University of Stellenbosch

HIV/AIDS ALIENATION: BETWEEN PREJUDICE AND ACCEPTANCE

JANET L. BROWN

Dissertation presented for the Degree of Doctor of Theology
At the University of Stellenbosch

Promoter: Professor H. JURGENS HENDRIKS

April 2004

DECLARATION

I, the undersigned, hereby declare that the work contained in this dissertation 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: Date:

ABSTRACT (English)

This dissertation aimed to ascertain, in a practical theological way, how to bridge the gulf between the congregation and the AIDS community using home based care as the vehicle of change. The initial hypotheses of the research were based upon a model initially developed by World Vision in Nkhotakota, Malawi.

The research question, which the study address, is as follows:

1. Can the negative attitudes, prejudices and behaviours which are held and demonstrated by many in the church towards those suffering with HIV/AIDS, be changed by using deliberate attempts to alter their perspective of this pandemic by providing accurate information, in juxtaposition with the demonstration of Christ's love and compassion to this community?
2. In conjunction to this first question comes a second: Can the compassionate outreach of the church, as it follows Christ's mandate to love change the perspective of those in the HIV/AIDS community so that instead of viewing the church (as a whole) as cold and unloving, their perception will change with the demonstration of such love and compassion by its membership that they begin to see the church as a source of hope and love?

To describe the contextual situation in which this study takes place, the historical background concerning the church's response to the issue of the HIV/AIDS pandemic was explored in chapter two. The third chapter discusses the cultural paradigmatic focuses, unique to the African situation, with attention to the role in the church as it seeks to comply with its mandated mission. Chapter four then examines the cultural practices found, specifically in the Malawian context, that promote the spread and transmission of the HIV/AIDS virus amongst the Chewa people and the surrounding tribes.

Over and against the identified traditional practices and their interrelationship with the worldviews of the people of Malawi, chapter five focuses on the practical theological implications of the church seeing to find identity in Christ. The ramifications of the praxis process regarding this hermeneutic, in consideration with the response of the Church as it seeks to reflect the character of the God, as represented primarily by the attribute of love towards those who are suffering from being infected or affected by this disease are explored in this chapter. It deals with the theological ramifications concerning the faith community as it represents the body of Christ by providing eschatological hope to this suffering world.

The remaining chapters describe the methodology and praxis process utilizing the research hypothesis developed from the Nkhotakota model. Final conclusions were then drawn in order to provide understanding as to how to obediently participate in God's witness to the world as the faith community addresses the problem of the HIV/AIDS pandemic in very poor areas in Malawi.

Although the initial optimistic goals of this research were not met as anticipated, essential discoveries that illuminate the faulty paradigms associated with critical issues such as the effects of abject poverty were exposed. Difficulties that

were initially considered secondary to the main thrust of this research, whose complexities are generally misunderstood by the western paradigm came to light as the praxis process unfolded. Attempts to sidestep stark issues such as poverty, in order to address the 'real' issues under study served to highlight these problems as their magnitude forced their recognition and consideration.

This research has exposed is the necessity for further exploration into the intricate ramifications of issues such poverty by demonstrating the unfortunate fact that for those struggling to survive at the lowest levels of Maslow's hierarchy, the luxury of benevolent service is simply not possible. For these, there is no other issue but survival. Calling on these sufferers to act as 'the church' when their need is so dire is not only unrealistic, it borders on sacrilege.

OPSOMMING (Afrikaans)

Hierdie tesis beoog om op ‘n prakties-teologiese wyse vas te stel hoe om die kloof tussen ‘n gemeente en ‘n Vigs-gemeenskap te oorbrug met tuisversorging as medium van verandering. Die aanvanklike hipoteses van die navorsing is gebaseer op ‘n model wat oorspronklik deur World Vision by Nkhotakota, Malawi, ontwikkel is.

Die navorsingsvraag waarop dié studie gerig word, is die volgende:

1 Kan die negatiewe houding, vooroordele en optrede van baie kerklidmate teenoor MIV/Viglyers verander word deur die gebruik van doelgerigte pogings om hul siening van hierdie pandemie te wysig deur die verskaffing van die korrekte inligting, tesame met blyke van Christus se liefde en medelye aan hierdie gemeenskap?

2. Tesame met hierdie eerste vraag, volg ‘n tweede. Kan die kerk se deernisvolle uitreik, met die betoning en uitvoer van Christus se opdrag om liefde te gee, die siening van mense in die MIV/Vigs gemeenskap só wysig dat, in plaas dat hulle die kerk (as ‘n geheel) ervaar as koud en liefdeloos, hulle hierdie begrip wysig deur die lidmate se betoning van dié liefde en deernis, dat hulle begin om die kerk te beskou as ‘n bron van hoop en liefde?

Die beskrywing van die kontekstuele situasie waarin hierdie studie plaasvind, sowel as die historiese agtergrond ten opsigte van die kerk se respons tot die vraagstuk van die MIV/Vigs pandemie, is in hoofstuk twee ondersoek. Die derde hoofstuk bespreek die kulturele paradigmatiese fokusse, uniek aan toestande in Afrika. Dit gee aandag aan die rol van die kerk in sy doelwit om sy sendingmandaat uit te voer. Hoofstuk vier ondersoek die kulturele praktyke wat, spesifiek in die Malawiese konteks, die verspreiding en transmissie van die MIV/Vigs virus onder die Chewa bevolking en omliggende stamme bevorder.

Bo en behalwe die geïdentifiseerde tradisionele praktyke en hul betrekking op die Malawiërs se lewens- en wêreldbeskouing, fokus hoofstuk vyf op die prakties-teologiese implikasies van die liefdesgebod. Die uitgangspunt van die hoofstuk is dat die kerk in haar uitreik tot hulle wat ly, iets van die (liefde) karakter van God moet weerspieël. Die praxis proses het dus liefde as hermeneutiese sleutel. Teologies gesproke moet die geloofsgemeenskap, as die liggaam van Christus, eskatologies hoop aan hierdie lydende wêreld verskaf.

Die res van die hoofstukke beskryf die metodologie, proses en navorsingshipotese wat ontwikkel is uit die Nkhotakota model. Die finale gevolgtrekkings spreek die probleem aan van hoe om die MIV/Vigs pandemie onder mense wat in uiters arm stedelike areas in Malawi woon, aan te spreek en ‘n Christelike getuienis te lewer.

Al is die aanvanklike optimistiese doelwitte van hierdie navorsing deels bereik, is wesenlike ontdekkings gemaak wat die foutiewe paradigmas in verband met kritieke vraagstukke, soos die invloed van volslae armoede, blootgelê. Probleme wat aanvanklik sekondêr beskou is tot die hoofmikpunt van die navorsing het aan die lig gekom in die navorsingsproses. Dit was duidelik dat die ingrype in die gemeenskap

die vervreemding tussen die kerk en vigslyers positief verander het. Veel meer waardering en aanvaarding het ontwikkel. Maar: die kompleksiteit van die probleem word in die algemeen deur die westerse paradigma oppervlakkig verstaan.

Die navorsing het bepaalde implikasies van armoede en blootgelê. Vir mense wat op die laagste vlakke van Maslow se behoeftes-rangorde ‘n stryd het om te bestaan, is die luukse van vrywillige diens aan ander eenvoudig nie moontlik nie. Vir hulle is een saak oorheersend: oorlewing. Om vanuit ‘n lewe vol sekuriteite hierdie armes op te roep om op te tree as onbetaalde dienswerkers, terwyl hul eie nood so groot is, is nie net onrealisties nie, maar ongevoelig.

KEY WORD ABBREVIATIONS

The following abbreviations will be used throughout this dissertation interchangeable with their full titles:

- ABC – African Bible College
- ABCCC – African Bible College Community Clinic
- AOG or AoG – Assembly of God
- CCAP – Church of Central Africa Presbyterian
- HBC – Home Based Care
- HBCPC –Home Based Care Planning Committee
- HCP – Home Care Physician
- HIV/AIDS – Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome
- IGA – Income Generating Activities

DEDICATION PAGE

This work is dedicated in gratitude to my husband Larry.
Without his support and encouragement this would have never been possible.

Mulungu Alemekezeke (To God be the glory!)

HIV/AIDS ALIENATION:
BETWEEN PREJUDICE AND ACCEPTANCE

TABLE OF CONTENTS

Chapter 1
The Problem of HIV/AIDS Alienation Described

1.1 INTRODUCTION OF THE PROBLEM

1.1.1 General Introduction of the Situation Surrounding the Problem.

AIDS is sweeping the globe with devastating results. Nowhere is the concern more paramount than in Sub-Saharan Africa. Numerous studies have demonstrated that the majority of the world's AIDS cases are found in this area of the globe (Church World Service AIDS Fact Sheet 2002). The Church, which should be a lighthouse of hope and compassion to those suffering from this dreaded scourge, is instead seen by most of those suffering with HIV/AIDS and their surrounding circle of family and friends as cold, judgmental, uncaring, and unloving - holding no promise for them (Greyling 2003:8). Love - the identifying mark of the Christian church, has been distorted and warped to the point where Christians have responded to this crisis with alienation, estrangement and prejudice towards those who most desperately need to be embraced by the true sense of God's character and identity.

> We [Christians] love because he first loved us. If anyone says, 'I love God,' yet hates his brother, he is a liar. For anyone who does not love his brother, whom he has seen, cannot love God, whom he has not seen. And he has given us this command: Whoever loves God must also love his brother. (1 John 4:19-21 NIV)

1.1.2 Identification of the Problem

People within the church, from the higher echelons of leadership to those lay individuals that make up the congregation, as well as those who have no active participation in the local church at all, but continue to consider themselves 'Christian' and part of the church, have demonstrated attitudes and behaviours which far too often allow, as well as promote a stance of judgment and condemnation against those suffering with HIV/AIDS (Teen Challenge 2002). Lack of understanding, ignorance and a flood of misunderstanding perpetuate this attitude (Fountain 1998).

Although this attitude may not be held by each and every member of the church, it is embraced by enough people that the church as a whole, is considered by many of those outside of her walls, (in particular many in the HIV/AIDS community)

as embracing these perspectives. Christo Greyling expresses this very bluntly in his challenging article (Greyling 2003), stating:

> Expressed or implied, the following is very often the feelings expressed by congregation members and religious leaders: 'It's not our people'; 'They brought it on themselves'; 'They sinned!' 'They were sleeping around'; 'It's Gods punishment for a promiscuous life!' It is clearly a 'them' versus 'us' situation with a very judgmental undertone.

Stella Kasirye, the country representative for World Relief Malawi, echoes these thoughts as she described the mindset and attitudes of churches in the Nkhotakota region of Malawi prior to the initiation of the World Relief Home Based Care program, which was begun there. In an unstructured interview with a schedule (De Vos 1998:299) with this researcher, she said in effect that the general attitude held by all the churches participating in the Nkhotakota home care program, regardless of denominational affiliation, viewed HIV/AIDS victims as the recipients of God's judgment for the lifestyles they have chosen (Kasirye, S., 1991. Interview with World Relief representative for Malawi).

The World Council of Churches, in their publication, *Facing AIDS, The Challenge, The Churches Response* (1997: 74, 75) describes the prejudices of the world as:

> …sparking a new type of hate crime: attacks on people because of an illness…For some people, the fear of AIDS has provided a powerful, if misguided, rationalization for attacks…Unfortunately, the reaction of many Christians and church members to HIV/AIDS has hardly been different from that of society in general – and sometimes has been even worse.

Outside the sphere of the church, the secular world has been using a multifaceted approach to address the AIDS issue. For example, the strategic plans developed by UNAIDS include such objectives as:

- to foster an expanded national response to HIV/AIDS particularly in developing countries;
- to promote strong commitment by governments to an expanded response to HIV/AIDS;
- to strengthen and coordinate UN action on HIV/AIDS at the global and national levels:
- to identify, develop and advocate international best practice.

Although this will hopefully have an impact on the treatment and prevention of AIDS, it is the contention of this researcher that a vast area of opportunity for the

prevention of this dreaded disease, as well as an outlet for compassionate care as a vital demonstration of the love of Christ, to be provided to those suffering from this disease is being overlooked by not incorporating the local church in the plan for the management and ending of the blight of HIV/AIDS.

Unfortunately the negative message given by many in the church exposes a deep bias often held by those confessing Christ (5.4). This message is not founded and supported by Scriptural reasons (as proposed by those holding these views), but rather it is founded on fear and the lack of understanding of this disease (Mertz & Schuklenk 1989). In addition to these attitudes, the cultural climate of Sub-Saharan Africa with its multi-layered cultural systems, promotes denial and superstitious practices that in effect, work to support this type of mind-set among the Christian community (Ayittey 2000).

People often respond to things they do not understand with fear and aggression. This comes as a result of an instinctive sense of protection that they display when faced with situations that they perceive as threatening. Due to ignorance in misinformation, the 'unknown' threat of this disease has fuelled this type of prejudice and contempt by many in the Church towards this group of HIV/AIDS sufferers.

Studies have shown that when people are afflicted with crisis and change, even when the change affecting them is good, they become more aware of their own mortality and begin to consider eternal values and circumstances (Kennedy 1996:26). This critical period is a time when people are open to hearing about the love of Christ and what a difference He can bring into their lives. A caring and sympathetic outreach to those who are suffering and in need would be a vivid demonstration of Christ's love and concern for them on a personal level. This caring outreach would serve to draw them to Christ as they experienced His love as demonstrated through the compassion of His followers.

This study will explore and examine how this unfortunate relationship, which has developed between the local church and the HIV/AIDS community can be altered when provided with the opportunity to learn about each other in safe, non-threatening ways using the vehicle of Home Based Care as the point of entry. The problems associated with the response of people in general and with the church in particular

may be seen as vague, and at times even intangible due to the vastness of the difficulties associated with the many facets of the ramifications of the disease. It will be the subject of this research to purposely examine a certain segment of the HIV/AIDS pandemic, and in particular the response of the church as a whole as they encounter this predicament. Specific attention will be focused on the faith community as they seek to determine their role as the body of Christ in this world crisis.

1.1.3 Scope and Delineation of the Problem.

Most of the efforts which have been made, both currently and historically, in the war against AIDS have been directed towards the symptoms and treatment of the pandemic, as opposed to looking for ways to mobilize the one force which should already be equipped to help in the most intensive area of emotional, spiritual and even physical support. The infrastructure of the existing church in Africa has the potential to be a tremendous resource for reaching out with the love of God to those suffering from this dreaded disease.

An informal survey done (2001) by simply using a basic search engine on the Internet reveals that by looking at the top thirty articles listed (out of 6,470,000 articles which can be found on the World Wide Web about AIDS), of the top thirty sites, only one site, which ranked number 7, dealt specifically with the critical issues of compassion and physical outreach to these people who are in desperate need of such care. By far, most HIV/AIDS literature deals with sounding the alarms to alert the populous of the crisis, prevention, education, and treatment choices; but comparatively little being done to deal with compassion issues that primarily find themselves outside of the scope of medical and official world help organizations.

This will not be a study on the medical treatment modalities, which are available to those suffering from HIV/AIDS in the more developed parts of the world where drugs and other treatments are available. It will also not be a study based on the despair felt by those masses of infected individuals who do not have the ways or means to access such medicines and therapy regimes for themselves. In addition, this study will not be dealing with, or issuing a comparison with any alternative forms of treatment, holistic, natural, or otherwise.

This study will be primarily involving the response of the Christian community, with a specific focus on the impact that can be made by the local church when they are adequately informed with accurate information about the disease and equipped with a valid understanding of the biblical injunctions given to us by Jesus Christ to 'love one another' (John 13:34 NIV) and thus fulfil the love of Christ. In addition to this area of lack of truthful information, and probably even more important if that is possible, will be the study of the reactions of those within the church when they are given the opportunity to witness and participate in a loving, non-threatening way, in the actual caring for those with HIV/AIDS which will make a difference in the lives of individuals suffering from this plague. Using Home Based Care as a vehicle for providing an opportunity for people to experience, in a 'hands-on' way, the hopelessness and helplessness of those suffering with AIDS, will allow them to begin breaking down the barriers of denial and separation. Once they are able to comprehend this pandemic on a *personal* level, getting to know these people as individuals with needs and fears that can be met by individuals such as themselves, as opposed to a vague sense of 'those people with AIDS'; the Church can begin to purposefully demonstrate the love of Christ and change the world.

1.2 NATURE OF THE RESEARCH AND THE RESEARCH HYPOTHESIS:

The research question, which will be answered by this study, is as follows:

1. Can the negative attitudes, prejudices and behaviours which are held and demonstrated by many in the church towards those suffering with HIV/AIDS, be changed by using deliberate attempts to alter their perspective of this pandemic by providing accurate information, in juxtaposition with the demonstration of Christ's love and compassion to this community?
2. In conjunction to this first question comes a second: Can the compassionate outreach of the church, as it follows Christ's mandate to love (through Home Based Care), change the perspective of those in the HIV/AIDS community so that instead of viewing the church (as a whole) as cold and unloving, their perception will change with the

demonstration of such love and compassion by it's membership that they begin to see the church as a source of hope and love?

In the first portion of this study, it is the proposal of this research to follow two case studies of attempts to change the underlying attitudes and mind-set demonstrated by the church towards the HIV/AIDS population.

1. The first of these case studies will be the evaluation of a pilot program instituted by the World Relief Organization in Nkhotakota, Malawi (Appendix A), utilizing such principles as: volunteerism; the benevolent service of the church, particularly as it relates to interaction with HIV/AIDS sufferers; the diminishing of stigma and prejudice; and positive results indicated in this research. The Nkhotakota program demonstrates significant promise of the optimum results hoped for by this study, but it has not been systematically studied for its actual effectiveness and reproducibility in other situations and environments. Preliminary promising results from the Nkhotakota project indicate that if this program can be studied and duplicated, it could have an impact on the Church and AIDS communities in Africa.
2. The second case study will deal with a local church community in Lilongwe, Malawi as the proposed plan of Home Based Care is presented and implemented in this study group.

There are four easily identifiable goals, *which have been successfully demonstrated* in the Nkhotakota project. With careful study and implementation of the information and methods practiced there, it is hoped that they can be duplicated in the Lilongwe study project:

1. From it's participation in this study, the church (to be specific, the Chimbalame Assembly of God congregation in Lilongwe, Malawi) will see how their example of Christ's love in action impacts the community. Nearby local churches will observe the positive changes in the attitudes within the church and the community and they will want to initiate a program within their churches.
2. The people in the community surrounding the Chimbalame congregation, who are suspicious of the church because of unfavourable experiences in the past due to the stigma often associated with HIV/AIDS patients (alienation,

estrangement, prejudice, etc), will become more accepting of the church, and change their viewpoint to one that perceives the church as a helpful, loving and compassionate resource in the fight against AIDS.

3. This congregation will become a beacon of light to the community as they are observed demonstrating Christ's love in action. The attitudes of those in need of loving support and nurture will change their belief that the Church is a hostile, unloving institution and instead begin to see the Church as a loving source of help and a place of comfort in their suffering. Seeing the love of Christ demonstrated in real, tangible ways will draw them to the Saviour in a new and meaningful way.
4. While participating in an intimately personal way with those suffering with HIV/AIDS the Chimbalame congregation will, as a body of individuals, be faced with the devastation of AIDS in a very real way forcing them to accept the horrors of this disease and begin working through the associated cultural denial issues. As they are faced with the reality of the pain and suffering of AIDS patients, they will become aware of their own vulnerability and take measures to protect themselves. Becoming aware of their own vulnerability and mortality as they face others like themselves who are suffering, helps them to realize that it could happen to them as well if they practice a lifestyle that makes them vulnerable to the disease.

The second portion of this research will then evaluate the impact on the actual HIV/AIDS community as the changing attitudes of the church are observed and felt as this community then changes in their response to the church.

1.3 RESEARCH DESIGN, PROCEDURE, AND METHODOLOGY: THE THEOLOGICAL NATURE OF THE RESEARCH.

In an effort to prevent the 'reinvention of the wheel,' this research was begun with the evaluation of pre-existing programs that could potentially be modified to meet the needs and goals of this research. Upon this discovery of the World Relief program in Nkhotakota, it was determined that this program would be integrated in this study, as it was found that this already existing program was begun incorporating many of the same identified goals.

It is therefore the intention of this study to evaluate all aspects of the program already in progress in Nkhotakota, and use this information in the development of a new program in the Lingadzi area of Lilongwe. This program, which although similar, will be separate from the Nkhotakota program in both location and with consideration of the uniqueness of the churches and individuals involved.

Research design and methodology for this study will be developed as the research progresses and evolves, with the expectation that several strategies of enquiry will be actually utilized. Initially, though the observation of participants, ethnographic strategies will be instituted, with interpretive data analysis to objectively assess the participants lived experiences.

Systematic enquiry, through the process of interviewing the participants, will be a primary source for extracting information and data collection. This will be done using several interviewing techniques (De Vos1998:299), including unstructured interviewing with a schedule to obtain research-relevant information from sources such as the World Relief workers and facilitators, the Nkhoma Synod HIV/AIDS task force, etc. Although this researcher does plan to become involved with the existing literature, it is none-the-less anticipated that in-depth interviewing will take place to elicit autohistories, personal narratives, and lived experiences of those who are involved in the study. This will include both those who are suffering from this disease, as well as those participating as volunteers. In order to develop relationships and mutual trust, these interviews will take place over an extended period during the course of the study. This will work to ensure the cooperation of the interviewees, as well as create a milieu, which will improve the quality of the collected data. In addition to individual interviewing, focus group interviews will take place within the already developed support group in the Nkhotakota study (both with the volunteer visitors and the patients themselves), and with groups that will develop in the Lilongwe study.

1. Using empirical or participatory action through the course of this research, efforts will be made to elicit participant accounts of meaning, experience and perceptions, which will necessarily involve identifying the individual and group's beliefs and value systems. Therefore, the research paradigm for this study will primarily be done by qualitative mode of enquiry, using

the ‘dominant-less-dominant model’, where the researcher presents the study within a single, dominant paradigm (qualitative) with one small component of the overall study drawn from the alternative (quantitative) paradigm, as discussed by Creswell (De Vos 1998:360). The positive research would necessitate a quantitative survey from a sampling of the local village population to ascertain overall attitudes and beliefs regarding the HIV/AIDS relationship to the local church. Everyday human behaviours and attitudes, which will be brought to light from the quantitative analysis, will be studied interpretatively. Utilizing this concept of triangulation will work towards warding off obvious biases that might not be obvious and detectible to the researcher.

Once baseline information has been obtained, studied, and developed, certain assumptions can be made regarding the milieu of the communities. This will be evaluated in comparison to attitudinal studies in other communities and churches to determine whether or not they are representative of the community at large, or if they are specific to the location in which they were developed.

2. This study will involve not only those churches and congregations selected to participate, but will also require a core group of individuals who are able to grasp and share the vision of home care. These volunteers will be essential in the development of the program as they will be the initiators as well as facilitators of the work.

   This essential position of facilitators will be provided by students from African Bible College as part of the outreach program provided by the college as it seeks to reach out to the surrounding community. These students will be trained in HIV/AIDS issues as well as home care principles and communication skills in order to develop sustaining relationships within the churches and patients they interact with (Appendix C). The students will have actual exposure to those involved in the Nkhotakota program, with opportunity for personal dialogue and discovery with the individuals engaged in the original program, both the patients and the facilitators.

3. The program determined, the students selected and trained, the next step will be to identify the churches that will participate. It is essential that this step be carefully undertaken so that the church will not misinterpret the motivations and ministry of the agencies (African Bible College and World Relief) involved.

As done in the Nkhotakota project, an open invitation was issued to the local churches in the 'Lingadzi' area of Lilongwe, as the African Bible College students presented themselves to the churches with the intention of helping them to develop their own home-based care program. This invitation was given to a smaller, more concentrated area than the one in Nkhotakota and at the time of this proposal, only one church (the Chimbalame Assembly of God Church) demonstrated a solid interest in participating in the development of an HIV/AIDS outreach program in their congregation. It is anticipated that other churches may express a desire to begin such as program as they see the fruits experienced in the Chimbalame congregation and will be incorporated into the plan as well[1].

It is essential that this program must never be identified as being an 'African Bible College' program, but rather will be identified as the program of the local church that the ABC students are assisting with. In this way, the local church will take 'ownership' of the program and it will become a vibrant, sustainable ministry into the community, continuing on when students are no longer available to implement it.

Through this study and ministry, the goal will be to change the attitudes of both the churches participating in the study and the local HIV/AIDS community. By observing the Chimbalame congregation action plan, the churches in the surrounding community will see the example of Christ's love in action, witnessing the impact it is making in their own community. If these churches follow the pattern demonstrated in the Nkhotakota area,

[1] During this time of initial developmental planning, there is only one church actively involved, the Chimbalame Assembly of God. There are two additional churches, which have expressed serious interest and it is anticipated that they will enter the program as well: the Kaning'a CCAP, (which was formerly, up until approximately 6 years ago, known as the Chigoneka prayer house of the Lilongwe CCAP congregation) with Rev. Khombe, and the Glorious Temple Assembly of God with Rev. Edward Chitsonga in Area 47.

they will want to become participants in the program so that they too can begin reaching out to HIV/AIDS victims and their families in a loving and compassionate way, and therefore acting out Christ's commandment to *'love one another.'*

> We love because he first loved us. If anyone says, 'I love God', yet hates his brother, he is a liar. For anyone who does not love his brother, whom he has seen, cannot love God, whom he has not seen. And he has given us this command: Whoever loves God must also love his brother. Dear children, let us not love with words or tongue but with actions and in truth.
>
> If one of you says to him, 'Go, I wish you well; keep warm and well fed', but does nothing about his physical needs, what good is it? In the same way, faith by itself, if it is not accompanied by action, is dead. But someone will say, 'You have faith; I have deeds.' Show me your faith without deeds, and I will show you my faith by what I do (1 John 4:19-21, 3:18; James 2:16-18 NIV).

4. With the churches and students selected and ready to begin, the churches will be asked to identify those within their midst who are sick. There will be no attempt at determining if these are truly 'AIDS'[2] patients. This is due to the strong denial system that is present in the Chewa culture (as with many other African cultures, refer to 3.2). If it were to become known in the initial phases of the ministry that this was an outreach to AIDS sufferers, there would be no one who would allow such a visit which would identify them as an AIDS patient.

   Patients thus selected, the visiting process will begin with ABC students teaming up with members of the participating church. Knowing that many will view these visits with suspicion and uncertainty, the initial efforts will be primarily to build trusting relationships.

5. Once relationships and trust have been established, additional needs can be met and ministries established. Some of the ministries which have been begun as a result of the Nkhotakota work that might be duplicated in Lilongwe include:

[2] Realistically, it is presumed that most of the homebound patients who will be involved, even in the initial steps of this program will indeed be HIV/AIDS sufferers based upon statistics given for both the general population and those who seek medical attention.

a. HIV/AIDS support groups where sufferers openly identify themselves as AIDS patients and meet on a regular basis for prayer and support.
b. HIV/AIDS patients being welcomed and loved within the local church.
c. Agricultural and other project development to meet actual physical needs – Income Generating Activities (IGA).
d. Youth intervention and awareness programs.

1.4 KEY WORD DEFINITIONS:

1.4.1 Church/church:

The Greek word *ekklesia*, the term translated 'church' in the New Testament, is the word that the Septuagint most frequently uses to translate the Old Testament term *qahal*, the word used to speak of the 'congregation' or 'assembly' of God's people (Grudem 1994:853). In defining the Church, it will be necessary to bear in mind the distinction between the invisible and the visible Church. (1) The former may be defined as the *company of the elect who are called by the Spirit of God*, or briefer still, as the *communion of believers*. (2) The latter is a broader concept, and may be defined as the community of those who profess the true religion together with their children. It is important to bear in mind that these two are not entirely parallel. Some who are members of the invisible Church may never become members of the visible organization or may be shut out from it; and some who belong to the visible Church may be unbelievers and hypocrites and as such form no part of the body of Christ (Berkhof 1933: 281, 2)[3].

Berkhof further describes yet another defining area of the church would be in the essence of its function as an Organism (1.4.14; 5.4.1), as opposed to the description of the Church as an Institution or Organization. This distinction applies only to the visible Church. The Church as an institution or organization becomes visible in the offices, in the administration of the Word and the sacraments, and in a

[3] In his work, *Christian Faith*, Hendrikus Berkhof (1973:398) addresses this concept historically, citing this divisive classification as originating in the 4th century when the church first became a privileged group and then a national church, making everyone want to belong to it.

certain form of Church government. But even if these were absent, the Church would still be visible as an organism, as a communion of believers, in their communal life and profession, and in their joint opposition to the world.

For the purposes of this research, there will be no attempt whatsoever to determine which individuals in the congregations studied are truly a part of the invisible church and thus make an attempt to determine the hearts of men, a task which God alone is capable of. This is why Paul says, *The Lord knows those who are His (2 Tim. 2:19).* All those who are members of the congregations referred to, either by formal membership or by association will be considered as being part of the local church congregation.

References in this study to the Church in it's larger, broader and more generic form will be applied to the world-wide church, the 'visible' church, as it is seen and interpreted from the standpoint of the rest of the world, whether they be indifferent to it or in opposition to it. As it is true that not all impressions of the Church from these varying factions can be considered as accurate, it is non-the-less the perceptions of many outside the church that colour and influence the way it is perceived by the world as a whole, so these attitudes will be considered when substantiated by publication or other sources as being representative of a significant portion of a group's perception.

No attempt will be made within the scope of this research to make any determinations as to the 'correctness' of one denomination over and opposed to any other. Any Church who defines itself as believers and followers in Christ, and claim to be part of His body, believing that the Bible is God's revealed Word to mankind, will be included in this study and will be considered, for the purposes of this research, as local representations of the Christian Church.

1.4.2 HIV/AIDS:

HIV/AIDS is an acronym standing for 'HIV' Human Immunodeficiency Virus, which is the actual name of the virus that is causing such destruction; 'AIDS' is also an acronym for Acquired Immune Deficiency Syndrome. When someone has 'HIV', it means they are infected with the virus, but their immune system is not necessarily compromised at this point. Once the disease has advanced to the point that the body has become symptomatic, displaying some of the various opportunistic

diseases the AIDS sufferer is susceptible to; it then progresses from being categorized as HIV to the classification of AIDS. When someone has AIDS (often referred to as 'full-blown' AIDS which symptomatic), their immune system is severely compromised and they then become susceptible to a host of infections, which will ultimately lead to their death. This brief explanation of HIV/AIDS is not meant to be a comprehensive medical definition, but rather to simply explain the basic premise of this disease.

This group heading will be used during the course of this study to distinguish all those who are suffering from or perceived to be suffering from the HIV virus, which results in the syndrome known as AIDS. There will be no attempt to distinguish between those who have contracted HIV with those demonstrating full-blown AIDS. For the purposes of this study, all those who are known (proven by positive response to physical blood testing), or suspected of having the disease by symptomatic response will be considered as falling within this group.

Although there are those exceptional individual cases that claim to be cured from this disease, it is widely accepted that there is no cure at the present time, and all those who are suffering from HIV/AIDS will eventually succumb to the disease. It will be the position of this research that this is indeed the case and no attempt will be made to refute this claim.

1.4.3 HIV/AIDS Community:

The HIV/AIDS community will include those who are 'infected' with the virus and / or those who are 'affected' by the virus. This would include all those who are in direct, and sometimes-indirect contact with those who are infected, such as family members and other loved ones. Also included would be those who have interacted with them on a fairly consistent manner, such as those in local environment of the infected person; including the church, work and neighbourhood environments.

1.4.4 Triangulation:

Triangulation: Originally coined by Denzin (1978), referred mainly to the use of multiple methods of data collection with a view to increasing the reliability of observation.

1.4.5 Man:

For the purposes of this work, 'man' will be an encompassing term, including the description of both men and women, as in the term 'mankind', except when otherwise indicated by context. Therefore the masculine terms 'man, his, he, etc.' will be considered in their inclusive form indicating as explained in Grudem (1994:440-441),

> In Genesis 5:1-2 we read, 'when God created man, he made him in the likeness of God. Male and female he created them, and he blessed them and *named them Man* when they were created' (cf. Gen. 1:27). The Hebrew term translated 'Man' is *'adam*, the same term used for the name of Adam, and the same term that is sometimes used of man in distinction from woman (Gen. 2:22, 25; 3:12; Eccl. 7:28). Therefore the practice of using the same term to refer (1) to male human beings and (2) to the human race generally is a practice that originated with God himself, and we should not find it objectionable or insensitive.

1.4.6 Truth Value:

As defined by Guba in De Vos's work (1998:349):

> Truth Value asks whether the researcher has established confidence in the truth of the findings for the subjects or informants and the context in which the study was undertaken. It establishes how confident the researcher is with the truth of the findings based on the research design, informants and context. In qualitative research, truth value is usually obtained from the discovery of human experiences as they are lived and perceived by informants. Truth value is subject oriented, not defined a priori by the researcher. Lincoln and Guba (1985) termed this 'credibility'. They argued that internal validity is based on the assumption that there is a single, tangible reality to be measured. If this assumption is replaced by the idea of multiple realities, the researcher's job becomes one of representing those multiple realities revealed by informants as adequately as possible. Researchers, then, need to focus on testing their findings against various groups from which the data were drawn or persons who are familiar with the phenomenon being studied. A qualitative study can be considered credible when it presents such accurate descriptions or interpretation of human experience that people who also share that experience would immediately recognize the description (Sandelowski 1986). Truth-value is perhaps the most important criterion for the assessment of qualitative research.

1.4.7 Gatekeepers:

Successful fieldwork is dependent upon the researchers accessibility to the subjects under study. In many cases the researcher must build up and maintain relationships with *gatekeepers*, which are often indigenous people who are part of the

setting to be studied who are willing to serve as an access point into the community (De Vos 1998: 258).

1.4.8 Home Based Care (HBC)

Home Based Care has come to mean many different things in various parts of the world. During the initial phases of this study, it was a fairly unknown entity, but gradually became more and more common in its usage, as more and more groups began to develop their own HBC programs. In most developed societies, HBC provides almost full service medical care specially designed to be provided in the patient's home.

For the purposes of the research and the HBC program under study, HBC is used to designate trained volunteers who visit patients in their homes, regardless of their disease status or environment at no charge to provide chaplainry visits, offering spiritual counsel, hope and encouragement.

1.4.9 African Bible College Community Clinic

African Bible College is a multifaceted mission work in Lilongwe, Malawi. In addition to the college itself, there is also a radio station (ABC Radio - 88.3 FM), a Christian Academy for grades R-9 (ABC Christian Academy), and a medical clinic (ABC Community Clinic), which currently serves as an outpatient clinic with a specialized malnutrition ward, with potential to develop into a fully equipped hospital in the near future.

1.4.10 Practical Theology:

As a relatively new field, practical theology has struggled to obtain and maintain its identity by those who have misunderstood its full definition and worked to keep it within the realm of a technical discipline. By so doing, practical theology was interpreted exclusively as a way of application, the means to the ends that had already been established outside the precincts of practical theology (Browning 1996:56).

Fowler (1995:4) offers the following definition of Practical theology:

> Critical and constructive reflection by communities of faith carried on consistently in the contexts of their praxis, drawing on their interpretations of normative sources from Scripture and Tradition, in response

> to their interpretations of the emergent challenges and situations they face, and leading to ongoing modifications and transformations of their practices; in order to be more adequately responsive to their interpretations of the shape of God's call to partnership.

In *Studying Congregations in Africa*, Hendriks (2003:11) brings the functional concepts of practical theology together in the following eight points:

1. Practical Theology is about the missional praxis of the triune God, Creator, Redeemer, Sanctifier, and
2. About God's body, an apostolic faith community (the church)
3. At a specific time and place within a globalised world (a wider contextual situation),
4. Where members of this community are involved in a vocationally based, critical and constructive interpretation of their present reality (local analysis),
5. Drawing upon an interpretation of the normative sources of Scripture and tradition,
6. Struggling to discern God's will for their present situation (a critical correlational hermeneutic),
7. To be a sign of God's kingdom on earth while moving forward with an eschatological faith-based reality in view (that will lead to a vision and a mission statement),
8. While obediently participating in transformative action at different levels: personal, ecclesial, societal, ecological and scientific (a doing, liberating, transformative theology that leads to a strategy, implementation and an evaluation of progress).

> Throughout the discussion of this definition's eight steps, the tenets of ecclesiology unfold. It is not a systematic ecclesiology, but rather a set of markers or beacons for orientation, such as those used in aeroplanes to fix the position and course…. the tenets are interwoven and are to be implemented in the process of doing theology in a living faith community, where believers participate in God's missional praxis.

These eight steps will now be explored within the proponents of this research dissertation.

1.4.10.1 The missional praxis of the triune God, Creator, Redeemer, Sanctifier

Throughout the history of mankind, the conception of God has been present in one form or another. Even without any formal pedagogy, through his innate knowledge mankind has consistently developed some form of god to worship in his attempt to order his world (5.1). The Bible is written with the presupposition that

written within the heart of every man (1.4.5) is the universal and foundational concept recognising the reality of God's existence.

> Wherever men exist, in all ages and in all parts of the world, they have some form of religion. The idea of God is impressed on every human language. And as language is the product and revelation of human consciousness, if all languages have some name for God, it proves that the idea of God, in some form, belongs to every human being…. The word God, however, is used in a very wide sense. In the Christian sense of the word, 'God is a spirit, infinite, eternal, and unchangeable, in his being, wisdom, power, holiness, justice, goodness, and truth.' This sublime idea of God no human mind ever attained either intuitively or discursively, except under the light of a supernatural revelation (Hodge 1871:159).

Since there is no question as to the 'if' of God, the question then comes to the 'who' of God. Who is God? How can man, who is finite understand the infinite? This is where the distinctions of 'gods' and the God of the Bible come into play. For the purposes of this study, the perception of 'god' will be limited to God, as understood in the Christian sense outlined by Hodge (above).

In its effort to explore the theology of God, Chapter five will develop a hermeneutical and correlational dialogue demonstrating how the church and the world interrelate to more fully comprehend the nature of God as creator, redeemer and sanctifier of the world. As Christians, the Bible is authoritative. It is not within the realm of this work to argue the validity of this point, but rather to provide clarification regarding the presupposition that this research is based upon. As Grudem describes in his *Systematic Theology* (1994:73),

> The authority of Scripture means that all the words in Scripture are God's words in such a way that to disbelieve or disobey any word of Scripture is to disbelieve or disobey God.

With this in mind, Hendriks (2002:22) further clarifies:

> The Bible is not a reference manual but a metanarrative. To use the Bible as a manual in a legalistic way to either approve or disapprove of modern issues, is to misunderstand its basic message. The Bible does not give us a set program, but invites us to participate in God's missional praxis, a process.

Based upon this Scriptural foundation, it is essential to determine the identity of man as he relates to God, his Creator. Genesis 1:27 clearly states that man was made in the image of God, *So God created man in his own image, in the image of God he created him; male and female he created them.* From this, it can be deduced

that God created man with purpose in mind. It is because God *is* love (1 John 4:8) that He created him *to* love, which characterises the essence of chapter 5. He did not *need* man, as He is complete in Himself. God created man with the ability to think and reason, to choose for God or against God. Again referring to Grudem (1994:440-441),

> He created us for his own glory…. God speaks of his sons and daughters from the ends of the earth as those 'whom I created *for my glory*' (Is 43:7; cf. Eph 1:11-12)….This fact guarantees that our lives are significant. When we first realize that God did not need to create us and does not need us for anything, we could conclude that our lives have no importance at all. But Scripture tells us that we were created to glorify God, indicating that we are important *to God himself*. This is the final definition of genuine importance to significance to our lives: If we are truly important to God for all eternity, then what greater measure of importance or significance could we want?

Because God wanted an intimate relationship with His creation, He has used various means to communicate with mankind, allowing an understanding to develop about who He is. From individual, personal contact (such as in the account of Adam and Eve in Genesis, and the incarnation of Jesus in the New Testament), to revelation through dreams and visions (Gen 37:20; 40:8; 41:8,12; etc.), to various creative theophanies such as the burning bush, God has revealed Himself to His creation. It is through the written Word however that modern man gains his most comprehensive insights and understanding of who God is. From Scripture, one can learn about how God interacted with mankind in the past, what expectations can be deduced for the present and what hope lies ahead in the future. As will be demonstrated in chapter two, the ecclesiastical historical record is often dismal in the way it has displayed its misconstruction of God's actual missional nature (2.2).

In addition to Scripture, believers since the time of Christ's resurrection also have the indwelling of the Holy Spirit to assist them in both communication with, and in their understanding of, the God of the universe. From these resources one begins to gain insights about God, but for mankind to gain a more comprehensive grasp on the relationship that God seeks with him; He has provided a way to enhance our understanding by using metaphors in His Word that are familiar to the human

experience. Family images[4] are particularly strong and the experience of parenthood can be used to significantly organize one's understanding of God (Wiltshire 1977:874).

This metaphor is particularly significant to the African world-view due to the centrality of the family in the African milieu, which will be discussed more fully in chapter four. To answer the argument that those individuals outside the framework of a close-knit family relationship will then be excluded from an understanding of intimacy about God, Wiltshire[5] gives the following clarification:

> Parenthood is finally a state of mind and spirit and not only of biology…. but the nature of that experience [parenthood] is essentially that shared by all who nurture -- whether, for example, single social workers, middle-aged adoptive parents, teachers who care about their students or, I suspect, those artists and poets who cherish and give birth to the world.

Because God created man, He designed him with the intention that man would find his identity in Him. From the metaphor of family, as well as others[6] that are illustrated in His Word, God has demonstrated His desire for a relationship with His children. One analogy that particularly expresses this point of affiliation is the illustration of God's relationship with man as exemplified in the marriage relationship. God chose this example to help his creation understand the close intimacy and identity that He desires with the church, as those who correlate with the bride or wife which will be examined more closely in point 2 below.

> When the New Testament tells us that marriage is 'a great mystery in reference to Christ in the Church' (Eph. 5:32), it is implied that the union of the human and the divine, begun in Christ, goes on in the Church.... (Dulles in Hendriks 2002:7)

Another key example that helps the church (as those who are believers and followers of Christ) to understand their identity in Him is expressed in the metaphor of the *body* (3.9). Just as the body cannot function and is literally dead without the head to lead, guide and sustain life; the church as the body of Christ cannot function

[4] Louw refers to four main groupings regarding the metaphors used in Scripture (Louw 1994:12, 13). For the purposes of this study, the Family Model and the Personal Model have the most relevance to the relationship demonstrated by the metaphors selected for illustration.

[5] As proponents of 'Process Theology,' the views of Wiltshire do not always match up with this writer's interpretation of God's methods and motivations, but in the way of explanation of the family metaphor, she has been able to illustrate the point quite well.

[6] Our bodies - 1 Cor 12:27; building - Matthew 7:24-27; the sower - Mark 4:2-20; the lost sheep - Luke 15:3-7; debts and debtors - John 7:41-43, etc.

without Christ as its head. All of these examples continue to revolve around one central concept – that God's design for man was not as the deist might define 'from a distance', but rather God's design for mankind is one of an intimate love-relationship with His creation, particularly those within the community of faith. This love-relationship is not in any way arbitrary, but purposeful – part of His plan of redemption for humanity, which is His mission mandate to humanity. Through this grand design the church finds identity as positioned in Christ, which in turn shapes the identity of the individual believer by being as part of the body of Christ. The contextual analysis of the role of the African church as it addresses the issues surrounding HIV will be examined in chapter three (3.9).

God's purpose is to bring mankind unto Himself. From the plethora of means and methods that He could have chosen, God chose man himself - through the agency of the church as His body - to be the means of heralding His message, using His church as His witness; through His body, manifesting His mission. It is through the Spirit that the continuing creational and redemptive work of the triune missional God operates. He sanctifies us to be God's stewards (Hendriks 2002:16). The theology of the church as the body of Christ, and its subsequent obligation in representing God to a lost and fallen world will be more fully developed in chapter five during an examination of the role of the faith community as the demonstration of God's love to the world, particularly in reference to the current HIV/AIDS crisis.

God, as the very essence of love (5.1.1, 5.9), formulates the core of missional praxis. Using the concept of lenses with which one looks through in order to see reality more clearly, Newbigin (1989:38) suggests that although the *focus* of the church is in its mission to the world, it needs to be ever mindful in a *tacit* way of the continuing need for contextualisation of it as our comprehension of the situation is shaped by the efforts needed to cope with it. Just as he uses the illustration of a machine being made for a specific functional purpose, God has designed mankind and His church for a specific purpose here on earth. The role of the church is therefore not merely to exist, or even to grow; but rather the mission of the church is by its very nature designed as the witness of God's love into the world (5.5).

In *Transforming Mission*, Bosch underscores the concept of *the church as mission*. He concurs with Newbigin that the church is both 'missionary' and

'missionizing'' (Bosch 1991:373). Glazik identifies the interrelationship of the church with the concept of mission (quoted by Bosch 1991:372) in saying,

> It has become impossible to talk about the church without at the same time talking about mission. One can no longer talk about church *and* mission, only about the mission *of* the church.
>
> … it cannot be denied that the *missio Dei* notion has helped to articulate the conviction that neither the church nor any other human agent can ever be considered the author and bearer of mission. Mission is, primarily and ultimately, the work of the Triune God, Creator, Redeemer, and Sanctifier, for the sake of the world, a ministry in which the church is privileged to participate. … Mission has its origin in the heart of God. God is a fountain of sending love. This is the deepest source of mission. It is impossible to penetrate deeper still; there is mission because God loves people (Bosch quoted in Hendriks 2002:11).

Bosch describes what he calls a 'abiding tension' encountered by the church as it understands its identity and mission to be the exclusive messenger of the salvation message, while at the same time holding the responsibility to serve as an illustration of God, in both word and deed, and His involvement in and with the world (Bosch 1991:381).

Chapter two (2.1) will illustrate how the HIV/AIDS crisis can be likened to the metaphor of leprosy as described in the Bible, but not merely by its clinical expression, but on the socio-cultural and religious implications (Saayman 2003:62, 63),

> This [the issue of HIV/AIDS and the church's response to it] is perhaps where Christian mission and Missiology faces its biggest opportunity to make a contribution in containing this pandemic which so terribly diminishes our humanness…. because AIDS is a socio-cultural disease, humanity looks in vain to biomedical experts only to provide a lasting solution. The solution will have to be found largely in modifying sexual behaviour, in other words in the areas of religion, ethics, morality and culture in general. What greater missiological challenge can the Christian community desire?

1.4.10.2 God's body, an apostolic faith community (the church).

God has ordained that the church as His body will represent Him in this world. The struggle revealed by the historic responsiveness of the church as the body of Christ interacting with the reality of the world, and in particular the HIV/AIDS crisis will take place in chapter two (2.2-2.4) of this work. When one refers to the church as

the body of Christ (1.4.10.2), the emphasis is on the unity of the community and on the complementarity of the *charismata* (Heitink 1999:199). Practical theology cannot do its work with the tacit assumption that peoples' bodies begin with their neck and extend only upward (Fowler 1995:8).

Berkhof exposes one of the great weaknesses of the Protestant movement (particularly in the West), which is observable in the emphasis of the individual over the community of the church. Individualism can lead to the formation of Christians who are seduced into thinking they can survive on their own without the loving support and accountability of the local faith community. Unfortunately, if they are not enveloped into the church, they revert to their accustomed manner of life secure in the belief that they now hold an eternal-life insurance policy (Gibbs & Coffey 2001:190). This phenomenon of individualism has also served to undermine the development of what could be called the modern church in comparison to the church of the New Testament. He points out that the early church creeds began with the individual, followed immediately by the church. Accordingly, for centuries personal faith was thought of entirely as a *sentire cum ecclesia* (Berkhof 1973: 341).

As evidenced by the tension concerning the individual and the community, throughout the two millennia since the time of Christ's physical incarnation the church, as the faith community representing the body of Christ, has continued to struggle with its identity *in* and relationship *with* God. There are exceptions of course, but all too frequently even when the church has formed a sense of community, instead of being identified as the body of Christ; it is 'guilty of becoming a congregation of self-satisfied conglomerations of like-minded people' (Mead 1996:52). This can lead to the type of 'group think' mentality, which has been evidenced in the church, particularly in its response (2.3) to AIDS.

Although this research was done in the United States, it does not take much imagination to see that the principles learned from the research done by the United Methodist Church can be applied in many different locations including Africa, as Africa is in no uncertain way being affected by global megatrends (Hendriks 2002:6). From research done among non-churched people, asking them to describe the public perception of the church, the results were staggering (Mead 1996:52),

> Almost no comments indicated an attraction to churches because of the sense of community found there. Instead people said: 'I have yet to find a church where people want to be there because of shared values in stead of just being cliquish and judgmental'

Later in his work, Mead cites a study evaluating the perceptions of unchurched Presbyterians:

> People are finding less and less sense of community in their world; they seem to be looking for it, but one of the very institutions that has traditionally met the need for community (and still does for many) simply is not on the radar screen of many who really want community. People simply do not look to the churches for that which is supposed to be one of its great values (Mead citing a study by Hoge, Johnson & Luidens 1996:52).

One danger ever facing the church lies in the tension which exists in the aspect of ministering to the needs of the community in a physical, tangible way (5.1); while at the same time not neglecting the spiritual inner needs of the community which may be crowded out by the magnitude of the physical. Attempts at ministering to, and meeting the needs stemming from the outcries of urgency that accompany the suffering of the masses must not overshadow the unique gift the faith community brings to the table (5.5). While the church is called upon to minister in a practical, physical means, it must resist the danger of spending all of its energy in meeting these needs with the effectual neglect of the spiritual needs it has been especially commissioned to meet. The church is therefore not a mere cluster of individuals sharing a common purpose and belief system; but should rather be understood as the community of believers providing the medium necessary for demonstrating Christ's love in the world. This demonstration of love (5.1.1.), and its antithesis - the warped understanding of this principle as the church withholds the very love it is to be demonstrating (5.4) - will be explored more closely in chapter five of this work as the theological foundations of this concept are observed. The lack of love resulting from this misapplied hermeneutic is one of the foundational pillars supporting the evil foothold obtained and exploited by HIV/AIDS which led to the need for development of a theological praxis opening the way forward for this research.

Central in the ideal of community is the concept of interdependency. The faith community labours to be a synergistic group of believers who are more than simply the sum of the parts. In the body of Christ, one plus one does not equal two; but

rather must be considered as a better, stronger, super *one*. Paul talks of this as the 'mystery' involved in the forming of one out of two in marriage, comparing it to the mystery involved in the relationship between Christ and the church.

> 'For this reason a man will leave his father and mother and be united to his wife, and the two will become one flesh.' This is a profound mystery--but I am talking about Christ and the church (Eph 5:31, 32).

The body of Christ (the faith community) is therefore called to be the witness of Christ in the world (1.4.10.2). The church, as the body of Christ, has been called to perform a specific mission in this world and with the unfortunate, yet unique opportunity afforded by the AIDS crisis, the mission of the church must not be marginalized. This sense of 'mission' must not be confused with the compartmentalization of missions that all too often happens in the institutional church of today. As Guder describes (1985:59),

> When, in the course of modern secularisation and the discovery of the vast unevangelized reaches of the world, the modern mission movement emerged, it was often motivated by this narrow definition of the gospel. This is very paradoxical, because the modern mission movement was, in fact, a rediscovery of the church's calling established at Pentecost. An yet we often did not proclaim the whole gospel as we went out to the 'unevangelized world.' The motivation was to 'save heathens from eternal damnation,' whereas the calling of the church is to be Christ's witnesses, proclaiming the wonderful deeds of God to enlist more workers for the harvest, and thus to expand the evidence of the gospel in the world *through the presence of the incarnational community,* the church (emphasis mine).

The last phrase of Guder's statement contains the fundamental nature of the church. As pointed out by Bosch (1991:512), it is too often overlooked, but the only way the church in the world can do what she is called upon to do is with the realization that it is the incarnational operation of the church that provides the power and vigour needed to accomplish the task it has been commissioned to do. It is only as the Spirit works through, and empowers the faith community as the body of Christ, that the church will find its identity and be a potent beacon of light and hope (5.5) in this suffering and dying world (1.4.10.2). The church must constantly remember that it was not created as an end unto itself, but rather as an instrument created by God for the accomplishing of His great salvation purposes (Guder 1985:70).

Another facet of the same paradigm of community within the church that serves as a weak or flawed surface, has to do with the way of entrance into the faith

community. Many, if not most, of those that make up the body of the church come from a heritage of Christian understanding. They are Presbyterians (or Baptists, or Lutherans, etc.) not because they particularly embrace the theological positions of that particular denomination, but rather because that is the church where their parents took them as children and the church where their family finds their sense of Christian identity. This group of people will often participate in the ecclesiastical environment simply because this is the way of life to which they have become accustomed.

A second group of people have entered into the faith community because of evangelistic efforts. Western visitors often express amazement over the fact that Africans (in Malawi and many other poverty stricken nations as well) are so open and willing to be evangelised. Chapters three and four will endeavour to explore some of the paradigmatic African worldviews (4.4.4) that contribute to such differences as these.

Most of the evangelistic training incorporated in such programs such as Evangelism Explosion (Kennedy 1996) spends a great percentage of their efforts in their attempts at breaking down the walls of resistance so that the Gospel can be presented. People experienced in this type of evangelism are astounded when Africans are eager instead of demonstrating resistance to hearing the Gospel. Many times short term mission trips report staggering numbers of 'new converts' as people respond to their efforts at sharing the Gospel during their evangelistic trips. The question which must be asked, is how many of these new converts to Christianity actually join into the faith community? The unfortunate fact is that many of these new *converts* are not converts at all, but have merely responded to the message in a positive way in an attempt to please the ones presenting the message.

1.4.10.3 At a specific time and place within a globalised world (a wider contextual situation)

HIV/AIDS is the contextual crisis facing the church in the wider contextual situation. As will be demonstrated in chapters two and three, the church was initially paralysed by the problem of AIDS because of the association it had with sinful activity. As illustrated in the following example given by Amon Kasambala at a recent NetACT HIV/AIDS Awareness seminar, the church is often guilty of focusing on the wrong aspect of the problem,

> Imagine an infant peacefully sleeping under a tree. The mother is watching as this child rests quietly, and then to her horror she realizes that a deadly snake has begun slithering its way towards the oblivious baby. In a panic, realizing that her choices are limited, the mother quickly evaluates the situation to determine how to save her child. She must either kill the snake or quickly rescue the child, removing it from immediate danger.
>
> But instead of choosing either of these options, the mother begins to ponder to herself, 'how did that snake get in here?' When her neighbour comes by a few moments later, the child is dead, and the two women begin to discuss the different possibilities as to how the snake entered the garden.

Standing outside of this scene, the observer feels the compelling urge to break into the picture and shout at the mother to forget the origin of the snake - save the child! It is in this same way that the church now must not spend its energies rehashing the obvious, but instead turn its focus onto the problem at hand (3.9).

> For the Christian, this means that AIDS cannot be viewed merely as a moral problem, merely as a situation reflecting the morality of the infected. In the final analysis, AIDS itself is not a moral issue. It is a disease, an enemy of humanity, and therefore is to be fought like all other enemies…Rather, it is *our* problem… we must join together in a concerted effort to attack and overcome the epidemic. A victory over AIDS is not only a victory for some; it is also a victory for all of us (Hoffman 1990:168).

Hoffman goes on to compare the incident recorded in Scripture of the man born blind. When the disciples tried to get Jesus to point out the guilty party who could be held responsible for this judgment of blindness suffered by this man, Jesus responded by concluding that neither he nor his relatives had sinned and therefore pronounced this judgment upon the man. Rather '…this happened so that the work of God might be displayed in his life (John 9:3).' Although AIDS is a vivid reminder of the relationship between acts and consequences, and there are many who have received the disease as a direct result of their participation in activities which are outside of God's plan for holy living; there are also vast numbers of innocent victims who have done no more to deserve the infection than simply being born.

1.4.10.4 Where members of this community are involved in a vocationally based, critical and constructive interpretation of their present reality (local analysis).

The anthropological nature of the church forms its identity as a faith community. This concept is built upon the foundational idea of its very nature being that of a living *organism*. The faith community serves as a vehicle to stimulate

opportunities enabling people to find a sense of community with others; the function of the congregation is therefore to be a generator of community (Mead 1996:57). Chapter four will discuss the essentiality of community in African culture (4.3), with attention given to the understanding the importance of family to the African mindset. The way this sense of community is so firmly interwoven into the traditional cultural practices (4.2) of the tribal customs helps one to grasp the challenge of the local church in reaching the people (3.9) with the transformative exclusive message of Jesus Christ.

The family unit forms the foundational building blocks of the faith community. People have always returned to family in times of crisis and upheaval in their lives. In today's world, where so many families are torn apart by the devastation of HIV/AIDS, the need to come 'home' to the comfort of family is even greater. Just as a small child runs to their mother to kiss his 'boo-boo' (injury) to make it 'all better', adults who have been hurt and damaged by the cruelty of this world need a place of solace and consolation as well. This need for family is magnified in the African setting, due to the nature of the African family, which will be more fully described in chapter four (4.3). The church, as the living organism representing the body of Christ has been commissioned to meet those family longings and needs in this wounded and dying world. Mead (1996:60) brings this into clearer focus:

> The congregation is one of the few family back-up systems in our society. *Simply being there* [emphasis author's] at the critical events that make and shape families is a central function of congregations – the bonding of two people, the birth or adoption of children, the milestones in children's lives, celebrations of new stages of life or work, the trauma of illness, the encounters with guilt, depression or despair, the uncertainties of new challenges, the farewells of death. Most of the churches have liturgies and traditions that help to bring many of these transitions and crises into perspective with a creative and redemptive sense of purpose modelled in our creedal statements.

Just as God 'breathed' into Adam (Gen 2:7), the breath of life, He must also breath the breath of life into the church if it is to be truly incarnational in its witness. It is during the worship of the church, that the church distinguishes and defines itself as not merely a group of likeminded individuals. The shared worship experience is the means by which the church as the faith community can plug into and utilize the transforming power of God. This is what forms its identity and, as will be brought

out in chapter five, the opposite is also true; the absence of Christ's love in the believer brings into question the actuality of Christ's presence at all (5.4.4).

The incarnational work of God in the faith community functions in such a way that it might be compared to the vascular system of the human body. Through this vast enclosed network, the life force of nutrients and essential ingredients reaches each cell in the body. When there is a communion of the human and the divine Spirit that takes place in worship, the Power of God is unleashed into the body of believers. Mead points out (1996:62) that,

> The act of worship itself is a cry to God for community, but it is also paradoxically an opening through which God's power to give community gets into our lives and into our inadequate community. Worship reaches out for community and is at the same time a means by which that for which we pray comes to us.

The church must beware lest it loses its focus by a quagmire of 'good' activities. Mead goes on to point out,

> …. established groups, such as Sunday School classes, choirs, teachers groups, guilds, [and] even committees can get so focused on their assignments that they simply overlook the chance to help generate genuine community.

Even without the HIV/AIDS crisis to sensitise people to their own mortality and need for God, the church can reach out to those who are hurting and suffering who are not part of the body.

> The Spirit, as Sanctifier, leads the body to grow spiritually, that body should, in turn, reach out to a broken, suffering world. The body of Christ should portray the image of God. We are a people called and a people sent, apostles to bring God's healing and recreation to a broken and suffering world (Hendriks 2002:23)!

The church must work as a strategic organism; demonstrating a living Christianity which envelops such seekers in such a loving (5.5-5.7) way as to bring them into the faith community with the purposeful intention of their becoming believers at some point.

> A sense of belonging places seekers in the position of observer-participant so that they can learn what the gospel is all about. They can observe at close quarters how it impacts the lives of individuals and shapes a community. Through this process the seeker comes to know when he or she is ready to make a personal decision to identify fully with both the Lord and with the body of Christ (Gibbs & Coffey 2001:194).

God has chosen to use the church as His representative here on planet earth. His church, as His body is the tangible manifestation of His spirit as He works through His people to accomplish His purposes. It is through the organism of the church that He has chosen to reach out to that tormented soul. This is no less true when considering the role of the African church.

This missionary/clerical paradigm has served in many positive ways to develop the church, but as shown in chapter two, the negative consequences of this paradigm must also be addressed if one is to move beyond the hurdles that have arisen.

> The church can play a major role in addressing the numerous problems that confront us in Africa, but that its theological methodology still adheres to the old missionary/clerical paradigm of a deductive theology (Hendriks 2003: 2.2)

The question, which then surfaces has to deal with the definition of church. The definition was offered (1.4.1), describing those who are part of the church, but for the purposes of this enquiry, the role or function of the church as the body of faith believers is at question. Are the faith communities themselves actually the church, or do they merely contain ecclesial elements that have been brought together for a uniting purpose (Boff 1986:10, 11)? In his work, Boff describes the functional structure of the church. Although he is primarily describing the hierarchy of the Roman Catholic Church, the praxis principle can be applied to the existing structures found in the vast majority of Protestant churches as well. His premise is that by allowing the top-down structure to prevail, the opportunities for the ground level church member are limited, imposing constrictions upon the ability of the church to function as a faith community, as the existing hierarchy cuts off all routs of participation. This effectively prevents the members of the local community from becoming involved in a critical and constructive interpretation of their faith community.

According to Boff,

> …this linear structure has been dogmatically reproduced and consecrated. It has been socialized by theology, and internalised by the ministers themselves, who, in striking their mutual relationships, do so in the framework of the prevailing structure, and thus perpetuate the problem.

Although Boff is using the examples of linear theory to describe the need for a new identity in the church regarding the decision making components allowed the laity, it would be the position of this researcher to contend that this same principle can and should be applied to the church in the way it as the local faith community represents Christ on the individual level to those who are suffering within their midst. It has long been the practice of many churches to consider the ministerial works of mercy, which should be evident in each believer, as they have been equipped by the indwelling of the Holy Spirit, as those tasks that belong exclusively to the cleric. Boff goes on to say that a new praxis must be implemented where the whole church works to 'reinvent itself,' right to its foundations (Boff 1986:32).

> … congregational activities revolved around the role of the minister the (following the clerical paradigm), cognitive expository preaching and teaching during worship. The result was that the ecclesiology of many mainline congregations and churches, founded by their missionary work, had a typical institutional design and way of ministering.

The post-modern situation, where individualism, pluralism and relativism abound, forces the local church (3.9) to find ways and means of regrouping in communities of faithful believers who make a deliberate choice to follow Christ and to be an alternative community in a secular world (Mead 1996).

Gone are the days when a people's church (*volkskerk)* collaborated with the state and where it was culturally important and profitable to belong to a church. The implication of this shift is that to preach and apply a systematic ecclesiology in ministry, is not enough. The context has changed and the basic principles of ecclesiology have to find a new institutional design and pattern for ministry. How to be the church in a new era and context must develop in a process under the guidance of Scripture and the Holy Spirit. It requires a new theological methodology.

One problem facing modernity's churches is that people are disillusioned with the church due to the generally negative mood it manifests regarding world events. In the Christendom era one can generalize and say that the church became an institution that people joined because of cultural etiquette, not necessarily because of a living relationship with a triune God (Hendriks 2002:17).

The only way this reinvention can happen is for the church to rise to the challenge of seeing the AIDS epidemic through the eyes of Christ (5.1) (Hoffman

1990:168). This requires a localized vision, which will enable the individuals who make up the local faith community to see their family and neighbours as those Christ refers to when he answers the question, 'Who is my neighbour' (Luke 10:29-37).

1.4.10.5 Drawing upon an interpretation of the normative sources of Scripture and tradition

> The *diaconate* can be used as a term for the benevolent work of the church as it stems from a blend of the Hebrew word *dabar*, signifying both the concepts of 'word' and 'deed'. As the faith community seeks to provide diaconal service, it must continually be reminded that this service is not an optional application or consequence of the salvation given her, but that this diaconal service concerns salvation itself in its comprehensive materials, social, political, and universal aspects (Berkhof 1973:369).

To successfully contexualise theology within a given culture today, the thought forms, world and life views of the Bible, as well as those of the contemporary culture must be well understood by the theologian (Cole, in *Issues in African Christian Theology* 1998:20). Chapters three and four seek to provide essential background information for this component as African paradigms are investigated for application. Fowler (1995:5,6) explains this more fully by describing the ways 'past memory and promise' develops in the minds and practices of the faith community,

> It includes the emotional dispositions formed in their hearts and ethical sensibilities through the prayers, music, sacraments, the examples of others, as well as the proclamation and teaching of Bible and tradition. All of this sedimented complex of knowing, attitudes, and patterns of behavior shape the interpretations the community makes of the present challenges and emergent conditions they face….[it is] through these practices they engage the society that surrounds them in mission and evangelization, in social witness and political *praxis*. As they make their interpretations of the challenges presented by the unfolding future, they do so with instincts and imaginations shaped by their personal and ecclesial memories of God's patterns of faithfulness in the past and their experiences of God's faithfulness in the present.

One's hermeneutic will make or break one's theology. However, through all of these the theologian must humbly realize that it is the absolute and inscripturated Word of God that is inspired and not his own theology (Cole 1998:22). One must therefore take care that it is not the mood of the contemporary society (Scroggs 1995:18) that guides one's hermeneutical perspective, therefore serving, as the judge regarding proper interpretation of Scripture.

> If assessments about biblical faith and ethics are made from contemporary sensitivities about what is right or wrong, *then it is our*

> *contemporary perspectives that are authoritative*. Where the Bible agrees with those sensitivities, it is invoked to support what one already knows to be correct. Where the Bible disagrees, it is relegated to its historical context and becomes something we have overcome in our struggle for the truth (Scroggs 1995:19).

Each person chooses the hermeneutical presuppositions they believe to be most consistent with what is truly normative for Scripture. The impasse stems from the reality that each person views the accuracy of their own hermeneutic through the lenses of their own accepted paradigm. Since it is not within the purpose or parameters of this dissertation to explore the various principles of hermeneutics, the basic interpretive beliefs held by this researcher will be explicated at this point.

