THE IMPLEMENTATION OF PASTORAL GROUP COUNSELLING:

A WAY TO CARE FOR HIV POSITIVE YOUNG WOMEN LIVING IN A SOUTH AFRICAN TOWNSHIP

JOAN MÖDINGER

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Department of Practical Theology and Missiology, Faculty of Theology

The University of Stellenbosch

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Supervisor: Dr. Christo Thesnaar

DECLARATION

I, the undersigned, declare that the work contained in this thesis is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

Signature: …….Joan M. Mödinger……

Date: ……March 2012……

TO WERNER, HEINRICH and SABINE, THOMAS and LISEL

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ABSTRACT

In South Africa young women in the age group 10 – 24 are the largest group infected with HIV. Those most at risk are young women living in South African townships where a multitude of factors reinforce the possibility of them becoming infected. Once infected, they are often abandoned or left alone, with no support system.

This thesis uses the following four tasks of Practical Theology,

- the descriptive-empirical task: Priestly listening,
- the interpretive task: Sagely wisdom,
- the normative task: Prophetic discernment and
- the pragmatic task: Servant leadership,

to analyze how pastoral group care could help these young women. The problem is investigated and set into the reality of Khayelitsha, a township in Cape Town.

By offering young women the possibility of belonging to a peer group, they are met within their cultural and social system. As the members of the group are all HIV positive, the stigma which often prevents people from socializing or talking about their sickness, is removed.

The important role of the leader of such a group is also investigated.

OPSOMMING

In Suid-Afrika is jong vroue in die ouderdomsgroep 10 – 24 jaar díe groep wat die hoogste aantal MIV infeksies het. Die hoogste risiko om deur die MI virus aangesteek te word, is by jong vroue wat in ‘n Suid-Afri kaanse *township* l ewe. ‘n Verskeidenheid fa ktore spee l saa m om hulle kwesbaarheid te verhoog. Sodra dit bekend word dat hulle die MI virus dra, word hulle dikwels verwerp en sonder enige ondersteuning alleen gelaat.

Na aanleiding van die volgende vier take van Praktiese Teologie nl.:

- die beskrywend-empiriese taak: Priesterlike luister,
- die interpreterend-hermeneutiese taak: Verstandige wysheid,
- die normatiewe taak: Profetiese onderskeiding en
- die pragmatiese taak: Dienskneg leierskap.,

word hierdie p roblem o ndersoek binne die r aamwerk van Khayelitsha, ‘n *township* va n Kaapstad.

Die tesis argumenteer dat pastorale groepssorg ‘n gepaste wyse is waarbinne daar na hierdie jong vroue omgesien kan word. Deur aan hulle die moontlikheid te bied om aan ‘n portuurgroep te behoort, kan hulle binne hulle eie sosiale en kulturele raamwerk tereg kom. Aangesien die lede van di e gr oep a lmal MIV positief is, word die stigma, wat dikwels m ense verhinder om te sosialiseer of om oor hulle siekte te praat, verwyder.

Die belangrike rol van die leier van so ‘n groep word ook ondersoek.

CONTENTS

CHAPTER ONE

Introduction to the Research Topic

CHAPTER TWO

Pastoral caregivers as agents who lead change

CHAPTER THREE

Understanding the world in which Precious Xaba lives

CHAPTER FOUR

HIV and AIDS in the African context

CHAPTER FIVE

The Church and HIV/AIDS

CHAPTER SIX

Pastoral group care as cross-disciplinary dialogue

List of acronyms:

AA: Alcoholics Anonymous

AIC: African Instituted Church

AICs: African Instituted Churches

AIDS: Acquired Immunodeficiency Syndrome

ARV: Antiretroviral

ARVs: Commonly used to denote antiretroviral medicines

F: Female

FBO: Faith-based Organizations

HIV: Human Immunodeficiency Virus

HPHR: Harvard Public Health Review

HRW: Human Rights Watch

M: Male

MTCT: Mother-to-child-transmission

NKJV: New King James Version

UNAIDS: Joint United Nations Programme on HIV/AIDS

UNDP: United Nations Development Programme

UNFPA: United Nations Population Fund

WCC: World Council of Churches

WHO: World Health Organization

List of Figures and Tables:

List of figures

List of Tables

CHAPTER ONE

Introduction to the Research Topic

1.1 Introduction

On 5 June 2011 the 30th anniversary of the discovery of AIDS was commemorated. Important progress has been made into the research and management aspects of the virus, but the epidemic continues to outpace the response of the medical profession and the churches. The very relevance of churches will be determined by their actions. Hence the saying: "If the church does not take care of AIDS, AIDS will take care of the church".

Essex (2011: 17) describes HIV/AIDS as " one of the most catastrophic epidemics in all of history". He calls to attention that there is almost no aspect of behaviour, policy, basic science, statistics, epidemiology, nutritional interventions – everything – that does not touch HIV/AIDS. HIV is challenging the way we think and operate on all levels. It creates and flourishes in a milieu of stigma and discrimination, which leads to the increasing isolation and suffering of those living with the disease.

Although there is not a continent which is not struggling with the HIV/AIDS epidemic, Africa as continent is the hardest hit. Poku & Sandkjaer (2007: 9) describe the situation as follows: "Amidst the unrelenting catalogue of horrors, a possible 60 million additional deaths worldwide, 50 million of them in Africa by the year 2025; the ghastly finding is that the epidemic is still in its early stages overall. To that must be added the real possibility that with HIV the very survival of the African state may well be at stake. Often in conditions of extreme poverty, conflict, weak institutional and physical infrastructure, deficient educational and health care systems, many societies are struggling with the epidemic that is changing the very character of everyday life".

It is estimated that thirty years after the virus was identified in 1981, 33 million people are living with the HI virus (Essex, 2011: 17). South Africa represents only 1% of the world population, but is home to 17% of the world's population infected with HIV (Smit, 2011: 87).

Among young people in sub-Saharan Africa, the HIV epidemic is super-imposed on already poor sexual health outcomes, including high levels of unintended pregnancies. Young people, particularly women, are disproportionately represented in the epidemic, with high prevalence in the age group 15 - 24. In South Africa, one-quarter of young adult women aged 20 – 24 are HIV infected (Harrison, 2008: 262).

Who are the "young people"? According to Harrison (2008: 263) the standard definition preferred by the World Health Organization (WHO) says that young people are those between ten to twenty-four years of age. In this thesis both the terms 'adolescent' and 'young people' will be used. Adolescent refers to a specific developmental stage that spans the period from puberty into young adulthood, which is characterised by transition, physical and emotional development and change.

An estimated 6,000 young people get infected with HIV every day, or 1 every 15 seconds, according to Alemtsehay Yemane (2008: 395). Yemane further quotes from the UNFPA, saying that it has been reported that out of the 60 million people who have been infected with HIV worldwide in the past twenty years, about half became infected between the ages 15 – 24.

To make it more concrete, it will mean that by the time you have finished with the reading of this page, four more people will have been infected with the virus. Three of them will be women who most probably will be under the age of 29. At least one of these people will be living in South Africa.

Concerning the *South African HIV/AIDS statistics*, the South African National HIV Survey 2008 (www.avert.org/aidssouthafrica.htm) estimates almost one in three women aged 25-29, and over a quarter of men aged 30-34, are living with HIV. The same survey shows that the prevalence of HIV in the Western Cape is the lowest in South Africa, 3,8%, compared to 10,9% nationally. However the influence on the individual is equally devastating.

1.2 The transmission of the HI virus to young women

How is the HI virus transmitted to young women? Heterosexual sex is the predominant reason for the transmission. However, mother-to-child transmission, also called vertical transmission of HIV, is one of the major causes of HIV infection in children. It is estimated that about 600,000

children in the world are infected in this way each year. This figure accounts for 90% of HIV infections in children according to the WHO (Van Dyk, 2009: 41). Unless preventive measures are taken, 20 – 40% of children born to HIV positive women are infected. HIV can be transmitted from an infected mother to her baby via the placenta during pregnancy, through blood contamination during childbirth, or through breastfeeding (Van Dyk 2009: 41).

1.3 The impact on children and young women

South Africa's HIV and AIDS epidemic has a devastating effect on children/young adults in a number of ways. Swidler (2007: 145) states that AIDS is changing the face of Africa, bringing life expectancies in parts of southern and eastern Africa, which had begun to approach First World standards, down to an expected 38 – 40 years. Because HIV is most prevalent in persons in the age group 25 – 34 years, it is therefore not uncommon for one or more parents to die from AIDS while their children are still young. The loss of a parent not only has an immense emotional, spiritual and social impact on children, but for most families it can spell financial hardship as well.

World-wide it is estimated that nearly 17 million children were orphaned in 2009 by HIV/AIDS (Essex: 2011, 20).

It is estimated that there are 1.9 million AIDS orphans in South Africa alone, where one or both parents have died. The proportion of maternal AIDS orphans – those who have lost their mother – is estimated at over 70 percent. Therefore, we have the fact that approximately 1.33 million orphans in South Africa live without a mother. These orphans are most often put in the care of an older relative. Very often the orphans have to relocate from their familiar neighbourhood and siblings may be split apart, adding additional strain to their lives. Many of these orphans are adolescents.

1.4 Antiretroviral treatment

In South Africa, more than one million people are receiving antiretroviral medication, according to Smit (2011: 89). The South African National HIV Survey 2008, states that the level at which a HIV positive person begins with antiretroviral therapy has a great impact on his/her chances of

responding well to the treatment. The WHO recommends that all countries, including poorly-resourced countries, start treatment at a CD4 count of <350 cells/mm^3. The 2010 antiretroviral treatment guidelines for South Africa, released in February 2010, do not adhere to these WHO recommendations (South African National HIV Survey 2008). Instead, those infected with HIV receive treatment only if their CD4 count is <200 cells/ mm^3. Only then, antiretroviral therapy is given free of charge at a local clinic.

This reluctance by the South African medical authorities to adhere to the WHO recommendations regarding the administration of ARV's to HIV positive people, puts many of the country's young women's health at risk. The requirements that a patient's CD4 count must fall to under 200 cells/ mm^3 has the consequence that a person's immune system might collapse, and as a result develop full-blown AIDS and die prematurely. In August 2011, the SA Government revisited this policy. From that date persons with a CD4 count of <350mm^3 are now allowed to receive free antiretroviral treatment. It will take some time before this new regulation filters down to all the South African health clinics. For many HIV infected people this new regulation might be too late. The availability of the necessary resources to supply the medication has an influence on the availability thereof to the poor.

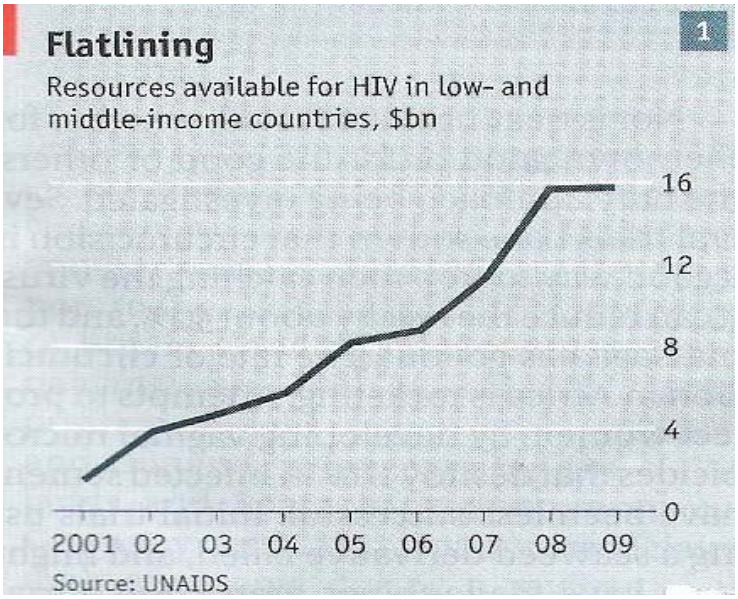

Figure 1: Resources available for HIV in low- and middle-income countries.

The available resources for HIV have flattened in low- and middle-income countries, of which South Africa is one. Despite that, the number of HIV infections keeps on rising, but the sources available for treatment remain the same. This will influence the availability of HIV treatment to the poor (The Economist, 4 June 2011: 89).

1.5 Precious Xaba: A case study[1]

The life of an HIV positive young woman living in a South African township, will serve as a case study to illustrate the problems which teenagers encounter.

Precious Xaba lives with her aunt in a one room shack at 3947, Nelson Mandela Drive, in Khayelitsha, a township of Cape Town.

Precious is eighteen years old. She was born HIV positive, due to mother-to-child transmission. Both her parents were HIV positive. She knows the woman who, according to her, infected her father, who in his turn, infected her mother and who indirectly then is responsible for Precious being HIV positive. This woman is still alive and lives not far from where Precious is living with her aunt. It is not known if her mother took any precautions to prevent mother-to-child transmission of the HIV while she was pregnant with Precious. Very little is known of Precious's birth, and whether her mother breast- or bottle fed her after birth.

By the time Precious was five years old, both her parents had died of AIDS.

After the death of both her parents, Precious was put in the care of her "gogo" – her grandmother. However, the grandmother also passed away due to Aids when Precious was 9 years old. She was then put in the care of a drug addicted aunt – the only remaining living member of the family. Precious, the aunt and the two year old son of the aunt, live together in a one room shack in Khayelitsha.

When still at primary school, Precious used to attend the local school. However, she left this particular school after a teacher absentmindedly left a letter from the clinic, which served to inform the school about her illness and medication, on the table in the staffroom. According to Precious, all the teachers read the letter and her HIV status became public knowledge. The children started teasing her and some of the teachers reacted in "funny, bad ways" towards her. She was too ashamed to attend the school any further and decided, on her own, to enrol at another school in a neighbouring suburb.

During the last summer vacation Precious, wanting to belong to an "in-group" in Khayelitsha participated in teenage activities and party-sprees involving liquor, unprotected sex and drugs. The result was that she landed in hospital, close to dying. Her CD4 count was found to be <120 cells/mm^3. In hospital she was placed on antiretroviral therapy.

[1] All names, addresses and other details are changed to protect privacy.

At home in Khayelitsha, Precious was dressed in an old track suit. She was watching a fashion programme on TV. On a bunk bed next to her, her aunt was lying, high on "tik" (Crystal Methamphetamine). Nkosinathi, the two year old toddler - Precious's nephew - was idling about the room while his mother was snoring off her "tik-effects". Nkosinathi obviously had a cold, as two snotty smears were running down his nose. The general impression of the room in which they were living, was one of neglect.

Precious should have been attending school. She is an enrolled Gr. 10 pupil. It was five weeks into the new school year and she had not been to school at all. She says that the ARV's she now has to take on a daily basis make her nauseous and sleepy. She does not want to attend school in this condition, drawing attention to herself and having the feeling of being a nuisance to the teachers.

Precious, although not very regularly, attends the church meetings of a Zionist church in Khayelitsha.

This all indicates that Precious, an orphaned HIV positive young woman, lives in an isolated world.

1.6 Motivation

Yemane (2008: 396) reminds us that sexuality is central to the lives of human beings. It affects every aspect of human life. According to him (ibid: 401) the Bible deals with sexuality in an extensive manner as it is a topic in every major Bible book. Yemane, however, also states: "It is sad to note that sexuality becomes the least taught topic in present day Evangelical churches (ibid: 398)". He (ibid: 395) quotes Stanley Grenz who indicates that presently, young people are far more sexually active than they have been before. Most probably, half of all teenagers may have had sex before completing high school. According to him surveys conclude that religious convictions apparently have little impact on the sexual behaviour and attitudes of young people who attend church. Yemane urges the church to listen to the stories of young persons, their confusions and frustrations, individually as well as in small groups. He makes a call for a peer accountability system which he describes as extremely urgent.

As indicated above, HIV is in most cases a sexually transmitted disease. The challenge for a pastoral care giver is to meet young people not only within their specific stage of physical development, but also within their peer and cultural environment. Dube (2003: 101) draws attention to the fact that HIV infection is a complex issue involving the social, cultural, spiritual, physical, economic and political aspects of a person's life. She further emphasises a person's

social location, which she explains as an individual's place or location in his/her society. "People are socially located and socially constructed into a number of relationships that empower or disempower them: within the family, church, work-place, government and international class. Social location includes gender, class, race, ethnicity, history, health status, weight, height, and how these categories are valued by a particular society." For this reason, pastoral care should take the social location of an individual into account. However, pastoral care in the African context should go even further, not only considering the social location of the individual, but also his/her social systems and social environment. Louw (2008: 180), when describing sickness and health in an African context, quotes from Eybers who warns that caregivers must always be aware of the connection between the care-receivers and their society at large. As in the case of Precious, many orphaned HIV infected young people in a South African township have no supportive family structure to which they belong. They are therefore in most cases also isolated from a supportive community.

According to Corey et al. (2007: 323) the adolescent years can be extremely lonely ones, and at times, adolescents may feel that they are alone in their conflicts, struggles and self-doubts. They often believe that their problems are unique and that they have only a few options for making significant choices. Meyer et al. (2008: 202) further add that the age group 13 – 19 is characterized by a *search for identity* and a clarification of a *system of values.* For an orphaned HIV positive teenager, with very few people in his/her "social location" to act as role models during the search for identity and his/her clarification of a system of values, the result is that the young person lives in a world of uncertainty and loneliness. This is made worse by the debilitating illness in his/her body.

How can the pastoral caregiver of a church step in to guide these searching young people? Demissie (2008: 11) invites churches to become communities of healing and compassion in the face of the devastating HIV and AIDS pandemic. This forms the basis for the research about pastoral group counselling as a tool to assist a pastoral caregiver of a local church in a South African Township to help his/her church to become a community of healing and compassion, caring for those HIV positive young women in his/her congregation.

Yalom (2005: 1), one of the world's most respected doyens regarding the implementation of group psychotherapy, states: "I suggest that therapeutic change is an enormously complex

process and occurs through an intricate interplay of various guided human experiences, which I shall refer to as therapeutic factors". Some of these therapeutic factors, for example the instillation of hope, the corrective recapitulation of the primary family group and the development of socializing techniques, can be used by a pastoral caregiver as a way to assist young people to help them discover that they are not alone and that there is hope for creating a better life.

This study acknowledges that there are other forms of care and counselling available to the pastoral caregiver. The argument for the implementation of pastoral group care is based on the fact that pastoral group care takes not only the social location of the individual into consideration, but it also incorporates the systemic connection of HIV infected young women and their communities, within the group setting. Clinebell (1966: 206) declared: "Group counselling methods constitute the most promising resource for major creative advances in pastoral counselling!" During pastoral group care, the individual becomes part of a community. If this is important in a Western context, it is even more so in the African context. According to Skhakhane in Louw (2008: 158), the community is the core of African spirituality which refers not only to the living, but also the ancestors. Pastoral group care can be an antidote to the impersonal, often problem saturated situation in which many HIV positive young people in the townships live. A caring group can provide the sense of community for which these young people yearn.

HIV infection is largely a human sexuality issue. During the adolescent years, sexual development is one of the most significant development characteristics. It is therefore necessary that the church takes a leading role in the imparting of knowledge regarding sexual development and safe sexual practices to young people. Khathide (2003: 1) states "that unless the church's attitude towards sex changes, our fight against HIV/AIDS will become increasingly difficult". He pleads for the church to break this "conspiracy of silence" around sexual issues by teaching and talking about sexuality. The silence of parents/elders regarding sexual issues is echoed by Mamphela Ramphele in her book "*Steering by the Stars*". According to Ramphele (2009: 134), parents in New Crossroads (a South African township in Cape Town) generally avoid discussions about sex and sexuality with their children. Ramphele states that this topic is taboo

to them. Parry (2008: 25) agrees by saying that "the bottom line is that HIV is predominantly transmitted through sex and this is an area we fail to address adequately in our churches".

Louw (2008: 186) refers to the pedagogical and "indirective" counselling found in African communities. He states: "Through the community and their stories, younger people are introduced to morals and core life issues. The role of elders is important in African communities. The intention behind education and the pedagogical dimension in pastoral care is to prepare young people for life". With AIDS being responsible for the deaths of a significant number of the parents and elders in the community, there is a lack of "indirective counselling to young people" – also regarding sex and sexuality. In pastoral group counselling, a pastoral caregiver in his/her role as servant leader, can take on the role of these elders who are absent due to their untimely death.

This thesis will draw on the case study of Precious Xaba, the statistics of the South African National HIV 2008 Survey and other relevant sources, as well as practical knowledge and experience gained in townships, to explain how pastoral group counselling can assist a pastoral caregiver of a local church in a South African Township as a way to care for the HIV positive young women in his/her congregation.

1.7 Problem statement

The problem to be addressed is complex.

Manala (2005a: 902) draws our attention to the existential situation of people living with HIV/AIDS. They are struggling with fear; struggling with an identity crisis; struggling with the question of meaning; being emotionally confused; being stigmatised and living with guilt. These existential problems are especially relevant to HIV positive young women.

The HIV/AIDS pandemic has proven to affect all aspects of the lives of both infected and affected by it. In a South African township, where poverty, inadequate schooling, health provision and housing, drug abuse and violence are rife, HIV exacerbates this problem for young

women. Very often they themselves are HIV positive. Furthermore, many young women have lost their parents/elders as a consequence of HIV/AIDS. This leaves them without the necessary care, support and guidance.

The "theological silence" from the church, despite the "*vale of misery*" caused by the HIV/Aids epidemic (Maluleke, 2003: 65) adds to the problem. HIV is predominantly transmitted through sex. There is duplicity when it comes to sex in the human nature – between what is known and what is done. Despite all the "condomise", "know your status", "one partner" and "be faithful" campaigns, the infection rate keeps climbing. The tension between head knowledge and the "desires of the flesh" remain. Throwing caution to the wind, when the lights go out, is a fact.

All of the above plays out in the life of Precious Xaba. One of her main needs is to find and experience a safe space where she will be allowed to share her fears and anxieties with those like her, and at the same time receive the support she so desperately needs.

This leads us to the research question.

1.8 Research question (Aim of research)

How can the implementation of pastoral group counselling assist a pastoral caregiver of a church in a South African township, to care for HIV positive young women?

1.9 Relevance for Practical Theology

Osmer (2008: x) explains that "the scope of practical theology comprehends the web of life". In this sense the thesis will link the theory as indicated in the scholarship review with proposals for the improvement of the existential situation in which HIV positive young women in a South African township find themselves.

Pastoral caregivers belonging to any of the local churches in a South African township have the responsibility to play an important role in the lives of HIV positive young women. Parry (2008: 8) indicates that with the progression and unfolding of the HIV epidemic, social fault lines have

been exposed through which the virus has moved relentlessly and silently. In many instances, faith-based organizations have also been a factor in the fault lines.

Is it possible for pastoral carers to address these fault lines? Can the pastoral caregivers of a church answer to the call of Van Huyssteen (1989: x) who asks: "Can theology still speak out contextually in such a manner that the liberating voice of the Gospel may be heard loudly and clearly in all facets of our own society?" A case will be made that a pastoral caregiver can use the safe space provided during a pastoral group session with HIV positive young women, so that the liberating voice of the Gospel in all aspects of their lives can be heard.

Parry (2008: 24) defines an HIV competent church as a church that acknowledges the scope and risk of HIV. It means that HIV should not be seen as "out there" but "right here". It is not a question of "those out there with HIV" but of "those amongst us who are HIV positive". If one of our members has HIV then we are all affected. "If one part of the body of Christ suffers, we all suffer." De missie (2008: 11) recommends that the church is to become a community of healing and compassion. This will be attained if the church provides space for openness, transparency, honesty, compassion and love in dealing with HIV and AIDS. In the church, people should find it easy and safe to disclose their HIV status without experiencing fear.

This thesis wants to emphasize how pastoral group care can assist to create that community of healing and compassion in the church especially for young women suffering from HIV and AIDS.

In his book "Practical Theology" Osmer (2008: 4) explores four questions that can guide our interpretation and response to problem situations, which are:

What is going on?

Why is this going on?

What ought to be going on?

How might I respond?

Osmer explains that answering each one of these questions will lead to one of the four core tasks of practical theological interpretation:

- *The descriptive-empirical task.* Gathering information that helps us discern patterns and dynamics in particular episodes, situations or contexts.
- *The interpretive task.* Drawing on theories of the arts and sciences to better understand and explain why these patterns and dynamics are occurring.
- *The normative task.* Using theological concepts to interpret particular episodes, situations or contexts, to construct ethical norms to guide our responses, and learning from "good practice".
- *The pragmatic task.* Determining strategies of action that will influence situations in ways that are desirable, and entering into a reflective conversation with the "talk back" emerging when they are enacted.

