 5 March 2009.

SPARKS, A. & TUTU, M. 2011 *Tutu: The Authorised Portrait*. Johannesburg: Pan Macmillan.

SPARKS, A. 2011. Malema is failing the new generation. *Cape Times* 6 July.

SQUIRE, C. 2007. *HIV in South Africa: Talking About the Big Thing*. London/New York: Routledge/Taylor Francis Group.

STATISTICS SOUTH AFRICA 2001. *Population Census 2001*. Available at: http://www.statssa.gov.za/census01/html/default.asp, accessed 16 May 2010.

STEVENS, M., SINANOVIC, E., REGENSBERG, L. & HISLOP, M. 2007. HIV and AIDS, STI and TB in the private sector: health care delivery. *South African Health Review 2007*. Durban: Health Systems Trust. Available at: http://www.hst.org.za/publications/711, accessed 15 May 2011.

STIMSON, G., DONOGHOE, M., ALDRITT, L. & DOLAN, K. 1989. Syringe exchange programmes for injecting drug users. *AIDS* 3(5):253-260.

STOCKMAN, J., STRATHDEE, K. & STEFFANIE, A. 2010. HIV among people who use drugs: a global perspective of populations at risk. *AIDS Journal of Acquired Immune Deficiency Syndromes* 55(Suppl. 1):S17-S22.

STRIMER, P. 2005. The emerging church. *Episcopal Voice*, June.

STUVLAND, A. 2010. The emerging church and global civil society: post modern Christianity as a source for global values. *Journal of Church and State* 52(2):203-231.

SUMARTOJO, E. 2000. Structural factors in HIV prevention: concepts, examples and implications for research. *AIDS* 14(Suppl. 1):S3-S10.

SUNDERLAND, R. H. & SHELP, E. E. 1987. *AIDS: A Manual for Pastoral Care*. Philadelphia: Westminster Press.

SWART, I. 2005. Networks and partnerships for social justice? The pragmatic turn in the religious social development debate in South Africa. *Religion and Theology* 12(1):20-47.

SWART, I. 2006. *The Churches and the Development Debate: Perspectives on a Fourth Generation Approach*. Stellenbosch, South Africa: SUN Press.

SWART, I. 2010. The third republic: hermeneutical key to the theological debate on the church and development? In Swart, I., Rocher, H., Green, S. & Erasmus, J. (eds.), *Religion and Social Development in Post-Apartheid South Africa: Perspectives for Critical Engagement*, 213. Stellenbosch, South Africa: SUN Press.

SWART, I., ROCHER, H., ERASMUS, J. & GREEN, S. (eds.) 2010. *Religion and Social Development in Post Apartheid South Africa: Perspectives for Critical Engagement*. Stellenbosch, South Africa: SUN Press.

TAC [Treatment Action Campaign] 2008. *Key HIV Statistics*. Available at: http://www.tac.org.za/community/keystatistics, accessed 12 December 2010.

TANNER, M. 1993. The time has come: a vision for a fifth world conference on faith and order. *Ecumenical Review* 45(1):4-10.

TAYLOR, N. 2006. *Working together? Challenges and Opportunities for International Development Agencies and the Church in the Response to AIDS*

in Africa. Tearfund HIV and AIDS briefing paper 7. Teddington, Middlesex: Tearfund.

TAYLOR, R. 2002. Interpreting global civil society. *Voluntas: International Journal of Voluntary and Non-profit Organisations* 13(4):339-347.

TEST DRIVE 2011. *Cape Times* (opinion page) 13 September.

THOM, A. 2009a. HIV statistics horrify delegates at conference. *Cape Times* (Health-e News), 22 July.

THOM, A. 2009b. G8 failure to renew Aids commitment is criminal – scientists. *Cape Times (*Health-e News), 20 July.

THOMAS, L. E. 2008. What the mind forgets, the body remembers: HIV/AIDS in South Africa – a theological and anthropological issue. *Currents in Theology and Mission* 35(4):276-286.

THORN, H. 2006. Solidarity across borders: the transnational anti-apartheid movement. *Voluntas: International Journal of Voluntary and Non-profit Organisations* 17(4):285-301.

THUNG, M. A. 1978. Alternative model for missionary church: an approach of the sociology of organisations. *Ecumenical Review* 30(1):18-31.