The hermeneutic used within this project is based upon the presupposition that the Bible is the written, inspired[7] Word of God, inerrant in the original manuscripts. It is an infallible and the final authority on all matters on which it speaks, containing the life-giving message of Jesus Christ, the incarnate Son of God, whose atoning work on the cross provides the means of salvation and eternal life. As such, the Bible is a foundational document[8] that allows it to serve as normative for the Christian faith. Rather than limit the Bible to a purely historical document, Scripture incorporates the transformative supernatural work of the Holy Spirit.

This stated, it is with the realization that despite their intentions, men and women are limited in their ability to be consistently reliable in their interpretation of God's message. It is therefore essential, that as brothers and sisters in Christ, we allow each other the grace to understand God as He leads them. It is the firm belief of this researcher that to use the Bible in such a way as to effectively wield it as a biblical club to pound those who differ with our interpretation must certainly grieve

---

[7] This researcher is in agreement with Hodge's (1871:154) description of inspiration: Inspiration was an influence of the Holy Spirit on the minds of certain men, which rendered them the organs of God for infallible communication of His mind and will. They were in such a sense the organs of God, that what they said, God said…This of course does not imply that the sacred writers were infallible except for the special purpose for which they were employed. They were not imbued with plenary knowledge. As to all matter of science, philosophy, and history, they stood on the same level as their contemporaries. They were infallible only as teachers, and when acting as the spokesman of God (:165).

[8] The term 'foundational' is used as in 'a principle, an idea or a fact on which something is based (Oxford 1999: 467), rather than to be associated with Scroggs' conception of the Bible as a 'foundational document' (Scroggs 1998: 23) whereby it sets the agenda for Christianity, but does constitute a normative undergirding which would affect the interpretation of Scripture.

the heart of God. A far better way would to respond by following the maxim, 'In essentials, unity, in non-essentials liberty, and in all things, love (charity)'.

Foundational principles of Scripture must be foundational principles in the faith community as well. Immutable attributes, such as righteousness, which are part of the very character of God, must also be reflected in the integral nature of the community as it finds its identity in Christ (Hendriks 2002:21).

> The righteousness needed for ordering a society had to be accompanied by a heart reaching out to embrace all, especially the weak, the poor, the alien. That is the way God is; therefore his people (later called his body) should be and act likewise.

This can only be accomplished through the transformative work of the Holy Spirit. The genuine love of God, which will be discussed further in chapter five, can only be reflected to others when it has first found its home in a believer.

Modern man, particularly western man, identifies himself with what he does. He defines himself beginning not with his relationship to God and the divine purpose of his life, but rather by the accomplishments he has achieved. His status has been reduced from the initial distinctive divine design of 'image bearer'. Man has instead allowed the parameters of how he is defined to become a summation of the activities he has performed. In essence, an ontological shift has taken place serving to reduce the human*ness* of mankind forcing man to become a human *doing*, as opposed to a human *being*.

There are certain presuppositions associated with the basic ideas linked with the term 'human being'. From an ontological framework, the *being* part of the human existence has served to puzzle philosophers for ages. Simply acknowledging the infamous words of Descartes *cogito ergo sum*, 'I think, therefore I am,' does not answer the question of humanity.

Following this framework of thought, the next logical application to be contemplated might be the current trend in practical theology which embraces the concept of 'doing theology', which will be discussed in more depth in the theological aspects of chapter five of this dissertation. One might consider a possibly more appropriate idea of 'being theology.' Considering the incarnational importance, theology should not be thought of as something that is *done*, and can be compartmentally segregated from other activities that are done; instead, theology

must be integrated with every aspect of ones life, incorporating the very fibre of ones existence (5.1.2). If theology becomes something that is *done*, it runs the risk of losing its unique character as demonstrator of the incarnational nature of the Gospel to the world. Transforming the social situation, not by the practices already established by the community, but by utilizing the intentional praxis of the spiral model in epistemology demonstrated the need for a theology of *doing*. However, looking beyond the *doing* of theology into the ontological dimension into the concept of *being* theology, or *being* the incarnational representation of Christ in the world, brings with it a more all-inclusive application of the way practical theology is understood.

1.4.10.6 Struggling to discern God's will for their present situation (a critical correlational hermeneutic)

''Doing theology' is not simply the task or prerogative of ordained clergy. Theological reflection should be central to the life of the people of God as a whole' (De Gruchy 1994:2).

Theology is therefore, about more than 'faith seeking understanding' in an academic way; it is also about obedience or faithful praxis. When these are brought together in struggling to witness to the gospel in our context, then our study of theology with all the critical rigour which that requires, is placed at the service of 'doing theology' and thus is able to make its vital contribution to the task of the church (De Gruchy 1994:12). Although the church may identify itself with the clergy and even to the point of giving up its responsibility towards others into their care, the fact remains that to many outside of the church, the average individual believer is seen as a reflection (either good or bad) of the beliefs and practices of the faith community. Chapter two will delve into how this has served to both help and hinder the cause of Christ.

Religious language can be ambivalent. It can be liberatory or it can be repressive. The 'touch' of Christ to those who are suffering must be done with love and compassion, and not with the club of judgement and condemnation. As described in the initial points of this research (1.1), all too often well meaning Christians have been guilty of defining the proper response of someone suffering from a disease such as AIDS. In their estimation, the only proper response is a demonstrative, energetic

repentance complete with loud crying and wailing, giving adequate evidence of remorse.

> Religious language does not only liberate and lead to new perspectives and change, but it can also increase the agony of the patient when it offers religious 'solutions' to the problems of suffering which do not help but rather confine the sufferer to his or her own isolation….talking about God can aggravate the misery instead of leading to a productive transformation and acceptance of suffering on the part of the patients. The story of Job can therefore serve as a true paradigm both for the counsellor and for the suffering person. It teaches both how not to talk *about* God and also how to talk *to* God (Wittenberg 1994:61,62).

As the church, or the body of believers that makes up the faith community, begins to grasp a proper hermeneutic of its identity in Christ, it can then provide a witness of Christ's love to the outside community; those standing on the outside will have the opportunity to engage in open and honest dialogue with people they know well and consider to be credible witnesses (Gibbs 2001:194).

1.4.10.7 To be a sign of God's kingdom on earth while moving forward with an eschatological faith-based reality in view (that will lead to a vision and a mission statement).

Considering Bosch's understanding of the church's mission as the essence of its existence, it is therefore imperative to determine what role that mission has concerning the current HIV/AIDS crisis now confronting the church. The church is not made up of the 'spiritual haves' the *beati possidentes*, standing over and against the 'spiritual have nots', the *massa damnata* (Bosch 1991:484). Rather, it is the church's responsibility to be not only a beacon of hope, bringing the light of the Gospel to a lost and dying world (5.1), but it is also called upon to bring transformation into the world as it teaches the wholeness and fullness of life as it was divinely designed to be.

> Western medicine is firmly rooted in the Enlightenment paradigm of natural sciences which reduces health and disease to natural cause and effect….Herein lies the failure of this western scientific approach to AIDS. Knowledge alone cannot stop the spread of AIDS. What is needed is a change in life style, a change in patterns of sexual behaviour…. Only the Christian Church has the answer in the transforming work of God in the lives of believers. Only through biblical instruction and the empowering of the Holy Spirit can life styles be changed and the transmission of the HIV virus cease (AJET Ed. 2000:104).

It is the goal of this research to not only look at where the church has been and currently is, as shown in chapter two; but to also envision where it could and should be (5.9). It is only with this kind of an eschatological vision incorporating God's missional nature that the kingdom of God can be visualised in this broken world.

1.4.10.8 While obediently participating in transformative action at different levels: personal, ecclesial, societal, ecological and scientific (a doing, liberating, transformative theology that leads to a strategy, implementation and an evaluation of progress).

If the church is going to meet the people of the community on the ground level (6.3), touching their real and perceived needs in a practical and meaningful way, the contextual milieu must be assessed and the resulting information incorporated into the methodology. 'People's reactions are often a reflection of the values, norms and taboos as shaped by their cultural environment (Louw 1998: 75).' Chapter six will fully describe the methodology used to gain this necessary information.

God's love for us is a prior condition for our loving others. The congregation is an instrument through which God's love is translated to those in need (Stone 1993:87). Fowler (1995:7) stresses the fact that in order for the practices of religious communities to change in their approach to the problems they face, the congregation must first come to the point where it is willing to face and name the points at which their practices are inadequate, unfaithful or both. He goes on to challenge the church to remain true to its mission and refrain from the seduction of some of the philosophical or systematic theologies to aim at timeless, universal or comprehensive interpretations of Christian tradition and instead remain contextual, local and positionally close to experience. This will allow the development of the praxis process (5.8) in the local church, which will be described more comprehensively in chapter five.

This researcher has personally experienced the importance of keeping the experience close and personal while avoiding the temptation to distance the issues and therefore the emotional impact of the situation. This truth was brought into focus during a time of local suffering caused by the hunger and starvation in Malawi (Bearak 2003:32-61) in 2001. Prior to the maize harvest, people all around the country were suffering from lack of available food, even to the point of death.

Although these issues had certainly been present in various parts of the world, one was able to remain relatively detached due to the barrier of multi-media distance separating the actual suffering from the viewing and acknowledgement. It was only when desperate individuals presented themselves directly under the care and responsibility of this writer did the issues take on a real and vivid format, which illustrates the problem addressed in 7.3.1. Probing, problematic questions surfaced that demanded an answer. Questions such as, 'If God promises to understand and provide for the needs of His children (Matthew 6), why isn't He doing so?' 'Does God really love His children in affluent places such as America more than He does His African children who are suffering so?' These types of questions find little satisfaction in answers that are typically offered from a search of systematic theology. It is only by looking for God in the depths of the suffering (5.1) that genuine answers can come.

The reality of this issue is that God *has* provided (5.9) for these children of His. He established His church in the world. Stone (1993: 88, 89) describes it simply as,

> The purpose of the church is to increase and promote among all people the love of God and of each other. The church helps to communicate this love in a real and concrete way to individuals, so that they can respond to it with increased love for God and for one another. The three traditional tasks of the church have been defined as *kerygma* (teaching and proclaiming the gospel), *koinonia* (fellowship), and *diakonia* (implementing the faith in Christian love and service). Crisis intervention realizes all three forms of ministry. It proceeds primarily out of love and service (*diakonia*), but it also helps individuals relate better with others as a part of the community of God (*koinonia*), and it facilitates new learning (*kerygma*) at a time when people are especially open to hearing the Word. It is within the local church fellowship, and not only through the minister, that persons can come to know and care for one another in a way that makes genuine Christian community possible and stretches the pastoral care ministry beyond what the pastor does alone.

The truth that Stone is saying is that God *did* provide for His children with the work and calling of the church. If people, particularly Christian people, are starving and suffering, it is *not* because God does not care. If people are suffering it is because the Christians who have been called to carry out His work have fallen down on the job! God has not failed them; *we* - as the church have failed them.

The church has lost its focus and perspective. Ministry is not world-centred, or even kingdom-oriented.

> This engenders an introspective and self-indulgent faith. Members of congregations expect to receive and not to give, to be ministered to and not to minister, to have the minister/pastor indulge their needs and their wants…. Most church praxis is church-oriented, that is, directed to creating, maintaining and developing membership of the local church (Cochrane, et al: 1991: 49, 51).

Cochrane explains that even when there are those within the church who are motivated and understand the urgency of the need, they 'often become a convenient excuse for a congregation as a whole to avoid the issues, as they allow an abdication of responsibility to occur' (1991:53). This is the result of theology being compartmentalized into theoretical and practical sections, praxis is lost; and with it the true sense of religion. Schreiter (2002:91-92) explains the necessity of balance in praxis,

> The dialectical process of reflection and action are both essential to the theological process. Theology cannot remain only with reflection; nor can it be reduced to practice. Good reflection leads to action, and action is not completed until it has been reflected upon.

Identifying theological praxis with liberation theology, Schreiter goes on to apply it specifically into other cultural settings less clearly marked by oppression, such as with the small-Christian-community movement. In this format, the theology of praxis meets with the grass-roots development of the faith community as it seeks to shape its identity in response to its environment. This can be seen as particularly apropos in the African church as it rethinks the responses made towards the HIV/AIDS epidemic. In this, he identifies three tasks (2002:92):

1. Theology as praxis is to help disentangle true consciousness from false consciousness (the latter which arises when oppressive societies accept their inappropriate responses as normative).
2. Theology as praxis has to be concerned with the ongoing reflection upon action and thus continually asking the question, 'what is the significance of the transformative praxis of the community?'
3. Theology as praxis is concerned with the motivation to sustain the transformative praxis, using the quality of action emerging from the practical moment as the measurement of its adequacy.

Chapter seven demonstrates how this praxis process was used in the particular situation under study in this research. By not just establishing the 'successes and

failures,' but by exploring the strengths and weaknesses of the project; realistic assessment and evaluation was done in an effort to refocus with plans, strategies and methodology were designed for implementation of the next level of the praxis process spiral as the theoretical and analytical data was revisited.

1.5 PARADIGMATIC REFERENCE POINTS OF RESEARCHER (SOCIAL LOCATIONAL BACKGROUND)

Regardless of the intensity of efforts to research and interpret the resulting data in a fair and unbiased way, it is impossible to totally remove the cultural 'lenses' that have come to reign so deeply within each of our beings. Because of this, we are often totally oblivious to the distortion they present in our attempts at unbiased, objective and honest interpretation.

Guder explains the importance of understanding the basic presuppositions of the writer, 'one of the most important tasks in theological study is to recognize the writer's presuppositions (1985:5). Although Guder is primarily speaking about theological assumptions, the same could be said for any work. It is therefore essential to understand the presuppositions, or lenses that a writer bases the tenets of his dissertation.

This becomes an ethical concern when the reliability of the material becomes in question:

> Just as science tries to insure objectivity by adhering to an explicitly disinterested method, so ethical theory tried to show that moral judgments, insofar as they can be considered true, must be the result of an impersonal rationality. Thus moral judgments, whatever else they may involve, must at least be nonegoistic in the sense that they involve no special pleading from the agent's particular history, community identification or otherwise particular point of view to establish their truthfulness (Hauerwas 1977:16).

In order to avoid such subjectivism, this researcher has made extensive efforts to collaborate all information with informed sources that are experts in the culture under study. In addition to these measures of accountability, past personal experience, which might colour the interpretations of the outcomes are taken into consideration during the examination and conclusion process. It must also be stated at this point, that not all former experiences and environmental scenarios work toward

causing one to view the events under study in a subjective, and therefore flawed manner. Just as it is essential that this hazard be guarded against and avoided, the inverse argument should also be kept under consideration: due to events and circumstances in the life of the researcher, the enhanced sensitivities and insights that are brought into the interpretation of the data should be seen with the potential of being positive indicators. Such life shaping experiences can be used to interpret the data more fully, and more realistically. In the same way that a male gynaecologist can never fully understand the pain of childbirth, neither can someone who has not suffered soul-wrenching pain fully empathize with someone in the midst of such a crisis.

This researcher has lived in Malawi, serving as a missionary and lecturer at African Bible College in Lilongwe, Malawi for over six years at the time of this writing. Even with these years of first-hand experience, as well as other sources of information, such as books, studies, student reports, stories from others, etc., this researcher continually finds that new aspects of the culture that had been previously overlooked surface for examination. Several areas have come to light in the process of this research project.

The cultural backgrounds, biases, and even our God images that we each carry with us from early childhood onward serve to formulate the 'lenses' by which we view the world. Although this will be alluded to in various parts of this dissertation, it is prudent to lay a foundational groundwork at this point so that the reader will be able to more accurately discern the known and unknown biases of this author.

Growing up in the latter half of the twentieth century in rural, mid-western America provided many of the lenses or filters that shaped the paradigms held by this researcher. Being of second-generation western-European (German) heritage mixed with 'deep-South (northern-Florida)' traditions and values brought a unique 'flavour' of mixed cultural traditions. To a western mindset, in particular an American mindset ethnicity is of some interest, but when practiced or made prominent in ones life it is considered to be an example of ones freedom of choice. For example, where this researcher grew up in the industrial area of the northern United States, it was the norm to have children from a variety of ethnic backgrounds in ones local milieu. It was not at all uncommon to go to an Italian friend's home and have spaghetti, then visit

another friend whose grandmother was speaking Polish, and go home to a treat of German '*kieflies*' as a snack. Although all of these differing cultural practices were not only tolerated, but expected and valued, they were nonetheless considered as interesting aspects of ones past, not to be confused with the fibre of the current status or the direction of the future. Keeping in touch and familiar with the cultural traditions of the past held some interest and value, but as people continued to mix in friendships and marriages, eventually these various customs faded into shadows. After several generations, most Americans have difficulty claiming any specific heritage, for example, this writer has a mixed heritage of German, Hungarian, English, Irish, Scottish, and who knows what else. Because of this 'melting-pot' phenomenon, most Americans have grown to think of themselves as 'American' instead of identifying with cultural practices of the past. With this mixed heritage, it is often difficult for westerners to understand how deeply ingrained the cultural practices in Africa are, and how strong of a hold they have on the African people. No one would give it much thought if an American girl were to decide she wanted to go to college, marry someone of a different nationality or background or even move to the other side of the country which might be thousands of kilometres away. However if a girl in the Chewa, or other African tribal culture were to have such aspirations, it would be a shock and scandal to the community.

In addition to the physical context of the natural environment (small family farm in rural America); the family unit in which the foundations of the truths held by this writer were developed in what could be described as an upper-lower class, very conservative (basically Republican), fundamentalistically Christian upbringing. Following a particularly powerful message on 'hell-fire and damnation', at the age of eleven years, this researcher had her first *remembered* encounter with God (*remember* is highlighted because when sharing this special event, which was interpreted as her first 'salvation experience' with her mother, this writer was told that she had earlier spiritual encounters with God that she no longer remembered). This significant part of the writer's spiritual journey begins at this monumental point in life. This event marked the first remembered encounter with God, and outside of a promise of a 'place reserved in heaven' not much changed in my life regarding my knowledge or relationship with God. With the 'assurance' of salvation firmly docked in my mind, I

grew up basically biblically ignorant. Even with weekly trips to Sunday School, my understanding of God was limited to following a list of 'dos' and 'don'ts', and knowing that because of that one-time revelation, I was a 'Christian'. Although this knowledge appeased my thoughts, it was never able to provide a sense of peace or actual assurance in my heart.

Adding to these variables, was the fact that in the mid 1960's Detroit, Michigan (which was the nearest large metropolitan city) suffered racial upheaval resulting in rioting which triggered a seemingly 'justified' racial bigotry in this researchers family, as well as in the local community which, while ethnically diverse, was none-the-less 100% Caucasian. While in high (secondary) school forced integration was mandated, causing fear and alarm within most families of this time.

Most of our prejudices are learned behaviour through association with prejudiced people (Rush 1960: 484), and since children are not given the luxury of choosing their own parents and role models who influence them as they develop and mature, many of our prejudices are so deep within us we are not even aware of either their existence or their actual intensity. For example, this researcher was raised in a very racially prejudiced environment, where racial slurs were common and believed, along with a basic fear and distrust of all members of other races. Although these feelings were projected towards all races and ethnic groups, a particular focus of hostility was aimed at African Americans. Growing up in this milieu, caused this researcher to observe numerous overt and obvious prejudices, and in an attempt to reconcile these attitudes with the Christian faith, *many* were analysed and discarded. Note that the term *many* was used in this sentence instead of *all*. It was this researchers intention to remove all from existence, and this was actually believed for some time, until evidence of prejudice was found to remain. This was brought to painfully clear recognition in the recent past as thought and discussion began to surround our adopted African son, and the stigma and prejudice which he may encounter as we move within our previous and anticipated new social groups when returning to the United States for visits and furloughs and the like. When considering how he may be treated in disrespectful or insolent ways which this researcher may have previously not even noticed, but would now be personally affronted by, the previous prejudice was revealed.

Another aspect of this writer's background, which has also served to fashion the paradigms held, has to do with work experience and personal medical history. While working as a trained nurse (R.N. License # FL1137752), a particular desire to work with patients suffering from Cancer developed as this researcher noticed how those patients who were facing the possibility of a terminal disease changed their mindsets, attitudes, and particularly their priorities. This phenomenon occurred as they realized how 'unimportant' previously 'important' things in their life now seemed; and how 'important' things (like their family relationships, appreciation of friends, enjoying life to the fullest, etc.), that had previously seemed so very secondary were now so very essential. This researcher watched close family members die from this disease, and then was personally struck with Cancer, which demanded facing those very issues in person, the realities already mentioned were magnified. These experiences, and the often-painful difficulties which resulted in personal relationships because of these issues, has sensitised this researcher to the veracity of the suffering (spiritual and emotional as well as physical) that accompany life-threatening illness. Admittedly, it is not the same experience as one suffering from HIV/AIDS, where the fatal outcome is unambiguous; but many of the fears and torments that go with the uncertainty and the results of facing one's own mortality can be transferred with understanding to the plight of those infected with HIV.

As with any life-threatening experience (such as cancer, AIDS, etc.), my understanding of God and His relationship to me as a particular individual was greatly impacted by my cancer experience. As mentioned previously, my spiritual journey began as a child, but remained rather static after that point until I was faced with the reality of my own mortality. This was the first time in my life that I faced something that was much bigger than myself, something that I could not 'handle' on my own, and with my own power and control. When faced with this monumental personal crisis, I turned to God. Although claiming Him previously, this was the first time I came to Him needy, desperate, and at the end of myself. What happened in my life at this point was the beginning of my true spiritual journey. Kneeling by my bedside, I cried out to God from the depths of my soul, and He answered. There were no 'tongues of fire' or anything else that an observer might see, but none-the-less, I felt the touch of God as He gave me an unquestionable sense of His presence, with a

peace ‘that passes all understanding’. I was no longer afraid. I knew in every fibre of my being that He was real and genuine. Although I had no sense of a promise of healing, I had no concern because I knew that whatever lie ahead, I wasn’t alone. He would be with me, holding me close as *we* went through it together.

This event (reaching the end of my self and desperately reaching out to God) effectually changed my life as no other event has. I have often told people that if this is what it took for God to get my attention, it was worth it, and I would not trade it for the world. Whether God healed me at that point, or whether He used the methods contained in the treatments of radical surgery, chemotherapy and radiation, I don’t know. I am only thankful that He did, as it has been nearly twenty-years, at the time of this writing, since these life-changing events took place.

All of this background has been provided in an effort to allow the reader to understand possible lenses and bias that may be exhibited, knowingly - but mostly unknowingly by this researcher during the course of this project. In addition, the inverse indicators should be taken into consideration as well as they help to provide insight into the heartfelt efforts involved in this study. In addition to these points, taking into consideration the spiritual significance of such life-threatening events in the life of a person infected or affected by HIV/AIDS, the reader may understand more easily why this writer finds it imperative that the church reach out with the message of hope contained in the Gospel to those who are facing such crisis’s in their lives.

1.6 PRESENTATION OF DISSERTATION – RESEARCH OUTLINE

The provisional table of contents is, as the name implies, provisional. By its very nature, using qualitative research design as the primary methodology for this dissertation, will anticipate an evolutionary development project as the research progresses. As the data is collected, analysed and evaluated, the research itself will dictate the conceptualisation of the structure of the dissertation.

1.6.1 Chapter 1 – Introduction: Scope of Study and Hypothesis

Chapter 1 of this dissertation will include the introduction of Research Proposal, scope of study, research hypotheses and parameters of research. This first

chapter covers the general introduction of the contextual situation surrounding the problem under study by this research, including such parameters as the scope and delineation, and nature of the problem of HIV/AIDS and its interaction and impact on and within the church. Key words will be identified and defined. The functional concepts of practical theology together with the eight points identified by Hendriks will be discussed as they relate to the research at hand, followed by an outline of the dissertation itself.

1.6.2 Chapter 2 - The Historic Response of the Church

The historic response of the church to the AIDS problem in general, as well as specific responses to the crises which have come on individual, group, national and global basis. From the general overview of the church's response, which will also recognize those exceptional movements from within the church as a whole where outreach attempts *have* been made into the HIV/AIDS community; a focus will begin to develop in this chapter as it deals with the problems of the unfortunate perception of the church as being unable to demonstrate Christ's love and compassion to a hurting world due to unfortunate situation of a hermeneutic which has been built upon faulty theology, misinformation and fear.

1.6.3 Chapter 3 – AIDS Concepts in Africa and the Response of the Church

This chapter will examine the conceptualisation, or the thought processes involving the HIV/AIDS phenomenon in Sub-Saharan Africa. In particular, the focus will be on the African mindset and how impressions or perceptions about HIV/AIDS have been formulated. The generic problems will be addressed along with a close look at the response of the African Church as it has responded to this crisis.

Looking specifically at the 'elephant in the living room' issue, this chapter will seek to honestly evaluate why the church in Africa in particular, has allowed this pandemic of AIDS to surround and engulf them without their actual acknowledgement of the problem. Cultural specifics and difficulties in the African community as a whole that contribute to the perpetuation of the problem will be explored.

1.6.4 Chapter 4 – Malawian Cultural Practices That Promote the Spread of HIV/AIDS

Following a look at the HIV/AIDS problem in Sub-Saharan Africa and the Church's response to it will come chapter four, which narrows the focus to specific aspects of the local culture, demarcating those particular areas (primarily from Chewa[9] culture such as the *Gule Wam Kulu* and *Nyau* dancers, male and female initiation rites ceremonies, etc.), which promote or maintain the spread of HIV/AIDS and the silence of denial. Underscored will be the understanding of the often unspoken need for love and acceptance from which most, if not all of these customs originate.

1.6.5 Chapter 5 – Practical Theological Perspectives regarding HIV/AIDS.

This chapter will explore the theological implications of the suffering experienced by those affected and/or infected by HIV/AIDS resultant from a warped and therefore damaging understanding of one of God's primary attributes – love. It is because God *is* love that it is essential to look at this pandemic with the lenses of love, and more specifically to examine the point of departure from God's plan through the distorted lenses that are often used to justify evil actions done in the name of love; actions that work towards the ruin God's perfect design and corruption of His plan of redemption. From the standpoint of Practical Theology, the role of the church will be explored as develops the praxis process essential to facing the theological challenges demanded by the scourge of HIV/AIDS. As it intersects with the local faith community, while seeking to develop it's own contextual ecclesiology, the research will use an anthropological approach to address the issues of love as a normative value and aspect of the church.

In addition to the biblical principles and responses mandated in the Christian ethic of the Church's responsibility to the AIDS pandemic, the role of the Christian leader (i.e., the role of the pastor or elder) will be considered. The basic principles that form the faith assumptions and motivational methods, which are necessary to develop a practical theory, can be applied to a theology of pastoral care.

[9] In both the Nkhotakota and Lilongwe areas, the demographics demonstrate a mixture of various tribal groups, with the largest influence being from the Chewa tribe (the primary language of both groups – as with all of those residing in Central Malawi, is Chichewa).

1.6.6 Chapter 6 The Nkhotakota Case Study and the Development of the Project in Lilongwe

Qualitative research methods will be used to collect data from the Nkhotakota model, which will be purposive in the usage of sampling methods and identification of access points leading to the selection of informative subjects. To gain a holistic understanding of the interconnected networks within the HIV/AIDS subculture in the Nkhotakota district, the research will begin with systematic enquiry to access and review records, and other written data from the World Relief Organization. In conjunction with this analysis, open-ended interviewing, unstructured interviews, with a schedule (De Vos 1998: 300) processes will be utilized with already identified informants within this organization who have intimate knowledge and understanding of the people and groups involved in the Nkhotakota project, to extract sufficient information to provide a basis for data collection and interview / relationship building at the case study site.

Entry points into the Nkhotakota HIV/AIDS community will be through already established gatekeepers. Although generalized permission has already been granted, this researcher understands the importance of development and maintenance of trust-based relationships to ensure cooperation and accurate information gathering.

Following the initial entry into the group, a guided use of 'snowball' or chain reference sampling, leading to theoretical sampling will be utilized as an important way to gain access to all those individuals who will be able to contribute to the research. Although methods may vary, as individual needs change, it is anticipated that the data collection will begin, as suggested by De Vos, with ethnography and participant observation as a strategy to gain an understanding of the life worlds of the subjects. Then, in order to gain a better understanding of the meaning that they attach to their worlds, it might be appropriate to switch to a phenomenological or ethnomethodological strategy and thus decide to conduct in-depth interviewing with the various levels of subjects, (i.e. this would include the actual patients suffering with HIV/AIDS and their families, the individual volunteers and support group facilitators, church leaders and others in the community who might be identified as potential contributors of information). It may also be advantageous to select one or two patients for a case study in order to provide an illustration of the needs of individuals

and groups (De Vos1998: 80). By continually collecting, recording and analysing data, a grounded theory will emerge, which will direct the course of further sources and opportunities for information exchange.

The grounded theory developed from analysing this phenomenon will be systematically assessed and a substantive theory developed, with the intention of broadening into the development of a formal theory (De Vos 1998: 266). From this point, information should be surfacing which will have application in the congregational, as well as the individual setting, leading to the formation of a praxis theory as well as a sustainable strategy on how to implement it.

The four cognitive processes identified by Morse and Field's approach (De Vos 1998: 340) towards data analysis will be used (comprehending, synthesizing, theorizing, and recontextualizing) with the stated goal of being able to place the results in the context of established knowledge and to identify the results that support the literature or claim unique contributions. Attention will also be given to Guba's model (De Vos 1998: 348), as he discusses the area of applicability, which he defines as the degree to which the findings can be applied to other contexts and settings or with other groups. With this working evaluation, theories will be derived on how to implement this program in the Lilongwe area, with the use of African Bible College students as facilitators in the local church congregations in Lilongwe.

1.6.7 Chapter 7 – The Way Forward: Conclusions and Evaluation of Project

The last chapter will contain the final conclusions, based on generated data and evaluation, with discussion of what can be learned from the study and how it can be applied to aid the church, as both a body as well as a group of individuals, in the war against HIV/AIDS. From the research conclusions, a praxis theory will be developed and formulated along with a strategy for its implementation.

The model at Nkhotakota will become the prototype of the desired response of the local church. As this model is researched and evaluated, a '*praktykteorie*' or philosophy of ministry will emerge which can then be reproduced in other churches as the praxis theory and strategy is developed and evaluated. As the processes are assessed and refined, programs of implementation can be constructed to reproduce the

positive effects demonstrated in the Nkhotakota model as it is applied to other situations and environments.

1.7 SUMMATION

As a medical professional (Registered Nurse), this researcher has been bombarded with the horrors of AIDS on many levels. Due to its global ramifications, the world has begun to band together to address the issues, and concerns of HIV/AIDS as it devastates our planet.

As demonstrated by the popular television series, *Soul City V* (Sowetan 2003) in South Africa, the church, and those leading it are often perceived as standing back and withholding God's love and compassion from those who need it most. Instead of leading the world in its outreach to the suffering and dying it has been accused of remaining silent, or even worse as it contributes to the problem with its discriminating and judgmental attitudes which in effect, serves to further alienate those who need Christ's love most from the source of finding Him. The response of the HIV/AIDS community to this perceived standpoint of the Church has been predictable, as it in turn has developed its own damaged perception of the Church. Instead of seeing the Church as an opportunity for hope and acceptance in a dying world, they view the Church as an inflictor of judgment and pain.

A paradigm shift must take place in the thinking processes of the Church as it looks at the AIDS problem. Finding a program in Nkhotakota that is doing just that – reshaping the perceptions of their congregation towards those suffering form this disease, has motivated this researcher to look further into the model they are demonstrating in an attempt to determine how and why it is succeeding. In addition to determining these factors, further study must be done in order to establish the reproducibility of such a program in differing milieus.

As the church as a whole learns to make a paradigm shift in its thinking about the pandemic of HIV/AIDS, it will begin to see those areas of weakness in its own perspectives that have allowed the invasive perceptions of many of their members to see those suffering from this plague in a new way. New experiences and opportunities designed to serve this needy and afflicted group will help guide those

from within the church into a new awareness and understanding which will begin to change their perspectives as they see those afflicted by this plague. Instead of seeing them with their old perceptions: as those who are receiving their just rewards; they will begin to see them with new, enlightened eyes. This will help them to recognize those suffering with HIV/AIDS as *individuals* not unlike themselves; individuals that they love, who desperately need the love and compassion of God which should be reflected by the Church. Once this shift begins to move across the Church, its members will reach out to the suffering as a visible, tangible demonstration of the love of Christ.

Although initially viewed with suspicion and distrust, the HIV/AIDS community will eventually accept these overtures of love and compassion by the church as genuine demonstrations of concern and brotherly love. This will in turn, alter the attitudes HIV/AIDS community as it begins to view the Church as 'islands of hope in a sea of despair,' instead of the harsh, judgmental group it once saw. This change in perception will contribute to a positive, upward spiral of hope as each of these two groups continue to influence each other.

The Church has been called upon to be the beacon of light for a dying and suffering world. As representatives of our Saviour here on earth, our role as the Church of Jesus Christ should be one of love and compassion extending out towards those who are suffering from this pandemic of HIV/AIDS.

> 'You are the light of the world. A city on a hill cannot be hidden. Neither do people light a lamp and put it under a bowl. Instead, they put it on its stand, and it gives light to everyone in the house. In the same way, let your light shine before men, that they may see your good deeds and praise your Father in heaven (Matthew 5:14-16 NIV).'

To gain a more comprehensive perspective on the complexity of the situation, it is important to investigate the background circumstances that have worked to develop and perpetuate the problem, which is now so evident. In the next chapter, a circumspective look at the historic response of the church as it has tackled various difficult and often controversial issues, as well as an examination of some of the specific responses to the crises it has met in the past will lay a background for understanding the present situation. In addition to reviewing some of its past struggles, this ecclesiastical overview will also distinguish those positive movements

from within the church as a whole where outreach attempts *have* been made into the HIV/AIDS community.

Developing this historical foundation in chapter two will assist in clarifying the problem to be explored in this research project. The unfortunate perception of the church and its overall lack of ability to demonstrate Christ's love and compassion to a hurting world will begin to emerge as the groundwork which has evolved into the main problem under investigation.

Chapter 2
The Historical Response of the Church

2.1 INTRODUCTION:

The church has been in existence for nearly two millennia, and throughout this time it has faced many difficulties, which have helped to mould and shape it into the form we find it in today. With the advantage of better vision when viewing hindsight, an observer reviewing the historical actions of the church can easily point to areas of weakness in which the church did not respond heroically, or even in such a way as would honour the name of the Christ she claims to represent. However, in all fairness it must be conceded that the church in the world is a body (1.4.10.2) of believers, who although they have the power of the Holy Spirit to guide them, are nonetheless a body of human beings subject to mistakes, failings, and outright evil, even when claiming to speak in the name of God.

Much has been written and studied about the phenomenon of change. People are notoriously reluctant to change on an individual basis, and this continuing resistance to change is no less true in institutions across the globe. Unfortunately the scope of this resistance includes the church as well.

It is with this understanding that we must now examine the role and response of the church, as demonstrated in the past, as well as it's current response to this modern day crisis – the problem of HIV/AIDS as it affects the population of the world of today. Following the normative moral guidelines laid down in Scripture, the church initially stood firm against all aspects of the AIDS crisis because, particularly in its initial stages, AIDS was almost entirely associated with people and behaviours that were in direct defiance of the principles set down by God in His holy Word. During these early, tentative days of the disease process, those suffering from the deadly virus and even the virus itself, including the deviant behaviours that propagated it, were all conveniently grouped into one easily identifiable box, and labelled 'untouchable' by the church as a whole. This brings remembrances of the biblical stories of those who Scripture labelled as 'untouchable' as well. Although there is no specific New Testament teaching on AIDS, some have said that HIV/AIDS

is the modern day equivalent to the biblical anathema of leprosy[10] (2.2) (Mt 10:8; Lk 17:12-19; et al) (Nicholson 1994:228).

As long as the disease was defined in such a way, the church had little to fear because by condemning those practices that exacerbated the progression of the disease, they could easily distance themselves from affirming any responsibility to any aspect of it. Unfortunately, it was only when the spread had become so rampant and far-reaching that not only were those sitting in the pews becoming either infected or affected by the deadly virus, but the clergy themselves were seeing their own families falling victim to its evil touch. At this point the church as a whole, began to realize that it must re-evaluate its past response; and with that realization, begin to explore ways to move forward using its material, but mostly human resources to seek ways to stem this rushing tide of disaster. At this point of crisis, the faith community began critical constructive interpretation of their present reality (local analysis) (1.4.10.4).

This chapter will examine the foundational issues surrounding the problem and the hypothesis identified and developed in chapter one (1.2):

1. Can the negative attitudes, prejudices and behaviours which are held and demonstrated by many in the church towards those suffering with HIV/AIDS, be changed by using deliberate attempts to alter their perspective of this pandemic by providing accurate information, in juxtaposition with the demonstration of Christ's love and compassion to this community?
2. In conjunction to this first question comes a second: Can the compassionate outreach of the church, as it follows Christ's mandate to love (through Home Based Care), change the perspective of those in the HIV/AIDS community so that instead of viewing the church (as a whole) as cold and unloving, their perception will change with the

[10] AIDS and leprosy are comparable in that both diseases carried not only the death penalty, but also the aspects of alienation, estrangement and prejudice. There is also some of the same shame due to the conception of leprosy being attributed to sin. The point of departure from the comparison comes when considering the fact that leprosy was a contagious disease that could be transmitted by close contact, so those suffering from leprosy were a real endangerment to the general public and therefore they were kept ostracized and isolated for the public safety. AIDS on the other hand, cannot be spread by casual contact, but is almost entirely contracted by sexual behaviour.

demonstration of such love and compassion by it's membership that they begin to see the church as a source of hope and love?

These questions will be examined in the light of the historical church context in an attempt to determine whether the relationship between the local church and the HIV/AIDS community can be altered when provided with the opportunity to learn about each other in safe, non-threatening ways using the vehicle of Home Based Care as the point of entry. Following this examination of the foundational issues surrounding the identified problem of the church's response to the HIV/AIDS crisis will come chapters dealing with the more specific cultural issues that serve to exacerbate the issues. Subsequent to this will be a descriptive explanation of the theological aspects of the problem with the methodological development of the research project under study, along with interpretation of the data received and, the various conclusions and evaluations leading to the way forward that came from this information in the war against AIDS.

2.2 HISTORICAL ECCLESIASTICAL RESPONSE TO HIV:

HIV/AIDS may have already been apparent in places like Africa, where it is thought to have originated. It has been reported that in 1998 a plasma sample from 1959 has been interpreted as suggesting that HIV-1 was introduced into humans around the 1940s or the early 1950s. Some scientists have suggested that it could have been even longer, perhaps around 100 years or more ago (Zhu *et al* 1998). Although it may have originated as early as indicated, it did not come to the attention of the world until it surfaced in 1981 and developed into a recognized threat in the Western world. For the first time, the CDC (Center for Disease Control) in the United States reported in Morbidity and Mortality Weekly (MMWR) five cases of Pneumocystis Carinii Pneumonia (PCP) among previously healthy gay young men in Los Angeles. Afterward additional cases were reported from New York City, San Francisco, and other cities (GBGM, 1981). On 5 July, one month following this report, the New York Times published an article about AIDS (New York Times 1981).

Scientists began to scramble for some explanation of this syndrome they were beginning to recognize. By 1983, the New York Times reported recognition on a global scale in their May 24th issue (Altman 1983),

> In many parts of the world there is anxiety, bafflement, a sense that something has to be done - although no one knows what - about this fatal disease whose full name is Acquired Immune Deficiency Syndrome and whose cause is still unknown. The World Health Organization (WHO) made plans to convene a meeting of experts in Geneva from, November 22-25, 1983 to address the issue.

These excerpts from an article published in *Christianity Today Magazine* (Frame 1985:51) demonstrates the confusion and difficulty experienced by the church in the early days of HIV/AIDS discovery,

> The Kaiser/Permanente Medical Center in Los Angeles first admitted patients with Acquired Immune Deficiency Syndrome (AIDS) about two years ago. At the time, chaplain Robert Bird avoided those patients.
>
> When AIDS began to capture headlines a few years ago, fundamentalist preacher Jerry Falwell said it could be God's judgment on homosexuals…
>
> …a young AIDS victim who became a Christian …wanted to be baptized by immersion in an evangelical church. However, his request was denied because of fears that the virus would spread in the baptismal water.
>
> Generally speaking, however, Christian ministry of AIDS sufferers has been limited to organizations that do not regard homosexual behaviour as sinful.
>
> Researcher Harold Ivan Smith, who heads a counselling organization called Tear Catchers, says the evangelical church has lost credibility over the issue. 'AIDS researchers are increasingly looking at evangelicals as idiots and bigots,' he says.

From the very beginning of the HIV/AIDS epidemic, some of those on the religious fronts were beginning to respond as a sign of God's kingdom on earth (1.4.10.7). Along with the role of providing compassion and benevolence to the needy, it has long been recognized that the relationship between an individual's faith and religions practices and their personal response to illness has been associated with increased coping skills and even increased healing (Somlai 1997:417) (5.6). The AIDS Interfaith Network was created in 1986 by a group of clergy and pastoral and lay counsellors who were providing spiritual and emotional support services to persons living with HIV/AIDS. These same individuals were attempting to educate

clergy, churches, and their congregations about HIV/AIDS in an effort to promote a more compassionate response to those who were struggling with the disease (AIDS Interfaith Network 1986). The Shanti Project which is a humanitarian project with some religious overtones in San Francisco, sponsored an all-day religious forum to address the spiritual needs of people with AIDS. Later that month, the Federation of AIDS Related Organizations, gathering for the second annual AIDS forum in Denver, CO, mandated the establishment of an AIDS Interfaith network.

In June 1986, the World Council of Churches (WCC) formed a study group to begin looking into the situation surrounding this newly recognized crisis, struggling to discern God's will for their present situation (1.4.10.6). From this study group came a recommendation of three main foci for ecclesiastical response: pastoral care, social ministry and education-prevention (WCC 2001). Realizing the potential for a legalistic response, which could potentially lead to a warped sense of justice in their misguided hermeneutic regarding God's principles and result in such negative attributes as alienation, estrangement and prejudice, the WCC (2001) also called upon faith communities to:

> ...to work against the real danger that AIDS will be used as an excuse for discrimination and oppression and to work to ensure the protection of the human rights of persons affected directly or indirectly by AIDS.

Unfortunately, the church's overall response to the AIDS situation follows its own history of lethargy against evil. This can be seen as one examines the churches response to historical issues that can now be recognized as unequivocally godless (the horror of the Crusades, the holocaust, slavery, etc.). T. N. Mohan vividly portrays the role of the church in its support of the German Nazi party in his documentary, *The Life, Convictions and Martyrdom of Dietrich Bonhoeffer* (Mohan 1996). Outstanding in this period of history is the small minority of Christians such as Bonhoeffer, who recognized this pervasive evil and stood firmly in his opposition to it, with the result of his own martyrdom. While he was standing for the truth of the Gospel message, conservative Christian groups were proudly standing under the banner of Nazism believing they were furthering the cause of Christ. This warped understanding of love as demonstrated by the church was effectually working to tear down the mission and witness of the Church instead of working to fulfil the mandate (5.4) of Christ.

In a similar way, many deluded Christians have allowed themselves to be persuaded to follow a similarly errant line of theology, which reinforces attitudes echoing those that served to perpetuate the Holocaust (3.2.3). This can be noted in the following excerpt from a World Council of Churches (WCC 1987:84, 99) document.

> From the beginning of the pandemic some Christians, churches and church-related institutions have been active in education and prevention programs and in caring for people living with HIV/AIDS. The consultative group was privileged to have worked with several of these during the study. The group observes, however, that by and large the response of the churches has been inadequate and has, in some cases, even made the problem worse. As the WCC executive committee noted in 1987, 'through their silence, many churches share responsibility for the fear that has swept our world more quickly than the virus itself'. Sometimes churches have hampered the spread of accurate information or created barriers to open discussion and understanding. Further, churches may reinforce racist attitudes if they neglect issues of HIV/AIDS because it occurs predominantly among certain ethnic or racial groups. These groups may be unjustly stigmatised as the most likely carriers of the infection.

In the early days of AIDS awareness and research, Johnson (1987:108) began investigating the inflammatory attitudes and prejudices he noticed were associated with HIV/AIDS. After reviewing the scientific information available at the time (even in the 1980's), he considered the reaction of the population to be seditious,

> The prejudice described here is greater fear and rejection of AIDS victims than would be considered reasonable based on the present evidence concerning the threat of AIDS carriers to the public health.

In his study focusing on the intolerance of the church towards AIDS victims, Johnson found that those who met a certain profile were most likely to exhibit prejudice against those infected and affected by HIV/AIDS. Using quantitative methodology, he found that those meeting the following four criteria were the most likely to show evidence of intolerance of AIDS victims:

1. Lowered educational levels
2. Political conservatism
3. Self-Esteem issues
4. Religious Fundamentalism

Although this study was done in the heartland of America, there are some interesting characteristics that cross national and cultural boundaries.

The church has seemingly confused the enemy when considering the big picture of the HIV/AIDS issue.

> If we choose to use military language in this context and describe the virus as the 'enemy', we must also make it very clear that the person carrying the virus is *not* the enemy, but a co-fighter against it (WCC 1987:84, 99).

Observing the response of the church, it appears that the person carrying the virus has indeed been considered the enemy. Many times, it seems that those churches commonly known as the 'liberal mainline denominations' were in the forefront of the war against AIDS, while those in the more conservative camps remained sidelined, denying any role of the church in the AIDS epidemic.

> Scientific research has shown Christian opinion to have a palpably harmful effect. Conservative religious views tend to lead to fear, prejudice, and discrimination toward AIDS sufferers concludes a study which analysed the determinants of fear of AIDS among Australian college students. Greater knowledge is associated with lower fear of AIDS. The stepwise analysis indicated that more frequent church attendance was associated with higher fear of AIDS (Wallack, quoted by Mertz 1989a).
>
> One in ten respondents (of all staff of a large metropolitan hospital in Manhattan) agreed that AIDS is God's punishment to homosexuals, 6% agreed that patients who choose a homosexual life-style deserve to get AIDS (Wallack, quoted by Mertz 1989b).

From man's beginning all of the major world religions have taught mankind to care for those who are suffering and in need:

> In each religion, there is the concept or idea of community and connectedness. From the creation stories of all religions, the idea of coming from one family or place of origin is central. 'This concept is at the heart of the conflict of how to relate to individuals infected with HIV/AIDS. Some people would like to pretend that these individuals do not exist. Others imagine they could have no connection to an HIV infected individual. It is similar to the disease of leprosy in ancient times. Lepers were considered different and outcast. To touch or interact with them was considered unclean. Much of the discomfort was that leprosy was a visible, disfiguring disease. Disease was seen as a direct punishment from God for some sin, rather than as a natural consequence of being human. Today many people still suffer from this misguided theology (AIDS Interfaith Network 2002).

When evaluating the response of the church to the HIV/AIDS crisis, one must give more than a cursory glance at the theology which many feel supports these attitudes (5.4). The Bible is explicit when it talks about sin and its consequences. Since most individuals infected with HIV/AIDS have received the disease sexually

(or through intravenous drug use in the Western world), both practices that are equated with sinful practices described in the Bible by most Christian theologians; the disease is therefore equated with sin. As the AIDS crisis became more known and understood, the church (1.4.10.3) as a whole along with individuals who were grappling with what their role might be, had difficultly in discerning a proper stance in how it should handle this world calamity.

This paradoxical viewpoint is expressed in a paper by Dr. David Roy, which was published in 1989, when the larger picture of the impact of HIV/AIDS was only becoming apparent (Hallman 1989:144):

> …religious moralizing and a perfervid commitment to principles blinds one to person and sets up a static so violent as to swamp all frequencies for sensitive and suffering presence to, and effective communication with, AIDS patients.

Understanding the problem of HIV/AIDS requires a certain amount of openness on the part of the church. In some areas of the church, particularly those groups associated with fundamentalism or separatists, concepts such as openness to new ideas and opportunities for educating those in the church have historically been met with responses ranging from indifference to open hostility. Education has sometimes been viewed with such suspicion that it has been equated with an invitation to defilement and compromise of beliefs. In the history of the Baptist Church for example, there is a group of separatists who were noted to be decisively 'anti-education,' particularly in the area of their clergy. They believed that 'if God wanted educated preachers…He would call educated persons' (McBeth 1987:287). Considering Christian universities and schools of higher learning as places that were associated with 'liberal' ideas, many people in these groups misunderstood the role of the church in the larger, contextual world situation (1.4.10.3), and instead looked disdainfully at formal education being convinced that they could only stay pure to the truth of the Bible if they refused to consider any new ideas that might be 'contaminated' by the world. This type of attitude leads to fear, sometimes even to the point of paranoia, and denial. Rasmussen (1993:17) puts it ingenuously when he says,

> Religious passion is often the most volatile kind, and most deadly; it is matched only by moral convictions held with religious fervour.

This phenomenon is not limited to the Western church, but is also very evident in the African church. Refusing to talk seriously about the issues (such as condoms, etc.) has caused the church to lose credibility in the eyes of the community, indicating a real loss of vision as to its primary purpose (1.4.10.2). It is not necessary for the church to espouse these ideas in order to be able to discuss them. For example, the church does not have to embrace the use of condoms in order to be able to talk sensibly about their use, and to give thought out, intelligent reasons as to why the church does not promote them. This could be a vehicle for education and reinforcement of biblical living; but by denying any and all dialogue, the church has instead undermined their own credibility. This is evidenced in the statistics cited by Forster in his research on *Religion, Magic, Witchcraft, and AIDS in Malawi* where he found that ministers of religion were seen to be not only among the *least reliable* as a source of information regarding HIV/AIDS, but they were also *not* perceived as being particularly credible nor trustworthy in terms of AIDS messages (emphasis mine) (Forster 1998:338).

With few exceptions, as noted above, most Christians (and particularly those in what would be defined as the 'conservative camp') chose the option of denial. By denying that the problem was involving the church, and considering that it only involved those sinful people who deserved such a punishment, they were able to continue on with 'business as usual'. Care for the wounded, the downtrodden, the destitute; these have always been seen as works of the church. The issue therefore, was not whether or not the church should care for the suffering, but rather the question became twisted to determine whether the church should care for those who were suffering from something that was a result of their own sinful acts (5.6).

Responding with denial is not unique to the church, as the crisis has been treated with denial at both the church and national level of most Sub-Saharan countries at one point or another. It has only been in recent history that the Church as a whole, has begun to recognize that this is an issue that cannot be ignored or denied. The church has been forced to be involved in critically examining the present reality of AIDS (1.4.10.4). As ministers look out over their congregations, they can count the vacancies left by those who are suffering from this horrific plight. They know from their own schedules, that more and more time is used in visitation to the sick

and the dying. Funerals are commonplace among the general community as well as amongst the Christian Church congregations. AIDS is not selective in who it attacks. The church cannot deny the fact that as many of its people are suffering and dying from this dreaded disease as those outside of the church.

The Church has been guilty of another aspect of denial as well. Instead of overtly denying the problem exists, it has sometimes been responsible for using 'religion' to so warp the image of the problem or its solution, so as to mould it into something they can view with righteous indignation.

> Often the malformed character of a community and its malformed convictions are a downward spiral fed by nothing so much as a homogeneity of membership and outlook and unspoken, tight consensus. The community then reads Scripture – and the world – in ways that reinforce its distorted character, and this only undergirds its most oppressive exegesis and moral convictions. That, . . . is exactly what happened in the Dutch Reformed Church in South Africa and in the use of the Bible to justify slavery, racial segregation, and racism itself in the United States (Rasmussen 1993:17).

For the Church to understand the role it needs to play, it must stop asking, how did you get it (1.4.13)? And start asking, how can we help? What can we do (Pick 2003:10)?

In recent years, various churches have made notable strides in their stepping forward against this disease. As early as 1994 *Missionalia Magazine* was publishing articles identifying the challenge and opportunity the AIDS crisis was opening for the church,

> This creates both a challenge and an opportunity for churches to make a unique contribution. Churches, more than any other institution in the country, are in a position to influence community attitudes, provide education about AIDS, diminish prejudice, provide care and nursing (Nicholson 1994:228).

This can also be seen in such cases as the Presbyterian Church of Southern Africa, which united with the Reformed Presbyterian Church of South Africa in September 1999 to form UPCSA. As part of this union, they identified three main thrusts: church growth (including evangelism); discipleship and ministry (including lay training, ministerial formation, children's ministry, youth); justice and social responsibility (including community development with special concern for children and youth, the environment and *AIDS*) (UPCSA 2000).

The Southern African Catholic Bishops Conference (SACBC) established an AIDS office in 2000 to coordinate and oversee the various pastoral projects that were beginning to develop as a response to the pandemic (Bate 2003:197). By 2002 there were eighty different HIV/AIDS pastoral care projects operating under the auspices of the SACBC AIDS office (:198). Others have followed in similar footsteps, such as this statement made by the Lutheran Church as reported by the World Council of Churches Ecumenical News International's Daily News Service, 8 May 2002 describing the events that took place as they met in Nairobi in May of 2002,

> '…our churches have not always been safe or welcoming places. In some cases Holy Communion has been refused to people living with HIV/AIDS, funerals of people having died from AIDS have been denied and comfort to the bereaved has not been given. We repent of these sins'. The Lutheran leaders vowed, to 'put our words into deeds following the example of Jesus Christ by making our churches safe places of support and community for those living with and affected by HIV/AIDS (Ross 2002:17).

Steps such as these are indicatory of the move forward that is currently being made by the Church as a whole, and in Africa in particular (3.9.5). The African Church is beginning to see the impact of this disease and making definitive steps to address the issues surrounding it. Francis Mkandawire, head of the Evangelical Association of Malawi, was quoted during an HIV/AIDS conference in Malawi as saying (Mkandawire 2002):

> Yes, we are doing something, but we can do so much more… This is the first conference for HIV/AIDS[11], but the disease has been in Africa for 20 years already!

In other parts of the world, such as the Western world, AIDS remains an issue of a different sort.

> In the USA by the end of 1992, 85% of all persons with AIDS were either gay men, or IV drug user, or both (CDC 1993). AIDS in Australia is a nearly exclusively male disease: 97.2% of all persons with AIDS in this (Australia) country are males (Australian HIV Surveillance Report 1993) which suggests an even greater concentration amongst gay-men than in the USA. The situation in Europe is not fundamentally different (Bundesgesundheitsamt 1993). It has become obvious that the predicted heterosexual AIDS epidemic has not happened, and is highly unlikely to materialize (Chapman, *et al* 1993).

[11] Forster reports findings from the National AIDS Control Programme Annual Reports confirming that AIDS was first confirmed in Malawi in 1985; by 1991 figures of thirty per cent seropositivity were being recorded, and one year later AIDS had become the leading cause of Adult death in Malawi.

Bearing this in mind, it must be understood that the ramifications of the HIV/AIDS is a very different disease in many ways in the Western world. Although the role of the church should remain the same, its perceived responsibility is in many ways more clouded in the West. This is due to the fact that in addition to evaluating the struggles with the issues present in the African context -- such as promiscuity, cultural biases, etc., the Western Church has also to face the difficulties inherent with the sorting out of issues such as the Christian response to the 'homosexual' issue and the desperation associated with drug use and abuse. It is not the purpose of this work to make any judgments or determinations about the issue of homosexuality, but it must be pointed out that due to the prevalence of AIDS amongst these two groups (homosexual men and IV drug users), in the Western Church, it is often even slower to embrace and respond to this issue.

As recently as 2001, a survey by Barna Research on attitudes within the church (in America) published in *Christianity Today* magazine stated that their findings demonstrated the following:

> An evangelical Christian is no more likely to support AIDS-related causes than a non-Christian.
>
> The survey of 1,003 American adults revealed 8 percent of non-Christians were certain they would donate to help AIDS orphans, compared with 7 percent of evangelical Christians…. A scant 3 percent of evangelicals said they would definitely give for AIDS education and prevention, compared with 8 percent of non-Christians (Stearns 2001:100).

2.3 CONCLUSION ECCLESIASTICAL RESPONSE:

In conclusion, the historic response of the Church has been less than laudable. Although there are certainly exceptions, (and we can be thankful for those), it is apparent that as a whole the Church's response to the pandemic of AIDS can be seen as evolving through several attitude echelons. Beginning first with honest ignorance as this disease in its initial stages, so it became recognized as a threat to humanity, the progress of the Church could be followed as it began moving into a phase of selective denial. Peering through lenses designed to filter out those areas with which it could not yet cope, it looked with obvious discomfort at such issues as homosexuality, promiscuity, and even the failure of the Church to make a significant enough impact

on the lives of individuals so as to cause them to live a lifestyle congruent with Biblical principles. While the holocaust of AIDS began to wreck havoc on the world, particularly in underdeveloped areas such as Africa, the extensive network of the church maintained its distance in a vain attempt to keep itself uncontaminated by the stigma associated with this disease.

As the Church looked on, it was forced to watch as its own congregations became entangled with the dreadful effects of HIV/AIDS. It watched as its members began to die en masse. No longer could it hide under the cover of its own self-righteousness as it was forced to admit that it was conducting an ever-increasing amount of funerals for those within its own membership. With the horrific evidence mounting against it, the church began to question its hermeneutic regarding the proper 'Christian' response to this plague (1.4.10.6).

As the world began to attack the issue of HIV/AIDS with the only tools it had, the church sat silently aghast (Warren 1996) while sexual issues and concerns once considered to be private, were being shouted from the mountaintops. The condom was heralded as the answer to the problem:

> Condom programming is a management system developed to respond to this crisis systematically at global and national levels. Condoms are an essential reproductive health commodity, and the UN Population Fund supports programmes that not only supply them but also build a country's capacity to meet its own reproductive health needs. Condoms are an effective method of preventing HIV/AIDS infection for both men and women. They also prevent sexually transmitted infections (STIs), reducing the risk of AIDS linked to STIs (UNFPA fact sheet 2000).
>
> Particularly because of AIDS, most countries need to do more to encourage condom use. Governments, health programs, manufacturers, donor organizations, retailers, and health care providers must work together to assure that condom supplies, information, and services meet the growing need (Smith 2002).

While there are some exceptions (Rosas 2003),

> Condoms promotion, sexual and reproductive health of young people and faith-based approaches should be placed at the centre of the discussion. …. Most important: allow young people to express their opinion about if they want to listen about sex and sexuality and condoms to prevent HIV and other STIs and pregnancies.

In response to the world's answer to HIV/AIDS – the condom (Smith 2002), the church as a whole has refused to cooperate with NGO's and other world organizations

as they desperately sought some way to offer hope to the suffering masses. As stated by the AME, the largest black Christian denomination in America, 'If we don't do something, most of the other issues facing the church will be of little consequence (Crunutte 2000).'

Slowly, with reluctant acceptance of responsibility, the church has begun to arouse. Like wakening a sleeping giant, the church is working to absorb an awareness of the problem. And like the sleeping giant, the church is now clearing the cobwebs from the corners of its mind attempting to look squarely into the problem (1.4.10.4), seeking out a solution.

An example of a positive, proactive stance of the church in Malawi has been the development of a four year *Why Wait?* curriculum based upon biblical morality, which is currently being used in 80% of their secondary schools (AJET 2000:104) to counteract not only the moral ramifications contributing to the spread of HIV/AIDS, but also to provide biblical alternatives to cultural practices (4.1-15) which promote the spread of the disease. Recognizing it's vast network and the powerful forces, the church is beginning to assemble its forces and look for an appropriate biblical response to this crisis.

> He was despised and rejected by men, a man of sorrows, and familiar with suffering. Like one from whom men hide their faces he was despised, and we esteemed him not. Surely he took up our infirmities and carried our sorrows, yet we considered him stricken by God, smitten by him, and afflicted. But he was pierced for our transgressions, he was crushed for our iniquities; the punishment that brought us peace was upon him, and by his wounds we are healed. We all, like sheep, have gone astray, each of us has turned to his own way; and the LORD has laid on him the iniquity of us all. (Isaiah 53:3-9 NIV)

In his informative book on HIV/AIDS and its relationship to the Church, Pick (2003:48) underscores the implications of the church's responsibility in this crisis,

> Our calling is not merely to render a type of charitable service to AIDS sufferers – it entails a lot more. As the community of believers, we dare not ignore the fact, however painful, that this destroyer is within our own 'body' – the Body of Christ.

Looking back to the charge made to the faith community by Mendis (1987:42) as he addressed the challenges made to the church during the early days of AIDS, one can only be stricken by the reality of the ground that has been lost as they lost sight of

their role as God's message to the globalised world (1.4.10.3). Referring to Jesus' words describing believers as the light of the world, Mendis (1987:42) relays this challenge to the church in 1987:

> The Church is truly a city on a hill. The eye of the unbelieving world is constantly upon it, looking to see if its actions will match its much-professed beliefs. How the church reacts to the AIDS patients in its midst will be clearly seen by the unbelieving world. …. If they reject and isolate the AIDS patient, if they drive him from among them, if their behaviour is no different from, if not worse than, that of the world, then their light will flicker and grow dim, and God will be dishonoured once again by the conduct of His Church.

One can only look at the history of the church's response with regret and determination that when another decade or two have passed, the heritage that we are now creating, will tell a different story as the church moves forward sharing the hope of an eternal future (1.4.10.7).

2.4 SUMMARY

Commencing from the first chapter where the research hypothesis was developed came the identification of the problem:

> Can the relationship between the local church and the HIV/AIDS community be altered when provided with the opportunity to learn about each other in safe, non-threatening ways using the vehicle of Home Based Care as the point of entry?

This second chapter has been designed to give an accurate perspective of the problem by providing a comprehensive assessment of the historical perspectives surrounding the matter of the church's response to this current HIV/AIDS crisis, as well as the role it has played in other historical cataclysmic periods in its past. One can only grasp the depth of the problem and understand the complexities and ramifications of the issues surrounding it when the contextual historical situation is considered. Trying to make the current issues stand-alone outside of this consideration would give a lopsided view (at best) of the crisis at hand.

From this foundational historical framework, the next juncture will be to examine the generalized African context, from which the unique problems associated with the contextual situation will be explored, as it is essential to grasp the distinctively African qualities that factor into the pandemic of HIV/AIDS (chapter

three). This continental picture will then be further focused and directed toward the more specific milieu of Malawi, and Lilongwe in particular, where the study now being examined takes place (chapter four). Special attention will be given to the various traditional and tribal customs that contribute to the continuance and proliferation of the problem.

Once these foundations have been laid, and the complexity of the AIDS phenomenon is more readily understood from the African perspective, the theological ramifications will be explored (chapter five), looking into the role of Practical Theology as it fits into the surfacing issues. At this point, with an understanding of the historical and contextual situations, a broad understanding of the situation can be appreciated.

Attention will then be turned to the methodology (chapter six) of the physical project under study with careful description and explanation as to the research methods used to reach the final conclusions and evaluation of the project (chapter seven), followed by recommendations with the projections for the way to utilize the information gained in a way to make a meaningful contribution in the war against AIDS.

Chapter 3
AIDS Concepts in Africa
And the Response of the Church

3.1 INTRODUCTION:

In the first chapter, the problem of the chasm between the church and the HIV/AIDS community was developed, and the unfortunate perceptions of these two groups towards each other, has been shown to have developed into an ineffective response by the church in its mission as witness to the world. The church has had a long history of dealing with the problems and difficulties of mankind and has never been able to hide from its responsibility towards issues that affect humanity, despite its attempts to do so. Chapter two specifically examined the way the church has dealt with the issue of HIV/AIDS, focusing particularly on the negative outcomes generated by the lack of Christ-like response from much of the faith community. Tracing the reactions from the earliest days of recognition to the present have demonstrated a variety of ways of dealing with this pandemic, some were successful but many were not. Those unproductive measures, which were taken by the church, admittedly became much clearer in hindsight than when they were current issues, are compounded by the specific and unique realities of the African Church.

Although the crisis of HIV/AIDS is worldwide, there is no denying the fact that it is concentrated most heavily on the continent of Africa. Since the problem under discussion and the historical context have now been examined, it then becomes important to look more closely at some of the identifying characteristics with in the African cultural context that contribute to the distinctive facets challenging the African church.

The continent of Africa is in many ways a world within itself. Of the many countries included in this great land, there are countless numbers of tribes and people groups, languages, religions, customs, etc. But with all of this diversity, there remains a certain aspect of unity. Although it is not within the scope of this dissertation to analyse each and every group, there are certain definite consistencies and patterns, which would emerge among the peoples of Africa if this task were to be undertaken.

Using the common patterns and practices which would be seen in those countries in Sub-Saharan[12] Africa as the point of reference, one can make certain generalities and assumptions regarding the 'African' mindset[13].

Before the comparatively recent western influence of the past couple hundred years, the average African's life was simplistic in many ways. Generation after generation acted and responded in much the same way to the unchanging world around them. Before the western missionaries came to the continent of Africa, life went on day to day as it had done each day for the centuries preceding it. Even in today's modern world, these same ancient ways and customs continue to be practiced in many rural areas of Africa.

With the influx of the western civilization, the world of the African began to change. The western world, with their 'advances' and 'progress' sought ways to plug in their success story into Africa. They began the process by attempting to assist Africans in achieving what had been accomplished in the west, endeavouring to bring the advantage of their knowledge and progress to the continent of Africa. Without taking into consideration the worldviews and experiences which separated them, those in the modern world began thinking that they could impose their values upon the African nations in an attempt to bring them up to the western standards by infusing western 'know-how' into them. After several generations of Western influence, frustration came due to the fact that invalid assumptions had been made in the effort to transfer the Western mindset into the African culture. This can be colourfully demonstrated in the following story, which chronicles an event in the history of the Boers encounter with the Ndebele tribe. Western (Boer) and African (Ndebele tribe) understandings of the same event demonstrate differing worldviews as they interpret

[12] Sub-Saharan countries have enough similarities to be grouped in many ways. Those northern countries will not be included within the scope of this study for several reasons, including the fact that they comprise most of the Islamic countries that have a strikingly different worldview than those who are predominately influenced by the Judeo-Christian worldview. Another significant point, which must be realized, is the fact that these countries are closed to outside probing regarding their actual HIV/AIDS statistics, which eliminates the possibility of an accurate portrayal of the role of HIV/AIDS in their cultures.