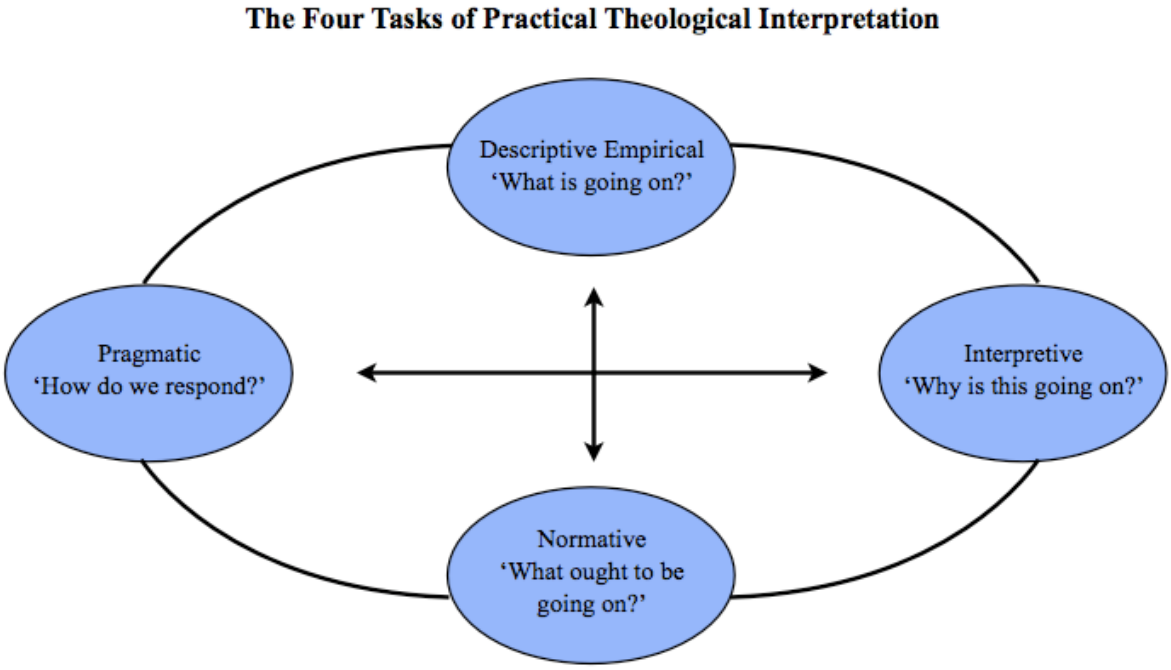

Figure 2: The four tasks of practical theological interpretation.

Osmer (2008: 11) explains that it is helpful to think of practical theological interpretation as more like a spiral than a straight line, as it constantly circles back to tasks that have already been explored.

In this thesis, the above core tasks will be applied to deconstruct Precious's story. The thesis wants to explore and see if it is possible to find answers to the following:

1. What are the questions and problems an HIV positive young woman like Precious has to face every day? What is going on?
2. Why are these contextual questions and problems in Precious's life? Why is this going on?
3. What ought to be going on in Precious's life?
4. How might caregivers as leaders of congregations respond to this?

1.10 Research methodology

Using Osmer's four questions, research will firstly be conducted by way of a scholarship review. A scholarship review is more than a literature review. Mouton (2011: 87) explains: "…your interest is, therefore, not merely in literature (which sounds as if it refers merely to a collection of texts), but in a body of accumulated scholarship. In short, you are interested in the most recent, credible and relevant scholarship in your area of interest. For this reason, the term 'scholarship review' would be more accurate!"

The research will therefore draw material from academic books, journal articles, encyclopaedias, dictionaries and electronic databases and interviews, using the hermeneutical interpretive approach.

Secondly, knowledge gained during practical counselling sessions done under the supervision of qualified pastoral counsellors in the South African townships, will be incorporated if found to be relevant to the topic of the thesis.

The research will, thirdly, seek to bring meaning to the theme "The implementation of pastoral group counselling: a way to care for HIV positive young women living in a South African township".

In this way the following will be attempted:

- Knowledge of the latest publications in the field of research
- Evaluation of the literature for relevance to the research topic

- Interpretation of tables and statistics
- Application of ethical principles especially when HIV and AIDS infected persons are involved
- Embedding the specific case of South African young women and localities into the wider context of Africa and the world
- Connections to relevant biblical texts

The *ubuntu* philosophy and epistemology from an African perspective (Louw: 2008: 154ff) will play an important role in the interpretation of the core tasks of practical theology in the context of a South African township. Manala (2005a: 897) explains that the *ubuntu way of living* (motho ke motho ka batho: a person is a person through other people) relates well to the world-view of the ancient Mediterranean culture, which is the predominant context of the biblical narratives. Manala explains further that group belonging, interdependence and communal life are therefore at the heart of Africanness. Mbigi (2005: 21) quotes Archbishop Desmond Tutu's definition of *ubuntu* as: "Africans have a thing called *UBUNTU*; it is about the essence of being human, it is part of the gift that Africa is going to give to the world. It embraces hospitality, caring about others, being willing to go that extra mile for the sake of another. We believe that a person is a person through other persons; that my humanity is caught up and bound up in yours. When I dehumanize you, I inexorably dehumanize myself. The solitary human being is a contradiction in terms and therefore you seek to work for the common good because your humanity comes into its own in community, in belonging". Pastoral group care dovetails with the *ubuntu* principle.

1.11 Proposed structure of the thesis

Chapter Two will look at the role of the pastoral caregiver as an agent leading change. This leadership is embedded in a spirituality of servant leadership.

In Chapter Three

- The necessary historical background of the HI virus and its connection to AIDS will be explained, as well as the use and functioning of antiretroviral medicine.

- A brief description of Khayelitsha, the township where Precious Xaba lives, will be given.
- The existential concerns of people, including young women, living with HIV and AIDS will be portrayed.

Chapter Four will focus on the HIV and AIDS epidemic within the African context. Why is the highest rate of HIV infection amongst young African women?

Chapter Five will look at the normative task of practical theology along three lines, that is theological interpretation, the use of ethical norms and the offering of an example of good practice.

Chapter Six will look at how the implementation of pastoral group care as an example of good practice can address the existential needs of HIV infected young women.

Chapter Seven will present some concluding remarks.

1.12 Notes on certain words and expressions

"Pastoral caregiver": A person, linked to a church, who cares for a specific need in the congregation. Synonyms are "pastoral carer" and "pastoral counsellor".

"Church": An organized Christian group with distinct principles of worship, leadership, teachings and ethics (see Allen: 1990: 253).

"HIV": As language shapes beliefs and may influence behaviours, considered use of appropriate language has the power to strengthen the response to AIDS. UNAIDS now suggests that the terminology HIV is used alone and not coupled with AIDS. A person with HIV does not necessarily also have AIDS. HIV is what they are infected with, whilst AIDS complications is what they die of (Parry, 2008:14).

"AIDS" should only be used when specifically referring to AIDS (Parry, 2008: 14). The term HIV will be used in the above sense, unless it is used as a direct quote from reference material.

"Young women": Females aged 10 – 24 (as used by the WHO).

"Adolescents": refers to a specific developmental stage that spans the period from puberty to young adulthood.

"Teenager": A person from 13 to 19 years of age.

CHAPTER TWO

Pastoral caregivers as agents who lead change

2.1 Introduction: Leading change

Within many churches being a "congregational leader" is not restricted to being a "pastor" or "minister". Very often congregants and volunteers do most of the actual implementation of care programmes. One of the core tasks of practical theology is to develop leaders who can think in terms of the entire congregational system and the church's relationship to its context. According to Osmer (2008: 176) one of the pragmatic tasks of practical theology is "*leading change*". This implies the task of forming and enacting strategies of action that influence events in ways that are desirable. He places this model of leadership in a spirituality of servant leadership.

In the field of HIV/AIDS, congregational leaders should asks themselves what role do they play in guiding those infected and affected by the disease.

2.2 Leaders as interpretive guides

Gerkin (1997: 36) describes pastors and congregational leaders as interpretive guides. He explains that pastoral care places at its centre an image of care, that is larger than the image of pastoral care conceived as simply involving the work of the ordained pastor. The pastor of the living Christian community is only one actor in the total enterprise of giving and receiving care, albeit an important actor. Gerkin (1997: 76) urges that pastors (and congregational leaders) need to become more proficient interpreters: interpreters of the Christian language and its ways of seeing and evaluating the world of human affairs and interpreters of the cultural languages that shape much of everyday life.

In theology the art and science of interpretation is associated with the field of hermeneutics. As an interpretative guide the congregational leader is asked to engage in the activity of interpreting and making sense of his/her experience. This challenges the "interpretative guide" leading a

group of young HIV-positive women to interpret the Christian message within the cultural language and existential environment of the group.

Gadamer (1975: 310ff) argues that all interpretation begins with pre-understandings that come to us from the past. He further argues that the pre-understanding with which we begin the interpretation, does not necessarily determine the endpoint of the interpretation. He developed the important concept of a 'hermeneutical experience' to describe the sort of interpretive activity that is open to encountering and learning something genuinely new. *This argument is important to understand the pragmatic task of leading change.*

Interpretative guides move through the experience along the lines of a hermeneutical circle. Gadamer explains that the hermeneutical circle is composed of five moments: pre-understanding, the experience of being brought up short, dialogical interplay, the fusion of horizons and the application thereof.

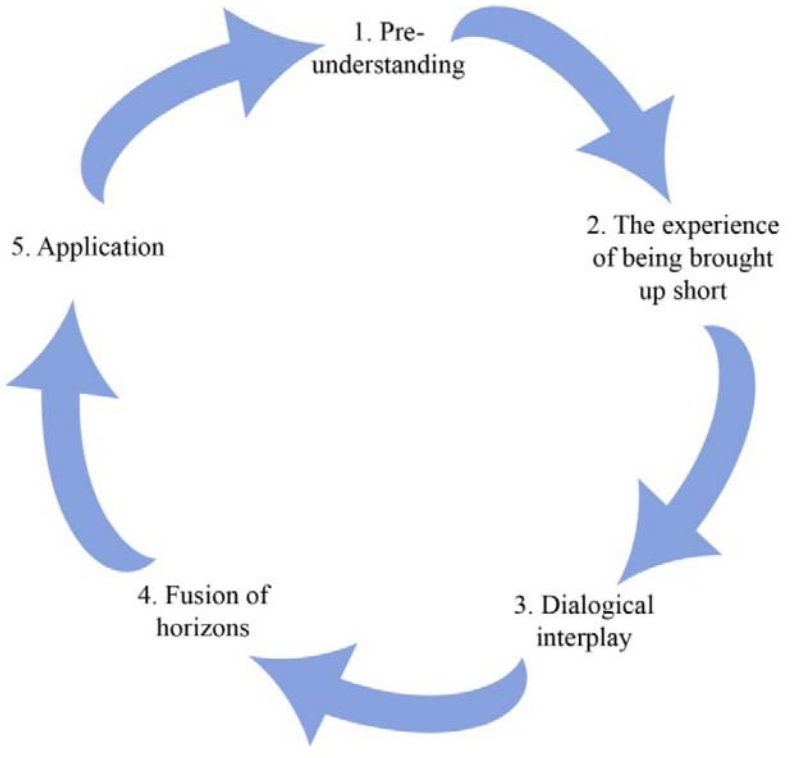

Figure 3: The hermeneutical circle

Interpretation starts with ***pre-understanding***. An interpretative guide leading a pastoral care group for young HIV positive women, will acquire his/her pre-understanding of the situation in which these women find themselves, from seeking answers to the first question for practical theology as suggested by Osmer, that is: "What is going on?" This is investigated in Chapter Three.

Gadamer described the next moment in the hermeneutical circle as ***the experience of being brought up short.*** This is the experience of running up against something that questions some aspect of our pre-understanding. For the interpretative guide leading a pastoral care group for young HIV positive women, this could be during the phase of answering Osmer's second question for practical theology, that is: "Why is this going on?" Answers to this question will be given in Chapter Four.

In Chapter Five this will lead to the third question of practical theology: "What ought to be going on?". This is the third moment of the hermeneutical circle, ***dialogical interplay***. Osmer (2008: 23) explains the dialogical interplay as allowing the text, the person or object to reveal itself to us anew. He invites us to listen for its "voice" and for us to open ourselves to the "horizon" it projects. The concept of the horizon is based on a visual metaphor. It indicates the farthest point that can be seen from a particular vantage point. Interpretation is thus like a dialogue in which there is a back-and-forth interplay between the horizon of the interpreter and the horizon of the text, person or object being interpreted.

Dialogical interplay leads to the fourth moment of the hermeneutical circle that is, the ***fusion of horizons***. Osmer (2008: 23) explains that the interpretation yields new insights when the horizons of the interpreter and the interpreted join together. Both contribute something. In this thesis the focus is on the fusion of the horizons of young HIV positive women and that of pastoral group care.

The fifth moment of the hermeneutical circle is the ***application***. Here new insights give rise to new ways of thinking, being and doing in the world. For leading this change, congregational leaders have to become "interpretative guides", as referred to by Gerkin. Application as the fifth moment of the hermeneutical circle leads in Chapter Six to the answering of the fourth question of pastoral care as asked by Osmer, that is: How might we respond?

The synthesis of the benefits of pastoral group care with the need for pastoral care experienced by young HIV infected women living in a South African township, invites application. This synthesis, leads to the exploration of the theme discussed in this thesis which is: The implementation of pastoral group counselling: A way to care for HIV positive young women living in a South African township.

Interpretive guides (Gerkin) thus must be able to move through the four tasks of practical theological interpretation (Osmer) along the lines of the five moments of the hermeneutical circle (Gadamer). This journey must not be seen as a straight line, but rather as movement within a spiral.

The Journey of an Interpretive Guide (Gerkin)

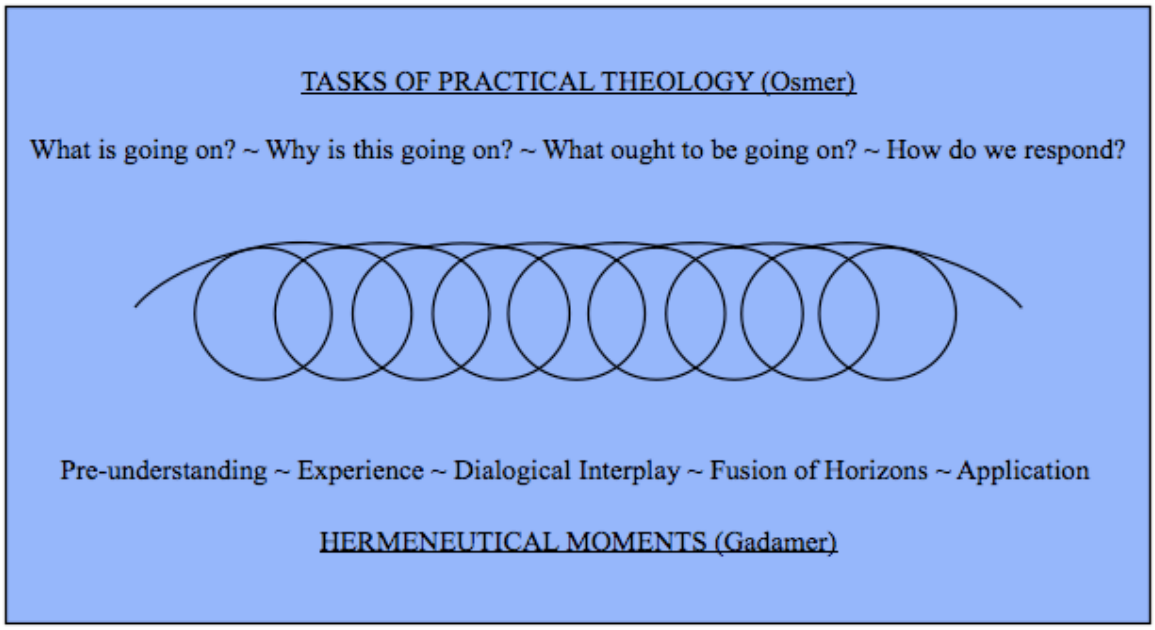

Figure 4: The journey of an interpretive guide

Pastoral group counselling needs leadership. Gerkin (1997: 114) argues that pastoral leadership must develop a quality of interpretive guidance that is clear and intentional. By interpretive guidance is meant not simply the interpretation of the Christian tradition and its implications for

communal, moral, individual and societal life, important as they are for the role of pastoral leadership and relational practice. It also includes the role of interpreting the conflicts and pressures, the contradictions and pitfalls, the lures and tendencies toward fragmentation of contemporary life. Leaders need to be accurately educated about the HIV epidemic; its causes, manifestations, impacts and they must have a mandate to respond. The interpretive guidance of pastoral leadership must relate to facilitating the dialogical process between life stories of the HIV infected and the Christian story of how life is meant to be lived.

For the pastoral caregiver who is leading a group of young HIV infected women the challenge will be to help them interpret how to deal with and how to understand life's problems through their relationship with God. What role does faith play in dealing with their personal and existential problems? The task of the pastoral group caregiver is to journey with the members of the group, guiding them along the path of Christian faith and hope. The pastoral group caregiver will be challenged to meet the members of the group within their own frame of reference and their own web of life.

2.3 Servant leadership and an African role model

The HIV and AIDS epidemic has played a significant role in changing the social context of people living in South African townships. Interpretive guides are challenged to rework their own identity and their mission when working in the HIV and AIDS environment.

Osmer (2008: 176) challenges interpretive guides to place their model of leadership in a theology of servant leadership. He (ibid: 192) explains servant leadership in the following way: *Servant leadership is leadership that influences the congregation (groups and/or individuals) in ways that more fully embody the servanthood of Christ.*

Greenleaf (1991: 7) explains that leading from a state of being rather than from doing leads to a leadership model of servant leadership. He asks the question: Servant and leader – can these two roles be fused in one person, in all levels of status or calling? If so, can that person live and be productive in the real world of the present? Greenleaf answers his own question by saying that the great leader is seen as servant first, and *that simple fact is the key to his greatness*. According

to him (ibid: 13) this approach begins with the natural feeling that one wants to serve, *to serve first.* He explains that that person is sharply different from one who is *leader* first – perhaps because of the need to own power or acquire material possessions. For such a person it will be the second choice to serve – after leadership is established. The leader-first and the servant-first are two extreme types. How is it possible to distinguish between the two? The difference, Greenleaf answers, manifests itself in the care taken by the servant-first to make sure that other people's highest priority needs are being served. The best test is to ask: "Do those served, grow as persons? Do they, while being served, become healthier, wiser, freer, more autonomous, more likely themselves to become servants?" And, Greenleaf emphasizes, what is the effect on the least privileged in society; will they benefit, or, at least, not further be deprived?

Servant leadership is to be understood as a form of leadership which more fully embodies the servanthood of Christ. This is made clear by the "visual aid" and example that Jesus gives us in John 13: 1–17 (NKJV, 2002: 1298). Christ provides us with a living example of what it means to be a servant leader. In John 13: 15-17 Jesus teaches his disciples "For I have given you an example that you should do as I have done to you. Most assuredly, I say to you, a servant is not greater than his master; nor is he who is sent greater than he who sent him. If you know these things, blessed are you if you do them". The following comment on these words has been offered by an African theologian: "As servants, they were expected to imitate their Master. As disciples of Jesus, each of them would be both master and servant at the same time. Each would receive service and render it. The concept of service to all, especially to those who are socially beneath one, is foreign to Africa. A chief serving his subjects would be unheard of. Yet that is what Jesus is asking us to do here. If our leaders in Africa would learn this lesson, it would take away more than half of the pain the African continent experiences from day to day" (Adeyemo 2006: 1282).

This leads us to the question whether the leader and interpretive guide of a pastoral care group working with young HIV infected women can be or can strive to become a servant leader? Are there any role models of servant leadership within the South African context that can act as a model for those interpretive guides in a congregation who want to serve a group of young HIV infected women?

The best known and most highly revered African role-model of servant leadership is the former State President of South Africa, Nelson Mandela.

The following extract is taken from the book "Leadership in the African Context" by Ebben van Zyl (2009: 173):

> On 18 July 1918, in the village of Mvezo, Transkei, one of the world's greatest leaders was born – Nelson Mandela. This is what Bill Clinton, the 42nd president of the US wrote in the foreword to the book *Nelson Mandela: From Freedom to the Future* (Asmal, Chidester & James, 2003):
>
> "He has taught us so much about so many things. Perhaps the greatest lesson, especially for young people, is that, while bad things do happen to good people, we still have the freedom and the responsibility to decide how to respond to injustice, cruelty and violence and how they will affect our spirits, hearts and minds.
>
> In his 27 years of imprisonment, Mandela endured physical and emotional abuse, isolation and degradation. Somehow, his trials purified his spirit and clarified his vision giving him the strength to be a free man even behind bars, and to remain free of anger and hatred when he was at last released.
>
> That freedom is reflected in the way he governed as president, bringing those who had oppressed him into his administration and doing everything he could to bring people together across racial, economic and political lines, and trying to get all South Africans to make the same 'long walk to freedom' that has made his life so extraordinary.
>
> The best gift we can give him on this occasion is to persist in our own struggle to forgive those that have trespassed against us and to work, every day, to tear down the barriers that divide us.
>
> At 85, President Mandela is still building bridges, especially those that unite us in the battle against HIV/Aids, which he calls an 'even heavier and greater fight' than the struggle against apartheid.
>
> Through times darker than most people will ever endure in their own lives, President Mandela saw a better and brighter future for himself and his country. Now, he gives hope that our work to eradicate HIV/Aids from the world is not in vain, and that one day, this awful scourge will exist alongside apartheid only in the history books.
>
> Mandela's enduring legacy is that, under a crushing burden of oppression, he saw through differences, discrimination and destruction to embrace our common humanity".

Was Nelson Mandela a servant leader? We apply Greenleaf's test: Did those he served, grow as persons? Did they, while being served, become healthier, wiser, freer, more autonomous, more likely themselves to become servants? What is the effect that this person has on the least privileged in society; did they benefit, or at least, were not further deprived? According to these criteria, we can declare that Nelson Mandela was indeed a servant leader.

Osmer (2008: 178-195) explains three forms of leadership that are commonly distinguished in leadership theories: Task competence, transactional leadership and transforming leadership. He places them within the spirituality of servant leadership.

- Task competence is the ability to excel in performing the tasks of a leadership role in an organization. This takes commitment, hard work, and experience – and more. It requires humility. Humility involves treating the needs of others and the common good of the community as having a claim on one's conduct.

- Transactional leadership is the ability to influence others through a process of trade-offs. Transactional leaders offer members a path of discipleship in which the needs of others gradually become as important as their own while guiding their congregations toward caring for the needs of people who are different from themselves.

- Transforming leadership means leading an organization through the process of "deep change" in its identity, mission, culture and operating procedures.

Leadership involves commitment, passion and courage, going the extra mile, having audacity, showing the way and staying on course. Servant leaders have the ability to influence the direction of their community. Parry (2008: 33) tells us that "Leadership" was chosen as the World AIDS Day theme for 2007 and 2008. The theme was chosen because of the clear evidence that where there is strong and committed leadership, significant advances in the response to HIV have been achieved. A leader has the ability to hold up an alternative set of possibilities, which may have the effect of catalyzing social transformation. "When a man can define where he stands, he can also draw a map of where he wants to go" (Nouwen, 1978: 61). Servant leaders who know what their goals are can influence the direction of their community.

Jaworski (1998: 2) takes the understanding of servant leadership a step further. He suggests that the fundamental choice that enables true leadership in all situations (including but not limited to hierarchical leadership) is the *choice to serve life.* He suggests that in a deep sense a servant leader's capacity comes from his/her choice to allow life to unfold through him/her. For the servant leader of a congregation serving people suffering from HIV and AIDS, it means that *he/she chooses* to become a channel through which the Holy Spirit can reach out to people

bringing the Good News of Hope to HIV and AIDS sufferers, through the theology of the cross and the resurrection (Louw, 2008: 426-438).

The essence of leadership is "the desire to serve one another and to serve something beyond ourselves, a higher purpose". In our traditional way of thinking, "servant leadership" sounds like an oxymoron (Jaworski 1998: 59). But in a world of relationships, which can be found in a group of HIV positive young women, where relatedness is the organizing principle, it makes perfect sense.

When reflecting on the concept of servant leadership in the African context, attention must also be given to the *ubuntu* principle which characterizes African communities. How does the *ubuntu* principle play out within the African viewpoint of the traits and characteristics of leaders? Shutte (2001: 32) describes the meaning of *ubuntu* in leaders as follows: "With regard to oneself, ubuntu takes the form of integrity, solidity or wholeness of character and spirit that is present in one's judgments, one's decisions and one's feelings. This shows itself in confidence and endurance, in joyfulness and vitality, and in general sense of one's own value and dignity". This sense of *ubuntu* is present in some African leaders as for example Nelson Mandela and Archbishop Desmond Tutu.

Any of the leaders in a congregation should strive to become interpretive guides with the spirit and intent of a servant leader. From the understanding of servant leadership, and specifically servant leadership in the African context, the focus now shifts to the specific traits that a competent group caregiver should have.

2.4 The caregiver as leader

What "genes" of leadership, to use a phrase coined by Glaser (2006) in his book *The DNA of Leadership,* must a group caregiver leading a group of young HIV positive women posses? In the previous section where servant leadership in an African context was discussed, much focus was placed on the "being qualities" of the person. In this paragraph we will focus on the group caregiver as a professional and give an overview of the specific group leadership "doing skills" that he/she will have to possess.

In addition to personal characteristics of wanting to serve, group leaders need to acquire a body of knowledge and a set of skills specific to group work. Counselling skills can be taught, but there is also an element of art involved in using these skills in a sensitive and timely way. DePree (1987: 3) says "Leadership is an art, something to be learned over time, not simply by reading books. Leadership is more tribal than scientific, more weaving of relationships than an amassing of information, and, in that sense, I don't know how to pin it down in every detail".

Louw (2011: 467) offers a scheme to pastoral caregivers for pastoral ministry. It identifies the most basic concepts which pastors (interpretive guides) should consider when dealing with problems. He explains that this scheme leads to a practical and realistic approach contained in a therapy of hope. The theological points of departure which a pastoral caregiver should always take into account are:

- The suffering God: solicitude and identification (involvement).
- Jesus as Friend and Redeemer: reconciliation.
- The Holy Spirit as Mediator: guidance.

These theological points of departure permeate all the skills required from a pastoral group leader.

The purpose of the different skills, when used in a pastoral group context, is two-fold: to change a group member's perspective and to make room for the transformation process of the Spirit of God (Louw, 2011: 264).

The following paragraphs will describe some of the specific skills a group caregiver will need to acquire and continue to refine to become a competent group leader.