TOEFY, Y. 2009. HIV/AIDS, religion and spirituality. In Rohleder, P., Swartz, L., Kalichman, S. C. & Simbayi, L. C. (eds.), *HIV/AIDS in South Africa 25 Years On: Psychosocial Perspectives,* 237-250. New York: Springer.

TSHABALALA-MSIMANG, M. 2006. Opening address at the Global Fund Replenishment Conference, Durban, South Africa, 4-5 July 2006. In *UNAIDS 2006 Report on the Global AIDS Epidemic*. Available at: www.unaids.org, accessed 12 October 2011.

TUCKER, G. M. 1977. Rain on a land where no one lives: the Hebrew Bible on the environment. *Journal of Biblical Literature* 116(1):3-17.

TULLY, M. 2008. *India's Unending Journey*. London: Rider/Ebury Publishing.

TURKLE, S. 2011. *Alone Together: Why We Expect More from Technology and Less from Each Other*. New York: Basic Books.

TURNER, V. 1969. *The Ritual Process: Structure and Anti-structure*. Chicago: Aldine.

TUROK, B. 1995. The struggle for the RDP: material power versus moral power. In Koegelenberg, R. (ed.), *The Reconstruction and Development Programme (RDP): The Role of the Church, Civil Society and NGOs,* 147-170. Belville: EFSA.

TUTU, D. 1985. How can you say you love God, whom you have not seen, when you hate your brother whom you have seen? *Engage/Social Action* 13(D):18-19.

TUTU, D. 2010. Ending violence and criminal sanctions based on sexual orientation and gender identity. Address to the United Nations Human Rights Council, Geneva, 12 September. Available at: http://arc-international.net/global-advocacy/human-rights-council/hrc15/panel-tutu-en, accessed 12 December 2010.

TYNDALE, W. 2000. Faith and economics in "development": a bridge across the chasm? *Development in Practice* 10(1):9-18.

UN SECURITY COUNCIL 2000 (July). *Resolution 1308*. Available at: http://www.un.org/Docs/sc/unsc_resolutions.html, accessed 19 September 2011.

UNAIDS (Joint United Nations Programme on HIV/AIDS) 2001. *Gender and HIV/AIDS*. Geneva: UNAIDS.

UNAIDS (Joint United Nations Programme on HIV/AIDS) 2002. *Report on the Global HIV/AIDS Epidemic*. Geneva: UNAIDS.

UNAIDS (Joint United Nations Programme on HIV/AIDS) 2006. *The Global AIDS Epidemic: a UNAIDS 10th Anniversary Special Edition*. Available at: www.unaids.org/en/HIV_data/2006GlobalReport/default.asp, accessed 14 December 2010.

UNAIDS (Joint United Nations Programme on HIV/AIDS) 2008a. *Global Report 2008: UNAIDS Report on the Global AIDS Epidemic 2008*. Geneva: WHO/UNAIDS. Available at http://www.unaids.org, accessed 13 October 2009.

UNAIDS (Joint United Nations Programme on HIV/AIDS) 2008b. *Annual Report: Towards Universal Access*. Geneva: UNAIDS.

UNAIDS (Joint United Nations Programme on HIV/AIDS) 2008c. *Status of the Global HIV Epidemic, 2008*. Geneva: UNAIDS.

UNAIDS (Joint United Nations Programme on HIV/AIDS) 2008d. *Religion and AIDS*. Available at: http://www.unaids.or/en/Partnerships/Civil+society/religionAndAids.asp, accessed 12 January 2010.

UNAIDS (Joint United Nations Programme on HIV/AIDS) 2010. *Global Report 2010: UNAIDS Report on the Global AIDS Pandemic 2010*. Geneva: UNAIDS. Available at: http://www.unaids.org/en/KnowledgeCentre/HIVData/CountryProgress/2010CountryProgressAllCountries.asp and at http://www.unaids.org/GlobalReport/golbal_report/htm, accessed 29 January 2011.

UNDP (United Nations Development Programme) 1999. *The Human Development Report*. New York, NY: Oxford University Press.

UNGASS (United Nations General Assembly Special Session) 2010. *Country Progress Reports 2010*. Geneva: UNAIDS. Available at: http://www.unaids.org/fact_sheets/ungass/index.html, accessed on 16 December 2010.