[13] Since it is beyond the scope of this dissertation to evaluate all African customs, this discussion is limited to attributes that contribute to the spread and propagation of HIV/AIDS. Therefore, only the negative aspects of the African culture are considered for assessment, and the reader is cautioned to consider this aspect in order to prevent the formation of a distorted image of the African cultural milieu.

the same event, which occurred in South Africa's history, in two very different ways (Boon 1996:18):

> The Boers arrived and stopped at the Vaal River, whereupon a group under Hendrik Potgieter was sent forward to reconnoitre. A Boer named Stephnus Erasmus, independent of the Voortrekkers, decided to make use of the presence of the Trekkers along the Vaal and organized a hunting trip into Mzilikazi's territory. He hunted in an area designated as the king's own royal hunting ground. The Ndebele reaction was quick and ruthless. Discovering the hunting party and their booty-laden wagons, they attacked, killing all but Erasmus and one son who was hunting with him. Thinking of the Trekkers now scattered along the banks of the Vaal, Erasmus galloped off with his son to warn them. He came across the Botha and Steyn families in the present-day Parys area and blurted out a warning.
>
> As soon as they could, the Voortrekkers gathered and formed a laager at a place now known as Vegkop (Battle Hill) between the Renoster and Wilge rivers, and awaited the attack they knew would follow. In this laager, there were only 40 men or boys capable of using firearms, one of who was a 12-year-old boy destined for great fame later in his life as president of the Boer Transvaal republic – Paul Kruger.
>
> On the afternoon of 15 October 1836, a great Ndebele army, some 6,000 strong, approached. Both sides waited out the night, and it can only be imagined what thoughts entered the minds of all those brave Africans that night. The leader of the Ndebele force was Mkalipi who, for some reason, did not employ normal Ndebele tactics of night attack. Instead, he waited until the next day when the sun was already high before initiating the assault. After three massive attacks on the wagons, each one seemingly more vigorous and terrible than the last, the Ndebele withdrew. To this day, the battle at Vegkop is celebrated as a massive Voortrekker victory.
>
> But there is also a different view, which comes to us through the *izibongos*[14] of the Ndebele. The story agrees with everything – except the result. After three massive assaults on the wagons, the Ndebele army withdrew to a great Ndebele victory, because they left with 4,600 cattle, 100 horses and 53,000 sheep. After all, what is the purpose of war if not for booty?

This story serves as an illustration of how the worldview of an individual or groups colours their interpretation of an event so thoroughly that the outcome can be seen in two opposite ways. Applying this story of the past to recent, as well as current attempts to 'westernise' Africa may shed some light on some of the difficulties and frustrations now being experienced by the Western world.

[14] *Izibongos* is the Zulu word describing the African traditions of praise poems, which are passed through the generations telling of the great deeds of famous ancestors or great events that affected those ancestors.

Since the Western world did not take into account the worldview and thinking processes of the African mindset, they met with disappointing results in their attempt to 'modernize' Africa. These same mindsets continue to exist today, affecting the way individual Africans view their current world. This 'African' way of thinking must be understood as it applies to the current HIV/AIDS epidemic if one is to find ways of changing this destructive tide. The way the African views the events happening to him and his people today reflect these same worldviews that the Western world has such difficulty understanding.

Some of the prevailing mindsets that serve to hold Africans back from moving ahead against the scourge of HIV/AIDS in an effective way can be seen in the way the average African views the areas of denial, various myths, the concept of time, home and gender issues. This chapter will take an in-depth look at these issues, along with other areas of ethnocentricity that are distinctly 'African' in context. Specifically, this chapter will observe those issues that are serving to work against the people of Sub-Saharan Africa by promoting cultural expectations and practices that are actually escalating the devastation and destruction of HIV/AIDS. These very practices may have served the people well in the past when they were begun, but now bring only ruin into the community. In addition to looking into these generalized African cultural practices, this chapter will also be observing and evaluating the response of the African church; discovering why it has allowed the pandemic of HIV/AIDS to envelop them without their actual acknowledgement of the problem until it had intensified to the point where it could no longer be ignored.

The chapter immediately following will venture to examine those particular traditions that are not only African in context, but specifically practised in the local Malawian culture contributing to the promotion and continuation of HIV/AIDS. Subsequent chapters will then look into the theological implications revolving around these issues with consideration of God's direction to His people as they seek to respond to this crisis. Following these foundational chapters that describe and explain the problem in its contextual environment, will come the final chapters of this research that will provide explanation of the methodology and conclusions derived from the examination of these issues.

3.2 DENIAL

To quote Oxford (1999:311) as a reliable source for definitions, *denial* can be described as:

> A statement that something is not true; a form of *deny* which can also mean; to say that one knows nothing about something; to refuse to acknowledge something.

Denial can come in many forms, from relatively harmless as in the caricature of a woman denying her age and claiming to be 'twenty-one' every year when asked her age; to a more sinister and harmful form of denial that equates with outright lies resulting in harmful injustices being allowed to occur. Although it may have begun innocently, the denial of HIV/AIDS by the Church in Africa and the world, has served to harm those who are suffering by denying them the Christ mandated love, compassion and care they deserve.

3.2.1 Denial at the individual level.

Probably the most widespread misconception about HIV/AIDS in the African mindset has to do with the difficulty of denial. Before any type of prevention, or change in attitudes can take place, one must first recognize the problem. Although Africa is now beginning to wake up to the fact that they must face the reality of HIV/AIDS, for far too long it has been an unspoken secret kept hidden below the surface. As with the proverbial 'elephant in the living room', where each person entering the home is faced with the fact that there is a huge elephant standing in the middle of the room taking up all of the space; looking around at the other guests each one says nothing, waiting for someone else to initiate a response. In order to be polite to their host, each person coming into the home participates in a conspiracy of silence; refusing to acknowledge the presence of the elephant to avoid offending their host. Because of this the people all suffer, as they must flatten themselves against the wall to move about the room. If they were to enter the home honestly and identify the elephant for what it was, as a group they could address the problem and remove the beast.

This story may be a simple metaphor, but it serves to demonstrate what extreme measures we are often willing to take in order to avoid the discomfort of honest confrontation. In East Africa, and in Malawi in particular, great lengths are

often taken to avoid disappointing someone, even if the truth will be found out eventually. The concept of it is better to delay difficulties to 'tomorrow' rather than deal with them today is very prevalent. An example of this way of thinking can be illustrated by an actual incident this writer encountered. In an attempt to order a special cut of wood for a project, exact measurements were taken to the local lumberyard. After checking the stocks, it was determined that the needed material was not available on that day, but if we would 'just check back again tomorrow, it will be ready'. When checking with the very same attendant the following day, we were told that they do not carry this type of material. They never did, and had no expectation that they would any time in the near future. The attendant knew this when we were there the previous day, but rather than disappoint us, he felt he was doing a better service to us by giving us false hope that the materials could be picked up the following day.

Several years ago, this writer was speaking to the Head Matron at Lilongwe Central Hospital in Lilongwe, Malawi. Knowing that it was estimated that 70% of the patients who were currently in the hospital were suffering with AIDS, it was surprising to hear the Matron's response to the question, 'What are the most common diagnosis' that you see here at Lilongwe Central Hospital?' To this question she replied without hesitation: pneumonia, malaria, anaemia, TB, etc. AIDS was not mentioned. Ask any villager as they are returning from yet another funeral of their brother, sister, or friend; 'What did they die from?' The response will be something like, 'They had pneumonia', or 'They had malaria', or 'They had TB', etc. Again, no AIDS. If AIDS is devastating Sub-Sahara Africa, where is it? Why doesn't anyone have it?

There are many reasons for this blatant denial of the problem; not the least of which has to do with the fact that AIDS is a sexually transmitted disease. Therefore, in order to bring it to the surface for discussion, sexual issues must be mentioned. Sex as a topic for discussion is not culturally appropriate in most African cultures, particularly in groups containing both men and women. Although sex obviously is happening, if one were to judge from the discussions being held by Africans, it simply does not exist. The vast majority of Africans consider sex a very private, and 'off limits' topic for casual conversation.

> ‘You have to realize that sex is a very delicate subject in Kenya,’ says Dr. Cleopus Mailu, Kenya's Minister of Health Reform. ‘Even though I'm a health professional, I find it difficult to listen to these radio commercials that say, `Let's talk about AIDS and sex.' That's when my hand starts reaching for the off switch.’
>
> There is a code of silence and denial surrounding AIDS, allowing secrecy and denial to persist even in the face of sickness and death. The wards of the hospital in Makindu (Kenya), for example, are filled with people whose charts identify their illnesses as pneumonia, malaria or tuberculosis. Many of them are suffering the diseases because their immune systems have been savaged by AIDS, yet many still refuse to be tested, hospital officials say. Government and civic leaders - and most average Kenyans - are reluctant to talk publicly about AIDS because of the enormous cultural stigma attached to the disease. Federal health officials recently sponsored billboards that urged Kenyans to think - and openly talk - about AIDS. But many of the signs were defaced, or even torn down, within a matter of days, Kenyan health officials say (Neville 1999).

3.2.2 Denial at the group level.

Although these quotes are from Kenya, they reflect ideas and attitudes that are well accepted and believed over all of Sub-Saharan Africa. Throughout the many people, tribes and tongues in this land of diversity lies a similarity in mindset and attitude regarding many of the basic issues of life.

The overwhelming denial of the problem stems from more than simply cultural mores. It has been observed by this writer, that when Africans (Malawians in particular for this example) are given an opportunity, where they feel safe to ask direct and probing questions without humiliation or reprisal from their peers, they will not only demonstrate a willingness to discuss such personal issues, but will appreciate the opportunity to do so. This suggests that the cultural taboo against the discussion of sexual matters has the potential to be broken, given the right circumstances.

Fear is one of the most powerful forces contributing to the ‘code of silence’ experienced by AIDS suffers and their families. Fear is a basic human emotion and is at the root of the denial. As demonstrated in chapter one, there is a heavy stigma associated with HIV/AIDS in Africa. No one wants to have that stigma linked to them or those they care about.

> Michel Carael, prevention coordinator for the United Nations AIDS Program reports: ‘many factors have contributed to the atmosphere of shame and the fear of discovery, including superstition, conservative religious beliefs and low levels of education….’There is a pervasive sense of sin that is not

> only attached to the person who is infected but to their family and group,' he says. 'There is a sense that, if you have become infected, you have done something against God and your ancestors. Something terribly taboo.'…So great is the depth of this epidemic that it borders on the unimaginable. Yet when you are there (Zimbabwe) it is almost as if this disease does not exist. The stigma attached to AIDS promotes an air of desperate denial. Admitting to having AIDS is a sure way of being ostracized. In the words of one AIDS sufferer: 'You become a monster.' Those who have the illness call it something else: fatigue, tuberculosis, malaria, anything but AIDS. But the cemeteries, overfilled with newly dug graves, tell the truth (Champagne 2000).

In predominately Christian Sub-Saharan Africa (World Factbook, 2000) [15], diagnosis of HIV/AIDS is perceived as a clear indicator that Biblical principles have not been maintained and sin is evident. As the above quote confirms, it is well established in African culture that HIV/AIDS is contracted from sinful sexual behaviour. Even for those who are not confessing Christians, but practice African Traditional religions, HIV/AIDS carries a stigma of shame to one's family and ancestors. Since no one wants to be responsible for bringing such shame unto themselves or their families, it is a natural recourse to use whatever means is necessary to prevent such a label. One of the easiest ways to do this is simply to deny the possibility of HIV/AIDS infection.

Considering the first question that comes to a person's mind when faced with the fact that someone has AIDS is 'how did they get it?' those who have been positively diagnosed with HIV/AIDS and are forced to face this disease are often quick to persuade their listeners that they were one of few who did not get the disease from an illicit sexual encounter. This was evidenced when this writer was visiting with AIDS patients in Nkhotakota, Malawi (Appendix F). After talking with several patients, it was noted that in each case, the patient took pains to explain that they had not encountered it in the usual (sexual) way. For example, one man shared that he thought he was infected by contaminated razor blades used by the witch doctor while making multiple cuts on his skin in order to apply potions for a medical cure for his continuing lack of stamina. Another said she had no idea how she got it; again saying it was possibly from razor blades. Several alluded to the impression that they had been 'bewitched'.

[15] The World cites the statistics for the Sub-Saharan country of Malawi as: Protestant 55%, Roman Catholic 20%, Muslim 20%, indigenous beliefs 3%, other 2%.

The reason behind such denial has to do with the underlying impression that if one has obtained the disease in an 'innocent' manner, they are then the *victims* of the disease and it is more tolerated by others. If however, they were infected in the way that most are (the vast majority of adults infected with HIV/AIDS were infected due to sexual encounters (USAID 2000), then they must also face the attitude held by many that they are suffering justly, receiving what they deserved; that they are being punished for their sins (Greyling 2003). This attitude affects not only the way people feel about those suffering from HIV/AIDS, but also it permeates the psyche of the individual, causing depression with a sense of fatalism that hinders their willingness to help themselves to a more healthy lifestyle (5.5).

> 'Stigma and the fear it engenders both fuel the spread of HIV, since those with risky behaviour in the past may be reluctant to change that behaviour in case the change is interpreted as an admission of infection. Fear of acknowledging HIV infection can stop a married man from raising the subject of condom use with his wife. Fear of advertising her HIV status may prevent an infected woman from giving her baby replacement feeding to avoid transmitting the virus through breast milk' (Hillery 2000).

3.2.3 Denial at the international level.

In addition to denial at the individual and family level, Africans are faced with ambiguous leadership, some which deny internationally accepted facts about HIV/AIDS. In an article comparing the denial of the devastation of HIV/AIDS in Africa with the attempts by some to deny the reality of the holocaust of WWII, one author stated that:

> South African President Thabo Mbeki appears to be actively flirting with a new form of holocaust denial, one that claims that HIV is harmless, AIDS is a phoney epidemic and the only thing endangering the health of Africans is the same set of poverty-related health issues the continent has long faced (Mirken 2000).

When faced with conflicting information such as this, which is often intermingled with misinformation and myths, it is difficult for Africans who are often uninformed about medical discoveries and up-to-date information to make proper and educated choices for their own well being.

Dr. Mamphela Ramphele, former vice chancellor of the University of Cape Town says:

> ... no coherent management strategy [has] yet [been] developed by the Government. This failure results not from lack of expertise in South Africa, but in its disregard by those in Government, with tragic consequences … the South African government's position on AIDS was nothing short of irresponsibility, for which history will judge it severely (Ackerman 2000).

Typical of the African mindset in dealing with denial, Malawi has one of the highest HIV-infected populations in Africa and statistics show that only 8 percent of the population is aware of its HIV status while 92 percent have not been tested. Some people choose to be ignorant of their status owing to the reaction engendered by HIV positivity while to others AIDS remains a mysterious disease that should not even be talked about (Ligomeka 2002). The unspoken sense that if it just isn't mentioned, isn't confirmed – then it can't really be happening.

3.3 MYTHS

Even amongst the diversity of the Sub-Saharan nations, there remains a consistency in many of the deeply held beliefs and myths that surround HIV/AIDS in Africa, crossing national and tribal boundaries. Listed below are some of the myths taken from an article, *Aw, c'mon, you don't really believe those Aids myths*[16]*!*, dedicated to the commonly held misconceptions about HIV/AIDS (Mail & Guardian 1999). Without attempting to give substance to them by refutation they will be explored briefly at this point, since many of these myths contribute to the continuing spread and confusion of HIV/AIDS:

- *Not everyone infected gets Aids.*

  This dangerous myth perpetuates the idea that one might be invincible, 'It can't happen to me.' This leads one into thinking that they can beat the odds and not be infected by this deadly virus. Young people are especially prone to feeling immortal, even if they know that rationally it cannot be true. The underlying feeling is that although death will come to all one day; it isn't something that will touch their lives for many years into the future. Another danger with this type of thinking is the possibility of carelessness if one does have the virus. Thinking that they may not necessarily be infecting others, they may continue to expose non-infected people without realizing they are

[16] ABC students confirm that these myths do continue to circulate in today's Malawian milieu.

indeed passing the disease. This myth is perpetuated by the fact that many people who are carrying and spreading the virus live for many years in what appears from the viewpoint of an outside observer to be a healthy, disease free life.

- *AIDS was invented by the CIA in a US Army biological warfare lab in Maryland (USA) to kill black people.*

  This type of thinking goes along with the basic idea of 'passing the buck'. Blaming someone or something else it makes it easier to justify anger toward the aggressor. How can one be angry at a virus? By putting a 'face' on the enemy, the victim has a focus for his or her anger and thereby removing the guilt that the problem may have stemmed from their own behaviour. This myth also forces an 'us verses them' mentality which undermines the genuinely benevolent efforts of the countless missionaries and humanitarians who are earnestly trying to find ways to help those suffering from HIV/AIDS. A cursory surfing exercise on the Internet in search of those who share these types of 'they're out to get us' attitudes yielded a frightening response. Many so-called 'facts' are touted regarding the diabolical plans the western nations have for Third World countries. One website boldly claimed the following:

  - In *fact*, the Roman Catholic Church is already deeply implicated in the spread of AIDS since 1975. The scientific community accepts that the initial *Big Bang* spread of HIV in Africa was caused by the re-use of unsterilized needles during inoculations in missionary hospitals (New World Order 2002).

- *Nothing happens by chance, AIDS is the result of witchcraft.*

  Very frequently believed in Africa, this belief also has the effect of removing the guilt and responsibility of infection from the individual, placing it in the realm of the unknown, the mystical. A person cannot be held responsible if they are afflicted by something of which they have no control. There is also a widespread belief amongst the Chewa of Malawi that AIDS does not really exist, but witches were using it to hide their own activities and thus were escaping detection (Forster 1998:542).

- *AIDS comes from grey monkeys. (Or green monkeys, or some type of monkey from Africa)*

Scientists have been able to trace the origins of the HIV/AIDS virus to a connection with monkeys, which make this less of a myth. Overshadowing the good news that monkeys can be studied to see how they were able to live with the disease and not fall victim in masse, is the notion that Africans have been having sex with monkeys, perpetuating the barbaric, jungle, less-than-human concept of some 'white supremacists'. This in turn perpetuates the African response of 'they're out to get me' (see myth number one)

- *There's a miracle cure.*
  This myth has the potential for causing not only false hopes in those who are suffering, but the opportunistic base nature of mankind provides opportunity for man to prey on the weak and the desperate. Within moments, an Internet search[17] for cures for AIDS turned up 375,000 so called cures, from 'Virgin Coconut Oil', to the 'Zapper (Clark 1993)' which could be quickly purchased for a mere $20 US dollars.
- … not Virodene, not Pearl Omega in Kenya, not oxytherapy, not Kemron, not the African potato, not the swill brewed by Billy Chisupe in Malawi, not dozens of other 'cures' sold the world over. . . saying something can stop AIDS is like selling silk shirts labelled 'bullet-proof vest'. Buy one if you like the colour; don't test it. Drug companies test hundreds of compounds, many of them poisonous. A few always show early promise. But some don't work for long; some help only some people; some kill the patient (New World Order 2002).
- *Organic food and/or vitamins will shield or cure you.*
  Although not as dangerous as the above myth, this idea can actually do some good if it improves the overall health and well being of a person; but it will not cure the HIV/AIDS and may cause a false sense of hope or worse; it could keep someone from seeking real medical treatment which could lengthen their lives.
- *Promoting the use of condoms is really a plot by white men to cut down the black birth rate / African condoms are no good. / Condom use perpetuates*

[17] Internet search utilizing 'www.google.com' search engine, and the words: AIDS cure

promiscuity.

Although the purpose of this dissertation is not to enter into debate over the place of condoms in the war against HIV/AIDS, the fact remains that while it is true that condom use will not completely *prevent* the spread of HIV/AIDS and other sexually transmitted diseases condoms, when used properly, will reduce the transmission of HIV. These types of rumours and myths discourage their use even when it would be very legitimate from most standards to use one.

- *Having sex with a virgin can cure AIDS.*

  Horrifying articles such as this give evidence to the prevalence of such an idea:

  - Baby rapes shock South Africa - Two men are due to appear at a court in Johannesburg on Tuesday, accused of raping a five-month-old girl who was discovered covered in blood and in tears. . . It is the latest in a series of rapes of baby girls - some of them involving children less than one year-old, which has left South Africans reeling with horror. . . Every day the newspapers bring awful revelations: a nine-month-old girl gang-raped by six men; an eight-month-old raped and left by the roadside (Phillips 2001).

- *'Dry sex', (wankie or other sexual preferences can prevent HIV/AIDS),* (Gay and Black Glossary (2002).

  This dangerous practice can enhance the likelihood of becoming infected because it promotes irritation of the tissues, causing increased tissue tearing. Even when trying to practice 'safe sex', without natural or artificial lubrication, condoms tear and come off (Ruden 2000:568).

Although there are certainly many more myths surrounding the spread and manifestations of the disease, particularly in the local arenas, this list gives the reader an idea of some of the destructive information and mis-information which is being believed and rumoured in the African communities.

Malawi can 'boast' of its own source of mythological cures as it remembers the claims of Billy Goodson Chisupe (Probst 1999:108-137), which gained worldwide attention in 1995. He claimed to have received a vision directing him to the creation of a cure for AIDS, causing an estimated 250,000 to 300,000 desperate people from all over the world to come seeking the 'cure' from this healer. To lend credibility to

his powers, stories began to surface including ones claiming he had died and resurrected with this formula (Schoffeleers 1999:407).

3.4 TIME

In addition to the problem of denial, another basic element of thought that contributes to the HIV/AIDS crisis in Africa centres on one's concept of time. If one remains ethnocentric in a Western perspective, he will be greatly limited in his understanding of the effect of this basic concept in the African mindset. Western culture centres around time to the point that time has become the medium of investment. When a new idea or project is proposed, the first question asked is not 'how much will it cost?' but rather has become 'how much time will it take?' Western life centres on daily planners and palm pilots that are designed to keep track of each minute of the day in an effort to provide the most efficient use of time. The concepts of 'saving time, wasting time, and losing time' are deeply held concepts within the Western culture. This perception can be seen most clearly from the words of Mbiti (1971:24-25), where he describes time as the:

> 'key to our understanding of the basic religious and philosophical concepts.'

According to Mbiti, in African culture time is all that has happened, what is currently taking place, and that what is expected to happen very soon, with no actual comprehension of a future beyond these parameters.

> For the Akamba [Mbiti's tribe used here to represent the overall sub-Saharan African tribal situation], Time is not an academic concern; it is simply a composition of events that have occurred, those which are taking place now and those which will immediately occur. What has not taken place, or what is unlikely to occur in the immediate future, has no temporal meaning – it belongs to the reality of 'no-Time'….. From this basic attitude to Time, other important points emerge. The most significant factor is that Time is considered as a two-dimensional phenomenon; with a long 'past', and a dynamic present'. The 'future' as we know it in the linear conception of Time is *virtually non-existent* (emphasis mine) in Akamba thinking.
>
> Time is a succession or simultaneity of events that 'moves' not forward but backwards. People look more to the 'past' for the orientation of their being than to anything that might yet come into human History. For them History does not move towards any goal yet in the future; rather, it points to the roots of their existence, such as the origin of the world, the creation of man, the formation of their customs and traditions, and the coming

> into being of their whole structure of society. The 'present' must conform to the 'past' in the sense that it is the 'past', rather than any distant future, by means of which people orientate their living and thinking.
>
> Time reckoning is governed by phenomena rather than mathematics. People reckon Time for a concrete and specific purpose: one event in relation to another….The day, for example, is reckoned according to the major events: rising up, milking cattle, herding, working in the fields, driving cattle to the watering places, returning home for the night, preparing and eating the evening meal and going to sleep. It does not matter exactly when the event of rising up takes place; the important point of reckoning time is the fact of rising up in the morning….There is nothing to indicate that this rhythm of nature will ever change radically or come to a complete halt (:29).

When one ponders the African time paradigm, and interplaying that with the difficulties and denials of the HIV/AIDS scourge in Africa, the reasons behind denial and lack of comprehension as to the devastating effects of the disease become clearer. To the Western mindset, the role of the future is very meaningful. Plans are often made even before birth as to what opportunities a child might have available to them as they grow and mature. Therefore, while it is very reasonable to tell someone from a Western perspective of the opportunities and dreams one might have for events which may happen 10 to 15 years in the future, to the African mindset, these are pipe dreams that can not be honestly considered as important to them at the present.

From another perspective, as the average lifespan drops lower and lower (Church World Service Fact Sheet 2002), many Africans have an almost fatalistic attitude. 'Why should I worry about what might happen so far in the future?' 'I don't know if I will even be alive then'. The concept of actions taken today, having devastating consequences on the cloudy image of some distant and elusive future, pale in comparison to the desire to take advantage of opportunities that present themselves solidly before an African today. Observing the lives of their peers, family and friends being snuffed out before them everyday gives credibility to the foolishness of living for the moment, as quoted in Luke 12:19, where Jesus talks of the destruction of those living to 'eat, drink, and be merry' with thoughts only of their immediate well-being. Due primarily to the impact of the HIV/AIDS pandemic, life expectancies for African children have dropped significantly over the past ten years. Life expectancies for children born in Africa in 1999, shown in the WHO report, are far below those even in most other developing countries. Only 9 of the 53 African

countries for which the WHO shows data have life expectancies of 50 years and over, as compared to 130 of the 138 countries outside Africa. Among the 52 countries with life expectancies less than 50 years, 44 are African and only 8 are outside Africa (Africa Policy Information Centre, 2000). When looking at life expectancy figures for countries in the world, Malawi places third from the bottom of the list (with only Niger and Sierra Leon below it), using the D.A.L.E. adjustment standards.[18]

3.5 INTERRELATIONSHIPS OF MALAWIANS

Another aspect of Malawian culture that has an impact, albeit indirect, on the spread and transmission of HIV/AIDS has to do with the underlying sense of suspicion and selfishness that is part of the fabric of Malawian, if not African culture. Although there is a strong sense of community and commitment within the Malawian culture and traditional values, lurking below the visible surface is a darker side. Needless to say, this is an area that is seldom spoken about, but nonetheless remains a significant aspect of society. This characteristic is often vague and difficult to accurately define. It may be of more value to give a clearer picture to use a comparison to American culture, with which this writer is more familiar. Contrasting these two very different cultures will help to pinpoint some of the paradigms now being explored.

These differences can be observed when examining the folklore and fables, which are common in each of these environments. In American folklore, for example, there are heroes portrayed who tend to display certain attributes which are held in high esteem by Americans. Examples of this might be Pecos Bill, Johnny Appleseed, Paul Bunyan and others (Schlosser 2003), who, being portrayed as bigger than life, were able to carve out the Wild West by their own grit and determination. They did not let difficulties stop them, but were instead strengthened by trials and moved forward to independently make way for others who would follow in their wake. They

[18] For the first time, the WHO has calculated healthy life expectancy for babies born in 1999 based upon an indicator developed by WHO scientists, Disability Adjusted Life Expectancy (DALE). DALE summarizes the expected number of years to be lived in what might be termed the equivalent of 'full health.' To calculate DALE, the years of ill-health are weighted according to severity and subtracted from the expected overall life expectancy to give the equivalent years of healthy life. http://www.africaaction.org/docs00/life0006.htm

were often loners, independent in their thinking and way, needing no one to guide their way.

In addition to these mythical heroes, there is a plethora of examples in real life of Americans and others who have gone against the current thinking and accepted ways of doing things, to work towards a goal that often they are the only ones to see the dream or the vision before them. Examples of this would be Henry Ford who, despite criticism and discouragement moved forward to perfect the assembly line, which led to the development of the automobile for the common man, therefore changing American society. There is probably no greater example of the American 'can do' attitude than can be seen by examining the life of our 16th president, Abraham Lincoln. On a website dedicated to him, this brief list of struggles was cited:

- *He failed as a businessman - as a storekeeper.*
- *He failed as a farmer - he despised this work.*
- *He failed in his first attempt to obtain political office.*
- *When elected to the legislature he failed when he sought the office of speaker.*
- *He failed in his first attempt to go to Congress.*
- *He failed when he sought the appointment to the United States Land Office.*
- *He failed when he ran for the United States Senate.*
- *He failed when friends sought for him the nomination for the Vice-Presidency in 1856.*
- *Not bad for a man many consider to be the greatest President of all and who attended school less than 12 months in his entire life!* (Neely 1996)

The attributes displayed by these heroes foster the concepts of rugged individualism, courage to step away from the crowd and be different, independent and progressive thinking – even if it goes against the common thought of the community. Values such as these, which are held in high regard in an American culture, are viewed as negative traits in Malawian culture. A Malawian would classify these traits as egotistical, selfish, and arrogant.

In consideration of this model, it is important now to consider the Malawian paradigm. Folk heroes in Malawian and other African cultures are very different. An example of a Malawian folk story would be 'how Spider got his thin waste' (Greaves 1993:126); a story describing the events around Spider, who receives his just

punishment for desiring more for himself than what everyone else has. African folk stories typically involve an individual stepping out of the customary and accepted norm for the group, often displaying characteristics of selfishness or individual (as opposed to group) thinking. A typical proverb that exemplifies this concept would be *Chakomachakoma pusi anagwa chagada*, or, 'the monkey in his greedy effort to grab all the good things fell on his back' (Hullquist 1988:95). The idea being promoted is one of working together with the community in order for all to remain comparable in their accomplishments.

Most people never question their basic foundational means of thinking. General attitudes and paradigms are considered by one's culture to be bedrock values, which everyone should automatically embrace. Unless these ideas are disputed for one reason or another, they usually remain unchallenged during a person's lifetime.

3.5.1 Limited Good

An example of such a paradigmatic thinking pattern can be seen in the concept of 'limited good.' (Appendix H) Many Africans believe in the concept of limited good, the concept that there is only so much 'good' for the world (Foster 1967:293-312).

> …an individual or family that makes significant economic progress or acquires a disproportionate amount of some other 'good' is seen to do so at the expense of others, such a change is viewed as a threat to the stability of the community… Individuals or families that lose something, that fall behind, are seen as a threat in a different fashion; their envy, jealousy or anger may result in overt or hidden aggression toward more fortunate people.

This concept is almost directly contrary to the American mindset. Time has been spent detailing the foundations of these mindsets in order to assist in the understanding of this aspect of Malawian culture. The underlying sense of suspicion, coupled with the fear and jealousy, control the core Malawian senses of reality and justice. This works against society, as it tends to prevent true altruistic and benevolent action. Tied in closely with the beliefs in magic and the power of the witchdoctor, the uneducated village Malawian feels that if he moves to work on behalf of those who are suffering, it can ultimately cause circumstances to bring more trouble upon himself. This can be seen in the Malawian proverb, *Chaona mnzako chapita, mawa chiona iwe*, 'What your friend has seen go, tomorrow it will see you.'

(Hullquist 1988:95), which demonstrates the idea that if one works to ease the suffering of their friend, the suffering will then find someone else, maybe even themselves, to trouble. This fatalistic attitude undermines the ability to see their community in proper perspective. Instead of seeing the need for collaborative efforts between individual villagers to work together to move forward, their sight is clouded by ideas that the ultimate good for those who are suffering will come at the expense of themselves or their family.

Mrs. Chisala, the head of the Malawian Social Welfare Department, explained this general concept to this researcher as she was describing an instance she observed (Chisala 2002). In her example, a group of girls were jealous over one girl being allowed a certain job they coveted. Therefore, they deliberately sabotaged her situation by implicating her in an undeserved accusation of theft. Their reasoning was that if she were fired from the position, it would then open an opportunity for one of them to move into it. From this example it can be seen that the motivations behind negative actions of the group demonstrate this principle, resulting in the unjust accusation of an individual. By attempting to destroy the credibility of the individual, the group interpreted the outcome as one that might improve their opportunity to move ahead. Mrs. Chisala explained that this was a very common way of thinking among Malawians because they are generally steeped in jealousy and greed that colours all of their thinking and actions.

3.5.2 The World of Spirituality

To the African mindset, 'the world is full of divinities, spirits, demons and their human allies in the form of witches and wizards' (Imasogie 1993:75).

> Thus for the African there is no solid line of demarcation between the sacred and the secular because the spiritual interpenetrates this world. Man is vulnerable and is open to the spiritual forces for ill or good. Consequently, man lives in fear of metaphysical anger and constantly needs the help of spiritual forces for security. This understanding of his world is reflected in numerous practices to ensure a measure of protection from the metaphysical forces that are ranged against him. For him, there is no accident; every happening has a metaphysical basis.
>
> This world view also reveals that man can find his real fulfilment only in relation to his human as well as his spiritual communities. This is emphasized in rites of passage which begin with the naming ceremony, followed by puberty rites, marriage, funerary rites and ancestral worship…The

> divinities who are regarded as intermediaries between man and God have an important place in the African world view. Having been created by God for the purpose of assisting him in the theocratic governance of the world….When an African worships any of these divinities he thinks he is really worshipping the Creator God through the intermediary.

3.6 GENDER

Throughout the world, the relationships between men and women have been pitifully anti-women in their bias in many, if not most, spheres. From the earliest of times, when men were looked to for physical protection and provision due to their increased body mass and strength, male/female relationships have tended to reflect male dominance. In addition to the obvious physical differences between men and women, there are a host of other variations that contribute to this way of relating to one another. For many years the primary thinking, as behavioural scientists studied the difference between the sexes, was that behavioural differences between men and women/boys and girls were due to environmental factors. Children were raised with expectations based upon their sex, and therefore, as adults, they came to think of themselves within the paradigms from which they were raised. These ideas have pretty much fallen by the wayside as scientists discover that giving dolls to little boys and trucks and guns to little girls does little to determine their actual behavioural patterns. What has been discovered is that the basic thinking patterns of males and females are different, and greatly affected by hormonal changes from within the male and female body (Conner 2000) In an article discussing these differences, Lee Cowan (2002) shares,

> Their boyishness goes back to the womb where, around six weeks after conception, a surge of testosterone targets embryos carrying the male Y chromosome, transforming not just their bodies but their brains and psyches. A second strong spurt follows at six months, then again at adolescence. Testosterone brings feelings of invincibility and power. It's an urge to action, to impulsive risk-taking, to aggression and dominance, and to a compulsive short-term energy cycle of tension, immediate gratification and release.
>
> To complicate the situation, boys have less serotonin than girls, the hormone that soothes our emotions, helping to control impulsive behaviour and facilitate good judgment. And they have a larger amygdala, the part of the brain, which triggers our adrenal glands into action when we perceive a

> physical or emotional threat. It can save our lives in emergencies, but it can also precipitate violence.
>
> These physical differences contribute to not only physical dominance, but also to psychological and emotional dominance as men relate to women all over the world. 'In parts of South Asia, Western Asia and Africa, for instance, men are seen as having a right to discipline their wives as they see fit. The right of a husband to beat or physically intimidate his wife is a deeply held conviction in many societies' (UNFPA 2002).

This quote was taken from an Internet article mainly referring to North African and Muslim areas, but this attitude has been evidenced in Malawi as well. As an example of this, this researcher can cite a time during a classroom 'Christian Ethics' class discussion on the roles of husbands and wives in a Christian marriage, when a student asked the question as to whether or not a husband has the right to beat his wife if he feels the need to 'discipline' her for some reason. Worldwide, studies have shown a consistent pattern of events that trigger violent responses. These include: not obeying the husband, talking back, refusing sex, not having food ready on time, failing to care for the children or home, questioning the man about money or girlfriends or going somewhere without his permission. A recent interview with a missionary couple from the United States (Rev. Edward & Judy Barnes, with S.I.M.) who were in Malawi doing Marriage seminars, revealed how prevalent this is. When husbands were asked the question, 'What do you do when your wife cries?' the appropriate response, according to the general consensus of the group was; 'beat her, that will make her stop crying.'

> 'Many societies in Africa and Western Asia (about 28 countries in Africa) practice female genital mutilation often referred to as female circumcision. Worldwide, some 130 million girls and young women have undergone this dangerous and painful practice, with an additional 2 million at risk each year. This terrible violation of girls' and young women's human rights is based on prevailing beliefs that female sexuality must be controlled, and the virginity of young girls preserved until marriage. Men in some cultures will not marry uncircumcised girls because they view them as 'unclean' or sexually permissive' (UNFPA 2002).

A member of the Research, Action and Information Network for the Bodily Integrity of Women, Ms. Toubia, says:

> 'there is tremendous denial in Africa about the issue of violence against women and girls. The abuses suffered by the continent itself, ranged from slavery to colonialism to the new economic order which has placed

> Africa on the lowest rung. As a result, Africans have created a defensiveness about any criticism of their society. They are very proud and they do not want to change their cultures or social systems. Women have paid a great cost. Whenever they speak out about violations of their rights, they are told that they are becoming 'western' or that they are adhering to the views of international agencies. It is disturbing that the issue of violence against women are escalating in Africa, largely due to the increasing conflict on the continent. There are the old forms of culturally-based violence, as well as those emerging from socio-economic disparities. Female genital mutilation and discriminatory inheritance laws, for example, deprive women of certain basic rights, and expose them to human rights violations' (USAID 2000).

A recent issue of one of Malawi's local newspapers, The Chronicle (Jamiseson 2003a) addressed the issue of rape (particularly within marriage) and the threat this poses upon women. The author cites statistics by the Centre for Health and Gender Equality produced in a report titled Ending Violence Against Women, around the world 'at least one women in every three has been beaten, coerced into sex, or otherwise abused in her life time.' The study further demonstrated that the HIV (and other STIs) infection rate is up to 30% higher in situations of rape, primarily due to the fact that the violence associated with forcing sex causes more tearing and injury to a woman's delicate tissues, allowing for more portals of entry for the virus to enter her blood stream.

Women have been taught that,

> …no matter what happens in a relationship with a man, it can be resolved, and the relationship must continue. It is with this kind of mentality that women continue to remain in a relationship that puts them at risk (Jamiseson 2003b).

In her candid article regarding practices contributing to the AIDS crisis in South Africa, Ruden comments,

> The most reassuring message to a typical African girl is that her community will protect her from early, chaotic sex and that she will be able to marry a man indoctrinated against adultery and raise her children in safety. Trying to get someone so powerless to 'take responsibility for her sexuality' is a cruel joke (Ruden 2000:569).

Comments from women who gathered at a maize mill in Chitipi, Malawi further underscore the foundation of the problem. When interviewed without their husbands present, women were highly vocal about the abuses they have suffered and

the helplessness they feel. One woman, named Sela, who is described in the article as an educated woman who has been married for many years, shares the following story,

> If I refuse to accept his (her husband's) advances, he can get physical and several times he has hurt me. A number of times he has hit me when I have refused to have sex with him because I know that he was with someone else. It feels as though I am being raped. It is very difficult to protect myself in this situation and I fear for myself.
>
> Other women verbalized their agreement with her concerns, 'What can you do if he is going to beat you and demand that you have sex with him?' Even if there is AIDS these days you just have to accept your fate and continue to sleep with him because he beats you', 'he says I am his wife and can do this with me whenever it pleases him' (Jamiseson 2003b).

Education is one way of enabling women to equip them with the tools necessary to break out of these types of situations where they feel powerless to change their situation:

> Poor women are especially vulnerable to coercion from their male partners, since they may be economically and emotionally dependent on them. Poor women are more likely to be constrained in their choices about relationships and living situations than middle-class women. Concerns regarding food, shelter, and care of their children may overshadow concerns about HIV/AIDS' (UNAIDS 1999).

Two thirds of the world's 876 million illiterates are women, and the number of illiterates is not expected to decrease significantly in the next twenty years (UNFPA, 2002).

Pupil enrolment increased a staggering 63 percent when Malawi introduced free primary school education in 1994, but education authorities are still battling to keep young girls in class.

> Girls opt for early marriages. As a poor country, Malawi is experiencing a great deal of girls who drop out from school because they are enticed by men to marry or because they get pregnant, says Kuthemba Mwale, Director for Education, Planning, Policy and Budget. He said Malawi had a dropout rate of 18 percent in its primary schools - one of the highest in the southern African region. The majority of these dropouts were girls.
>
> HIV/AIDS has contributed to the high dropout rate. 'The HIV pandemic has taken away most breadwinners (between the ages of 24 and 49) in most families. Consequently, girls take care of their families more than boys,' Mwale said.

> According to deputy Director of basic Education in the ministry of Education, McKnight Kalanda, HIV/AIDS is a major threat to the future of girls education.' HIV/AIDS is one of the major problems that are frustrating the efforts by the government and other international organisations which are trying to promote girls education,' said Kalanda. He said that in most cases it is the girls who are forced out of school to help take care of HIV/AIDS victims, or to take care of orphans whenever someone has died leaving children behind (Zingani 2003).

3.7 EDUCATION

AIDS has cut a deadly swathe through the teaching profession: up to 10 per cent of teachers are expected to die in the worst affected African countries over the next five years. Often the graduation rate from teacher-training colleges barely replaces the sick and dying workforce. Teacher deaths due to AIDS in Zambia in 1998 were equivalent to two-thirds of the number of newly qualified teachers, and those who die are often the most skilled and experienced. Consequently teacher morale is often low; though the teachers themselves may not be infected, colleagues or family members might be. Education officials and planners, who keep the system running, are also liable to be affected by the disease.

Fewer children can afford to attend school. Many drop out to look after infected family members or because they experience shame or stigma through association with the disease. In Côte d'Ivoire, for example, it is estimated that by the year 2010, there will be 778,000 maternal and double orphans, of which nearly three-quarters will be orphaned as a result of HIV/AIDS (UNESCO 2001).

As more and more children are forced to abandon educational goals, the growth of uneducated, unskilled individuals multiplies. These children, virtually forced into abject poverty due to their lack of any resourceful skills by which to make a living, find themselves entering the ranks of those living in the groups associated with high risk for infection for HIV/AIDS (4.13).

The educational systems in many African countries are lagging far behind what would be considered adequate by any world standard. Dealing with limitations caused by lack of such basic resources as electricity, books, paper and pencils; compounded by overwhelming class size makes even the most dedicated and gifted teacher is unable to educate students adequately.

> ...shortage of classrooms, equipment, teachers and materials contributed to high drop-out rates among boys and girls alike. 'The conditions in the schools are very, very bad. The children are frustrated. There is lots of absenteeism, poor performance and a very high repetition rate,

says Kuthemba Mwale, Director for Education, Planning, Policy and Budget in Malawi (UN Integrated Regional Information Networks 2001). In desperation, teachers have conspired to assist students in ways to cheat on MSCE examinations. The Malawi News Online says:

> More than 50 per cent of candidates who sat for the Malawi School Certificate Examinations (MSCE) this year have failed, the examinations board has announced. Malawi National Examinations Board (MANEB) said out of the 14,000 candidates who wrote the examinations in secondary schools, only 5,000 have qualified for the award of a certificate. The board also said that out of almost the same amount who sat for the examinations from the Malawi Distant Education Centres, only 1,600 had qualified. The board has also announced that 6,000 candidates had been disqualified for malpractices which included cheating during examinations (Malawi News Online 1998).

The Malawian government mandated free education in 1994, but many children are still too poor to pay the school fees required for uniforms and other items necessary. Families are seeking ways to educate their children in private schools, but the costs of tuition and other expenses, keep private education above the means of most Malawians.

AIDS mostly affects people in their productive years - young people and adults. Around half of all new HIV infections occur among those aged 15 to 24 years. Little or no access to education reduces the capacity of young adults to find work and earn enough to support themselves. Instead, this lack of access may constrain them to turn to risky professions to survive. Lack of education also reduces opportunities to learn about AIDS or about methods of protection from HIV infection (UNAIDS 2000).

3.8 THE AFRICAN CONCEPT OF 'HOME'.

The African conception of space is closely linked to their understanding of time. What matters is what is (geographically) near; this could explain why particularly for Africans, their own piece of land is of the utmost importance. Home

is the land or the area where a person was born – i.e., from where the family comes (4.3). Even when working in the cities, Africans want a piece of land, 'home.' Ancestral land ties them to the past and to the future; it is not only where their ancestors come from, but where they themselves, will also be buried. Thus, land is not merely a spatial factor, but it also attains temporal qualities. Therefore, 'to remove Africans by force from their land is an act of such great injustice that no foreigner can fathom it' (Mbiti 1969:27).

This sense of 'home' has some connections to the western mindset, as described by Mead (1996:43, 44):

> The yearning for 'going home' is deep and universal. It is a feeling that is larger than the geography of home, often deeper than our actual relationships with anyone there. Even those who have experienced 'home' as a very dysfunctional place or community yearn for what the word points to.
>
> The tug to find our return 'home' triggers a hope for a network of memory and relationship, sometimes romanticized with time. That network is what the word community reaches for…. We need to belong – to be part of a larger world. The need to belong drives us to community, a place where we know we belong. It is also a place where we will be safe-a kind of 'home base' in the world's chaotic game of 'tag.'

Africans in general and with Malawians in particular, the perception is that cities are temporary residences; they are not perceived to be 'home' (Joda-Mbewe 2001:25). It is in this scattered and isolated intercity community that the Church of Jesus Christ plays a vital role as Christians seek a new sense of 'family' amongst the family of God. Many who have travelled to the cities in hopes of finding employment or career development, find that the essential ingredient necessary to give them a sense of belonging is missing (4.14). The Church family is now being called upon to replace the eroding structural integrity lacking in these urban areas. Mead again identifies this phenomenon and calls upon the church to address this challenge (Mead 1996:50):

> …the church of the future must become a center within society that feeds and supports the human need for community. The challenge is made more important because of the increasing experience of deprivation of community. The challenge is made more difficult because of the church's loss of credibility as a source of community in our time.

3.9 THE RESPONSE OF THE CHURCH

Into this multifaceted crisis stands the Church, the Body of Christ (1.4.10.2). Assaulted from all sides, the Church of Malawi is struggling to survive as it dodges the attacks from all of these areas. Yet it does survive.

Initially, the Malawian church was no different than the worldwide church in its resistance to any involvement in the HIV/AIDS crisis (chapter 2). With a misguided hermeneutic, it believed that the issues surrounding the HIV/AIDS crisis were practices that took place outside and against the teachings of the church (5.3,4), and therefore they were areas of concern that did not need to be addressed by them. As the plague worsened, the individuals in their congregations began to be numbered amongst the afflicted. In addition to the suffering, which had begun to affect their congregations, it was obvious that it was even beginning to affect their own families as well. With these frightening realizations the church slowly began to recognize the horrifying fact that this was an issue which was not only touching them, but it must be addressed - and soon. With the recognition that something must be done came the next logical question, *what should we, as the church do about this problem*?

Addressing the issue of HIV/AIDS in the church brought about deeper implications than merely how to deal with the issue of the disease itself. It caused the church to re-evaluate its role in the very life of the believers who made up its body, as discussed previously (1.4.10.2). What had been primarily a role of spiritual guidance and resource was now beginning to shift to one of responsibility in other areas of life as well (5.6).

3.9.1 The Role of the Church

Since the beginning of the church age nearly two millennia ago, the church has not only undergone an evolution in its own right, but its very nature along with the role it has been called to fulfil, have been viewed in many different ways as well. The first early churches sought to define themselves; first in their own eyes and then to demonstrate the reality of their entity to the world in general.

In today's world the concept of 'church' brings many things to mind. To some, it is seen as a place of respite, a sanctuary away from the hassles of everyday life where one can pause a moment in their life and meditate upon and worship God.

To others, the church is a place to avoid because with it comes the heavy baggage associated with guilt and condemnation. These people feel the strain of the weight of sin in their life and don't understand the grace and love the true church has to offer, so when they give thought to the ideas involving their concept of 'church' they want to stay far away from it. For a variety of different reasons most people fall somewhere between these two polar models. Both of these extremes fall short of describing the role of the church because they focus more on the effect of the church on particular individuals, instead of looking at the function of the church to the individual as well as its function toward those within its body and to the world at large.

In order to give further consideration to the role of the church, it might be wise to revisit the working definition of Church, which has been established in this dissertation.

3.9.2 Definition of Church

The actual process of defining 'the church' is on the surface, not a difficult task. It was defined in chapter (1.4.1) one of this dissertation as:

> The Greek word *ekklesia*, the term translated 'church' in the New Testament, is the word that the Septuagint most frequently uses to translate the Old Testament term *qahal*, the word used to speak of the 'congregation' or 'assembly' of God's people (Grudem 1994:853).

In defining the Church, it will be necessary to bear in mind the distinction between the visible and the invisible Church. (1) The former may be defined as the *company of the elect who are called by the Spirit of God*, or briefer still, as the *communion of believers*. (2) The latter is a broader concept, and may be defined as the community of those who profess the true religion together with their children. It is important to bear in mind that these two are not entirely parallel. Some who are members of the invisible Church may never become members of the visible organization or may be shut out from it; and some who belong to the visible Church may be unbelievers and hypocrites and as such form no part of the body of Christ (Berkhof 1933:281-282).

Berkhof further describes yet another defining area of the church, which would be in the essence of its function as an Organism as opposed to the description of the Church as an Institution or Organization. This distinction applies only to the

visible Church. The Church as an institution or organization becomes visible in the offices, in the administration of the Word and the sacraments, and in a certain form of Church government. But even if these were absent, the Church would still be visible as an organism, as a communion of believers, in their communal life and profession, and in their joint opposition to the world.

3.9.3 The Mission of the Church

But what the church is and what role it plays in society and in the individual lives of people who are either inside or outside of its distinctions may be a more elusive and difficult task to explain. For many, the role of the church can be defined by its mission, which in itself lends to a variance of definition. Van Engen (996:26) defines mission as:

> Mission is the people of God intentionally crossing barriers from church to nonchurch, faith to nonfaith, to proclaim by word and deed the coming of the kingdom of God in Jesus Christ; this task is achieved by means of the church's participation in God's mission of reconciling people to God, to themselves, to each other, and to the world, and gathering them into the church through repentance and faith in Jesus Christ by the work of the Holy Spirit with a view to the transformation of the world as a sign of the coming of the kingdom in Jesus Christ.

This definition of mission encompasses much of what the role of the church, as a whole must be. It more closely links the role of the church with the concept of it being an 'organism' (1.4.1; 5.4.1) as described above, giving the connotation of a living, thriving creature that interacts and responds to the world environment in which it finds itself. In thinking of the church in this way, it is easier to define its role in the world.

In other words, the role of the church is to interact with the world (people) in such a way as to demonstrate God's plan of salvation through the saving work of Jesus Christ and the transforming and sanctifying work of the Holy Spirit to reconcile man to Himself and to others. This will result in the transformation of the world as the church reaches out by its word and deed, proclaiming the Gospel message of the God who saves to the world that desperately needs Him. It is only by witnessing God at work through His people (the church) that those outside of the church can realize their need for Him (5.7).

It is beyond the capacity of this paper to delve into the broad concept of the church's role in the world. It is within this scope however, to explore that particular facet of the church's role in the world that deals specifically with the responsibility of the church in dealing with this current HIV/AIDS crisis. The church is the body of Christ (5.1.1) and therefore must be His representative in the world as it stands for Him.

The leaders of the church were beginning to realize that there needed to be a shift in their thinking as to how they viewed the role of the church. There has been disunity in the church as a whole as to what part it should play in the pandemic of HIV as it affects the people in the world in general, but on the continent of Africa in particular. For many, it was not an issue to be addressed by the church, because they saw the role of the church as primarily being one of meeting spiritual needs (5.1), which they were somehow able to separate from the physical needs of mankind.

> The ministry of the church is an extension of the ministry of Christ. That has been described in the tradition of the church under three offices – *munus triplex* – of prophet, priest, and king. It can be quickly seen that these three offices are closely related to the marks of the church in the Reformation tradition. The church is, they said, where the Word is truly preached (prophet), sacraments duly administered (Priest), and godly discipline maintained (king).
>
> Here the crucial problem emerges. This classical Reformation definition describes these roles in relation to the internal life of the church. The consequent temptation was to forget that the exercise of these ministries in the church is intended as preparation for the exercise of these ministries in the world by the church as a whole (Williams 1998:101).

The church has often been guilty of thinking of itself in these roles as outlined by Williams above. By keeping its focus on the internal aspects, to the point of disregard to the external but yet essential components, which certainly should not be neglected, it often becomes guilty of the incriminating statement: 'The Church is so heavenly minded that it is of no earthly good' (source unknown). Williams (:102) goes on to put the whole problem in perspective by describing the balance that must be maintained by the church in order to effectively communicate the love of Christ to the world:

> Often a contrast is made between the ministry of renewal in the church, so that the internal life of the church is deepened, and the ministry of mission to the world, in which the church is turned out toward the needs of the world.

> The point we are making is that the ministry of the church includes both, and that these two aspects are inseparable. To be concerned for inward renewal and to forget that this new life is given for the service of the world is to destroy the servant character of ministry. But to be concerned for servant mission in the world and to separate this from the life of the renewed community is to forget that this community life is meant to be both a sign of the new life the world needs and the source of servant life for the world.

Of course there are many instances where Christians have truly taken on the servant role as demonstrated by Christ and served to be a tremendous witness of Christ's love (5.5) to those within their sphere of influence. Often those individuals see their obedience to Christ as their ministry or 'calling' as they seek to represent Him to the world. They see those who are isolated, grieving, depressed, etc. and recognize the need for His touch in such situations. There are many in the church, outside of the HIV/AIDS crisis who need the compassionate understanding that they can bring:

> Many church members carry substantial loads of unresolved grief. It comes from a variety of places – disappointments over lost opportunities, remembrances of lost loved ones, bitterness about real or imagined unfairness, alienation or a sense of having been left out or left behind. Everyone has a personal version of this sense of loss, and everyone carries it alongside his or her personal strengths and weaknesses (Mead 1994:109).

The work of Christ then is often done in many isolated incidences which although they do make an impact on an individual basis, it could be of much greater magnitude of the efforts were unified and strengthened by the entire body.

3.9.4 Parachurch Organizations:

History displays many fine examples of the church ministering to the physical needs of the body as a demonstration of Christ's love. The church, since its infancy has been marked by the compassion it has offered to the masses and those suffering in and around her. For centuries, the church (in particular the Roman Catholic Church) has stood for mercy and compassion, as hospitals, schools, shelters, etc. have been established in its name all over the world. It is only in recent times however that this source of hope and compassion has shifted hands. Acts of mercy and kindness that may have been performed by the church in the past and interpreted as benevolent ministries of the church were once considered to be essential ingredients in the makeup of the church. In more recent times, many of these benevolent ministries

have been transferred from the hands of the church and into the hands of what have been called 'parachurch' organizations. It is the parachurch agencies, especially the newer relief and development agencies, which dominate the twentieth-century scene, exemplifying all the strengths and weaknesses of modern Christian charity (Scott 1987:212). Many times the Church has been guilty of handing over its benevolent responsibilities to Parachurch and even governmental social institutions and organizations that may or may not have any Christian ties at all. In so doing, the church has given away a valuable tool in reaching out to the hearts of mankind.

This began simply and most likely innocently enough, as the church became more and more focused upon internal issues and dealing with the souls of men, it naturally became less and less concerned with the physical human needs of those same men as outside agencies began looking after those needs. This can be clearly demonstrated in the United States and other developed nations as social welfare programs developed to such a capacity that the church's response to those in need is not to help them in the name of Christ, but rather to direct them to the appropriate governmental agency that can meet their need.

What has happened as a consequence of this course of action is that the Church has weakened its position in the world by limiting her function to the spiritual realm only. By removing itself from the nitty-gritty issues of life that bring man to point of facing the reality of his need for God, it has unwontedly given up a most valuable and strategic position that could be used to touch the lives of those it seeks to serve at their very point of need (5.6). Scott (1987:208) points out how this has served to bring the church away from its original focus, as demonstrated to us in the church of the New Testament, that initial purpose of ministering to the world as a servant:

> Generally speaking, however, the New Testament sees the ministry of mercy not only as an individual obligation, but as a corporate endeavour of the church, to be carried out first of all within the church itself. 'So then, as we have opportunity, let us do good to all men, and especially to those who are of the household of faith' (Galatians 6:10). Thus members of the first Christian congregation 'sold their possessions and goods and distributed them to all, as any had need' (Acts 2:45).

Instead of reaching the world as its servant, much of the church has been quite content to focus its energies on more spiritual issues and leave the meeting of physical

needs to others. The relatively recent development of the AIDS crisis is causing this comfortable arrangement to be questioned. The church is realizing out of necessity that it must take a part in this crisis, but is often at a loss as to just what part that should be. As it looks at the various aide agencies, whether secular or Christian based, it is aghast at what seems to be the primary message given, as aptly illustrated in this '*Malawi Success Story*' presented by USAID in their work in the prevention of AIDS in Malawi:

> The Ntcheu Child Survival Project's (NCSP) Maternal and Child Health (MCH) department is working with communities to better understand and prevent the spread of HIV/AIDS.
>
> NCSP conducted surveys in 50 villages. Reproductive health and HIV/AIDS issues were discussed. From a sampling of community and religious leaders, a few initial observations emerged: that any individual already infected with HIV/AIDS 'deserved' the disease because s/he is promiscuous, condoms are not widely accepted or acknowledged as a method to prevent HIV transmission and Christian community members did not need condoms as they were not promiscuous.
>
> Based on these findings, NCSP and the community developed a number of activities:
>
> - Train youth and drama groups to advocate for behavioural change and promote the use of condoms.
> - Select individuals to be role models and to give 'straight talk' on condom use.
> - Train Village Health Committees (VHCs) and village chiefs through intensive briefing on HIV/AIDS and condom use. These community members were then charged with the responsibility to distribute condoms and educate people on proper condom use.
> - Conduct an intensive media campaign in 50 villages. The information emphasized behavioural change and the importance and proper use of condoms.
> - Improve condom availability / accessibility / acceptability through already-formed and operational drug revolving fund volunteers, VHC members and youth-to-youth condom distribution initiative so that the communities can protect themselves against Sexually Transmitted Infections, HIV and other infections.
>
> Achievements:
>
> The most important achievement, perhaps, is that when communities are actively involved in discussions and distribution, condom use becomes increasingly acceptable to a wide variety of community members. Also, participants were very attentive throughout all training events, eager for

> information on HIV/AIDS and able to respond correctly on preventative measures, including the proper use of condoms (USAID/Malawi 2002).

Not wanting to participate in such propaganda, the church is often at a loss as to what its role *should* be as it seeks to represent Jesus Christ. This became blatantly obvious when this researcher asked several church leaders and pastors if it would be possible to sit down and discuss with them the possibility of working with their church to help them develop a program to work with the HIV/AIDS crisis within their church community. Although not all of them embraced the proposal of Home Based Care for their particular church, it was readily apparent that they were urgently searching for some way to address the issue of AIDS in their congregation, and were open to all ideas that may be of some benefit.

One of the new realizations of the church has to do with the current cultural mandate of not discussing sexual issues and the realization that this practice was actually working against the standards and ideals of morality in their youth. They began to realize that these issues must be addressed (1.4.10.4). The message promoted by the secular world, that condoms are the answer, was not what they as the church wanted instilled into their young people. On the other hand they were beginning to realize that if they refused to address the issue and continued to avoid it, the youth would look elsewhere for their answers (1.4.10.6). This was unfortunately demonstrated by the lack of credibility evidenced by the clergy in the perceptions of the youth (2.2). God does have the answer to the world's problems, and the church needs to be the voice that shares that message.

> Against the climate of our age, children need to learn that sex must be pure before God, and not simply safe, in order to be OK. But to know the Bible's morality does not in itself bring either repentance or new life. To change our lives, the commandments must be heard as God's voice, spoken in God's plan to point us to Calvary.
>
> The church, however, as the community of Christ's kingdom, can show the world an ethical integrity it must respect. When Peter describes the impact of Christian righteous deeds in a pagan world, he is thinking not of isolated saints, but of the *people* of God, called out of darkness into God's light [2 Peter 2:9-12]. Christian witness that is limited to private religious experience cannot challenge secularism. Christians in community must again show the world, not merely family values, but the bond of the love of Christ. Increasing the ordered fellowship of the church becomes the sign of grace for warring factions of a disordered world. Only as the church binds together

those whom selfishness and hate have cut apart will its message be heard and its ministry of hope to the friendless be received (Clowney 1995:147).

3.9.5 Practical Application of Role of Malawian Church Mission, Overcoming Challenges.

The church of Africa is now participating in transformative action at different levels (1.4.10.8) by shaping its concept of its role as the Church as it deals with the devastation of HIV/AIDS. History will actually be the one to demonstrate what its actual role has been once this segment of its record has been completed. What does seem apparent during this current time is that the role of the church must be one which will impact people, all people, including those suffering because of infection from the HIV virus, as well as addressing the needs of those not *infected*, but nonetheless suffering because of being *affected* by those who are. The needs of people in this crisis are multifaceted, and the church's role will be to discern these needs and develop ways to speak to them in ways that will be meaningful as well as impacting them in a real and tangible, as well as spiritual ways (1.4.10.6).

Beginning before the issue of prevention will be the church's responsibility to teach their people, from the early youth to the adults what God's principles are concerning the moral behaviour He has outlined for His people. This fact was recognized by MAP International, and discussed in their booklet aptly titled, 'Choosing Hope' (MAP 1996:5 *counselling*):

> Traditionally, the Church has avoided talking about these issues. The AIDS epidemic has come upon the world primarily because we have left God's plan for sexuality. The Church … must teach people about God's view of sexuality, which includes: the roles of husband and wife, man and woman; attitudes and relationships that we should have towards one another; the relationship of men to women and women to men; sexuality as a reflection of Christ and the Church.
>
> Similarly, the Church must discuss sexual issues with youth and parents. This includes talking to youth about body changes, sexual temptation and healthy sexual experiences within marriage.

But before this message can have an impact, there must be the message of salvation and changed lives, as the apostle Paul says in Titus 2:11-15:

> For the grace of God that brings salvation has appeared to all men. It teaches us to say 'No' to ungodliness and worldly passions, and to live self-controlled, upright and godly lives in this present age, while we wait for the blessed hope--the glorious appearing of our great God and Saviour, Jesus

> Christ, who gave himself for us to redeem us from all wickedness and to purify for himself a people that are his very own, eager to do what is good. These, then, are the things you should teach. Encourage and rebuke with all authority. Do not let anyone despise you. (NIV)

Reaching people with the Good News of Jesus Christ has been a success story in Africa where records indicate a steady growth of Christianity. Whereas church growth in the developed nations can be graphed as a horizontal line, African church growth shows a continuous steady incline. The challenge here in Africa, is to make Christianity meaningful and life changing. This problem is certainly not unique to Africa but it is if anything, more difficult to overcome in Africa due to the severe shortage of trained clergy and other levels of leadership in the church. Ongoing efforts continue to broach this challenge as various mission agencies such as African Bible College continue to train qualified leaders in an effort to meet the need.

The role of the church in Africa towards the pandemic of HIV/AIDS must be multifaceted in order to deal with the multifaceted challenges that abound. There are no simple answers. But the first step, that of becoming not only aware of the problem but also taking ownership of it with the realization that the church has a significant part to play in this drama as well is now being made by the African church (1.4.10.4). Awareness and sensitisation of the issues will be a major part of the movement forward as the African church seeks to overcome the prejudices and stigmas associated with this disease that have served to hold it back from moving forward in its work as it seeks to minister to those suffering with HIV/AIDS (5.7).

Some churches, such as the Church of Central Africa Presbyterian (CCAP in Malawi) have realized their error in ignoring this issue until it has become a pandemic and instead of crying over the spilt milk, they have opted to move forward in a positive, proactive way. One of the resultant effects of this change of mindset can be observed in a document they issued called the Chongoni Declaration of the Nkhoma Synod[19]:

[19] A copy of the Chongoni Declaration document was provided by Rev. Dr. Hennie van Deventer, Principle of Nifcott (Nkhoma Institute for Continuous Theological Training), PO Box 38, Nkhoma, Malawi.

We,
Ministers of Nkhoma Synod CCAP,
Gathered here at Namoni Katengeza Church Lay Training
Centre from 10 to 11 May 2000;
Noting with great concern the devastating effect
Of HIV infection and AIDS in Malawi,
Do hereby **DECLARE** that we as a Church Confess and repent before
The Almighty God that we have not obeyed His Word,
And that we have not been fully involved in addressing the HIV/AIDS crisis,
And that we ask for God's forgiveness,
And that from now onwards, we were take a preventative,
care and support stand.
So Help Us God.

As the CCAP has addressed this issue, so have many other denominations as they share in the devastation of this pandemic upon their congregations. They have picked up the gauntlet and begun to fight in the war on AIDS. Each faith community, as it moves forward in this conflict, joins the globalised world in the wider contextual situation in addressing this issue 1.4.10.3). Denominations are beginning to work together to present a united front as they do battle. Individual churches are taking the responsibility to educate their congregations about HIV/AIDS and how they can work as a church to combat this plague by fighting the disease while loving the infected and affected.

Interdenominational conferences are being held to educate, inspire and challenge not only the church leadership but also the congregations to make an activist stand[20]. People are beginning to realize that as Christians, they are called upon to not only live biblically moral and holy lives, but in order to obediently participating in the transformative action (1.4.10.8), they must also to live overtly with their faith in action reaching out to DO something to combat the problem.

[20] As an example of this phenomenon, at the current moment this sentence is being written, there are at least two conferences (NetACT and World Relief as sponsors) being held this very week in Malawi for church leaders and those interested in working to fight this battle.