2.4.1 Listening

Mbigi (2005: 220) defines listening and reflecting as essential to the growth of the leader. Listening means, getting in touch with one's inner voice and seeking to understand what one's body, spirit and mind are communicating.

Listening is perhaps best summarized in the prayer of St Francis of Assisi: "Lord, grant that I may not seek so much to be understood as to understand". That asks of the counsellor not to be afraid of silence. It is often a devastating question to ask – but it is sometimes important that the servant leader asks – "In saying what I have in mind, will I really improve on the silence?" (Greenleaf, 1991: 17).

This suggests that a non-servant who wants to be a servant might become a natural servant through a long, arduous discipline of learning to listen, a discipline sufficiently applied, so that the automatic response to any problem is to listen first. Greenleaf (ib id: 17) states: "True listening builds strength in people".

One of the best examples of truly listening is found in one of the great stories of the human spirit – the story of Jesus when confronted with the woman taken in adultery (John 8: 1 – 11, NKJV, 2002: 1289). Jesus listens to all the sides of the argument, while remaining silent. He is a leader. He has a goal with his silence. He wants to bring more compassion into the lives of people. The adulterous woman is cast down before him by the mob who challenges his leadership. They say: "The law says she shall be stoned. What do *you* say?" Jesus must make a decision; He must give the right answer, right in the situation, and one that will bring his leadership toward his goal. What does He do? He bends down to write in the sand. In the pressure of the moment, He remains silent. And then goal orientation, knowledge of the human character, art and awareness open His creative insight when He answers with an answer that is still alive today, 2000 years later: "He who is without sin among you, let him throw a stone at her first". Adeyemo (2006: 1268-1269) reflects on this passage and comments: "The accusers left one by one … Jesus was not in the world to condemn it but to save it … and those needing to be saved included this woman. He commanded her to begin a new life".

Being listened to is a gift to any person, more so to a person suffering from HIV and AIDS. Listening is a way of showing compassion. Demissie (2008: 8) defines compassion as the fundamental virtue of the pastoral tradition that motivates all charitable and caring acts into events of moral and spiritual significance. "The listening and compassionate caregiver is therefore the one who exemplifies a deeply felt sense of solidarity with all suffering persons." Somé (1999: 115), who equates the elders in an African community with the leaders, says that "the best medicine for a young man in crisis is listening. Listening equals respect and

recognition. A young woman, feeling recognized, can begin to develop the trust that is needed for her crisis to be resolved and her inner gifts to be delivered to the world". Somé (ibid: 136) also says: "There is an elder in the making in everyone, but it is most visible in those who have the receptivity to listen to the stories of others. The ability to listen and the willingness to support others in difficult situations are the heart and the soul of elderhood. Young people have many difficulties to report. Anyone who wants to become an elder should lend them a listening ear".

Corey et al. (2007: 39) state that a skilled group leader is sensitive to the congruence (or lack of it) between what a member is saying in words and what he or she is communicating through body posture, gestures, mannerisms and voice inflections. Van Dyk (2009: 232) urges caregivers that HIV and AIDS infected people want more than the physical presence of the caregiver; they want him/her to be present psychologically, socially and emotionally.

To listen with empathy involves attending, observing and listening in such a way that the counsellor/caregiver develops an understanding of the client and his or her world. Van Dyk describes this kind of listening as a "being with" the client.

The interpretative guide and leader of a group must go further than practising empathetic listening – in his/her task of leading change, he/she should also teach the members of a group how to listen to one another.

2.4.2 Empathy

Mbigi (2005: 220) explains empathy as the need people have to be accepted and recognised for their special and unique spirits. The most successful leaders are those who seek to see situations from others' perspectives in a sympathetic way.

A dictionary definition of *acceptance* is: receiving what is offered, with approbation, satisfaction, or acquiescence. *Empathy* is the imaginative projection of one's own consciousness into another being. The closest we can come to finding a metaphor for empathy is "walking in the others person's shoes". The opposite of both acceptance and empathy, is the word *rejection,* to refuse to hear or receive – to throw out. Acceptance, empathy and compassion lie on a

continuum. Compassion means "suffering with". Compassion goes a step further than empathy by "suffering with" the other person.

Louw (2011: 467) describes empathy as an attitude that the leader portrays: "I know it causes pain. I care and I'm aware of your needs". Louw (2008: 443) explains empathy with HIV infected people as the message that must be brought home: "I understand your loneliness, anxiety and feelings of guilt". Louw (ibid: 266) describes the main objective of empathy is to create a feeling of self-acceptance within the parishioner so that it will lead to a deeper level of self-understanding. In pastoral counselling, empathy should be considered as an expression of Christian ethics: unconditional love. Love is linked to the process of gaining in sight, to promoting human dignity and to nurturing a sense of personal significance.

Van Dyk (2009: 247) describes "empathy as being empathy in any culture or language" – it is a way of being, regardless of the people we are in contact with.

Acceptance of the person and empathizing with him or her requires a tolerance of imperfection from the servant leader. Anybody can lead perfect people – if there were any. A group of HIV infected young women are not perfect either. These young women will have the opportunity to tell their stories in the group, and, as in the case of an AA group, will be understood because of "shared experiences" (Tonigan et al., 2010: 121). In such a group they can be accepted and recognised for their own uniqueness, and encouraged to tell their stories. They need to understand their own story. This is often facilitated when telling one's own story or while listening to someone else's story. Joseph Campbell in *The Power of Myth* (1988: 5) says: "We all need to tell our story and to understand our story. We all need to understand death and to cope with death, and we all need help in our passages from birth to life and then to death. We need for life to signify, to touch the eternal, to understand the mysterious, to find out who we are".

Louw (2008: 427) portrays the stigmatisation and labelling that HIV and AIDS sufferers are subjected to, and which is synonymous to immediate isolation, as the leprosy of the twenty-first century. In pastoral care to HIV/AIDS sufferers, the leaders/interpretive guides are challenged not only to have empathy with the person/persons, but to show the way towards a God who has empathy and compassion. The pastoral caregiver has to reveal a God who "suffers with" and cares for all. God's empathy for all people as expressed, inter alia, in Isaiah 49:15–16 can be

shared with the group: "Can a woman forget her nursing child, and not have compassion on the son of her womb? Surely they may forget, yet I will not forget you. See, I have inscribed you on the palms of my hands; your walls are continually before me".

People grow taller when those who lead them, empathize and when they are accepted for what they are, even though they may be judged and criticised in terms of what they are or what they have done. Servant leaders who fully accept those whom they lead and are able to empathize with and show compassion, are more likely to be trusted which will enable them to lead change.

2.4.3 Communication and persuasion

According to Mbigi (2005: 220) persuasion is the clearest distinction between the conventional authoritarian leadership style and that of servant leadership. The servant leader is effective at building consensus within groups. This is the heart and soul of African leadership, which is rooted in the philosophy of *ubuntu.*

Somé (1999: 22) writes in his book, *The Healing Wisdom of Africa,* that "the community is important because there is an understanding that human beings are collectively oriented. The general health and well-being of an individual are connected to a community, and cannot be maintained alone or in a vacuum". Further in his book (ibid: 244) he writes "that everyone is gifted. This means that everyone has something to give. A person who does not feel gifted is lost in a pit of oblivion and confusion. Sometimes we are the last people to recognize our own gifts. When they are shown to us by a group of people, they carry a different and larger meaning, and we feel acknowledged and recognized, which increases our sense of belonging". An "interpretive guide", leading a group in a township, realizes that a web of relationships is present within the group. Respecting the collective cohesion of the group, while acknowledging the gift each individual brings, will lead to the sense of *ubuntu* amongst the members and opens the way for effective communication.

DePree (1987: 95) argues that "the best way to communicate is through behaviour". He explains that communication through behaviour happens all the time. This reminds one of the fact stated

in the beginning of this chapter that a servant leader's being is more of an example to the group than his/her doing.

Louw (2011: 467) describes analysis as part of communication with the following example: "Let us examine all that has happened. Tell me everything; your story is important".

DePree (1987: 95) states that in most vital groups, "there is a common bond of interdependence, mutual interest, storytelling, interlocking contributions, and simple joy". Part of the art of leadership is to see that this common bond is maintained and strengthened, a task certainly requiring good communication. Just as any relationship requires honest and open communication to stay healthy, so the relationships within groups improve when information is shared accurately and freely.

Proclaiming the Word of God should be part of what the pastoral caregiver communicates to the group. Louw (2008: 264) quotes Thurnysen who writes that pastoral care is mainly the directing of the proclaimed Word to the individual, and one could add, to the group. Thurnysen brings to the fore, that the aspects of encounter, conversation and listening are essential attributes of the pastoral counsellor.

Louw (2008: 118) also portrays how illness can lead to conflict on a number of different levels, which for an HIV and AIDS sufferer goes to the core of his/her very existence. Illness affects a person physically, it can lead to conflict taking place within the person him/herself, it causes conflict within the environment, it generates conflict on the religious plane and lastly illness influences basic choices and a sense of purposefulness and direction. Inviting open communication regarding all the mentioned aspects can lead to a catharsis, more acceptance and a moving forward in life by the members of the group. This can also lead to healing.

2.4.4 Healing

According to Mbigi (2005: 222) in terms of the African Leadership Paradigm, many people have broken spirits and have suffered emotional hurts. Servant leaders should recognise that they have an opportunity to 'help make whole' those with whom they interact. "One of the key functions of leadership is the ability to manage meaning by creating the memory of an attractive future. In

principle, healing implies that you need to understand or have a picture of the future in order to make certain sacrifices or understand the sacrifices you have to make. A good example is the struggle against apartheid, where people made significant sacrifices, even gave their lives, to achieve the vision of a South Africa where all are equal and free."

Healing is an interesting word, with its meaning, "to make whole." Louw (2008: 291) talks of pastoral care as life care: cura vitae and the healing of life (the therapeutic dimension). He (ibid: 263) quotes Guthrie who writes that "healing also implies growth, spiritual growth as an indication of the work of the Spirit". Healing can then be seen as the making whole and the healing of life through the work of the Holy Spirit.

According to Richards et al. (2010: 133) there is growing empirical evidence that a person's spiritual values and behaviours can promote physical and psychological coping, healing and well-being. Louw (2008: 263) refers to Maddocks who points to the comprehensive meaning of the concepts of healing and peace, "which in the Old Testament covers the idea of well-being in the widest sense of the word – prosperity, bodily health, and contentedness, good relations between nations and men, and salvation".

Greenleaf (1991: 36) discusses the meeting of twelve ministers and theologians of all faiths and twelve psychiatrists of all faiths who had convened for a two-day off-the-record seminar on the one-word theme of *healing.* The question asked at the opening of the seminar was: "We are all healers, whether we are ministers or doctors. Why are we in this business? What is our motivation?" After only ten minutes of intense discussion they were all in agreement, doctors and ministers, Catholics, Jews, and Protestants: "For our own healing," they concluded. This suggests that healing is something that one never makes. It is always sought.

It is in this sense that the servant leader of a group of HIV positive women can acknowledge that his/her own healing is part of his/her motivation. There is something subtle communicated to one who is being served and led if, implicit in the relationship between the servant-leader and the group, there is the understanding that the search for wholeness and spiritual health is something that they all share. In the previous chapter the installation of hope during pastoral group care was discussed. Yahne & Miller (2010: 229) describe the evocation of hope as one of the most important and central elements of healing, and explains that in Spanish, the verb for hope,

esperar, also means to wait. The servant-leader is challenged to seek with the group what their sources of hope are and in this way they search for meaning and spiritual healing together. In this sense hope and healing is not given, but sought. When found, it is a gift the servant leader as interpretive guide can give to the group.

Spiritual healing is possible when a group member experiences spiritual fellowship with other group members and intimacy with a God who accepts him/her unconditionally. Galatians 2:20-21 reads, "... it is no longer I that live, but Christ lives in me; and the life I now live in the flesh I live by faith in the Son of God, who loved me and gave Himself for me. I do not set aside the grace of God; for if righteousness comes through the law, then Christ died in vain".

In the face of the HIV and AIDS epidemic, the pastoral caregiver can lead the group to become a small community of care, healing and compassion. As the servant leader/interpretive guide he/she can provide the space for openness and honesty. In the group, members should find it easier and safe to disclose their HIV status without experiencing fear and as such group members should be able to experience true fellowship or koinonia.

2.5 Conclusion

The purpose of this chapter has been to show that in the spirituality of servant leadership, the pastoral caregiver as interpretive guide must accept his/her main task as leading change. A role-model within the African context was looked at, and his life was measured according to the criteria for servant leadership. True listening, empathy, communication and healing were seen as those skills a servant leader should posses and continually hope to improve. It is within the art of leadership that a leader of a group can create a spirit of *koinonia* which will allow the members to feel safe and accepted. Proclaiming the Christian message of hope by his/her priestly compassion and through the work of the Holy Spirit who communicates the faithfulness of God, the pastoral caregiver can help the members of a group of HIV infected young women, to find meaning in their lives.

Nouwen (1978: 64) points out that only Jesus can be called 'pastor' in the real sense. But when Jesus was asked about the source of His knowledge, He answered and said: "My doctrine is not

Mine but His who sent Me. If anyone wills to do His will, he shall know concerning the doctrine, whether it is from God or whether I speak on My own authority. He, who speaks from himself, seeks his own glory; but He who seeks the glory of the One who sent Him, is true, and no unrighteousness is in Him (John 7: 16-18).

In the next chapter the world in which Precious Xaba lives, will be investigated. This descriptive-empirical task is a form of priestly listening, grounded in a spirituality of presence: attending to and engaging with others in their circumstances within the presence of God.

CHAPTER THREE

Understanding the world in which Precious Xaba lives

3.1 Introduction: Priestly listening

The aim of this chapter is to pay attention to the descriptive-empirical task which Osmer calls *Priestly Listening* (Osmer, 2008: 31). On page 33 he states that congregational leaders experience episodes in which people share their problems with them, seek help, are hospitalized, lose loved ones and pass through the stages of life. When congregational leaders then make observations and gather information in the face of such incidents, they are attempting to answer the question, "What is going on?" This question lies at the very heart of the descriptive-empirical task of practical theological interpretation. In this chapter the life of Precious Xaba will be observed in order to answer the question: "What is going on here?"

Osmer (2008: 35) quotes Keck who notes that intercessory prayer is a priestly act only when the leader does not merely pray *about* the people but also offers a prayer to God *from* the people on their behalf. As Keck states: "The pastor is truly a priest when his prayer articulates the situation of the congregation, through his or her prayer for them." For this to happen, one must listen to the people and establish a critical identity with them. To pray on their behalf, one must enter into their lives to the point that one begins to feel what they feel, yet without losing one's identity. This will call for a hermeneutics of the environment in which Precious Xaba lives, as well as a hermeneutics of her inner world as young HIV infected woman.

To enter the world of Precious Xaba and establish a critical identity with her to the point where one is able to satisfactorily answer the question: "What is going on?" will be a multi-faceted, complex and daunting task. Good ministry is not only a matter of solving problems. It can be seen as a journey to be ventured along and a mystery to be explored. Priestly listening in the context of the HIV epidemic implies more than looking at the phenomenon in isolation. The priestly listener takes on a hermeneutical stance towards the HIV epidemic. He/she attempts to interpret the dynamics of the interrelatedness/interconnectedness of the virus with its history and the environment in which it operates. For this reason priestly listening implies that a

congregational leader will look at the HI virus and those infected/affected by the disease in a holistic way. Therefore as part of the task of priestly listening:

1. Information will be given on the HI virus with which Precious was born. AIDS and its relationship to HIV will be explained. Information on antiretroviral medicine will be provided. This information will assist the congregational leader to understand the situation better.
2. The physical environment in which Precious lives will be described.
3. The existential concerns and inner landscape of a person like Precious, living with HIV, will be explored.

3.2 Background information on HIV/AIDS

3.2.1 Historical background

Thirty years ago, the first case studies of the outbreak of an unusual form of pneumonia in Los Angeles were reported by America's Centres for Disease Control and Prevention. A few weeks later, scientists in San Francisco noticed a similar cluster of a rare cancer called Kaposi's sarcoma. They suspected that something seriously was going on. That something was AIDS (The Economist, 4 June 2011: 13).

In 1983 AIDS was diagnosed for the first time in two patients in South Africa. The first recorded death from AIDS came later that year. By 1986 South Africa had only 46 recorded AIDS cases. Today it is estimated that the number of South Africans infected with HIV is 5,6 million – that is the highest for any country in the world. An estimated 1,4 million South Africans are receiving antiretroviral therapy in both the public and private sectors (Thom, 2011a: 27).

The Economist (4 June 2011: 13), states that since its first outbreak 30 years ago, 25 million people have died from AIDS world-wide and another 34 million are infected.

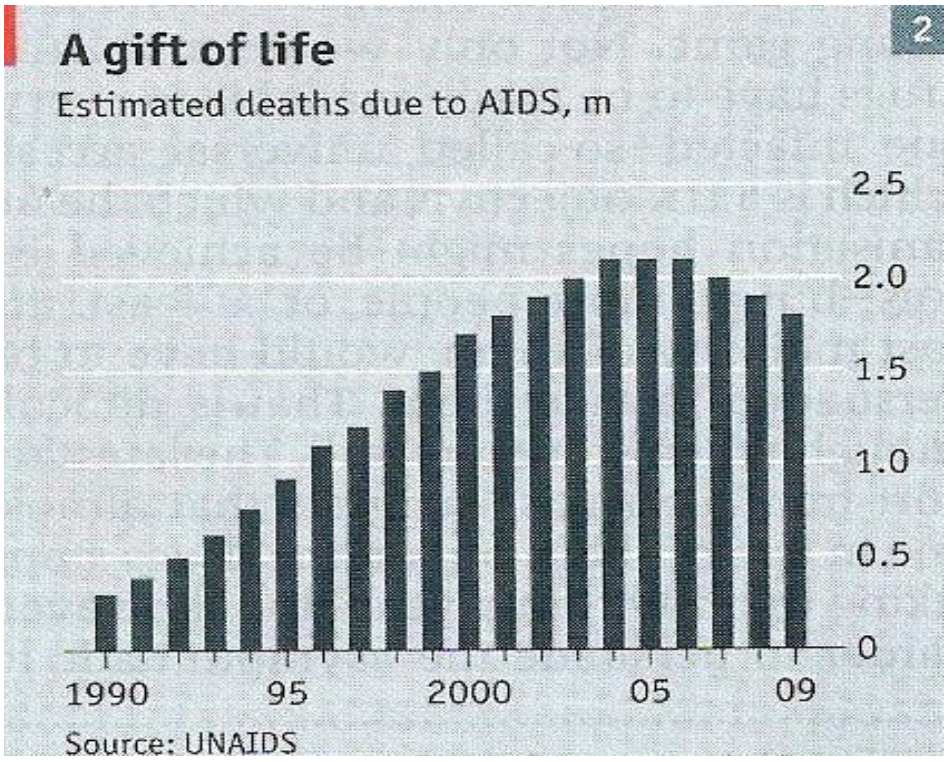

Figure 5: A gift of life. Estimated deaths due to AIDS

This figure shows how the number of persons dying world-wide from AIDS peaked in the years 2004-2006 at over 2 Million per year and is gradually declining since then (The Economist, 4 June 2011: 89).

3.2.2 Medical background of HIV

HIV is an abbreviation of Human Immunodeficiency Virus.

In Southern Africa, young women in the 18 – 25 year age group are the most at risk for contracting the virus. The men tend to start catching up as they get older, and older women similarly remain at risk throughout their lives (Venter & Rees, 2011: 146).

This virus attacks the human body at the point where it is most vulnerable – the very "heart of the immune system" (Van Dyk, 2009: 4). The HI virus attacks and destroys the CD4 lymphocytes in the body – the cells that should be protecting the body against diseases.

Like all other viruses, the HI virus can only reproduce itself by taking another living cell hostage, and then continue to live in that cell as a parasite. The HI virus cannot live and reproduce itself outside a human cell.

But if this is true of all viruses, what makes the HI virus so dangerous?

According to Van Dyk (2009: 11), the HI virus does something that no other known virus has ever done: it directly attacks the most important defensive cells of the human immune system, the CD4 or T helper cells. The result is that with the CD4 cells being destroyed by the HI virus, the body has no way of defending itself against the HI virus or any other diseases.

3.2.3 Medical background of AIDS

When Precious Xaba, with her body already weakened by the HI virus, went on a party spree with her friends during the December school holidays, she was possibly re-infected with one of the other strains of HIV and ended up with a multiple viral load. This in turn lead to a further decrease in CD4 cells and an accompanying further weakening of her immune system which finally tipped the scale from HIV to full-blown AIDS.

AIDS stands for Acquired Immune Deficiency Syndrome. This acronym emphasises that the disease is *acquired* and not inherited. It is caused by a virus that invades the body. This virus then attacks the body's immune system and makes it so weak and ineffectual that it is unable to protect the body from both serious and common infections and pathogens (Van Dyk, 2009: 489). It is important to know what the relationship between a person's CD4 count and his/her viral load is. This relationship is important as it is within the relationship between the two that a person's health can deteriorate from being HIV positive to having full-blown AIDS.

3.2.4 What is the relationship between HIV and AIDS?

A young South African woman like Precious Xaba has little or no understanding of the relationship between HIV and AIDS. All she knows is that she was "positive" and now she has "become sick" and has to take tablets for the rest of her life or she will die.

In order to grasp the difference between HIV and AIDS, it is necessary to understand the terms *viral load* and *CD4 count.*

The CD4 count: This is a measurement of the number of CD4 cells in a person's blood. It is done in a laboratory in the same way that other blood tests are done. A machine counts how many CD4 cells a person has in a micro litre of blood – that is an extremely small drop of blood. Most healthy people have a CD4 count of between 500 and 1 200 cells in every micro litre, and that is what is meant when a person is said to have a "normal CD4 count". However, most of the body's CD4 cells are not in the person's blood at any one time – they are in other tissues throughout the body, and cannot be measured. For example the gut associated lymphoid tissue (GALT) is thought to contain most of the body's CD4 cells. Another way of expressing the number of CD4 cells is the CD4 percentage. This refers to the percentage of all the lymphocytes in the blood that are CD4 cells. This is usually about 40 – 45%. As the CD4 cell count drops – so does the CD4 percentage.

The HIV viral load: This is a measurement of how many HI viruses a person actually has in their blood. This laboratory test needs specialised equipment. Because there are millions of HI virus particles in a drop of blood, the difference between one or two or five thousand viral particles is not very significant, whereas the difference between 1 000 particles and 50 000 particles is very significant. The viral load can help in keeping track of how well or how badly a person is doing, or if the treatment they are on is helping or not – but the CD4 count is more reliable for this. Sometimes the result of the "viral load" test is reported to be "undetectable". This does not mean that the virus has been completely removed from the blood. It means that the equipment is not sensitive enough to measure the actual number of viral particles. The test cannot tell how many viral particles are present in other parts of the body, e.g. the lymph nodes, spleen or brain.

CD4 count and viral load.

The higher the viral load of a person, and the lower his/her CD4 count, the more at risk is the person to become seriously ill.

The relationship between HIV and AIDS can thus be explained as follows: a person is diagnosed with AIDS if he/she is infected with the HI virus, and has a CD4 count of 200 or less per mm^3 blood. The viral load of such is person at this stage is so high and aggressive that his/her body, despite possible medication cannot fight the virus effectively. This is regarded as the last stage of the HIV infection. At this stage the person usually also suffers from one or more opportunistic infections characteristic of AIDS, for example TB.

Opportunistic infections or diseases are caused by micro-organisms that do not normally become pathogenic (in other words make a person sick) in the presence of a healthy immune system because a healthy immune system will kill them or render them inert. But when an immune system is unable to defend the body because it is being destroyed by HIV, opportunistic infections will "*take any opportunity*" to attack the body successfully (Van Dyk, 2009: 55). Pulmonary TB (Tuberculosis of the lungs) is often called the twin accompanying the HI-virus.

People who die of AIDS may have a CD4 count of 50 cells or less in every micro litre of blood. Occasionally some people with very low CD4 counts appear to be quite healthy. A few of them may have a very rare condition known as " idiopathic CD4 lymphocytopaenia" (ICL), which means having a low CD4 count for unknown or undetermined reasons.

It is significant that one of our township HIV clients had nursed her AIDS stricken boyfriend back to relative health – from a CD4 count of 40 to a CD4 count of above 500, and an undetectable viral load – through proper diet, regular ARVs and sufficient exercise – accompanied by acceptance, care and compassion.

3.2.5 The transmission of the HI virus

Louw (2008: 421) clearly states that it is important to bear in mind that the only way of transmitting the virus is by the introduction of infected blood or semen into the blood stream.

The HI virus is mainly transmitted by intimate sexual contact, breast feeding and to a lesser extent by blood transfusion, intravenous drug users sharing needles, pregnant mothers to their unborn babies and health-care workers via accidental pricks by contaminated needles.

The focus of this thesis is on young women of childbearing age. Therefore Mother-to-child transmission (MTCT), also known as vertical transmission, has to be considered because it is one of the major causes of HIV infection in children in South Africa.

Mother-to-child transmission: By the end of 2009 it was estimated that 300 000 children under 15 years old were living with the HI virus in South Africa, due to MTCT.

Unless preventative measures are taken, 20 – 40% of children born to HIV positive women are infected. HIV can be transmitted from an infected mother to her baby via the placenta during pregnancy, through blood contamination during childbirth or through breastfeeding.

According to Venter and Rees (2011: 146) pregnant women are at higher risk of contracting HIV if they have unsafe sex. The physiology of pregnancy makes them more vulnerable to infection as well. Without antiretroviral medication, a third of women will transmit HIV to their uninfected infant. Once infected, children are at risk of early death if not treated, and of growth stunting if antiretroviral therapy is not instituted timely.