UNICEF 2006. *South Africa – Statistics*. Available at: http://www.unicef.org/southafricalhiv_aids_729.html, accessed 15 May 2010.

UNICEF 2007. *Children and AIDS: A Stocktaking Report*. New York: UNICEF.

UNICEF 2008. *The Importance of Christian Advocacy Efforts for Children Suffering from the HIV/AIDS Epidemic.* Multiple Indicator Cluster Surveys, Demographic and Health Surveys and AIDS Indicator Surveys, 2007. Available at: http://www.uniteforchildren.org.knowmore-28702.htm#image4, accessed 17 March 2010.

UNICEF, UNAIDS, USAID 2004. *Children on the Brink*. New York: UNICEF.

UNITED NATIONS COMMISSION ON HUMAN RIGHTS 2005. *Economic, Social and Cultural Rights, Item 10. 61st Session of the Commission on Human Rights.* (Intervention of Archbishop Tomasi, Permanent Observer of the Holy See to the UN, 30 March).

UPI (United Press International) 1998. AIDS conference tries to close the gap. 25 June.

URCSA (Uniting Reformed Church in Southern Africa) 2005. Press statement on the HIV/AIDS situation. 30 November. Issued by Daniel Kuys, media spokesperson for the Moderamen of the General Synod of the Uniting Reformed Church.

URDR (Unit for Religion and Development Research) 2005. *Transformation Research Project: Report on the Demographic Profile of the Helderberg Basin, a Comparative Analysis Describing the Demographics of your Area.* Stellenbosch, South Africa: URDR, Stellenbosch University.

VAN ARKEL, J de J (ed.) 1991. *Living in an AIDS Culture.* Pretoria: University of South Africa.

VAN DER WESTHUIZEN, C. 2010. Fracas over media freedom could be a turning point for civil society. *Cape Times* 06 September.

VAN DYK, A. 2008. *HIV/AIDS Care and Counselling: A Multidisciplinary Approach*, fourth edition. Pinelands, Cape Town: Pearson Education.

VAN DYK, A. C. & VAN DYK, P. A. 2003a. "What is the point of knowing?": psychosocial barriers to HIV/AIDS voluntary counselling and testing programmes in South Africa. *SA Journal of Psychology* 33(2):118-125.

VAN DYK, A. C. & VAN DYK, P. A. 2003b. "To know or not to know": service-related barriers to voluntary HIV counselling and testing (VCT) in South Africa. *Curationis* 26(1):4-10.

VAN KLINKEN, A. S. 2008. The body of Christ has AIDS: a study of the notion of the body of Christ in African theologies responding to HIV and AIDS. *Missionalia* 36(2/3):319-336.

VANDORMAEL, A. 2007. The TAC's "intellectual campaign" (2000-2004): social movements and epistemic communities. *Politikon* 34(2):217-233.

VETTEN, L. & BHANA, K. 2001. *Violence, Vengeance and Gender: A Preliminary Investigation into Links Between Violence Against Women and HIV/AIDS in South Africa*. Johannesburg: Centre for the Study of Violence and Reconciliation.

VOGELS, W. 1994. The human person in the image of God: Gn. 1:26. *Science et Esprit* 46(2):189-202.

VOLBERDING, P. A. & DEEKS, S. G. Antiretroviral therapy and management of HIV infection. *Lancet* 376(9734):49-62.

VOLF, M. 1996. *Exclusion and Embrace: A Theological Exploration of Identity, Otherness and Reconciliation*. Nashville: Abingdon.

WALKER, R. B. J. 1994. Social movements/world politics. *Millennium* 23(3):669-700.

WALSCH, J. C., HORNE, R., DALTON, M., BURGESS, A. P. & GAZZARD, B. G. 2001. Reasons for non-adherence to antiretroviral therapy: patients' perspectives provide evidence of multiple causes. *AIDS Care* 13(6):790-720.

WAMOYI, J., STONES, W. & FENWICK, A. 2008. Women's bodies are shops – beliefs about transactional sex and implications for understanding gender, power and HIV prevention in Tanzania. Paper presented at the XVII International AIDS Conference, Mexico City, 3-8 August. Available at: www.aids2008.org/Pap/Psession, accessed 13 September 2009.