While at different levels: personal, ecclesial, societal, ecological and scientific (a doing, liberating, transformative theology that leads to a strategy, implementation and an evaluation of progress).

3.10 SUMMARY

This chapter has demonstrated that African thought processes; in particular Sub-Saharan thought processes of the Malawian mindset, involving the perceptions and impressions of HIV/AIDS, have often been guilty of serving to extend and broaden the problem. After examining cultural specifics and difficulties in the African community as a whole that contribute to the perpetuation of the problem, the focus was then moved to more carefully scrutinize the impact these practices have had as they specifically affected Malawi.

With reflection upon the special challenges that affect the African church in general, these challenges have been explored. Special consideration of the difficulties being confronted by the Malawian church in particular, have been addressed as it has faced up to the HIV/AIDS crisis. Observations were made in this chapter regarding the movement of the Malawian church from a position of helplessness as they allowed this pandemic of AIDS to surround and engulf them without their actual acknowledgement of the problem, to a proactive and positive stance. Although it is certain that challenges will continue to surface and the crisis is far from over, the strides which have been taken by the church are encouraging as it seeks to shed those hindering attributes and apply itself to the task of being 'the church' and therefore, as fulfilling the role described earlier in this chapter (3.9.3) so that it begins to:

> …interact with the world (people) in such a way as to demonstrate God's plan of salvation through the saving work of Jesus Christ and the transforming and sanctifying work of the Holy Spirit to reconcile man to Himself and to others. This will result in the transformation of the world as the church reaches out by its word and deed, proclaiming the Gospel message of the God who saves to the world that desperately needs Him. It is only by witnessing God at work through His people (the church) that those outside of the church can realize their need for Him.

HIV/AIDS concerns impacting the church in general, as well as the particular struggles affecting the Malawian church serve to emphasize the continuing need for the church to take necessary measures to work within the framework of her mission to respond in a positive way to these issues. The problems identified (5.4): alienation,

estrangement and prejudice affect the effectiveness of the church's ability to communicate hope and love to those drowning in despair. Chapter five will look at the theological implications of these problems, addressing some of the current thinking and attitudes taken by those in the theological field, as they work to sort out God's directed response to these issues.

Addressing these factors on the macro level only serves to demonstrate more clearly the need for intervention on the micro or individual level. Change will not come to an individual, or the church, or the world for that matter by merely identifying the problem. Paradigmal changes in the way the church views this crisis, and those caught in the midst of it must come with slow, deliberate and determined steps.

If one were building a road and discovered that a mountain lay in the middle of the desired path, it would be a foregone conclusion that something other than merely recognizing the presence of the mountain must be done. Throwing ones hands up in defeat at the apparently insurmountable task of moving the mountain would have no effect on the need to move it. Only by taking measured, proactive steps can a solution take place. In the same way, if a shovel is used to move the mountain; shovel full by shovel full, even though the task looks monumental initially, eventually, the mountain will be conquered.

By the same token, determined, methodical steps must be taken to make the changes necessary to conquer the HIV/AIDS pandemic. The project under investigation in this study is only one aspect, or one shovel full (to continue the metaphor), of the multifaceted approach needed to conquer this mountain of HIV/AIDS as it seeks to explore the question:

> Can the relationship between the local church and the HIV/AIDS community be altered when provided with the opportunity to learn about each other in safe, non-threatening ways using the vehicle of Home Based Care as the point of entry?

The forthcoming chapter will look more closely at cultural patterns that serve to defeat the efforts of the church as she seeks to address this deadly issue. Specifically, the actual tribal practices and detrimental influences, which are used by the major tribes in Malawi, and serving to promote the disease will be analysed.

Once the dark, and often occultic, side of the cultural practices have been exposed and brought into the light, exploration of these issues will begin with the task of examining the theological implications, and in particular within the scope of Practical Theology with the development of a praxis process for change. The final chapters will then demonstrate the systematic methodology and evaluative processes that took place in this study regarding HIV/AIDS alienation, and in particular, the relationship between prejudice and acceptance within the context of the specific evangelical congregations involved in this study.

Chapter 4
Malawian Cultural Practices
That Promote the Spread of HIV/AIDS

4.1 INTRODUCTION:

The problems associated with an improper hermeneutic of God's intention towards those suffering with HIV/AIDS addressed in this paper: those of alienation, estrangement and prejudice (5.4), as experienced by those who are either infected or affected by the disease, in relation to the response of the local faith communities dealing with these issues, have now been examined in several ways. After identifying the problem in chapter one, the broader perspectives regarding the historical ecclesiastical context within the church as it began its response to the pandemic of HIV/AIDS was examined in chapter two. The scope was narrowed further as chapter three began looking at the AIDS related issues affecting the African church, therefore affecting the methodology of the African faith communities as they addressed the issues surrounding this crisis.

This chapter will now narrow the focus further with the intention of examining some of the specific traditional practices and patterns that contribute to the current HIV/AIDS crisis in Malawi, primarily within the Chewa culture, along with some assessment of the neighbouring tribal customs. These customs are significant due to the influence they impose on the Chewa culture. This is particularly true in the urban areas, where individuals of all tribes gather and intermix with a continuation of their tribal heritage and customs, but the influence of other tribes can be noted as well. Since this is the case in the Lilongwe area where a good portion of this study takes place, this phenomenon is worth examining at this point.

One of the most notable treasures of the African continent is the rich cultural heritage displayed in the vast tribal practices, which are deeply ingrained in the people of Africa. Each tribe has its own set of rules and regulations that have served over the years and even centuries to provide standards of living and actions which have been passed down from generation to generation. Although this research cannot begin to be an exhaustive account of African traditions, those particular traditions that have

impacted the HIV/AIDS crisis will be examined in light of how they relate to the identified problem, seeking to provide comprehensive understanding regarding the reasons why the pandemic of HIV/AIDS has exploded in Africa. This exploration will also seek to give some explanation as to the difficulty experienced by the church as it has sought to make inroads penetrating into the heart of the issue.

There are African cultural distinctiveness which are practiced over most, if not all of the Sub-Saharan African continent, several of which were discussed in chapter three. Many, if not most of these practices were initially begun as a result of some factor or threat perceived by those who originally started them. For example, the practice of *Chokolo* (4.11), which will be explained later, certainly began with benevolent purposes as the people sought a way to provide for the unfortunate widows in their community. As with many customs, variations developed through the years as various clans separated from one another. This lead to an eventual evolution of the original custom allowing a natural progression of the practice to change slightly from group to group until various clans saw their version of the practice as being the right and proper way of doing things. Although this has contributed to the development of subtle differences from clan to clan, overall there are many similarities between the customs in each tribe. So much similarity has been maintained that despite the slight differences, the ethnicity for each tribe can be described in a general and acceptable way.

In Malawi, there are eleven primary tribes and languages[21], and although each has its own special set of tribal customs and practices, there is much overlapping between them. The Chewa tribe is by far the largest and most influential of all the tribes in Malawi, with Chichewa, along with English, being the official language of the nation. Making up approximately fifty percent of the population, the Chewa people and their cultural practices are deeply felt in all areas of Malawi, but particularly in the Central Region where the research for this dissertation is taking place. Because of this, it will primarily be the Chewa culture that is discussed, with consideration to the other tribal practices that have been influenced by the Chewa culture due to the moderate mixing that occurs in a cosmopolitan setting.

[21] Lambya, Ngoni (northern), Chewa, Ngoni (southern), Sena, Lomwe, Mang'anja, Yao, Tonga, Tumbuka, Nyachusa, Nkonde.

Coming from the 'melting pot' of a Western cultural setting (1.5), it is often difficult to fully understand the depth which these customs and cultures are ingrained in the tribal peoples of Africa. Although they are diminishing in their grip on the individuals who have broken free of the traditional village setting and have moved into the urban areas where many people of differing practices live in close proximity to one another, even in these city dwellers the culture affects the fibre of their being.

African customs and traditions do not only play a major part in the formation and development of a child as he or she grows into adulthood, they also make up the very character of the world view that individual will develop which colours the understanding that person will have about all aspects of life. A person cannot divorce himself from his cultural heritage without destroying a major portion of his identity as an individual.

Because of the way the culture is interwoven into every aspect of life, change comes slowly. Even when practices are obviously no longer useful and may even prove dangerous, it is difficult to remove them from the group's practice because of the significance they have in other parts of their life. An example of this might be seen in the use of amulets. Even when converted to Christianity and the concept of a sovereign God to interact in every aspect of life, many 'Christian' Malawians continue to wear them or provide them for their children to wear. Nervi (1994:68) explains this as a practice that begins in infancy, as a Malawian mother will,

> Around its waist [the infant's] she ties a string of amulets, making sure that they are placed near the bodily openings which are regarded as the 'doors' by which the spirits enter his body. Protective charms are seen as essential for guarding the child from the 'evil eye' and from certain diseases. If the child is a girl, the mother adds to her waist some colourful little beads to ensure fertility.

This researcher once noticed one of the students at African Bible College wearing these colourful little beads under her clothing. When asked about it she said it was nothing, just something fun to do. Although this practice of wearing little colourful beads may be recognized as a harmless cultural practice, even in this student who was a 'strong' professing Christian, there was a certain amount of authenticity that was given to this practice. Along with the secreted credibility ascribed to it, there remained a certain amount of fear stemming from deep within, deeper than informed

thought, at the very essence of her being which told her that this was something she must do. It must never be forgotten or taken lightly, that when one considers the cultural practices in Malawi, the fact that these observances are not just customs that are practiced but rather a way of life for each individual that define their identity and give them a sense of balance and purpose in their world.

With these factors in mind, it is imperative to analyse the impact of these customs on Malawian society, and more specifically upon the church in Malawi and the resulting theological implications that arise which will be addressed in the succeeding chapter. This investigation can only be done with methodical analysis and evaluation leading to conclusive determinations for change, which will be described and developed in detail in the following chapters. Some of the customs that will be identified and examined include: adolescent initiation rites, marriage customs (including matrilineal customs and polygamy), and funeral customs such as *Chokolo*. In addition to these customs that deal intimately with the individual as a part of the family unit, this chapter will also address the more general issues of gender, poverty, urban challenges and loss of workforce; issues which are tied to the HIV/AIDS phenomenon in either direct or indirect ways.

Before entering into the descriptions of the various practices, it must be noted that it is admittedly the negative side of the culture, which is being emphasized in this chapter. The reader must realize that there are many positive cultural practices in the Chewa and surrounding tribal cultures that serve to promote positive values adding dimension to the congregation's ministry and mission. Although it is beyond the scope of this research to present all of the positive influences in the African culture, the following example is presented at this point for illustration.

One such practice was observed by this researcher at an engagement celebration. The primary uncle from each the bride and groom's families came forward and began pulling a cooked chicken apart. As they did so, they made the following exclamations: As one would pull of a wing, he would emphatically state to the watching crowd, 'when these young people have trouble, they will *fly* to me to advise them'. The other uncle would then pull off a leg and say even louder to the crowd, 'when they have trouble, they will *run* to me to help them!' They would continue these pronouncements to the delight of the people in attendance until the

entire chicken was pulled apart. They would also involve the people by charging them to watch over the young could and help whenever they could because they (the uncles) would not live for ever, but the couple would continue to need the watch care of those who wanted to help them succeed.

This is only one of many positive cultural practices that provide identity and meaning into the lives of the Chewa people. It has been added at this point to offer a token of balance to the following description of the culture's negative side, which will now be presented in this chapter. No attempt will be made to give a balanced report since the purpose of this section is to reveal cultural practices that contribute to the spread of HIV/AIDS. Using criteria such as this ensures that all of the practices described will be naturally negative.

4.2 CHEWA CULTURE

As stated, of the eleven tribes found in Malawi, the most prominent and largest is the Chewa. Due to the close proximity of the various tribes, there is naturally some overlapping of customs between the Chewa and the neighbouring but prominent tribe of the Tumbuka in the northern part of Malawi, along with some of the smaller tribes such as the Tonga, Ngoni, Lomwe, Lambya, Mang'anja, Nkhonde, and the Yao in the southern region. The Chewa tribe goes beyond the national borders into surrounding countries such as Mozambique and Zambia. Rich in its ancestral heritage, the Chewa have many customs and traditions rendering them unique amongst other African tribes.

Extensive efforts were made to qualify and authenticate the following information regarding tribal practices. Sophomore students at African Bible College were given an essay assignment 20 November 2002 in which they were to describe tribal and traditional practices that promote the spread of HIV/AIDS in their own particular tribe. Their contributions to this dissertation are noted as 'student quote' and then the individual student's name is indicated. The integrity of these students as they presented this material is not under any suspicion, as they were under no pressure to provide information, which might have caused them to embellish or exaggerate the claims they made in their reports (in other words, there was no promise or insinuation

made that their grade or acceptance would be in any way affected by the content of the traditions described). Since most of the students were of the same tribal heritage, the phenomenon of constructive replication was noted as students repeatedly described the same customs practiced within their tribal heritage. The quotes used in this paper are representative of many repetitions that were found in their reports. This researcher simply selected the quotes that were worded or expressed in such a way as to best represent the concept being described.

Much of the information in this chapter was taken from a book by Luciano Nervi, *Malawi, flames in the African Sky*. Nervi was a missionary to Malawi for six-teen years. In addition to these facts, most of the customs described were already familiar to this researcher from experiences and information received first-hand from actual experiences of living in Malawi and working with the students of African Bible College and the people of the villages, as well as other missionary experiences shared with this researcher during the six years of living in this country. In addition to these measures to assure accuracy, as an additional safeguard, this material was also read and critiqued by Mrs. Grace Banda (Appendix B) who is a native Malawian and can therefore be considered as an expert witness of Chewa (and other Malawian Central Region tribes) culture.

4.3 THE FAMILY UNIT

As with most African societies, the family is the basic nucleus of society. To gain even a rudimentary understanding of Malawian culture, one must understand the importance of the family. The term 'family' is much broader in the African sense than the way a Westerner might define it[22]. Rather than being comprised of the immediate members, father, mother and children, the African family includes the extended family, with uncles, aunts, grandparents and cousins included. Because of the communal nature of the family, there is no word in Chichewa for cousins, with all children who are born for relatives being considered as brothers and sisters.

Imasogie clarifies this point in his description of this trait (1993:76):

[22] 'Family' in the Western sense consists of the 'nuclear' family - father, mother and approximately two children. Grandparents, aunts, uncles and cousins would be considered as part of the 'extended' family, but not on the same intimate grounds the nuclear family.

> In human relationships the blood tie is so strong that everybody who can be identified with a particular clan is regarded as a 'brother' or a 'sister' to other members of the clan and must be treated accordingly. For this reason there is hardly any African ethnic language that distinguishes between the term 'brother' and 'cousin' as we have in other languages such as English. The only word that refers to blood relationships is 'brother' or 'sister' as the case may be.

This system works as a benefit for those in this society who might otherwise fall through the cracks of the normal family structure. This can easily be seen when considering the plight of orphans, where (in Africa alone) more than 9 million children under age of 15 have been left without a mother and father because of HIV/AIDS (Stearns 2001:100).

> Because of the inclusive and empathetic way of life among traditional Africans, orphans and problem children are drawn into society, and absorbed into other families. In this way they are cared for, nurtured, given love and develop as full and active members of the community. Everyone becomes the mother, father, brother or sister of these children (Boon 1996:34).

The problem comes when this overwhelmed cultural system can no longer absorb and care for the massive numbers of orphans. This is poignantly illustrated in this excerpt from an article describing the loss suffered in one family from AIDS,

> Caring for orphaned children brought new complications… Imboela was orphaned as an infant. The boy lived with his grandparents until they both died [of AIDS]. Then Imboela lived with two uncles and one aunt, all of whom are now dead. At age 10, Imboela has known nothing but loss (Morgan 2000:42)

The family within the village setting is very strong and the bonds and duties of each member interplay with each other. 'The entire family, which includes married brothers and cousins, is involved in all relationships. In real terms, marriage is a contract between two families and not two individuals as in the Western way. Because of this, the family remains involved in the individual couple's relationship. Everything is everyone's business, so it is practically impossible for problems to build up to a critical point where, for example, a family murder occurs, without the extended family being aware of and diffusing the danger' (Boon 1996:34). This concept of mutual accountability helps to keep the Malawian family ties close and works to ensure a continuing level of answerability as each member's behaviour is evaluated by the rest.

The ethic and interaction that occurs in the extended family comes from the concept of *Ubuntu. Ubuntu* describes the heritage of philosophy dealing with the interrelationships within the African culture regarding morality, humaneness, compassion, care, understanding and empathy (5.4.1).

> *Ubuntu* is best described through the expression: *Umuntu ngumuntu ngabantu* (Zulu), *Motho ke motho ka batho* (Sotho), *Umundu nimudu niunde wa andu* (Kikuyu), *Munhu munhu pamusana pevanhu* (Shona). All of these mean: *A person is only a person because of other people* (Boone 1996:31, 32).

The hierarchy of allegiance extends to the extended family or clan, above the loyalty to the immediate family. Even though they may be happy together and have children, the husband and wife continue to belong to two different family units to which they are tied by rights and duties even more important than those acquired through marriage. In other words, the couple and their children do not exist as an independent unit. The most important products of their union - the children, do not belong to them but to the respective family clans according to the kinship system they belong to (Nervi 1994:64). Even though the immediate family may move far away from the clan, it is expected that their first allegiance will be to the clan. To illustrate this point, it has been observed among Malawian students at African Bible College, that when they have opportunity to share their testimony with the entire student body, they begin introducing themselves by describing their family identification, indicating what place they are in the family, how many brothers and sisters, etc. They then follow this by giving the name and location of their home village, when in all probability; their family has not actually lived in that village for many years.

In Malawian culture, the individual is eternally tied to his or her respective village. For instance, if one of our ABC students were to go back to their home village, they would be given property as their right of inheritance. If they decided to join a village that is not their ancestral home, they would seek permission from the Chief in order to buy property.

4.4 VILLAGE TRADITIONS

4.4.1 Village Traditions – Matrilineal

Chewa are matrilineal, called *mbumba*, which means that the children remain the property of the wife's ancestral clan and the biological father has no real authority or rights of fatherhood in their lives. *Avunculate* (the exercise of domestic authority by the wife's brother) (Phiri 1998:130) is practiced, whereby the mother's brother becomes the guardian or *nkhoswe* (:138), and actually exercises more control and responsibility over a woman's children than their natural father does. The woman will also be the one by whom the land ownership passes, even though the actual control of it is handled by a man, usually her elder brother or maternal uncle. This tradition dictates that when a man and woman marry, they will move to the woman's village where he will then enter her clan (*uxorilocality*), since she is the property owner and not the man.

> Even though they may be happily together and have children the husband and wife continue to belong to two different family units to which they are tied by rights and duties even more important than those acquired through marriage. In other words, they do not exist as an independent unit…. [For example, if the husband] were to undertake any commercial enterprise, such as simply buying a goat, he will do it within his own *mbumba*, and not in his wife's village from which he can be dismissed at any time. At his wife's death, he will have to leave the place where he has spent his whole married life, carrying with him only his sleeping mat (Nervi 1994:64-5).

> The family was for the most part dependent on the larger social unit to which it was affiliated, the matrilineage, which embraced most of the woman's relatives. In fact, it was the matrilineage that defined the rights and obligations of the individual family or household, gave it its sense of belonging, provide it with both social and material security, and defined its status within the larger community (Phiri 1982:259).

4.4.2 Village Traditions – Night Dances

Night dances are common and typical entertainment for most of the tribes in Malawi. There are several purposes for these dances, many having to do with sharing of ones heritage and traditions, but they also can provide a breeding ground for high-risk behaviour.

> 'Young ladies and men gather together to compete for a dance. Most of these young men and women are not independent at this time but are under the guidance of their parents. This dance is called *Manganje* (Chewa). They are allowed even to travel long distances to other villages just to compete for a

dance, and as a result when they are going back to their village, they turn to give their bodies up to each other since it is night and they know that their parents are not with them. Sometimes ladies also, look for the guy who has been a *star* that night. A guy who has performed well so that they can go out with him. This star wants to prove that he is a *star* also so he proposes to more ladies. The ladies do not turn down the offer but accept to the so called *star*. As a result the *star* will have multiple ladies and he will not mind about who he sleeps with, as long as he knows he is the *star*.'

(Student quote – Maria Theresa Makhalira)[23]

4.4.3 Village Traditions – Weddings and Funerals

Weddings and funerals can also be a time when unguarded sexual activity takes place in some tribal customs. Among the Lambya and Ngonde tribes, for instance, it is customary for people to 'spend (three to five) nights at the funeral place or house. Some women and men don't just go for the funeral but they feel that it is the right time for them to go around with other people's wives or husbands.

Magolowazi (Tumbuka, but also common in others as well) is a marriage ceremony, which takes about three days to celebrate. 'They start with the first day where relatives and friends of the bride takes it as their day. The second day for those related to the bridegroom while they join together on the third day. But *Magolowazi* is what people do during the evenings of these three days. Some people go to sleep while there are some who continue with the dancing and giving out money but those who go to sleep pay some money as well. What differs most is that a lot of the young boys and girls find this as an opportunity to meet and know each other. What happens is that boys who want to dance with any girl first give out some money to the cashier in charge that night and then that boy goes to that girl to dance with him….The fact that the boys give some money to the ladies in order to dance with her is like the boy usually says, 'I have paid for this', and they take this as an opportunity to do anything they want with the girls.'

(Student quote – Maria Mahowe)

4.4.4 Village Traditions – Traditional Medicine

The traditional medicine, with the herbologists and witchdoctors, contribute to more difficulties in Malawian culture than just malpractice of medical care. They have a powerful hold on the thoughts and ideas of many people due to their 'supernatural powers' and influence.

[23] Sophomore students at African Bible College were given an essay assignment 20 November 2002 in which they were to describe tribal and traditional practices that promote the spread of HIV/AIDS in their own particular tribe. Their contributions to this thesis are noted as 'student quote' and then the individual student's name is indicated.

> …everything in the universe is seen as a potential vehicle for divine revelation and mediation…. Even herbs are said to be capable of being incarnated by spiritual forces for the purpose of revealing their therapeutic potency to the herbalist in the service of mankind. In the same way, the seers, priests and diviners are believed to be able to enter a state of spirit-possession during which they become mediums for divine revelation. Dreams are also interpreted as a divine method of unravelling the mysteries of life to those who are specially tuned into spiritual realities (Imasogie 1993:77).

Witchdoctors and the like are often aligned against medical practices, which have been proven (usually considered 'Western' practices) to be more reliable in treating various health situations, and Christian practices and beliefs (3.3).

In addition to the attack on the family and focal units of society, Christians are being called upon to forsake traditional healers and witchdoctors as they are tied to occultic practices, yet many find there is no opportunity for other medicinal treatments available to them. Western clinics are few and far between, and the treatments available may be far above their financial resources even if they are available. Many times Western medicine lacks the comprehensiveness (spiritual/psychological/emotional) of the traditional medicine and therefore the recipients lack the sense of fulfilment received when they believe the witchdoctor has isolated the spiritual component of the disease that threatens them. Being able to 'intellectualise' the purposes of Western medicinal means, does not always take away the deeply ingrained 'gut' fears and sense of wonder that accompanies the magical powers of traditional practices.

This phenomena is more accurately described by Osadolor Imasogie's discussion of the failure of the typical African Christian to fully rely on Jesus Christ in times of crisis (Imasogie 1993:69,77):

> Given the technological superiority of the missionary, many Africans, though only on a superficial level, did what they were told to do. But deep down in the subconscious dimension of their beings, their cultural conditioning remained intact to determine their behaviour in moments of life-problems….Consequently, many African Christians perceived the 'God' of Christianity as a 'stranger-God,', the god of the white man, who is unfamiliar with the local spiritual problems….Thus,…the first reaction of many African Christians is to gravitate towards the traditional religious methods for coping with such a crisis…In the face of such crises he naturally reverts to traditional religious practices to establish metaphysical security.

Many Christian Malawians sport the rows of tiny cuts, approximately .5cm neatly placed in lines looking like small rows of railroad ties, indicating treatment from various sorts of witchdoctors and traditional healers as they sought to find relief from the hardships plaguing them. It is from these very practices that many AIDS sufferers blame the source of their acquiring their disease.

One tradition that is widely practiced in Malawi by the witchdoctors has to do with their influence over the people they are 'serving.'

> They (the witch-doctors) usually always lie to the patients that they will be healed if and only if they will have sex with them. Usually this happens to those who are barren or have some female problems.
>
> (Student quote – Chimwemwe Kumwenda)

> There is a belief that there are some witch-doctors in some villages that can cure AIDS, therefore some people still think that when they are affected they will go to such traditional African witch doctors for medications. . . Some in villages still believe that AIDS can be cured by pleading with ancestral spirits.
>
> (Student quote – Saidi Munyonga)

4.5 INITIATION PRACTICES

As a child begins to reach puberty, they are exposed to the tribal initiation ceremonies. It is the initiation ceremony that gives the boys and girls the possibility to come to know deeply the traditions and customs of their tribe and culture. Only by means of initiation can they become official members of the kinship group. Those who have not been initiated are not considered to have reached adulthood (Nervi 1994:70).

Although individuals vary in their descriptions of these ceremonies (probably because villages have altered the customs to accommodate their individual village needs), there are several common threads that are part of each one's interpretation of the events that take place for initiation into adulthood.

For the Chewa, initiation involves the affiliation to a male secret society known as the *Nyau*, sometimes referred to as the *Gule Wa mkulu* after its most famous dance. This traditional dance has the place of religion in many of their lives. The place where they meet is called the *dambwe*, which is usually located in the local graveyard.

> I understand they have about three women who are called the 'owners of the *dambwe*' and when the young men / boys are joining the *Nyau*, as part of their initiation they are supposed to have sexual relations with all three women.
>
> (Student quote – Tapiwa Chakwera)

> This affiliation to the *Nyau* begins with terror. The boy is stripped naked, beaten with canes, forced to drink strange and fetid medicines (perhaps containing excrement and urine), and finally, to swallow the raw and dirty bowels of a chicken. It is the elders who exact all this, with the intent of making the young candidate lose any sense of decency or shame. Then they reveal to him, under strict secrecy the history of the organization and its commandments. Meanwhile, they teach him how to make the mask that he will wear for the dances and how to perform the particular dance of the mask that he is wearing. He is taught secret passwords, which will enable him to move about, unchallenged in order to enter the villages, naked at night, to steal chickens…. At the time of *Gule Wa mkulu*, the *Nyau* may steal, inflict violence on women and on property, and, in general turn the rules of normal society upside down. This is possible because of the fear they spread among the people and the immunity of anonymity (Nervi 1994:70-71).

> To dance *Nyau* was to stand out against the White Fathers and the Dutch Reformed Church, who were making a concerted effort to suppress the Nyau in the Central Region of [Malawi]…To dance *Nyau* was to support traditional society and to show respect for the elders. It was to be Chewa. Participant in *Nyau* and the defiant continuance of initiation rites produced a sense of Chewa identity (Linden 1975:33).

Many times young men from Christian families are also forced to participate in these initiation ceremonies. One Christian man (Peter Banda) shared with this writer that as an adolescent boy, his parents required that he undergo the initiations rites for his own protection. He explained that while walking along a path, if he were to encounter a *Gule Wa mkulu*, he would be expected to respond appropriately with the proper secret greetings and responses. If he were unable to do so, he would be beaten. Because of this very real and physical threat, many boys from Christian families continue to be initiated into this practice. Following these initiation ceremonies,

> Young men (in the Lomwe Tribe) are advised to sleep with a girl to prove that they are men soon after they get out. If they don't they are cheated that when they take a bath even when they take body oil they will not look handsome.
>
> (Student quote – Leisten Ew Nashire)

Initiation practices are not limited to males. Young Malawian girls also experience a 'right of passage' process designed specifically for them:

> When a young girl reaches puberty her parents, in particular, her 'aunt' (*Phungu*), will go to the chief with a white chicken and tell him that their daughter is mature.'
>
> (Student quote – Noel Mbuka)

> Thereafter the Chief begins to prepare the '*Chinamwali*' ceremony. The initiation of girls is divided into various stages corresponding to their physical development….When she reaches her first menses, thus begins the girl's first private initiation. She will be taken, often with other girls who are also at this stage of development, for the four or five days during which she remains inside the house (this period of time can be up to a month in some tribes such as the *Mang'anja*)… 'elderly women are called upon to play a role in upbringing and rescuing this girl for fear of her being misled by friends and /or others of ill will.'
>
> (Student quote – Rebium Manyuna)

On the last day of the initiation the hair of the girl (this includes the hair on the head as well as the pubic areas) is completely shaved off, and the following night she is made to have sexual intercourse with a man known as *fisi* (this means hyena, because he comes secretly at night) who has been hired for the purpose (Nervi 1994:72). Depending upon the custom of the local village, the *fisi* will either be a married man from that village or possibly the chief himself. This final part of the initiation ceremony follows a time of *Gule Wa mkulu* dancing and celebration where songs are sung with sexual implications,

> …the aim of the masked dancers is to remove from the girls the fear of the male sexual organ. The chief is also (depending on the custom of the local village, it may be another man who is chosen for this role of *fisi*) given the role of opening the womb of the young girls.
>
> (Student quote – Shadreck Chikoti)

He will be paid for his services with a cock or other reward. This is done in secret, with the man disguising himself to prevent recognition, and the girl is not supposed to know who will be coming to have sexual intercourse with her. For the man involved, it is considered an honour to be the man who is chosen to assume this role.

> Usually the girls are very excited and looking forward to this adventure, and also look forward to having more sex once they 'graduate' to prove their womanhood.

(Student quote – Shadreck Chikoti).

The girls are told that they must pass this 'test' as a preparation for their future house. Some of the girls who experience this custom,

> …find it so enjoyable they become sex addicts who can thereafter start inducing and seducing their opposite age-mates to go and have sex with them. Such types of sex addicted girls do not consider this as prostitution but rather 'Gift Sex' as popularly acknowledged by some men.

(Student quote – Noel Mbuka)

When the initiation instructors redo the floor of the hut with a new layer of mud, the family of the girl knows that their daughter has become a woman. Students have shared with this researcher that 'there are some beliefs, like after girl or boy initiation ceremonies, they require the graduates [of the initiation] to engage into some sexual experience where a strange man is arranged to sleep with a girl graduate in a secluded house or a boy graduate is in some cases encouraged to rape a girl in order to 'remove dust' ('*Kusasa Fumbi*') i.e. to shake off his inexperience in sex by actually doing it. In most cases such acts are not deemed rape, but part of the culture.

> 'They are warned (in the Mang'anja tribe) that if they fail to have sex with any girls, their skill will start to moult and finally they will die.'

(Student quote – Sullivan Kenneth Kandulu)

This is done,

> …in order to prove that they know what is expected of them from that time onwards. The boy or girl has no say in who these elderly people are and literally the boy or girl will just accept what is imposed on them (Banda 2002:1).

> Some traditional teachers encourage the girls to sleep with their boyfriends so as to have a feel of sex.

(Student quote – Harold Chiuza)

In addition to teaching these girls about sexual issues and how to 'treat a man', there are some things taught during these sessions which have a positive value. The girls are taught by the older women, the *agogo*, about other areas in life such as cooking, raising children and keeping a home. A similar tradition is practiced by the Yao tribe called *Ndakula*.

In her informative article (Phiri 1998:129-45) describing the female initiation rites amongst the Chewa from a personal as well as an objective research standpoint, Isabel Phiri's testimony give evidence to the accuracy of these students accounts

regarding these traditional practices. She identifies four main areas of traditional initiation rites in the life of a female Chewa child, (1) *Anakungwi*, which is the time of private teaching initiated by the first menses, to be followed by the group teaching with other girls; (2) the second initiation comes just prior to marriage, which emphasized techniques for pleasing her future husband:

> Submission in every way to her husband was taken seriously. The girl was told never to argue with her husband and to treat him like a king,

(3) following marriage the newlyweds were instructed together by the *Nankungwi* on how to conduct themselves as a married couple; (4) the first pregnancy called for the *chinamwali cha Chisamba* ceremony which dealt mainly with how a husband and wife were to relate to each other during the pregnancy and how they were to look after the children. So important were these ceremonies that in the olden days, mothers who did not include their daughters in such initiation ceremonies were punished. Children born of a mother who had not been initiated were buried alive. With punishments this severe, it can easily be assumed that women would seek out such initiation rites if for no other reason than to protect their children and save themselves from embarrassment and humiliation (Phiri 1998:134).

> Parents make everything possible for their daughters not to miss this kind of initiation because they believe that if she misses this, she will not make a good wife when she gets married.
>
> (Student quote – Mirriam Mkuka)

4.6 GOWELO

Gowelo is a traditional cultural practice, which can also contribute to the practice of high-risk behaviour amongst teenagers. Once children begin to mature and reach puberty, it is no longer considered appropriate for them to sleep in the same house with the parents. *Gowelo* are houses made for young people, in an effort to show respect for their parents. Girls and boys are separated and have their own communal houses, but since these houses are situated away from their parent's house they are no longer under their direct influence. The original design was to provide adolescents with a place to grow and develop without infringing on the privacy of their parents now that they are aware of sexual relationships. Often the reality is in fact a newfound freedom among these teenagers to explore their own relationships

with the opposite sex without any parental accountability. Added to the inherent danger of an environment free of accountability and supervision is the fact that in addition to the natural hormonal surges present at this age of development, these adolescent children have just been introduced to sexual experiences from the initiation process, with clear instruction that they are now adults, and ready for such relationships.

4.7 COUSINS

Chisuweni is the practice of considering cousins (offspring of the parents siblings) as spouses.

> Whatever they do as regards to sex is not questioned for it is their right as *asuweni* to treat one another as husband and wife. The parents do not say anything, and in fact they encourage such behaviour (Banda 2002:2).

Children have been encouraged to marry their *asuweni* as such marriages were seen as factors that strengthened the villages and kept them together.

4.8 ARRANGED MARRIAGES

Many of the traditional cultural patterns continue to have a stronghold in Malawi's rural areas, but have diminished in their importance in the more urban areas. This is due to increased exposure to Western ideas and attitudes. One of the older customs involves the selection of marriage partners by the family of the child in question. Families considered it favourable to make such arrangements in order to keep order among the youth and prevent riotous living.

> The families think it wise to find spouses for their children… They always call the boy to come and talk to the uncle of the girl then his uncle comes to make the wedding arrangements. The girl is given a few minutes to chat with the boy to know each other although this is not enough. The girl cannot say no as the final decision is made by the uncle.
>
> (Student quote - Mirriam Mkuka)

4.9 SITTING-IN-HUSBAND

If a couple has been married for one or more years without conception of a child, a man who has proven his fertility by fathering children with other women will

be chosen to 'sit in' for the marital husband. This is done in hopes of providing offspring with the assumption that there is a problem with the reproductive capabilities of the husband. It can be arranged in several ways, depending upon the individuals involved and the actual village practice. Often the husband arranges it, and he then makes plans to be gone from his home for the evening. (This same practice is called '*Kuvwira Kuuska Nyumba*' in the Tumbuka culture, where it is usually arranged without the knowledge of the husband.) It is sometimes

> …arranged by the elders in the village who are worried about the childless couple. They will meet together to discuss what to do, and then the couple will be consulted to find out any problem, which is delaying them in having children. Traditional medicine is given, and the couple is given a certain period to work the problem out. When the medicine fails, they discuss bringing another man into the house.
>
> (Student quote – Cecilia Kamwana)

> 'This is done under maximum secrecy between the real husband and the sitting-in-husband'
>
> (Student quote – Gilbert Madimbo).

This step-in-husband is also called *fisi* because he comes secretly at night, as does the hyena. Supposedly, the wife will not be able to notice that it is not her husband who has come in during the night to have sex with her.

> When it is proved to be true that the husband is impotent the *fisi* business becomes habitual as long as the couple wants several children as it is believed that a family must have several children. This practice might involve several men, depending on the relationship between the husband and the *fisi*. Also, there may be some sort of exchanging of wives in compensation for the act.
>
> (Student quote – Gilbert Madimbo)

Having children is a serious issue in many African countries and it is important in the Chewa culture as well. Most couples consider childbearing one of their first priorities, as it has the connotation of accompanying wealth.

4.10 MARRIAGE RELATIONSHIPS

Polygamy is a common practice in Malawi. It is practiced for many reasons and is often seen as an indication of stature. Most headmen and chiefs are expected to have more than one wife as an indication of their importance in the community.

> The significance of this custom was that being a chief, he has many visitors and normally visitors are or must be entertained by the wives of the chief.
>
> (Student quote – Alex Kamowa)

> If a man chooses to have only one wife, he may be considered by others in the village community as being 'mean and selfish.'
>
> (Student quote – Chance Kalolokesya).

There are other reasons why it is widely practiced as well. One of those reasons has to do with the quality of a man in his role as husband. If a family has a daughter who is married to a respectable man who is treating their daughter well, they might be inclined to give this man another daughter as a 'reward' as a token of their appreciation for this good behaviour towards their daughter. This is practiced as the '*Skazi*' in the Ngoni Tribe and '*Mbiligha*' in the Tumbuka and Ngonde tribes of the Northern regions as well. This has a dual purpose of providing a good husband for their second daughter while they hope to prevent him from marrying other women and bringing more wives into the family that they do not know. This practice is also practiced in the Nkhonde Tribe, particularly among the royal and wealthy families, without the benefit of a formal marriage agreement. Instead these women, who must be related to the wife, are considered more in the role of concubines.

Another reason a man might seek an additional wife has to do with childbirth. It is widely accepted that following the birth of a child, a couple should refrain from sexual intercourse for at least one year. No one expects that a man should be required to refrain from sex during that time, so it is understandable that he should gain an additional wife to meet his needs (there doesn't seem to be any concern over meeting the sexual needs of the wife however). If the wife has only given birth to female children, the husband and wife may agree that he should marry another wife in order to gain a male heir. This can also be seen as a reasonable way for a man to continue fathering children once his wife is no longer of childbearing age.

Men sometimes see polygamy as a powerful tool to control their wives and families. A man may want to marry more than one wife as a measure of disciplinary action towards them.

> If you are not very careful with me, I will marry another woman.
>
> (Student quote – Alpheus Banda)

Such threats can be a warning to the wife to manipulate her behaviour and maintain the husband's sense of power in the home. Polygamy places many stress factors in the home, and on the wives involved in particular.

> It becomes very difficult for the polygamist to satisfy all his wives sexually as well as financially, therefore there are instances where by, one or some of the wives start relationships with other men in order to support her neglected (by the father) children and also to get sexually satisfied since she is ignored by her husband.
>
> (Student quote – Chance Kalolokesya)

Infidelity on the part of the wife can also be done as an underlying effort of 'retaliation to their husband's behaviour' in response to the hurt and rejection she feels.

(Student quote – Chance Kalolokesya)

4.11 CHOKOLO

One dangerous practice in this culture that deals with the subservient attitude towards women is the practice of *Chokolo*, which is otherwise known as 'widow inheritance', practiced in many of the local tribes, including the Chewa, Tumbuka and Ngoni. Chokolo occurs when a widow is expected to marry any of the relatives of the dead man. The decision on who should marry her is made by the senior members of the family without the consent of the widow who has no choice in the matter. There were some advantages to this practice when it was initiated, as the widow and children may get some protection and provision as the new husband assumes responsibility for their well-being. This situation is usually less than optimal however, as the woman will be entering the family as a second or third wife with accompanied low status (Banda 2002:2).

Although practiced in Malawi, *Chokolo* is common throughout Africa. For example, the Shona of Zimbabwe practice a very similar tradition with a subtle twist. The motivating factor for them is fear.

> They fear God the Creator *Musiki* and their ancestral spirits. If the young brother refused to marry the widow, there is a belief that he will be attacked by misfortune sent by their god the creator….The widower is to be given the youngsters of the deceased. The innocent young sister will come and stay with the husband of the deceased sister….They believe that all the

> sisters from that family will not be married unless one of the sisters commits herself to go and stay with the widower.
>
> (Zimbabwean student quote – Luxmore Mandevani)

Unfortunately, there are times when caring concern for the remaining spouse is not the motivating factor at all, but greed is actually the driving force behind this action. If the wife is left with property or possessions, the deceased husband's brother may be looking at this practice as an opportunity to gain wealth. His greed clouds his judgment so that he acts without considering what caused his brother's death, and whether or not it might infect him if he marries the remaining spouse.

This custom, which probably originated as a benevolent idea to come to the aid and assistance of those newly widowed who would have no way to care for their dependent families has much more ominous shadows accompanying it in this modern day. This becomes a very dangerous practice when one considers what the husband may have died from. If he died as a result of HIV/AIDS, then the probability is high that his wife will indeed be a harbourer of the disease as well. This has menacing implications for the new husband, who is trying to help her, as she will no doubt infect him as well. He will then infect his current wives, and a whole new family system will be doomed with this plague of HIV/AIDS. When presented with the fact of the threat of AIDS, the response is often one of denial,

> This is our forefather's way of doing it.
>
> (Student quote – Alexander Mfune)

4.12 GENDER ISSUES

Women have a subservient role to the man in Chewa culture, (as with most African societies). Women, who are generally the 'workhorses' of the family, are expected to cater to their men, holding them in a position of utmost authority in their lives. As an example, during mealtimes, the men are fed first, with what food remaining when he is finished becoming available to the wife and children. When a woman addresses her husband, she has to kneel before him in a subservient position. Many churches and NGOs in Malawi are addressing the gender issues and roles of

women in this country, and although there is more awareness, dramatic inequality continues to be a significant problem.

> *Mwambo* is a traditional cultural practice related to behaviour. It's a cultural practice teaching young people how to behave among the elders.... and teaching good manners such as kneeling down when speaking to an elderly person, etc.
>
> (Student quote – Alpheus Banda)

Even with the advances that have been made in recent years there remains a significant amount of gender inequality in most African countries, Malawi included.

During the girls' initiation ceremony in the Yao tribal tradition, which is almost entirely Moslem in its beliefs with traditional elements included,

> Girls are encouraged to submit to the wishes and demands of any man who wants to sleep with them. They are also taught to tolerate any sexual harassment such as rape without any complaint because they believe that men are more superior to women and in addition to this, girls are taught not to report any rape cases because they are sexual objects. They are strongly encouraged not to reject any man who wants to take them to bed because rejection of a man is seen as an open defiance and sin before God who made a woman for a man and not a man for a woman (Adam and Eve)
>
> (Student quote – Mirriam Mkuka)

4.13 POVERTY

If the woman does not take up with other men in the family, she is often faced with severe hardship and destitution. Poverty and sudden reduction in income (e.g. when a husband loses his job and the family suddenly loses his salary which they need for food, rent, school fees and health care), have led some women to the desperate situation of being willing to do anything they can to bring in the needed money to provide for their families basic survival. As a last resort some women turn to prostitution to keep the family going. This may be seen as an altruistic act on their part to provide for their families at the expense of their own health (Banda 2002:1).

Economic dependency and social norms make it hard for women and girls to deny men sex. Women account for 55 percent of the continent's HIV infections. Teenage girls suffer 5 to 6 times the infection rates of boys because older men prey on them. At the same time, women and girls tend to bear the main burden of caring for

sick family members, and often have less care and support when they are infected (Swarns 2000:10).

A lot of men in authority (e.g. in Government, NGOs, private sectors or business) abuse their powers through forcing their employees or prospective employees to have sex with them. Female job seekers who are desperately seeking for jobs in a very competitive job market may be offered the job on condition that, *you will become my girl friend.* In desperation to get a job many girls have given in to such men and accepted the job along with 'the conditions of employment' (Swarns 2000:10). It has been reported that as many as fifty percent of teachers expect sexual favours from their students as an incentive for good grades and special treatment. This is especially true in the upper classes of the primary levels (standards 6, 7, and 8).

Double standards reflecting societal norms regarding the appropriateness of sexual behaviour of men and women are similar to those in many other parts of the world. In Malawi, as in the West, a respectable woman is to remain faithful to her spouse, while obediently 'looking the other way' as her spouse is unfaithful to her. It is her obligation to be a quiet and understanding observer of this behaviour, realizing that men have 'special needs,' requiring frequency and variety in their sexual encounters. It is an unspoken test of manhood and a source of pride for a man to experience many partners prior to his marriage, where he takes vows of faithfulness with the expectation that infidelity is, if not expected, certainly allowed.

A story was related to this author of a Christian Malawian woman, married to a Christian Malawian man who was professionally successful by any world standard. When casual conversation with this woman turned to her children, the comment was made to her that it was fun to watch children grow up and develop into the adults God had planned for them to be. This woman turned to the speaker (who was of a Western mindset) and said,

> You really don't have any idea, do you? I have no hope of seeing my children grow up to adulthood. I fully expect to die from AIDS [from my husband] long before that.
>
> (Personal communication with researcher 1999)

In association with the problem of poverty comes the problem of idleness. When people are left with too much time on their hands, the will automatically seek ways to pass the time. Without purpose in life, one way of filling this void is in the brewing and consumption of local beers and other alcoholic beverages, either at home or in local taverns called '*Vilabu* (Lambya).' This is a way to numb the senses and help time to slip by unnoticed. One obvious danger with such activities is the loss of inhibitions, which normally keep behaviour in check, and therefore promiscuous behaviour is even more rampant with this element factored into the picture.

4.14 DENIAL

Denial of the problem of HIV/AIDS is a huge problem in Malawi (3.2), as well as in many other parts of Africa, where people refuse to acknowledge the source of their illness. Even for those who are willing to admit they are afflicted with HIV/AIDS, it is rare for someone to disclose that it was acquired in the traditional way, from high-risk sexual practices.

Another area of evidence to support the problem of denial in relation to the HIV/AIDS pandemic can be noted during funerals. There is a tendency in Malawi to report the history of the deceased during a funeral ceremony. In most cases the truth is not said concerning the actual cause of death, i.e. that the deceased died of AIDS. Instead of factual reporting in these matters, the one giving the account of death will usually indicate that the death was due to Malaria, Headache, or some other opportunistic disease. This is done to avoid embarrassment to the remaining family. This accepted practice continues to foster the denial in the entire community.

A random survey conducted by *The Malawi Insider* showed that the majority of people do not want to know their HIV status (Ligomeka 2002). Most argued that once someone tested positive, they would die prematurely. Alfred Chanza of Kawale in Lilongwe said it this way,

> In my case, I will never go for an HIV test no matter what. I have seen so many people who went to that test dying just months after testing positive because knowing you have the virus will psychologically kill you just like that.

Most of the men interviewed by *The Malawi Standard* said they had multiple sexual partners at some point in their lives and could have been exposed to the HIV virus then. For that reason they would not go for a test lest they came out positive. One journalist working for the Malawi Broadcasting Corporation shared his feelings in the article (Ligomeka 2002):

> Until recently, I was one guy who always had two or three partners even though I have been married for six years. I have changed my behaviour because I have seen many people die of AIDS but I will not go for an HIV test. All I am doing now is to live positively and for that I do not think I need to know my HIV status.'

This sense of denial carries the idea of the proverbial 'ostrich with its head in the ground,' as people respond as if it is not a threat of affecting their lives at all. When they are able to continue to deny the existence of the possibility that they are infected with the disease, they continue to neglect taking the necessary precautions to prevent the further spread of the disease. Those in the more remote villages tend to:

'think that AIDS does not exist or that the disease is for the town people and that they can't catch it.'

(Student quote – Sullivan Kenneth Kandulu)

In addition to the denial described above by those who have the opportunity to understand the problem of HIV/AIDS in their culture, there is also an additional factor, which contributes to this problem (3.3).

> This is the fact that many people, particularly those in more outlying areas, have not had the opportunity to get accurate information and are therefore forced to believe what is often dangerous misinformation. Some of the tribes, such as the Lomwe have a tendency to shun outside information and educational opportunities, calling this the 'White man's culture' as education is commonly called. The people of the society they always think of simple life whereby the duty of the men and women is agriculture and marriage and with this kind of philosophy they also tend to limit the mind of young ones, hence it is difficult when it comes to change of attitudes… A lot of people believe that AIDS is not real. They argue this from the fact that their ancestors and forefathers never knew it. They do believe that it must be certain form of infection that has come into effect because there is moral decay and that people have abandoned the worship of ancestors. Some have boldly professed that this disease does not exist.

(Student quote – Sean Kampondeni)

> Instead, many people 'put their trust in the charms, witch-doctors, and when a person gets sick with the HIV/AIDS virus, they have the concept that he/she has been bewitched.'
>
> (Student quote – Leisten Ew Nashire)

4.15 THE WORKFORCE IS DYING

Another significant impact of HIV/AIDS in Malawi has to do with the country's workforce dying, compounding to the already overwhelming poverty crisis. The *Africa Journal of Evangelical Theology* cites statistics in Zimbabwe (which can be applied to the surrounding countries such as Malawi as well) that the life expectancy is projected to drop from 61 to 33 years and 80% of those dying with AIDS are workers between the productive ages of 20-50 (AJET Ed. 2000:103). This spirals downward as funds that would have normally gone into development of the church and the country are being funnelled away to care for skyrocketing needs due to increased sickness, orphans, etc.

The Joint United Nations Program on HIV/AIDS (UNAIDS), International Labour Office (ILO) economist Desmond Cohen said in a July 11 press briefing (Porter 2002),

> 'nations can not achieve the goals of sustainable development if they continue to lose the people who know how to run the machinery of civilized society. 'How (do you) keep schools functioning, or transport systems functioning, or water supplies functioning, or police services functioning when 20-30 percent of the people you have trained are, in fact, dying of HIV/AIDS?' Cohen asked rhetorically. Cohen says the ILO analysis, focusing on the most seriously affected nations in Sub-Saharann Africa, found that up to 30 percent of teacher positions in Botswana are unfilled, largely because of deaths from AIDS. In the same country, predictions are that 40 percent of health workers could be lost to the disease over the next ten years.

Cohen goes further in depth regarding the economic ramifications of HIV/AIDS in the general population by citing flaws in the methods of estimating the cost implications of AIDS. One example which must not be overlooked is the reality that when estimating the gross national product for a given country, the contributions of women and all they do in the supportive traditional family roles have not usually been factored in to the equation. When these contributions to the fabric of society are

lacking, they will be sorely felt as the effects of AIDS strikes deeper into the female population of Malawi and other African nations.

Overall predictions for labour force losses due to HIV/AIDS in Malawi reflect a loss of 10.7% by the year 2005, with an increase up to 16.0% by the year 2020 (Beresford 2001). This affects not only those who work outside of the home, but also impacts the vast majority of Malawians who are subsistence farmers. Overall in Africa, it estimated that there would be reductions of 61 per cent for maize, 49 per cent for vegetables and 37 per cent for groundnuts. The impact of AIDS reaches beyond the growing capacity of farmers and hits long-term agricultural capacity as well. Livestock is often sold to pay funeral expenses, and orphaned children often lack the skills to farm or look after livestock in their care (Beresford 2001).

An article in Malawi's *The Nation* describes the impact HIV/AIDS is having upon the hunger and poverty situation in Malawi. Country director for The Hunger Project Malawi, Callista Chimombo says (Mwalwimba 2003),

> The organization's mission to ensure sustainable end to hunger and poverty is being undermined by the HIV/AIDS scourge. She goes on to say, HIV/AIDS is affecting food production in the country because productive labour force is forced to stay home and look after infected people instead of committing [themselves] to agricultural and income generating activities.

4.16 URBAN CULTURAL CHALLENGES

The villages under study for this paper lack many of the fibres that keep the more rural villages strong. Many of the people living in Chimbalame and neighbouring villages are of a much more transient nature than is typically found in a more traditional village setting. Located on the outskirts of Lilongwe, Malawi's capital city, these villages attract many who have left the more traditional village style of life in hopes of finding more opportunity in the city. Leaving their homes and support systems, they find themselves living in a situation foreign to what they have grown up identifying with in their home village. As they raise their own families in this intercity village situation, their children lack the strong family ties from which the society is based. Without the accountability that accompanies the traditional village life, people find themselves in a position where their behaviour is no longer under the control and influence of the tight knit family structure.

> The consequences of this modernist[24] movement are that the individual becomes the centre of people's attention and concern. The individual is concerned with his/her own survival and is seldom concerned with one's neighbour. This also has an impact on support structures, such as the family. The family has disintegrated. This is seen, for example, in the rapid increase in the number of single mothers, single fathers, street children, homeless people, and in the breakdown of public morals (Zulu 2001:5).

This allows them the opportunity to experiment in behaviours and actions that they may have never considered participating in while in their more protected family milieu. In some individuals, this leads to an erosion of values as they realize that what might have been considered inappropriate behaviour in their more traditional family setting is overlooked or not even noticed as they fade into faceless masses of a large intercity village community. The continuing interaction of the family works to help keep members of the community acting in a more traditional, predictable behaviour in order to avoid the ire of the group. This same customary interaction and the strong hierarchical structures of the long-established family serve to promote behaviours that will meet with the group approval. Approval and acceptance by the group is foundational in the sense of personal value and identity in Malawian society. This also works in a reverse manner as individuals respond in appropriate means while participating in the group as an attempt to avoid bringing disgrace upon the family.

In addition to the threats placed upon the family unit by dislocation of the family members, there is another serious threat with potentially more dangerous ramifications to the family in Africa, and in Malawi in particular as it attempts to deal with the compounding threat of HIV/AIDS. Charles W. Colson quotes statistics citing 'an estimated 10.4 million African children lost both parents to AIDS during the 1990s. That number is expected to double or triple by 2010' (Colson 2000). This brings to light the ever-increasing problem of orphans. Orphans are a growing, multi-faceted problem in all parts of Sub-Saharan Africa. Due to the devastation of AIDS upon the portion of the population most noted for not only its potential contribution to the workforce, but also those in the prime childbearing years, countless numbers of children are being left without parents. Even with the built-in support structure of the

[24] Although not the focus of this research, the post-modern movement that has so affected the West has not left the developing nations unscathed. As is evidenced in this quotation, it has already had a profound effect on the fibre of the family and community makeup.

extended family system, which under normal circumstances would be able to absorb these children, the problem is becoming overwhelming. Parents are dying, often leaving no one remaining in the family to care for the children.

An article published by National Council of the Churches of Christ in the U.S.A. states that,

> Orphans are at far greater risk of malnutrition and unlikely to receive the health care or education they need. They are also more likely to engage in hazardous labour, including commercial sex work, which in turn exposes them to greater risk of HIV infection. Infant mortality is doubling, child mortality is tripling, and life expectancy is plummeting by twenty years or more.' (Church World Service 2000)

Malawi has one of the lowest life expectancies in all of Africa, and therefore in the entire world. Depending upon which source you are comparing, the life expectancy for Malawi has been listed in the low thirties range. Children are left to fend for themselves with the only tools for their survival being their own wit and cunning as they try to find the basic life necessities of food and shelter for not only themselves, but often for younger siblings as well. Not only does this increase crime from the children themselves, many will find that selling their bodies is one of the few ways they can earn money for their continued existence. This of course works to threaten their survival as they participate in such high-risk behaviour, leading to the devastation of HIV/AIDS in their own lives.

This discussion on urban cultural challenges demonstrates the underlying causes of the erosion of traditional values and safeguards that might normally be present in a traditional village and are not necessarily found in the villages under study. Due to this lack of accountability and instability, high risk behaviours which might have come under the control and influence of the family group and subjected to the individuals sense of morality and their own personal conscience. This sense of individual responsibility is foreign, and in many ways in opposition to, the community model of interaction and accountability. In these intercity villages, the new model of the 'nuclear' family is replacing the old established values of the extended family, which have traditionally included the grandparents, aunts, uncles, etc.

Aspects of city living bring other changes that threaten the fibre of the rural Malawian as well. The time-honoured tradition of the family working together in the planting and growing of food for ones family, has been replaced by a different set of work ethics and values in the city as individuals now compete for jobs in various sectors and businesses. Many are disillusioned as they find the number of jobs available failing to match the large numbers of people seeking them. Wages are low, so that even those fortunate enough to find consistent and reliable employment struggle to provide their family's basic needs with the income they earn. Theft and crime are high in these areas, so that personal security is a primary concern. The villages under study in this project are collectively nicknamed 'thieves village' due to the high rate of crime in this community.

4.17 CONCLUSION

The cultural practices described in this chapter are deeply ingrained in the people of Malawi, and prior to the pandemic of HIV/AIDS these kinds traditional practices were not life threatening. With the threat of annihilation looming over them, the people of Malawi, and indeed those people throughout Sub-Saharan Africa, are beginning to re-evaluate some of their traditional practices. Due primarily to the Christian influences which have been felt in this country since the early days of Christian missions beginning with David Livingstone, many of the customs described in this chapter are diminishing; some to the point where they are practiced only in the most remote areas where the Christian influences have had the least amount of impact. Other practices are being re-evaluated, and if not discarded completely they are being revamped and restructured in such a way as to keep the rich cultural aspects and purposes, with revisions designed to eliminate the dangerous practices which have been associated with them.

The struggle of the church to discern God's will for their present situation (1.4.10.6) has not been easy. One shining example of these types of changes can be seen in the area of female initiation practices. In many areas the churches have undertaken to look for ways to keep the foundational messages that have been valued in this important cultural practice, such as the instruction given by the older women

(*alangizi*) on behaviours, modesty and interpersonal relationships. Transforming the sexual focus of this important time in a girl's life to one of mutual respect with sexual abstinence before marriage, coupled with faithfulness afterward, has had many positive outcomes. Not only has it served to reduce the spread of AIDS, but it has also served to enhance the family structure, as well as impacting the self-concepts and attitudes of these girls. This leads them to the discover the empowerment so desperately needed among African women to see themselves as individuals capable and deserving of value and respect.

Examples such as this demonstrate the beginning of a softening of the church's approach to the problems addressed in this research; dealing with the attitudes of the church towards the HIV/AIDS community. Even with shining areas of hope such as these, there is still much work to do regarding the acknowledged problems of alienation, estrangement and prejudice which have far too often been the identifying factors regarding the church's relationship with those infected or affected by HIV/AIDS, instead of the opposite – the love of Jesus Christ (5.4).

These chapters have sought to provide the reader with an in-depth understanding of the multifaceted problems involved in the pandemic of AIDS in relation to the response of the African church as it seeks to demonstrate the Christian mandate to demonstrate the love of Christ to a lost and dying world. Assessment of the unique factors demonstrating the complexities of the issues surrounding HIV/AIDS in Africa has been done by examining the historical response of the church in general, as well as the African church in particular. Building upon the historical perspective, the cultural practices common to many African communities; and then more specifically, the cultural practices in the Chewa culture of Malawi specifically, have brought some light to the complicated issues involved in this most difficult problem. With this foundational background, it is now time to turn to the theological implications involved in these complicated matters which will be dealt with in chapter five, which will then lead into the specific methodologies and conclusions which can be drawn from a study such as this.

Chapter 5
The Theological Implications of Applying Christ's Mandate to Love in the Context of HIV/AIDS

5.1 INTRODUCTION

In the preceding chapters, the focus has been upon the diaconiological approach of society at the macrolevel of the world, with particular attention then turning to the ecclesiastical approach at the macrolevel of the church in general as it has addressed the crisis of HIV/AIDS that enveloped it. As a whole, it has been demonstrated that the church has mournfully missed the mark (1.1.1) as it sought to be a lighthouse of hope and compassion to those suffering from this dreaded scourge; and has instead developed the perception by most of those suffering with HIV/AIDS and their surrounding circle of family and friends, as cold, judgmental, uncaring, and unloving - holding no promise for them (Greyling 2003).

In the initial chapters of this dissertation, broad vantage points such as the response of the church in general as it regarded the HIV/AIDS pandemic have been inductively addressed from the human perspective. Chapter three examined the generalized and unique attitudes of people within this larger sphere with efforts to observe the conceptualisation, or the thought processes involving the HIV/AIDS phenomenon in Sub-Saharan Africa. In chapter four, attention was contexualised to understand the Malawian mindset and how attitudes have been formulated concerning the issue of HIV/AIDS. It is now time to look at HIV/AIDS and the issues that surround it from the divine perspective. How does the crisis of HIV/AIDS touch the heart of God?

Theological methodology will be explored in this chapter, with particular emphasis on the role of the local faith community as it seeks to develop its own contextual ecclesiology in relation to its understanding of Christ's command to love one another. This will be done with particular focus on how that mandate for the church to love, applies to the current HIV/AIDS epidemic. Using the theological hermeneutic described earlier in this work (1.5); this chapter will approach the theological aspects of love and its counterfeits from this evangelical framework. In

relation to the methodology discussed in 1.4.10, this chapter endeavours a correlational hermeneutical dialogue by contrasting the 'exegesis' of the context, described in chapters 2 - 4, with an interpretation of the normative source of Scripture (1.4.10.5) and identity (1.4.10.1). The theological implications of Christ's mandate to love are related to the attitudinal problems of the AIDS context.

In the beginning chapters of this research, the historical responses of the Church as the body of Christ and His representative here on earth have been examined. Examining the reaction of the church as it responded to this crisis, one does not see the attribute of love immediately shining forth; yet it is that very attribute of love, if no other that should be used descriptively when depicting the qualities of the church. Following the ecclesiastical and historical chapters dealing with the contextual situation in Africa came chapter four, which focused on various customs and traditions as described relating to Malawi in particular within the context of dialogue concerning the HIV/AIDS situation. Even in these circumstances, which oftentimes seem so far from the concept of love, the underlying issue of love and acceptance amongst ones family and peers is the motivating factor leading to the disastrous practices described.

This chapter will address the theological challenges of the church as it deals with an anthropological approach on the microlevel of person (Heitink 1999:88), seeking ways to communicate the love of God in the individual setting. As the church interprets its position and role in the present crisis, it evaluates and restructures its response thereof as a hermeneutical activity. The faith community is therefore a community of interpretation (Fowler 1995:5) as it recognizes these new challenges and patterns of response and praxis in light of the application of love in obedience to God's command. This discovery process will result in the intentional practical theological engagement and praxis that is both hermeneutical and correlational.

Systematic theological studies have approached such questions using a 'top down' method to determine God's position on a given point, often beginning with the attributes of God as applied to a given situation or circumstance. Hendriks (2003:2.11) exposes a new trend in the application of doing theology as he describes a fundamental shift in the methodology being used.

> Previously, theology was done in a way that boils down to 'obediently analysing and systematizing' our faith tradition. We now realise that, while this approach is not without merit, another way to do theology is to 'participate obediently' in God's missional praxis.

Browning cites the point of departure from systematic theology as the time when the other dimensions are brought into the picture. Practical theology entails questions about the particular, concrete situation in all its particularity (Browning 1996:55).

> This consists of the special histories, commitments, and needs of the agents in the situation. It consists of the interplay of institutional systems and how they converge on the situation. And it includes an analysis of the various religio-cultural narratives and histories that compete to define and give meaning to the situation.

Dingemans brings the approach of practical theologians into focus as they have been more and more influenced by the social sciences,

> In recent decades practical theologians worldwide have agreed on starting their investigations in practice itself. Practical theology has become descriptive of and reflection on the 'self-understanding of a particular religious tradition'. This approach moves from practice to theory then back to practice (1996:83).

De Gruchy relates the importance of 'doing theology' as opposed to the mere 'reading of theology' in order to emphasise the connection between theological reflection and Christian witness or mission (1.4.10.1) in the world (De Gruchy 1994:2). Theology addressing the love of God, or the mercy of God; is certainly of value but how do these answers relate to the felt needs experienced at the grass roots level? How does it answer the questions of the individual sitting alone in their hut, feeling estranged, alienated and ostracized from those he or she loves -- because they wear the label; and carry the stigma and prejudice associated with the diagnosis of AIDS? How does this abandoned and rejected person understand and apply the theological prepositions that might be applicable to their situation? How can they relate to God in a meaningful way that will address the devastating felt needs that enclose and engulf them? When the best they can do is cry out from the depths of their soul with the word of Jesus, 'Abba Father' (Gal 4:6), as they search for some sense of meaning in their suffering; does theology have an answer that will touch the torment in their soul?

Heitink links the essence of this dilemma with the central hermeneutical problem faced by practical theology: how to connect the divine reality and the human reality at the experiential level (Heitink 1999:193). The pneumatological basis of a theological theory of action is his point of departure in the application of praxis in the church.

On a cerebral level, theological study attempts to answer the questions of the seeker as he or she seeks to understand who God is, and in this study the more specific question of *how* God's love translates to man as He relates in the life of the individual believer. Neat and tidy answers provided by such an endeavour are enough to provide a sense of appropriateness and order to the world for many. It is when tragedy strikes at the heart of a man or woman, that the classic answers which had previously sounded very lofty and appropriate, suddenly seem to ring hollow and inadequate. It is at these times that the believer needs a way to apply God's love to the chaos of their life in such a way as to create order and a sense of purpose.

This can be particularly true in the African context. Osadolor Imasogie gives an observation of this (Imasogie 1993:68),

> For years many sensitive pastors/theologians in Africa have noticed that in times of existential crisis, the average African Christian reverts to the traditional African religious practices. In some instances, pastors/priests (theologians, if you please) have themselves fallen victim to this almost irresistible reaction to existential confrontation.

Imasogie accuses the mechanical, pluralistic western worldview of the missionaries as the causative factor for this obvious dualism. Embracing post-modern thought the western worldview did not include the reality of the spiritual dimension experienced by the African. The spirit world, which is an obvious reality to the African is not only misunderstood by the *azungu* (white western) missionary, its importance as part of the foundational belief system that is usually incorporated into the Christian faith accepted by the African is not recognized. 'Many African Christians perceived the 'god' of Christianity as a 'stranger-God,' the god of the white man, who is unfamiliar with the local spiritual problem (Imasogie 1993:69). The scientific mindset of the *azungu* missionary has so permeated their thought processes that it is difficult for them to comprehend the importance placed on the spirit world of the African. This chapter will therefore attempt to analyse the African context of this

crisis of HIV/AIDS with recognition of the spiritual realities that are so crucial to Africans' existential comprehension of Christ.