It is reported (Pienaar, 2011: 9) that at least 11% of pregnant women who were tested HIV negative during their first visit to a prenatal clinic, tested positive when they were 32 weeks pregnant. The same article indicates that the SA Health Department's ARV programme for mothers and children reports that this is the group of women they are most concerned about because the period just after infection is the time when the virus spreads the easiest to a baby or bed-fellow due to the high viral load in the effected person's blood. According to Pienaar (2011: 9) the SA Health Department reported further that one third of pregnant mothers only visit their health clinic in the third trimester of pregnancy, which is too late for the effective implementation of the necessary ARV treatment to protect the baby from MTCT.

3.2.6 How effective is antiretroviral treatment?

A medical doctor explains the use of ARVs to a patient at a local clinic in Khayelitsha: "Antiretroviral treatment is 100% effective if taken 100% correctly for the rest of your life. If taken correctly only 99,9% of the time, its effectiveness cannot be guaranteed". Precious Xaba, who was a victim of MTCT, was placed on ARVs at the age of 18. Her December holiday party spree ended with herself in hospital where it was found that her CD4 count had dropped to <120 cells/mm³ and her viral load had increased dramatically.

Precious's initial reaction to the ARVs was favourable. She was suddenly filled with new vigour. However, within a couple of days she came face to face with the all too familiar double edged sword of ARV treatment: She became tired and lethargic with frequent headaches and dizzy spells, but the most debilitating side effect in her case was diarrhoea and nausea. The result of these side effects to the "medicines" is that Precious doesn't want to go to school anymore. She feels like a burden to her teachers and she is reluctant to take her ARVs at school because of the stigma attached to AIDS.

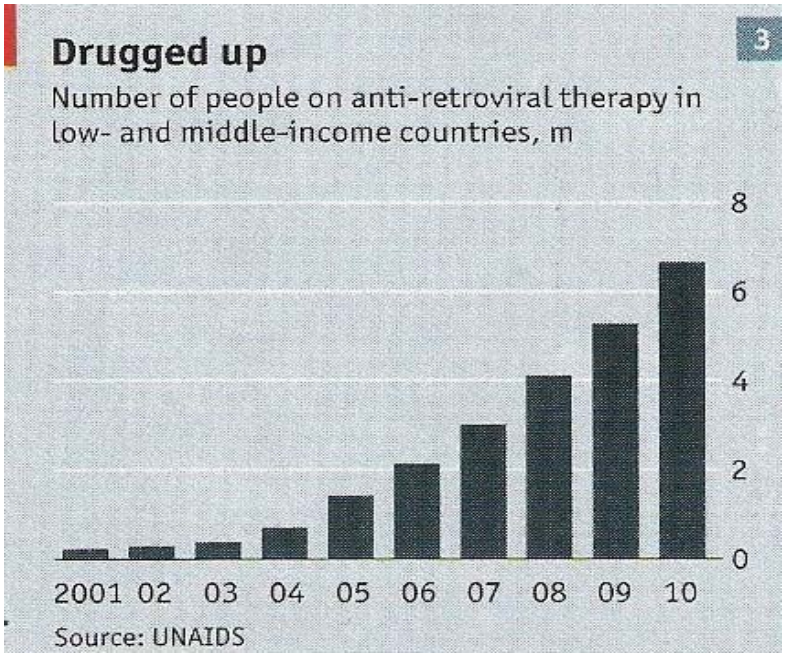

Figure 6: Number of people on anti-retroviral therapy in low- and middle-income countries.

Figure 6 shows the number of people in low- and middle income countries who were taking ARV's. By 2010 the number had grown exponentially to 6, 2 million (The Economist, 4 June 2011: 90).

Antiretroviral drugs act by blocking the action of those enzymes which the HIV virus uses to replicate itself inside the CD4 cells. Effective ARV therapy has been shown to reduce the number of new cells infected by HIV and to interfere with the ability of the virus to develop drug resistance (Van Dyk, ibid: 95).

According to Van Dyk (2009: 108) people benefit from antiretroviral therapy as it:

- preserves or restores the immune function (CD4 cell count),
- provides sustained suppression of the viral load,
- promotes or restores normal growth and development,
- improves quality of life,
- prevents complicating infections and cancers,
- prolongs the person's life.

Venter & Rees (2011: 147) comment that "antiretroviral therapy has had the same revolutionary impact on HIV that penicillin has had for bacterial infections and insulin has had for diabetes. Highly effective, affordable and safe, the same 'first-line' drugs used in New York or London are available in many African state health sectors. Life expectancy for those on antiretrovirals (ARVs) has been increased by decades and may approach near-normal levels. Quality of life is dramatically improved with effective treatment, much like in the case of diabetes or asthma. Effective early treatment for pregnant women stops transmission to their infants in almost all cases".

However, the success rate of ARV treatment is a highly individual one. It inter alia depends on how well the patient tolerates the antiretroviral drug. Patients must also be prepared to commit themselves to life-long treatment and to daily adherence for the treatment to be effective.

Van Dyk (2009: 105) emphasizes the importance of strict adherence to antiretroviral therapy. This is a most difficult task for patients on ARV treatment as it is a life-long routine. Not one

day or one session may be skipped. Adherence to antiretroviral therapy is extremely important to achieve viral suppression and to avoid the risk of viral mutation, the development of resistant strains and drug failure. Drug resistance can develop very rapidly with missed or inadequate doses of medication. Missing even a few doses in a week may lead to the development of drug resistance.

In most cases a combination of ARV tablets must be taken twice a day, along with vitamin and mineral supplements. To prevent opportunistic diseases, a daily dose of an anti-biotic is prescribed as well. A HIV positive person on ARVs can thus be asked to swallow between 5 – 10 tablets twice daily. This is not an easy task and this is not something that a person can do privately without being "caught out" at some or other stage. Many patients develop a deep seated hate and anger towards these tablets.

Venter and Rees (2011: 147) remark that although access to antiretroviral treatment has improved steadily, treatment is usually initiated very late, when the immune system is already severely affected and a patient requires complex and expensive treatments for various opportunistic infections and cancers. This late presentation is probably largely a product of three things: patient stigma, fear and inappropriate health service provision.

According to the statistics, (Thom, 2011a: 27) there are 5,6 million people in South Africa infected by the HI virus, but only 1,4 million are receiving antiretroviral therapy.

The very first handing out of free antiretroviral medicines to the public in South Africa, happened in 2001. This took place at the Ubuntu Clinic in Khayelitsha. Then, only 100 people dependant on government medical treatment received their ARVs from the Ubuntu Clinic. Today 20 000 people receive their ARVs at the Ubuntu Clinic in Khayelitsha (Brits, 2011b: 7).

It is important to note that not all persons infected with the HI virus need to receive antiretroviral therapy. In fact, it is recommended that ARV therapy should be delayed as long as possible and only started when a patient's CD4 count drops to below 350 cells/mm³.

The South African HIV Clinicians Society on its web page (www.sahivsoc.org), recommends that maximally suppressive antiretroviral regimes should be used, whenever possible, in order to obtain the best clinical results and to prevent resistance. HAART (or highly active antiretroviral

therapy) is therefore recommended for optimal results. An antiretroviral drug regime refers to the medication schedule, plan or routine that a patient will have to follow.

3.3 The physical environment in which Precious Xaba lives

Precious lives in a one room shack in Khayelitsha. Where is Khayelitsha, and what are the conditions of the environment in which she lives? The pastoral care giver has to take this into account if he/she wants to apply the holistic approach as mentioned earlier.

3.3.1 History and Geography

Khayelitsha is a partially informal township located on the Cape Flats in the City of Cape Town. The coordinates are: 34º02'25"S; 18º40'40"E. The name in isiXhosa means "New Home". Khayelitsha is South Africa's third largest township, after Soweto and Sharpeville which are both near Johannesburg. It is reported to be the fastest growing township in South Africa (Ndigaye, 2005: 6).

Picture 1: Informal housing in Khayelitsha

Picture 1 shows the building materials used – scrap metal, wood off-cuts, plastic, in fact any object that can be used as building material to provide shelter. Besides the informal housing, a better kind of formal housing is prevalent.

Xoliswa Ndigaye (2005: 2) describes an informal township as a place where people live "informally" and the shelters are generally made of used scrap metal, corrugated metal sheets, and plastic and other materials (see picture 1). These shelters are irregular in shape and are erected in between the formal brick housing. Squatting occurs when people decide to build their shacks anywhere without permission from the authorities. Squatting, according to The Concise Oxford Dictionary (Allen, 1990: 1508), is the act of a person who settles on a new place or public land without title or takes unauthorized possession of unoccupied premises.

Khayelitsha was established in 1985. Large numbers of black people, mostly Xhosa speaking, were forcefully relocated there. After the historic 1994 elections and the advent of democracy in South Africa, hundreds of thousands of black people, mainly Xhosas, moved to Cape Town in search of employment or education or both. Many of them settled in Khayelitsha (Ndigaye, 2005: 5).

3.3.2 Demographics

According to The Population Register Update, Khayelitsha: 2005, Khayelitsha has an estimated population of 406 779 (as of 2005). This population is very young. Fewer than 7% of its residents are over 50 years old and more than 40% of its residents are under 19 years of age. (Please also see table 2 which has, however, a different age grouping).

About 75% of the residents consider themselves Christians; while about 20% follow traditional beliefs and a negligible number consider themselves Muslim.

The following tables were compiled by Strategic Development Information and GIS from 2001 Census data supplied by Statistics South Africa. These are the latest official data as South Africa had its next census only in October 2011. The results will only be known in 2012.

TABLE 1 (2001)						
ETHNIC GROUPS	**Male**	**%**	**Female**	**%**	**Total**	**%**
Black African	157,262	47.80	169,841	51.62	327,103	99.42
Coloured	784	0.24	991	0.30	1,774	0.54
Indian/Asian	21	0.01	18	0.01	39	0.01
White	51	0.02	33	0.01	84	0.03
Total	***158,118***	***48.06***	***170,883***	***51.94***	***329,000***	***100.00***

This table clearly shows that the overwhelming majority of the persons living in Khayelitsha are black Africans, with the women outnumbering the men by approximately 4%.

TABLE 2						
AGE GROUPS	**Male**	**%**	**Female**	**%**	**Total**	**%**
0 – 5	20,088	6.11	19,778	6.01	39,866	12.12
6 – 12	21,975	6.68	23,001	6.99	44,976	13.67
13 – 17	15,505	4.71	18,098	5.50	33,603	10.21
18 – 34	60,864	18.50	68,082	20.69	128,947	39.19
35 – 54	33,814	10.28	35,403	10.76	69,217	21.04
55 – 64	4,196	1.28	4,441	1.35	8,637	2.63
65+	1,676	0.51	2,079	0.63	3,755	1.14
Total	***158,118***	***48.06***	***170,883***	***51.94***	***329,000***	***100.00***

This table indicates that about three quarters of the inhabitants of Khayelitsha are younger than 34 years of age, with about half in the reproductive age bracket.

3.3.3 Level of education

Khayelitsha has 35 Primary and 18 Secondary Schools. Table 3 shows that the average level of education is relatively low – the majority of people in Khayelitsha tend to drop out of school before they reach Grade 12. Nearly two thirds reach a level between Grade 8 – 12.

TABLE 3						
EDUCATION LEVEL OF ADULTS (20+)	**Male**	**%**	**Female**	**%**	**Total**	**%**
No schooling	6,804	3.49	6,810	3.49	13,614	6.98
Grade 1- 6	19,259	9.88	12,877	6.60	32,136	16.48
Grade 7	8,636	4.43	8,235	4.22	16,871	8.65
Grade 8 – 11	37,861	19.41	46,287	23.74	84,148	43.15
Grade 12	17,369	8.91	21,694	11.12	39,063	20.03
Certificate with less than Grade 12	324	0.17	440	0.23	765	0.39
Cert/dip with Grade 12	2,398	1.23	3,932	2.02	6,330	3.25
Bachelor's degree	593	0.30	634	0.33	1,228	0.63
Bachelor's degree and diploma	225	0.12	290	0.15	515	0.26
Honour's degree	78	0.04	139	0.07	217	0.11
Higher degree (master's or doctorate)	63	0.03	67	0.03	130	0.07
Total	***93,609***	***48.00***	***101,407***	***52.00***	***195,015***	***100.00***

3.3.4 Health care

The South African government launched a major HIV testing campaign in 2010. According to Health Minister Motsoaledi in his 2011 Health Budget Policy speech, 11.9 million people in South Africa now test for HIV every year (Thom, 2011a: 27).

There are three Provincial Government clinics in Khayelitsha. Khayelitsha (Site B) Community Health Clinic is the principal clinic and is the only 24-hour trauma and emergency unit in the township as well as an abortion clinic. Fokazi (2011: 6) reports that between 1997, when legal termination of pregnancy was introduced, and last year about 702 354 abortions were performed at public health care facilities nationwide. About 528 000 of these abortions involved teenagers. In the Western Cape, the abortion pill is available only at the Khayalitsha clinic. The other two Provincial Government clinics are Michael Maphongwana in the Harare sub section and Nolungile in the Site C subsection. There is also a mobile tuberculosis clinic and numerous small municipal clinics throughout the township. Services offered at the municipal clinics include Child Health, Family Planning, TB treatment, HIV testing, Pap Smears and the treatment and diagnosis of Sexually Transmitted Infections. These clinics also train people from the community as health workers to, inter alia, promote HIV awareness.

According to Ndingaye (2005: 59) Site C is serviced by a Day Hospital. Private clinics, run by the University of Cape Town and their Community Health Project, also operate in the area and help to deal with the insatiable health needs of the community.

3.3.5 Economical and sociological status

Tables 4 – 9 give detailed information on the economic and sociological situation of the people living in Khayelitsha. This is the world which Precious Xaba is part of – young people, poverty stricken and with little hope for the future.

TABLE 4						
WORK STATUS ECON. ACTIVE (Aged 15 - 65)	**Male**	**%**	**Female**	**%**	**Total**	**%**
Employed	45,156	28.11 33	,892 2	1.10	79,048	49.21
Unemployed	35,689	22.21 45	,918 2	8.58	81,608	50,79
Economically Active Total	***80,845***	***50.32***	***79,810***	***49.68***	***160,656***	***100.00***

More than half of all residents in Khayelitsha are unemployed. This emphasizes the fact that one working person has to support a number of dependants. A large number of the people living in Khayelitsha survive on state grants. Table 5 further indicates the reasons why the economically inactive are unemployed.

TABLE 5						
WORK STATUS - ECONOMICALLY INACTIVE Aged 15 to 65	**Male**	**%**	**Female**	**%**	**Total**	**%**
Scholar or student	17,380 2	5.66	21,413	31.62	38,793	57.28
Home-maker or housewife	164	0.24 3	,305 4	.88	3,468	5.12
Pensioner or retired person/too old to work	1,323	1.95 2	,379 3	.51	3,702	5.47
Unable to work due to illness or disability	2,325	3.43 2	,404 3	.55	4,729	6.98
Seasonal worker not working presently	572	0.84 594	0	.88	1,166	1.72
Does not choose to work	1,691	2.50 2	,528 3	.73	4,219	6.23
Could not find work	4,505 6	.65	7,144	10.55	11,649	17.20
Economically Inactive Total	***27,959***	***41.28***	***39,767***	***58.72***	***67,726***	***100.00***

The fact that a large number of Khayelitsha's residents live in poverty, has an influence on the type of dwelling they live in. Nearly two thirds of all residents live in informal shacks. Many of the people living in Khayelitsha have moved there from the Eastern Cape in recent years, the majority looking for better education for their children - or else in search of possible employment.

TABLE 6						
INCOME OF EARNERS (PER MONTH)	**Male**	**%**	**Female**	**%**	**Total**	**%**
0 - R1 600	33,120	41.90	28,407	35.94	61,527	77.83
R1 601 - R6 400	11,468	14.51	5,106	6.46	16,574	20.97
R6 401 - R25 600	472	0.60	337	0.43	809	1.02
R25 601 - R102 400	81	0.10	36	0.05	117	0.15
R102 401 or more	15	0.02	6	0.01	21	0.03
Total	***45,156***	***57.12***	***33,892***	***42.88***	***79,048***	***100.00***

Table 7 indicates the type of dwellings in which residents of Khayelitsha stay, whereas table 8 shows that despite the fact that most buildings are informal shacks, most dwellings have electricity. However, not all connections to the net are in accordance with the municipal regulations, some are even illegal.

TABLE 7		
TYPE OF DWELLING	**Number**	**%**
House or brick structure on a separate stand or yard	25,699	29.89
Traditional dwelling/hut/structure made of traditional materials	1,978	2.30
Flat in block of flats	262	0.30
Town/cluster/semi-detached house (simplex; duplex; triplex)	585	0.68
House/flat/room in back yard	929	1.08
Informal dwelling/shack in back yard	6,250	7.27
Informal dwelling/shack NOT in back yard	49,051	57.05
Room/flatlet not in back yard but on shared property	422	0.49
Caravan or tent	440	0.51
Private ship/boat	6	0.01
Not applicable (living quarters are not housing units)	362	0.42
Total	***85,983***	***100.00***

TABLE 8		
TYPE OF FUEL USED FOR LIGHTING	**Number**	**%**
Electricity	65,397	76.03
Gas	354	0.41
Paraffin	18,773	21.83
Candles	1,363	1.58
Solar	60	0.07
Other	69	0.08
Total	***86,016***	***100.00***

Table 8 also shows that a large number of households are dependent on gas, paraffin or candles for cooking and/or light. The use of candles and/or paraffin often leads to the burning down of shacks or groups of shacks with devastating consequences. People loose their life belongings and very often their lives in such fires.

TABLE 9		
ACCESS TO WATER	**Number**	**%**
Piped water inside dwelling	17,286	20.10
Piped water inside yard	35,757	41.57
Piped water on community stand: distance less than 200m. from dwelling	18,335	21.32
Piped water on community stand: distance greater than 200m. from dwelling	13,583	15.79
Borehole	9	0.01
Spring	12	0.01
Rain-water tank	18	0.02
Dam/pool/stagnant water	208	0.24
River/stream	3	0.00
Water vendor	18	0.02
Other	788	0.92
Total	***86,016***	***100.00***

TABLE 10

TYPE OF SANITATION	Number		%
Flush toilet (connected to sewerage system)	54,422	63	.27
Flush toilet (with septic tank)	1,467	1	.71
Chemical toilet	66	0	.08
Pit latrine with ventilation	141	0	.16
Pit latrine without ventilation	75	0	.09
Bucket latrine	7,555	8	.78
None	22,290	25	.91
Total	***86,016***		***100.00***

Tables 9 and 10 show the typical picture of problems with access to water and sanitation in a mainly informal settlement where no infrastructure is developed before the shacks are built.

All these tables describe the physical landscape in which Precious Xaba lives. The information given (Wikipedia: 2001a) in the tables portrays a life filled with poverty and hardship.

3.4 The internal landscape of a person living with HIV and AIDS

If the external world of a young woman like Precious Xaba living with AIDS leaves a lot to be desired. Of what does her internal landscape consist?

AIDS has been the subject of immense and often distorted, indeed seriously misleading publicity. Those who are HIV positive, but have not yet developed AIDS, often face an uncertain future. They are aware, and have often witnessed, how AIDS can lead to a debilitating sickbed and an uncomfortable death.

Louw (2008: 116) described illness as a problem of the total human being. "Illness is associated with the basic bodily needs of our existence, which means that illness is primarily an issue which affects the area of 'embodiment', i.e. the way in which one experiences one's uniqueness within

one's body. One not only has a body, but *is* one's body". *"One not only has an illness, one is sick."*

Van Dyk (2009: 66) refers to Watts who describes AIDS: *"Aids is the stuff of our nightmares, triggering many of our deepest fears".*

The above quote reflects the severity of the anxiety that a HIV infection or AIDS diagnosis evokes. Such a diagnosis attacks the core of a person's whole being. It is different from most other life-threatening diseases in that it brings severe emotional reactions to the fore.

3.4.1 People living with HIV and AIDS struggle with fear

"The other people cry at night", says one of the most talkative patients dressed in his green hospital tunic, with the tubes draining fluid from his lungs into plastic bottles. He wears a baseball cap to hide the oozing sores on his head. I notice the pills on his bedside table. "Are you drinking your pills, Jake?" He nods his head, and then he smiles slyly. "During the day I ask for pain killers, I say I have lots of pain. Then I do this. . ." He shows me how he rolls the tablets in his serviette and puts it away in the drawer of his bedside table. "Then I keep two slices of bread from my meal. In the middle of the night when the others cry, I take those pills, I put them between the bread slices and I eat them." I am speechless from sheer amazement at his ingenuity. "If I don't take those pills, oh Lord, I'll never make it through the night . .!"

Pain is not a stranger to an HIV sufferer. It is known to be incurable. A person living with AIDS is understandably afraid of dying – and particularly of dying alone and in pain. Many HIV infected persons have seen family/friends/neighbours die of AIDS. They do not know how it is going to affect them personally and do not know how exactly or when they might die. Fear due to not knowing what is going to happen, fear of desertion, fear of becoming a burden to others and fear of pain, occupy the minds of people living with HIV and AIDS (Manala, 2005a: 902).

Adding to this, according to Louw (2008:169) illness in the African context is also a religious concept. Illness means that the spiritual chain of protection has been damaged and this gives rise to the anger of the ancestors and the influence of spiritual powers, which harm or cast evil upon the person or community. People living with HIV and AIDS thus fear the anger of the ancestors

and also those spiritual powers which can cast evil upon the person. There is a lot of fear in African communities around HIV and AIDS and those affected are unlikely to seek help and are unwilling to disclose their status. In African communities HIV and AIDS is often attributed to witchcraft (Kwanda, 2011: 22).

People living with HIV and AIDS – especially the already marginalised younger women – fear that other people may find out that they are infected, a fear induced by the stigma attached to the pandemic (Louw, 1994: 131). The egocentricity of adolescents strengthens this fear, because they feel as if everybody is watching them. HIV positive teenagers often don't want to take their medicine at school due to the fear that "everybody will notice" (Van Dyk, 2009: 187).

3.4.2 HIV and AIDS sufferers struggle with an identity crisis and low self-esteem

I recall the woman who told me that she hates taking her ARVs because it reminds her every time of whom she is. She made this statement quite bluntly and completely without self-pity. Yet, I couldn't help noticing the involuntary movements of the tiny muscles round the corners of her mouth which gave away her true feelings of self-disgust and bitterness.

Meyer et al. (2008: 202) refer to Erickson, who says that identity is a complex concept which can be defined as people's image of themselves, including the feeling that a thread of continuity runs through their lives and that their self-images and the views others have of them are essentially in agreement. One of the main psycho-social tasks of the adolescent years is identity formation – to ask and answer the questions: "Who am I?" and "What do I want from life?" Due to his/her illness, an HIV positive young person struggles to find answers to these questions.

The self-esteem of HIV infected people is often threatened due to the rejection by family, colleagues and friends. It leads to the loss of social identity, dignity and reduced self-worth.

In the African context in which ubuntu is central, the harm done to one's identity as a result of such destructive perceptions becomes exaggerated. If other people become judgemental and label one, they destroy one's identity. Being unable to engage in familiar social and loving relationships diminishes the person's self-esteem. It is therefore not surprising that a person

living with AIDS sometimes experiences society, especially church people, as alienating hypocrites (Manala, 2005a: 903).

Further to this, Van Dyk (2009: 269) states that the physical consequences of HIV infection such as physical wasting and the loss of strength and bodily control contribute even more to a lowering of self-esteem. People with AIDS try to hide their lesions, skin rashes, raptures and uncontrollable diarrhoea. All erode their body pride and lead to shame.

3.4.3 People living with HIV and AIDS experience loss and grief

Van Dyk (2009: 268) describes how HIV positive people experience loss of control, loss of independence. They experience the loss of their ambitions, their health, their physical attractiveness, sexual attractiveness, sexual relationships, status and respect in the community, financial stability and independence. People with AIDS also feel that they have lost their privacy once they need constant care. Thus, the most commonly experienced loss is the loss of confidence and self-worth caused by the rejection of people who are important to them.

The experience of so many losses, combined with a feeling of hopelessness and low self-esteem, leads to a feeling of grief. They mourn the loss of life itself (Van Dyk, 2009: 268). They grieve for their family and friends who have died of AIDS. They grieve for those loved ones who are going to stay behind once they are not there anymore.

One of the patients in the final stages of AIDS has a photo, the size of a 50c coin, of his two young sons – or as he fondly refers to them, "my laaities." He is the only township patient I have got to know in hospital, who actually possesses a physical photo of his children and keeps it with him in this particular hospital where he has come to spend some of his last days. He has already lost his wife, the mother of his two sons to AIDS, but with every visit I paid him, he puts on a brave smile and proudly showed me this photo: "Look at my laaities!" On my final visit before he died, he took out his photo as always, but this time he asked me, "Tell me, what is going to happen to my laaities?" He wasn't actually asking me a question. He was making a statement. He knew that the answer was not within his or my reach.

3.4.4 People living with HIV and AIDS are emotionally confused

Identification of the HIV positive status may cause intense emotional perturbation, which can lead to suicidal ideas and behaviour – especially if the sufferer has received no pre- and after-counselling. The diagnosis of HIV is a catastrophic trauma, and is usually followed by the same emotional symptoms resembling those encountered with other life-threatening illnesses. This includes shock and numbness, denial, guilt and self-reproach, anger and sadness.

Green (1988: 69) writes: "Taking all of these stresses into account, and recognising the high incidence of neurological complications in HIV and AIDS patients, it is no surprise to find that psychiatric disorders are a common association. These include anxiety reactions with marked hypochondriacal self-concern, depressive mood disorders, obsessive-compulsive disorder, psychoses associated with organic brain disease, dementia and in particular the AIDS dementia complex due to HIV encephalitis, and delirious reactions".