WANING, B., DIEDRICHSEN, E. & MOON, S. 2010. A lifeline to treatment: the role of Indian generic manufacturers in supplying antiretroviral medicines to developing countries. *Journal of the International AIDS Society* 13(1):13-35.

WASSERMAN, H. 2007. Is a new worldwide web possible? An explorative comparison of the use of ICTs [Information and Communication Technologies] by two South African social movements. *African Studies Review* 50(1):109-131.

WATNEY, S. 1987. *Policing Desire*. New York: Routledge.

WATTS, C. & GARCIA-MORENO, C. 2000. Violence against women: its importance for HIV/AIDS prevention and care. *AIDS* 14(Suppl. 3):S253-S265.

WEBER, M. 1977. Science as Vocation. In Weber, M. *Essays in Sociology*. New York: Oxford University Press, 129-156. (Translated by Gerth H. H. & Wright Mills, C.).

WEBER, M. 1978. *Economy and Society: An Outline of Interpretative Sociology*. Berkley, CA: University of California Press.

WEISER, S. D., LEITER, K., BANGSBERG, D. R., BUTLER, L. M., PERCY DE KORTE, F., HLANZE, Z., PHALADZE, N., IACOPINO, V. & HEISLER, M. 2007. Food insufficiency is associated with high risk sexual behaviour among women in Botswana and Swaziland. *PLoS Medicine* 4(10):1589-1598.

WEISS, E. & RAO GUPTA, G. 1998. *Bridging the Gap: Addressing Gender and Sexuality in HIV Prevention.* Washington, DC: International Center for Research on Women.

WEISS, E., RAO GUPTA, G. & WHELAN, D. 2000. Gender, sexuality and HIV: making a difference in the lives of young women in developing countries. *Sexual Relationship Therapy* 15(3):233-245.

WEST, G. & ZENGELE, B. 2006. The medicine of God's word: what people living with HIV and AIDS want (and get) from the Bible. *Journal of Theology for Southern Africa* 125:51-63.

WEST, G. 2003. Reading the Bible in the light of HIV/AIDS in South Africa. *Ecumenical Review* 55(4):335-344.

WEST, M. 1975. *Bishops and Prophets in a Black City*. Cape Town, South Africa: David Philip.

WHITE, T. J. 2002. Diakonia. In Lossky, N., Bonino, J. M., Pobee, J., Stransky, T. F., Wainwright, G. & Webb, P. (eds.), *Dictionary of the Ecumenical Movement*, second edition, 305-310. Geneva/Grand Rapids, Michigan: World Council of Churches/Eerdmans.

WHITESIDE, A. & PARKHURST, J. 2010. Innovative responses for preventing HIV transmission: the protective value of population-wide interruptions of risk activity. *Southern African Journal of HIV Medicine* 37:19-21.

WHITESIDE, A. & SUNTER, C. 2000. *AIDS: The Challenge for South Africa*. Cape Town: Human & Rousseau/Tafelberg.

WHO (World Health Organisation) 2000. *Fact Sheets on HIV/AIDS: A Desktop Reference*. Geneva:WHO.

WHO (World Health Organisation) 2005. *WHO Clinical Staging System for HIV/AIDS and HIV/AIDS Definitions for Surveillance*. Available at: http://www.who.int/hiv/pub/guidelines/clinicalstaging.pdf, accessed 25 April 2009.

WHO (World Health Organisation) 2006. *The World Health Report 2006 – Working Together for Health.* Geneva: World Health Organization. Available at: http://www.who.int/whr2006/en, accessed 09 November 2009.

WHO (World Health Organisation) 2007a. *Global Tuberculosis Control: Surveillance, Planning, Financing*. Geneva: WHO.

WHO (World Health Organisation) 2007b. *Appreciating Assets: Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho*. Available at: http://www.arhap.uct.ac.za/, accessed 25 September 2008.

WHO (World Health Organisation) 2010a. *Antiretroviral Therapy for HIV Infection in Infants and Children: Towards Universal Access*. Revised edition. Geneva: World Health Organization. Available at: http://www.who.int/entity/hiv/pub/paediatric/infants2010/en/index.html, accessed 12 September 2010.