In all contexts, theology must be more than a way to organize and understand God. Theology must be a way to convey the answers God brings into the desperate situations that are faced everyday by individuals everywhere as they struggle in the process of surviving life. How can the individual mentioned earlier who is alone and afraid 'feel' God in a meaningful way? To illustrate this point, there is a story of a child who was trying to understand who God was. In asking various people who and where God was, he was given answers like 'God is all around you', 'God is in your heart', etc. Unsatisfied with these lofty answers, he shouted in frustration, 'But I want a God with skin on!'

It is the pneumatological aspect of theology that allows a connection between the theoretical concepts of God and the reality of His presence and influence in the lives of individual believers. The relationship of the Holy Spirit in the lives of believers is key. Heitink (1999:193,4) describes this essential work of the Spirit as,

> The Spirit, as the firstfruit, is God's eschatological gift (Rom 8:23) for the renewal of creation. The Spirit opens a new kind of existence in the here and now (2 Cor 5:16), characterized by freedom (2 Cor 3:17)…this is in total contrast with every form of patronizing or condescension. The church with all its members participates in the gifts of the Spirit, to be equipped for its mission in this world (1 Cor 12:4ff.). The Spirit leads the church toward the truth (John 16:13) and convinces the world of sin, righteousness, and judgment (John 16:8, 11). These presuppositions are basic for a faith of the Christian church.

The works of the Holy Spirit in mankind set apart Christianity from all other world religions. It is the infilling of the Spirit that allows God to work through an individual to touch those who are suffering with pneumatological synergism (Veenhof 1987 as described in Heitink 1999:194). To understand this relationship in the depths of the despair experienced by the AIDS sufferer, exploration must begin not starting with God and working down to man, but rather it is necessary for one to start with anguish of man and explore what he finds as he lifts his suffering eyes up to God.

It will be the purpose of this chapter to discuss the normative attribute of love (1.4.10.5) as it pertains to the HIV/AIDS crisis, which is a direct result of man's attempt to redefine love by standards of the world's understanding as opposed to God's perfect design. Particular attention will be given to the aspects of love, as used

by the evil one to counterfeit God's precious gift of love, confusing His people to the point were unloving attitudes and actions are actually performed in the name of Christ by the Church as it seeks to serve Him, which in turn contribute to the magnitude of the AIDS crisis. This perverted response of the church has damaged its witness to the world at a time when it is needed most.

5.1.1 God's Communicable Attribute of Love as it relates to the HIV/AIDS crisis.

In the secular world as well as the sacred, 'love' has been the subject of much time and debate. Everyone, from poets to theologians claim that love is the greatest thing, yet even after thousands of years human language seems incapable of fully describing this elusive concept. Although the point of this dissertation is not to research the characteristics of God, it is nonetheless essential to attend to this all-encompassing attribute in order to give a balanced view on the HIV/AIDS crisis. It is because God *is* love that it is essential to look at this pandemic with the lenses of love, and more specifically to examine the point of departure from God's plan through the warped and distorted lenses that are often used to justify the actions done in the name of love; actions that ruin God's perfect design and cause the corruption of His plan of redemption.

Care must be taken to avoid the trivialization of this word, which is so overused in the English language. Phrases such as 'I love chocolate!' and 'I love my puppy', and 'Didn't you just love that movie….?', along with catchy song lyrics such as, 'all you need is love', have relegated the value of this most precious gift from God. Biblical love is not a platitude. It is not an attribute that stems from any shallow attempt to gain that 'warm fuzzy' feeling the world often associates with love. Biblical love, as commanded by Scripture does not come from man's natural abilities, but rather it is a reflection of the divine love that lives within the Christian. Trying to love from merely human ability results in a warped understanding of this attribute of God. It is only with this deep, abiding love that comes from God Himself that man can truly demonstrate genuine biblical love, the kind of love that goes beyond feeling and permeates every aspect of ones being.

In his text on Biblical Ethics, McQuilkin tackles the subject of love as the first issue to be understood in the area of biblical ethics, or the ways in which Christians should interact with each other and the world. He describes love as:

> There are both internal and external elements in the biblical concept of love. Love is a noun that may indicate a particular kind of feeling, but it is also a verb that emphasizes how we should behave. The internal aspect focuses on emotion, disposition, and motive. The external aspect focuses on volition, choices, actions, and a way of life.
>
> He further defines biblical love as:
>
> 1. Biblical love, then, is an affectionate disposition that motivates the lover to consistently act for the welfare of another, whether or not the other deserves it or reciprocates.
> 2. To love those who love us is nothing great. It is when we choose deliberately to love those who do not deserve it that we have reflected divine love. (McQuilkin 1989:4, 10)

Quoting R. Niebuhr, Browning defines Christian love as the inner character of God and the love of Jesus. Love as *agape*[25], is self-sacrificial love, the love that takes on itself the suffering and sin of others (Browning 1996:147-148). He goes on to say that sacrificial love is the essence of God and the perfect norm of the Christian life.

The Westminster Eternal Decree Love describes love as an immutable attribute of God (Westminster Confession of Faith 1646):

V. Those of mankind that are predestined unto life, God, before the foundation of the world was laid, according to his eternal and immutable purpose, and the secret counsel and good pleasure of his will, hath chosen in Christ, unto everlasting glory, out of his free grace and *love* alone, without any foresight of faith or good works, or perseverance in either of them, or any other thing in the creature, as conditions, or causes moving him thereunto; and all to the praise of his glorious grace.

Because God is love, it is essential that the nature of His love be understood as it relates to the issues surrounding HIV/AIDS. In order to understand this more fully, the hermeneutic-communicative character of love, referring to the verbal and nonverbal interpretation of written and spoken texts and their verbal and nonverbal communication (Van der Ven 1998:41) as it relates to basic functions of the church praxis will be examined (1.4.10.5).

[25] Strong's concordance defines *agape* love as: (G 26). agape, ag-ah'-pay; from G25; love, i.e. affection or benevolence; spec. (plur.) a love-feast:--(feast of) charity ([-ably]), dear, love.

God's eternal nature is interwoven in all aspects of the Bible, coming into focus in 1 John 4:8, where John emphatically states that 'God is love'. This tiny sentence is immense in meaning as one gives consideration to the fact that God does not only love, God not only loves, but God *is* love. Without God's demonstration of love to mankind through general and special revelation, there would be no way to grasp such a concept. All that can be known about love comes from God Himself. It is through God's missional praxis (1.4.10.1) that the hermeneutical and correlational dialogue is developed to guide the church and the world as they interrelate to more fully comprehend the nature of God as creator, redeemer and sanctifier of the world. Throughout the entire Bible, the theme of love runs strong and consistent. From the very beginning, God's love is demonstrated to individuals through the creation story, to the family of believers. The laws and Covenants outlined in the Old Testament give credence to His unfaltering loving concern and compassion for His people through the ages.

Grudem describes God's love (Grudem 1994:199), and our relation to it, as:

> We imitate this communicable attribute of God, first by loving God in return, and second by loving others in imitation of the way God loves them. All our obligations to God can be summarized in this: 'You shall love the Lord your God with all your heart, with all your soul, and with all your mind…. You shall love your neighbour as yourself' (Matthew 22:37-38). If we love God, we will obey His commandments (1 John 5:3) and thus do what is pleasing to Him. We will love God, not the world (1 John 2:15), and we will do all this because He first loved us (1 John 4:19) (NIV).

Equating the demonstration of love with the actuality of our Christianity allows our actions to be effective spiritual indicators. Therefore, if our life is not indicative of this normative attribute of God (1.4.10.5), we are in effect denying the very existence of God in our lives. The concept of denying God, by acting or thinking in an unloving manner, may have more intricacies than first apparent, especially when considered in relationship to the issues at hand: alienation, estrangement and prejudice as they relate and lead to the problems and difficulties revolving around the HIV/AIDS pandemic. John left no doubt about the relationship of love and belief in God. Whoever hates his brother is in the darkness (1 John 2:9). Whoever does not do right and love his brother is not of God (1 John 4:20). 1 John 4:8 is the climax: ' Whoever does not love does not know God, because God is love.' (Holman: 1992)

Even though everyone needs to feel the love of God, those affected or infected by HIV have a more immediate and intense need for the love of God to be manifested in the lives of those in the faith community towards them due to the impending and mortal nature of the disease. It is God's design that His love would be manifested through His children. It is His plan that those seeking Him would find Him; it is therefore the responsibility of the church to provide opportunities for God's love to be demonstrated in real, tangible ways.

5.1.2 The Significance of Christian Love

In the New Testament love culminated in the person and work of Jesus Christ. A key to understanding the importance God places on love can be seen in the words of Jesus Himself as described in the Johannine writings, which magnify the significance of love. One of the most quoted verses in the entire bible focuses on love, '*For God so loved the world, that He gave His only begotten Son, that whosoever believes on Him shall not perish, but have eternal life'* (John 3:16). Jesus moves from beyond using love as a description of God's response to mankind, to His teaching on love as the new commandment (John 14), centralizing His teaching in the same way as the Ten Commandments centralized the teaching of the Old Testament. The Ten Commandments are the backbone of the Old Testament law, forming the structure by which the entire Jewish systems originated. Knowing this understanding described the paradigm of His listeners; Jesus assigned this same level of importance to the new law. This was not a new concept for them to consider, it was a command they were expected to obey (1.4.10.5).

Jesus' directive to love one another gives us insight into the nature of Christian love as it relates to the faith community. What is commanded is not an emotion; it is the disciplined will to seek the welfare of others. Jesus speaks with the authority of the Father, the only One with authority to make such demands of men and women. Jesus speaks as the incarnate Word (John 1:1,14), crediting Him with the authority to give conditions for discipleship.

Therefore, it is because God *is* love, that the Christian as an individual and even more as the body of believers composing the faith community, finds its identity in God's missional outreach of love (1.4.10.1), which should be a natural outpouring

of the Spirit within. This outpouring of love by the church must reach out to the world with the love of Christ. The love, compassion and sense of community that was being demonstrated in the early church (Acts 4:32-5:16), worked as a powerful magnet to draw people into the faith community.

The African attribute of *ubuntu* (4.3; 5.4.1), mirrors many of these same qualities with the strength of community and cohesiveness. The African church can use this similarity in focus effectively to serve as a bridge, linking this known cultural practice with what was happening in the early church. This will facilitate the understanding of the concept of love and community being commanded by Christ.

As a radical in his day, Jesus continually shook-up the comfortable belief systems of those who eventually sought to crucify Him. He exposed the hypocrisy they demonstrated by confining their responsibility to the overt actions they displayed instead of being accountable for the motivations of their hearts. He addressed these issues in the Sermon on the Mount, which represents Jesus' expectations for those who have followed Him as disciples, both ancient and modern (Holman 1992-94) (Matthew 5:21-22). Murray addresses the externalism that Jesus was trying to correct, by instead focusing attention on the emotions of the heart and the words of the lips (Murray 1957:160). The significance of Christian love, as it relates to these words of Jesus, is in its depth and genuineness. He used the idea of murder in these verses to demonstrate that the concept is much deeper than to simply not actually kill someone, but rather involves the attitudes of the heart. Analogous to this illustration involving murder, is the hypocrisy associated with substituting platitudes for the deep, abiding investment of one's self in the commitment required for genuine love.

5.2 LOVE AS THE PRIMARY MOTIVATOR OF LIFE

Among the strongest drives found in man, the need for social interaction, or more specifically – love and acceptance, is certainly one of the strongest. There is an inner need deriving from the necessity for a sense of satisfaction that can only be achieved by the realization that he has a place in society and he, in himself, is of some social value (Ruch ca. 1960). From earliest childhood, many parents use social isolation as a form of discipline, knowing that depriving a child of this intrinsic need

for interaction with others will stimulate desired behaviour as the child attempts to do whatever is necessary to rejoin the group. While a child is born without any social skills, and admittedly considers his or her needs to be the centre of the universe; as he or she matures into adolescence there is nothing more important to a developing adult than social interaction (Wong 1990). 'There is no question that… one of the most powerful social influences on children's behaviour is the peer group' (Barlow 1992).

> Basic Human Needs are generally satisfied through the normative participation in the social practices of a community. Cultural displacement leaves the displaced person without access to his old cultural practices and without the personal characteristics required for the normative participation in the host culture. The consequence for the individual is the experience of significant basic human need frustration and resultant negative psychological and psychophysiological effects (Alsworth 1980).

As an example of this, the early penitentiaries in the United States were designed on the principle of social isolation as being one of the most devastating forms of punishment. As the public became more aware of this inhumane treatment there was a public outcry against it. As prison reform evolved the milieu inside these prisons, many changes have come. Prisoners now have many amenities available to the common public but the one thing that remains, as a standard of punishment is isolation and restriction from their normal family and social relationships. Indeed, 'solitary confinement' is the way to punish those who are already in the penal system (Pelican Bay State Prison, ca. 2000).

This has been outlined in order to underscore the essential importance of the primal need of each person to be able to find loving interactions with others. Buying into the lie of the devil that love is equated with sex, many people (particularly adolescents and young adults, but it is certainly not limited to them) turn to sexual encounters as a means of finding love and acceptance. The current statistics of AIDS in Africa, where it is a primarily heterosexual disease gives ample evidence of the risks people are willing to take to find 'love'. Although it is true that infection rates are reduced with concentrated efforts at education and awareness, the sad fact remains that AIDS is particularly high amongst those who are educated and understand the risks involved with such behaviours, but are willing to take those risks in order to feel loved.

5.3 EFFECTS RESULTING FROM A MISUNDERSTANDING OF THE NATURE OF LOVE

One does not have to look far in Western culture to see the distortions of love that are being presented as 'true love'. Using the very same tactics he used in the Garden with Adam and Eve, and again repeated with Jesus Himself, the devil is once again twisting the truth with just enough of a lie so that it presents with a sense of legitimacy, while destroying the beauty of the truth. Although there are many distortions being presented, a particular triad of lies is specifically applicable to the HIV/AIDS crisis under study in this research.

The first of the triad follows the post-modern paradigm of relativism, where love as *commitment* has been replaced with the whims of one's feelings. Wedding vows which once firmly proclaimed 'until death do us part', have been replaced with lines such as, 'as long as we continue to love one another'. This erosion of the sense of love as a lasting commitment can be seen in such appalling divorce statistics as found in Divorce Magazine (Divorce 2003), an Internet Magazine geared specifically for 'Generation X'ers':

Median Duration of Marriage (1997)	7.2 years
Likelihood of new marriages ending in divorce in 1997:	43%
Percentage of marriages that break up within first 15 years:	43%
Percentage of first marriages that end in divorce in 1997:	50%
Percentage of remarriages that end in divorce in 1997:	60%

Although the above figures represent divorce in the USA, it is also a growing phenomenon worldwide. Even in Malawi where such figures are not readily available, one only has to listen to the students at African Bible College as they give their testimonies, as freshman to realize there is a high divorce and separation.

The second aspect of the triad of lies involves the misconception of relativism, causing an equally if not more damaging fallacy. One only has to turn on a television, listen to the radio or read a newspaper or magazine to be hit with the frontal assault of the propaganda: love equals sex. Consumerism has found the goldmine in the message - 'sex sells'.

The third characteristic in the triad relates with the second. By twisting the truth of love and equating it with sex, the enemy further corrupts it by removing the beauty and function of sex as designed by God and warping it through areas of homosexuality, pornography, illicit relationships etc.

It is not the purpose nor the intent of this research to examine all of these issues comprehensively, but rather this section has been added to provide a brief descriptive overview of the perverse nature of the lies and tools the enemy has used in his war against God, and how these areas have served to further the damage of HIV/AIDS as it destroys the individual, the family, the community and even the world. In each of these areas, people have been fooled into believing the lie with the understanding that by doing so, they will receive love and acceptance they so desperately seek.

If the consequences of buying into evil such as this resulted only in painful disappointment for the individual, it would be bad enough. It is when one gives consideration to the magnitudes of the HIV/AIDS pandemic, it then becomes obvious that believing such fallacies leads to suffering and death unparalleled. The penalty for partaking in these forbidden fruits leads to such unbearable agony on such a massive scale, that the world is reeling and unable to stop the downward spiral that threatens to destroy it.

5.4 LOVE IS DISTORTED AS DEMONSTRATED BY THE CHURCH AND INDIVIDUALS

Seeing how the distortion of love exacerbates the problems leading to the spread of the HIV virus, the next consideration is to examine how a warped image of love, as a demonstration of God's love to the world, is hindering if not overtly destroying, the mission and witness of the Church as it seeks to fulfil the mandate of love given to it by Christ.

Admitting to a misunderstanding of God's plan for the faith community to love those suffering from HIV/AIDS is by no means easy. It requires a conviction by the Holy Spirit along with a willingness to admit that one is wrong. Wood (Wood & Dietrich 1990:235) suggests that many of those living in high lifestyles contrary to

biblical principals try to justify ungodly actions by clinging to their misguided hermeneutic of love. Those who do this would say,

> Love is the overriding emphasis in Scripture; therefore, *any* love between people is acceptable.

To this obtuse statement Wood answers:

> This is the sort of theology emphasized in Bishop Robinson's *Honest to God* and Joseph Fletcher's *Situation Ethics*, both published in the 1960s. Many other works since then suggest the same ideas. But the love spoken of in the New Testament is self-sacrificing *agape*, not the grasping for self-desire evident in the free-love culture.

If there is any good side to the scourge of AIDS, it can only be seen by observing the way in which death and destruction serve to bring those who are suffering to the point where they begin contemplating their eternal future. Prior to such a pivotal point in one's life, most people tend to think of themselves as basically immortal. Concerns of eternity suddenly become relevant when it seems that eternity might start sooner rather than later. As cited in chapter one (1.5), this researcher has seen how facing a terminal disease such as cancer can dramatically change one's perspective, causing one to become sensitised in such areas as the importance of relationships and how the future will unfold. It is no less so when one deals with AIDS. In fact, with the certainty of death along with the associated pain, suffering and stigma attached to AIDS, sensitisation in these areas must certainly be enhanced.

Unfortunately, coupled with this one glimmer of hope in the sea of despair of AIDS comes the disastrous result associated with the church as it buys into the lies of the enemy and refuses to respond with loving compassion to those who are now open and seeking the love and hope that only a relationship with Jesus Christ can offer. This fateful phenomenon has been outlined more clearly in chapter one as the problem of AIDS is described as it affects the church (1.1.2). Far too often, instead of finding arms open in love and acceptance, those who find themselves in such peril are met with alienation, estrangement and prejudice – all in the name of God!

5.4.1 Alienation

From the beginning of this dissertation the response of the world in general, and the church in particular have been charged with an inappropriate response to those infected or affected by the crisis of HIV/AIDS. Of all the injustices done

towards those afflicted by this disease, alienation is probably the most devastating. When one is well and strong (emotionally as well as physically), being alone or isolated can often be overcome by filling the resulting void with other activities. In the West, were individualism abounds; many people learn to overcome isolation by pouring themselves into their work, or their hobbies and interests to keep themselves too busy and occupied to have time for loneliness. In the third and fourth chapters of this dissertation, it was demonstrated that in the African context, with the importance of a sense of community and group dynamics (as described in the concept of *Ubuntu* 4.3), isolation not only affects one's identity, but it can have dour implications on one's very survival.

Louw (1994:22) illustrates the ominous ramifications of this when the bonds of community are broken due to illness:

> For the illness / health continuum this implies that when one breaks the moral codes of society, the cosmic ties between oneself and the community are broken. This factor then could be the main issue in a patient's experience of illness. Recovery and cure thus obtain a new dimension: it is firstly not the person who must be cured, but the broken ties and relationships.

The Oxford Dictionary (Oxford 1999:28) defines alienation as:

> To lose or destroy the friendship, support, sympathy, etc of somebody; to cause somebody to feel different from others and not part of a group.

This definition obviously runs counter to God's divine plan for man. Throughout the Old Testament, it is evident that God's intention is for man to be part of His covenant community in the form of His chosen people, the nation of Israel. This concept is repeated in the New Testament with the introduction of the church as the body of believers, functioning as not just an organization, but as a divine organism (1.4.1). Even with the indwelling of the Holy Spirit in each believer, God still chose for His people to be a community because it follows His original plan and design for mankind. Man was developed with a communal purpose according to God's sovereign plan.

When man is living or walking in such a way as to separate from this divine purpose and design, he will break fellowship with not only God, but the rest of humanity as well. It is in this broken fellowship that alienation comes to play, particularly as it relates to the AIDS scourge. This follows the natural definition of sin, which can simply be defined as, 'Sin is lack of conformity to the moral law of

God, either in act, disposition or state' (Strong 1907:549). Following a lengthy description of the various philosophical schools of thought regarding the essence of sin, Hodge expands on this definition by isolating five elements that contribute to the overall description,

1. That sin is a specific evil, differing from all other forms of evil
2. That sin stands related to law. The two are correlative, so that where there is no law; there can be no sin.
3. That the law to which sin is thus related, is not merely the law of reason, or of conscience, or of expediency, but the law of God
4. That sin consists essentially in the want of conformity on the part of a rational creature, to the nature or law of God.
5. That it includes guilt and moral pollution (Hodge 1993:180)

Although it is beyond the scope of this work to delve into the depths of the theology of sin, it is important at this point to establish that sin is not merely a moral wrong, acted out by the wilful evil intention of man; it is an assault and affront to the holiness and integrity of God. As an act against God, sin carries significantly more weight and magnitude in its power over man and the ramifications that follow in its wake.

The alienation associated with those infected or affected by HIV is therefore not merely an unfortunate state or a pitiful condition; but rather it is a matter of evil against man. Because of its opposition to the design of God, it is an overt sin and an obvious affront to God Himself. It is only when it is addressed in these harsh terms that the full ramifications of this evil can be understood.

Human beings will naturally seek ways of avoiding such alienation. Many of the African customs described in chapters 3 and 4 of this research were developed for this very purpose. If the void in one's life caused by alienation cannot be filled within God's design, man will use his own means to do so. These ways are often manifested in his attempts to find love through the distorted lenses of the lies described earlier.

5.4.2 Estrangement

Again turning to The Oxford Dictionary (Oxford 1999:398), estrangement can be described as,

> A verb to make somebody who was formerly friendly towards one become distant or hostile.

Estrangement then, is the active process that leads towards the end result of alienation as described above. The essential task of the Christian is to be more and more Christlike. The whole context of John 15:5-14 involves the idea of abiding in Christ, and its close affiliation and interdependency with the concept of love:

> Abide in me, and I in you. As the branch cannot bear fruit of itself, except it abide in the vine; no more can ye, except ye abide in me. I am the vine, ye are the branches: He that abideth in me, and I in him, the same bringeth forth much fruit: for without me ye can do nothing. If a man abide not in me, he is cast forth as a branch, and is withered; and men gather them, and cast them into the fire, and they are burned. If ye abide in me, and my words abide in you, ye shall ask what ye will, and it shall be done unto you. Herein is my Father glorified, that ye bear much fruit; so shall ye be my disciples. As the Father hath loved me, so have I loved you: continue ye in my love. If ye keep my commandments, ye shall abide in my love; even as I have kept my Father's commandments, and abide in his love. These things have I spoken unto you, that my joy might remain in you, and that your joy might be full. This is my commandment, That ye love one another, as I have loved you. Greater love hath no man than this, that a man lay down his life for his friends. Ye are my friends, if ye do whatsoever I command you. (KJV)

Although the NIV uses *remain*, the KJV using the term *abide*. The Greek term *meno* is used here, which has the idea of:

> *meno*, men'-o; a prim. verb; to stay (in a given place, state, relation or expectancy): -abide, continue, dwell, endure, be present, remain, stand, tarry (for), X thine own. (Rairdin 1992)

From this definition it is readily apparent that our command from Christ to abide in Him is diametrically opposed to the concept of estrangement. The hermeneutic of abiding in Christ helps one to understand the depth of love expected in the obedient following of Christ's command to love. Love dwells and remains in the believer through the presence of the Holy Spirit. The argument might be suggested that if all of this love comes from God, is He not responsible for its maintenance and outcome? This question stems from the comparative didactic of God's sovereign will and man's free choice. Paul answers this question (Rom 9:19 ff) with the adamant charge that man is indeed responsible for his own actions and attitudes. Working within the framework of God's design, man freely chooses his path. He freely chooses whether to act lovingly towards others. Obviously these choices are not always easy. There are some people who are naturally easy to love, and others who,

by human standards, are impossible to love. The command is to love our brother; it is only with God's love that this is possible.

Love is the foundation of the Christian faith. It is the love of Christ that we, as His children, can demonstrate to the world as evidence of His claim upon our lives. When asked what was the greatest commandment, Jesus said,

> One of them, an expert in the law, tested him with this question: "Teacher, which is the greatest commandment[26] in the Law?"
>
> Jesus replied: "'Love the Lord your God with all your heart and with all your soul and with all your mind.' This is the first and greatest commandment. And the second is like it: 'Love your neighbour as yourself.' All the Law and the Prophets hang on these two commandments." (Matt 22:35-40 NIV)

This conversation took place as the teachers in the law were attempting to catch Jesus in a snare or trap, which would equip them with ammunition they could use against him. Understanding their motives, Jesus cut to the heart of the matter by avoiding the particular nuance of their question and addressing the underlying concept of love. Using love as the foundation upon which all of the law is laid, he effectively eliminated the debate by demonstrating the essential nature of love in every aspect of life.

The objective is not to delve into the theology of various terms translated as *love* in Scripture, but rather to examine the distortion of the form of love spoken of by Jesus and His disciples as they point out how many had missed the mark. Instead of reflecting biblical love, they were instead demonstrating their own warped version of love that they had created to suit their own, as opposed to God's, purposes. In his writings, the Apostle John makes explicit statements about the ethical implications of love. He was addressing Christ's opponents who had claimed enlightenment and communion with God, insinuating that they loved God in spite of their unlovely temper and conduct (Holman 1992). From this, it can be ascertained that although both Christ and His opponents were using the same terms for love, they were not communicating the same message. The *love* of the Pharisees and other opponents included the element of estrangement; the *love* of Christ did not.

[26] Jewish rabbis counted 613 individual statues in the law, and attempted to differentiate between 'heavy' (or 'great') and 'light' (or 'little') commands (Barker 1985:1519).

Throughout the Bible, the unifying and underlying centrality that can be seen, from the beginning verses in Genesis, to the last verses of the book of Revelation, is the concept of love. In an effort to remove themselves from the weight and comprehensiveness of this commandment, an expert in the Law (Luke 10) tried to wriggle out of this responsibility to it by trying to find a loophole that could be used to escape the accountability implied by it. Knowing his heart, Jesus deftly manoeuvred him into unwittingly aligning himself with the proper principle and understanding of God's concept of love. It is this concept of love that applies to the Christian of today as well. There is no room in God's definition and expectation of love for the faith community for estrangement as they relate to those suffering with HIV/AIDS.

Many Christians would be much more 'comfortable' today allowing escape clauses and loopholes in this command of Christ. 'We are to love our neighbours, as long as _____.' This blank can be filled in by any number of 'dos' or 'don'ts' that might fit the situation at hand. This characteristic is not limited to Christians, it is a generally 'human' characteristic; which is why to display a genuine *agape* love, as we are commanded is not a natural, human trait or characteristic. To demonstrate such love can only be done as we 'abide' in Him, and allow His love to work through us as a demonstration of His claim on, and working in our lives.

Realization of the quintessential nature of biblical love as commanded by Christ, demands accountability to God for our loving or unloving acts and attitudes. Ostracizing anyone, for any reason, from that love is in direct violation of His command. When qualifiers are placed upon who is a recipient of the love we give, then we are contravening His work within us.

There are places in the Bible where actions are required that might be interpreted as conflicting with the concept of love as presented here. Such verses as contained in 1 Corinthians 5, which describes Paul's directive to excommunicate the errant, unrepentant sinful ones from the community do not seem to carry the same message of wilful love to the brethren. How does one reconcile these 'hostile' messages with the command to love?

When giving the command to love (as noted above), Jesus was talking to people on an individual level to touch their hearts with the truth He was trying to

convey. He was trying to show them that their actions and attitudes mattered, that they were not to look for 'loopholes' by which to remove themselves from this responsibility. This is a different context than when Paul is speaking to the Corinthian church. Since the original letter containing the message to which Paul was responding is not available, the actual situation he was addressing was unknown; but from his response, certain assumptions can be deducted. Apparently, there were those within the body of believers who were acting in an overtly unrepentantly sinful way. Their destructive behaviour was damaging to the entire body (1.4.10.2) causing disruption and division between the individual membership as well as discrediting the reputation of the church as a whole. Due to this destructive situation, Paul deemed it necessary to demonstrate what in modern times would be called 'tough love' (7.6.1). This does not mean that the love commanded by Christ should be withheld. On the contrary, in much the same way as a parent is called upon to discipline an errant teenager who is acting in a way that will obviously lead to disaster, Paul lovingly and nurturingly administered a severe corrective measure with the intention of bringing this erring one back into the fold. The wayward teenager is not being punished because the parent no longer loves him. Although it may not 'feel' like love in its most painful stage, but when looking at the big picture, the distasteful action will be clearly seen as the truly loving action.

This type of action is not to be confused with the errant interpretation of love that leads to the warped images seen in alienation, estrangement and prejudice as described in this paper. When the concept of genuine love is applied to the relationship between the church and the HIV/AIDS community, the estrangement demonstrated by some in the name of Christ must not be misinterpreted for the loving rebuke described, but can rather be understood as direct defiance to Christ's command. Therefore, instead of being a demonstration of His will and working in our lives; our unloving actions become a glaring indicator of the *lack* of God's influence and instead reveal the enemy's operational influence in the life of the Christian.

It must therefore be concluded, that estrangement is not only a detrimental attitude but also a manifestation of the sinful nature that is not under the control and influence of the Holy Spirit, but rather under the power of evil. There is no room in the life of the Christian for attitudes of alienation or estrangement. It was Christ

Himself who said, 'I tell you the truth, whatever you did not do for one of the least of these, you did not do for me' (Matthew 25:45).

By equating our responses to those around us with the love we have for God, Jesus is indicating in this text that it is not just the attitudes we hold, but the actual actions we demonstrate to others that reveal and measure our love towards Him. These words of Christ should bear great weight on the Christian. Even more significant however, are the words that follow. These are the words that should pierce the heart of a Christian, as he searches his own heart to determine if these attitudes are amongst his own. Following the comparison of Himself to those who are oppressed and estranged around us, He then goes on to complete the thought of the consequences of these attitudes and actions. In the verse following (46) He says, 'Then they will go away to eternal punishment, but the righteous to eternal life.' The 'they' includes all who did not act in a loving way towards those who are alienated and estranged. The command of Christ to love, cannot, must not, be underestimated. As the underlying theme of God's message to mankind, His people must demonstrate this attribute of God.

As individual Christians demonstrate these alienating and estranging tactics towards those suffering in the HIV/AIDS community, they are acting in such a way as to include the entire body of Christ, which therefore affects their sense of identity in Him (1.4.10.1). Representing their own congregation, by *social suggestion*[27], and the psychological process of *transference*[28], those observing their hostile attitudes will assign those same attitudes to the congregation they represent with the assumption that all in the group must reflect those views they have observed.

5.4.3 Prejudice

Turning once more to The Oxford Dictionary (Oxford 1999:909) as the standard for definition, we find *prejudice* defined as:

[27] Social Suggestion: tendency to pay attention to what is pointed out by others, or to perceive an object in the same way other perceive it (Ruch 1960).
[28] Transference: process by which a patient in psychoanalytic therapy attaches to the therapist feelings formerly held toward some persons who figured in an emotional conflict, often by a parent or lover (Ruch 1960).

> A dislike or distrust of a person, group, custom, etc. that is based on fear or false information rather than on reason or experience, and that influences one's attitude and behaviour towards them.

With this definition in mind, it is also important to consider a sister term, *stigma* as it relates as well. Oxford (1995:1171) defines stigma as:

> A bad reputation that something has because many people disapprove of it, often unfairly.

It is from the seed of prejudice that alienation and estrangement can grow and bloom. Ross (2002:16) gives an example of this in his book, *Following Jesus and Fighting HIV/AIDS*, with the following story,

> As the World AIDS Day celebration in the Roman Catholic Cathedral in Bujumbura in 1995, the priest said, in the course of his sermon, 'We must have compassion for people with AIDS because they have sinned and because they are suffering for it now.' At that point something propelled Jeanne Gapiya to rise from her pew and walk up to the front of the church. 'I have HIV, she declared, 'and I am a faithful wife. Who are you to say that I have sinned, or that you have not? We are all sinners, which is just as well, because it is for us that Jesus came.'

This story serves as an illustration of the bias or prejudice that is often held in the hearts of people. Although one might try to conceal such ignorant hostilities by trying to project the image loving spirit, one must recall the world of Jesus as He said in Luke 6:45,

> The good man brings good things out of the good stored up in his heart, and the evil man brings evil things out of the evil stored up in his heart. For out of the overflow of his heart his mouth speaks.

Prejudice runs deep within the psyche of man. The concept of prejudice is often, if not usually associated with racial issues, and although AIDS is not specifically a racial issue, there is certainly some transference in attitudes. Since racial prejudice is more easily understood, it will be used for comparison at this point.

Although research has shown that there is little scientific basis for a believe in the innate superiority of any ethnic group (Ruch 1960:483), it is none-the-less human nature to be culturally relativistic, or to believe that the choices one makes, or those choices made by the social or familial group to which one belongs, are in some way superior to those made by individuals or groups not within ones own circle or sphere of influence. By the same token, individuals within one's own group are considered to be inherently preferred, or possibly even superior to those outside of the group.

With the enculturation process one endures to attain the knowledge, skills, attitudes and values that enable him to become a functioning member of the group or society, come the attitudes, often cloaked under various other defendable attitudes, of higher or superior standards or intrinsic abilities (Grunlan 1988).

Some prejudice is culturally based on misunderstanding. Without realizing the error inherent in the interpretation of ones behaviour, negative attitudes not only surface but also are fuelled in their intensity and outcomes. An illustration of this can be seen in the misinterpretation between the white and black cultures in the United States. For example, the average white child is taught that you are to look someone directly in the eye when speaking to him or her. White children are often scolded by their parents to 'look me in the eye when I am talking to you!' Looking someone in the eye is seen as an indication of integrity and truthfulness, and failure to do so is an indication of shame and lying[29]. On the other hand, in the African American culture, black children are often taught that to look someone directly in the eye when speaking is a challenging form of defiance and lack of respect. The cognitive anthropology of this situation reinforces the prejudices on both sides of this issue. One could easily see a situation where a white person accuses a black person of theft (for the sake of this example, lets assume innocence on the part of the accused). The black person, as a sign of respect, does not defiantly stare into the eyes of the accuser, which is then interpreted by the accuser as evidence of guilt and lying. Both parties are then misinterpreting each other's motives and the prejudices they brought with them to the situation (white people will always believe you are guilty; black people are thieves, etc.) are thus reinforced.

It is evident that prejudice is learned behaviour. It is learned by others and often absorbed into our very makeup without our realizing the depth of its integration into our thinking and emotional processes. It can be seen as nothing less than evil as it comes in direct opposition to the very nature of God by viewing those made in His image with less than His intentioned love and acceptance. The question then, is not whether or not we are guilty of harbouring prejudices, but rather how can we work

[29] This trait was beautifully illustrated in the movie, *Pushing Tin* (1999), when the main character, played by John Cusack was unable to look his wife directly in the eye and proclaim his innocence of extra-marital affairs, which therefore revealed and unquestioningly affirmed his guilt.

through our own prejudices, as well as helping others to understand and work through their own, in the light of the love and righteousness of Christ. In doing so, His love is then demonstrated by our thoughts, words and deeds instead of the fears and hatred that we had been exhibiting.

Relationships suffer when people fear rejection due to prejudice from those who should be a source of strength and encouragement to them as this story illustrates,

> A scene of pathos awaits anyone undertaking ministry to a person with acquired immune deficiency syndrome (AIDS). The pathos may be glimpsed in this portion of a letter written by a mother whose son had recently died of AIDS-related causes. The letter was addressed to the pastor who briefly attended this small-town family gathered around the son's deathbed in, a city hospital:
>
> > My husband and I wish to express our appreciation for your visits, prayers and sincere concern for us and John. I know John didn't want to die. Part of it was because he was afraid. You reassured him when you reaffirmed what he had been taught as a child. John felt he must be a terrible person because he had this disease and was dying at such a young age. . . John and his Dad loved each other, but John didn't receive the love he wanted from his Dad. My husband knew John was gay but didn't tell him he knew, and John was a nervous wreck around his Dad. He felt his father would reject him if he knew. That is the reason he didn't know about John's illness. . .
>
> Although this mother had learned the nature of her son's illness soon after he had been diagnosed nine months earlier, the father was not informed until the final hospitalisation, two weeks before the death of his son-who by then was too weak, pain-ridden, drugged or demented to communicate effectively (Schaper 2003).

The question could be asked; didn't this father love his son? Wouldn't he have wanted to know this terrible secret so that he could truly help in and support him in this, the biggest crisis of his life? Sadly, although this actual circumstance is unknown to this researcher, it is none-the-less played out numerous times every day for so many people on this earth. For the majority of these cases, the perception of prejudice is not in error, but is in fact reality.

Prejudice leads to rejection, and as image bearers of God (Berkhof 1959:205), we have been created to need acceptance. Mankind needs acceptance by other people, and in particular by those he loves, but most of all by God. People will do

almost anything to avoid rejection. This young man in the story is typical of so many people who have fathers with whom they cannot really communicate. Beyond the obvious tragedy of a limited, broken relationship lays a much bigger issue. Most people tend to view God, as they see their own father. If their father is kind and loving, then that is how they will tend to interpret God's consideration of them. If their father is cold, distant and difficult to please, then a cold, distant and difficult God is what they will see when they try to understand God. It is very possible that this young man in the story, in addition to feeling that his father would never understand or forgive him, would also transfer those same feelings to his beliefs about God.

Our actions, our attitudes and our beliefs are not merely private affairs that we have the luxury of keeping to ourselves. These are the aspects of who we are and make up the formula that determines how we will respond to varying situations. To use an old expression, 'no man is an island.' Each one of us has a sphere of influence around us. The fact is: people are affected by our actions or lack of actions, regardless of whether we would chose for that to be the case. Applying this principal to the local church, it can be seen that the impact of the faith community as it responds to those within its sphere, to those suffering from AIDS will have an impact on its mission and witness to the entire community.

Being interconnected is a fact of existence for mankind. We see this played out in Scripture as Paul accuses Peter in Galatians 2:11-14 of behaving differently in front of the Jews than he did in front of the Gentiles. Why this change in his behaviour? Fear of rejection. He knew the prejudices that were held in the hearts of the Judiazers in the Galatian churches. Rather than take a chance on facing their rejection, he altered his behaviour in an attempt to align his actions with what he believed they would find acceptable.

Earlier in his spiritual life, we see Peter also succumbing to the fear of rejection. When Jesus Christ was arrested, Peter denied Him three times (Matthew 26). Why? He was afraid that if he were known to be an associate, let alone a close follower of Christ, those he was now trying to blend in with would then reject him – the very Jews who were trying to crucify Christ! Following this humiliating experience, Peter went on to become one of the staunchest apostles, respected by all (Acts 15). Yet, as indicated above, the natural human inclination to fear rejection can

be so strong that even someone like Peter could surrender to its grip. If the Apostles could succumb to temptation to respond in such a purely human way as to what they may have been perceived as a potential for rejection, certainly the church of today must realize the propensity to follow such a path as well. This cannot be understood as an excuse, but rather should be deemed as a warning to the church of Jesus Christ today.

5.4.4 Theological implications for alienation, estrangement and prejudice

Each of these factors, alienation, estrangement and prejudice has been shown to be diametrically opposed to the very core attributes of God. One cannot study any aspect of theology without the realization that God, being a loving, interacting God who seeks relationship with His creation would be directly affronted by these negative attributes.

Alienation against God must precede alienation against our fellow man. It is when we have lost that fellowship with God that comes from a 'right relationship' with Him that we will be prone to demonstrate such unregenerate types of behaviours. Until we reach that point of perfection when our sanctification is complete (when we leave this life and are joined together with Christ for eternity) (Berkhof 1959:534); we must continue to suffer with the battle of sin and imperfection that plague our mortal lives. He further describes (1959:40) the continual confession of sin before God that is required for continuing sanctification.

> Confession of sin and prayer for forgiveness are continually required. Jesus taught all His disciples without any exception to pray for the forgiveness of sins and for deliverance from temptation and from the evil one, Matthew 6:12,13. And John says: 'If we confess our sins, He is faithful and righteous to forgive us our sins, and to cleanse us from all unrighteousness,' 1 John 1:9. Moreover, Bible saints are constantly represented as confessing their sins, Job 9:3, 20; Ps. 32:5; 30:3; 143:2; Prov. 20:9; Isa. 64:6; Dan. 9:16; Rom. 7:14.

Since we will continue to struggle with sin, it is imperative that we constantly seek God's guidance and forgiveness in our lives so that we may continue to 'abide' in Him and have His love overflow through us to those in need. When we are part of the true body of believers (the invisible, as opposed to the visible church), Christ indwells the believer, and His Spirit works within us to do those things that honour and please Him.

> This indwelling of Christ affects our response to those in need. Whatever we do to help a Christian brother or sister, we do to Christ (Matthew 25:40). Keeping Jesus' commandments is an indication that He is in us… (Grudem 1994:845).

Grudem brings up another important issue in the behaviour of a Christian when he points out that not only are our actions a reflection of the genuineness of Christ's indwelling within us, but they are also a direct reflection of how we are treating Jesus himself. The way we treat others, especially the downtrodden and the ones society has alienated, estranged and shown prejudice against; the way we treat these who are 'the least' is how we treat Christ Himself.

> 'The King will reply, 'I tell you the truth, whatever you did for one of the least of these brothers of mine, you did for me.' 'Then he will say to those on his left, 'Depart from me, you who are cursed, into the eternal fire prepared for the devil and his angels. For I was hungry and you gave me nothing to eat, I was thirsty and you gave me nothing to drink, I was a stranger and you did not invite me in, I needed clothes and you did not clothe me, I was sick and in prison and you did not look after me.' 'They also will answer, 'Lord, when did we see you hungry or thirsty or a stranger or needing clothes or sick or in prison, and did not help you?' 'He will reply, 'I tell you the truth, whatever you did not do for one of the least of these, you did not do for me.' 'Then they will go away to eternal punishment, but the righteous to eternal life' (Matthew 25:40-46).

Christ makes this comparison, that of how we treat 'the least of these,' which could easily be replaced for the purposes of this study with the terms, 'the alienated, the estranged and those who are treated with prejudice'; with how we are actually treating Him. This should serve the Christian as a vivid reminder of how intricately interwoven our actions are with our relationship to and with Him. Without giving credence to a 'works' type of theology, it is nonetheless imperative that Christians do not discount the importance of works in our lives. The works of a Christian acts as an indicator regarding the reality of the Spirit dwelling within us. Not only is love the demonstration of the love within the believer, but it also can be used as an indicator of the level of spiritual maturity one has gained in his or her Christian experience,

> Maturity in faith must be regarded as love in action. The concepts *service* and *sacrifice* describe maturity in faith in terms of the standard of priestly involvement in the needs, problems and suffering of fellow men (*the service component of grace*) (Louw 1994:12).

James points out the importance of our works matching the faith we claim, as a natural outpouring of that faith when he says,

> But someone will say, 'You have faith; I have deeds.' Show me your faith without deeds, and I will show you my faith by what I do. You believe that there is one God. Good! Even the demons believe that--and shudder. You foolish man, do you want evidence that faith without deeds is useless? Was not our ancestor Abraham considered righteous for what he did when he offered his son Isaac on the altar? You see that his faith and his actions were working together, and his faith was made complete by what he did. And the scripture was fulfilled that says, 'Abraham believed God, and it was credited to him as righteousness,' and he was called God's friend. You see that a person is justified by what he does and not by faith alone (James 2:18-24 NIV).

The pragmatism in James' words brings his point into vivid focus. He is underscoring the actuality of ones faith as being authenticated by the actions or deeds one performs. Love, like faith, can be elusive, and difficult to prove if left merely to the feelings and thoughts of an individual. James is using godly actions to establish the existence of faith in the same way that loving actions confirm the existence of love (above).

5.4.5 The role and influence of clergy in the faith community

The role of the pastor regarding these basic principles that form the faith assumptions dealing with this area of HIV/AIDS alienation, estrangement and prejudice cannot be overemphasized. It is not the place of this paper to delve into the full ramifications of the role of pastor in the church, but it is important to delineate this role as it applies to the issue at hand: HIV/AIDS.

In the Bible, the pastor has often been depicted as the shepherd of the flock. This 'shepherd' metaphor continues to be applicable in the current concern of HIV/AIDS alienation as well. One of the most beloved illustrations of God's relationship to His children has to do with His being our Great Shepherd (23rd Psalm; John 10). It is surely not inconsequential that Paul uses these terms in discussing the role of the church pastor, for the pastor is to lead the sheep, to guide them to knowledge and understanding of His Word. The literal 'shepherd' never drives the sheep, but rather guides them as a dedicated leader.

> It should be the ambition of the pastor not 'to run the church,' but to teach the church intelligently and Scripturally … the word 'minister' means,

> not master, but servant. The true pastor inspires, but he does not drive (Strong 1907:908).

In the issue of HIV/AIDS alienation then, the example set by the pastor will set the tone of the entire church as they develop their attitudes towards those infected and affected by this plague. There are many who will want to emulate the pastor, seeking his approval more eagerly than that of Christ Himself. An example of this can be seen from two churches this writer has had the privilege of being associated with. One church, Coral Ridge Presbyterian Church (Ft. Lauderdale, Florida, USA), has as its pastor, Dr. D. James Kennedy, the man who created the Evangelism Explosion (EE) form of evangelistic witnessing that has been taught and used by churches around the globe. This entire church embraces this program, backing it fully. As a prerequisite to teaching or even singing in the choir on Sunday mornings, one must have completed an EE course. The church has an active visitation program that centres around this dynamic program. When EE classes are held, and each week during their mid-week visitation night, Dr. Kennedy can be seen actively participating in, if not actually leading the program. People do not mind the importance that is placed upon this program in their church because they know, love and trust their shepherd – Dr. Kennedy, and if he is promoting it, then they are all for it.

Another church, First Baptist Church of Indian Rocks (FBCIR) (Largo, Florida USA) has also 'embraced' the EE program. Dedicated trainers teach the basic program twice a year and practice the evangelistic principles in their weekly outreach activities. On the surface this sounds similar to the Choral Ridge experience but a closer look reveals some significant differences. At FBCIR, the pastor will make announcement supporting and encouraging the program, but does not actually participate in it. The associate pastor responsible for overseeing the program has several other responsibilities, so that although he is in agreement that it is a good program, he doesn't have the time or inclination to take an active part in it. The result: trainers have to beg for recruits into the program, and once trained, they eventually fade into the woodwork. Overall it is a weak program that doesn't begin to compare to the dynamic program at which can be observed at Coral Ridge.

Although there are certainly many factors that contribute to the different responses of these two churches, it is obvious to even the casual observer that the role

of the pastor is the pivotal ingredient making the difference. In one church (Coral Ridge) the pastor is leading and shepherding his flock in the process of EE, and they eagerly follow him and embrace the program. In the other (FBCIR), the pastor cheers from the sidelines, but since he has placed his priorities in other places, his flock follows him on the same path as well.

This same principle has been demonstrated in a local church here in Lilongwe regarding the HIV/AIDS phenomenon. The home visitation program, which was designed to reduce the alienation and stigma felt by those in the HIV/AIDS community by the church, began with great support and fanfare by the pastor, but eventually the program diminished until it stopped altogether (See chapters 6 and 7 for more specific details). When asked about the attitude of the church, one elder said that the pastor and the elders were indeed speaking about the HIV/AIDS problem in their churches, much more than they did in the past. Although this initial report sounds encouraging, when pressed for additional information, the elder said that the message which was being preached from the pulpit was one that followed the concept of 'those people with AIDS, they did a sinful, evil thing, and they are getting their just rewards!' Needless to say, the attitudes of the HIV/AIDS community did not change, but instead were reinforced as the congregation began (as a whole, certainly there are many specific variances) to pick up, absorb and reflect the attitudes of their pastoral leadership.

In light of this aspect of the pastor's role in the shaping, moulding and motivating of his congregation, it cannot be stressed heavily enough that he must lead the way in the changing of feelings and attitudes regarding those who are infected and affected by this plight. It is not enough for him to recognize the problem and then support those who are going to work toward changing things. He must be in the forefront of the assault on HIV/AIDS.

It is true that the pastor of a thriving congregation is usually wearing so many 'hats' of responsibility that to take on such a major commitment could take him away from some of his other pastoral obligations. But the reality in every Malawian pastor's life is that more and more of his time is being taken up by conducting funerals and dealing with all of the social, physical, emotional and spiritual hardships that are affecting his congregation. If he doesn't directly take the lead in addressing

this most vital issue, he will find himself in a role of only responding to the symptoms instead of working proactively to stop the problem.

Caution must be taken, that the pastor or leaders of the church are not perceived as having sole responsibility for dealing with this monumental issue. The people in the faith community form the church, as the 'body of Christ,'(1.4.10.2). It would be a dreadful mistake to leave the ecclesiastical responsibility towards this pandemic exclusively in the hands of clergy. With the church leadership taking the lead, it is the congregation, who must develop and work out their own contextual ecclesiology within the parameters of God's overall design for the church,

> At present, due to contextual changes, it seems important to emphasize the role of faith communities and the laity, who constitute the church. A practical theological ecclesiology has become important. The devastating reality of AIDS that confronts every person in Africa, compels Christians, individually and as a faith community, to realize that they must make ethical decisions, for example, not to indulge in immoral sexual behaviour and to structure their faith community and society in such a way that all enjoy a safe and healthy environment. While emphasizing the local church's importance and the role of the laity, the significant role of denominational and ecumenical church structures and leadership should not be negated; however their role, function and style must change. (Hendriks 2003:13).

In the African context, allowing the faith community to have such a voice in the praxis development of the ecclesiastical methodology of addressing this paramount issue may require a significant paradigm shift. Changes in attitudes and customs come slow in Africa, as with the rest of the world; but without movement toward change, the issues will not stop or become stationary, they will continue to escalate.

> One might say it is easy to address the problem of HIV/AIDS, but much more difficult to develop a practical theory [that] can be applied to a theology of pastoral care. Practical application of a working theory can be done by a church as a group of people committed to a common goal, and led by a leader who can envision and lead the people into a practical response to the HIV/AIDS crisis.
>
> We are called upon to bear one another's burdens and with God's perfect love working in us, fear will be cast out, giving us greater freedom to serve the needy (Sanderson 1994:78).

5.5 LOVE AS GOD'S PLAN FOR THE FAITH COMMUNITY

Even outside of the arena of AIDS, social scientists have long been interested in the relationship between religion and individual well-being. Referring to a study by Idler, Musick (Musick 2000) asserts that empirical research supports the presupposition of this dissertation that religion has important consequences for improved well-being through four mechanisms:

1. Religion provides a sense of comfort in times of trouble;
2. The integrative aspect of religion gives access to a large network of potential support providers;
3. Religious norms discourage behaviours that might lead to health problems; and
4. Religious beliefs furnish a cognitive framework through which people can better understand the meaning of pain, suffering, and death.

These four mechanisms are indicative of the appreciation derived from a dialogue between secular studies and generalistic religious affirmation. Intrinsically valuable in their own right, one can extrapolate the importance of application of this concept when the concept of love, (as used in this paper to represent the Christian's response and action as a demonstration and verification of incarnation) is used to replace the generic sense of religion referred to in Idler's study. A closer examination of each of these factors is therefore warranted.

The first mechanism, *religion provides a sense of comfort in times of trouble* can hardly be overstated in relationship to the AIDS crisis. Citing Berger, Musick proposes that because individuals experience problems and traumas, they must have a system of belief to account for such experiences. Although there can be any number of plausible theodicies, all of the possibilities share the single purpose of providing meaning. Indeed, it is religion's ability to provide meaning and hope for the future, particularly as it relates to the HIV/AIDS pandemic; even in the face of current life adversity that may have such powerful effects for well being. In this vein he quotes Berger in saying that regardless of whether or not one's belief system carries with it the promise of eternal relief and comfort, the underlying theodicy in its own right causes comfort (Musick 2000):

> If theodicy answers, in whatever manner, this question of meaning, it serves a most important purpose for the suffering individual, even if it does not involve a promise that the eventual outcome of his suffering is happiness

> in this world or the next. It would, for this reason, be misleading to consider theodicies only in terms of their 'redemptive' potential. Indeed, some theodicies carry no promise of 'redemption' at all-except for the redeeming assurance of meaning itself.

Van der Ven (1998:159) sees the heart of the question as hermeneutical-communicative in nature as he addresses this issue as a practical-theological question in his study by probing, 'How can pastoral workers offer, within the Christian faith, aid to people who are confronted with irreversible, existential suffering…[30] [such as one might see with AIDS]?' One explanation offered for this phenomenon provides the function of religion not trying to do away with life's problems but rather serving as an avenue towards their elucidation.

The second mechanism, *the integrative aspect of religion gives access to a large network of potential support providers*, is particularly meaningful in the African setting when its antithesis is considered. Referring to chapters three and four of this dissertation, regarding the important and even essential nature of the family and communal associations to the African paradigm, one can see that if this support network provided by the faith community is removed due to the alienation and estrangement (5.4) associated with HIV/AIDS, it can have devastating physical as well as spiritual and psychological ramifications.

The third mechanism, *religious norms discourage behaviours that might lead to health problems,* has obvious direct ramifications on the prevention of HIV/AIDS. If the love commanded by Christ was demonstrated in such a way as to help people see the reality of Christianity and therefore embracing Christian principals of morality and sexual behaviour; no further prevention would be necessary. This aspect of prevention was noted in the Nkhotakota study (6.6.2) as a 'side effect' of the home based care training.

The fourth mechanism, religious beliefs furnish a cognitive framework through which people can better understand the meaning of pain, suffering, and death, deals with the correlational hermeneutic as it brings purpose and meaning to the lives of those who are affected and infected with the disease. As cited (1.5) in the social locational background section of this research, finding a sense of purpose in suffering

[30] Although he asks this question primarily regarding illness which is caused neither by any fault of their own nor, primarily, by others, it can be used for the purposes of this comparison to illustrate the perplexity which exists in dealing with human suffering, even amongst clergy.

is essential to the development of effectual coping strategies needed to interpret and deal with such tragedies in life. The correlational hermeneutic of God's love as applied to pain and suffering can bring an emotional and spiritual healing, which will in turn lead to an improved sense of well-being as indicated in Musick's study.

These four mechanisms, although certainly not exhaustive, demonstrate how essential religion, and for the purpose of this study - the reality of God, as demonstrated through the love of the believer as they reach out to those suffering from HIV/AIDS - is to the well-being of those infected and affected by AIDS.

5.6 LOVE DEMONSTRATED – DOING THEOLOGY IN THE HIV/AIDS CRISIS

As will be demonstrated in the evaluation portion of this work (7.4.1), the anticipated positive outcomes of the research were significantly diminished due to the underestimated magnitude of poverty in the lives of those infected and affected (including the caregivers) by HIV/AIDS. Those coming from a Western paradigm have difficulty comprehending the intensity of this situation. But what became markedly clear was the fact that it is simply impossible to demonstrate the love of God without giving credence to the physical plight of those to whom one is attempting to minister.

This is 'doing theology' as explained by Chopp (1986:10) in her work on the Suffering of Christ[31],

> …explorations for a new way of doing theology based on God as liberator of the poor, with the suffering Christ as model, and the church as the local community where praxis is engaged in liberating individuals as well as history. This *logos* of the *Theos* is a new way of doing theology both because it interprets anew human existence and Christian tradition and because it understands the purpose of theology to be that of reflecting on and guiding Christian praxis.

Chopp goes on to explain the underlying passion of Gutierrez regarding the liberating praxis and Christian love which forms the centre of Gutierrez's theology; Christianity as a praxis of solidarity, of love for the neighbour (1986:52). God

[31] One cannot help but take note of the Latin American Liberation Theologians as they struggle with oppression and poverty. Relief of repression cannot be separated from the proclamation of the message; it *is* the demonstration of the message.

recognized the propensity of His children to become so 'academic' in their theological ideologies that the actual application of His Word would become obscure. Love, when understood from an academic standpoint, as originating in God and therefore being an essential element of all of His creation, can be far removed from the reality of one's daily existence. The concept can become so lofty that it loses it concrete reality in the lives of those who claim to be Christians, the bearers of love. Because God understands our limitations, He helps us to understand the principle of 'doing theology' as He tells us in His word that when we reach out in even the smallest ways, such as a cup of cold water (Matthew 10:42) in the name of Christ, we are acting as if we were responding to God himself. God defines religion, not as having an intimate grasp on the most intricate details of Systematic Theology, but rather God describes the demonstration of His love as, 'Religion that God our Father accepts as pure and faultless is this: to look after orphans and widows in their distress' (James 1:27a NIV).

> The words of Jesus bring this point into clearer focus yet as He distinguishes between loving with mere words from the mouth and actions that provide tangible evidence of the truth the Christian is trying to relay. As Tracy affirms, 'doing the truth' also involves 'saying the truth' (Tracy 1981:71).
>
> This is not the time for pious platitudes (often done by perverting the biblical truth that 'all things work together for good to those who love God' into the meaningless 'be warmed and be filled' type of statement that is condemned in James 2:15-17), or for 'beating him over the head' with scripture texts on God's sovereignty…. the simple 'cheer up, God loves you' counselling approach is not going to make the grade (Mendis 1987:38).

Not only does Jesus present the concept of demonstrating our love in both word and deed as normative for the Christian life, He also includes a component to indicate empirical evidence is the verification (as opposed to a verbal profession) of incarnation.

> If anyone has material possessions and sees his brother in need but has no pity on him, how can the love of God be in him? Dear children, let us not love with words or tongue but with actions and in truth (1 John 3:17,18 NIV).

5.7 LOVE CAN BUILD WHERE THE ENEMY HAS DESTROYED

Giving more thought to this analogy brought to us by Paul, lets consider the Christian response to other parts or members of the body. In particular, it is the purpose of this chapter to explore the purpose of the body as it responds to those members who are suffering. Following this analogy, it is easy to understand the necessity of the various parts working together in cooperation and harmony in order to accomplish the tasks set before it. If the body consisted of only hands, with no eye to guide or feet to carry them, it would soon become useless and ineffective. The application of the analogy goes deeper than this however, when one considers what is our normal, human response when one member of our own physical body is suffering.

> The presence of HIV in our community –particularly, but not exclusively, in the church community – requires this shift in our understanding of acceptance. We are not called simply to offer charity to those whose physical bodies have the virus. Our undeniable belonging to the community challenges us to embrace the fact, however painful, that the virus has come into *our* body (WCC 1997:29).

For the purpose of example and explanation, lets consider that there is a 'sample' Christian man named 'Joe Christian.' Joe has been in an automobile accident and has just severely injured his left foot, causing multiple fractures and risk of infection. Would it be possible, even for one moment for Joe to determine that he no longer wanted to associate with his foot because it was too time consuming, or too demanding, or too emotionally taxing? If the foot eventually healed but remained deeply scarred and caused a continual limp; would Joe have the option of disassociating with his foot because it was no longer pleasant to look at, or because it could no longer perform the function for which it was intended, and was holding him back from accomplishing all that he had hoped and planned to do for his life?

This analogy borders on the ridiculous, but it serves to demonstrate the intimacy each of us, as human beings have with the members of our own bodies. It must be admitted that Joe's response would be one of grave concern and nurture as he did everything within his power to see that his foot was carefully tended and cared for. All activities would stop and take secondary positions until this crisis with his foot was attended to. All meetings and decisions, no matter how essential, would be put on hold as he underwent whatever surgical procedures were required for the

restoration of his foot. All attention would be focused on the healing and nurturing of this injured member.

In the same way, this is how the body of Christ (1.4.10.2) *should* respond when one of its members is suffering. As the body of Christ, the church cannot disassociate itself from those in its body who are in crisis. If a member of the body of Christ is diagnosed with HIV/AIDS, then the whole body suffers with that one suffering part. If that one is agonizing and pulling the rest of the body down, then the body must put its focus on that one part, in order to give it all of the love and nurturing required to heal, support, comfort and bring relief to the suffering.

Too often, Christians have been guilty of insulating themselves so effectively from the pain of others that they are no longer able to feel the need to reach out with the love and compassion of Christ to those suffering around them. This is illustrated well by Hall (1986:45) as he describes the response of the developed world to the hunger in Ethiopia. Although this is not directly related to the HIV/AIDS pandemic, the underlying principles can be easily transferred:

> Our response to the starving in Ethiopia is a species of the sympathy that begets charity (and that is not to be discouraged), but it seldom leads to deeper sympathy (*syn* + *pathos*), which is the recognition that the pathetic condition of 'the other' is also our own fundamental condition – that we share a common lot, *mutates mutandis*… The suspicion that we may be the cause of the suffering of others, that the very freedom from pain and want for which we have striven and are willing to fight may be a source of gross injustice for others – this seems to be a conclusion that few of our contemporaries permit themselves concretely to entertain.

When the New Testament was written, the plight of HIV/AIDS was not yet conceived by humankind. Yet, the correlative hermeneutical application of Scripture is no less relevant today. The normative principals of Scripture, in the expression of love by the Christian to the world cross all boundaries. When the Church first began to deal with this issue, as described in chapter two, it struggled to come to grips with the proper hermeneutic and praxis process. Hindsight, of course, allows us to see ever so much more clearly the failures of the past.

Historical disappointments should never be a determining factor regarding the future of an individual or of the church. Because of God's redeeming grace, His forgiveness and cleansing, the church can begin anew as stated by the Apostle Paul, 'Therefore, if anyone is in Christ, he is a new creation; the old has gone, the new has

come!' (2 Cor 5:17) It is with a proper hermeneutic of love that the church can move forward in this fight against AIDS. By demonstrating love in all situations, the world can be changed. This includes loving the unlovely, and the difficult to love. It is relatively easy to love and care for the innocent: the orphan whose parents died of AIDS, the innocent widow whose husband has left her destitute. Caring for such as these demands a compassion that is not difficult to stir within one's heart.

The challenge comes to the Christian when we are called upon to love as Christ loved. When a repentant sinner comes to Christ, he or she is embraced with love and forgiveness. Can we do any less? Must we once again be reminded of Jesus' own words as he spoke of forgiveness, 'But if you do not forgive men their sins, your Father will not forgive your sins' (Matthew 6:15)? When the commercial sex worker begs for assistance, do we remind her of her guilt, or are we reminded by our Saviour of the 'Good Samaritan', and respond in kind? Another scenario which might be even more difficult: can we love and forgive the outspoken 'Christian' who has done so much damage to the cause of God's Church and its mandate to love by his or her abrasive, even hateful proclamation of 'Those sinners! They are getting their just reward!!!' Is the Christian even expected to love one such as this, especially when they do not comprehend the error in their hermeneutic and may return a reciprocal accusation?

Even ones such as these can be 'loved' in general, in an abstract way, but Christ's description of love goes beyond that. He expects an *agape* love, the kind of love that meets the definition cited earlier by McQuilkin (5.1.1); 'Biblical love, then, is an affectionate disposition that motivates the lover to consistently act for the welfare of another, whether or not the other deserves it or reciprocates.' This is the love that, when demonstrated, will reveal Christ to the world in the life of the believer. This is the transforming love that can stop AIDS in its tracks.

5.7.1 AIDS Opens Love Opportunities to Share Jesus Christ

People facing their own mortality need the Gospel. As discussed in chapter one (1.1.2), there is an openness associated with impending death that brings sensitivity to spiritual matters as no other factor can. This component of the Christian witness and mission is developed further in the intensive instruction given to the

Home Based Care volunteers in order to prepare and equip them for ministering to the sick (refer to chapter six on methodology and appendix C and D). It is incomprehensible for a Christian, who knows the eternal hope of the Gospel to deny it to those who need it so urgently.

5.8 DEVELOPMENT OF THE PRAXIS PROCESS IN THE LOCAL CHURCH

Determining that love is the correct response of the church as it actively seeks to respond to the AIDS crisis can become an academic exercise unless there is purposeful commitment toward activating a positive reaction. One must be careful to avoid becoming so scholarly that there is no practical value in the work and study being undertaken. Too often churches, as well as other organizations, are guilty of observing the problem and then developing a committee to look into it further, followed by the development of a report, or possibly just forgetting about it completely. Everyone feels his or her burden of guilt removed because 'somebody is looking into it,' but nothing is ever really done.

In his book on strategic leadership, Dayton (1993:44) uses the following illustration to demonstrate a workable and practical way of addressing and attacking a problem in a purpose-driven and meaningful way:

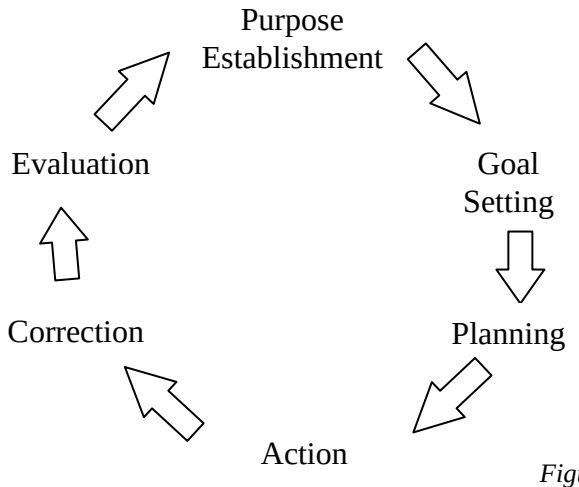


Figure 1

This process has been purposely illustrated in the form of a spiral, because that allows it to incorporate many variables as it cycles through a recurring or repetitive process. It is expected that while desired results may be obtained, a continuing process of re-evaluation and the changes that would be associated with a continuing updating and improvement process, would continue as an ongoing process.