Adolescents, due to their physical, cognitive, personality and social development, experience emotional changes. Even without being HIV positive, young people experience negative emotions, mood swings and emotional outbursts. The focus which young persons have on themselves can contribute to feelings of anxiety, guilt, shame and embarrassment (Van Dyk, 2009: 186ff). Loneliness and negative thoughts overwhelm the thought processes and perceptions of people living with HIV and AIDS (Manala, 2005a: 905).

People living with HIV and AIDS are in need of a cure, but are informed that no cure has yet been found. Young people are aware of this. They are not sure who their friends are. They are not sure who knows about their disease and who not. They are not sure how they are going to survive.

It is clear that the anguish and anger felt by HIV and AIDS sufferers are mostly suppressed and internalized. Their entire ego-structure and self-esteem could be negatively affected and even be destroyed as a result of thisinternalised confusion.

3.4.5 People living with HIV and AIDS are stigmatised

Because the main way in which people become infected with HIV is through sex, it used to be socially unacceptable to admit to being infected with HIV. Unfortunately it is still true that people who are infected are often discriminated against and often avoided by their friends and sometimes even by their families. Due to the sexual transmission of HIV, its link to death and the fact that the drugs for treatment were stigmatised, the result is that testing for HIV remains low.

Stigma is a powerful discrediting and tainting social label that devalues individuals who display attributes that violate acceptable standards in society. It infers something unusual and wrong about the moral status of the person affected. "The presence of a stigmatized condition evokes disgust or fear or discomfort in the members of the non-stigmatized group. It arouses deep human responses such as avoidance, reticence, denial and scape-goating. Stigma has inevitable moral implications: it tells us who is considered evil or wicked and it tells us much about the limits of a society's understanding and compassion" (quoted in Parry, 2008: 28).

Of Precious Xaba's entire ordeal with HIV and AIDS, the single most painful incident for her was the day that one of her teachers left the confidential letter from the clinic, informing the school of her HIV status, in the staff room for all the other teachers to read. This was the utmost betrayal in her mind. "Surely they are not allowed to do this?" she pleaded with me, exposing her shame. After that day the teachers and other children started treating her "in a funny, bad way", according to her. Disclosure of a person's HIV status is against the law, but a young female orphan like Precious is defenceless and vulnerable. She courageously took it upon herself to find another school to attend, but still she has no guarantee that she will receive the respectful confidentiality that she deserves.

In a paper by Sorsdahl et al. (2011: 1), HIV-related stigma is associated with deleterious consequences for people living with HIV. According to them, the HIV related stigma interferes with HIV prevention efforts by impeding voluntary testing and counselling. Additionally, stigma has the potential to lead to adverse behavioural and emotional consequences, including not adhering to ARV treatment, engaging in unsafe sex practices and the development of depressive symptoms.

Manala (2005a: 906) describes stigmatisation as extremely cruel, so much so that it is likened to the greatest crimes against humanity, such as "medieval witch hunting, anti-Semitism of Nazi Germany and the McCarthyism against Communists in the USA". Manala stresses "conservatively speaking, such hostility can isolate people living with HIV and AIDS because the worst effect (e.g. murder) cannot be ruled out". The widely reported case in KwaZulu-Natal of a young woman, Gugu Dlamini, who was killed by a mob of people after declaring her HIV and AIDS status, is a case in point.

Stigmatisation of people living with HIV and AIDS occurs due to the associations that members of the society have based on their knowledge of the causes of HIV infections. Many members of society associate it with "unclean living" such as the use of intravenous drugs, shared needles and/or promiscuous sexual behaviour.

According to Louw (2008: 426) stigmatisation is a very complex issue. When we identify something as negative, bad, dangerous, weak or sinful, we tend to label it as wrong or even evil. Such a label or attribute becomes a stigma, especially when its negative effect is very extensive. Stigmatisation and labelling are synonymous with isolation. HIV and AIDS could be seen as the leprosy of the twenty-first century.

In the community where I do my pastoral counselling, as a matter of course, I attend to the woman who had allegedly given Precious's father the HI virus, which he in turn passed on to her mother, and then inadvertently to Precious herself. Precious pointed her out to me in person. She was a tiny, already emaciated woman with sly, but lively eyes . . . in spite of the fact that she was already on her deathbed. "People around here will tell you lots of bad things about me," she told me conspiratorially the first time I met her, "don't believe them." I wanted to smile inwardly at first, but then I realised her desperate need not be stigmatised and to be regarded as a moral person – if not by her own people, then at least by a stranger. I honoured that desire in her.

3.4.6 People living with HIV and AIDS struggle with the question of meaning

Twice in the past, a young HIV positive woman in Khayelitsha whom I have met during my counselling sessions has taken her two children and went to sit on the train tracks, waiting for the

train to put an end to her insolvable situation. Twice she and her children had been rescued just in time. Others have not been so lucky.

Living with HIV involves suffering. People living with HIV wonder about life and what meaning there is in living, since the scourge obscures the future and denies hope. The following questions are pertinent in this context: Does this suffering have any meaning? Do I still want to live – or could suicide be a possible way out? People infected with HIV struggle with the question: Does somebody still love me? (Manala, 2005a: 904). "What am I living for - is there any purpose in living like this? Is there anybody out there who is willing to accept me as I am with my HIV positive status?"

According to Manala (2005a: 905), part of the question of meaning is the struggle with fate. A young person born HIV positive might ask: "Why me? What have I done wrong? Why must I die when I have hardly lived?" The feeling that God has failed them by not protecting them against this "underserved death" may be part of the experiences of people living with HIV.

"The Lord has chucked me away," a dying AIDS patient whispered to me, "but I won't chuck the Lord away. I will shout to Him!" Then he grabbed my hand and held it firmly. "Djesus Auntie! What is going on with me? Auntie, my auntie, I'm so lonely, I have nothing, no-one ..." and started sobbing.

3.4.7 People living with HIV and AIDS often experience spiritual crises

The fear of death, loneliness and possible rejection, often leads to spiritual questions. The fear of being rejected by God as well, occupies the mind of people living with HIV and AIDS.

Spiritually, HIV and AIDS sufferers experience a crisis (Ruele, 2003: 77). They ask why they are the ones affected, whether God loves them, whether they have sinned or are just unlucky. They might ask if the disease is a form of punishment brought upon them by God. This last question suggests that it is fuelled by some biblical interpretation which links HIV and AIDS to sin.

HIV and AIDS sufferers might want to discuss concepts of sin, guilt, forgiveness, reconciliation and acceptance. One of the most important functions of religion is to provide coping strategies for accepting the inevitability of death (Van Dyk, 2009: 325).

The spiritual crisis and reality of death could have the HIV and AIDS sufferer revisit his/her faith, beliefs, relationships with others, as well as his/her relationship to God. This kind of introspection in itself can be seen as the positive side of being diagnosed with a deadly disease such as AIDS. However, earnest seeking to find answers to life's most existential questions is likely to unleash a dark night of the soul experience. And a young woman like Precious Xaba has not yet attained the spiritual maturity and stamina to endure such an intense experience. This means that Precious believes her life is in the hands of fate. Unless she receives effective, consistent support to help her to make better choices, she will fall prey to the pattern that was set into motion by her HIV positive mother, and end up giving birth to an HIV positive child herself. Precious is the second generation HIV and AIDS sufferer in her family. She is overwhelmed and traumatised by her situation and her only ego defence, at this stage, is denial. She will most probably begin to take drugs. Then she will be forced to turn to prostitution to enable her to support this habit. She will be re-infected with HIV time and time again. And she is most likely to be dead within a couple of years . . . possibly leaving behind a HIV infected orphan.

3.5 Conclusion

In this chapter the 10 – 24 year old females living in a typical South African township were identified as the fastest growing group of HIV infections in the world. We examined these HIV/AIDS sufferers by addressing the question: "What is going on?" The reality of the disease was sketched together with all the problems it entails. The outer as well as the inner worlds of this group of HIV and AIDS sufferers were investigated, based on the data available from literature studies as well as the personal experiences of the writer of this thesis during her practical pastoral care work.

In the writer's objective to propose the implementation of pastoral group counselling as a way to care for HIV positive young women living in a South African township, the next question to address is: Why is this going on?

CHAPTER FOUR

HIV and AIDS in the African context

4.1 Introduction: Hermeneutics and a systemic approach

This chapter focuses on the possible causes of the rapid spread of the HI virus within a South African township environment.

The specific question we will attempt to answer is: "Why is the highest rate of HIV infection amongst young African women in South Africa?"

For a hermeneutical approach to understand why the highest rate of HIV/AIDS infection is amongst young African women, the previous chapter dealt with the pre-understanding of the phenomenon by answering the question: "What is going on?"

In this chapter an attempt to explain why this is going on, will be made.

To contextualize the pastoral encounter hermeneutically, the focus is on a *systems approach*, which pays attention to the way parts are linked to one another with in the dynamics of interaction and mutuality. "Encounter" does not describe a relationship between a personal God and an isolated individual. Encounter implies, in terms of the Gospel's covenantal framework, a network of relationships, reciprocal interaction and associations. The pastoral encounter implies "connectedness" (Louw, 2011: 73). The paradigm in care and the science of care has developed from an individual approach to a relational and systemic understanding – all is seen within the character, quality and content of relationships.

A systems approach is important in a situation where group bonding, as found in a family or tribe, is a primary value. It is also true in the case of young HIV positive women living in a South African Township.

Graham according to Louw (ibid: 74) lists four characteristics of a systemic view of reality:

- It affirms that all elements of the universe are interconnected in an ongoing reciprocal relationship with one another.

- It affirms that reality is organized. The universe is an organized totality of which the elements are interrelated.
- It emphasizes homeostasis, or balance and self-maintenance. Balance is maintained by transactional processes such as communication, negotiation and boundary management.
- It emphasizes creativity in context, or finite freedom. Although systems are self-maintaining, they are also self-transcending.

This implies a new way of thinking. It means that the seventeenth-century Newtonian mechanical view of the universe has become increasingly dysfunctional in these times of interdependence and constant change. "The world we create is a product of our way of thinking," Einstein said. "Nothing will change, until we change our way of thinking" (Jaworski, 1998: 9).

Jaworski (ibid: 10–14) describes the systemic view of reality as a shift from seeing a world made up of things, to seeing a world that is open and primarily made up of relationships. He explains that a deeper level of reality exists beyond anything we can articulate and that we live in a world of possibilities. Everything around us is in continual motion. Nothing in nature stays put. Jaworski argues that when this fundamental shift of mind occurs, our sense of identity shifts too, and we begin to accept each other as legitimate human beings and perhaps, he argues, that is what love means: the quality of seeing one another as legitimate human beings. And when that happens, we see ourselves as part of the unfolding. We also see that it is actually impossible for our lives not to have meaning. Our lives develop a different sense of what it means to be committed.

Graham in Louw (2011: 73) too believes that a systems approach in the pastoral encounter implies a new way of thinking. For him "systemic thinking" is firstly a view about the universe, or a picture of reality, affirming that everything that exists, is in an ongoing mutual relationship with every other reality. The systemic view of reality takes into account that people live their lives embedded in a cultural context in which attitudes, values, customs and rituals play and important role. Secondly, the position and status which people have within a certain network of relationships can be related to their specific problems.

For a pastoral caregiver living in the daily reality of his/her own broken life and the lives of HIV infected people, the knowledge that life is lived in a world of relationships, motion and

possibility, calls for him/her to understand that the whole is necessary to understand the parts and that the parts are necessary to understand the whole. The universe, as a whole, influences local events. Local events have an influence, however small, on the universe as a whole. A Chinese proverb says: "If you cut a blade of grass, you shake the universe".

This evokes responsibility as well as humility.

4.2 Theoretical maps help us understand the lay of the land

To assist young HIV positive women in an African community, we have to identify the important issues with which they are confronted. According to Osmer (2008: 80), one has to be able to identify and draw on theories that will allow one to understand these issues. This is the interpretive task of theological understanding. Working with someone like Precious Xaba calls for wise judgement from the pastoral caregiver.

In the previous chapter the "descriptive-empirical task" was that of gathering information about the living conditions of a young woman like Precious, who lives with HIV and AIDS in a typical South African township. In addition the state of her internal landscape was examined. In this chapter the interpretative task of "Why is this happening?" is addressed. Osmer (2008: 80) firstly instructs guides, including pastoral caregivers, to bring theoretical maps with them when they are leading others. He explains that such maps offer a picture of the lay of the land they are travelling in and possible paths that might be taken.

He warns that map readers must learn two skills early on: First, they must learn that "the map is not the territory", as it is sometimes put by cartographers. Maps portray certain features of a territory but, necessarily, leave many things out. So too, theories help us understand and explain certain features of an episode, situation or context but never provide a complete picture of the "territory". Wise interpretive guides, thus, retain a sense of the difference between a theory and the reality they are mapping. They remain open to the complexity and particularity of people and events and refuse to force them to fit the theory. Once again, this takes wise judgment on their part.

Secondly, Osmer explains that skilful map readers must learn to choose a map that is suitable for their purposes. Some maps are good for some purposes but not for others. Topographical maps portray the height of mountains and depth of valleys and plains, using contour lines that connect points of similar elevation. They are used by geologists and engineers. The meteorological maps used by television stations' forecasters commonly show cities, temperatures, jet streams and storm patterns. They help us decide what to wear on a given day and provide information about possible delays at the airport. Likewise, different theoretical maps are good for some purposes but not for others. Interpretive guides, thus, must be wise in discerning which theoretical maps will be most helpful in guiding others through the territory they are entering.

To be able to draw a theoretical map, describing the lay of the land in which to find answers to *why* a young African woman like Precious is finding herself in the position she is in, we will examine three different perspectives:

- Health and illness from an African perspective;
- Gender issues, specifically referring to male dominance;
- Poverty and depressed socio-economic conditions.

Osmer (ibid: 118) declares that reality is composed of interconnected systems located at different levels, or strata, of life. He (ibid: 16) further explains that "pastoral care … attends to the web of relationships and systems creating suffering. Social systems are located in an interconnected web of natural systems. It is important, thus, to think in terms of the *web of life,* not just the living *human* web. Living systems are nestled in other systems, which together make the web of life".

Practical theological interpretation is thus deeply contextual. It functions in terms of inter-connections, relationships and systems. Thomas Moore (1994: 257) describes such relationships as going further than the relationship with people: "Relationship is not only about the people who interact with each other. It is a vehicle as well to the absolute factors that shape human life fundamentally. Every relationship that touches the soul leads us into a dialogue with eternity, so that, even though we may think our strong emotions focus on the people around us, we are being set face to face with divinity itself, however we understand or speak that mystery".

When addressing the three issues mentioned, we have to bear in mind that "the map is not the territory", and that there is a contextual web of relationships and structures that maintains these systems.

To understand the "web of life" in which Precious Xaba is living, it is necessary to understand what the religious, cultural and historical concepts are, which underlie an African world-view – and specifically how they relate to the causes of health and sickness. Precious cannot be understood separately from the cultural issues and values instilled in her from childhood. These are imbedded in her community and every other South African township community in which HIV and AIDS is so prevalent.

Within this "web of life" in which young HIV infected women in a township live, the primacy of religion must be noted. The study of the rites and symbols in the life of black African peoples, the veneration they offer to their ancestors and their attitude to God, leads us to the conclusion that religion permeates the whole life of black Africans – their personal, family and socio-political life. Religion has the psychological and social function of integration and equilibrium; it enables people to understand and value themselves, to achieve integration, to accept their situations in life, to control their anguish. Thanks to religion, the duality between human beings and their world, visible and invisible, is overcome and unification achieved (Mulago, 1991: 127).

Mulago (ibid: 127) further quotes Bishop le Roy who explains that "religion in Africa, if it is involved in everything, is also confused with everything: with laws and received customs, feasts, rejoicing, mourning, work and business, events and accidents of life. It is even difficult at times to distinguish it in practice from medicine, science, superstition and magic. That is why there is no word to indicate religion in general; it is included under the general expression 'customs' – what is received from the ancestors, what has always been believed and done, the practices which must be observed to maintain the family, the village, the tribe and whose neglect would bring about certain misfortunes". According to Mbiti (1975: 15), religion is a difficult word to define, and it becomes even more difficult in the context of African traditional life. He says that he will not attempt to define it, expect to say that for an African it is an ontological phenomenon; it pertains to the question of existence, of being. Within the traditional life, he says, the individual is immersed in a religious participation.

A systems approach in pastoral anthropology helps us to understand how religion permeates everything in the traditional African culture.

4.3 Health and sickness in an African context

"I am sick and might die, not because of the sickness in my blood, but because I lost my family. That is making my heart and my body bleed. . ." These are the words of a township woman in the very early stages of HIV. Waruta (2005: 78) explains this response as follows: "Health in Africa is a sign of a correct relationship between people and their environments, with one another and with the supernatural world". Therefore, from the African perspective – if health has a social cause, rather than a biological one – people with HIV in its early stages are sick, *although they may look healthy*.

Manala (2005b: 58) describes relationships as an important pursuit in African life, health and illness. He quotes Bujo who explains the situation: "In the African world view, all things hang together; all depend on each other and on the whole. This applies particularly to human beings who are closely connected with each other and with God". Manala further quotes Maimela who states that an African is fully made aware that the individual's life and the pursuit of life are not attainable in isolation and apart from one's fellows because life is possible only in a network of mutual dependencies between an individual and his/her community".

Louw (2008: 146) explains that when he uses the concept of "African", it does not denote so much a continent, race, ethnicity or merely a culture. When trying to explain health and illness in an African context, it is to be understood as a *philosophical concept* which describes the complexity and diversity of different cultural, local and contextual settings as it relates to a state of being and mind. He further describes "Africa" as also having a *spiritual category*. It is an inclusive category portraying the "spirit" of people living in Africa. The "spirit of the people of Africa" functions as a hermeneutical paradigm, indicating a unique approach to life that differs from the analytical approach emanating from Western thinking and Hellenism. De Gruchy (as cited in Parry, 2008: 40) adds to this that religion is overwhelmingly significant in the African search for well-being, deeply woven in the rhythms of life and deeply entwined in African values, attitudes, perspectives and decision making frameworks.

Van Dyk (2009: 244), in describing the differences between Western thinking and some traditional African approaches, refers to the holism of the traditional outlook - an outlook that integrates the biological, psychosocial and transpersonal aspects of life. Traditional philosophies do not necessarily distinguish between physical and mental illness, but see illness as affecting the whole human being – including the person's relationship with his or her ancestors and the community. Physical, mental and social systems are seen as interconnected – changes in one system inevitable effecting changes in the others.

When referring to "an African worldview" in this paper, the holistic interconnectedness of systems as described by Olupona, Waruta, Manala, Maimela, Louw, De Gruchy and Van Dyk will be upheld within Osmer's "web of life".

4.3.1. Collective nature of the African culture

Badi (2008: 346) describes how illness and health within an African understanding are part of systems thinking: the whole is more important than its parts; components do not function according to their "nature" but according to their position in the network. Daily life events and the interrelatedness of people should be seen as ingredients for a holistic and integrated approach to healing. Life is a dynamism of systemic relationships. Badi quotes Berinyuu, who says in his book *Pastoral Care to the Sick in Africa:* "In Africa, there is no division and/or differentiation between the animate and inanimate, between the spirit and matter, between living and non-living, dead and living, physical and metaphysical, secular and sacred, the body and the spirit, etc. Most Africans generally believe that everything (human beings included) is in constant relationship with one another and with the invisible world, and that people are in a state of complete dependence upon those invisible powers and beings. Hence, Africans are convinced that in the activities of life, harmony, balance or tranquillity must constantly be sought and maintained. Society is not segmented into, for example, medicine, sociology, law, politics and religion. Life is a liturgy of celebration for the victories and/or sacrifices of others".

Badi (ibid: 347) states that the above quotation underlines the fact that life for the African is the integral whole of cosmic as well as social events.

The relationship between the individual and the group is explained by Bührmann (1984: 25) in the following way: "In general, it is accepted that the main aim is the survival of the group and its healthy social functioning. The importance of the individual resides largely in his service to the group, and on the whole his personal achievements are secondary. This naturally leads to considerable interdependence within a family as a group. This is to some extent still the situation in those areas where contact with the industrial push of the West has not yet seriously disturbed their basic approach to life. The above way of life is in sharp contrast to Western values and Western ideals of independence, ego development and the striving after ego goals and gains. Treatment, especially for any mental dysfunction, is not individual, but requires the co-operation of the family and at times the active treatment of others in the family".

Similarly, Bosch (1991: 399) argues that Christians must "minister to people in their *total* need, that we should involve the individual as well as society, soul *and* body, present *and* future in our ministry of salvation". When we reflect on the implementation of pastoral group care as a way to care for young women living with HIV in a South African township, we should take into account that the collective nature of the African culture and the ministering to people in their *total need* are the main arguments and driving forces for the need of pastoral group care.

4.3.2. Perception of illness

Health for a traditional African means the correct relationship to one's social order and to the environment. In an attempt to understand illness traditional Africans will always ask the questions "Why?" and "Who?" Illness means that the societal order and correct relationships are out of harmony; the equilibrium has been disturbed and destabilised. There is a belief that every illness is directed by an intention and has a specific cause. In order to fight the illness, it is therefore necessary to identify, uproot, punish, eliminate and neutralise this cause. The agent of the cause and intention must also be identified. Illness is therefore a sociological phenomenon. Traditional Africans regard illness as that the "web of life" of the family, clan or society is affected.

Louw (2008: 169) states: "Illness is also a religious concept: the spiritual chain of protection has been damaged and this gives rise to the anger of the ancestors and spiritual powers, which harm

or cast evil upon the person and community. It is within this context that the actions and power of the so-called witchdoctor or *isangoma* figure must be understood. In this regard it is important to take the magical dimension of the health-sickness continuum within an African context into consideration."

Van Dyk (2009: 201) explains that there are beliefs that mental as well as physical illness can be caused by disharmony between a person and the ancestors, by a god or spirits, by witches and sorcerers, by natural causes or by a breakdown in human relationships.

The fact that the concept of illness is closely linked to behaviour, which has awakened spiritual powers within the community or has evoked the anger of the ancestors, has important consequences. Healing and recovery are impossible without the patient's integration in society. The therapeutic role played by the relatives of the sick person must also be taken into account. Bührmann (1984: 25) says that certain healing ceremonies cannot be done without some relatives of the patient being available to fulfil certain obligations. In addition to the living, Bührmann states, no ceremony can hope to succeed without the guidance or co-operation of the "living dead kin" – the ancestors.

Regarding the emergence of HIV, Badi (2008: 347) remarks that it is still difficult for African people to accept this disease as being transmitted through sexual intercourse and other related ways of transmission. Rather, they believe that HIV is a result of the following agencies of illness: Angry ancestors, God's wrath to disobedient sinners, witchcraft, sorcerers, pollution and sometimes even germs. Many Africans blame white people for the disease. This African perception causes much confusion in the struggle against the pandemic, where millions could have been saved if such confusion did not exist. Traditional Xhosa people for example, do not believe that AIDS is from sexual or other means of transmission. They also see God as a Supreme Being or Creator who has withdrawn himself from human beings. God is distant and remote. The living spirits of deceased ancestors are seen as mediators between human beings and God. In this regard Badi warns that Xhosa spirituality should play an important role in pastoral hermeneutics.

To summarize, the following can be said regarding health and sickness in an African context (Louw 2008: 170):

- Illness is not necessarily connected to bacteria, viruses or infection. It is most often perceived as a relational issue, associated with systemic, spiritual and religious dimensions.
- Illness implies that the harmony of the societal order has been disturbed. A person can therefore only be cured if his/her relationships have been repaired and the community is healthy.
- Illness and health have a communal dimension. The important question to ask is: "Who disturbed the order, and why?"
- Illness is a cosmic event that befalls one and cannot be separated from the reality of death. Death is the enemy of life and is not normal.

According to Saayman and Kriel in Louw (2008: 171), health is thus a systemic issue. "What has to be healed is not a disease, but a community."

4.4 Gender issues, specifically referring to male dominance

"What Drives Men To Such Brutality?" is asked by Tutani (2011: 8) as the head-line of an article in the Zimbabwean Newsday. The article reported the brutal attack and disfigurement of a young woman by her husband. The husband, consumed by jealous rage after suspecting her of being HIV positive and of cheating on him, attacked her with a machete (a broad heavy knife used as an implement and weapon) inflicting grisly injuries and completely severing her thumb. "*This amounted to sadistic torture. The husband now faces a long stretch in prison after being charged with attempted murder and the evidence against him is overwhelming."*

Our question is: "Why did this happen?"

Manala (2005a: 901) mentions patriarchy as one of the reasons for the power relation between men and women in African societies. He says that African societies, in spite of the enviable *ubuntu* philosophy, are deeply patriarchal. The problem inherent in patriarchal societies is that they are gender-insensitive and oppressive to women, a situation that predisposes, precipitates

and perpetuates HIV infection. Men make the sex-related decisions, which women as "minors" have no right to oppose, however unfair and unsafe these decisions may be.

There is a young woman who comes to the writer for counselling in Khayelitsha. She discovered that her husband was having an affair after, by chance, she answered his cell phone while he was not at home. When she gave him the message that his "lover" had left on the phone, the husband was furious at her and beat her up. He is still seeing his "lover" regularly. Whenever my client wants to discuss the matter with him as it is unacceptable to her, he shouts at her, beats her and tells her in no uncertain terms that he is allowed to do as he wishes – it is none of her business! Both she and her husband are HIV positive.