WHO (World Health Organisation) 2010b. *Antiretroviral Therapy for HIV Infection in Adults and Adolescents: Recommendations for a Public Health Approach.* Revised edition. Geneva: World Health Organization. Available at: http://www.who.int/hiv/pub/Abstracts.aspx?AID=3822, accessed 05 December 2010.

WILEY, D. J., VISSCHER, B. R., GROSSER, S., HOOVER, D. R., DAY, R., GANGE, S., CHMIEL, J. S., MITSUYASU, R. & DETELS, R. B. 2000. Evidence that anoreceptive intercourse with ejaculate exposure is associated with rapid CD4 cell loss. *AIDS* 14(6):707-715.

WILLIAMS, G. (ed.) 2007. *Called to Care* (A toolkit comprising: *Positive Voices*, *Making it Happen*, *Time to Talk*). St Albans, Herts: Strategies for Hope Trust.

WINFIELD, F. 1995. For nothing can separate us from the love of Jesus Christ. *Ecumenical Review* 47(3):364-372.

WOOD, C. & ELLISON, G. T. H. 2003. What have clinicians learnt from working with HIV/AIDS? A medical perspective from London. In Ellison, G., Parker, M. & Campbell, C. (eds.), *Learning from HIV and AIDS,* 111-147. Cambridge: Cambridge University Press.

WOOD, E., BRAITSTEIN, P., MONTANER, J. S. G., SCHECHTER, M. T., TYNDALL, M. W., O'SHAUGHNESSY, M. V. & HOGG, R. S. 2000. Extent to which low level use of antiretroviral treatment could curb the AIDS epidemic in sub-Saharan Africa. *Lancet* 355(9221):2095-2100.

WOOD, R., FOX, M., CONRADIE, F., CORNELL, M., DEHLINGER, M., INGRAM, C., IVE, P., ORRELL, C., PANCHIA, R., RASSOOL, M., STEVENS, W., TRUTER, H., VAN DER HORST, C., ZEINECKER, J., MCINTYRE, J. & SANNE, I. 2009. Nurse management is not inferior to doctor management of ARV patients: the CIPRA South Africa randomized trial. Paper presented at the V IAS Conference on HIV Pathogenesis, Treatment and Prevention, Cape Town, South Africa, 19–22 July (Abstract LBPED03). Available at: http://www.ias2009.org/pag/, accessed 11 October 2010.

XINGWANA, L. 2009. This is not art! *Cape Times* 29 April.

YIN, R. K. 2009. *Case Study Research: Design and Methods*. Applied Social Research Methods Series, Volume 5. California: Sage.

Personal interviews

BISHOP VV 2006. Personal interview (Bishop, Anglican Church), 16 August.

CANON U 2008. Personal interview (Priest, Ecumenical & Public Relations & Training, Anglican AIDS & Healthcare Trust), 06 August.

CHURCH ELDER A 2008. Personal interview (Elder, Anointed Christian Ministries [Pentecostal] Church), Zola, 12 July.

FATHER C 2006. Personal interview (Priest, Catholic Church, Helderberg Basin), 25 July.

FATHER E 2006. Personal interview (Priest, Catholic AIDS Network, Athlone), 08 June.

FATHER P 2006. Personal interview (Priest, HOPE Association Project, Cape Town), 05 July.

HOME-BASED CARE VOLUNTEER B 2008. Personal interview (home-based care volunteer, Methodist Church, Somerset West), 16 July.

IMAM JJ 2008. Personal interview (Imam, mosque, Helderberg Basin), 01 July.

IMAM S 2008. Personal interview (Imam, mosque, Helderberg Basin), 31 July.

IMAM UU 2008. Telephone interview (Imam & spokesperson for Muslim Judicial Council of the Islam Peace University of South Africa), 31 July.

LAY MINISTER TT 2006. Personal interview (Lay minister, Anglican Church, Sir Lowry's Pass), 28 July.

LAY MINISTER V 2008. Personal interview (Lay minister/church warden, Anglican Church, Macassar), 24 July.

MAZAMISA, W. 2009. Personal interview (Lecturer and specialist in African Theology, Department of Religious Studies, University of Cape Town), 18 May.