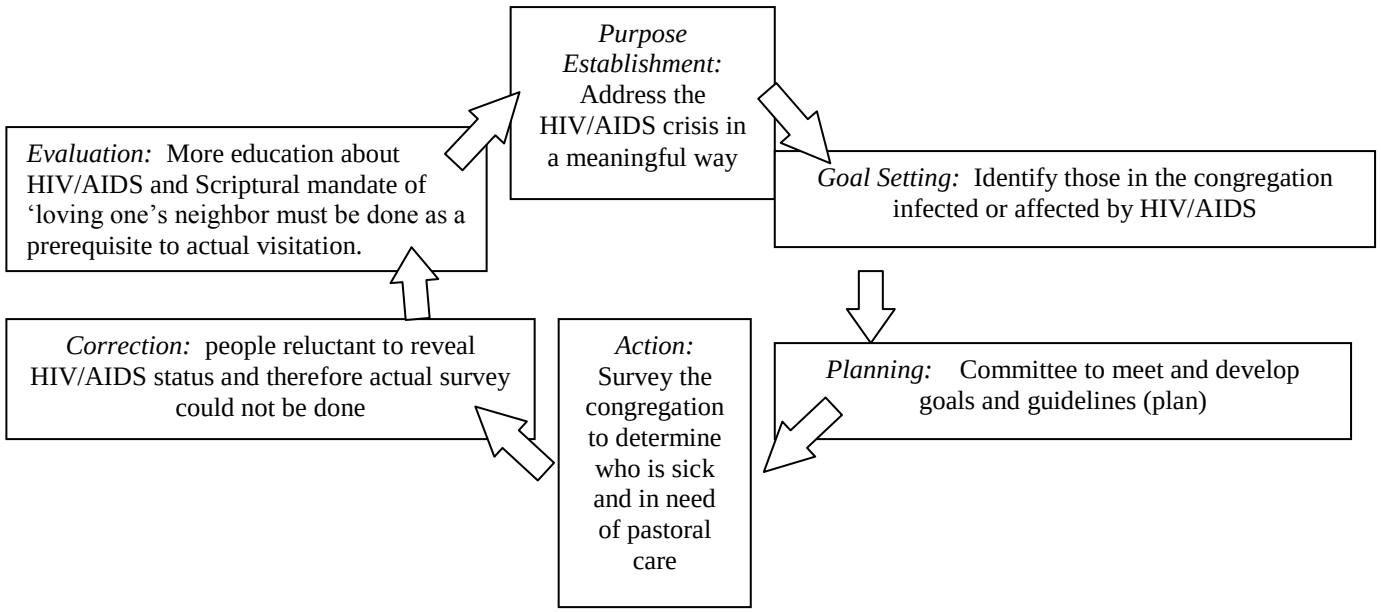
In the ideal situation, the organization begins with purposes, goes through the cycle to discover better purposes, set more effective goals, establish clearer priorities, do better planning, do a better job of managing; and then goes on with the re-evaluation (Dayton 1993:44).

Application of this model to the actual situation under study as an indicator of what might be anticipated by applying the same model to another particular individual and specific situation must be done with the understanding as expressed by Van der Ven (1998:48),

> An important fact to bear in mind is that there is no such thing as 'the' present-day situation out of which the intergenerative communication occurs. There are a multiplicity of contemporary situations, determined by a multiplicity of demographic, economic, political, cultural and psychological factors.

Bearing this in mind, a sample scenario that could be applied to a church's/pastoral initial situation might include some of the following elements:

This praxis process will be continually adapted and reformatted to reflect the individual perceived and realized needs of the faith community as it moves forward in its approach towards developing a ministry aimed at impacting the HIV/AIDS community with the Gospel of Hope. Changes in the plan are not only inevitable, but also expected and welcomed as the progress of the Home Based Care evolved under continuous assessment. This process is demonstrated in the actual situation under study in chapter seven of this dissertation, as the methodology is evaluated and the praxis process implemented.



Changes in the approach or methodology are not to be interpreted as an indication of a flawed plan or the occurrence of a judgment error. One would be reminded of the Apostle Paul, as well as the other Apostles, as they were moving forward with their ministries. The fact that they were often re-directed on their course by angels sent as messengers by God was not an indication that they were in error or that they were outside of God's fellowship or influence, but rather the inverse is true. Christians can therefore interpret a change of course as an expected outcome of following on His path of direction. This was evidenced in the current study as the

entire direction of the project was shifted due to unforeseen circumstances that could not have been predicted in the initial planning stages of this study.

A somewhat legitimate concern might be voiced regarding the application of business principles, regardless as to how sound they are, as inappropriate in the House of God; because reliance should be on God giving guidance by His Holy Spirit, and not on 'sound business principles'. Van der Ven (1998:12, 16) voices this same principle of concern in his explanation of empiricism in Practical Theology. He rhetorically asks the question,

> If religious phenomena are approached from a purely empirical viewpoint and conceptualised in pragmatic terms, is there not a danger that they will be reduced to a purely instrumental significance? Will they not lose their identity, their intrinsic worth? Is religion really nothing more than a stimulus for moral action, or a means to achieving other ends? And is such view not in stark contrast with the real aim of religion, which can only be God? …

He provides the answer to this tension by explaining that pragmatism in theology must be transformed into a theological pragmatism in which there is no priority of man over God, but rather a dialectical relationship between God and man, between religious and moral values.

The process outlined by Dayton shares components from various origins. In the late 1970's a version of this process was taught to this researcher as *The Nursing Process*, and has been adapted in various forms to meet various situations. In Practical Theology a variation of this process has been developed by Paul Ricoeur and called *the hermeneutical circle*. Ploeger (1999:73) discusses it in his article, *Practical Theological Theory and the Praxis of the Church*, where he says,

> The hermeneutical circle has to do with 'the spirally development which can be noticed in a special area of thinking', namely the kind of thinking which is about acquiring experiences with the aim of developing knowledge: (1) Observing, (2) Guessing, (3) Predicting, (4) Checking, (5) Evaluating, (1b) Observing, (2b) Guessing, etc.

Newbigin (1986:58) discusses the hermeneutical circle with basic agreement as it applies to the faith community. He takes the following point of departure,

> But I have asserted that it is not possible to use the model of the hermeneutical circle to account for what happens at the boundary between this community of faith and the world that lives without this faith. I have suggested that at this boundary one has to use other models – such as are suggested by the biblical image of death and birth…the language of the Bible

> should be translated into the terms of our culture so that it may correspond to reality, as we know it.

The point here is that our theology and ecclesiology must focus on a contextual praxis, that is, on a reflective engagement as faith communities in the world (Hendriks 2002:76). The faith community, as God's representative here on earth must carefully, prayerfully and with reflection, address the AIDS crisis that threatens to envelop it, if the church is to complete its missions to be the witness of God's love in the world.

> The Church should be the one place to which the AIDS patient should know for certain that he [or she] can turn and find the loving, compassionate support he [or she] so desperately needs (Mendis 1987:39).

One way of breaking the old cycles and allowing new insights to the problems being faced by the faith community might involve using creative methodology to allow fresh ideas entrance into the mind that has been conditioned by continuous repetition of the same, mind-numbing systems. Introducing creative imagery, such as drama, dramatic dance, and other artistic expressions that the congregation is not used to, into the normal and expected liturgy of the congregational service may open doors of imagination and new vision. Dealing with issues that have such a dramatic influence on so many people in so many areas of life requires 'thinking outside of the box.' Trying to apply the same old, and often antiquated, methodology to the new and modern problems associated with this pandemic will not be effective in solving this crisis.

5.9 SUMMATION: LOVE (GOD) IS THE ANSWER

This chapter on the theological implications of Love, along with the inverse implications of alienation, estrangement and prejudice, has examined these issues in light of their relationships with the HIV/AIDS pandemic in both the psychological and anthropological framework. Focusing on both the fundamental nature of the issues themselves in their relationship to faith assumptions, along with the Christian ethical response by the Christian leader of today, this chapter has sought to examine the contextual situation of the congregation as it initiates its response to the HIV/AIDS pandemic.

The importance of the role of the church leader can not be overestimated, particularly in relationship to the impact, for good or bad, that he or she will have on the congregation. Using the biblical metaphor of the shepherd and the flock as a picture of the relationship of the pastor and the congregation, the importance of leading the congregation into a proactive position on this pandemic was addressed using leadership example as the primary motivational format. A working model of the praxis process was developed as an example of the practical theory of how a church leader might begin to initiate and organize a realistic response to the problems associated with HIV/AIDS as they are faced in the local church congregation. Using this model as an example, the church leader can then make an applicable response with the theology of pastoral care.

> The Eschatological character of salvation means that pastoral care cannot be conceived merely as an empirical event with verifiable facts. The message of the Gospel is conveyed in terminology which must be understood metaphorically in terms of a covenantal relationship. It is important to note that when theology exchanges faith for empiricism, it loses its unique character as interpreter of the meaning of the Gospel (Louw 1998:86).

The preceding chapters dealt with the issue of HIV/AIDS historically, and within the framework of the African context and more specifically, the Malawian context; addressing the issues specific to the local challenges facing the local faith communities as they seek to address these concerns in biblical ways. In so doing, this chapter has sought to look more closely at the hermeneutical and correlational implications involved in the contextual ecclesiology of the church as it explores the challenges associated with the patterns of response and praxis regarding these issues.

Focus will now be turned from the issues surrounding the problem to the actual methodology used in this research project. Using qualitative as well as quantitative research methods for data collection and evaluation, a holistic understanding of the interconnected networks within the HIV/AIDS subculture will be developed for interpretation and evaluation. Using this working evaluation, praxis theories will be developed which will lead to the final chapter of this research where discussion regarding the applicability of this project to other contexts and settings or with other groups will be explored.

Chapter 6
The Nkhotakota Case Study
And Subsequent Project Development

6 INTRODUCTION

Although divided by chapters for reference and organizational purposes, the methodological procedures involved in the actual 'doing' of the study have been interwoven into all aspects of this project. In the first chapter, the general problem of the church's negative response to the HIV/AIDS pandemic and the consequential alienation, estrangement and prejudice that became associated with it was identified, using various sampling techniques including interviews and surveys. Before any of the data collection and processing could begin, it was essential to first discover the minutiae surrounding the problem. To better understand all of the nuances involved, it was imperative that the broader picture be assessed. Within this framework, the historical perspectives of the church were evaluated and integrated into the development of the total image as the problem was examined. From this data, more information was compiled regarding specific traditions and cultural gradations specific to the African paradigm. With the picture of the African perspective thus identified, focus was then addressed to the more specific issues within the communities that were actually involved in this study. Just as there are no simple answers to the HIV/AIDS problem, even the questions themselves can be multifaceted and complex. This brought the study to the next logical step, that of determining the theological implications relating to the problem under study which were discussed in the previous chapters.

This chapter will reconsider the entire project, outlining the methodology and rationale taken in order to ascertain precisely the data to be collected for systematic evaluation and interpretation. Once gathered, the resulting data will be analysed and interpreted in the final chapter.

6.2 INITIAL STEPS – THE NKHOTAKOTA HOME BASED CARE PROJECT

Before beginning the project, several fact-finding missions were carried out. In an effort to determine what types of projects were already in process in the local area, as well as assessing the needs of the community, multiple interviews with various organizations and NGOs (Non-Governmental Organizations) were carried out utilizing a guided 'snowball' or chain reference sampling technique (De Vos 1998:254). When the proposed ideas of this researcher were presented, and the 'snowball effect' had begun, theoretical sampling was then employed to direct its course.

One of the main reasons for these initial interviews, other than for the obvious information gathering aspects, was to attempt the avoidance of the 'reinvention of the wheel' by first ascertaining what work was being done in relation to the proposed field of study. Since qualitative research is not 'linear', meaning that one step automatically leads to the next, many of these preliminary fact finding interviews did not offer valuable information in themselves, but often instead lead this researcher to other sources of information that did prove useful to this study.

One such interview that proved significant was with Stella Kasirye, the World Relief country representative for Malawi, and her associate Amos Chigwenembe. They outlined the program they had begun in Nkhotakota, Malawi with HIV/AIDS affected people working from within the church. From this initial interview it seemed apparent there was more that could be learned from the program in Nkhotakota. Therefore in order to gain a holistic understanding of the interconnected networks within the HIV/AIDS subculture in the Nkhotakota district, the research began with systematic enquiry to access and review records, and other written data from the World Relief Organization. In conjunction with this analysis, open-ended interviewing, unstructured interviews with a schedule (De Vos 1998:300) processes were utilized with already identified informants within this organization who have intimate knowledge and understanding of the people and groups involved in the Nkhotakota project. This allowed for the extraction of sufficient information to provide a basis for data collection and interview / relationship building at the case study site.

One of the fundamental attributes of this program was the approach of using the church as the foundation of the work, instead of building it upon the NGO. By keeping the focus on the church and the work coming through the church, the potential for a continuing, viable program that the people involved could take ownership of emerged. Research has shown (Dudley 1996:115) that churches who worked to develop ministries that were consistent with aspects of their own history, vision and mission, instead of seeking new programs which were very different and foreign to their already accepted procedures tended to have less radical and more predictable and satisfying outcomes.

The steps followed by World Relief in the establishment of their program were as follows:

- A needs assessment survey was done in August 1999 to determine the needs of the community. From this assessment, it was concluded that an outreach program designed specifically for those suffering from HIV/AIDS was needed.
    - Already in place was the cultural practice of opening of one's home to visiting members from the church, therefore proving access to those sick in the community by 'opening doors' that might not be otherwise available.

Selection of Churches:

- Once the felt-needs were established, they began to share with the churches the vision of what they called 'Resource Mobilization', issuing an open invitation to all community churches that might be interested in participating in the program.
- Twenty-six Churches responded to this initial appeal, but upon the realization that 'gifts' such as bicycles and blankets were not being distributed; the number of actual churches participating dropped to four.

Selection of Volunteers:

- The churches were asked to identify volunteers demonstrating a heart as well as availability to reach out to the sick and needy in their communities.

- They wanted to get a variety of different volunteers, from various socio-economic backgrounds.
- Volunteers had to be church members so that a church based foundation could be developed (as opposed to a community based program)
- The pastor from each participating church was asked to do two things:
  1. To recruit ten volunteers (to be known as 'ministry team members') to do the actual visitation work
  2. To identify five potential patients based upon the following criteria:
     - Chronically ill, recent hospitalisation, on TB treatment, Outward appearance looks like HIV/AIDS (wasting, lethargy, etc.)

From these initial steps, the rudimentary formation of the Nkhotakota HBC developed. After watching the development of the program and the change in the attitudes of the people, in December of 1999, one additional church came forward requesting the program in their church. By December of 2000, there were a total of eight churches involved, and by December 2002, twenty-one additional churches were expressing interest in developing the program in their churches. Due to an inability to properly supervise and undergird additional works, it was suggested that these churches partner with churches that were already participating in the program (Appendix A).

Because of the work previously done by World Relief, entry points into the Nkhotakota HIV/AIDS community were available with already established gatekeepers. Although generalized permission had been previously granted, understanding the importance of developing and maintaining trust-based relationships to ensure cooperation and accurate information gathering, this researcher made certain that proper permission protocols were continually followed.

Several meetings with the Nkhotakota group followed, both by this researcher with the accompaniment of the HBC ABC student volunteers, and later with established gatekeepers. Following the initial entry into the group, a guided use of

'snowball' or chain reference sampling was again utilized, leading to theoretical sampling which was acknowledged to be an important way to gain access to all those individuals who will be able to contribute to the research. Data collection began as suggested by De Vos, with ethnography and participant observation as a strategy to gain an understanding of the life worlds of the subjects. Then, in order to gain a better understanding of the meaning that they have attached to their worlds, it was appropriate to switch to a phenomenological or ethnomethodological strategy and thus conduct in-depth interviewing with the various levels of subjects, (i.e. this included the actual patients suffering with HIV/AIDS with their families, the individual volunteers and support group facilitators, and church leaders). Several patients were considered for the purposes of providing a case study (Appendix F) in order to provide an illustration of the needs of individuals and groups (De Vos 2001:80). By continually collecting, recording and analysing data, a grounded theory began to emerge, which directed the course of further sources and opportunities for information exchange.

It was important to maintain the focus of the heart of the project directed towards the local church community in order to keep the mission of the project in focus. This allows the faith community to have a more realistic ownership of the mission, which is supported by Dudley's article demonstrating the propensity for church members to be consistently more concerned with helping people in their own communities deal with the tangible problems they face, as opposed to involvement in the resolution of seemingly elusive problems of society (Dudley 1996:115).

For the purposes of this research, one church, the Chididi Baptist Church, was selected as representative from those participating in the Nkhotakota study. This church was chosen, not because it had better results or more respondents; but rather because it was the most typical representation of the whole of the group. The following case study demonstrated the growth and development of the HBC program within the Chididi Baptist Church:

6.2.1 Case Study: Home Based Care at Chididi Baptist Church

Reverend Akiwa Chimsolo has been the pastor of Chididi Baptist Church, which is located in Mgombe 2 Village for the past 10 years. It currently has a membership of 233. In 1998/99, it was one of the churches that expressed an interest in the initial appeal to local churches to begin a HBC program. Eight volunteers from this church were identified as interested and qualified to begin visiting the sick. By the time the program had been in existence two years, there were approximately fifty volunteers, and the following year (2001-2002 the present time) this number rose to one hundred volunteers who are visiting the sick in their community.

The church developed a committee specifically for the visitation work with Rev. Chimsolo as the chairman. Primarily those who are participating on the committee and the youth do visitation. Comments were made during the interviewing process that the youth are doing a commendable job in their participation and involvement in the HIV ministry.

Attitudes present in the church prior to the beginning of the HBC program[32]:

- 5-6 years ago people (children, as well as adults) would laugh at people afflicted with HIV/AIDS, commenting that 'it is your own fault', 'you were negligent', etc. They would not associate with them.
- HIV positive people had many needs. In addition to basic physical needs, they were found to be lacking basic human needs such as fellowship with God, thinking that God didn't love them.
- Orphans left by the devastation of HIV/AIDS were sometimes ill-treated.
- Approximately 75% of those in the church shared these negative attitudes.
- Patients were afraid to go for testing or declare publicly their HIV status.
- The program initially started with 25 volunteers, but because of peer pressure and discouragement from the majority of the congregation, that number dropped to the initial eight volunteers.

[32] This reflects the attitudes reported by Rev. Chimsolo and supported by others from the congregation as well as workers involved with World Relief

- The following story about the late Abiti Ahamadi was told by Pastor Chimsolo as an illustration of people's attitudes prior to the development of the HBC program:
    - Abiti Ahamadi was shunned by her family and forced to run away and live in the bush. Her uncle softened in his harsh behaviour and began to look for her. When he found her, he brought her to Chididi Baptist Church, where she received emergency shelter and provision, along with emotional and spiritual care. Once her condition was stable, those in the church reached out to the family, providing them with loving acceptance, along with accurate information about HIV/AIDS and its effects. In the end, the family reached out to Abiti Ahamadi in love, and they were able to provide compassionate care for her until her death.

Current attitudes held by the vast majority (approximately 95%) of the congregation:

- People suffering with HIV/AIDS are part of the church family and are embraced with love.
- People are accepting the fact that HIV is real.
- Some of the people most active in the antagonism against the program have now gone for testing.
- Some members of the church are going for testing, and sharing their positive test results with the church.
- Even the local chiefs receive AIDS Awareness Campaigns warmly.

According to Pastor Chimsolo, the dramatic attitude changes noted in the Chididi Baptist Church can be attributed to the following:

- Education and counselling about HIV/AIDS.
- Individuals with positive HIV declaring their status in public.
- At funerals people are now able to declare in public when a patient died of AIDS, contributing to a change in perception towards these patients by the community.

- Items of relief (by World Relief, first as an example, and then by the volunteers themselves) that can be distributed to those in need which demonstrated love and kindness in a tangible way.
- The people's attitudes changed as they became more open and aware.

It should be noted that each person interviewed concurred with the same comments that Rev. Chimsolo was an outstanding demonstration of Christ's love as he continually sought out those who were suffering and offered them love and hope as he not only invited them to join the fellowship group, but also provided counselling, physical assistance and transport as well as sharing his own personal resources with them when necessary. It appears that he is willing to give and do anything for the cause of Christ. Certainly it must be concluded that his excellent example has greatly contributed to the direction this church has taken in their fight against AIDS.[33]

From this initial program of visiting the sick and homebound in Nkhotakota, several other secondary programs have been developed. Examples of these projects include an HIV/AIDS support group, home visitation by the HIV/AIDS members themselves to others in their groups who are suffering, garden planting and feeding projects, youth awareness programs, health education information sharing, etc.

Of these outcomes and perhaps the most significant, at least to those who are currently HIV positive, is the HIV/AIDS support group. When visiting with these people, it was clearly the support group that they felt benefited them the most; ministering to them in such a way as to give them a constant source for encouragement and hope. In addition, it gave their lives cause and purpose while providing them with an opportunity to lose their role as 'victim' and once again become a vibrant, contributing member of the group. The formation of this support group has led to the group seeking creative ideas for I.G.A. (income generating activity) and land has been identified that team members/patients can use for food production as an I.G.A.

Through the mutual and ongoing support from this group, those infected by the virus were able to gain a sense of purpose and identity, thus giving them the

[33] For additional case studies of individuals in the Nkhotakota program, please see Appendix (F)

courage to be more open and outspoken about their HIV status. Members of this group have shared publicly in churches, schools and even on the radio about their personal journeys with HIV/AIDS, educating those hearing them and breaking down the walls of stigma and isolation caused by ignorance and fear. This has helped to remove the shame and disgrace from this disease, giving others the courage to admit their own status, or that of their loved ones.

Another very important offshoot from the program has been the positive effect it has had on the youth. The youth have become active participants in the visitation of the sick and have also sought creative ways of expression such as the use of drama and song, which prove to be a witness to others as well. As the youth are exposed to the sick and dying, the horrors they have witnessed have served to provide a strong reality based message for them to avoid behaviours that contribute to such demise. The church itself has seen a new vibrancy and sense of caring as its members join the efforts of the volunteers; and visiting the sick and needy becomes a church wide activity.

6.2.2 Initial Steps – Formulation of ideas

The Partners in Hope[34] core group used the information gleaned from these interviews in consideration for determining the way forward for the HBC development. This resulted in the formation of the Partners in Hope HBC Planning Committee (HBCPC), which included Dr. Perry Jansen, Mrs. Grace Banda (Appendix B) along with this researcher. Sensing the growing and exorbitant need, and through the desire of their hearts to find a way of impacting this problem of HIV/AIDS in this part of the world, this group began meeting on a regular basis to determine the direction and vision of the concept of HBC in the local community. While accumulating information from the various sources previously indicated, a grounded theory began to develop. Some of the issues raised for discussion were:

1. Overview of vision for HBC
2. Foundational / needs assessment

[34] 'Partners in Hope' is the name of the department of the ABC Community Clinic whose mission is to reach out to those suffering with HIV/AIDS in Lilongwe. Dr. Perry Jansen, the ABCCC medical director heads this organization which includes the HBC as well as counseling services and treatment options available to those suffering with HIV/AIDS.

3. Village Permission
4. Funding alternatives
5. Defining criteria for recipients of care
6. Who will be involved in HBC (staffing)
7. Training for HBC volunteers
8. Tentative time frame / scheduling

6.3 OVERVIEW OF VISION FOR HBC

Initial attempts were begun towards the development of HBC, in the form of chaplainry (non-medical) visits, using ABC students as the visiting chaplains in conjunction with those churches that would express an openness and willingness to participate in the HBC program. This would also be part of an outreach activity designed to meet the students' scholastic practical application requirement for ABC. In these initial meetings, the vision was expanded to eventually include an eventual medical component. With the proper funding, it was hoped that a full department of medical home care would be developed in conjunction with the ABC Community Clinic (ABCCC). This will include the use of registered nurses and other medical staff who will work to meet the physical and spiritual needs of those suffering with illnesses that confine them to their homes.

6.3.1 Funding Alternatives

Dr. Jansen submitted a proposal for funding, which would underwrite the total program cost, including medical personnel and vehicles (Appendix I).

In addition to this, a proposal was submitted to Second Presbyterian Church (Memphis, Tennessee, USA) Special Project Committee for funding for a special medications fund to provide basic medications such as analgesics and antibiotics for $1000.00 (USD). It is anticipated that this will be enough to provide medicines for 1-2 years worth of HBC visits.

As the plan began to formulate and the vision began to emerge, it became clear that a grass roots level of church involvement was essential. As ideas and options were explored, home care began to emerge as a promising entry point into this

group of marginalized people. Once awareness of the situation and possible solutions came under discussion, it became apparent that it was essential for this to be a program designed with a commitment to *empower the local church* as opposed to one that would be a source of gifts and supplies to be given to the churches. With this as a priority, it was therefore determined that a program must be developed in order to avoid donor dependency, enabling it to be fully 'owned' by the local church, with only training and facilitation provided by an outside source.

6.3.2 Village Permission

In order for the project to proceed in a harmonious way, it was deemed necessary to obtain the permission and blessing of the Mtsiliza Village chief. Due to lessons learned from past dealings with this chief, and in consideration of his opportunistic nature, it seemed good to assemble a small Malawian delegation to meet with him. Prior to this meeting, a meeting of those delegates (Mrs. Grace Banda, Richard Chigwenembe ABCCC Chaplain/Lab Director, Rev. David Phiri, pastor of Chimbalame Assembly of God – which had previously indicated interest in their church participating in the program, and his associate and church treasurer, Thomas Mambo) took place to ascertain the best approach for the meeting with the chief. From this meeting it was determined that the best approach would be to avoid any obvious connection with the ABCCC in an attempt to minimize the concept that this program was connected with resources which could be manipulated by the chief for his financial gain. Throughout the formation of the program, and including these beginning meetings, it was emphasized that this was to be a 'grass roots' type of program which would empower the local church to mobilize itself in reaching out to the sick and dying in the community, not a Western backed program from which funds and material items could be extracted.

6.3.3 Needs assessment (including Quantitative Approach Survey)

In order to undertake a preliminary investigation of the target group prior to the more structured study, a randomised cross-sectional quantitative survey was developed (Appendix G), targeting the villages adjacent to the ABC campus

collectively known as the Lingadzi[35] area, to assess their perception of the attitudes of those in their community who are suffering with HIV/AIDS and their families as they view the Church. The single-system design (De Vos1998:140) was used to specify the problem as well as establish a baseline for measurement of change as the researchers worked to ascertain the prevailing attitudes of those in the village as they perceive the attitudes of the Church towards those in the community suffering with HIV/AIDS. This was done to assist in determining the needs of the community as well as for formulating the baseline of information for use as a comparison for studies and surveys in the future. This information would also establish the baseline criteria necessary to determine the effectiveness of the program once it has had an opportunity to impact the target population.

The quantitative portion of this study was limited to the Lingadzi area and therefore did not including the Kaning'a area for the following reasons:

- Due to the poverty of Lingadzi (all of the people are restricted to pedestrian travel), the villages within this containment area were condensed into a more controlled locale that could be canvassed on foot.
- Kaning'a' level of affluence (the people are able to drive and travel greater distances) allowed for the distribution of their containment area to be much broader and less concentrated, which would have caused considerable difficulty in accurately assessing those influenced by this project.
- Although both groups were involved in this study, the major focus of this project involved the first class of HBC volunteers, with the second class (the Kaning'a group) being used primarily as a balance and model for comparison.

Further research with quantitative studies of this group would be advisable but were not within the scope of this research.

Prior to beginning the survey, a working hypothesis had been developed to formulate the problem based upon discussions with clergy and individuals in the target area. Based upon the information gleaned from the Nkhotakota project, it was extrapolated that similar problems would be also prevalent in the target community. Elders of the community had previously come to the ABCCC voicing a need for

[35] The villages included in the Lingadzi area include the following: Mtsiliza, Chimbalame, Pearson and Mtandira.

Home Based Care, saying there was nothing of that nature in the area, and people were desperate for this type of service.

This assessment survey was done utilizing ABC students, interviewing those people who live in these villages. These surveyors were selected based on several factors.

- They were knowledgeable of the geographical areas in the targeted village and could make educated determinations regarding which areas would most typify the village as a whole, along with consideration of which areas were more isolated and therefore less likely to reflect an accurate picture of the villagers.
- In addition to knowing the area, the surveyors were all Chichewa speakers (as their primary language) who had intimate knowledge of the Chewa culture and would be able to ask their questions with such sensitivity as to avoid offending the people who were being asked to participate in the study.
- The surveyors also had to demonstrate a personal interest in the HIV/AIDS crisis and have an interest in the results of the study. It was believed by this researcher that those with a heart for this type of work would be more likely to take the steps outlined to ensure an accurate and reliable survey.

The first step in developing this survey was to identify the research population as the Mtsiliza village and those small villages adjacent to it (known as the Lingadzi area), which would contain the people in the geographical area that would be involved, either as patients or volunteers in the HBC program. Because of the large population of this area, it was determined that in order to get a representative cross section of individuals, the research assistants would canvas every fourth to fifth home. People who were clustered in groups were to be avoided as an opportunity to gather information from many people at the same time, due to the fact that these groups would probably be less reliable in their accurate portrayal of individual feelings and attitudes. Considering the strong influences of peer pressure that might be exerted by the individuals in the group, the reliability of truthful response might be diminished

causing respondents to give answers that they thought might be more acceptable to the group, than actually reflecting their personal thoughts and ideas.

In addition to an in-service meeting explaining the nature and purpose of the survey, a detailed instruction sheet was made for each surveyor with additional guidelines to ensure as unbiased outcome as possible (Appendix E). Because of the anticipated high illiteracy rate of the subject communities, this informative meeting was designed to take the place of the covering letter explaining the survey, which De Vos described as an 'integral part of any questionnaire (201:157)'. Once this researcher was satisfied that each field worker had an accurate grasp of the vision and mission of this project, they were then released in eight teams of two in order to accomplish this task.

It was decided that the survey must be completed prior to the time when the Partners in Hope HBC Volunteers would be trained and beginning to make visits in the community, the surveyors were accordingly instructed in the time frame requirements for the completion of the survey. No attempt was made for mailing the surveys or relating to the individuals in the community in any other way. This was because for the purposes of this survey, the target group is made up of people on the lower echelon of society, with a high rate of illiteracy, therefore causing an oral communication style in their native language of Chichewa to be the best alternative for an accurate attempt of communication. The number of respondents finally included in the needs assessment survey totalled 424[36] individuals. Of these individuals who participated in the survey, the following breakdowns were noted.

Age Level of Respondents:

15-20	21-30	31-40	41-50	51+
97	117	107	61	36

Educational Level of Respondents:

Primary School	Secondary School	College	Trade School	Other
222	100	15 *(questionable)*	54	25

Religious Beliefs:

Christian	Muslim	African Traditional	None	Other
330	66	9	21	25

[36] The difference noted in the numbers of each category can be attributed to the fact that not all respondents answered all questions.

Of those who considered themselves Christian:

CCAP	Assembly of God	Roman Catholic	New Apostolic	Anglican
63	5	104	1	26

Zambezi Evangelical	Abraham Church	Baptist	Church of Christ	7 Day Adventist
7	2	5	16	38

African Chipangano	Lutheran	Other
21	1	28

Those that believe HIV/AIDS has affected their immediate family:

Yes	No	Uncertain
178	151	92

Efforts were made to reduce the tendency of individuals to answer according to what they considered to be the expected norm by encouraging the respondents that there were no 'right' answers, that all answers were valid providing they were an accurate reflection of the beliefs held by the individual. In addition, as noted above, surveyors were instructed to avoid groups because those in a group may be motivated to answer the questions according to their perception as to what the group might deem most acceptable. Children were also to be excluded because they may not fully understand the questions, which would contribute to too large of a section of variables. It was hoped that the target group for obtaining responses to the questions being posed to them by the surveyors would reflect those who are most likely to contract the disease.

Survey questions were designed with the basic principles outlined by De Vos (1998:157):

- Sentences must be brief and clear, and the vocabulary and style of the questions must be understandable to the respondents.
- Questions and response alternatives must be clear and not reflect the bias of the researcher.
- Every question must contain only one thought.
- Every question must be relevant to the purpose of the questionnaire.
- Abstract questions not applicable to the milieu of the respondents must rather be avoided. Researchers must also not take it for granted that respondents will have knowledge about a subject.

- The sequence in which the questions are presented must be aimed at general, non-threatening questions first and more sensitive, personal questions later.

The pilot testing of the questionnaire was done with ABC students who are sensitive to the cultural understanding and mindset of the test population, and would become the fieldworkers performing the survey. Since they would be posing the questions that were given to them in English, in Chichewa, they were given the flexibility to word the questions in what they considered to be the most easily understandable, culturally sensitive way.

A variety of response systems or question types were used in the actual questionnaire. There were some dichotomous questions, but this format was kept to a minimum in order to get more depth of insight from the responses obtained than can be done from simple 'yes and no' questions. There were some questions designed as basic multiple choice questions, but most were within the nominal scaling framework, primarily utilizing the numerical scaling method (De Vos 2001:169) with a modified use of the Thurstone technique (De Vos 1998:171). Modified in the sense that instead of using a scale of 11 with number six (middle) being neutral, this method was simplified to using a scale of 5, with number three (middle) being the neutral response. Therefore, the questions were designed with number one being the least favourable, number three being neutral, and number five being the most favourable answer. Numbers two and four were not defined, but available for those respondents who didn't feel their answer clearly fit into the category on either side. These modifications were deliberate as it was felt that having eleven choices would leave the respondent confused and diminish the reliability of the questionnaire results.

The actual questions used for the survey (a sample questionnaire) follows:

*Question #1: How do you think people in the Church feel about those suffering from HIV/AIDS? (total respondents 321)***

1	2	3	4	5
Christians don't get HIV/AIDS. Those that do are receiving the punishment they deserve for the sins they have committed.		There aren't any people in the church with HIV/AIDS. It isn't a problem that they have to deal with.		They want to reach out to them with the love of Christ and do all they can to relieve their suffering.

*Question #2: How do you think people in the AIDS community feel about the Church? (total respondents 424)***

1	2	3	4	5
People with HIV/AIDS are not welcome in the Church because		People with HIV/AIDS can come to the church, but people		People with HIV/AIDS feel love and acceptance when

they are sinners.		keep their distances from them.		they are in the Church or around Christian people.

*Question #3: Do you think attitudes between the church and the HIV/AIDS community have changed in the last few years? (total respondents 342)***

1	2	3	4	5
There is no difference in attitudes in these groups.		People are more open and aware, but continue to act in the same way		The church is seen as more loving and accepting of the HIV/AIDS community now.

*Question #4: Has anyone in the family suffered from HIV/AIDS? (total respondents 421)***

1	2	3
Yes	No	Uncertain

*Question #5: Level of Education (total respondents 416)***

1	2	3	4	5
Primary	Secondary	College	Trade	Other

*Question #6: Religious Beliefs (total respondents 427)***

1	2	3	4	5
Christian*	Muslim	African Traditional	None	Other

For a breakdown of the various Christian denominations, please refer to Appendix G.

6.3.4 Development of working Grounded Theory

A substantive grounded theory began to emerge as the above data was analysed and evaluated (see chapter 7 for conclusions, De Vos 1998:266). From this point, information surfacing had application in the congregational, as well as the individual setting, which led to the formation of a praxis theory as well as a sustainable strategy on how to implement it.

6.3.5 Defining criteria for recipients of care

When the churches and students selected were prepared and ready to begin, the churches were asked to identify those within their midst who are sick. There was no attempt at determining if these are truly 'AIDS'[37] patients. This is due to the strong denial system (3.2) that is present, as with many other African cultures, in the Chewa culture. If it were to become known in the initial phases of the ministry that this was an outreach to AIDS sufferers, there would be no one who would allow a visit that would effectively identify them as an AIDS patient.

No attempt was made to limit patients to those who attend, or are members of, or are in good standing with, the churches cooperating in the program. It was recognized that most of the patients, especially in the initial phases of the program, would be comprised by members of those participating churches, and it was hoped that as word spread about the services offered; those outside the church's direct sphere of influence would then seek HBC assistance for themselves and their loved ones as they began to recognize this as a beneficial service that could help them.

There was no selection criterion regarding patient's financial considerations, their family's funds or ability to pay for services. All services provided by the HBC volunteers were entirely free of charge. The only criteria was that a referral (from physician, or church or other) and the recognized need of the patient for services. No attempt was be made to visit anyone who is not receptive to being visited.

The focus of this study was the goal of changing the attitudes of both the churches participating in the study and the local HIV/AIDS community. By observing the local congregations action plan, the churches in the surrounding community will see the example of Christ's love in action, witnessing the impact it is making in their own community. If these churches follow the pattern demonstrated in the Nkhotakota area, they will want to become participants in the program so that they too can begin reaching out to HIV/AIDS victims and their families in a loving and compassionate way, and therefore acting out Christ's commandment to *'love one another.'*

[37] Realistically, it is presumed that most of the homebound patients who will be involved, even in the initial steps of this program will indeed be HIV/AIDS sufferers based upon statistics given for both the general population and those who seek medical attention.

We love because he first loved us. If anyone says, 'I love God', yet hates his brother, he is a liar. For anyone who does not love his brother, whom he has seen, cannot love God, whom he has not seen. And he has given us this command: Whoever loves God must also love his brother. Dear children, let us not love with words or tongue but with actions and in truth.

> If one of you says to him, 'Go, I wish you well; keep warm and well fed', but does nothing about his physical needs, what good is it? In the same way, faith by itself, if it is not accompanied by action, is dead. But someone will say, 'You have faith; I have deeds.' Show me your faith without deeds, and I will show you my faith by what I do. 1 John 4:19-21, 3:18; James 2:16-18 (NIV)

6.3.6 Who will be involved in HBC (staffing)

During the initial phase of the HBC, the staffing consisted of ABC students as they participated in the HBC program as part of their outreach requirement for ABC. Amos Chigwenembe from World Relief came to ABC to help the students understand the basic components of HBC, using various teaching methods such as PowerPoint presentations, small group question and answer, and informal lectures. Once he had shared the initial vision for the program, the students who were familiar with the churches currently working in the targeted village area were asked to consider which churches would be most likely to want to participate in the program. Three churches were identified and the students proceeded to make contact with them in an effort to enlist them in the project. Due to various difficulties, such as the heavy bureaucratic nature[38] of some of the churches[39] (CCAP in particular), only one church was initially identified as willing to participate in the HBC program, the Chimbalame Assembly of God. Once the target church was identified, the students began as 'chaplains' to immediately seek volunteers from the cooperating church to become the primary HBC visitors.

It was important from the start to delineate and establish the roles of the ABC students. They were never to be seen as the primary visiting force, but only in a supplementary role of the HBC program from within the church. Although this aspect

[38] To qualify this statement, the researcher has questioned approximately 60 students who are members of the CCAP who all have described the governmental structure of the CCAP as being heavily bureaucratic.

[39] Mr. Amos Chigwenembe, himself a member of a large, local CCAP church has been unable to introduce HBC into the church due to the heavy bureaucratic system of government that has proved to be a stumbling block to every effort he has tried to make to introduce this program into his church.

was recognized in the initial stages of development, its significance was not fully appreciated until the visitation actually began. Because of the ABC class and semester schedule, it was deemed important that the students take a secondary role to the church's volunteers in order to maintain continuity of care for the patients during holidays and breaks from classes for the students.

Another significant development became apparent when the students began making visits. As the students teamed up with the volunteers, the volunteers had a natural tendency to take a secondary position, with the assumption that since the ABC students were Bible college students, they were more educated, and therefore in some considerable ways superior to the village volunteers. Noting this tendency from the start, appropriate measures were taken to avoid this mindset in both the students and the village volunteers.

6.3.7 Training for HBC volunteers

The criterion for selecting volunteers was to search for those demonstrating a 'heart' for the sick and homebound from within the church membership. It was envisioned that as more churches enter the program, each church would have their own members who would become HBC volunteers for their own respective congregations. ABC students were to be seen as resources for assisting and encouraging the churches as they develop their own program.

It was determined that all those who volunteer and demonstrate a willingness to participate in the program, along with possessing an ability to learn, were to be included in the training as HBC volunteers. Some discussion was held amongst the committee members regarding qualifications and selection of capable volunteers. It was decided that at least initially, all those who are interested in participating would be invited to come and be part of the training program. During the actual training sessions the individuals would be evaluated and their commitment and performance abilities assessed. Based upon local experience along with the results of the Nkhotakota project, it was assumed that a fair number of those who expressed an initial interest would drop out as the program developed and they realized there would be no financial reward for their time and energy spent; that it was only for those truly committed to this Christian benevolent work.

ABC students were taken to Nkhotakota to visit with the HBC volunteers in the model World Relief program. In addition to in-depth personal interviews with the volunteers themselves, the ABC students, along with this researcher were able to directly observe through participant observation the ethnography of the groups in an effort to gain an understanding of the life worlds of the support group members during their scheduled meetings. During these times they were able to interact with the already established control group in Nkhotakota, along with actual HIV/AIDS patients who were currently participating in the HBC program. They also met with the leadership of the participating churches utilizing open-ended interviewing, and unstructured interview with a schedule (De Vos 1998:300) techniques with the purpose of relationship building, as well as gaining intimate knowledge and understanding of the people in order to gain a better understanding of the HBC program in Nkhotakota.

Prior to this fact-finding interviewing session, the ABC students were given generalized overviews of the vision along with the anticipated hopeful responses of the local churches by the World Relief leaders who were participants in initialising and maintaining the Nkhotakota program. It was initially anticipated that several levels of training would be offered. The first level training course will consist of (tentatively) a four-week plan. At the end of the four weeks, it was expected that the participants would be able to demonstrate commitment and competency in the areas of instruction.

6.3.8 Home Based Care Curriculum Development

Work then commenced on the development of the proper curriculum. A team of three: this researcher, Mrs. Grace Banda, and Mrs. Hillary Edwards, a registered nurse practitioner from England[40] who specializes on palliative care, set out to develop a plan for teaching that would effectively equip the volunteers in the basics of physical and spiritual assessment, teaching them how to deliver care and compassion to the sick. Dr. Perry Jansen, the medical director of ABCCC and Partners in Hope was available for medical consultation as well. A comprehensive overview of the

[40] Mrs. Edwards was working with the V.S.O. in Malawi, for one year during the time of this study with the Lilongwe Central Hospital HBC as their palliative care nurse specialist.

four critical areas identified was developed, with full translation into Chichewa with the anticipation that most villagers who would want to participate in the program would not have an adequate understanding of the English language for instruction. After much discussion and needs evaluation development, basic needs identified for instruction became apparent. Home Care workers will be equipped to function as agents of the ABCCC Home Care Program in the following ways:

1. Each HBC volunteer will be required to attend the HIV/AIDS awareness class (provided by the ABCCC) giving evidence of a thorough understanding of the basic components of the HIV/AIDS virus as well as how the human body reacts and responds to it. Within the framework of this class, participants will become knowledgeable in the prevention, transmission, and various manifestations of the disease, as well as the treatment modalities, available worldwide, as well as in Malawi in particular.
2. Each HBC volunteer will be taught the basic principles of aseptic technique to assist in the reduction of transmission of germs and disease. Basic medical assistant skills will be taught in order to fully equip the Home Care workers to give basic physical care in a safe and compassionate manner.
3. Each HBC volunteer will be instructed on basic counselling and listening skills in order to assist and equip them in dealing with patients in a caring and emotionally sensitive way.
4. Each HBC volunteer will be taught various ways of sharing their faith so that they will be fully equipped in order to, as stated in 1 Pet 3:15,

> But in your hearts set apart Christ as Lord. Always be prepared to give an answer to everyone who asks you to give the reason for the hope that you have (NIV).

It was determined that this could be accomplished by providing four structured training sessions one each week for four weeks, with one of the above topics covered at each session. With this framework in mind, classes were scheduled; the selected churches notified and work began to develop the actual training materials (Appendix D). Once word began to spread in the area that training opportunities existed for HBC development within the church, many requests began to surface from churches in the surrounding areas. It was obvious that this could soon develop into something far too

big to be managed adequately, and therefore it was decided that only these three churches who had already been identified would be allowed to participate for the first year, and only after evaluating their responses and the impact of this program, would the decision be made as whether to expand and further develop the HBC program.

6.3.9 Selection of Volunteers

ABC students participating in the program were selected by their own admitted interest in desire for working in the HBC setting. In addition to their college coursework (which includes spiritual instruction and ministry), they will be given additional training in counselling and interpersonal relationship skills. This actually proved to be more of a challenge than anticipated as some of the students had no previous experience with long-term care/relationships and had a tendency to 'pounce' on the patients with the Gospel message, so special 'sensitivity' training was developed and utilized to aid these students in understanding the special needs of the chronically ill and dying patient.

Following the recommendations of the Partners in Hope HBCPC, and in consideration regarding the local churches in the area that might be open to developing a HBC program in their congregation, three churches stood out as realistic possibilities.

1. The *Chimbalame Assembly of God* was considered because of its past relationship with ABC[41]. They have proved themselves to be open to participating in various outreach programs with the students at ABC as they seek to develop ministry skills in the local churches. The pastor of this church, Rev. David Phiri is energetic and forward thinking. This church is growing and innovative in its ideas for moving ahead in the future. After a personal interview with Rev. Phiri and his associate and interpreter, Tom Mambo, they were able to see the potential for such a program. Rev. Phiri confirmed the suspicions of this interviewer by

[41] The Chimbalame Assembly of God have been allowing ABC students to work with their members in outreach activities to children, and widows; including orphan programs and feeding programs. They have also hosted the JESUS film from their church as a joint ministry with ABC students. These programs have proved to be mutually beneficial for both the students as they seek ministry experiences and for the Chimbalame church as they reach out to their membership and community.

saying that in general the church has a very poor attitude towards those suffering from HIV/AIDS in their community. He estimated that approximately 75% of church members in his church and the surrounding local area shared such negative views.

2. The *Kaning'a CCAP* (Church of Central Africa Presbyterian), Nkhoma Synod, was considered because it is physically the closest CCAP congregation to ABC. This researcher was interested in working with the CCAP because this is the largest protestant denomination in Malawi[42]. Overtures were made through students of ABC who are already members of this church, as well as attempts by Amos Chigwenembe, an ABC graduate currently working as one of the national leaders of World Relief Malawi, who is also a member of the CCAP and familiar with the leadership of this particular congregation. Due to the heavily bureaucratic nature of the CCAP, it has been found by ABC's past experience to be extremely difficult to work with, since new ideas for ministry have a tendency to get bogged down in the local committee level and never have the opportunity to develop. With this history in mind, this researcher attempted a more creative way of approaching this congregation. After discussions with Rev. Dr. Hennie van Deventer, the principle of Nifcott (Nkhoma Institute for Continuous Theological Training), it was suggested that this researcher meet with the AIDS task force that was already in place within the Nkhoma Synod to work with HIV/AIDS patients and problems in the central area of Malawi. This task force was attempting to meet the problem with HIV/AIDS in Malawi with a multi-faceted approach, addressing the issues of gender, families, orphans, poverty, etc. Their vision was large but their actual capabilities were found to be quite limited due to resources that kept their influence restricted to the local Nkhoma Hospital area. After meeting with the task force and sharing ideas and concerns it was obvious that they were

[42] Apart from the traditional religions, Christianity and Islam have become established in Malawi. Most Christians belong to one of the four major churches: Presbyterian, Seventh-Day Adventist, and Anglican. Of the four major denominations, the Church of Central Africa Presbyterian (CCAP) is the largest. Collection and organization of data © 2000 by Adherents.com.

interested in this project but because of their limited resources, they were unable to have any work of significance outside of the immediate Nkhoma area. They were therefore pleased to be allowed the opportunity to participate and work in cooperation with a work of this nature in Lilongwe. Following the full endorsement of the National AIDS Taskforce by the Nkhoma Synod, this researcher then approached Rev. Khombe, the pastor responsible for the ministry at the Kaning'a CCAP. It was obvious from his response that he had been duly informed of the work we were attempting to do and was anxious to have his congregation involved. He expressed enthusiastic interest in the prospect of bringing HBC to his congregation (about 2.8 thousand members). Rev. Khombe stated they are ready to begin as some are visiting the sick already, but they need some organization and this training should be just what is needed. Listening intently to the concept of HBC development from within his congregation, both he and his wife eagerly said they would like to be involved, and would be members of the first training class.

3. The third church, which initially seemed to hold possibilities for participation was the *Glorious Temple Assembly of God*. Following an intense classroom discussion on HIV/AIDS in Malawi, addressing the role of the church as well as the individual in the fight against AIDS[43], one student (Joseph Wowa, freshman student at ABC) shared the events he observed in his church the following Sunday. He shared in amazement, that his pastor, Rev. Edward J. Chitsonga, had preached a message about HIV/AIDS from the pulpit that very Sunday, covering much of the information he had received from our classroom discussion. While meeting with Rev. Chitsonga, who has experience as a trained Clinical Officer, and also chairs the commission on HIV/AIDS at the national level of the Assembly of God denomination in Malawi, the opportunity was presented to him for his church to participate in HBC

[43] This discussion took place in the classroom setting where this researcher works as a lecturer at ABC, teaching Christian Ethics and Leadership Development.

training. Although personally interested, it was his wife who seemed to more fully grasp the significance of this project.

The pastors from each of these faith communities were in full agreement that the general attitudes within their churches, along with others in this local community reflected and supported the negative attitudes identified at the beginning of this dissertation.

6.3.10 Tentative time frame / scheduling

The saying 'timing is everything' is applicable to the study and work of the church with HIV/AIDS in today's world. Just a few short years ago the church as a whole, was acting as the proverbial ostrich with its head stuck in the ground. By pretending that if it didn't see and often refusing to acknowledge the problem (2.2), it would not have to address or deal with it. Due to world circumstances the church, of Africa in particular, is being forced to realize that this is a problem that must be attended to, but the looming question remains as to how this is to be done (2.3). Many individuals and groups within the body of the church were beginning to realize that something must be done, but an overwhelming sense of helplessness often prevailed as they saw the magnitude of the problem and had no idea as to how to begin. It was into this sea of mixed confusion and despair that this researcher found many of the churches. This is particularly significant when considered in conjunction with the African *ubuntu* philosophy (as discussed in point 4.3). Although the associated negative connotations of AIDS kept the African church at a distance from those suffering from the disease, the cultural sense of *ubuntu* caused them a sense of discomfort and frustration. Because of this, when presented with an opportunity to train their members, equipping them to actually 'do' something from within the church to deal with these issues, the churches excitedly listened with attention on how they might participate in order to make a difference in their local congregation and community.

An unforeseen turn of events evolved as Rev. David Phiri, the pastor of the church initially selected as the study church, the Chimbalame Assembly of God, took it upon himself to solicit interest from other churches in the local village area to join with him in this project. With his encouragement, fifty-two individuals from ten

churches, representing ten different denominations, from a conglomeration of several villages immediately surrounding the Lingadzi area stepped forward to have some of their members participate in the training programs.[44]

There was some preliminary concern that mixing the members of the village churches with those from the Kaning'a CCAP, who come from a higher socio-economic status might prove difficult, but in actuality this did not prove to be a problem. Because of scheduling and other difficulties, neither the Kaning'a CCAP nor the Glorious Temple Assembly of God elected to participate in this first training class. This left only the village churches to participate and resolved the potential difficulty.

In an attempt to convey the message that this was a serious class, it was emphasized that classes would begin at exactly 9:00 o'clock A.M., and each member would be expected to be there at the beginning of each class. In order to keep the class motivated and under-gird the idea that this was an important event, it was decided that attendance at all four sessions would be required in order to complete the course. In additional to their comprehensive HBC training manual, each person completing the course was given a certificate of completion, a 'Partners in Hope' tee shirt and tote bag, a Chichewa Bible, a folder with necessary paperwork and an official picture name badge indicating they had completed the course and were recognized as an official HBC worker by their church and the ABCCC Partners in Hope HBC program.

Because of the emphasis on the importance of the program as well as the motivation and desire of the individuals to participate in the program, all fifty-two of those who had indicated an interest were lined up and ready to start a full hour before class was due to begin. At the end of the four-week session, *all fifty-two* participants had met the requirements, and were therefore qualified to receive certification of completion and begin changing their community. The unexpected total commitment and enthusiasm of this group exceeded the expectations of all those participating in the facilitation of these training sessions. At least a significant amount of this

[44] The 10 churches participating in this initial training class were as follows: Assembly of God (18 participants), CCAP (14), Roman Catholic (9), End Time Pentecostal (7), Anglican (2), African Chipangano (2), Zambezi Evangelical (1), Pentecostal Holiness (1), Baptist (1), Church of Christ (1)

commitment can be attributed to the fact that Rev. Phiri, and those interested in this program held an all night prayer meeting the night prior to the first meeting, seeking God's will, vision and intervention in this project.

6.3.11 Ownership of Home Based Care program - Issues in Development

Although the structure and content of the training program was pre-determined, it was deemed important to instil a sense of 'ownership' of the program into the volunteers. With this concept in mind, an allotment of time at the end of each class was set-aside for practical matters such as determining the means of management and structure for the group.

The group quickly voted to continue using the name, 'Partners in Hope' for the HBC volunteer program. At the outset, the proposal was that each church would have its own HBC program, but what this group decided was to continue as a perpetual group, functioning in such a manner so as to include all of the churches in the efforts of the group. When it came to determining the management system, the individuals in the group became quite interested in determining a rather formal system of government. For facilitation purposes, during the discussion several possible alternatives were suggested by the HBCPC, leaving ample openings for additional ideas to be brought forward for consideration as well. With the goal of determining their organizational structure before them, they then decided that a committee should be selected which would represent the entire class. This committee would then be able to make decisions regarding questions and policies as they were needed. Since there were ten churches, or denominations involved in the training session, it was suggested that an equal representation from each group be selected for the committee. After some discussion, they opted to continue the discussion throughout the week, and when they returned for the next training session, they would have worked out the details of how to establish the committee.

The following week they came with their ideas formatted. Ever mindful of a sense of fairness, they decided that equal representation would not be the most effective way of selection for the committee because of the fact that several of the churches represented only had one member, and others had as many as eighteen. They were mindful of both hazards: having smaller churches with too much power

and having the larger church overrun all decisions. Therefore, they suggested that a vote would be held with nominations from the entire body. From this election, eight members from the entire group were elected as the committee. From the governing committee, they then proceeded to take nominations and subsequently vote on offices such as president, secretary, etc. Rev. David Phiri, the pastor of the Chimbalame Assembly of God was elected as the chairman or president of the committee (despite concerns voiced by the trainers as to whether he would have the time to commit to such a project with consideration to his many other duties as pastor); Ruth Kasingi of the Church of Christ was elected vice president and Moses Malengo from the End Time Pentecostals Church was elected as recording secretary of the newly formed, 'Partners in Hope Home Based Care' Program.

Once this committee was selected, in an effort to stimulate interest and cohesiveness, several special meetings and a dinner were arranged. This produced the desired effect of providing unity in spirit within the committee as well as giving them a sense of approachability to freely meet with the HBCPC.

By the end of the four-week session, the volunteers expressed satisfaction with the course materials and curriculum, commenting that they felt quite well equipped to begin visiting the sick in a meaningful way. A graduation ceremony took place during the last session when certificates of completion, name badges, etc. (6.3.7) were distributed. The committee decided that it would report back to the HBCPC after a four-week period.

Suggestions were offered and discussion ensued as to how the committee could maintain the emotional balance and motivation of the volunteers. This is a significant consideration when one realizes the emotionally draining tendency that comes from caring for the types of patients that will be cared for by the volunteers. Since the volunteers will be receiving no monetary reward, it is especially important they are given a strong sense of accomplishment and motivation from within their own ranks. The committee divided the total number of volunteers so that each committee member would oversee 5-6 volunteers. It was also decided by the committee that they would meet on a regular basis (every 1-2 weeks) for emotional support and sharing times.

6.4 TRAINING COMPLETED – MOVING FORWARD

At the completion of the four-weeks, the committee met with the HBCPC to share progress and problems. They had developed a natural format when meeting with HBCPC that began with a detailed explanation of how poverty-stricken the people in the community were and how desperate their physical needs were. It was shared with the committee that although there were significant problems and difficulties, it was not the purpose of HBC to meet all of their physical needs and that their emotional and spiritual needs were the primary focus of this group at present. Reminding them of the vision of reaching out with love and compassion to the sick and dying, they were then able to move to the next item of discussion.

6.5 ASSESSMENT

The four cognitive processes identified by Morse and Field's approach (De Vos 1998:340) towards data analysis were used (comprehending, synthesizing, theorizing, and recontextualizing). With continuing assessment with the resultant synthesizing, theorizing, and recontextualizing, theories began to be derived as to how to not only implement this program for use in the local control Lingadzi area, but also to be evaluated for adaptation for uses in other local faith communities in Lilongwe and elsewhere.

6.5.1 Assessment: Need for Goals Clarification

Utilizing Morse and Field's approach with the first step of comprehending brought the central and peripheral referents to the researcher's attention. Using intraparticipant microanalysis as an interviewing method, it was soon discovered that there was some misunderstanding about the goals of the HBC program. The committee proudly stated that they were currently caring for over 365 sick in their community. Knowing that many of these people were working, and should only have a small amount of time to invest in the care and well being of others, this claim was investigated more closely. By working with what Morse and Field call the 'comparison of transcripts' (De Vos 1998:341) from several respondents, this researcher was able to synthesize the information presented. Interpreting the

relationships between the findings brought the discovery that the volunteers were equating large numbers of patients under their care with the expectation that they were doing a 'good' job. This provided an ideal teaching opportunity of 'quality' versus 'quantity'. This concept, of keeping the numbers small and manageable exposed a cultural difference between the volunteers and the HBCPC, which mainly consisted of Western missionaries (3.4). After taking time to explain to them that the objective was to take really good care of the individual, with the goal of demonstrating the love of Christ to that person in a real and meaningful way, they were able to see and grasp the concept. In an effort to recontextualize the situation, it was explained to them that following the usual African pattern of trying to give a 'little to everybody' instead of a 'lot to a few', would inevitably lead to providing sub-standard care. This would not allow them to care for the patient adequately; it would also cause them a sense of frustration, as they would be faced with doing less than what was necessary. This dissatisfaction would lead to 'burn-out'. In addition to the damage done to the potential reward for the volunteer of the satisfaction in knowing they were helping their fellow human beings, and thus fulfilling the law of Christ (5.6), they would also be giving a poor demonstration of Christ's love and compassion to those they were seeking to win to Him. This would have the counter effect of working directly against the goal, as the patient himself (or herself) would become dissatisfied with the care and see the visit as not only not helpful, but possibly destructive. With these thoughts in mind, the volunteers were able to easily grasp the concept and pared their number of patients down to a more manageable sixty-five.

6.5.2 Assessment: Paperwork Challenges

A very simple[45] form of paperwork was introduced during the training sessions, but this became more of a hindrance than help as time went by. A problem developed since the volunteers were not used to being responsible for records of this nature. Although a few attempts were made in an effort to please the HBCPC, it soon became obvious that since there was no actual *medical* care taking place, it was not necessary to expect them to keep records of their visits and outcomes. This might

[45] In comparison to the reams of paperwork mandated by HBC programs in the United States with which this research is familiar, the paperwork requested seemed very insignificant at the time.

have proved useful for this researcher and those in the HBCPC, but ultimately it was not serving any meaningful purpose to the individual volunteers or their respective churches and was therefore abandoned. Volunteers were encouraged to keep communicating with the committee on a verbal basis, and any additional concerns or problems could be brought to the attention of the HBCPC for further evaluation or intervention.

6.5.3 Assessment: Hunger crisis

Within the first two months another problem surfaced which demanded attention. Hunger. Malawians were starving, and had no way to get or purchase food. This was particularly apparent in the HBC population. This is due to the fact that this area is an extremely poverty stricken environment[46] in the best of times. Another factor was the fact that often it was the 'bread-winner' of the family who was the patient, the money that could have been used to provide for the family, was now being diverted towards medical care. In addition to these problems, the nation of Malawi was suffering as a whole due to lack of food stores from what some have considered to be a governmental problem.

With this devastating factor considered, the HBC volunteers were faced with a dilemma. They were trying to provide care to their neighbours; yet they were in no better position to provide additional food sources to their patients than the patient's families. When they brought this problem to the Partners in Hope HBCPC, urgent requests were sent to stateside sponsoring churches for benevolent help to meet this crisis. With the first $1000.00 of the total of $2500.00 USD that was given to help the need, *ufa*, the maize based flour used in the staple *nsima* was purchased. The committee then determined the most effective way of distribution and worked tirelessly to provide food for those who were suffering. The need was limitless, and the volunteers suffered some verbal abuse and threats as neighbouring villagers accused them of not sharing all that they had. When word got out that free *ufa* was available, it became evident that everyone was in need.

[46] It is estimated by a resident of this village area that approximately one half of the population of this village has a 'real', consistent job, another quarter manage to find temporary jobs here and there, and another quarter live by small jobs of piecework and abject poverty.

In re-evaluating the situation, it was determined by the Partners in Hope HBCPC that in the future, *ufa* (which was the staple food for all Malawians) would not be distributed, but *lukuni phala* would be distributed instead. *Lukuni phala* is actually more nutritious than *ufa* because it is vitamin fortified, but it lacks the desirability of *ufa* in that it is considered more of a 'porridge' than as a real food. The next $500.00 worth of food provided was in the form of *lukuni phala*. Changing food substances revealed the 'actual need' of the people diminished considerably when the offering was perceived as a less desirable product. People did not want to receive the *lukuni phala* unless they were truly desperate for food, so changing sources had the effect of helping to determine those in the most genuine need. In fact, after this distribution of *lukuni phala*, the committee informed the Partners in Hope HBCPC that they did not need any additional food at present, but would let them know when it would be needed again.

6.6 SECOND TRAINING CLASS USING DIFFERENT MODEL

A second training class of twenty-nine students (with twenty-seven completing the training) was begun following requests from the Kaning'a CCAP. Although the tribal and cultural backgrounds were very similar to the initial class, there was one significant difference in that this class was made up of all members from one particular church, representing several different 'prayer houses' which comprised a total membership of approximately 2,800 members.

This class was handled in very much the same way as far as the actual training design and curriculum content were concerned, but because of significant variants in the group dynamics of this group with the initial training class (7.3), there were a few differences in approach to the class from the pedagogic standpoint. Even though there were several prayerhouses that varied in their economical and educational levels, the overall level of literacy was greater and therefore the teaching was done at a somewhat higher standard. Even with the consideration that their educational level was higher and therefore their English comprehension was generally better, all teaching was done in English, and translated into Chichewa to serve two purposes: 1.) to reinforce the message given in English as it was then repeated in Chichewa, and

2.) to make certain that those who were not as proficient in English would have full access to all information in the language they were most comfortable with and certain to understand. The workbook used was the same as with the first class and prepared with both Chichewa and English text.

As with the first training class, independence and autonomy were paramount. It was considered essential that the group takes ownership of their home visitation program and this principal was stressed from the beginning of the training program and they seemed eager to make their own decisions as they developed their program.

Since this class was made up from one church, it developed a very different type of governing and management system. No attempts were made to bend this group into the mould developed by the first group since from the onset, the goal has been for each church to develop their own program and take ownership of it. Structures were all ready in place for visiting the sick that fell under a benevolent department involving other issues as well, such as orphans, etc. Therefore, there was no need to develop a 'committee' as was done in the first group. Rev. Khombe, the minister or pastor of Kaning'a CCAP was interested and supportive of the program from the very beginning. He was personally unable to attend the training sessions, but his wife and others leaders from his church were part of the training classes. The existing governing structures simply extended themselves to encompass this new aspect of their benevolent care. Since those who had already been established as the leaders of the existing groups were present in the HBC training class, this was an easy and well-received transition.

Members of this class were all members of the same church, so therefore upon completion of the four week training program the Kaning'a CCAP formally presented them to the church. They were all called to the front of the church and Rev. Khombe described to the congregation the essence of the HBC ministry. In his presentation, he was careful to explain that this group would be visiting the *sick* in their congregation and took care to avoid presenting the concept that this was an *AIDS* care group.

6.7 DAY TO DAY PROCEDURES

After the volunteers had been making their visits for a couple of months, the visitation process began to stabilize. By the time the ABC students were ready to begin their end of school holiday (June-August), the local village volunteers were able to continue making their visits to those in the community independently. Regular meetings were scheduled with the committee and other volunteers as individual needs and concerns arose. As the 'newness' of the program began to wear off, the volunteers began to seek additional training in areas where they felt inadequate. The HBCPC purposely did not offer suggestions, but took a passive role of leadership so the committee could be empowered. Responding to the 'felt' needs of the volunteers as they were presented to the HBCPC instead of directing their path worked to establish their sovereignty from the beginning. From the suggestions of the volunteers, additional training was organized in a seminar format on a monthly basis at no charge to the participants. Subjects were determined by the need and requests of the volunteers. A preliminary list of topics was developed (first aide, disease processes, gardening techniques, etc.) and classes began with avid enthusiasm and support by the volunteers.

In this same way (of passive direction), other avenues of outreach were begun as well. The HBCPC saw to it that Partners in Hope HBC was known in the community and members were asked to participate in various functions in Lilongwe that were designed to bring together the various HBC groups which were developing in the city.

6.8 ABC STUDENT VOLUNTEERS

When the ABC college semester began in September 2002, the HBC program at Chimbalame was well established. As a requirement for graduation, ABC requires all students to be involved in some type of ongoing weekly ministry. The students are allowed to choose from various already established ministries, or encouraged to initiate their own if they choose. HBC was offered as a ministry choice[47] and an

[47] Other ministry choices include hospital, prison, and door-to-door ministries, as well as open air evangelism, various children's ministries, sports evangelism and HIV prevention programs for local secondary schools.

assortment of seven students volunteered, several of which had been involved in the more unstructured HBC visitation, which was available the previous semester.