Dube (2004: 7) states that in research and documentation it is found that gender inequalities are the major driving force behind the AIDS epidemic. He goes further and says that gender constructions almost always disempower women in the area of decision-making, leadership and property ownership. It is women who are in the centre of the HIV and AIDS storm. Due to their ascribed gender roles, women are highly vulnerable to infection; they bear the burden of caring for the infected; they carry the HIV and AIDS stigma and when infected they are less likely to have access to quality care. In all the four concerns of the HIV and AIDS epidemic (prevention, care, stigma and confronting social injustice) women are the hardest hit due to their gendered roles.

Gender inequalities also render the prevention through abstinence from sexual activity ineffective and expose women to high HIV and AIDS infection risks. Some, especially religious leaders, hold that abstinence is the safest method against the HIV and AIDS epidemic. Unmarried women who choose to abstain are often subjected to gendered violence, especially in the form of rape. Therefore abstinence does not protect them from HIV and AIDS. As a matter of fact, violence against women, especially in the form of rape, has grown considerably with the rise of HIV and AIDS (Ministry of the State President as reported in Dube, 2004: 9).

Several researchers contend that the culture of "multiple concurrent partnerships" by men is a driving factor behind the epidemic in Southern Africa. The "one love" monogamy programme was undermined by the revelations regarding President Zuma's sexlife. He confessed to multiple affairs, often with women decades younger than himself (Venter & Rees, 2011: 151).

Van Klinken (2010: 4), in a study on gender issues, quotes Phiri who says the following: "Gender injustice is particularly important in the church's fight against the HIV and AIDS pandemic. The African Women Theologians have argued that as long as there is gender injustice in Africa, HIV and AIDS will continue unabated". He further states that the issue of masculinities and the call for their transformation has only recently appeared after the realisation that HIV is a gendered epidemic. He states that in their critical account, theologians point to patriarchy as the root problem of masculinities that are harmful in the context of HIV. Masculinities in patriarchal cultures are characterised by power, potency and fertility. In patriarchal cultures men are often preoccupied with sexuality, engage in risky sexual behaviour and are not likely to use condoms. Additionally patriarchy makes sexuality a central domain of masculinity. Van Klinken (ibid: 5) emphasizes that the critical issue in the context of the HIV epidemic is that patriarchy attaches power to men over women's bodies and women's sexuality, leaving women vulnerable to gender based violence and to HIV.

Desmond Thompson (2011: 3) quotes Dr Kate Joyner: "the interface of intimate partner violence (IPV) and HIV is crucial in light of the fact that South Africa tops international rates of both HIV and sexual and domestic violence". According to Karim and Karim (2008: 257) the risk for sexual transmission of HIV is heightened in women who experience violence and threats of violence. Fear of violence prevents women even from discussing HIV with their partners, let alone requesting condom use. In some countries there has been a shift from intimate/domestic violence to more random acts of violence against young women in particular. In countries with high HIV prevalence, such as South Africa, there is evidence suggesting that the increase in rape of young women could be related to a perception of sexually active women being vectors of HIV infection and of virgins being "disease-free". In some settings, HIV infected women using health services are about ten times more likely to report violence compared with similar aged HIV negative women. Gender violence is a recurrent theme in South African life, with 13% of women in the last national Demographic and Health Survey reporting that they were beaten by a partner. Studies have also uncovered high levels of violence and coercion to obtain sex among urban teens.

Van Dyk reports (2009: 186) that many girls who participated in her study on school children's perception of AIDS, described their immense fear of rape at some point in their lives: 15,3% of

girls in the age group 16 – 18 years old, 15,3% in the group aged 13 – 15 years old and 5,1% in the age group 10 – 12 y ears reported this fear. Not one boy referred to the possibility of bei ng raped. Many girls also feared the "virgin-cleansing myth" and they were confused by the double-bind message of: "it is good to be a virgin" versus "it is dangerous to be a virgin".

Tradition acc ords a low st atus to women and they are f urthermore denied th e authority to negotiate safe sex practices. Dube (2004: 9 using two other sources) states that married men who are sexually involved outside marriage, still feel that they have the right to unprotected sex with their wives. Mp inda (2008: 215) comments: " ….many women are unable to sa y no to their husbands even if they know that their husbands could be infected. At the same time, it is true that if a man has sexual relations with an unwilling woman regardless of her age (i.e. rape), there is a tendency of physical harm to the woman's vagina making exposure to HIV infection even more inevitable".

Dube (2004: 9) states that wi th the HIV and AIDS epidemic, heterosexual marriages, due to the patriarchal d istribution of power, hav e turned out to be one o f the m ost d eadly in stitutions. Women who ha ve bee n constructed as powe rless cannot in sist on sa fer sex. They can ha rdly abstain, nor do es faithfulness to th eir partners help. Patriarchy and t he low stat us it ascribes to women, provides the fertile soil upon which the HI virus thrives.

4.5 Poverty and depressed socio-economic conditions

Socio-economic conditions exist today in Africa and in other Third World countries which make the comm unities m ore vu lnerable t o sexually tr ansmitted a nd other inf ections. Mp inda (2008: 212) explains: "In the world of AIDS, we can look at poverty in a physical or spiritual sense. In the physical sense, poverty means the lack of proper food, clothing, shelter, proper sanitation and sufficient medicine; in the spiritual sense, poverty means lack of moral discipline".

In Khayelitsha, the home of HIV/AIDS sufferer Precious Xaba and a microcosm of the multitude townships in South Africa, economic poverty is endemic. In t he following paragraphs, we shall examine t he socio-ec onomic conditions i n Khayelitsha, t he township's resultant phy sical poverty, lack of moral discipline and its link to the spread of HIV.

4.5.1 The poverty trap

According to the statistics for the economically active persons aged 15 – 65, almost 51% of the people living in Khayelitsha are unemployed (Table 5). Almost 78% of the people living in Khayelitsha survive on 0 – R1 600 per month (Table 6). This is below the breadline of $1.00 per day. People in informal settlements, like some areas of Khayelitsha, are caught up in what sociologists call the "poverty trap". Wikipedia (2011b) uses a quote from Azariadis & Stachurski to define the poverty trap as "any self-reinforcing mechanism which causes poverty to persist". If it persists from generation to generation, the trap begins to reinforce itself if steps are not taken to break the cycle. Lack of skills due to low levels of education, low income due to unemployment and retrenchment, poor health due to poverty, overcrowding and the spread of infectious diseases all contribute and help to sustain the poverty trap. Widespread illiteracy and poor education reinforce the poverty stronghold on those residents living in townships.

Poverty influences the choices people make, particularly in the case of women resorting to survival transactional sex-work, where HIV risks are manifest. Both poverty as well as HIV never stand alone. Poverty may lead women to exchange sex for money (Snidle & Yeoman, 1997: 13). Poverty may also be connected to behaviour that increases the risk of HIV infection such as alcohol abuse, violence and multiple sex partners. Though poor people may not be more at risk to HIV infection than others because of their poverty, it is also true to say that poverty may be coupled with poor underlying nutrition, food insecurity and unsanitary conditions. Basic education and health services might not be readily available or unaffordable.

The poverty trap often leads to people becoming entrenched in the welfare trap. In a country like South Africa, which uses the Means Test for state grants, the poorest individuals may face high effective tax rates if they increase their income or wealth. This can seriously weaken their incentive to work their way out of poverty. It is easier to remain within the welfare system and to receive the monthly state grant.

Ruele (2003: 79) informs us that HIV also adversely affects people's economic performance, due to increased absenteeism by employees who are ill and stay at home to recover, who look after the sick or who attend funerals. In addition, bereaved families often incur heavy funeral

expenses. All these factors lead to low productivity, minimal savings and investments and a spiralling down ultimately, towards poverty.

- Poor health is one of the factors keeping people caught in the poverty trap. Due to a lowered immune system, people with HIV are prone to opportunistic diseases. Van Dyk (2009: 62) calls the relatedness of tuberculosis and HIV the curse of Africa. Brits (2011a: 13) reports that if the number of TB patients that land up in South African hospitals "are the ears of the hippopotamus, then TB is swimming in an ocean of HIV and AIDS". The socio-economic conditions so rife amongst people caught up in the poverty trap, e.g. poorly built shelters, the wet, cold winters in the Western Cape, the use of open fires or "konkas" in the homes and over-crowding, all promote the spread of tuberculosis. Van Dyk (2009: 62) reports on a community in Hlabisa, KwaZulu-Natal, were the percentage of adults with TB increased from 8,7% in 1991 to 70% in 1997. Most of these TB patients were co-infected with HIV. The combination of TB and HIV is deadly. The Tuberculosis Advocacy Team has announced that it is now official that the Western Cape has the highest TB figure in the world, with 559 out of 100 000 people suffering from this disease (quoted in Pretorius, 2004: 43). A young woman living in a township caught up in the poverty trap, has little chance of escaping both HIV and TB, due to the socio-economic factors in which she lives.

- Thom (2011b: 6) reports that the abuse of pregnant women in government facilities is rife and that in a 66 page Human Rights Watch communication released in Johannesburg, horror reports are given of women who were physically and verbally abused, turned away from clinics without examination while in labour, ignored by nurses when they call for help and forced to wait hours and days for care. South Africa's maternal mortality rate has more than quadrupled in the last decade, increasing from 150 to 625 deaths per 100 000 live births between 1998 and 2007 (Government data). More deaths were reported especially of women living with HIV. This is the fate of those women dependent on the Government Health care and caught up in the poverty trap.

Louw (2008: 417) states that "in such a poverty scenario, the HIV pandemic flourishes. Poverty creates the social context within which the pandemic flourishes in Africa and South Africa. Thus HIV and poverty are intricately linked; they interplay and create a vicious circle. Poverty contributes to the spread of HIV and in turn HIV causes poverty, which exacerbates the pain and suffering of the infected and affected people". This vicious circle will remain until something is done against the poverty trap.

4.5.2 Population movement

Venter and Rees (2011: 138) state that the African continent is characterised by changing demographics. Migration from rural to urban settings is the norm and the resulting slum settlements characterise all major sub-Saharan African cities. While rural life predisposes many people to diseases of poverty, urbanisation has increased lifestyle diseases. Violence and trauma, as experienced in the townships, have created a new context for infectious diseases.

Widespread movement of people can occur through forced migration as a consequence of economic pressure and/or climate change, personal conflicts, war or natural disasters like floods or droughts. The consequential isolation from traditional culture and social networks frequently results in risky sexual and other behaviour.

Karim and Karim (2008: 298) emphasize that this population movement has played a critical role in the spread of HIV throughout southern Africa. It is generally assumed that when young men leave their rural homes in search of work in urban areas, they may engage in sex with women at high risk and are themselves at high risk of infection. When they return to their rural homes, they may carry the virus with them and infect their rural partners. This circular migration typifies the pattern of movement of many young men throughout Southern Africa.

It is estimated that about 10 000 new arrivals, mostly from the Eastern Cape, pour into the Cape Town townships each month, quoted by Pretorius (2004: 44). According to Smit (2011: 96) the Western Cape is presently experiencing a growth due to immigration of 10% per year. The new immigrants are mostly from the previous Trans- and Ciskei. Migration also subjects marriages to a great strain. Any subsequent divorce or abandonment mostly leaves a woman at a disadvantage

– often she is HIV-positive and deprived of economic support. Karim and Karim (2008: 299) state that the epidemiological and social evidence argues strongly for the need for intervention programmes aimed specifically at migrants and their partners as one of the measures to try and break the circular spread of the HI virus between those townships close to the big cities and the rural areas.

4.5.3 Alcohol abuse

Venter and Rees (2011: 164) emphasize that alcohol is implicated in interpersonal violence and sexual risk-taking and HIV acquisition, along with other problems like liver dysfunction, mental diseases, oral cancers and a host of other illnesses. This is in addition to the personal, social and family effects of alcoholism. Some South African communities have the highest rates of foetal alcohol syndrome in the world.

Van Klinken (2010: 9) quotes Banda who points out that alcohol has a strongly negative effect in the HIV context as it diminishes men's ability to control themselves. He also mentions that because of alcohol abuse, men do not take their responsibilities as a husband and a father seriously. Van Dyk (2009: 127) says in this regards that the use of alcohol and recreational drugs diminishes the power of individuals to make responsible decisions. Even subjects, who had a firm intention always to use condoms and who had often used condoms in the past, reported that they often had sex without condoms when they were under the influence of alcohol or drugs, because their responsibility threshold was drastically lowered and sensible decision-making was compromised.

4.5.4 Crime and violence

The community of Khayelitsha is subject to crime and high levels of violence. Increased poverty and powerlessness can also lead to physical and sexual violence. In Pretorius (2004: 42-44) we find selected reports from various Cape Town newspapers which provide an indication of the socio-economic context and the accompanying circumstances in which the majority of the black people in Cape Town find themselves:

- Shocking figures of violent deaths in the Mother City (all population groups included) emerge from the police's mortuary in Salt River, which also manages the most violent deaths in South Africa and possible also in the world. South Africa, with a population of one sixth of that of the USA, has a number of murders equal to 60 per cent of that of the States. Most of the violent deaths in the Cape Town area occur in the black townships of Khayelitsha, Gugulethu and Nyanga (*Die Burger*, 2 August 1994).

- 560 cases of rape in Khayelitsha were reported between January 1995 and August 1997 (*Saturday Argus*, 12/13 December 1998).

- A local woman, MN – allegedly a witch – was killed by an angry mob from a squatter camp near Strand after she had apparently kept a woman prisoner in a shack for nearly two years (*City Vision*, 13 May 1999).

- While confusion about the relationship between HIV and AIDS spreads practically as fast as the virus itself, health workers in Khayelitsha struggle with superstition and absolute ignorance. According to counsellors here many people believe that Aids is an "evil illness" which is spread by evil spirits or white witchdoctors. This is the reason why especially Xhosa patients often prefer to visit a *sangoma* (*Die Burger*, 3 November 2000).

4.6 Conclusion

In this chapter we looked at some of the risk factors which give an answer to the question: "Why is this going on?" They all facilitate the spread of HIV within a South African township like Khayelitsha. It is realized that HIV is not just another medical condition, but an epidemic within an epidemic of social inequality. It is a disease that affects every aspect of a young HIV positive woman's cultural, spiritual, economic, political, social and psychological life. Her structural, social and cultural relationships determine to a large extent the degree to which she as an individual has personal control over her life and the ability to make her own choices. The African perspective of health and illness and the consequential denial in traditional African

communities regarding the sexually transmittable nature of the HIV virus, along with the prevalence of male dominance in South African township communities, put young township women at a high risk of HIV infection. The depressed socio-economic conditions and the resultant poverty with the concomitant lack of moral discipline in the above-mentioned township communities are added risk factors. These are some of the reasons explored in the chapter to determine why the highest rate of HIV infection in the world, is amongst young South African women.

In the following chapter the normative task of practical theology will be addressed. Answers to the question: "What ought to be going on?", as a way to assist young HIV infected women to cope with their dire circumstances and lonely inner landscape of being, will investigated.

CHAPTER FIVE

The Church and HIV/AIDS

5.1 Introduction: Prophetic discernment

In this chapter Osmer's third question in Practical Theology, that is: "What ought to be going on?", is investigated. He describes this as the normative task.

Osmer (2008: 132) explains that for the normative task of practical theology, prophetic discernment is a prerequisite. He explains that the prophetic office in ancient Israel can best be understood in terms of the community's covenant with God. He explains how the Old Testament prophets listened to the Word of God and that the New Testament draws on the prophetic traditions of Israel in a variety of ways. Jesus is portrayed as similar to the prophets of old, announcing God's word to the people. In short, Jesus does not merely serve as the messenger of God's words; He is God's Word. Prophetic discernment is then the task of listening to this Word and interpreting it in ways that address particular social conditions, events and decisions before congregations today.

Discernment can thus be seen as the activity of seeking God's guidance amid the circumstances, events and decisions of life. To discern means to sift through and sort out, much as a prospector must sift out the dross to find nuggets of gold.

Lisa Dahill (quoted in Osmer, 2008: 138) in writing about Bonhoeffer, says that the first move of discernment for him was simply the admission that, in reality, "We don't know". Discernment begins when we put aside our self-confidence and certainty about what we ought to do. We might see before us several paths and it is not clear which one we should take. This requires humility and trust. The second move is actively seeking God's will. Bonhoeffer grounded this active seeking in three practices of discernment that he taught and lived throughout his life:

1) Scriptural listening: attending daily to the living Word, which comes to us through the study and prayerful reading of Scripture;

2) Confession and radical truth telling: opening our hearts to trusted friends, who may save us from self-deception and help us to distinguish God's guiding voice from other voices;

3) Loving and being loved: discipleship as loving others in personal relationships and communities is a grounding point and focus of discernment; it is here that we learn to recognize Christ in the concrete other, especially those who suffer present-day crucifixions of poverty, violence and oppression.

According to Da Hill (quoted in Osmer, 2008: 138) these three practices of Bonhoeffer assist us with the normative task of practical theological interpretation which is grounded in the spirituality and practices of discernment. How will pastoral caregivers be able to find the correct words to offer to the suffering others, or the right lesson to teach, unless they first have admitted that they "do not know" what they are to say and do and, in humility and trust, actively seek God's guidance? For pastoral caregivers working with HIV and AIDS clients, this is especially true. There is no cure for HIV and AIDS to date. What hope can we bring to our clients? If we are honest, we can only truly admit: "We do not know". HIV and AIDS pastoral caregivers have to seek God's guidance in humility on a daily basis, in order to do the work they are called to do.

According to Osmer (2008: 161) normativity can be approached by means of:

1) A theological interpretation: Using theological concepts to interpret particular episodes, situations and contexts informed by a theory of divine and human action.

2) An ethical interpretation: Using ethical norms to reflect on and guide practice towards moral ends.

3) Good practice: Models of good practice offer congregations help in imagining how they might do things better or differently.

The research proposal: The implementation of pastoral group counselling: A way to care for HIV positive young women, living in a South African township, will be investigated according to these three approaches as a practice in discernment.

5.2 Theological interpretation

Theology and ethics must be practised in the midst of people having HIV/AIDS. HIV/ AIDS requires to look deeply into our understanding of God, what it means to be human and what the relationship between God and humans is supposed to look like.

Osmer (2008: 12) sees the theological interpretation of situations as the most formal dimension of the normative task. He explains that theological interpretation takes place in all the specialized sub-disciplines of practical theology, that it characterizes the interpretive tasks of congregational leaders and that when the common structure of practical theological interpretation in both the academy and ministry is acknowledged, it can help congregational leaders to recognize the interconnectedness of ministry. Theological interpretation looks at the interpretation of *present* episodes, situations and contexts through theological concepts, that is, by means of a hermeneutical approach.

Theology, according to Hendriks (2010: 283), is hermeneutical by its very nature. It depends on the interpretations which fallible people try to make of their reality. People place their reality within their belief assumptions, their normative sources such as the Bible, creeds and the Christian tradition. In the task of interpreting normative sources, various role-players and actions are involved. Working with a group of HIV infected young women, specific attention should be given to their stories, traditions and history.

The situation of HIV and AIDS demands an exploration of our theological interpretation. Who is this relationally orientated God that reveals Himself to the world in and through Scripture? What do we understand under being human? What does being human look like to a young HIV infected woman living in a township? What do we as humans need in order to survive and thrive? If God the Creator created man in His image, can we then also see the HIV infected in that light? Cimperman (2005: 21) argues that the starting point for any discussion of HIV and AIDS must be the experience and reality of suffering. If theological anthropology explores the meaning of human existence, it must encounter the reality, the voices and the faces of human suffering. Working in a township like Khayelitsha, one needs only to listen to stories of the marginalized and oppressed to begin to understand wholesale suffering. It includes bodily,

psychological, emotional and spiritual suffering. As seen in the previous chapter, such suffering exists in the midst of and stems from experiences of poverty, violence, repression and oppression.

God's character forms the basis of our ecclesiology and anthropology. We profess that God loved the world and gave His Son to save it (John 3:16), therefore as members of the body of Christ we are called to be actively engaged in this world and to serve it. It should be the church's mission and that of each individual member, to proclaim the Good News about the life in Jesus Christ.

Theology, thus, asks from us a discernment process that must take place as we obediently participate in the transformative action and service at different levels: personal, ecclesial, societal, ecological and scientific. We know that HIV and AIDS affect all these levels. The challenge for us working in the field of HIV/AIDS is to develop a theology that reflects our understanding of God, our understanding of theological anthropology and our understanding of the relationship between God and man.

In this sense Osmer (2008: 140) reflects on the theological interpretation of H. Richard Niebuhr. Niebuhr, in *The Responsible Self* (1963), develops a "Christian moral philosophy" in which the answer to the "ought" question, "What shall I do?", is portrayed as dependent on answering a prior question, "What is going on?" Niebuhr argues that the moral life is best characterized in terms of *responsibility,* rather than the obedience to moral laws and moral commands. He portrays responsibility as composed of four elements:

1) All our actions are *responses* to action upon us.

2) Our responses are shaped by our *interpretation* of these actions, which place particular episodes, situations and contexts in larger wholes.

3) Our responses involve *accountability to others for the consequences of our actions* within the context of ongoing interaction.

4) Our responses are shaped by the *community of interpretation* with which we identify; this community provides us with schemes of interpretation and ongoing dialogue with other moral selves.

Taking these four elements of responsibility into consideration, the following questions arise:

- From the perspective of theological interpretation, what has the mainline and indigenous churches' (the African Indep endent Churches) response been to the HIV and AI DS epidemic?

- Is religion a p artner of the HI virus, assisting it to spread across th e country like a veld-fire?

Dube (2003: ix) gives an answer to these questions and states that religion has become part of the problem. It includes silence and indifference from the church. It includes a lack of response by both fait h co mmunities and their t raining in stitutions. T he origin of the epi demic w as associated with punishment for si n and immorality of those who are suffering. Th is leads to a second epidemic, namely that of stigma and discrimination.

Khathide (2003: 2) echoes Dube's observation in her answer to what the church's response to the HIV and AIDS epidemic has been. In an essay titled *Teaching and Talking about Our Sexuality*, she state s th at th e chu rch's original stanc e on HIV a nd AIDS sin ce i ts adven t h as shown reluctance to get involved in the debate about the epidemic and the fight against it. "HIV and AIDS ha ve been c onsidered as G od's p unishment f or the i mmoral c orruption of h umankind". Further on she urges, "as HIV and AIDS is largely a hu man sexuality issue, i t is urgent to look into our (the c hurch's) attitude towards sex. Unless this c hanges, our fight against HIV/AIDS will become increasingly difficult".

Charles Klagba (2011: 1724), an ordained Methodist minister and theological consultant for the Ecumenical HIV and AIDS Initiative in Africa, explains that for the churches in Africa, the Old Testament has historically occupied a prom inent place in theol ogical thinking. "Our theology is constructed with the image of God in the Old Testament. It is for this reason that the reaction of many churches on t his continent to t he e pidemic is very much influenced by t he be lief t hat illness i s a punishment for i ndividual si ns," he sa ys. " This theology is ve ry vivid in the Old Testament. This interpretation has reinforced the stigma and hindered the ministry of the church to be competent." He pleads for a "theology of deconstruction". He views theology as a dynamic and c ontextual p rocess b y which C hristians – as individuals a nd a s c ommunities – ref lect on events and experiences of dai ly life, try to c omprehend t hem in t he lig ht of th e G ospel a nd

commit themselves to actions of transformation. He pleads for a theology that should go beyond intellectual exercises and provide practical tools to Christians at all levels.

Fulata Moyo in Van Klinken (2010: 7) makes the following statement: "In the Church in Africa, not only is sexuality a taboo issue, but it is also a power issue at the mercy of those who have the decision-making power – in this case, the men". It is a well-known fact that those with power in the church are mostly the men. The male dominance issue and the role of the church overlap and reinforce one another.

Pretorius (2004: 259), when reflecting on the theological dimension of morality preached by the leaders of the Zionist churches found on the Cape Flats, says the following: "While much is said about sexual adventures of married people, the sexuality of young adults and children is ignored. In the light of the prevalence of AIDS this is a serious omission". Parry (2008: 26) comments: "Many African Independent Churches, Syncretic and traditional religions, which command a large adherence, do not have a clear stand on cultural practices which are still widely practised and can expose people to infection risks". Such cultural practices are, for example, underage marriages, unhygienic male circumcision, wife inheritance, widow cleansing practices and polygamy coupled with unfaithfulness.

Louw (2008: 425) warns against the great danger in the church's reaction towards the HIV and AIDS epidemic. He warns against the church's stance of apathy that borders on neutrality and he stresses that apathy, which readily results from viewing AIDS as a sinner's disease, is damaging to the Christian task because it may be accompanied by a refusal among individual Christians to view persons in the high-risk groups as the proper focus of the church's mission. Furthermore he warns against an attitude of smugness, hypocrisy and prejudice. The good guys are the heterosexuals and the bad guys are the homosexuals and the drug addicts. As one of my fellow-church goers confronted me personally when she heard of my involvement with HIV and AIDS infected persons: "Why do you bother about 'them'? They only got what they deserve and what they were looking for! You are wasting your time. Get something better to do!"

Through the centuries, there have been attempts to give answers to the question " WHY?" Unfortunately in the Christian church sickness and suffering became too closely linked to sin and punishment. It follows therefore that people asked whether HIV is a punishment from God – a

result of personal sin? Theological interpretation challenges us to clarify what Scripture means when it talks of sin and punishment. The HIV epidemic in the past has strongly been influenced by the church's negative attitude towards sex by often equating sex with sin. The self-righteousness of the church in many instances has taken an "us" opposed to "them" stance, heterosexuals as opposed to the homosexuals and the good guys as opposed to the bad guys. The power that men have had in the church structures up to very recently, and very often still have, reinforces the negative attitude that many churches and churchgoers have towards HIV and AIDS infected persons.