MINISTER D 2006. Personal interview (Minister, Calvinist Protestant Church, Macassar), 06 August.

MINISTER DD 2006. Personal interview (Minister, Helderberg Dutch Reformed Church), 02 August.

MINISTER FF 2008. Personal interview (Minister, Anglican Church, HIV/AIDS spokesperson, Fikelela ["We are reaching out"] AIDS Project, False Bay Diocese), 08 August.

MINISTER H 2008. Personal interview (Minister, Bizweni Community Church), 15 July.

MINISTER HH 2009. Personal interview (Reverend, Seventh Day Adventist Church), 29 April.

MINISTER I 2008. Personal interview (Umfundizi [Minister], Zionist Christian Church, Lwandle), 17 October.

MINISTER K 2006. Personal interview (Minister, Methodist Church, Helderberg Basin), 02 August.

MINISTER LL 2008. Personal interview. (Minister, Dutch Reformed Church, Helderberg Basin), 10 July.

MINISTER M 2008. Personal interview (Minister, Methodist Church, Lwandle), 18 July.

MINISTER N 2008. Personal interview (Minister, Strand Baptist Church), 15 July.

MINISTER O 2008 Personal interview (Minister, Every Nation Church [part of Vineyard Group]), 04 July.

MINISTER QQ 2008. Personal interview (Minister, Helderberg Christian Church), 16 July.

MINISTER T 2009. Personal interview (Minister, New Apostolic Church), 29 April.

MINISTER W 2008. Personal interview (Minister, Anointed Christian Ministries, [Pentecostal Church], Zola), 08 September.

MINISTER WW 2008. Personal interview (Minister, United Church), 02 July.

MINISTER Z 2008. Personal interview (Reverend, Rustof Methodist Church), 17 July.

MRS CC 2006. Personal interview (Lay counsellor and HIV/AIDS support group facilitator for Philippi Trust), 23 August.

MRS EE 2006. Personal interview (Lay minister [and minister's wife], Ephesians Faith Mission Church of South Africa, Sir Lowry's Pass), 16 August.

MRS R 2006. Personal interview (Elder [and Pastor's wife], Kronieke Pinkster Gospel Church, Sir Lowry's Pass), 02 August.

PASTOR MM 2006. Personal interview (Pastor, Rhema Good Hope Church, [charismatic/Pentecostal church], Macassar), 24 August.

PASTOR SS 2008. Personal Interview (Pastor, Bethesda Evangelical Church, Rustof, Strand), 15 July.

REV. G 2008. Personal interview (Reverend, Baptist Church, Lwandle), 22 July.

REV. OO 2006. Personal interview (Reverend, Calvinist Protestant Church), 06 September.

SISTER KK 2008. (Nursing sister, Community Day Care Centre, Macassar), 24 July.

SPOKESPERSON AA 2008. Personal interview (AIDS Desk, Southern African Catholic Bishops' Conference), 02 August.

SPOKESPERSON BB 2009. Personal interview (Director, Health Ministries, Seventh Day Adventist Church), 29 April.

SPOKESPERSON F 2007. Personal interview (Christian AIDS Bureau of Southern Africa [CABSA]), 06 April.

SPOKESPERSON GG 2008. Personal interview (trainer and educator, Philippi Trust), 06 August.

SPOKESPERSON II 2009. Personal interview (Community Development Officer, Prochorus, Shofar, Stellenbosch), 05 May.

SPOKESPERSON J 2008. Telephonic interview (Catholic Welfare and Development), 05 July.

SPOKESPERSON L 2008. Personal interview (outreach manager, Helderberg Christian Church), 10 July.

SPOKESPERSON NN 2008. Personal interview (social worker, BADISA, Helderberg Basin), 15 July.

SPOKESPERSON PP 2008. Personal interview (outreach manager, Helderberg Dutch Reformed Church), 01 August.

SPOKESPERSON Q 2008. Telephonic interview (spokesperson, Capacity Development/Training, Siyafundisa), 04 August.

SPOKESPERSON RR 2006. Personal interview (Transformation Project), 01 August.

SPOKESPERSON X 2009. Personal interview (spokesperson, "Voices in Africa" [publishing arm of SHOFAR, charismatic church]), 21 May.