Several concerns and challenges were identified regarding the introduction of student volunteers at this point:

- Since the students were only going to be available during the scheduled school year, their ability to consistently visit patients long-term was limited, and therefore it necessitated their 'partnering' with village volunteers who would maintain the relationship with the patients when the students were unavailable to participate in the home visitation.
- The perception of the village volunteers towards the student volunteers:
  - In the past, the volunteers tended to regard the students as their superiors (due to their advanced educational status) and allowed them to take the lead in all visits.
  - The village volunteers might look at the students with suspicion, thinking their intention was to evaluate them in their effectiveness and competency as HBC volunteers.
  - The village volunteers may resist 'sharing' their patients with whom they had worked to develop relationships, with the students.
- The perception of the student volunteers towards the village volunteers:
  - The students may not value the education and experience of the village volunteers and try to assume leadership.
  - The students may not want to work with the village volunteers and want to develop independent relationships with the patients.

After consultation with the training team, it was determined that the students entering this ministry would require a period of training, but it would not take the shape of the same structured four week course, and therefore a modified training component was developed and implemented. One purposeful reason for this was to allow the village volunteers the realization that as far as the HBC visitation program was concerned, they had the advantage of having had a more comprehensive training along with more experience. It was also stressed to the village volunteers that the students were there to give them 'added hands' and to assist them, and it was stressed that it was essential that the program not be built around the students, because they

would not always be available. Even with this focus in mind, the village volunteers elected to reserve Thursday afternoons as their focal visitation time because that was the 'official' ABC time of visitation when the students would be accessible.

It was also determined that the ABC student volunteers would work along side the Chimbalame village volunteers only, and not with the Kaning'a CCAP volunteers. This determination was made due to the fact that the Chimbalame volunteers were already accustomed to ABC students and also, and mainly for the reason that the Chimbalame volunteers worked within a more contained area that could easily be reached by foot, whereas the Kaning'a CCAP area was much more vast and depended upon vehicular transportation.

6.9 ADDITIONAL TRAINING CLASSES

Although there were numerous requests for training from other churches and areas that had heard about what was being done here, it was determined by the HBCPC that there would be no further training sessions for the remainder of the fiscal year. This determination was made so that these two groups could be given the proper supervision and direction and their advancement could be studied thoroughly. It was felt that if too many groups were allowed into the program, it would soon become unmanageable in addition to the added difficulty in assessing their progress and problems.

6.10 KANING'A CCAP METHODOLOGY

Although the planning and implementation of training curriculum was the same for both study groups, the follow-up methodology differed for several significant reasons. The Kaning'a group already had in place a structural format for managing their volunteers; so stringent oversight was not as necessary for Kaning'a.

The same goals and focus of the initial group remained in place for this second group as well, those of autonomy and ownership of the program. Therefore the training team only made overt gestures at interaction at infrequent intervals to avoid the concept that it wanted to take any authority away from the already existing structure and makeup of the group's management systems. Aside from occasional

phone calls for the purposes of gentle assessment and inquiry of needs, to Mr. Lungu, the key contact person for this group, outside intervention was avoided and the group was allowed to mature and develop independently. Each phone call was cordially received, and the HBCPC was assured that things were 'going well' and no further help was necessary. This group was invited to attend the additional training sessions requested by the first group, but few members took advantage of these sessions. In an effort to allow this group to evolve on its own, and therefore to take full 'ownership' of its members and ministry, contact was avoided after the first few months of assurances that all was 'going well'.

6.11 SEVEN MONTH ASSESSMENT AT CHIMBALAME

By the time seven months had passed, significant changes had occurred in the Chimbalame group (7.4.2) and it was obvious that some intervention was needed to get the group back on track and focused to move forward. Elections were held and new committee officers were elected during a meeting of the group with opportunities for sharing of ideas and concerns. Once again energized and focused upon their task, the group once again was back on tract, working toward visiting the sick and meeting needs in their community.

6.12 ONE YEAR REVIEW AND EVALUATION

As the time neared for the completion of the first year of HBC formal efforts of evaluation and re-assessment were begun with attention given to Guba's model (De Vos 1998:348), as he discusses the area of applicability, which he defines as the degree to which the findings can be applied to other contexts and settings or with other groups.

In conjunction with this analysis, for both the Kaning'a and the Chimbalame groups, open-ended interviewing, unstructured interviews with a schedule (De Vos 1998:300), were utilized with already identified informants within their respective organizations who have intimate knowledge and understanding of the people and structures involved. This was done in order to extract sufficient information to provide a basis for data collection and continuing interview / relationship building at

the case study sites, along with providing assessment information for continuing grounded theory development from the analysis of the data. From this information, the program was systematically assessed and a substantive theory developed, with the intention of broadening into the development of a formal theory (De Vos 1998:266), leading to the formation of a praxis theory as well as a sustainable strategy on how to implement it (7.6; 7.7).

Each of the one-year assessments will now be reviewed:

6.12.1 Chimbalame Home Based Care –

This researcher, along with the others involved in the Partners in Hope, HBC initiative met with a representative group from the official 'committee'. The following observations were noted:

- Instead of the normal hierarchy of the committee being present, those present instead chose to have Tom Phiri (the associate and 'right hand man' for Rev. David Phiri, the original committee chairman) join with their group to serve as their spokesman.
- All participants of this meeting made sure to wear their 'official' name badge identifying them with Partners in Hope HBC.
- They came with a planned agenda and were pleased that this meeting was called, as they had some items they wanted to discuss.
- They voiced the following concerns:
    - They were promised new 'tote bags' and were expressing disappointment that they had not been delivered. (When this researcher asked them where they had gotten such an idea, because it was never intended that they would get new bags, they emphatically stated that it was indeed this very researcher who had made such promises).
    - They didn't have enough gloves and presented a long, detailed case as to why they thought it was necessary, (they admitted that they had never asked the HBC nurse, or the supervisor for more gloves).
    - They were upset that other agencies were having more food distributed to them, and expressed concern that they were not

getting their fair share, with the insinuation that ABCCC Partners in Hope was withholding from them what they had rightfully coming to them. (This was a MAJOR issue).

    - Some of their group's official 'T' shirts were becoming worn and needed replacement, so they felt that they should all be given new shirts.

- Unstated, but perceived from their comments was the idea that they were not happy with the new HBC Nurse who was now directly involved in monitoring and assessing their visitation performance. They were suspicious of her and felt that their integrity was being challenged.
- Although an exact count was difficult, by their own estimation (which did not agree with the report from the nurse) most of the volunteers were continuing to make visits to the sick, with the exception of a few that had moved from the area.

The HBC Training Team evaluated each of these concerns and response was made to each concern (7.4).

6.12.2 Kaning'a Home Based Care –

Mr. A. K. Lungu, the main contact person for the program from the beginning was very willing to sit down and give this researcher an honest report of the activities of the HBC initiative from the Kaning'a CCAP.

The following observations were noted:

- The HBC volunteers were active for approximately the first six months, and then their visits began to diminish until they were no longer making visits. This was due to the following reasons:
    - The perception arose in the church congregation in general, and within those serving as guardians and caregivers of the patients in particular, that the HBC program was actually an AIDS program and therefore all those they visited were suffering from AIDS.
    - Due to the continued stigma perceived from association with this diagnosis, with its resultant alienation, estrangement and prejudice, the caregivers became resistant to the home visits,

fearing the stigma would rest on them as well. Mr. Lungu offered comments such as, 'you don't want to get a wife from *that* family, they have AIDS', as a sample of their feelings and responses.

  - As the caregivers resisted the visits, the volunteers began to feel unwelcome and eventually stopped visiting all together.
  - There was no apparent inter-group support system to help the volunteers deal with the pressures and stresses of visiting the sick and dying.

- Other benevolent ministries (orphan, widow, etc.) that had already been established were continuing to thrive.
- One notable exception was Mrs. Khombe, who was a trained volunteer and also the wife of the pastor. She did not feel that guardians were shunning her and she continued to make visits to the sick (7.5).
- The caregivers seemed willing to let the program die a natural death, but were willing to explore possibilities of how it might be revived as they had not given up the ideals and vision with which they began the program.

Following this meeting, the resultant situation was discussed in detail with other members of the HBC Training Team. Following this several other fact-finding interviews with purpose were held, mostly by telephone with Mr. Lungu, and then with the elders responsible for the benevolent ministries of the church to further explore the situation and find ways of moving forward with the program in a constructive, meaningful way (7.5).

At the completion of one year of home visits, a second Quantitative Approach Survey was performed. The same questionnaire was used with the addition of the following two questions:

*Question #8: Are you familiar with Partners in Hope HBC which was started one year ago? (total respondents 250)***

1	2
Yes	No

*Question #9: Do you think the HBC has helped to change attitudes between the Church and the HIV/AIDS community? (total respondents 195)***

1	2	3	4	5
Attitudes are worse now		No change in attitudes		Attitudes are better now

* The denominational codes are as follows: CCAP – Church of Central Africa Presbyterian; RC – Roman Catholic; AoG – Assemblies of God; EP – End Times Pentecostal; A – Anglican; AA – African Abraham; NA – New African; JW – Jehovah's Witnesses

**The number of total respondents varies from question to question because the surveyors were instructed to allow participants to not answer any questions that they chose not to answer for whatever reason in an attempt to get accurate and honest answers for the ones they did choose to answer.

The goal of such a survey following one year of service was to have an indication as to whether there was any notable resultant attitude change or shifts in the subject communities as a result of the initiation of the HBC Program. The above-mentioned two additional questions were included as in an effort to reveal precisely that information. The survey was preformed in the same manner with one notable exception; only one field worker was used. Other qualifying factors for the surveyor remained the same. The reduced number of surveyors did produce a somewhat smaller sampling of respondents, as well as a longer surveying period, but it was thought by this researcher that having one person do all of the surveying would eliminate the possible variable of differences of interpretation of data by the field workers as they filled out the survey forms based upon the responses of those in the community being assessed (7.1.2).

6.13 TRUSTWORTHINESS OF QUALITATIVE RESEARCH

In his chapter (22) on Data analysis in qualitative research, De Vos describes Guba's model of trustworthiness of qualitative research (De Vos 1998:348). This model was designed as a way of providing researches alternative models in order to evaluate the trustworthiness of the data and interpretive results, which are determined by various research areas. Based upon this model, the variables of this study were posed to several others who share in the line of work with individuals based in the

field of HIV/AIDS, HBC, and in the more general area of working with volunteers, and the concept of volunteerism.

Consensus from among these professionals concurs with the basic tenets of this research without variance:

Name of Individual	Area of Expertise
Dr. Perry Jansen	HIV/AIDS, difficulties with volunteerism, HBC
Mrs. Anna Kamanja, R.N.	HIV/AIDS, Volunteerism, Chewa Culture
Mrs. Caroline McLean, R.N.	HIV/AIDS
Mrs. Grace Banda	HIV/AIDS, Volunteerism, Chewa Culture
Mr. Amos Chigwenembe World Relief)[48]	HIV/AIDS, Volunteerism, HBC, Chewa Culture
NAPLAM[49]	HIV/AIDS, Volunteerism, Malawi Culture
Lilongwe HBC Stakeholders[50]	HIV/AIDS, Volunteerism, Malawi Culture

6.14 OVERALL SUMMARY OF METHODOLOGY

Qualitative research is a like working on a continually evolving project. Dealing with the variables presented by human vacillations often poses a challenge at best. As was indicated at the beginning of this research, the process of exploration developed as the needs of the project were evaluated and formatted to make the adjustments necessary to adapt to the continuing variations presented. Indeed by continually collecting, recording and analysing data, a grounded theory began to emerge, which directed the course of further sources and opportunities for information gathering and exchange.

The speculations and envisioned outcomes which where predicted during the preliminary phases of this project were purposefully readjusted and redirected to

[48] Please refer to Appendix 'J' for details of World Relief's contributions to 'volunteers'.
[49] When visiting this organization, the coordinator told this researcher that not only are his volunteers paid for their services, the HIV/AIDS patients with whom they counsel are also paid to attend support group meetings and other activities.
[50] HBC is a very recent development in Malawi, and the Lilongwe HBC Stakeholders have developed as a result. Representatives from each of the various HBC institutions come together on scheduled meetings for idea sharing and planning purposes.

accommodate variables and situations which had not been initially anticipated. Using the methodology outlined in this chapter helped this research to develop in a logical, systematic way, therefore allowing accurate triangulational research, combining quantitative and qualitative methodologies. By using multiple methods of data collection, an increasing reliability of outcome was anticipated.

It is hoped that this research will meet the goal of fulfilling the following definition recorded by (Grinnell, 1993; Rothman & Thomas, 1994; and Rahman, 1993) in the work by De Vos (1998:20):

> Basic professional research, whether its objective is exploration, description or explanation, is a scientific enquiry into a relevant problem that provides an answer contributing to an increase in the body of generalisable knowledge about the particular profession; applied professional research is geared to the development of knowledge and technology with a view to achieving meaningful intervention which, ideally, should be participatory interventive action, based on participatory action research, in that professional researchers should empower research participants to understand and solve their own situation and problems, become aware of their own potential and regain their own sense of dignity, so as to take collective action for their self-development.

All that has been recorded to this point serves as a solid foundation to provide an objective, comprehensive appreciation of the problem with its many varying components. From this base of understanding, the research problem developd as scientific methods were employed to determine the conclusions resulting from the data received by the methodology described in this chapter. From the data, trends and responses were realized that had not been anticipated; which in turn served to shape and reshape the problem allowing for more refinement and direction as the facts was interpreted and conclusions were drawn. The praxis theory was continually moulded and re-formatted as the events unfolded.

During their initial year, from the graduation of the first class to the evaluation done at the completion of their first anniversary; many anticipated as well as many unexpected factors became apparent. These factors caused the envisioned developmental process to demand a critical re-thinking, with a resultant shift in the project focus and corresponding action. The program under study in this dissertation served as the praxis model as the project continued to evolve.

In the next chapter, the final conclusions developed from the work done on this project will serve to provide a contribution to the increasing body of knowledge regarding the field of HIV/AIDS. This information is particularly relevant in light of the relationship that has developed between the church and those infected or affected by this deadly virus. The findings from this study impact the information regarding how AIDS community sees and interprets the role of the church, as well as the response of the church to the AIDS community as it serves as God's witness in this devastating pandemic.

As the final chapter of this dissertation, chapter seven will provide the elucidation necessary to draw the appropriate conclusions from the data presented in this current chapter on methodology. These conclusions will provide interpretation to the significance of this project, which will allow the beneficial contributions, as well as the unexpected disappointments to be instrumental in the formation of the new and revised vision necessary in order to continue with the foundation that has been laid by this project.

Chapter 7
The Way Forward:
Conclusions and Evaluation of Project

7 INTRODUCTION

All of the information, which has been presented to this point has been designed to lay the foundation needed for the development of the project leading up to this final chapter. The entire project now comes into focus making possible the development of projections looking at the way forward.

The initial stating of the problem in chapter one lead to the subsequent questions demanded by it:

1. Can the negative attitudes, prejudices and behaviours which are held and demonstrated by many in the church towards those suffering with HIV/AIDS, be changed by using deliberate attempts to alter their perspective of this pandemic by providing accurate information, in juxtaposition with the demonstration of Christ's love and compassion to this community?
2. In conjunction to this first question comes a second: Can the compassionate outreach of the church, as it follows Christ's mandate to love (through HBC), change the perspective of those in the HIV/AIDS community so that instead of viewing the church (as a whole) as cold and unloving, their perception will change with the demonstration of such love and compassion by it's membership that they begin to see the church as a source of hope and love?

This study has explored and examined how the relationship between the local church and the HIV/AIDS community has been altered as it was provided with the opportunity to learn about each other in safe, non-threatening ways using the vehicle of HBC as the point of entry. The subject of this research has been to specifically examine a certain segment of the HIV/AIDS pandemic, specifically the response of the local church as they visualize the problem and attempt to determine the role that the body of Christ (1.4.10.2) should play in this world crisis.

In a systematic and disciplined way, the historical response of the church has been reviewed with reflection regarding its reaction to the pandemic of HIV/AIDS, first in a global, and then in a more focused way. This historic groundwork being laid, the next logical step was to explore the unique cultural paradigms in the African context that must be recognized and incorporated into our understanding in order to more fully realize the impact HIV/AIDS has had on the African continent. With this much of the foundation laid, it was then important to look at the Malawian, and even more specifically at the Chewa, along with other local cultural practices that contribute to the spread and continuation of the disease in the local milieu of the focused study area.

In view of these factors, the theological implications which gave rise to this pandemic were then investigated in chapter five, as the hermeneutic of Christ's mandate to 'love one another' was explored with the unambiguous ramifications that this command demands in the action and ecclesiastical response by the faith community. The issues resulting from an improper hermeneutic of God's command to love -- alienation, estrangement and prejudice when explored in light of the development of a praxis process from the standpoint of Practical Theology.

Chapter six offered a detailed narrative regarding the specific procedures and methodology used to draw together the data necessary for this final phase of elucidation that will now be disclosed as the information is assessed, evaluated and interpreted.

7.1 CONCLUSIONS FROM SINGLE-SYSTEM DESIGNED RANDOMISED CROSS-SECTIONAL QUANTITATIVE SURVEY

One of the unexpected findings that came to light from this survey was the fact that the initial information used in the most preliminary planning stages was in error. Instead of the community being completely replete of home care (as had been reported by the local authorities), there was indeed a HBC program already established in the community which had on a limited basis, obviously made some inroads towards the objectives of this study within the particular scope of their work. This program was developed and run by the local Roman Catholic diocese and was

primarily, although not entirely, limited in scope to the community belonging to the Roman Catholic Church.

The survey also revealed that 78% of the study population from the target villages claimed to be Christian and of those, almost one third (31%) were Roman Catholic. Therefore, since they were obviously aware of their own program, a larger than anticipated number of respondents responded in a positive way when asked if they believed the Church was having a positive effect on the attitudes of the people.

Although the Roman Catholic Church was not to be excluded in the HBC program to be undertaken, neither were they considered integral participants, as this work was to be primarily Protestant in nature. Indeed, as seen from the initial volunteer training, there were ten denominations represented in the class. Three of the volunteers were Roman Catholic and it should be noted that they were the only people in the class that claimed to have any previous training, as they were part of the Roman Catholic volunteer HBC force. When this was discovered, they were welcomed into the class but it was requested that they make a commitment and determination to work with only one group or the other. They unanimously chose to work with Partners in Hope and relinquish their roles with the Roman Catholics. As time progressed, it was found that these volunteers did indeed return to their previous organization. This was primarily due to the fact that their motivation for working for Partners in Hope was suspect in that they were looking to see if they would be recipients of more goods and services in the new group. Once Partners in Hope was established as a solely volunteer group, they no longer felt the need of participation. The focus of Partners in Hope was also substantially different in its scope than the Roman Catholic program[51], which probably also served to contribute to their returning to their original work.

7.1.1 Results of the initial survey revealed:

(See Appendix G for actual figures)

[51] The Roman Catholic work had been established years ago and was primarily focused on meeting some of the physical needs of the community in a multi-faceted approach. Although they were making an impact, it was seen as spread too thin to be effective. Partners in Hope's focus was inversed from the Catholic work in that it was spiritually based as its primary task, with the meeting of physical needs as secondary.

Question #1: How do you think people in the Church feel about those suffering from HIV/AIDS?

1	2	3	4	5
Christians don't get HIV/AIDS. Those that do are receiving the punishment they deserve for the sins they have committed.		There aren't any people in the church with HIV/AIDS. It isn't a problem that they have to deal with.		They want to reach out to them with the love of Christ and do all they can to relieve their suffering.
19 %	11 %	8 %	18 %	43 %

Question #2: How do you think people in the AIDS community feel about the Church?

1	2	3	4	5
People with HIV/AIDS are not welcome in the Church because they are sinners.		People with HIV/AIDS can come to the church, but people keep their distances from them.		People with HIV/AIDS feel love and acceptance when they are in the Church or around Christian people.
7 %	4 %	25 %	11 %	53 %

Question #3: Do you think attitudes between the church and the HIV/AIDS community has changed in the last few years?

1	2	3	4	5
There is no difference in attitudes in these groups.		People are more open and aware, but continue to act in the same way		The church is seen as more loving and accepting of the HIV/AIDS community now.
29 %	8 %	26 %	8 %	52 %

Question #4: Has anyone in the family suffered from HIV/AIDS?

1	2	3
Yes	No	Uncertain
42 %	36 %	22 %

Question #5: Level of Education

1	2	3	4	5
Primary	Secondary	College	Trade	Other
53 %	24 %	4 % (questionable)	13 %	6 %

Question #6: Religious Beliefs

1	2	3	4	5
Christian*	Muslim	African Traditional	None	Other
77 %	15 %	2 %	5%	0 %

** For a breakdown of the various Christian denominations, please refer to Appendix G.*

Question #7: Age

1	2	3	4	5
15-20	21-30	31-40	41-50	51+
23 %	28 %	26 %	15 %	8 %

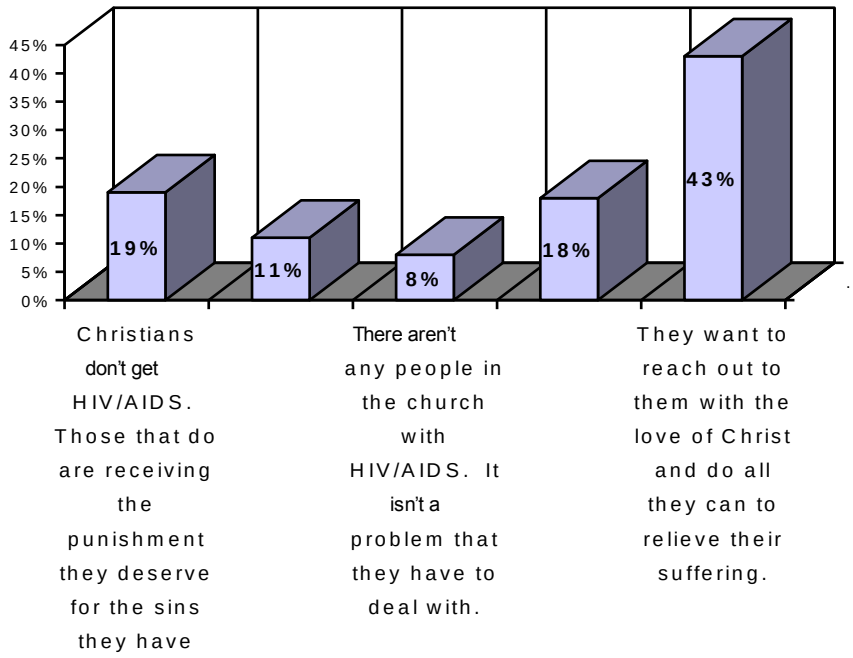
Using the raw data from this quantitative paradigm survey, the following information was extrapolated:

The data was reduced for analysis, by elementary convention in statistical counting by means of univariate analysis (De Vos1998:204) methodology, with all the data for each one of the variables gathered for utilization. Since each variable was itemized individually, we will proceed first by examining the simple frequency distribution of each question.

Question #1: How do you think people in the Church feel about those suffering from HIV/AIDS?

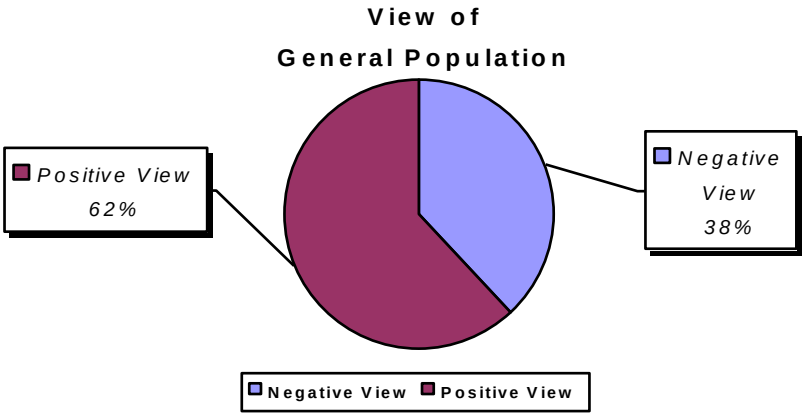
The bar graph below serves as a pictorial device to illustrate the data for question number one. While it is encouraging that a large number (61%) of the respondents answered affirmatively (choosing numbers 4-5 for their response) that they felt the church was responding with a loving message towards those suffering HIV/AIDS, the collective response of a full 38% indicated a neutral or less response (choosing numbers 1-3 for their answer) with 20% of respondents answering that they felt there the church looked negatively (choosing numbers 1-2 for their answer) upon those suffering with HIV/AIDS.

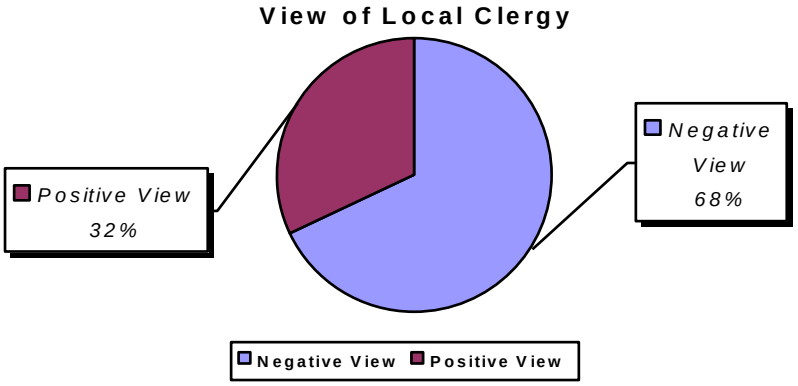
Question #1: How do you think people in the Church feel about those suffering from HIV/AIDS?



The results from this initial survey question significantly contradicted the beliefs held by the clergy in the community. Clergy from at least four different denominations were interviewed extensively and each one confirmed the facts as they saw them. From their perspective, the congregations held primarily (80-95%) negative views towards those suffering from HIV/AIDS up until the recent past. At the beginning of the test period, the pastors were estimating that between 60-75% (average figure of 68% used for illustrative graphic purposes) of those within their

own congregations continued to have negative attitudes but did feel optimistic that they were becoming more open to change.

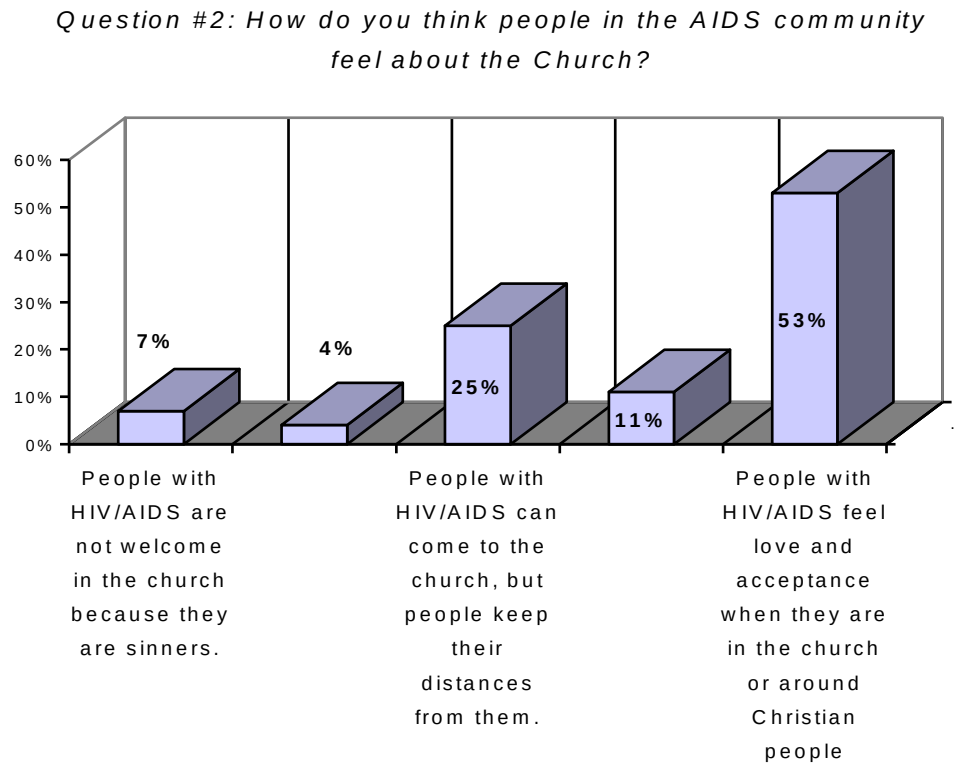




It is an interesting phenomenon to note that there is almost an exact inverse relationship between the perceived views of the clergy toward the church, and those of the surrounding community toward the church. As a reminder, the questions were deliberately worded so that the individual responding would not feel 'on the spot' by being asked to give *their own personal* opinion. In Malawian culture, a person will try to give the answer they perceive the questioner would be most pleased with, even if it means they are not telling the truth by doing so. Therefore, the questions were worded so that the responder would be giving his or her opinion of what *other* people in the community think about the issues at hand. It is hoped that by doing this, a more honest result would be obtained about the actual views of the community.

Following this first question about the perceived attitudes of the church towards the AIDS community, a natural follow-up question was designed to determine the perception of the community as it attempts to interpret the feelings of the HIV/AIDS community towards the Church.

Question #2: How do you think people in the AIDS community feel about the Church?

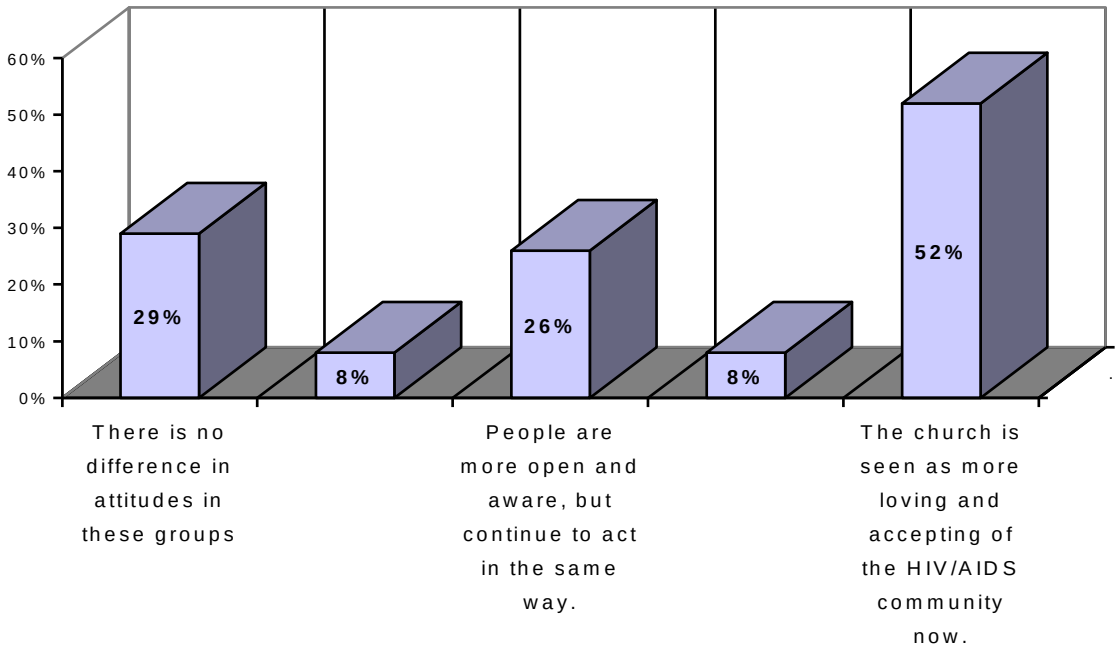


Overall, the response was quite positive, using a relative frequency distribution technique (De Vos 1998:208), the majority (64%) of the respondents indicating a belief that those in the AIDS community feel optimistic about receiving a positive response if they were to go to the church. It is the opinion of this researcher, based upon personal interviews with both clergy and laypersons in the community, that much of this optimistic opinion is reflecting a more hopeful thought than realistic outlooks found in the community.

Question #3: Do you think attitudes between the church and the HIV/AIDS community has changed in the last few years?

This question was designed to help determine whether the people in the community feel there is any change in attitudes in these two groups over the past few years. It is beyond the realm of this study to hypothesize as to why changes are occurring; in this univariate analysis the only perception being assessed is whether or not change is indeed occurring.

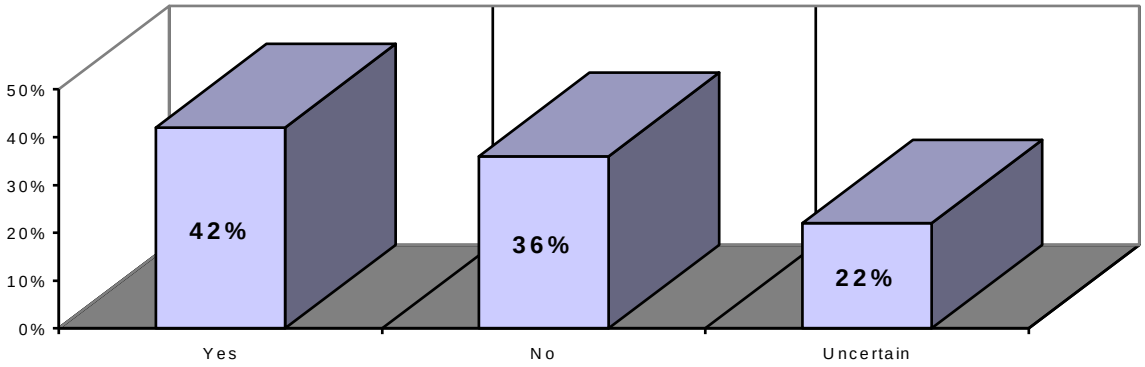
Question #3: Do you think attitudes between the church and the HIV/AIDS community have changed in the last few years?



Question #4: Has anyone in the family suffered from HIV/AIDS?

This simple, yet direct question was presented not only to evaluate the obvious information received from the answer, but also to be used as an indicator to ascertain the level of awareness and acceptance the respondents demonstrated about their own willingness to disclose. Researchers were instructed to use great sensitivity and

Question #4: Has anyone in the family suffered from HIV/AIDS?

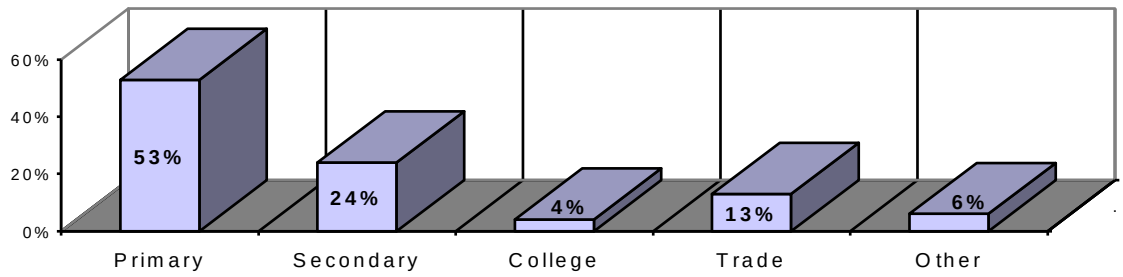


discretion when asking this question, and not to push for any answers the participant was not willing to share with the questioner. With this consideration, it is apparent that almost one quarter of the participants (22%) responded with uncertainty. Although this may be lack of knowledge in some cases, most people are at least moderately aware of the signs and symptoms of advanced AIDS. Therefore, it can be hypothesized that a significant portion of the existing uncertainty may be more accurately labelled denial.

Question #5: Level of Education

This question was for range and balance as only those who were fifteen years old and older were questioned. To qualify for a category, completion was not necessary. For example, if someone had finished at least 'some' of secondary school, they were counted in this category. The mean category, that of 'college' this

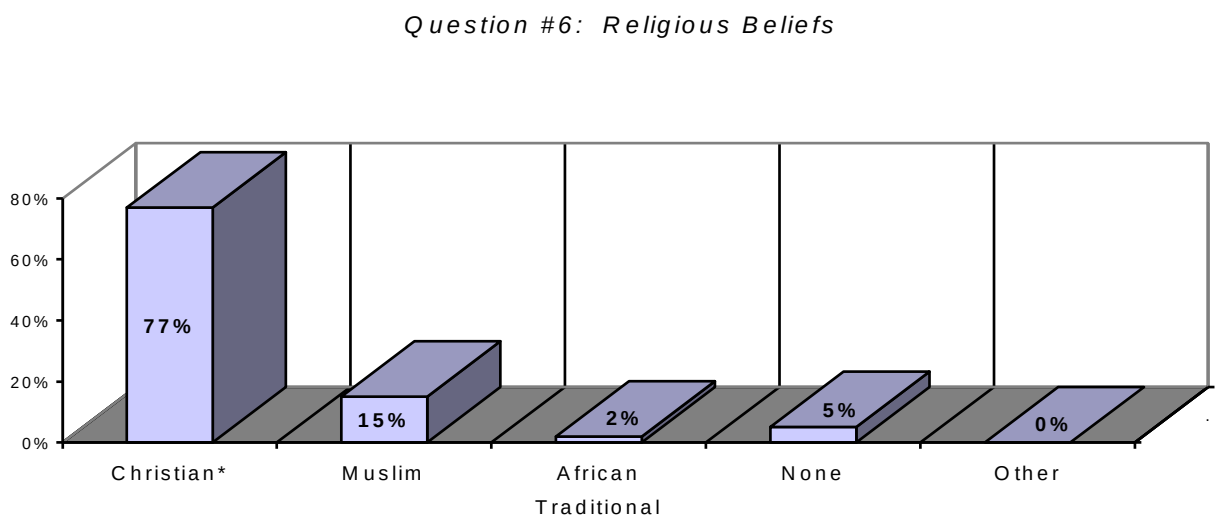
Question #5: Level of Education



researcher finds suspect, as the vast majority of village area where the survey has taken place is made up of unskilled, and many literate people who have not had any opportunity to receive any college education. No attempt was made to differentiate what types of advanced programs may have been taken or gender percentages. This aspect of analysis was added for perspective of the respondent survey group.

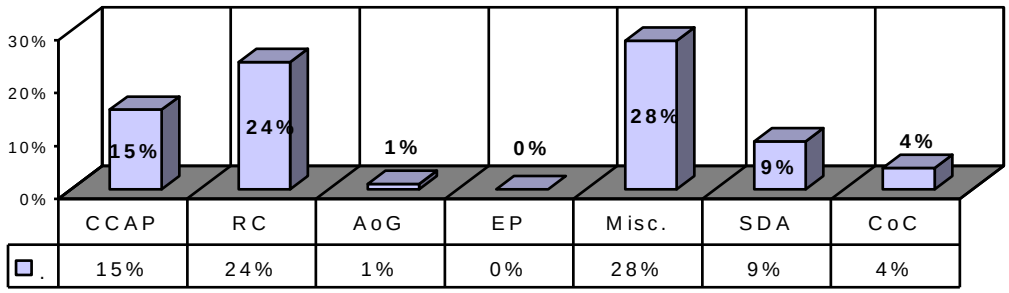
Question #6: Religious Beliefs

The information gleaned for this aspect of the study proved interesting since twenty-three percent of the respondents were admittedly non-Christian, yet they were commenting on their impression of the attitudes of the church and those responding to it. Although the various Christian denominations were sorted and categorized; no attempt was made to filter out the various groups and examine the data to make



determinations as to what trends might be associated with each denominational persuasion as that is not within the realm of this study. The overarching look at the religious picture of the community's religious preference demographic indicates that they are roughly within the overall national statistics for Malawi (UNICEF 2002).

Christian Denominational Breakdown

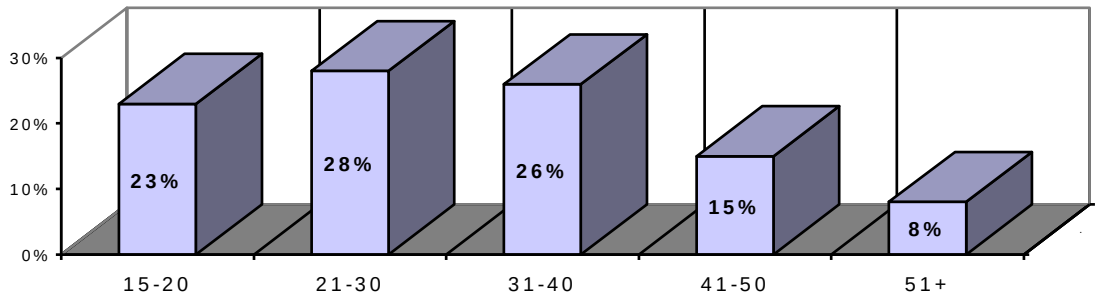


The denominational codes are as follows: CCAP – Church of Central Africa Presbyterian; RC – Roman Catholic; AoG – Assemblies of God; EP – End Times Pentecostal; A – Anglican; SDA – Seventh Day Adventist; CoC – Church of Christ; Misc - AA – African Abraham; NA – New African; JW – Jehovah's Witnesses

Question #7: Age

The ages of the respondents reflect the national trend of decreasing age (UNICEF 2002) with the average life expectancy from birth being 40 years[52]. With over half the population being under fifteen years of age, less than half the population was even available to participate in this survey, as the field workers were instructed to only survey those fifteen years old and older, because this is the age when the curve rises steeply regarding new cases of HIV infection.

Question #7: Age



[52] When this researcher came to Malawi in 1997, the average life expectancy was 47. Various reports give different findings to this question, some as low as a current life expectancy of 36 years for Malawi.

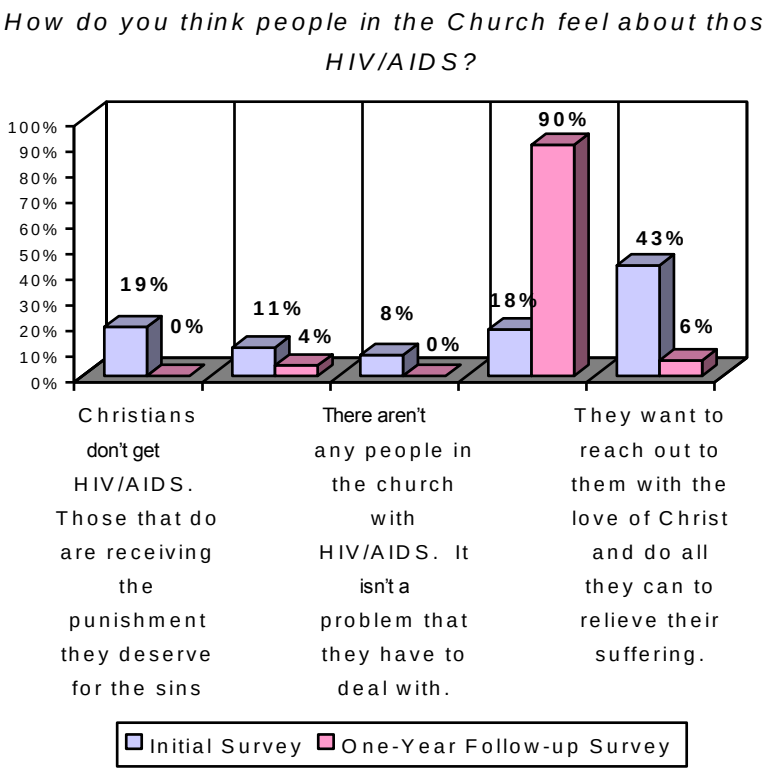
7.1.2 Results of the ONE YEAR LATER survey revealed:

One year following the initial survey, and subsequent to the HBC workers continuously visiting in the villages, another Single-system designed randomised cross-sectional quantitative survey was performed. In an effort to control variables, only one surveyor was used so all respondents were questioned in the same manner. The survey was identical in nature and method to the first, with the exception of only using one surveyor as indicated, and two additional questions were included with the survey.

- Question #8: Are you familiar with Partners in Hope HBC, which was started one year ago?
- Question #9: Do you think the HBC has helped to change attitudes between the Church and the HIV/AIDS community?

These questions were added in an effort to ascertain whether or not the community as a whole was becoming more aware of the HBC program and if they had any perception of its impact among the people of the community. The same guiding principles used in the first survey were utilized for the methodology of this follow-up survey. From the results of the first study, a comparison was then made between the results of this second survey one-year later. These results and the comparison study from this survey are as follows:

Question #1: How do you think people in the Church feel about those suffering from HIV/AIDS?

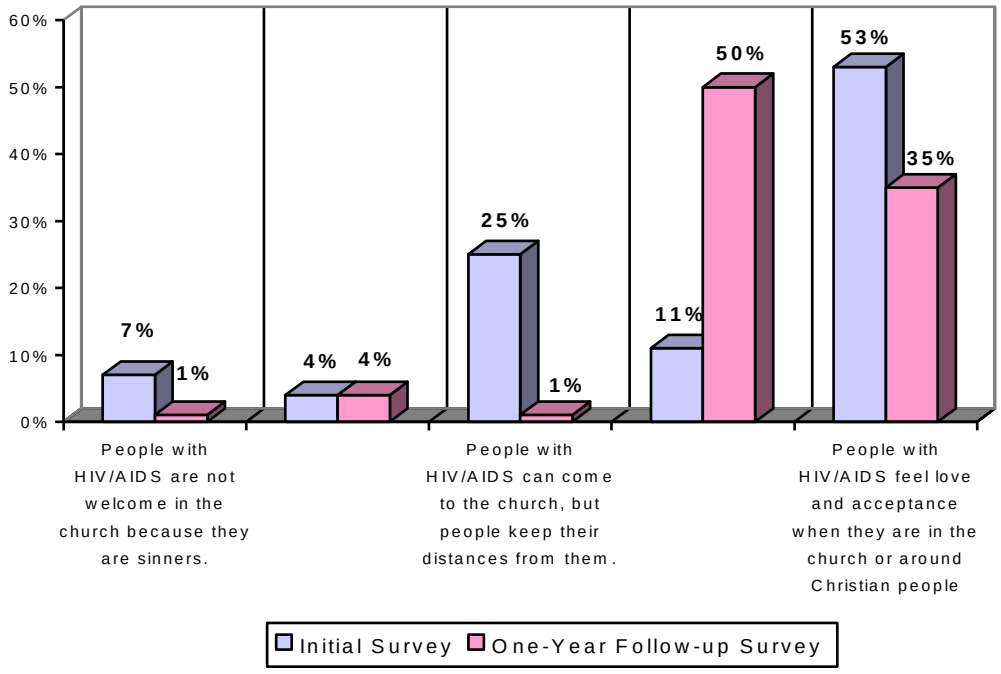


The one-year follow-up survey reveals a significant decrease in negative attitudes of a 34% cumulative drop in the first three categories. An interesting component to this question is the change in attitude perception in the positive categories. The overtly positive response on the far right of the graph diminished overtly, while the second category demonstrates a sharp rise in positive attitudes. Considering the possibility of field worker interpretive error, and averaging these two figures to a sum of 48 makes a less appreciable, but possibly more reliable indicator of the result, which continues to be encouraging, even with this adjustment.

Question #2: How do you think people in the AIDS community feel about the Church?

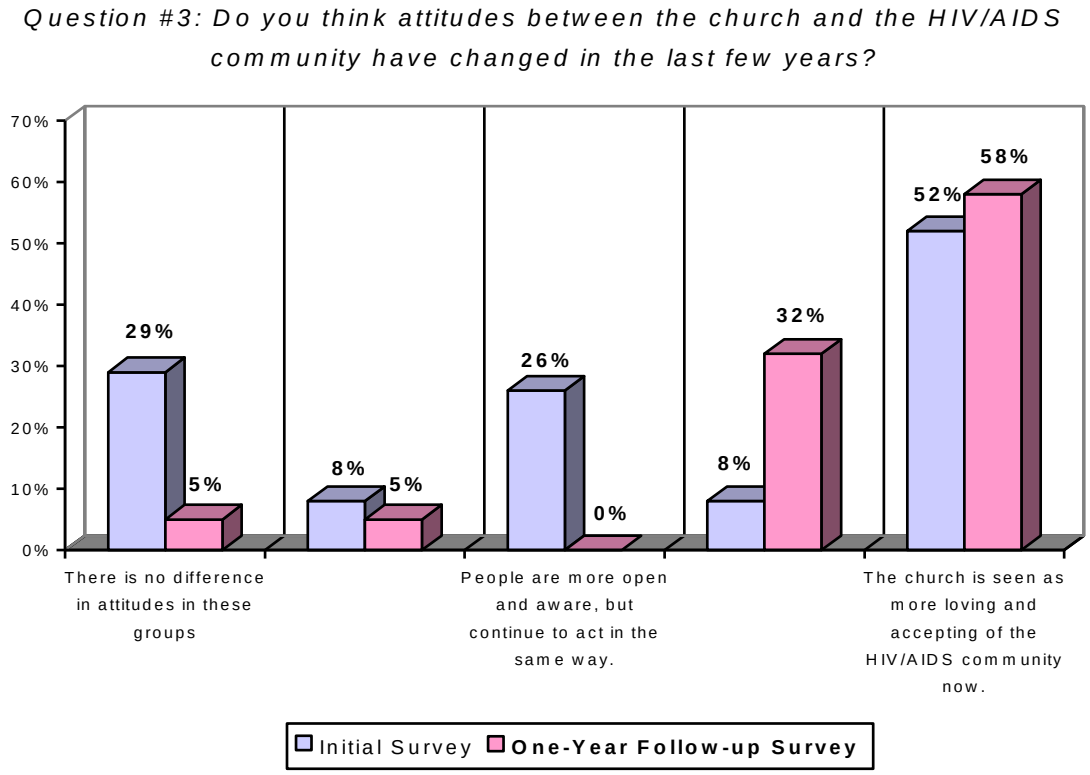
The appreciable differences noted on the negative side of this question are relatively minimal, with only a decrease of 6% at the lowest indicator, and no change at the next level. The median indicator, which is the more neutral of the questions, showed a 24% drop in negativity, along with an 18% decrease at the most positive indicator. What is surprising on this positive side of the graph is the midland indicator that has an inverse report of 39% *increase* in the positive response from the previous year.

Question #2: How do you think people in the AIDS community feel about the Church?



Question #3: Do you think attitudes between the church and the HIV/AIDS community have changed in the last few years?

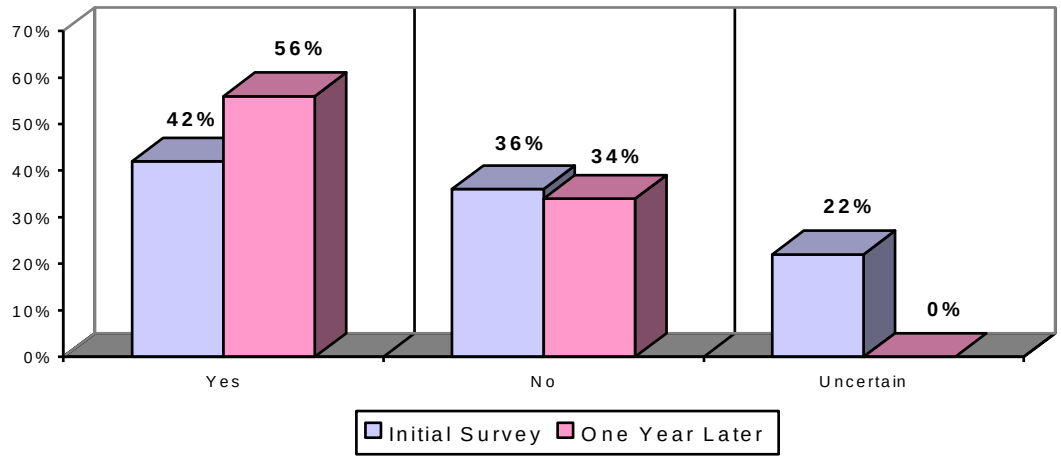
This question holds considerable optimistic promise as it indicates the perception of the community that change is occurring *for the better*. The people surveyed have indicated a positive influx in how they perceive the church and its role in the community regarding its effect on the HIV/AIDS crisis. Only one year ago, almost one third of those surveyed felt that there was no change to be seen over the previous few years. This number decreased by 25 percentage points in one year's time.



Question #4: Has anyone in the family suffered from HIV/AIDS?

A 14% increase in the affirmative response indicates more awareness of the affect this disease is having upon those in the immediate families of those surveyed. An interesting indicator can be observed in the 'uncertain' category, which might be attributed to the way the question was handled by the field worker, or it could be an indication that people are living with less denial and becoming more aware of the actual circumstances surrounding the tragedy all around them. Most likely, this response is a combination of both of these factors.

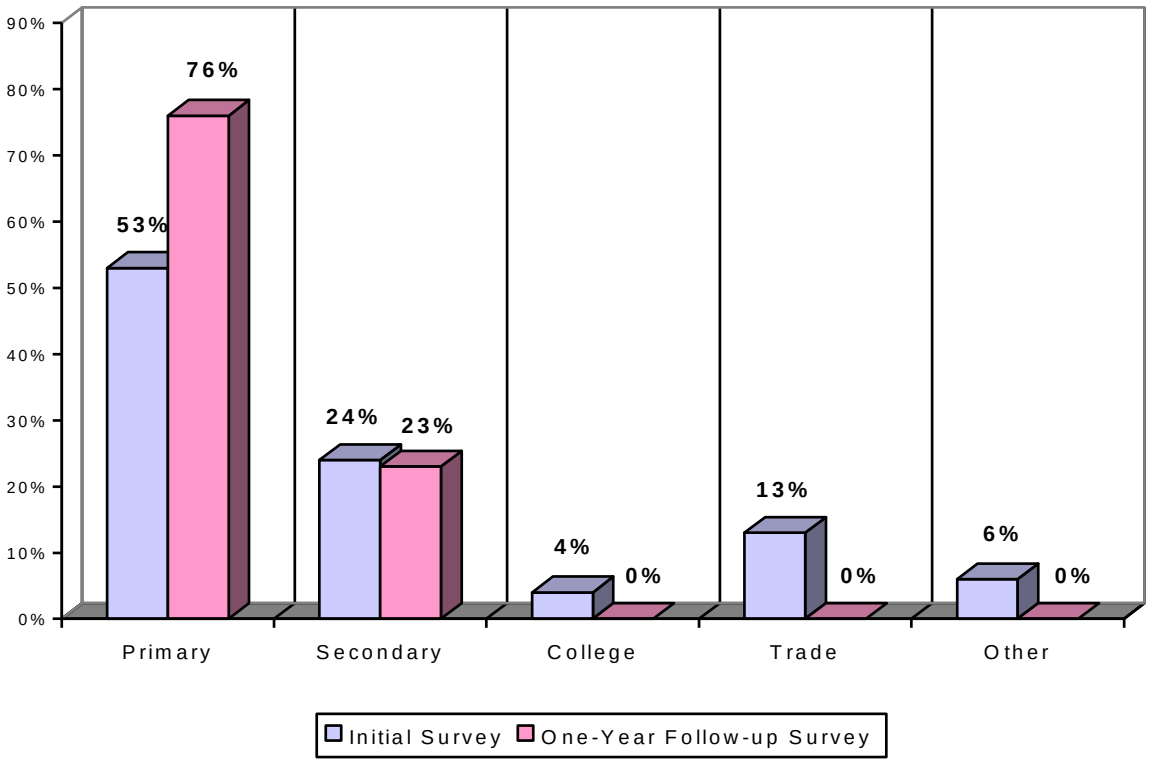
Question #4: Has anyone in the family suffered from HIV/AIDS?

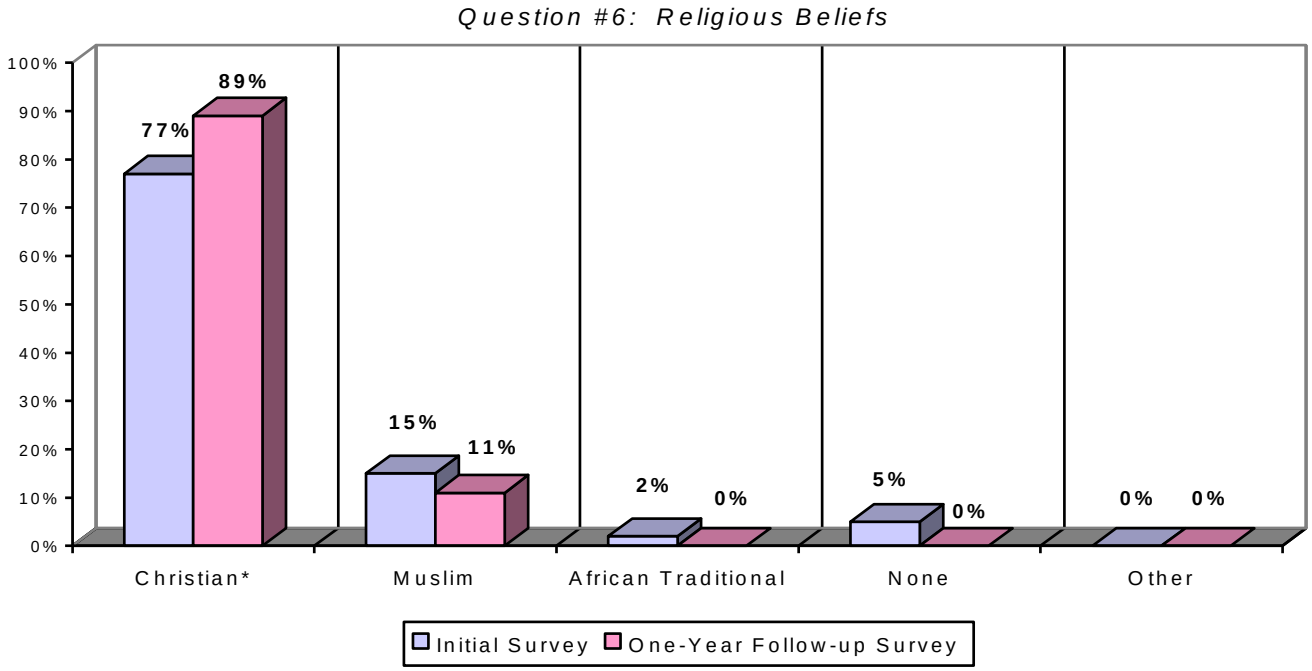


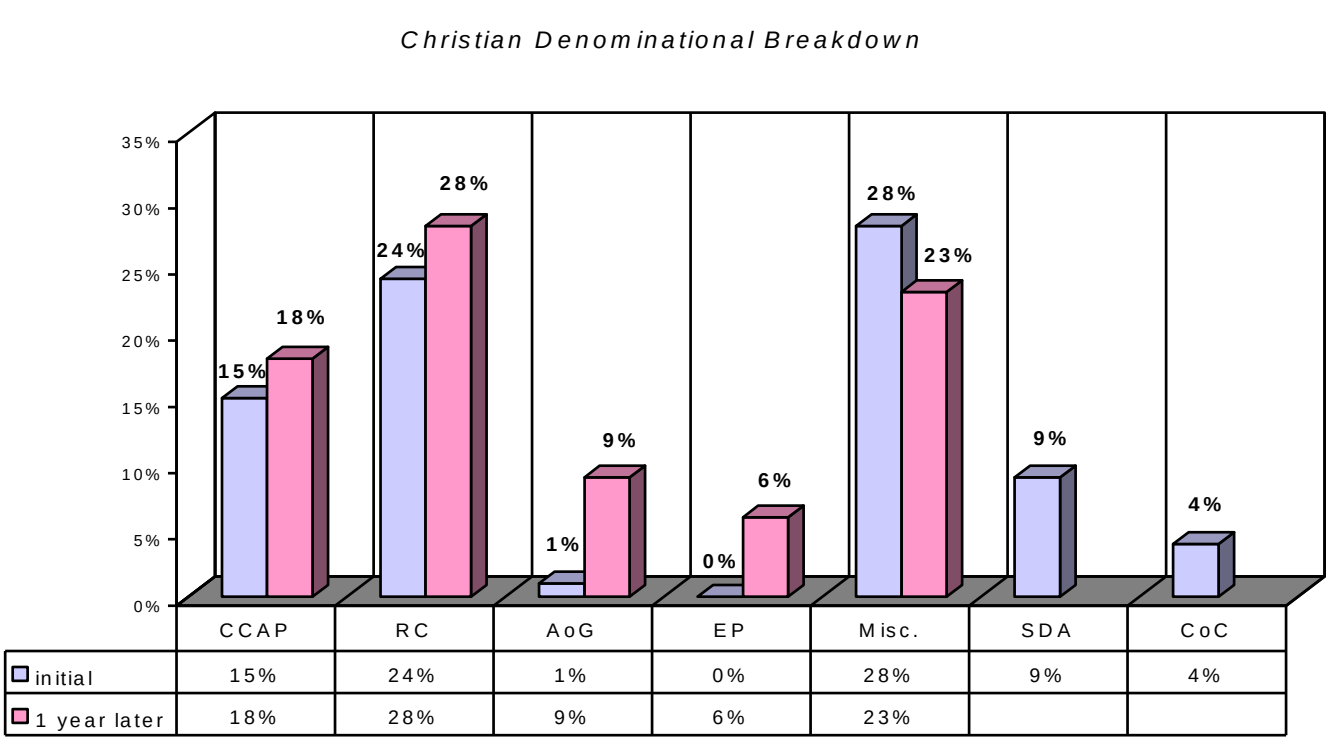
Question #5: Level of Education

Knowing the subject village personally, the one-year follow-up survey has what this researcher considers to be a more realistic response. It is doubtful that any in the village have an educational level beyond that of secondary school. There is an exceptionally high (76%) number who have attended, but not necessarily finished primary school. This is collaborated by the very few people in the village are fluent and competent in English; these two facts correspond to the fact that although English is taught in Primary School, but in order to function in Secondary School, one must be proficient in English because all classes are taught in that language and not in the local vernacular.

Question #5: Level of Education



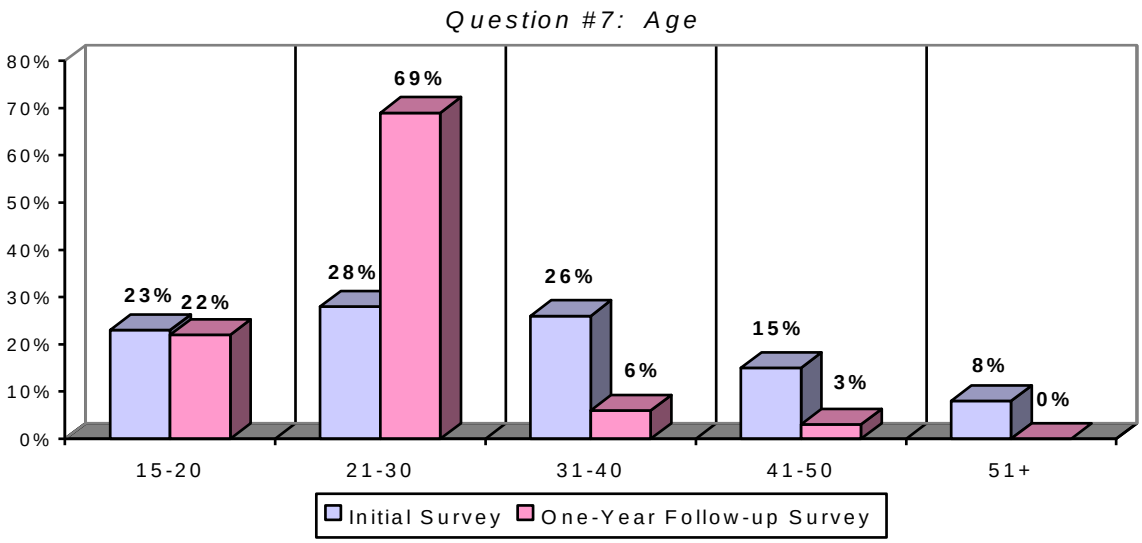




Question #6: Religious Beliefs

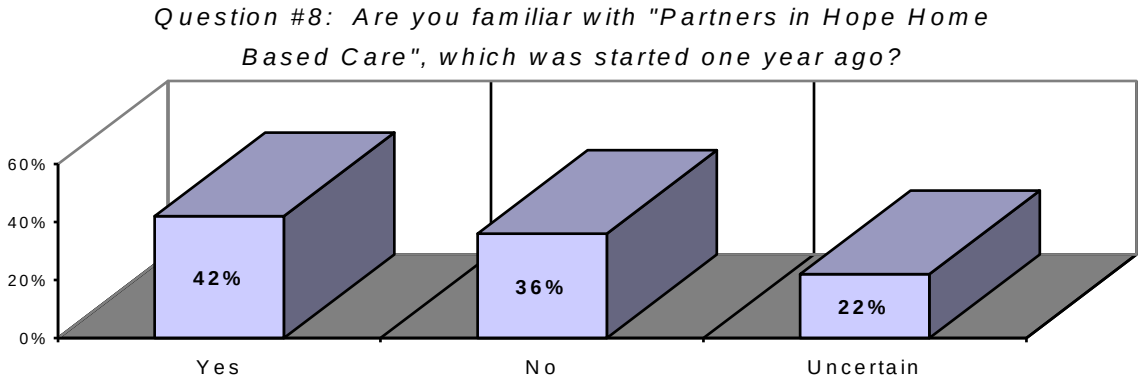
** The denominational codes are as follows: CCAP – Church of Central Africa Presbyterian; RC – Roman Catholic; AoG – Assemblies of God; EP – End Times Pentecostal; A – Anglican; SDA – Seventh Day Adventist; CoC – Church of Christ; Misc - AA – African Abraham; NA – New African; JW – Jehovah's Witnesses*

Question #7: Age



The age of the respondents in the initial survey was surprising considering the national age related figures. This one-year follow-up study shows a significant increase in the 21-30 age group that this researcher believes more closely corresponds to the general population of the community assessed.