Theological interpretation asks from us to discern our stance regarding specific issues such as sexuality, forgiveness, healing, care and compassion. These issues have an important place if we are to speak in a credible way to people who daily have to live with HIV in their bodies or in their families and neighbourhood. Theological interpretation challenges us to address issues such as what and who God is. Where is this God to be found in my life? How does my faith influence the choices I make? Why did God create us as humans? What is my purpose? How can God see people suffer and do nothing? How can I forgive myself? What role does the message of Jesus Christ play in the HIV epidemic?

Philippians 1: 9-10 reads: "And this I pray, that your love may abound still more and more in knowledge and all discernment, that you may approve the things that are excellent, that you may be sincere and without offense till the day of Christ" (NKJV, 2002: 1447). Having knowledge and discernment within the HIV/AIDS epidemic is a challenge to all who are infected as well as those that are affected by the virus. Pastoral care to the HIV infected must be done in such a way that our theology and churches become places of refuge and solace to all who are carrying the virus. The relevance of our care and compassion will be determined by the way we care. We are created to reflect on the love of God. The way we care will be determined by our theological stance of how we understand ourselves and God, and the way in which we reflect His love.

5.3 Ethical interpretation

When it comes to the second approach to normativity, Osmer (2008: 148) states that amongst contemporary American practical theologians, Don Browning has given perhaps the most sustained attention to the importance of ethical norms in practical interpretation. Browning (in Osmer 2008: 149) explains that the primary task of pastoral theology is to bring together theological ethics and the social sciences in such a way that a normative vision of human existence can be articulated. Pastoral theology as well as practical theology need theological ethics. Osmer explains that Browning draws on the work of Paul Ricoeur to describe the role of ethical norms in a practice-theory-practice model of theological interpretation. Ricoeur in *Oneself as Another,* offers a three-part account of the moral life:

1) The identity shaping ethos of a moral community that is embodied in its practices, narratives, relationships and models;

2) The universal ethical principles that a moral community uses to test its moral practices and vision and to take account of the moral claims of others beyond this community;

3) The *phronesis*, or practical moral reasoning, that is needed to apply moral principles and commitments to particular situations (quoted in Osmer 2008: 149).

Louw (2008: 268) attempts to give a working definition of theological ethics. He describes theological ethics as a science that focuses on:

- Applying knowledge regarding the meaning and destiny of life issues – the quality of life, objectives and modes of living (lifestyles);
- The "ought" of human behaviour – the evaluation of life in terms of normative criteria as they are related to basic commitments and belief systems;
- The tension between good and evil – the assessment of the notion of human wellbeing in terms of moral issues;
- The quality of responsible decision making and value judgements – the character of human choices;
- The identity and character of human ethos – the characteristic traits and mode of human behaviour, attitude and aptitude;
- The promotion of human dignity – the issue of justice and human rights;

- The understanding of the will of God – the function and cause of life (purposefulness) from the perspective of the intention of God with creation and our being human.

Taking the above into account, it is acknowledged that universal ethical principles are particularly important, for they allow moral communities to test their present practices and norms against universal ethical principles. Within the HIV epidemic, ethical moral decision making becomes difficult. Do we regard the moral worth of others as equal to our own? When the interests of our community conflict with the interests of others, are we committed to procedures that are fair and open to all parties? Can we enter sympathetically into the perspectives of other groups, e.g. HIV groups that are different from ourselves? These types of ethical tests are important. In situations of moral conflict, human beings are likely to put the interests of their families and local communities above those of other people.

The most crucial question now arises: How can Browning's appropriation of Ricoeur's model guide practical theological interpretation in the HIV and AIDS epidemic – ***and specifically when implementing pastoral group care?***

In the previous chapter we have looked at some of the most important reasons as to why the spread of HIV and AIDS is so prevalent in poorer South African communities. Gender issues, relating to patriarchy and the inferior position in which many women in the townships find themselves were looked at. Ethical discernment is never straightforward. Choices are seldom clear-cut and direct. They are always relative and embedded in relational issues.

During my practical work in Khayelitsha I was asked to assist with the counselling of a young HIV positive woman as preparation for her appearance in court. This young woman grew up with a father and mother who were both dealers in the drug trade. They very often left their young daughter in the company of her uncle as her "guardian". Both her parents died of AIDS when she was twelve. She was left in the care of her "guardian". When she was fourteen years old, he started to "abuse her sexually". As an orphan, she had no way to fend for herself. Not only did he abuse her sexually, but he also infected her with the HI virus. In February this year (shortly after her seventeenth birthday), the uncle came home drunk again one evening. He once again started with his usual advances towards her. She consequently "lost all self-control" and started stabbing him.

What is the correct ethical stance towards both the young girl and towards the uncle? The epistemology of ethics requires a questioning phase to take place during the pastoral encounter, for good ethics is characterised by a passion for knowing what one is talking about (Louw, 2008: 293-295). Theology is not fundamentally concerned with finding solutions or answers to difficult questions. Rather it is truly concerned with learning to ask the right kind of questions and to courageously reflect upon them. We may never find the answers that satisfy us completely, but we should never tire in our search. In the above case the question should be answered: What does the situation look like in which the stabbing is embedded? Why, how and to what purpose did the stabbing take place? A further question needs to be asked as well – what are the consequences of the stabbing? Due to the physical harm the uncle incurred, he almost bled to death. He had to spend more than a month in hospital and now suffers permanent back injuries. Will the young woman be freed from his sexual force? What if the court finds her guilty and sentences her? What is my stance as pastoral councillor towards her? Towards her uncle? Towards the police? Towards the court?

In *Jesus before Christianity*, Nolan (1995: 79) explains that if Jesus had refused to argue, discuss and mix socially with the Pharisees, then, and then only, could one accuse him of excluding them or treating them as outsiders. The Gospels abound in examples of his conversations and meals with them (e.g. Luke 14 and Mark 8) and of his persistent attempts to persuade them. In the end it was they who excluded Him; at no stage did He exclude them. Our positive regard as counsellors should therefore be both towards the young woman *and* the uncle.

Nolan further says that this is not to deny the very obvious fact that Jesus did side with the poor and the sinners. The acid test, however, is whether this solidarity with the poor and the oppressed is exclusive or not. To love them to the exclusion of others is to do nothing more than to indulge in group solidarity. Jesus did not do this. His special but non-exclusive solidarity with such people becomes therefore another sign of his solidarity with all people as people.

When considered from an ethical perspective, pastoral care is clearly not a neutral science (Louw 2011: 468). The dimension of meaning and the normative dimension of being human clearly play a significant role in any pastoral encounter. In the dangerous sea of the HIV and AIDS epidemic with all that it brings along in a township like Khayelitsha, the ethical stance of "equal regard" as promoted by Browning (in Osmer, 2008: 151), must act as a guiding star when it comes to

making ethical decisions. Browning argues that the ethical principle of agapic love is the most important norm found in Christian Scripture. However, he criticizes that stance of the Christian tradition that portrays agapic love primarily as self-sacrifice and self-denial. Rather, the logic of the *imago Dei* and of Jesus' call to love our neighbour as ourselves is better captured in an ethic of equal regard. In this ethic the worth and dignity of our neighbour is equal to – nor greater or less than – our own, or any other person.

Ethical interpretation is in essence the making of value judgments. One of the difficulties in Christian ethical interpretation is that only a few problems are simple. Most problems are contextual and complex. In the HIV world everything and everybody is in a relation to something/someone else. It is a complex world which touches every aspect of behaviour and therefore it challenges all pastoral counsellors to the sensitive implementation of prophetic discernment and wise judgement.

5.4 Good practice

The third approach to the normative task of practical theological interpretation focuses on good practice. Good practice provides congregations with normative guidance in two ways:

1) It offers a model of good practice from the past or present with which to reform a congregation's present actions;

2) It can generate new understandings of God, the Christian life and social values beyond those provided by the received tradition. Here good practice is more than a model; it is epistemic. It yields knowledge that can be formed only through participation in transforming practice. Models of good practice offer congregations help in imagining how they might do things better or differently. It helps leaders imagine what their congregation might become and also provides resources and guidelines with which to move it in the desired direction.

In HIV infected communities, there are many young women who struggle to overcome their own fear and uncertainty of what the future holds, they are alone while suffering from stigmatization, a low self-esteem and they are experiencing loss and grief.

Louw (2008: 9) describes the art of coping with illness as putting meaning into suffering, living in the face of death and trusting while everything seems futile. How can we best offer young HIV infected women an "environment of compassion" in which we can assist and support them in a spirit of koinonia to practise the art of coping with illness? We will have to listen to the Word of God and interpret it in such a way that it addresses the particular social conditions in South African townships as described in the previous chapters, while developing a form of "good practice".

5.5 Conclusion

In this chapter the focus was on the normative task of practical theology, answering the question of "What ought to be going on?". Theological concepts were used to interpret particular episodes, situations and contexts within the HIV and AIDS epidemic and its effect on young women. The construction of ethical norms to guide responses was investigated. Browning's ethical principle of agapic love as the most important norm found in Christian Scripture is seen as of vital importance when relating to people suffering from HIV and AIDS.

Good practice that offers a model from the past or present with which to reform a congregation's present actions was looked at. Models of good practice help leaders imagine what their congregation might become, as well as providing guidelines with which to move in the desired direction.

The next chapter will focus on the implementation of pastoral group care as a specific model of good practice to care for young women infected with HIV and AIDS.

CHAPTER SIX

Pastoral group care as cross-disciplinary dialogue

6.1 Introduction: Cross-disciplinary dialogue

The previous chapter concluded with the third normative task of practical theology that is, of good practice. This thesis argues that pastoral group care is one form of "good practice" to be implemented as a way of caring for young women suffering from HIV and AIDS. This will require cross-disciplinary dialogue. Osmer (2008: 163) gives a definition of cross-disciplinary dialogue as "a special form of rational communication in which the perspectives of two or more fields are brought into conversation". To gain an understanding of what is implied by pastoral group care, a multidisciplinary dialogue, bringing a number of fields into conversation simultaneously, has to take place. "Group Theories", taken mostly from psychology and education, will be used to establish a model of good practice when investigating the implementation of pastoral group care as a way to care for HIV positive young women living in a South African township.

6.2 Why is there a need for pastoral group care?

According to Egan (2010: 5) people come to therapy, individual and/or group therapy, because they need help. In their own eyes or in the eyes of others, they are involved in problem situations that they are not handling well. Others seek help because they feel they are not living as fully as they might. Many come because of a mixture of both. Therefore, clients' problem situations and unused opportunities constitute the starting point of the helping process.

In Chapter Three, the inner landscape of young women living with the HI-virus was explored. We know that loneliness, fear, isolation and shame will be some of the emotional experiences they will have to deal with.

During practical work as a pastoral counselling student, I was introduced to a young first year female student. This student comes from a family of three daughters. She knows who her father is. She knows where he lives and what he looks like. But, he is an absent father. She hardly ever meets with him. She and her two sisters were raised by their mother. She describes her mother as hard-working and strict. This young woman is the first of her family to enter tertiary education. She was diagnosed being HIV positive three months ago. She is alone in the Western Cape, having no family or "home-town friends" in this area. The test results shocked and shattered her. The "boyfriend" that gave her the unasked for gift of the HI virus, was her first love and sexual encounter. He told her later on that he knew he was HIV positive, knew that he should have used condoms, but didn't want to spoil their "fun!" Her CD4 count presently lies at 460 cells/mm³. When she went home during the winter semester break, she did not have the guts to tell her mother about her status. "It will break my mother's heart. She has done everything possible to give us a good education. At the school where I come from, the teachers refer to me as a role-model for others to follow. I feel so ashamed of myself. I feel as if I can share this with nobody!"

This young woman is alone – no family or friends close by. In this new environment, nobody who knows her knows about her status. The stigma associated with the illness as well as her cultural background silence her. In which way can "good practice" in the church environment, conducted by a pastoral caregiver assist this young woman, as well as Precious, the orphan of our case study in the first chapter, and all the other young women mentioned and not mentioned in this thesis who are diagnosed as being HIV positive? Do they have to struggle with so many existential questions on their own?

Eric Fromm (1950: 58) in Psychoanalysis and Religion says: "Man is by origin a herd animal. His/her actions are determined by a distinctive impulse to follow the leader and to have a close contact with the other animals around him/her. Inasmuch as we are sheep, there is no greater threat to our existence than to lose this contact with the herd and to be isolated". In the same vein Slavson (1964: 7) states that grouping is not an invention or discovery of man, but has its roots in nature. Groupings are essential for the biological survival of lower animals and, because of his frailty, they are particularly important to man. They are also essential to man's psychological and spiritual life. Man consciously uses groups for enhancement of personality and for social survival. Very often young HIV positive women have lost their family, and due to the stigma

attached to the HI virus, do not belong to any group with whom they can share their pain, and as such are 'cut off' from a person's primary means of socialization. Rollo May (1969: 289) reminds us that care is a state in which something does *matter*; care is the opposite of apathy. Searching for 'good practice' in pastoral care and counselling, we are compelled to search for solutions in which the loneliness of young HIV infected people matter to us.

- In the search for "good practice", is there something more than the one-on-one counselling that can be offered to young women, to provide them with a safe environment in which they might find a temporary "home" and place to belong to?
- How many other young women are there throughout South Africa presently going through the experience of shame and isolation as described earlier on, due to their HIV positive status?
- What if these young women could get together forming *support groups* to assist *one another* by sharing their fears and anxieties, and learning from one another?

If the above questions are taken seriously, the next question to be examined will have to be:

"What is a group?"

6.3 What is a group?

Jackson (1969: 9) explains that the concept of the group is so basic that it is hard to define. He agrees that it is the functional base of operations of a social being. But, he goes further to say that the group produces emotional responses among its members which are so distinctive that the group is always different from, and more than the sum total of its members. Things can happen in a group which none of the members of the group would permit if alone.

Jesus was aware of the importance of functions in group relations. He might have designated a group as " where two or three are gathered in my name…'. (Matt. 18:20). In a pastoral group, people are in a relationship with one another, who, in the light of the Gospels seek to find ways to answer life posing questions.

Johnson and Johnson (1991: 10-13) identify seven characteristics which define a group. They do this in order to understand that a group is not only a collection of people who are together. A group is so much more than a collection of people! The term "aggregate" is the word used to refer to collections of individuals who do not interact with one another.

Here follows a brief description of these seven characteristics:

- Interpersonal interaction: A group may be defined as a number of individuals who are interacting with one another. According to this definition, a group does not exist unless the individuals are interacting with one another.

- Goals: Groups exist for a reason. People join groups in order to achieve goals they are unable to achieve by themselves. A group may be defined as a number of individuals who join together to achieve a goal.

- Motivation: A group may be defined as a collection of individuals who are trying to satisfy some personal need through their joint association. According to this definition, the individuals are not a group unless they are motivated by some personal reason to be part of a group.

- Interdependency: A group may be defined as a collection of individuals who are interdependent. According to this definition, the individuals are not a group unless an event that affects one of them affects them all.

- Structured relationships: A group may be defined as a collection of individuals whose interactions are structured by a set of roles and norms. According to this definition, the individuals are not a group unless their interactions are structured by a set of role definitions and norms.

- Perceptions of membership: A group may be defined as a social unit consisting of two or more persons who perceive themselves as belonging to a group.

- Mutual influence: A group may be defined as two or more persons who are interacting with one another in such a manner that each person influences and is influenced by each other person.

Not all of these characteristics are equally important. It is impossible for social scientists to agree as to which characteristics are most important. The authors Johnson and Johnson (1991: 14) give their preferred definition of a group as follows: "A group is two or more individuals in face-to-face interaction, each aware of his or her membership in the group, each aware of the others who belong to the group and each aware of their positive interdependence as they strive to achieve mutual goals".

Though there may be some groups that do not fully fit his definition, the most commonly recognized examples of groups do.

Precious and all the other young women mentioned in this thesis are participating in one-on-one therapy at the moment. This leads to the question, what are the differences between individual and group care?

6.4 How individual and group care differs

Groups provide a natural laboratory that demonstrates to people that they are not alone and that there is hope for creating a better life. Group therapy is therefore treatment of choice for certain types of problems, such as complicated grief, trauma reactions, adjustment problems and existential concerns over individual therapy. In our country Alcoholics Anonymous, personal growth groups, living with cancer groups, HIV/AIDS groups etc. are all known groups tapping into the same theory and practice of 'group therapy' – with each having its own specific customer made adaptations.

Nichols & Jenkinson (1991:2) explain that the key point is that groups can provide certain direct personal experiences which are difficult to come by elsewhere (e.g. in individual therapy) and which can be profoundly valuable as events in personal educational development or personal support.

Therapeutic groups usually are closed, meaning there is a designated group membership meeting for a predetermined length of time. The nature of this group is to create a safe environment in

which to experiment with getting and giving feedback and exploring new behaviours and understanding within a social context.

Some of the advantages of group therapy over individual therapy can be seen as:

- Certain clients are more comfortable in a group setting. Some people find the unrelenting intensity and intimacy of individual counselling/therapy uncomfortable and threatening. Clinebell (1966: 207) agrees and states that group counselling methods can be used to stimulate the growth of many who will not come for formal "counselling".

- The ratio of members to therapists alters the power position to a more democratic basis. The client thus has more opportunity to exert influence than in individual work.

- Every member is a potential helper (Nichols & Jenkinson 1991: 20). Clinebell (1966: 207) defines one of the vital new elements in group therapy as the presence of mutually "giving" relationships, as distinguished from the largely "taking" relationships of individual therapy. The counselling group participant is described by Clinebell as often being the *helper* and *helped* in the same session.

- Group therapy, as individual therapy, is based on the premise of confidentiality, so that what is shared in the group remains private and individual confidence is honoured in this manner.

- Group therapy is based on a screening process by facilitators to assure that members are well suited for this therapeutic process and ready for group work.

- Most groups have a theme that defines the nature of the group. At other times it is open and the members themselves bring forth the themes they are working on.

- Groups are time-efficient for the professional worker. Clinebell (1966: 207) states that it is obviously better stewardship of the pastoral counsellor's time to help fifteen people simultaneously than to spend the same period in helping one individual. He describes group counselling as the key to broadening a church's caring ministry.

For Clinebell it allows scores of people to drink the nourishing milk of meaningful small group relationships. The counsellor who has mastered group counselling has a way of supporting, challenging, nurturing and helping many times the number he/she could serve by individual counseling.

- Groups are generally less expensive than individual therapy sessions and the experiences generated are often multiplied for every person in the group. The dynamics of multiple experiences and reflections often means more feedback and support than individual therapy can provide.

It is however important to realize that group counselling is not for everyone. Participating in a group may be harmful for some people and an individual who does not want or is not ready to be in a group can disrupt it (Jacobs et al., 1994: 22).

6.5 What makes group care so valuable?

Yalom (2005: 1) asks the question: "How does group therapy help patients/clients?" He concludes that if we could answer this seemingly naïve question with some measure of precision and certainty, we would have at our disposal a central organizing principle by which to approach the most vexing and controversial problem of therapy. He further says that once identified, the crucial aspects of the change process will constitute a rational basis upon which the therapist may base tactics and strategy.

Yalom (ibid: 2) warns that therapeutic change is an enormously complex process and occurs through an intricate interplay of various guided human experiences, which he refers to as "therapeutic factors". He explains that there is considerable advantage in approaching the complex through the simple, and the total phenomenon through its basic component processes. According to him the natural lines of cleavage divide the therapeutic experience into eleven primary factors.

Yalom (ibid: 2) stresses that these factors are interdependent: They occur together and never function separately. The factors will be named and described very briefly.

- **Instillation of hope:** In a mixed group that has members at various stages of development, a member can be inspired and encouraged by another member who has overcome the problems with which they are still struggling. Listening in the group to the successes of clients who have struggled with the same problems instil hope, a strategy successfully used e.g. by the AA in their group sessions

- **Universality:** Very often people with problems become socially isolated; withdrawing into a world centered upon their pain and loss. The recognition of shared experiences and feelings amongst group members leads to the realization that these may be widespread or be universal human concerns in specific circumstances. This serves to remove a group member's sense of isolation. It validates a member's experiences and raises self-esteem.

- **Imparting information:** While this is not strictly speaking a psychotherapeutic process, members often report that it has been very helpful to learn factual information from other members in the group, e.g. about treatment or access to services. Research indicates that achievement in all types of more complex thinking skills, such as concept attainment, problem-solving, categorization and prediction, is higher when co-operative, rather than competitive, individual learning strategies are used. (Fountain 1994: 11)

- **Developing of socializing techniques:** The group setting provides a safe and supportive environment for members to take risks by extending their repertoire of interpersonal behaviour and improving their social skills. These skills are very often picked up in an informal way.

- **Imitative behaviour:** One way in which group members can develop social skills is through a modelling process, observing and imitating the therapist and other group members. For example, sharing personal feelings, showing concern and supporting others.

- **Cohesiveness:** It has been suggested that this is the primary therapeutic factor from which all others flow. *Ubuntu* is expressed as an instinctive need to belong to a group. Personal development can only take place in an interpersonal context. A cohesive group is one in which all members feel a sense of belonging.

- **Existential factors:** Learning that one has to take responsibility for one's own life and the consequences for one's decisions.

- **Catharsis:** Catharsis is the experience of relief from emotional distress through the free and uninhibited expression of emotion. When members tell their story to a supportive audience, they can obtain relief from chronic feelings of shame and guilt.

- **Interpersonal learning:** A rich and subtle interplay between the group member and the group develops over time. Each group member responds and reacts, shaping and eliciting response from the other members. Members often rather learn from other members in the group, than from the leader. Group members achieve a greater level of self-awareness through the process of interacting with others in the group, who give feedback on the member's behaviour and impact on others.

- **Self-understanding:** This factor overlaps with interpersonal learning but refers to the achievement of greater levels of insight into the genesis of one's problems and the unconscious motivations that underlie one's behaviour.

- **Altruism:** In therapy groups, the intrinsic act of giving something of value to another person, leads to a huge lift in the self-esteem of many clients. Often as in the case of young HIV infected women, the clients are so overwhelmed and entrenched in the feeling that they are a burden to everybody, that it is an uplifting idea to find out that they are important to others. This lifting of a member's self-esteem helps to develop more adaptive coping styles and interpersonal skills. In the group they offer one another support, reassurance suggestions, and insight as well as share similar problems with one another.

- **Corrective recapitulation of the primary family experience:** Members often unconsciously identify the group therapist and other group members with their own parents and siblings in a process that is a form of transference specific to group psychotherapy. The therapist's interpretations can help group members to gain understanding of the impact of childhood experiences on their personality, and they may

learn to avoid unconsciously repeating unhelpful past interactive patterns in present-day relationships.

Yalom (2005: 4-75), gives an extensive explanation of the above factors.

According to Manala (2005a: 900) group belonging and interdependence are at the heart of Africaness. The above therapeutic factors found in group care, complement the group belonging and interdependence which lie at the core of the culture found in South African townships.

6.6 Specific benefits of pastoral group care for HIV/AIDS infected young women

For pastoral group care in a congregation, all the therapeutic factors as explained by Yalom (2005: 4-75) come into play. They are all interdependent and cannot be put into clear-cut boxes. For the purpose of this thesis, however, attention will be given to those therapeutic factors which are mentioned most often by HIV positive young women. They are the instillation of hope, universality and the way in which the group setting can be used to impart valuable medical and life-style information.

6.6.1 Pastoral group care facilitates the instillation of hope

Parry (2008: 80) eloquently addresses the place of hope in the HIV debate. She says: "One of the first casualties of a positive diagnosis of HIV is hope". Parry quotes Fr Damien Byrne who says: "What we seek to do in our response, more than just bringing care, support, treatment and advocacy, is the restoration of that hope. Our task is to proclaim the hope of the Gospel more frequently and preach to the limit of our vision even though we do not fully embody that vision. Jesus did not, after all, announce bad news. He announced good news. He was a prophet of hope. He was not a moralist who threatened punishment and created feeling of guilt. Rather He is the spiritual master who gives back hope to all who are burdened with sorrow and feeling of guilt". Parry then reminds us of 1 Corinthians 13:7-8: "*Love bears all things, believes all things, hopes all things, and endures all things. Love never fails".*

How a person diagnosed with HIV loses hope is illustrated in the following example. A young student and I take a walk through Khayelitsha. She opens her heart and tells me: "During the week I'm OK, because I have to attend classes. But over the weekends, I lie in my bed and cry! What is going to happen to me? What if I become sick in two years time, before I can even graduate? What if I have to start taking ARVs, when my mother doesn't even know I'm HIV?"

My heart goes out to this young, beautiful, intelligent woman, whose narrative at this moment is saturated with questions, fear and a feeling of hopelessness. Seligman (1990: 43) tells us that hopelessness emanates from explanations that attribute one's suffering to causes that are "personal, permanent and pervasive". How true is this for people being diagnosed HIV positive! When HIV positive young women are given more accurate information regarding their situation it may enhance hope in them. They will realize that their situation is not uniquely personal, unchangeable or generalized to all aspects of life.

"Hope" is the antidote to the "fear" that so many HIV and AIDS sufferers live with. Cimperman (2005: 45) says that hope is the virtue that gives us a particular sustained moral vision. She refers to Lynch's work on hope and how the imagination connects quite directly with hope. Lynch writes that the importance of imagination "is not so much that it has vision as it is able to wait…to wait for a moment of vision which is not yet there". Hope not only gives us the vision, it sanctions and sustains the vision. Christian hope tells us what type of vision we have. Hope is a prime Christian resource of the imagination – something desperately sought for by HIV and AIDS sufferers.