Addendum A

Sample list of questions/areas for discussion with interviewees, pursuant to research on HIV/AIDS care by churches in the Helderberg Basin.

1. **Introduction and summary of purpose of the interview**

2. **Brief discussion about the church in terms of broad "typology", membership, congregants, local problems for the church**

    Hierarchy of the church in terms of policy making.

    Has the church formulated an HIV/AIDS policy?

    Role of women in the church.

3. **HIV/AIDS: general summary of the situation in sub-Saharan Africa / South Africa**

    Cognisance of the disease, primarily within the church's geographical area.

    Church HIV/AIDS formal policy: contents.

    What is the church's involvement in addressing HIV/AIDS-related issues?

    Church action in terms of prevention, treatment and care to those infected with or affected by the disease.

    HIV/AIDS: sin/punishment; compassionate or judgemental approach?

4. **Modes of transmission of HIV – primarily sexually in South Africa**

    Church's stance on sex.

    Are issues of sex and sexuality discussed?

    Where does the church stand on condom use?

    Church's views/discussion of issues such as drug use, homosexuality, sex workers, concurrent sexual partners.

    How are these issues raised? Sermons? Church ministries? Youth / men's / mother's meetings?

5. **Factors fuelling the pandemic and church action in respect of dealing with these factors**

Poverty

Gender inequality

Patriarchy

6. **Probe help provided in terms of care for those infected with or affected by HIV**

Charitable relief – food, blankets, clothing or other forms of help?

Home visits? Family support?

Remembering those who are HIV-infected in prayer? World AIDS Day commemoration?

Has anyone in the church congregation revealed their HIV status? Reaction by the church minister/congregants.

Church work with other churches of the same denomination/ affiliation with national or international bodies.

Utilisation of networks – with other churches, faith-based organisations, community-based organisations.

Work with other organisations and bodies (for example, the Philippi Trust, Christian AIDS Bureau [CABSA]), local clinics/hospitals, HIV/AIDS support groups, the Treatment Action Campaign (TAC).

Church engagement on political issues (for example, the Minister of Health's refusal to make ARVs available, or the pricing of drugs/drug patents).

Participation in protests, delegations or representations designed to make impact on HIV/AIDS.

7. **Prevention**

Education initiatives: talks, workshops, courses, etc.

Voluntary counselling and testing: have any church ministers taken the test? Encouragement to congregants to test?

Has a person living with HIV/AIDS (PLWHA) talked to the congregation?

Has anyone within the church been on an HIV educational course?

Addendum B

Sample transcript of an interview with a church representative of a Pentecostal/charismatic church.

TRANSCRIBED NOTES

CHURCH: SHOFAR – MEETING WITH: Spokesperson X (Voices in Africa)

21 May 2009, 'xxx' coffee shop, Stellenbosch, 11.30 am

Q: How would you describe SHOFAR (compared to mainline churches, such as the NGK, Anglican, Catholic Churches)?

Spokesperson X: Shofar is probably best described as Bible-based (Word-based), guided by the Holy Spirit.

Q: But aren't most Christian churches word based?

Spokesperson X: I can only speak for SHOFAR.

Q: What is the role of the church (talking in particular about Shofar) and HIV/AIDS?

Spokesperson X: There has to be a distinction between prevention of the disease and managing the disease. This is where government and some churches are sending out mixed messages. For example, if government talks of condom use to the youth, the message might be taken to mean that it is okay to have sex.

Q: But the reality is that young people are having sex – is it not better to arm them with information?

Spokesperson X: Young people are having sex because of a lack of understanding of the consequences. Churches need to get out the message that it is important to listen to God's word and **why.** The reason why we are told to keep ourselves pure until marriage is for our protection – to prevent things such as sexually transmitted diseases, pregnancy, etc. God's law is a law of love and grace, giving protection in cases where our understanding of the consequences of our actions is blurred.

Q: What initiatives has Shofar taken with regard to HIV/AIDS?

Spokesperson X: In 2003/4, I (Spokesperson X) was led by the Holy Spirit into publishing a book dealing with the stigma of HIV, gender inequality, discrimination and the management of sex by setting sexual boundaries. Acknowledging that sex is one of the strongest drives in the make-up of human beings and the importance of managing it – the book concentrates on educating young people to set sexual boundaries before they get into a situation where their body (sexual drive) controls their actions, instead of a well thought-through decision. It deals with delayed sexual debut and the reasons why it is important.

200 000 copies of the book have been sold and it is aimed at children in the 11-15 year age range. It is available in townships, rural areas, urban settings, etc. 65% of schools in the Western Cape are using the book. In addition, it has guidance for use by teachers, parents and churches.

Q: **Given that Shofar in Stellenbosch comprises a congregation of young adults, is the book available to them?**

Spokesperson X: No, as the book is meant for a younger age group (children).

Q: How do you then deal with young adults?

Spokesperson X: We help young people to understand the benefits of staying sexually pure and help them to examine the consequences of sexual immorality.

Q: What is the church's view of condoms?

Spokesperson X: If one is sexually pure/has one partner, the issue of condoms does not arise. However, in circumstances where the disease could be spread, in the interest of love (to prevent the other person getting infected), condoms must be used.

Q: How would the church react if a congregant came forward and said that he or she were infected?

Spokesperson X: The church would react with acceptance and it would give support. There would not be discrimination or stigmatisation, as the person would be treated as though they had any other disease, such as cancer. The heart of the church is to help people, so there would be compassion. In the case where sexual immorality is the cause of the disease, there would have to be correction facilitated and a commitment from them to change their ways and align them to God's will. If there were no change, the church would have to act.

Q: What action would or could the church take?

The church would request repentance (amending his/her behaviour) in a spirit of gentleness and with counselling.

Q: HIV/AIDS is fuelled by all sorts of factors including, importantly, issues of gender inequality that subject women to violence, abuse, etc. What does the church say about a woman's role in society?

Spokesperson X: Shofar's view is that the woman is the helpmate of her husband. They have their own identities and roles to play in a covenant relationship, supporting each other. The meaning of true love is that both would respect each other and that the husband would love his wife – that means a willingness to lay down his life for her.

Q: Does Shofar's leadership have women playing a prominent role?

Spokesperson X: Yes. There are both men and women pastors e.g. Pastor AAA and his wife, BBB.

Q: Does the church talk about HIV testing?

Spokesperson X: Yes, it is advised. The church undertakes pre-marital classes where such issues may be discussed. However, it must be understood that the church can only give guidance and cannot take ownership over people's decisions. Every person must make and act upon his/her own decisions.

Q: What help does Shofar give to those who are HIV infected?

Spokesperson X: The church supports NGOs working is the field such as Prochorus Community Development in Kayamandi. They have established 18 crèches and also operate a rape clinic and offer food daily for people on HIV treatment. The church also provides pastoral support to individuals who are going for testing.

Q: Will the church do anything in Somerset West, where it has just started a church?

Spokesperson X: Cannot say at present as the church is fairly new. The church, however, wishes to be actively involved in all communities where we have representation. (We are not actually officially a church in SW – it is still an extension service.)

Q: What about care for adults who are HIV infected?

Spokesperson X: If we want to curb the rate of HIV infections, the priority must be prevention of HIV infection in young people. That doesn't mean that we don't care for adults who are infected – we will do everything in our ability to help, but if we really want to have an impact and bring about change, we have to concentrate our efforts on prevention, and by doing that securing a future for the next generation.

Q: In terms of treatment with antiretrovirals, churches such as the Anglican Church, have been very prominent in demanding access to treatment. Has Shofar networked and joined with such churches to fight for access to treatment?

Spokesperson X: Treatment is a government funding issue and not one that Shofar has been involved with. I don't really know the position of the church, but I think that Shofar's primary priority is to teach the word of God and, secondarily, to reach out to meet practical needs in their own community before we involve ourselves in putting pressure on the government. I'm sure, if need be, we will engage in negotiations with the government.

Q: Is Shofar South African based?

Spokesperson X: No, it is international and belongs to the IFCC group (International Federation of Christian Churches).

Q: What is the hierarchy of the church?

Spokesperson X: The website: www.shofaronline.org would give an explanation.

Q: Who decides the church's priorities, for example, that HIV/AIDS should be given priority?

Spokesperson X: The members decide on priorities, facilitated by the leadership and inspired by the Holy Spirit. As a result, my focus as a member of Shofar is prevention of HIV.