Cimperman (ibid: 45) further remarks that in addition to a horizon for our expectations, five other points underlie the virtue of Christian hope: (1) hope is communal; (2) hope includes the dead as well as the living; (3) hope is connected to help; (4) hope is connected to the paschal imagination; and (5) hope has a fundamentally eschatological dimension. Louw (2008: 439), when referring to pastoral care from the perspective of a theology of the resurrection, talks about vision, imagination and future. He explains: "Hope is an indication not of wishful thinking, but a new stance in life, a new mode of being, i.e. of who we already are in Christ".

The communal/group nature of hope is such that it not only imagines, but imagines with; it is inherently collaborative and promotes mutuality. This mutuality of hope in our case is so needed

by young African women suffering fear and loneliness. If Precious and the young student mentioned above had a small group of HIV positive friends, they could support one another in the day-to-day challenges that the HI virus brings, it could bring hope and a sense of being cared for to their lives. Sharing day-to-day experiences in a supportive group setting can reduce shame and isolation and foster practical problem solving. The installation of hope for a possible vaccine or a cure for AIDS, for the better treatment for HIV and AIDS patients or for the intimacy of a relationship, can develop through young women, who all suffer under the HI virus, sharing their life stories.

Hope is also connected to help. While hope is within us, hope is also the sense within us that there is help outside of us. Research has demonstrated that high expectation of help before therapy is significantly correlated with the positive outcome of therapy. Hope ultimately reaches out to all that is good, all that is God.

Many of the self-help groups place heavy emphasis on the instillation of hope. One of the great strengths of Alcoholic Anonymous is the fact that the leaders are all ex-alcoholics – a living inspiration, giving hope to the others in the group (Yalom, 2005: 5). Likewise young HIV positive women can find hope in a group setting when seeing other members dealing with problems and growing. Such persuasive modelling of hope can be a distinct advantage of group experience over individual psychotherapy (Yahne & Miller, 2010: 225).

The evocation of hope can be one of the most important and central elements of healing (Yahne & Miller, 2010: 229). Helping HIV positive young women to find and realize their sources of hope can be a process of waiting together for a clearer vision of their situation to emerge. It is helping people to call forth from their own resources, their own vision of hope. It is not a once-off procedure. It is an ongoing journey of discovering and embracing.

6.6.2 Universality

"When I sometimes hear how my friends talk about people who are HIV positive, my body starts to shake. What will they do to me if they know that I am HIV positive?", a student in one of our counselling sessions tells us. I ask her to tell us more about the kinds of things they say. "My

friends say things like, if I had to find out I am HIV positive, I will just go and kill myself, or they will say shame on those types of people, they are just getting what they deserve. How can I ever tell them I am HIV positive? I know I will lose my friends if they had to know. I wish I knew just one person who was HIV positive that I could talk to".

Due to the stigmatization and the fear of disclosure that HIV and AIDS sufferers have to cope with on a daily basis, they most often live in isolated worlds. A pastoral care group can offer young women like the above student a forum to share and disclose her HIV story.

Yalom (2002: 97) describes universality as a key therapeutic factor in group care. He later explains (2005: 5) that many people enter therapy "with the disquieting thought that they are unique in their wretchedness, that they alone have certain frightening or unacceptable problems, thoughts, impulses and fantasies". There is some truth in this as all people have their own set of life stresses. Young HIV positive women's sense of uniqueness is heightened by fear and social isolation. Van Dyk (2009: 267) remarks that HIV positive people have many fears. They are particularly afraid of being isolated, stigmatised and rejected, as the testimony of the young student indicates. Yalom (2005: 6) emphasizes that in the therapy group, especially in the early stages, the disconfirmation of a person's feelings of uniqueness is a powerful source of relief. After hearing other members disclose concerns similar to their own, people report feeling more in touch with the world and describe the process as a "welcome back to the human race" experience.

Johnson & Johnson (1991: 91) say "we are created not for isolation, but for relationships. At heart, we are not a thousand points of separated light, rather, part of a larger brightness". Once we realize that relationship is the organizing principle of the universe, we begin to accept one another as legitimate human beings. We then begin to see ourselves and others in an *I and Thou* relationship as Martin Buber (1958: 59) describes it. It is a necessity, not a luxury for a young HIV positive female to find friends who are in the "same boat" as she.

There is no human deed or thought that is fully outside the experience of other people. Yalom (2005: 7) explains that despite the complexity of human problems, certain common denominators are clearly evident amongst members of a group and that group members are not long in perceiving their similarities. The three major themes that people have a real deep

conviction of basic inadequacy, a deep sense of interpersonal alienation and the third is some variety of a sexual secret. These three themes are operational in all the cases this thesis has reported on and are prevalent in all the interviews I have had with young HIV positive females to date.

In a group setting, young HIV positive females will find relief when they discover that they are not alone and that others share the same dilemmas and life experiences as they do. This form of help is not limited to group therapy alone. Universality plays a role in individual therapy also, although in individual therapy less of an opportunity for consensual validation and support exists. Demissie (2008: 7) quotes Hunter from the *Dictionary of Pastoral Care,* which defines "healing" as the process of being restored to bodily wholeness, emotional well-being, mental functioning and spiritual aliveness. In a pastoral group setting a member is enabled to overcome destructive negative emotions and to find a new sense of purpose and direction. The behaviour of a HIV positive person becomes less dominated by fear and hostility because of the sharing of mutual anxieties. In a pastoral group setting due to the therapeutic factor of universality, healing can involve a new relation to self, to others and to God.

Universality, like all the other therapeutic factors, cannot be appreciated separately. As young HIV infected women realize their similarity to others and share their deepest concerns, they benefit further from the accompanying catharsis and from the ultimate acceptance by the other group members.

6.6.3 The imparting of information

Hopelessness and fear very often have to do with a lack of information and perspective amongst young women who have been diagnosed as being HIV positive. The young student's sigh "What is going to happen to me ... what if I become sick before I can even graduate …?", mirrors this fear and feeling of hopelessness. I asked her why she thinks she will become "sick", that is have full blown AIDS before she graduates and she tells me that she is concerned about her CD4 count. At the moment it is 460 cells/mm³. She is concerned that in two years time it will have deteriorated to below 350 cells/mm³ - the present cut-off line in South Africa to start with ARVs. I asked her whether she knows that her CD4 count is to some extent in her own hands. By living

a healthy life-style it can even increase and does not have to decrease at all. No, she did not know that! She thought that her CD4 count could only deteriorate – and in two years time she will have no option but to be "sick". Not having the correct - or any - information about her illness and how much control she has in her own hands, places her in the grip of anxiety.

From where should young HIV infected women get their basic information regarding the illness? Very often these young women are orphans, or with no direct family close to them and with no-one to take a personal interest in them. Because the extended family system, which traditionally would have provided support, is greatly overextended in those communities most affected by AIDS, it can no longer take care of its young people. Due to the stigma associated with HIV, young women are afraid to ask for information – scared that this will lead to a forced disclosure of their status. Ignorance regarding their rights often leads to abuse and sexual exploitation by others in the community. The clinics which could act as sources of information are overcrowded, and the clinic staff do not have the time to sit with each individual patient to answer all the patient's questions and personal concerns.

Maluleke (2003: 72) clearly states that HIV is not just a virus that afflicts individual human bodies. *It is a condition of life* – a condition in which millions of Africans find themselves, whether their individual bodies are HIV positive or not. In this condition, people live in fear, suspicion and tremendous insecurity. Fromm-Reichmann as quoted in Yalom (2005: 11) points to the role of uncertainty in the production of anxiety. She points out that being aware that one is not in control, that one's perceptions and behaviour are controlled by forces outside oneself, is in itself an important source of anxiety. Often this secondary anxiety stemming from uncertainty about the illness and about their own future creates just as much havoc in young women living with HIV as the virus itself.

Young women living with the HI virus must be given the necessary knowledge about the virus they are living with, about healthy living, about their own social and sexual life, and about stress management – to mention only a few of the topics that could be discussed during group sessions.

Corey et al. (2007: 12) define "psycho-educational groups" as groups who focus on developing members' cognitive, affective and behavioural skills through a structured set of procedures within and across group meetings. The goal is to *prevent* an array of educational deficits and

psychological problems. This group work deals with imparting, discussing, and integrating factual information. This kind of group work as a way to assist people living with HIV and AIDS is specifically mentioned.

Yalom (2005: 8) explains that under the general rubric of imparting information the following is included: didactic instruction about mental health, mental illness and general psychodynamics given by therapists, as well as advice, suggestions or direct guidance about life problems offered either by the therapist or by other members of the group. He says that often such instruction functions as the initial binding force in the group until other therapeutic factors become operative. However, he explains further that explanation and clarification function as effective therapeutic agents in their own right. Human beings abhor uncertainty. For most people, the understanding of a phenomenon is the first step toward its control.

Van Dyk (2009: 374) states that patients with HIV infection and AIDS need physical, emotional, psychological and spiritual care. Any care programme should be holistic, compassionate and person-centred. To integrate the physical, emotional, psychological and spiritual care, as well as legal and ethical issues into pastoral group care, specifically when imparting information, the following topics can be discussed during group sessions:

- Topics regarding physical care can start with the most important health measures that HIV positive people can take to stay as healthy and fit as possible. This includes, inter alia, information on rest, exercise and a healthy diet, avoidance of drug and alcohol abuse and smoking, routine visits to the doctor or clinic, infection control in the home, information on their social and sexual life, how to manage stress, live positively and the use and place of alternative therapies.

- Topics that can be integrated into emotional and psychological information sessions could be on fear, loss, grief, anger and depression, thoughts of suicide, obsessive conditions, hypochondria and guilt. These are emotions and psychological distresses that all HIV positive young women can identify with.

- Topics that can be integrated into spiritual information sessions can include the search for meaning, the sanctity of life, negative attitudes towards sexuality, appropriate God images, spirituality and religion, theological questions such as: is HIV and AIDS

punishment for sin and/or is a HIV positive person necessarily a bad person who is getting what he/she deserves, as well as issues surrounding death and dying.

- The question whether HIV and/or any other illness are caused by angry ancestors and/or witchcraft can be deconstructed. Manala's (2005b: 66) argument for a more sacramental ministry that accepts collaboration with other medical and health care intervention approaches can be successfully implemented within a small group. Manala argues that the maxim in this ministry is "God is the most superior Physician". He is the conqueror of witches and restorer of health in Africa.

- Topics that can be integrated into legal en ethical information sessions can include the basic rights of people living with HIV and AIDS, the National policy of testing for HIV and the HIV/AIDS and Employment Code of Good Practice. All these mentioned policies have clear guidelines as to the rights and responsibilities of people living with HIV and AIDS. In the case of young women who are very often marginalized due to their status and/or gender, having access to the correct information shared during a pastoral care group session can significantly empower them to stand up for their rights.

6.7 The life-cycle of groups

Groups, like nature, go through seasons. The pastoral care-giver as leader should be aware of the laws of nature and the changing of seasons as its reveals some fundamental principles of existence – also of groups.

Ecclesiastes 3: 1 – 3 (NKJV 2002:788) tells us that

To everything there is a season….
A time to be born, and a time to die;
A time to plant and a time to pluck what is planted…
A time to break down, and a time to build up.

Groups, like all social institutions follow the same patterns. Their forms are not permanent. The group process is made up of different stages. Olsen (1984: 39–106) calls it: the Initiating Stage, the Formation Stage, the Functioning Stage and the Terminating Stage. Corey et al (1987:

131-284) describe the same stages with the names the Initial Stage, the Transition stage, the Working stage and the Final Stage. Each of these will now be explained individually. Corey et al also include a Pre-group Stage (ibid: 110) and a Post-group Stage (ibid: 279).

6.7.1 The pre-group stage

According to Corey (2007: 110-130) during this stage the pastoral caregiver as leader of the group sets up a proposal in which the he/she will describe the purpose and goal and function of the group. It is also the stage in which the leader will make contact with possible group members to determine if they are willing and able to join the group. This is important for young HIV positive women to understand, as it assumes disclosure of their status.

It is very important that potential members understand exactly what the function and purpose of the group will be and that members are not coerced into a group in which they do not want to partake. It is therefore also very important that the pastoral care-giver schedule interviews with potential group members to assess if they understand what the goals and aims of the group are and that they "buy in" on the purpose of the group.

The leader should also arrange a first meeting for the group during this stage, as well as taking care of all the necessary administration, and also developing an useful evaluation system for the group to evaluate their own process and group work.

6.7.2 The initial stage

Corey (2007: 130-178) explains that during this initial stage, the first meeting of the group will take place. Depending on the group members and the pastoral caregiver, this stage usually only last for the first session, sometimes the first two sessions.

This stage consists of a lot of practical work. First, however, the pastoral caregiver as leader will facilitate that the members become acquainted. Then the practical aspects should be discussed, for example: When will the group meet? Where? For how many sessions will they be meeting? How often?

After this is established, the rules of the group will be discussed. The members will learn the norms and function of the group and it is sometimes necessary to determine the rules of the group together as a group. Confidentiality is of utmost importance and should be stressed as a very important rule.

In this initial stage members will be careful to disclose too much information, because trust will not be established immediately. Gradually however, the more members begin to trust each other, the easier they will start to share their feelings and experiences. Then cohesion will start to form in the group. It is important that members actively participate and that they do not sit around and wait for something to happen. This can be an obstacle in the group process. It is important that the group leader teaches the members some basic skills in how to participate actively in the group. This can be done by helping the members to establish their own personal goals for their experience in the group. It is also important that the leader is present in such a way that he/she can determine the feelings of the group, so that the needs can be met.

6.7.3 The transition stage

According to Corey (2007: 179-226) this stage is marked by feelings of anxiety and some resistance may occur. During this stage the members of the group will gradually start to get concerned about rejection and acceptance, as they disclose more about themselves and learn more about themselves. Testing of the leader and other members of the group may happen to determine the safety in the group. There will also be some observing of the leader to determine whether he/she is trustworthy.

In this stage members should be able to recognize and express any forms of resistance. Resistance can include negative feelings. The members should be able to recognize their own resistance, and work with it. They should learn how to confront other group members in a constructive way and not to avoid conflict, but rather be willing to work through it. It is important that the leader pays attention to the possibility of cliques forming within the group. It is the role of the leader to teach the members how to deal with conflict constructively.

6.7.4 The working stage

Corey (2007: 227-264) states that when this stage is reached the members in the group usually feel supported and listened to. Conflict is dealt with immediately and directly. The group can communicate freely and openly with one another. Members of the group trust each other and the cohesion of the group is good.

The group members will bring into the group things that they are willing to discuss. They will be open to feedback and not feel criticized. Members will not be scared to practice some new skills they have learned during the group sessions which they live out in their daily lives. In this stage they will assess their position in the group and their level of satisfaction. It may also happen that members will be so relaxed in the sessions that they will not challenge each other.

It is important for the leader to continue as role model of good and acceptable behaviour. The role of the leader is to establish a balance between supporting members and confronting them. Furthermore the leader should support members in the task of self-exploration to help them to grow and benefit as much from the group as possible. The leader should promote members' behaviour that will benefit the group and increase group cohesion.

6.7.5 The Final Stage

According to Corey et al (2007:265-284) during this final stage, there may be some sadness and anxiety amongst group members because of the separation that is bound to happen. As the group is bound to end, members will start to withdraw and participate less in conversations. They will also start to determine for themselves what the way forward should look like. Evaluation of the group and the leader will take place. Some feedback will be giving. Some members may have some fears about going back to their daily lives without the group. Accountability and follow-up sessions may be arranged.

It is important for the group members to determine for themselves what they have learned by being a part of the group. During this stage, they will have to review their participation and

experience. Some tasks they will have to consider are: the preparation for the life without the group, effectively dealing with anxiety over termination and separation. Members should also complete their unfinished business. Lastly they should also determine the changes they want to bring about in their lives and how they will achieve it.

The role of the leader during this stage is one of support. The leader should support members with feelings of anxiety about separation. He/she should give members opportunities to deal with unfinished business. Leaders should provide clients with resources to enable members to continue with the changes they made and provide the opportunity for the members to give feedback to each other and to evaluate the group and leader. The importance of confidentiality should be stressed again as at the beginning of the group.

6.7.6 The post-group stage

After the termination of the group, members should apply what they learned in their daily lives (Corey et al (2007: 279). It is also important that members learn to establish their lives without the group meetings. It will benefit members if they try to keep a record of their changes, challenges and problems. Some members may have difficulty applying what they learned in the group and will have feelings of discouragement and negativity towards the group.

The leader should provide a follow-up session for the group if necessary and also provide individual sessions for any member that may have the need. The leader should also follow-up any referrals and resources given to members and should try to establish a post-group assessment over a longer period of time. After the evaluation the leader should also determine the value of such a group.

6.7.7 Some remarks on the stages in the group process

The process in group work strongly depends on the leader and group members. They can set a limit to each stage, but that will be determined by the design of the group and the leadership qualities of the group leader. A very important aspect of groups is confidentiality.

Every group is different from the next and each of the above mentioned stages will happen according to the design, function and role of the different groups.

All groups will terminate someday. That is built into their very nature. Life-cycle understanding can be seen in the mystery of death and resurrection theology

6.8 The role of the group leader

The role of the pastoral caregiver as leader was dealt with during the various stages of the group's life-cycle and extensively in Chapter Two.

6.9 Conclusion

Pastoral group care can provide the space for young HIV positive women to experience "Christian sharing and caring". It can provide the safe environment in which they can share common problems, asks troublesome questions, laugh and cry together. Together they can learn. In an integrated, holistic sense they can "experience healing" by sharing. Pastoral group care can provide a feeling of "being at home". The latter is described in Connors et al (2010: 237) as the place where we find peace and harmony that comes from learning to live with the knowledge of our own imperfections and from learning to accept the imperfections of others".

The "Serenity Prayer" which is often credited to Reinhold Niebuhr (1963: 237), a 20th-century theologian, plays a significant role in programmes by e.g. the AA. The text of the prayer includes elements of acceptance and letting go of those elements over which a person does not have any control. The text prompts to develop trust in and surrendering to God's will. It surrenders to accepting life on life's terms, having a present-day orientation and to experience joy. This prayer

can serve as an inspiration and guide to young HIV positive women. This chapter on pastoral group care concludes with this prayer:

The Serenity Prayer

God, grant me the serenity to accept the things I cannot change,
The courage to change the things I can,
And the wisdom to know the difference.

Living one day at a time,
Enjoying one moment at a time,
Accepting hardship as a pathway to peace,
Taking this sinful world as it is,
Not as I would have it.

Trusting that you will make all things right
If I surrender to your will,
So that I may be reasonably happy in this life
And supremely happy with you forever in the next.

CHAPTER SEVEN

Remarks, recommendations and conclusion

Practical Theology as a science poses questions about the reasons or intentions of human actions as well as the norms and values that direct actions and influence decisions. In the previous chapters, the complex physical as well as emotional world, in which young HIV infected women live, was sketched. The research issue of how pastoral group care can be a way of caring for these young women was attended to by using a series of penetrating questions. All the arguments were embedded in the art and science of pastoral care and counselling.

7.1 Remarks

One of the main functions of such care is healing. Clinebell (1981: 15) explains that the most fundamental goal of all counselling is to maximize human wholeness! In African tradition it is generally believed that everything is in constant relationship with each another and with the invisible world. People are in a state of dependence upon invisible powers and beings. Healing in an African context means bringing disturbed relations back to good order. An integrated model for pastoral care, in which there is a paradigm change from individual and aggressive healing to a systemic way of thinking, has points of intersection with the African view of health and healing. The horizons of the African paradigm regarding health and healing and the integrated systems approach for pastoral care meet and reinforce each other in pastoral group care.

Healing as experienced in an African context can occur in small groups as proposed in this thesis. It should however also take place in congregations. Precious, the young HIV positive woman of the case study in the first chapter occasionally attends a Zionist Church. "When you ask AIC members why they joined their church, they may often say it is 'because I was healed there'. Their experiences may have been of physical healing, but spiritual matters and relations with other people are also included. They may have received financial help, or perhaps they were

set free from witchcraft or sorcery, or maybe they simply found a place where they were loved and cared for" (Oduro et al., 2008: 73).

Louw (2008: 75) explains that "the act of healing implies the restoration of a loss and the search for integration and identity; to regain what has been lost or to attain new coping skills, coping mechanisms, or the re framing of existing concepts and ideas. A holistic and comprehensive approach to healing includes physical, psychological, relational, contextual and spiritual healing. Spiritual healing within a Christian context is closely related to the notion of salvation". As such it is connected to the Christian eschatological understanding of our being human. Spiritual healing is also connected to the existential consequences of our Christian identity.

HIV is a medical condition that requires healing. But HIV is far more than only a medical condition. It is a condition that affects the "whole" person as "an embodiment of soul and ensoulment of body. One does not have a soul; one is one's soul in terms of mind, will, emotion and body" (Louw 2008: 83). Pastoral care to HIV infected women must also be seen as "soul care – taking care of the whole person". Louw (2008: 78) explains that the focal point, the "what?" of spiritual and Christian healing, is the "soul". Health is more than the absence of a disease and broader than a single dimension of suffering. Health has to do with the quality of life and with the richness that is invoked when truly asked: "How are you?"

Louw's definition of pastoral care as 'soul care' is augmented by Ganzevoort and Visser's definition of pastoral care as 'caring for the stories of people in relation to the story of God'. These two stories according to them are not opposites, but the stories of people and the story of God are involved with each other and are interwoven. The content of the stories of people and the relationship between those stories and their story of God will differ with every client and every group and every pastoral caregiver. In the group however, people are invited to bring their stories and listen to the stories of others. A variety of stories and how those stories relate to the story of God can be experienced by all.

How does pastoral group care then correspond with the above definitions of pastoral care?

Pastoral group care:

- invites young women infected with HIV to come and share their stories;

- through Christian fellowship, opens the doors of hope by offering them a safe space to talk about their difficulties and the challenges they are experiencing in their lives;
- within the community of the group, systematically breaks down the walls of prejudice, stigma and discrimination;
- by creating a safe and compassionate place, creates an environment for these young women to experience acceptance, love and support;
- encourages those infected and affected to meet regularly and support one another through prayer and reflection and
- assists young women with the necessary knowledge and guidance to make correct choices regarding their life-style.

Pastoral group care as such thus incorporates pastoral care with:

- Pastoral care: Through caring for the stories of people in relationship to the story of God is engaged in 'soul care'.
- An integrated systems approach: Paying attention to the way parts are linked to one another within the dynamics of interaction and mutuality
- Health and healing from an African perspective: The quality of the relationships with the family, the tribe, with the ancestors determine health and healing

Schematically it can be seen in Figure 7: Pastoral group care

7.2 Recommendations

If we as church and faith communities do not respond effectively to the HIV challenge, we will have failed in our calling. When we provide people only with knowledge, ability and tools we are giving too little. We are called to reach out with a healing attitude. Jesus invites us: "*Then the righteous will answer Him saying, 'Lord, when did we see You hungry and feed You, or thirsty and give You drink? When did we see You a stranger and take You in, or naked and clothe You? Or when did we see You sick, or in prison, and come to You?' And the King will answer and say to them, 'Assuredly, I say to you inasmuch as you did it to one of the least of these My brethren, you did it to Me"* (Matthew 25:37-40). All belonging to the body of Christ are called to get involved in the HIV epidemic.

- Pastoral care in the field of HIV needs leaders who stand up and demonstrate an attitude of speaking up about AIDS as a point of pride and not of shame.

- Leadership needs to be expressed in actions with the adoption of specific programmes supporting HIV and AIDS initiatives. On the other hand, pastoral caregivers are called to serve with more than programmes alone. They are called to restore dignity and to bring hope compassionately.

- They have to ensure that whatever they do, their actions are theologically sound, socially relevant and culturally appropriate, as well as technically correct. Such leaders of change have to have more than factual knowledge. Pastoral caregivers must have a working knowledge of the HI virus, its modes of transmission and what facilitates its spread, its physical effects, management and treatment issues.

- It is of equal importance to understand its impact on the individual, on the family and on the society. It requires the appropriate knowledge of the people concerned, the context in which they live and what contributes to their vulnerability to HIV infection.

- It requires consideration of cultural heritage including those negative aspects of a culture that may expose people to risk.

- It should also be investigated where such leaders implementing pastoral group care to HIV positive persons are active and what their successes are (networking).

- Another area that should be investigated is how pastoral caregivers engage in bringing forth leaders from the HIV infected community of women. Haddad (2010: 83) calls for those who are HIV positive to become more engaged. She quotes de Gruchy who argues that "What has not taken place has been the sustained theological engagement between people living with HIV in community settings and scholars theologising in the academy". She makes the case that the vast majority of the literature is written from the perspective of the well-intended but HIV negative (or HIV status undisclosed) persons. She argues: "If we are to change the predominant ideo-theological orientation of faith communities, enabling them to hear the voices of those among them who are HIV positive, is vital!" Haddad also quotes Benson Okyere-Mana who says that the silence surrounding the epidemic will only be broken as people living with HIV are engaged.

7.3 Conclusion

The notion of shepherding has become a classic representation of pastoral care as a theological endeavour. Louw (2008: 75) explains that the unique feature of pastoral care is that it embodies the identification of the suffering Christ with our own human predicament.

In John 10:11-14 Jesus teaches his disciples: *"I am the good shepherd. The good shepherd gives His life for the sheep. But a hireling, he who is not the shepherd, one who does not own the sheep, sees the wolf coming and leaves the sheep and flees; and the wolf catches the sheep and scatters them. The hireling flees because he is a hireling and does not care about the sheep. I am the good shepherd; and I know My sheep, and am known by My own".*

May each, according to his/her own talents, be a good shepherd, accepting responsibility towards the HIV world where the darkness of fear, uncertainty and hopelessness seems to be overpowering. May he/she serve with the fruits of the Spirit: love, joy, peace patience, kindness gentleness, faithfulness and self-control.

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