Question #8: Are you familiar with Partners in Hope HBC, which was started one year ago?

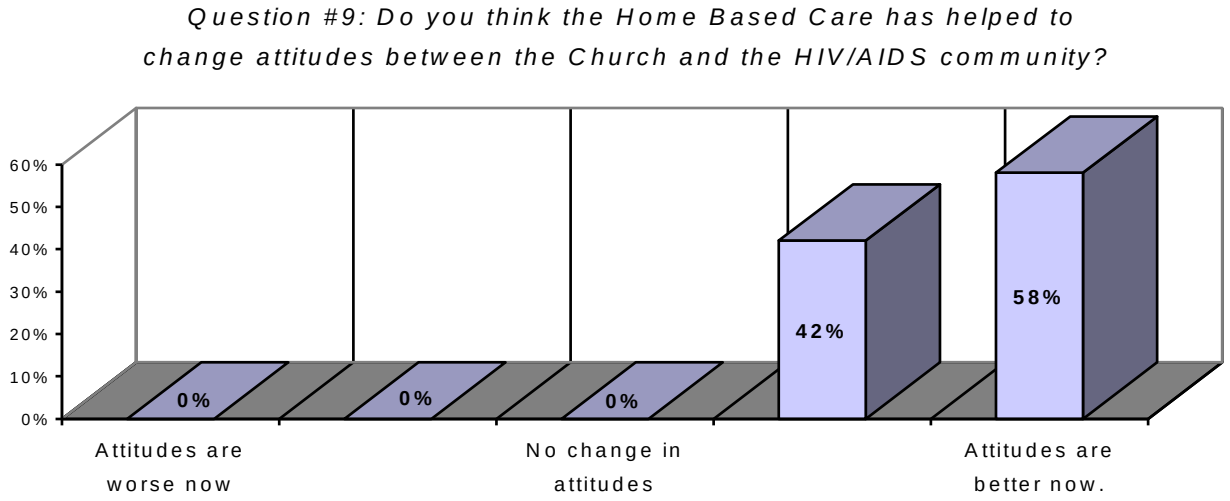


This question was asked simply to get a feel for the community's awareness of the HBC program. Since it is primarily limited to the local milieu surrounding the

participating churches, it would be reasonable that it was not too well known throughout the general population of these villages.

Question #9: Do you think the HBC has helped to change attitudes between the Church and the HIV/AIDS community?

This question was not designed to require interpretation on the part of the respondent, only a general indication of his or her perception about the changing of attitudes, and whether or not the HBC program has had any impact in this area. Again, it must be noted that although measures were taken to avoid answers given with the intention of attempting to please the interviewer, it must be realized that with a question like this one, there is a significant possibility of this type of risk as the participant is fully aware that this survey is being performed by Partners in Hope HBC. The respondent may therefore, because of his or her cultural background be tempted to provide at least a neutral, if not a positive response. Even with this consideration the findings are optimistic as everyone reported a positive change with the larger majority (58%) affirming a more significant change, and the remaining 42% feeling that at least some change for the positive has taken place.



7.2 INTER-GROUP RELATIONSHIPS AND DYNAMICS

Because of separate training sessions of the Chimbalame group and the Kaning'a group, along with a significant variance in demographics between the two groups (see chart below), only minimal attempts were made to solidify these groups. They did occasionally come together for the monthly seminars, but tended to function very independent of each other overall.

The third church originally identified never did participate in the program. Since it was deemed important for the church to take the lead, it was felt by the HBCPC that it would be counterproductive to try and 'woo and encourage' them to participate, feeling that this would lay a foundation for their participation as a response to a perceived need on the part of Partners in Hope. This would give the impression that they were participating in *our* program, instead of us taking a minor role in helping them to develop *their* program.

ATTRIBUTE COMPARISON BETWEEN TWO STUDY SUBJECT GROUPS

	Chimbalame	Kaning'a CCAP
1	10 churches representing 10 denominations	One church from one denomination
2	From an overpopulated area with several villages sharing boundaries	Larger area
3	People very poor	Most people financially secure
4	People mostly uneducated, or limited	Most people are literate and many educated professional people
5	Large unemployment or pieceworkers	Most have secure jobs
6	Few people have bicycles, most travel by foot	Many have their own cars or means of transportation
7	People live in mud brick homes, often with grass roofs	People have homes with plumbing and electricity
8	Clothes at subsistence level, usually well worn and chosen for function	Wearing Malawian designer clothes
9	Very dependent upon Partners in Hope	Very independent of Partners in Hope
10	Chichewa speakers, with limited English	Chichewa 1st language, but proficient if not fluent in English
11	Placed great importance in hierarchy and status in the group makeup	Worked within existing structure and hierarchy
12	Liked to work in groups	Liked to work in groups, but often worked independently due to scheduling

		difficulties
13	Liked identifying group clothing	Liked identifying group clothing, but this eventually worked against them as identifying them as 'AIDS' group
14	Individual churches had some pre-existing home visitation programs, but with no connection to this committee	Pre-existing home visitation program in place, in connection with other benevolent ministries (orphans, elderly, care, etc.)
15	Initial class size: 52	Initial class size: 37
16	Number of volunteers visiting one-year later: 45	Number of volunteers visiting one-year later: 0
17	No one in group with previous HBC experience	Group primarily made up of Kaning'a's benevolent committee, including 2 nurses
18	Many are displaced persons (individuals, or individual family units) from more remote villages who have come to the city for work	Many have lived in Lilongwe for a length of time and have an established familial support system in place

Comparisons between the two groups initial composition are listed in the chart above. These differences were not appreciable during the training process or in their grasp of the information given. The immediate response from both groups was similar in that both groups gladly received the training sessions and expressed appreciation of materials and information gained from the experience. Both groups began with zeal and enthusiasm, and were encouraged to take 'ownership' of their ministry with Partners in Hope available for further consultation and assistance.

Following the training and initial beginning of the HBC program, notable differences began to be observed. From the beginning, the Kaning'a group exhibited a sense of ownership of their program (item 9 from chart above). In their church organization, (CCAP is infamous for their strong bureaucratic infrastructure) a provision was already in place for benevolent ministry (item 14).

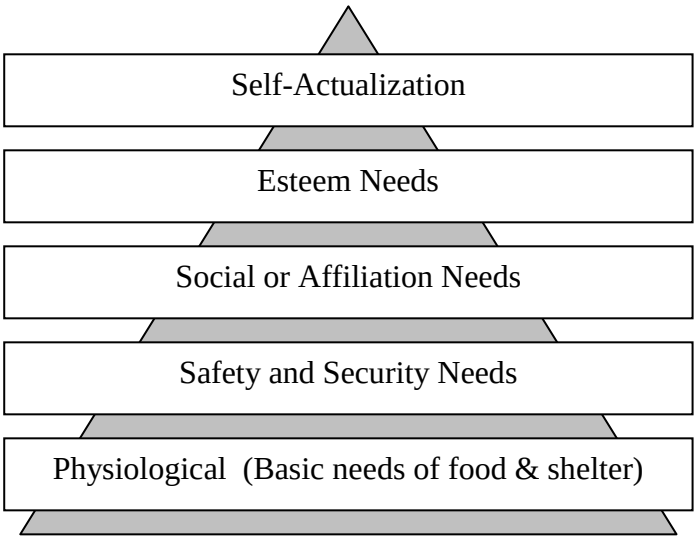
7.3 CHIMBALAME GROUP EVALUATIONS

Without the existing framework already in place, the Chimbalame group was forced to develop its own organizational structure. The initial plan of the HBC was to develop a functional augmentation of the visitation program already existing in the church. This goal was modified however in order to comply with the overriding need of allowing the group to control their own development based upon their perceived

needs and vision. The initial goals and plans of this research were intentionally allowed to fade from the focus in a deliberate attempt at allowing the Chimbalame group to take 'ownership' of the project. Seeing group ownership as an essential function, which would serve as a foundation of the entire program justified the change of goals at this point in the evolution of the program.

7.3.1 Poverty – a major impediment

As the Chimbalame group began to identify their organizational structure, a strong central committee developed which later developed into an entity of its own (see below for further explanation of this feature). Several factors must be considered as to why this phenomenon took place. One of the most significant features that must be considered is the abject poverty that is prevalent in the Chimbalame group. As already pointed out, the Kaning'a group was made up mostly of individuals who had a more secure level of living, with relative job stability and intact familial family support systems in place. They would probably then be placed in the third to fourth level of Maslow's hierarchy of need (Barlow 1992:355).



Because of their level of affluence, they have progressed beyond the needs of the physiological and safety needs, and are therefore able to exercise the *luxury* of volunteerism. Through the development of this study, this researcher has become acutely aware of the devastating effects of poverty. Outside of the manifestation of an overflowing divine love, coming from within and exhibiting itself in such munificent

action, is simply impossible for those at the lowest levels of the hierarchy to give of themselves in what might normally be thought of in the idea of volunteerism (as perceived by those on the higher levels of Maslow's hierarchy). Their basic physical needs were simply too great to be able to look beyond their own seemingly hopeless situation to care for the needs of others. To ask someone to give benevolently of their own time and resources, when they themselves have not eaten was found to be simply beyond their capability.

Bate identifies this phenomenon of acknowledging poverty as a problem but then attempts to minister without ever fully addressing it. In his research, he points out that although poverty was identified in the initial planning stages, it was overlooked as an actual component of the ministry until circumstances demanded a change (Bate 2003:201),

> A few projects initially envisaged a poverty relief component as an essential aspect of their work, but the majority preferred to focus their efforts on providing care which directly responded to the HIV/AIDS crisis. But most, especially those working in rural areas, eventually found that there work was impossible without a poverty relief component.

One of the effects of this phenomenon of poverty was how the Chimbalame group began to intensify their identity of themselves as a group. Since most were either unemployed or if employed, they were working in temporary unstable job situations, they did not derive their sense of identity (item 5 from Attribute Comparison chart above) from their work situation. Another significant factor, which is akin to the poverty challenge, has to do with the fact that they did not have the normal support systems in place that most Malawians have come to see as their source of identity (3.8; 4.14), also item 18 from Attribute Comparison chart. Because of these two reasons, the Chimbalame group began to perceive its identity *from the group itself*. The committee took on a significant role in their lives and the hierarchy of the committee and the power of the ruling positions became of paramount importance to them. Professing to have the interests of the patients as their priority, they continued seeing the patients or often merely claiming to see the patients; with the ulterior motivation underlying of an eventual reward for their efforts, either financial or substance. Since for many of the volunteers, if not for most, this was

their primary motivation for service; their frustration at what they perceived a lack of items due to them becomes more understandable.

Many of the Chimbalame group also saw the training they received as a possible entry into employment by ABCCC and were therefore wanting to maintain, if not intensify their relationship with the clinic and the HBC department. The Kaning'a group, on the other hand did not have such aspirations due to their more secure employment situations.

Another important factor for consideration was the fact that those in the Kaning'a group were significantly more comfortable with their English comprehension and therefore they were able to communicate more effectively with the HBC trainers. This allowed them to feel more independence from their trainers and confidence in their ability to move forward autonomously.

This phenomenon of internal intensification at the expense of external outreach of the Chimbalame group as opposed to the outward focus of the Kaning'a group bears some resemblance to the phenomenon described by Newbigin as he discusses McGavran's concept regarding his 'mission station' theory. McGavran studied the reasons why some mission churches multiplied rapidly while others in similar situations stagnated. What he found was:

> As converts were detached from their natural communities to which they belonged, and attached themselves to the foreign mission and its institutions, which required them to conform to ethical and cultural standards that belonged to the Christianity of the foreign missionaries a two-fold outcome was observed. As they were removed from their own environments [cultural surroundings], they were no longer in a position to influence non-Christian relatives and neighbours; and secondly, the mission station churches soon became exhausted in their efforts to bring the converts, or more often their children, into conformity with the standards supposed by the missionaries to be required by the gospel. Both factors have the effect of stopping the growth of the church (Newbigin 1995:122).

Similarities to the findings in this HBC study begin to surface when one examines the eventual outcomes of these two groups. Chimbalame, which maintained a strong identity with the ABCCC, severed their identity with their individual churches, and lost all interest in looking outward, thus losing their focus and vision of serving the Kingdom. This led to their ultimate demise as they became so self-serving (as did McGavran's stagnating church) that they could no longer function.

The Kaning'a group, in comparison to McGavran's growing churches, retained its focus and mission even though it suffered from struggles in other areas.

7.3.2 One-year evaluation Chimbalame HBC:

The first trainees began their initial classes in early February 2002. Although they began with one heart and one focus, once the HBC project had been in place and actively working with patients in the local area several degenerative changes became increasingly apparent. Although the volunteers continued to claim commitment to the program, a number of disruptive undercurrents began to surface based upon the rational described above.

After investigating the situation more thoroughly, several areas of discontent became apparent from amongst the volunteers. Up until this point, these areas were not brought to the attention of this researcher or others assisting with the program. The main catalyst for the discovery of the problems was the hiring of a full-time home-based care nurse to assist the volunteers with the medical components relating to their patients care.

During this initial year of practice and development, the HBC volunteers were functioning primarily in the role of chaplains, giving spiritual support and comfort to those they were seeking to help. In accordance with the initial goals of the project, the medical training received by the volunteers was intentionally very rudimentary. They were therefore not equipped with the necessary skills needed in order to allow them to actually assist with any medical decisions for the patients in any real way.

As the one-year anniversary of the HBC program approached, evaluations were done concerning the viability of the program. From this data, it seemed feasible to seriously consider the option of outside funding to enable the hiring of a registered home care nurse to aid in the development of the medical component of the program. Because of the nature of the HBC patients, who were primarily suffering from AIDS or other disease processes that caused them to be confined to their homes; many of the volunteers expressed feelings of frustration and a sense of helplessness when visiting patients with obvious physical needs, since they were unable to address their actual bodily needs.

By the end of the first year, funds became available through Partners in Hope to hire a full time nurse. This nurse was to act in the role of medical liaison to Dr. Perry Jansen at the ABCCC. An experienced Malawian HBC nurse was hired to work primarily in the village areas, supervising the home care volunteers, and overseeing the medical needs of the patients involved in the program.

The volunteers continued to meet regularly with HBCPC for feedback and follow-up. The HBCPC took deliberate pains to work within the guidelines established with the goal of keeping the ownership of the program within the hands of the volunteers themselves. Therefore, other than monthly updates, and encouragement of the volunteers, additional obvious oversight was kept to a bare minimum. Time was given for the volunteers to assess their own needs and then bring these needs to the attention of the HBCPC instead of direct intervention begun when a need began to surface and reach the attention of the trainers.

The program trainers made regular visits to the field, but kept these visits limited in scope due to the disrupting effect noted by this researcher when these visits were made. It became quite apparent when this researcher made visits with the volunteers that the patients, although quite gracious and most likely genuinely pleased by the visit, felt quite unnerved by the fact that there was an *azungu* (white woman) in their house. What inevitably happened would be a degeneration of the actual purpose of the visit to provide loving concern and comfort to the patient; and instead the visit turned into a time when the patient would feel compelled to express continued gratitude to this researcher for the kind assistance of the volunteer. Because of this tendency noted in the patients, and the cultural and language barriers between the researcher and the patients, most contact and evaluation of patient status was done through the opinions and judgment of the volunteers.

These factors caused a considerable amount of difficulty in getting an accurate picture of the actual home and patient situation due to the cultural tendencies of Malawians to please along with their willingness to offset the actual truth with what they perceive would be the information desired by the researcher. It was not until the Chichewa speaking, Malawian-born, full-time HBC nurse was hired and actually began making visits to the patients that some disturbing underlying problems were discovered in the HBC program.

The following difficulties were noted:

1. As the volunteers were becoming increasingly dissatisfied with the lack of 'incentives' being received, they lost their altruistic heart. This caused their focus to change from their original goal of visiting patients for the purpose representing their church by demonstrating the love of Christ as they lovingly cared for the sick and suffering in His Name. Instead, their focus had degenerated into an opportunistic consideration of what advantages they could obtain by participating in the 'program'.
2. As the homecare nurse made visits to the patients, she began to become aware of discrepancies between the number of visits made by the volunteers and the number of visits reported and confirmed by the patients. Although the volunteers continued to express great satisfaction to this researcher and the HBCPC, and continued to attend meetings, and training seminars, the actual number of visits being made to patients had diminished significantly.

   In addition to the discrepancies noted in visiting schedules, when patients were asked about items that were given to the volunteers for the patients, patients reported that they did not receive any such items. Measures were then put in place to call for more careful accountability on the behalf of the volunteers, which were met with increased suspicion and resentment.
3. The individual churches represented by the volunteers participating were no longer the *sending* agency for the volunteers. Instead, the 'committee' had taken on a larger role, usurping the churches role of ministering to the sick and suffering in the name of Christ. The committee had developed into an entity in itself. Members of the committee were often not making visits at all or only occasionally. The growing strength and importance of the committee had shifted to be perceived as their worthwhile cause.

- Rather than seek out lonely isolated individuals from their churches or surrounding community who were suffering and in need of comfort

and spiritual guidance, they readily joined in assisting those patients who had already been identified as needy by other agencies. Many of the patients under the care of this program were also receiving services and care by the Catholic home care unit which was working in the area (which was in direct conflict with the agreement made with the Catholic Sister in charge of the program when the original plans were being put into motion).

This did not pose too significant of a health risk to the patients when the HBC was performing only chaplain type visits, as it would be doubtful that anyone could receive too much comfort and loving care from others. The danger of this practice became apparent when the medical component was added and patients were then given medications, which had the potential to contraindicate or exacerbate the complications already established by the regime prescribed by other medical health professionals who were unaware of the double medical attention they were receiving.[53]

Another difficulty associated with this problem surfaced when the other agency involved was giving out more food items than Partners in Hope. This resulted in the patients and volunteers perceiving that they were not receiving their fair 'allotment', causing them to become disgruntled and accusatory toward the volunteers (who then began to share in their suspicions) believing that Partners in Hope was appropriating what was rightfully theirs.

- This practice can be observed in the documentation of a 'volunteer' program describing 'volunteers who work for little or no recompense' (Bate 2003:2001), which demonstrates the underlying perception that 'volunteers' should be compensated in some way for their services, and that *working with little or no recompense*, was working above what could be expected. This difficulty is compounded by the fact that

[53] This came to a alarming head when it was discovered that one of the patients was prescribed Lasix (a diuretic) because of fluid retention by another HBC physician and also by the Partners in Hope physician. This was caught quickly, but nonetheless had the potential of serious consequences for the patients health and well-being.

some governments (as Bate cites South Africa in his article) actually *provide cash incentives* for registered volunteers (emphasis mine). This increasing problem began to undermine the entire program. The following example is offered as an illustration of the significance of the suspicion and discontent exhibited by this group:

The volunteers had developed a repertoire of songs, poems and dramatic presentations that they have used for their own benefit, as well as for communicating to others about HIV/AIDS. When a visiting group from the USA expressed an interest in seeing some of these demonstrations, the HBC volunteers were asked to come together and share some of their songs, poetry and dramatic presentations with these guests.

Several of the volunteers came and following the time of sharing with the guests, after the farewells were made, the home care nurse spoke to them. She expressed disappointment that more of them were not present and they told her of their disillusionment with the HBC program. They were upset because they were not getting the 'incentives' they believed they deserved. They said that the Partners in Hope training team were 'all getting fat, while we are getting thinner', or in other words, revenues were surely coming in for them that were being siphoned off by this researcher and the others in the Partners in Hope office so that the volunteers were not getting the food and money they felt they had coming to them. They were unwilling to believe the claim that was no wealthy funding agency supporting this research.

4. Another problem that surfaced during the first year, of which we were already aware, but will be listed at this juncture for sake of reference, was noted with a shift in enthusiasm from within the volunteer force after it had been active for approximately 6-8 months. The chairman of the committee, Rev. David Phiri, who had initially worked so hard to mobilize the effort of the HBC concept, was conspicuously absent from many of the activities. It was feared from the beginning that this man, who was already over-taxed with his obligations might not be

> able to keep up with the demands required of the committee chairman; but upon further investigation it was discovered that this pastor was purposely stepping back with the intention of allowing the progress of the HBC to diminish until it faded from existence. Apparently this pastor, who had joined so vigorously in the initial efforts, had done so with the presupposition that there would be either financial or material dividends forthcoming that would be a benefit to himself personally, or for his church. When the truth of what was promised (no financial or material incentives) materialized, he dropped out of the program. Although many of the volunteers from his church continued visiting patients, it none-the-less had a demoralizing effect on the entire program.

When this researcher and the HBCPC became aware of these problems, a time of re-evaluation and examination was called for.

7.3.3 Chimbalame intervention research.

As stated in the definitions cited by De Vos, what really distinguishes intervention research from program evaluation is that when intervention research is attempted, something new is created and then evaluated, whereas program evaluation assumes the prior existence of a program or intervention designed and developed by some else, perhaps long before the evaluator ever entered the field (De Vos 1998:365). It is therefore the goal of this research to endeavour to evaluate the intervention provided by the HBC program that was initiated by this project design. From the conclusions drawn above, the strengths and weaknesses of the program can be identified and a praxis theory can be formulated along with a strategy for its implementation.

Following a strategic planning sessions with both the ABC Partners in Hope HBCPC and the Chimbalame HBC committee, the following measures were considered as a way forward in formulating the continuing development of the program:

1. It was first determined by querying the pastors of the various churches whose members were involved in the program that HBC was indeed an

asset to the ministry of the local community churches. It was also established that efforts should be begun towards re-evaluating it to determine what would be the best way to move forward in such a way as to build upon the strengths and turn the weaknesses into opportunities for growth. This was difficult in itself, because as a whole, the pastors did not readily agree to further discussion with this researcher. From this lack of interest and commitment, it was surmised that the pastors of the various churches who had once begun so enthusiastically had ceased to consider the HBC program, which was initially begun as a program to equip their congregation with skills for visiting the sick, as something that held any meaning for their individual faith community.

2. The ABC Partners in Hope HBCPC felt that the following systems which were recently put into place would work to assist in achieving the continuing goals:
    a. The HBC Nurse would oversee the volunteers in a more controlled and organized manner, addressing the areas of accountability and resource management.
    b. A simplified record keeping system would be developed which would allow the volunteers to keep records of their work and visits.
    c. The Catholic mission would be contacted and discussions would take place to ensure a way to establish patients who are being cared for by the HBC volunteers to avoid patients being treated by two different systems.
3. The Chimbalame volunteers committee felt that the following interventions would be helpful in moving forward to meet the goals as outlined in this work:
    a. They wanted more ‘incentives’ such as financial backing for IGA (income generating activities).
    b. They wanted more food to be provided for the patients.

c. They felt it was important, because of cultural expectation to provide some type of 'gift' item when visiting, which they thought should be provided by Partners in Hope.
d. More meetings of the committee with the rest of the volunteers for support and emotional regeneration.
e. More training and equipping sessions to continue to enhance their skills.
f. A 'field trip' of the Chimbalame volunteers to Nkhotakota to see their program in action might prove enlightening and motivating.
g. More medical supplies such as gloves, medicines, etc.

7.4 KANING'A CCAP GROUP EVALUATIONS

The bulk of the discussion thus far has been surrounding the ramifications made by the initial class of trained volunteers and their impact in the local church and the surrounding community. There was a second class of volunteers trained which could pose as a second model for study as well. Along with many similarities with the first group under study, there are also a number of significant differences, which were explored earlier in this report (7.2).

From within their pre-existing framework of benevolent work within the church, several ministries were already taking place at the time of their initial training. These ministries included such services as an orphan's and widows program. Although there was an effort at visiting the sick, it was not done in any structured or methodical way. The church leadership shared a perceived need of improvement in this area and was therefore eager for an opportunity to equip their congregation in such a way as to be more effective in this area. When the pastor and his wife were first approached with the idea of HBC for their church, they readily embraced the idea and stated emphatically that they would both be the first to sign up when the class would be offered (in actual fact, the wife did attend, but the pastor had too many other obligations to commit the required time to the training sessions).

The HBC training allowed them to configure their HBC structure in whatever way they thought best and most workable given their own particular situation. As a group, they were given the task of determining how to proceed and develop their program. As a group, they discussed this issue and decided it would be best to work within their existing framework and develop their HBC program as a specialized component within this existing organization.

Once the training was completed, follow-up was limited and only after initiation by Partners in Hope. After one month, they were contacted and evaluation was requested from Mr. Lungu, the primary contact. It was reported that things were going well and people were continuing to make visits in a meaningful way. Following this, the Kaning'a group became increasingly self-determining and did not require or request any further assistance or guidance from the trainers. In an effort to promote autonomy and self-sufficiency, the group was allowed to progress independently.

The Kaning'a group was invited to various functions in conjunction with the Chimbalame group, but rarely were any of their volunteers present at any of these meetings or functions. When they did send representatives there was an obvious separation between the two groups. Although the Kaning'a group seemed open and ready to join with the senior Chimbalame group, an interesting development was observed in the reaction of the senior group.

7.4.1 Challenges faced when mixing the two training groups

Those in the Chimbalame group became increasingly suspicious of the Kaning'a group, to the point of overt jealousy. They openly questioned who they were and why they were present at 'their' training seminars. Although they seemed to accept the fact that these too, were HBC volunteers working to serve the sick in their community they never seemed to fully embrace the concept of this other group belonging within their number. Their open antagonism worked sufficiently to keep the Kaning'a group from choosing to participate in any further cross-group meetings and functions.

7.4.2 Kaning'a one year evaluation

At the time of the one-year evaluation, the Kaning'a group was once again contacted for an update. Rev. Khombe, the pastor of the church was contacted first out of respect for his position and to maintain the proper protocol of the strong hierarchy within the CCAP framework. As expected, Rev. Khombe was unaware of the current status of the Kaning'a HBC ministry and it was suggested that this researcher contact Mr. Lungu, the head of the compassionate service committee (*Bungwe la za chifundo*), who had already been functioning in the role of 'key informant' for the purposes of this study. Mr. Lungu had been involved with this researcher during some of the initial steps of development of the program within the CCAP. Upon meeting with Mr. Lungu, the following discovery was made:

The HBC program initially began with great gusto and enthusiasm. It remained strong and functioning for several months and then began a serious decline, as the members of the group began to diminish their HBC activities. By the time six months had passed, the group had virtually given up all of their visitation of the sick and suffering and had gone back to functioning as they had previously, by ministering to the orphans and widows with minimal attention to the sick and suffering in their church body.

After careful evaluation, several critical issues surfaced in explanation of this phenomenon. Although there were numerous factors involved in the dissolution of the HBC program, the one dynamic that seemed to undermine the program most significantly was the underlying perception that this was an 'AIDS' program.

Following graduation from the training, Rev. Khombe earnestly promoted this new ministry in the church. All of the members of this new HBC ministry were presented to the church with their identifying group tote bags and *chitenje* (Malawian wrap skirt cover). It was explained before the congregational body that this group had been specially trained and equipped and was now going to commence visiting the sick and suffering in their church and local community. Rev. Khombe wisely made certain that AIDS was never mentioned during this ceremony; and there was no indication that this was to be an AIDS ministry at any time during the introduction or during the initial stages of the ministry.

The group received a warm welcome from the congregational body and passionately began visiting the sick. As time progressed, the volunteers began to sense an underlying tension developing in the homes they visited. Although the patients were responding well to the visits, it was becoming increasing apparent that the caregivers were less than warm in their reception of the volunteers. The caregivers as a whole were becoming notably resistant to the visits of the volunteers and began making complaints because they were coming 'empty handed.' Eventually these increasingly negative comments lead to their suggesting it would be better if the volunteers did not continue to visit their relative.

As the opinion increased that the volunteers were AIDS workers, the families of the patients became sensitised to the stigma surrounding the AIDS situation. This caused them to begin working towards ending the visits as a way to reduce the perception of their neighbours that their loved one was suffering from AIDS. Caregivers shared their concerns that others in the community who might be observing the visitation would conclude that the patient had 'misbehaved' or that 'you don't want a wife from that family', and other such suspicions. As these concerns increased, the hostility towards the volunteers increased proportionately, until they simply gave up and stopped the visitation.

7.5 IDENTIFIED PROBLEMS AND CHALLENGES

7.5.1 Identified Problem: Lack of peer-group support reduces effectiveness

Many ministries have a built in sense of reward. Orphan care as an example, is very rewarding; as one ministers to the needy children, they are repaid with numerous smiles, laughter, and hugs of appreciation from the children. This can serve as a positive motivator, encouraging the continuing of such behaviour. HBC however, is often just the opposite. Instead of energizing the caregiver, HBC often takes from the caregiver as he or she gives of him/herself in an effort to serve the needs of the suffering. Often the emotional strain can be intense in dealing with people who are genuinely suffering as relationships develop between the patient and the volunteer. These relationships can be emotionally draining to the volunteer as they try to seek ways of assisting someone with increasingly difficult needs. In

addition to this, once the volunteer has made a significant investment of his or her own time and energies into the patient in their effort to serve, the eventual death of that patient can be devastating to the volunteer.

With these factors in mind, it is easy to see why HBC volunteers need to find ways, usually through the mutual support from group members, to strengthen each other and lift each other up with positive reinforcements to promote continued efforts. Without this, they will either consciously or unconsciously seek out ways of ministering to people that do not require such a depth of commitment. If the added factor of unreceptive caregivers must also be addressed, the volunteer may simply give up on their efforts to serve in this area, which is precisely what happened with the Kaning'a group.

When asked whether there has been any change in the way the church is addressing HIV/AIDS issues, the key informant responded affirmatively that the church leadership is indeed addressing the issues of HIV/AIDS from the pulpit. When questioned further, about just what types of messages are being given it was found that although the speakers are beginning to talk more about AIDS in the open in the church, what is being said is not productive, but rather serving to reinforce the old attitudes suggesting that those suffering from HIV/AIDS are 'getting their just rewards'.

7.5.2 Kaning'a CCAP Intervention Research.

Following a strategic planning session with the Kaning'a key informant, the following measures were considered as a way forward in formulating the continuing development of the program:

1. It was first determined that the HBC program was an asset to the ministry of the church and efforts should be begun towards re-evaluating it in an effort at re-establishing the viability of the HBC program.
2. The key informant agreed to confer with others in the group to evaluate their perceived needs and difficulties as they considered the way forward for their HBC program.
3. The ABC Partners in Hope HBC Supervisor and Medical director would be consulted and queried regarding their thoughts in the continuing

development of the Kaning'a CCAP HBC program and these ideas would then be shared with the Kaning'a CCAP HBC group or their designated leadership (probably the key informant).

4. It was suggested that the Kaning'a CCAP HBC group be taken to Nkhotakota so that they may interact with the volunteers there and observe first hand how their program works in order to better understand the interactions and methodology.
5. A focused 1-2 day seminar will be provided to the Kaning'a CCAP volunteers with the goal of re-energizing and motivating the group to regroup and begin moving forward towards their goal of providing compassionate care and nurturing to those who are sick in their congregation and community.
6. Two influential members of the Kaning'a CCAP women's guild are to attend the NetACT AIDS Awareness seminar, in an attempt at beginning to retrain the church leadership (who will then both by example and by direct intervention begin to change the paradigm mindsets of the parishioners and caregivers.)
7. Formal address of the Kaning'a Session with the attempt at education and destigmatization of the HIV/AIDS pandemic within this congregation. When discussing the NetACT HIV/AIDS Awareness seminar, the key informant felt it would be very beneficial for the church, and in particular the church leadership, to be exposed to such ideas. It was therefore suggested that a brief 'taste' of the seminar be given to the Session so that they would have the opportunity to seek additional training if they so desired.

Mr. Lungu (the key informant) was unable to meet with the volunteers as intended, so another meeting was scheduled. Prior to this meeting, this researcher and Mrs. Grace Banda, the HBC Supervisor met with Mrs. Khombe (wife of Rev. Khombe), and Mrs. Juma, who were both attendees of the NetACT HIV/AIDS Awareness Seminar developed by Christo Greyling, as a precursor to a meeting with the entire home care visitation group. From this productive meeting several essential points came to the surface to be further explored and addressed.

Mrs. Khombe, and Mrs. Juma, who had made commitments to the entire NetACT group for continued follow-up and action with the other women representing the women's guilds of the other CCAP churches in attendance had done nothing towards reaching the goals to which they had committed. This exploratory visit served as a catalyst to renew their enthusiasm and get them back on target for the interchurch movement in this area.

Once committed to moving forward with their previous commitment, the concept of HBC was discussed, along with the ideas outlined above that were suggested by the home care volunteers themselves. Because of the devastating effects of the perception that the volunteers were actually 'AIDS workers', it became crystal clear during these discussions, that it was essential that the church's efforts towards HIV/AIDS awareness and change be kept obviously and deliberately separate from the HBC initiative. Because it is essential that the perception of the congregation undergo a paradigm shift in its concepts of the purposes of HBC, from this meeting the following ideas were discussed as reasonable possibilities:

All AIDS training attempts for the Kaning'a CCAP were to be encouraged, but to be made obviously separate from any and all mention of HBC. Several areas of HIV/AIDS training that would be further discussed and implemented by those in the church will include:

1. Training, such as the NetACT HIV/AIDS Awareness Seminar designed by Christo Greyling, (to be provided by those who had attended the conference with Mrs. Banda as a consultant), would be given to those individuals set apart and specially designated as counsellors for the youth and young people in preparation for marriage (the *alangizi*). This training seminar would be hosted by Kaning'a CCAP, but would be open to the *alangizi* from all of the local CCAP congregations.
2. The already existing organization of pastor's wives from all local denominations which meets monthly has asked for further training in HIV/AIDS, and in response to their request, this seminar will also be offered to them.

Following the input from this meeting, the leaders of the Kaning'a CCAP HBC met with this researcher and Mrs. Banda. Although they were anticipating hearing the details of how the previous suggestions were to be implemented, they appreciated the concerns and wisdom in keeping the HIV/AIDS issue completely separate from the idea of HBC. In the discussions from this meeting, the following ideas were brought forward. A new goal was developed, that of desensitising the congregations from the negative perception already in place. It was unanimously decided that the first priority would be to change the perception of the HBC program within the congregation and community. Following this, other steps geared toward re-establishing the program could be instituted.

1. It was determined that efforts should be made to slowly make a paradigm shift in the attitudes of the faith community by subtly and deliberately beginning a campaign designed to change their perceptions by the following means:
    a. Change the name. 'Home Based Care' has begun to be recognized in the community as AIDS workers due to this name being applied to more and more HBC initiatives in the community which are dedicated to that work. It is therefore deemed important to choose a name that will not be associated with this negative concept.
    b. In an effort to promote the idea that the home visitation program was not just an AIDS program, an educational program strategically designed with the implicit purpose of changing the perception of the home visitors would be executed (7.8) and overtly promoted within the church on a regular basis.
2. By making these subtle but deliberate changes, the perception will slowly evolve from 'AIDS workers' to caregivers for individuals who are homebound due to chronic disease of all types, including, but not exclusively for HIV/AIDS patients.
3. Re-evaluate the attitudes and perceptions of the faith community, on a regular basis by the home care volunteers, noting any shifting in sensitivity.

4. Re-evaluate the attitudes and perceptions of the faith community on a regular basis by members of the congregation at large who are not involved in the home care initiative, noting any shifting in sensitivity. Due to the fact that it took approximately four to six months for the original program to slide from a status of 'decline' into actual 'death' of the program, intervals of no more than three months would be recommended between these times of re-evaluation.

7.6 MOVING FORWARD

7.6.1 Moving Forward: Chimbalame

The following issues were carefully considered and discussed by the Partners in Hope planning and training team:

1. The original goals and vision for the development of the HBC program which were taught and discussed at length during the training session, that of HBC serving as an avenue of benevolent ministry whereby the 'volunteers'[54] could tangibly demonstrate the love of Christ, as commanded in Scripture, to the sick and suffering, were no longer the motivating factors by the volunteers.
2. The volunteers were no longer serving solely as a benevolent ministry to the sick and suffering without any thought of gain or reimbursement. Instead their primary focus, which had been to demonstrate the love of Christ to the sick, has shifted to seeking 'incentives' to enhance their personal (as well as the patient's) welfare.
3. The initial plan to help the church develop and enhance their own visitation program to more effectively meet the needs of the sick in their congregations has been completely sidelined. The 'committee' had taken all responsibility for home visitation and the church was no longer directly involved, if at all.

[54] The concept of 'volunteerism' (charitable work without expectation of payment for services) was explained in great detail during the training sessions.

4. Actual patient visitation has been reduced and is often sporadic. Patients are being seen who are already associated with other home care initiatives.
5. The volunteers are becoming increasingly dissatisfied with their role, believing that they are not being treated fairly and insinuating that Partners in Hope is taking food and money that was supposed to come to them, as well as not providing 'incentives' they feel they were promised and deserve.

Following discussion and consideration of the above situation, it was determined by the HBCPC that despite efforts aimed at moving the program back towards its original goals, the outlook of the home care volunteers and their relationship with Partners in Hope has continued to deteriorate. Because of this, the HBCPC has decided to completely disband the Partners in Hope HBC volunteer visitation program in Chimbalame. A letter detailing this was shared with the 'committee' by the Home Care Nurse to ensure that there was no question or misunderstanding as to what was happening and why (Appendix K).

Volunteer efforts have not succeeded in this community by this and many other organizations due to several significant reasons, such as: extreme poverty, and the fact that virtually all of the NGO's are *paying* their 'volunteers' either monetarily or with other incentives (Appendix J), so people have come to understand payment for services as the standard. Because of this the following recommendations are being considered for the purpose of moving forward:

- Develop a paid, professional medically based HBC program with the ABCCC. This way, the health care workers will be compensated for their service and accountability and quality of care can be demanded in return. ABCCC currently employs one full time nurse. It is proposed that two home health aide workers should be employed (either hired as already trained, or trained by ABCCC) to be supervised by the nurse. More personnel may be added as the need demands and funding becomes available.
- Disband the current HBC Partners in Hope program (Appendix K) and start over.

- Begin training in a local church to assist them with the development of their own visitation program as initially envisioned by this study. In order to do this, the following modifications should be instituted:
    - Work within only one church at a time.
    - Do not work with any of the churches that have already been associated with the previous effort, as those churches have demonstrated a lack of interest and accountability. If they are genuinely interested, they are already equipped to move forward as they already have trained volunteers within their congregation that can institute the program.
    - Make certain that the pastor is fully supporting, and even participating in the program.
    - Make efforts to help the people work within their own congregation (at least initially) and keep the entire program under the management of an existing (or newly established if necessary) benevolent committee in the church.
    - The home visitation program will be accountable to the church benevolent committee; they will NOT be accountable to ABC Partners in Hope.
    - The home visitation program will not be called 'HBC' because in this local environment, that has become synonymous with 'AIDS workers'.

In response to the abovementioned letter (Appendix K), the following letter was hand delivered to the HBCPC:

From: Village Committee
Partners In Hope
Mtandire

Attn: Dr. Perry Jansen
Mrs. Janet Brown
Mrs. Grace Banda
Sr. Anna Mpanje

Date: 26 November, 2003

Dear Sir/Madam

SUB: DISBANDMENT OF PARTNERS IN HOPE

Reference is here made to the above subject. We are greatly disappointed for disbanding partners in hope without clear reasons to our understanding. Although you have said so, this will not discourage us from visiting our patients whom we treat as our Brothers and Sisters as you taught us in reference from the book of 1 John 4v19 and 1 Corinthians 13v1…..

By doing so we are encouraged by this verse from the Bible Luke 17verse 1. Since in your letter which you wrote to us, you stated that Sister Anna Mpanje will continue to minister to the sick in our community, so we request to meet Sister Mpanje before she resume her ministry.

Lastly, we would like to thank you for all services you rendered to us during our cooperation.

Please take note that we will continue ministering despite your disbandment. GOD is able and he will lead us.

WE REMAIN (signed)
M. Malenga
M. Gamphani
H. Ofama
C. Tepani

It is believed by the HBCPC that the intention of this letter was designed to cause concern and remorse on the part of the HBCPC, but the actual effect is quite different. From the intention cited in this letter, *we will continue ministering,* it is clear that the volunteers have truly been adequately trained as to enable them to continue with the work in a manner close to the original vision. This uplifting and encouraging reassurance that the ministry will continue, with total 'ownership' (1.3) now being transferred to the volunteers themselves is a lesson in responsibility. It is obvious from this response, that the longer ties were maintained with the committee to ABC, the growth of the dependency continued. In much the same way that a young baby bird must be forced out of the nest in order to fly, the Chimbalame HBC has learned to spread and stretch its own able wings.

This lesson has proved invaluable to both those who are now taking ownership to carry on with the work; as well as those of us in the HBCPC who struggled with the agony of what appeared to be a failure as the 'official' ABC Partners in Hope

HBC was dissolved in defeat. This timeless lesson, of painfully practicing 'tough love[55]' to allow one's progeny to develop independence has been played out and relearned with each generation since God first created the family. Hindsight draws one to understand that the painful dissolution of the HBC was the very action, which was necessary to enable the volunteers. It was only by this forced action that they became empowered to do the task they had originally trained for and committed themselves to do. Further study on this point, as a follow up to their intentions would be of value to ascertain whether or not they did indeed continue with the work they claim they are so committed to, as well as to study whether this reconfigured hypothesis, which was made as a result of this letter (the value of severing the relationship to activate the growth and responsibility of the group) is indeed accurate.

7.6.2 Moving Forward: Kaning'a CCAP

Following the discussions with the Kaning'a CCAP elders and the Partners in Hope training team, it was determined that the first priority was to instigate a paradigm shift in the mindset of this faith community. After discussion as described above, it was decided that the only way forward was to make a purposeful and deliberate plan in an effort to 'move this mountain'. Slowly, deliberately, and subtly a campaign must be begun aimed at changing the mindset of the congregation. In order to do so, it was suggested that an effective way to accomplish this would be to borrow a method used in advertising and marketing[56].

Professional advertisers use commercials to continually place their product before the eyes of the consumer. In addition to frequent reminders, there is also an attempt to associate the product with something positive. This strategy was so effectively used by the Tobacco industries in the United States (aiming at capturing the youth), that laws had to be made in order to have them banned on television. By always placing a cigarette in the hands of happy, vibrant, successful, beautiful, wealthy people, the message was being instilled into the minds of the viewers that 'if I

[55] 'Tough Love' is a type of controlled discipline used in situations where normal discipline is ineffective. It is particularly useful in dealing with unacceptable situations in child-rearing and marriage counseling to help those involved understand boundaries and acceptable responses in a loving situation. More information can be found at the following website: http://www.toughlove.org/.
[56] As proof of God's sovereign plan in all things, it was surely not 'accident' that this researcher has a background in health care marketing strategies.

smoke X brand of cigarettes, I will be happy, vibrant, successful, beautiful and wealthy too!'

Using this method of repetitive stimulus with associated positive imagery is the method decided upon by the group of elders heading up the HBC division of their church's benevolent ministries department. The goal was to disassociate the home visitation with AIDS workers. The name 'HBC' has become tantamount with AIDS worker, so the first thing the volunteers would do would be to select a new name that more closely identifies their actual purpose of compassion and mercy to the sick and suffering, from whatever reason. Therefore, instead of calling themselves 'Home Based Care', they have agreed to rename themselves *Kaning'a Zachifundo*[57] *Committee,* which will have the idea of compassionate visitation to the sick and needy, but will disassociate itself from the AIDS crisis. Even though the knowledge remains that most of the sick and suffering ARE indeed AIDS patients, this can never be the overt focus. Secondly, instead of giving specialized HIV/AIDS training to the home visitors, it was decided that it must be obvious that the HIV/AIDS training which would continue to be promoted within the church would not be associated in any way with the home visitors.

The third step in the plan is essential; because it is the key to helping the congregation change its perception of the home visitors. The faith community must subtly and repeatedly be exposed to ideas and imagery associating home care with issues *outside* of HIV/AIDS. In order to accomplish this the following plan was developed:

- Monthly training sessions would be initiated on topics that are not associated and in fact very distant from AIDS related topics. (Suggested topics might include: how to help a family deal with a child suffering from chronic respiratory disease such as Asthmatic Bronchitis; How to provide emotional support to families of disabled children; Dealing with the aged; various Cancer topics; etc.)
- These training sessions would be open to all interested, but it would be obvious that the training was designed for the home visitors.

[57] *Zachifundo* is a Chichewa word depicting the understanding of a feeling of pity towards another person, which would lead one to want to give a gift to offer comfort to the one suffering.

- Special speakers would be addressing each issue who had expertise in these areas.
- One day a month (to be determined by the church) would be designated for training sessions.
- *Each* Sunday, during announcements, a brief announcement would be made promoting the training session, and equating it with the work of the home visitors. This is emphasized here because it is the essential element of the plan.

By repeating the message each week that the home visitors are dealing with various issues, in addition to AIDS, and receiving quality training in all these areas, the faith community will slowly change their perception to one that removes the 'AIDS workers' stigma, which has been so firmly associated with the current HBC program.

With these steps in place, it is hoped that the mindset of the faith community will begin to shift to a more loving and positive one. Once these attitudes have begun to change, then the home visitation program can become the vibrant program of compassion and mercy that Christ commanded His church.

7.7 FINAL CONCLUSIONS AND SUMMARY

It is no secret that HIV/AIDS is real, and it is devastating the world and the continent of Africa in particular. There is no one cure or one approach that will eradicate this plight. The Church stands in a pivotal spot for making an impact on both the micro and macro levels as it issues its response to this crisis. This study has approached this mountain with one way to begin chipping away at this pandemic. Changing attitudes one by one is a slow process, but it is a good, solid process that will cause erosion to the very foundation of the problem. This project studied the use of HBC as a vehicle of change as an attempt to develop the means by which a paradigm shift of attitudes can occur.

Although initial impressions when reviewing this research seem disappointing in the light of the (probably) over optimistic image of change that was envisioned at the beginning of the study, there have none-the-less been some positive areas of

contribution which can be ascertained from this work. Change comes slowly, even when the change is for the good, or even for the best. Such is the case with the changing of attitudes between the church and the HIV/AIDS community. At the beginning of this study, it was hoped that using HBC as the vehicle of change would begin a series of positive revelations as people began to realize the impact of presenting the love of Christ to those who were suffering with HIV/AIDS. With a 'domino effect' this change would then impact others who would initiate change in not only their own lives, but those in their sphere of influence as well.

Unfortunately, the reality of the fact that change comes *slowly* remains a reality. The good news is that change *does* come. Through the process of this study, hearts have been touched and individual lives have been changed, and changes are continuing. Although overt paradigm shifts in the thinking and actions of the faith communities studied did not change significantly as a whole, there were notable changes in the attitudes of many individuals from the various churches participating in the research (Appendix L). Lessons have been learned during the development of this project that can initiate changes, which when implemented, can alter the path enabling a more optimal result to be experienced.

At the beginning of this dissertation, a vast area of opportunity for the prevention of HIV/AIDS, as well as an outlet for compassionate care to be provided to those suffering from this disease was demonstrated as being overlooked by not incorporating the local church in the plan for the management and ending of the blight of this dreaded disease. This statement remains true. However, this study has shown that the church *can* make a difference. Home visitation programs, initiated as a grass-roots movement within the local church, can touch lives on the micro level as the faith community follows the mandate set down by Christ to love one another. When lives are touched by all of God's people, it will begin change on the macro level as well. By gaining from the lessons learned from this study, new endeavours can begin with the same types of optimistic goals to serve the sick and dying in their communities and avoid some of the pitfalls experienced in this project.

The failure of the HBC to meet its stated goals, although admittedly disheartening, must be re-evaluated in light of the unanticipated positive outcome of uncovering a faulty paradigm regarding the paramount importance of issues such as

the overpowering impact of poverty. Important information has come to light through the process of this research, in relation to the immense problems associated with the extreme poverty suffered by so many in Africa. When the president of South Africa, President Mbeki, announced to the world[58] that 'poverty', not HIV was the cause of HIV/AIDS disaster (Sithole 2000), most of the world was amazed that someone in such a position could make such a profoundly ignorant statement. Due to the dramatic effects poverty has had on the study described by this dissertation, this researcher has come to understand how his statement does hold meaning and relevance. It is an unfortunate fact that although acknowledged by most westerners, the stark issue of poverty, and the seemingly endless ramifications associated with it *are* indeed significant enough to be a *cause* of HIV/AIDS. The hopelessness associated with such dramatic poverty – which is only one aspect of the downward spiral of despair; high risk behaviour, lack of understanding and knowledge, etc., has sucked those in this plight deeper and deeper into this continually escalating crisis. Unfortunately, this researcher is not the only one who has had such misguided thoughts as, 'ok, there is the poverty issue, now let's move on to the 'real' problem….', indicating a total lack of appreciation for the magnitude of this factor in the equation of HIV/AIDS. Further research in this area is necessary to prevent continued disappointments as benevolent organizations and governments attempt to 'fix' the problems of Africa without a full understanding of the complex ramifications involved in this matter.

This research project has also served to reinforce the idea that it is unwise to attempt to 'plug in' western ideas into an African setting and expect to have a predicted outcome such as what might take place in America. HBC is a growing, thriving business in the USA. It is serving the needs of many people there that are suffering with illnesses causing them to be homebound. Trying to import that same HBC program, that has proved itself successful in the USA into an African setting, without taking into account such factors as: poverty (mentioned above); transportation and communication difficulties; the deep seated stigma associated with HIV/AIDS; lack of resources; etc, is a prescription for frustration and failure. HBC can work in

[58]South African President Thabo Mbeki opened Africa's first international AIDS conference (July 2000) by telling thousands of health experts that poverty was the continents biggest killer.

Africa, but it must be designed with perceptive perspicacity to be sensitive to the complexities of the African situation.

This dissertation has chronicled the attempts by this researcher to explore ways to bring a good program into the African setting, making the adjustments necessary to ensure its survival and productivity. Lessons have been learned along the way which demanded a change in course and the development of new ways of approaching the difficult issues surrounding those suffering from AIDS. An example of this is the problem of stigmatisation. Although this problem was anticipated, and measures were taken to avoid the impenetrability associated with it, it was none-the-less a substantial factor in the strangulation of one of the pilot programs under study. From this, and other lessons, new praxis theories were developed to respond to the issues in more effective and meaningful ways so that forward movement and growth could be maintained.

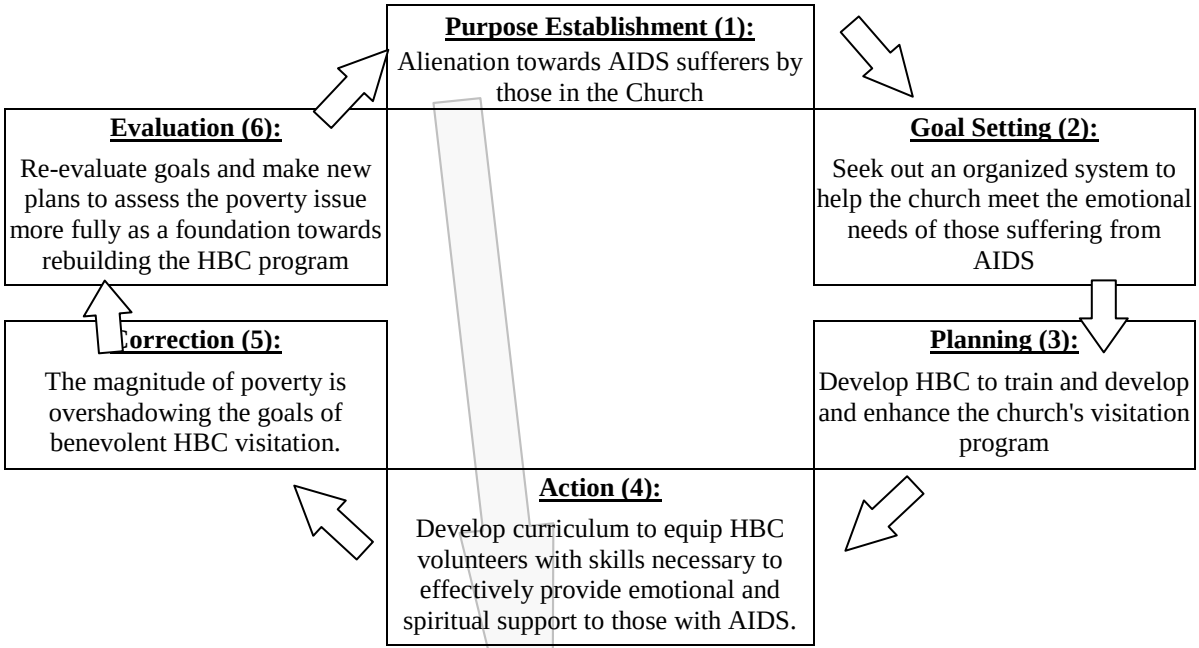
In the end, as with many 'good' ideas, not every program will work in every situation. Through numerous up-hill attempts to reach the goals set out in the initial steps of the program, there were eventually enough pitfalls in the course to cause the apparent failure of one of the study groups. From the beginning, it was considered essential to allow the groups to evolve on their own course in order to allow them to take the ownership necessary to develop a thriving program. Hindsight, which is always 20/20, has allowed this researcher to understand that new programs such as HBC, which have no precedent in this culture, require more direct intervention and direction to keep the participants mindful and directed toward the goals than was given. The risk of the perception of it being an 'ABC program' would still have been present, if not intensified, but the fact remaining, that this fear eventually became the reality, even with the precautions taken. Therefore, it would be recommended for the next time this process is begun, that more continuous oversight be maintained, to keep the program goals and vision always in the forefront. Strongly keeping the mission of the project always as the target may have helped to overcome some of the deviations from the path which took place eventually leading to the development and following, of some unworthy and self-serving goals.

The final, unexpected result of the Chimbalame group's reaction to the official disbandment of the organization indicated that although the above recommendation is

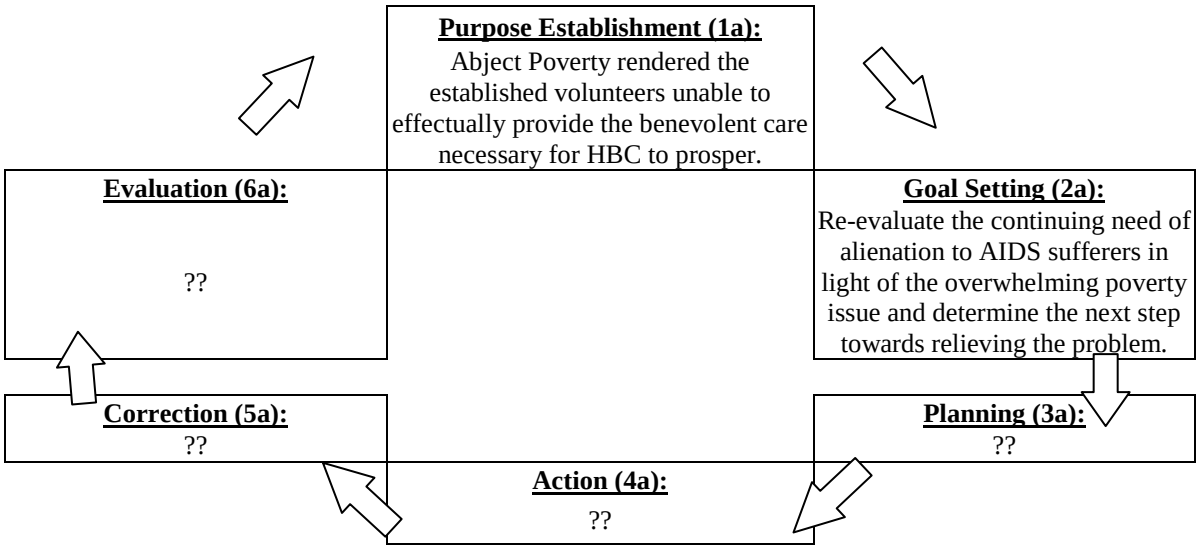
still pertinent, in order to sever the donor dependence, there must be a time when it is made clear to all, that the community will take full and complete responsibility for the continuance of the work. From general observations of how a gradual hand-over of authority and responsibility has worked in the other situations (in many different areas, such as the gradual independence of various types of church ministries), leading to a continued dissatisfaction and frustration on both parties; this researcher believes that it would be a valuable study to explore the implications of such abrupt and total separations. As in the case of this research, while proving initially painful on both sides, it ultimately did prove to be the necessary catalyst for the development of what is hoped would be genuine growth and autonomy.

Looking forward to reproducing this type of a work in a new situation, one can be optimistic in achieving a more hopeful outcome based upon the lessons learned from this study. Ideas that were outlined previously (7.6 and 7.7) can be used to implement ways of achieving better and more predictable results in the future.

The praxis spiral must not end in a circle, but continue in the upward spiral towards solutions for these most difficult problems. The initial praxis model (5.8) for this project concerned the following aspects:



Upon evaluation, it was determined that the original problem leading to the Purpose Establishment was premature. It became apparent that an adjustment of the initial plans was in order, leading to the second round of the praxis spiral:



It is essential that the praxis process not be considered a circle, in which connecting the ends of the loop signals the completion of the project. Instead, the praxis process must be considered as a continuing spiral with the evaluation phase being recognized as the starting point for the next circle of the spiral. The large grey arrow in the figure above is to depict the connection between these two levels of the spiral as new problems are identified and addressed, based upon the initial research and understandings reached during the process of the first circle of the spiral. Steps 1-6 as indicated in the first spiral produce the information and research necessary to proceed to the adjusted second circle of 1a-6a. These steps in turn, upon evaluation and reflection will be interpreted to determine the adjustments necessary to begin the next phase of the process (not shown in the diagram) 1b-6b, and so on. In juxtaposition of the findings demonstrated by this research, with the praxis process outlined above, the essential nature of the continuation of this study can be seen as a step in the path towards finding realistic, workable resolutions to some of these crucial issues involved in the multifaceted problems associate with AIDS. Areas requiring further research include not only the obvious areas of IGAs to produce ways to relieve the actual poverty, but also those areas affected by poverty in more indirect ways, such as determining the emotional and spiritual needs associated with abject poverty and the associated sense of hopelessness, dependence and loss. In addition to this, would be the theological dimensions revolving around these issues and the relationship between the hope and faith of those who may feel abandoned by God.

These are only but a few of the many issues that require further exploration and discovery.

In conclusion, it must be stressed that although the original optimistic goals proposed by the research hypotheses were not fully reached, other important issues, such as exposing erroneous paradigms (particularly those held by the more affluent, western mindset) have been brought to light. The importance of dealing holistically and concretely with existential issues in combination with relating biblical love and compassion revealed remains an area for further study and research.

The continuing fact remains that attitudes need to change in order to slay this monster of HIV/AIDS. The church with her bounty of human resources, if equipped with not only knowledge and understanding of the problem but also and most importantly; when the church uses the power of God's love as a demonstration of Christ, an impact can be made that will shake the world. A mountain isn't moved in a day but if, as in the following Chinese folktale (Frankel 2002:23), the shovel is filled with dirt day by day by day, it will one day be moved.

> Once, there was an old man, who, everyday, would walk to the mountain with his shovel. 'What are you doing, old man?' people would ask. 'Are you trying to move that mountain?' He would not respond, but only keep digging at the base of the mountain. And every day he would return to the mountain with his shovel, digging away, stubbornly determined to move the mountain. And every day, people would tease him and taunt him: 'You foolish old man, do you really think you can move that mountain?'
>
> After digging with his shovel day after day, month after month and year after year, a young girl approached him, and said, 'Old man, do you really think you can move that mountain?' And he looked at her and said, 'Little girl, I don't think I can move this mountain. Not by myself. But if my sons and grandsons return to this mountain with their shovels, generation after generation, yes, little girl, we can move this mountain.

In the same way, AIDS will not disappear tomorrow, but if one person's attitude is changed and they reach out to someone infected or affected with HIV/AIDS with the love of Jesus Christ, then two people's lives have been changed. If those two, change two more…. The cycle doesn't have to spin viciously downward, but it can instead be an uplifting cycle of hope as people share Christ's love and compassion with their brothers and sisters who are suffering from this plight.

It is hoped that the lessons learned during this study will be instrumental in assisting the next attempt to be even more fruitful and productive. The motto of

Partners in Hope, ‘we love, because He first loved us’ (1 John 4:19), continues to be as valid today as it was two thousand years ago. Therefore, we must continue to move forward in our efforts to demonstrate His love and move this mountain of HIV/AIDS.

Appendix

Appendix A - Churches participating in the Nkhotakota Program

Churches Participating in the Nkhotakota Program (World Relief)

The core group of churches which remained interested in reaching out into the HIV/AIDS communities once it was determined that they would not receive free handouts and support were as follows:

Anglican Churches:

- Chididi Holy Trinity Church
- St. Cyprian Church (Kasamba Parish)
- Chombo Parish
- All Saints Cathedral
- St. Joseph's Church (Katimbira Parish)

Pentecostal Churches:

- Living Waters (Msenjere)
- Good News Revival Church (Chididi)

Baptist Church:

- Chididi Baptist Church

Appendix B - Curriculum Vitae for Mrs. G. Banda

GRACE REJOICE BANDA (MRS)

1. Personal Information

Surname	:	Banda
First name	:	Grace
Other names	:	Rejoice
Maiden name	:	Mwenifumbo
Nationality	:	Malawian
Date of Birth	:	13 September, 1950
Marital status	:	Married with six children
Religion	:	Christian
Languages	:	English, Chewa, Yao, Tumbuka, Kyangonde
Hobbies	:	Netball, baking, reading and travelling

2. Contact Address

P. O. Box 30805
Lilongwe 3.
Tel:(285)770363

3. Educational background

1986-1988	Bachelor of Education
Institution	University of Malawi, Chancellor College
1968-1971	Diploma in Education
Institution	Soche Hill College, University of Malawi
1964-1968	AO@ Level GCE
Institution	Mzuzu Government Secondary School

4. Current Position

2001-Present	Partners in Hope Home Based Care Supervisor ABC Community Clinic HIV/AIDS Counsellors

5. Teaching and Administrative Experience

1998-2000	Headmistress	Mkwichi Secondary School
1996-1998	Deputy Headmistress	Lilongwe Girls Secondary School

Head of Science Department	
1988-1996 Teacher of Biology, And Agriculture	Lilongwe Girls Secondary School
1975-1988 Teacher of Biology, Geography and Agriculture	Blantyre Secondary School
1974-1975 Teacher of Biology and Geography	Masongola Secondary School
1972-1974 Teacher of Biology and Geography	Umbwi Secondary School
1971-1972 Teacher of Biology and Geography	Ntcheu Secondary School

6. Career Development and Professional Training

6.1 Training

February 2003	CABSA Training Programme for HIV/AIDS Facilitators 'Churches, Channels of Hope'
April 1987	MSCE Examiner Training
September 1986	Workshop by MCDE on the preparation of Course Materials in Biology and Geography
August 1984	Workshop on the teaching of Biology and Geography at MSCE level

6.2 Development

1993-2000	Committee member for STAM (Coordinator for Central Region)
1977-2000	MSCE Biology Chief Examiner

1993-1998	Head of Science Department, Lilongwe Girls Secondary School
1990-1998	Disciplinary Committee, Lilongwe Girls Secondary School
1990-1998	Senior Mistress, Lilongwe Girls Secondary School
1990-1998	Patron of the UNESCO Club
1990-1998	Career advisor, Lilongwe Girls Secondary School
September 1996	Appointed by MANEB as Assistant Chief Examiner in Paper II Biology
August 1996	Appointed to be member of MIE Secondary School Curriculum Review (Biology) Committee
Apr-July 1994	Acted as Deputy Headmistress, Lilongwe Girls Secondary School
1991-1993	Acting Head of Science Department (Internal Arrangement)
1990-1992	Chairperson, Parents-Teachers Association, Lilongwe Girls Secondary School
1972-1988	Umpire, Girls Netball at Umbwi, Ntcheu and Blantyre Secondary Schools, respectively.

7. Professional Development

16-21 April, 2000	Participated in the training of teachers in the Awhy Wait?@/Family enrichment Curriculum@ - a curriculum Teaching life skills for young people to prevent the spread of HIV/aids, Scott Theological College, Kenya.
15-19 March, 1999	Attended a workshop on Gender Equity by CODE and C.I.D.A., Lilongwe, Malawi

12-15 April, 1994	Participated in the character development and Why Wait?/Family Enrichment Workshop, Lilongwe, Malawi

8. Special Education Interests

X Special Education for people with disabilities

X Student/Teacher relationships

X Student Counselling

9. Memberships held

9.1. Professional Membership

1997 to date	Member of CODE (Canadian Organisation for Development in Education) Local Advisory Committee
June 1996 to date	Senior Examiner Biology MSCE
June 1996-July 1998	Board member of the National Library Service
July 1998 to date	Member of MSCE and JCE Biology Syllabus Committee

9.2 Membership in Christian Organisations

X Treasurer in the Lingadzi C.C.A.P. Women=s Build, Lilongwe

X Member of PACWA, Lilongwe Branch

X Member of Women Aglow, Lilongwe chapter

10. Referees

Dr. Kuthemba Mwale
Ministry of Education
Private Bag 328
LILONGWE 3.

Dr. Lucy Binauli
Home Economics Department
Chancellor College
P. O. Box 250

ZOMBA.

Professor Dick Day
Why Wait? / Family Enrichment Programme
P. O. Box 250
ZOMBA

Appendix C - Initial Training processes for facilitators.

The actual facilitators will be selected from two different categories. Although similar in many ways, there will be substantial differences in the training they will receive.

The first group of facilitators will be African Bible College students. As part of their regular curriculum of study, they are receiving instruction in Biblical studies and general knowledge. In preparation for the Home Based Care visits, they will also receive supplemental instruction in the following areas: basic counselling skills (which will include listening techniques and development of interpersonal relationships), psychology of death and dying (including classic instruction in this area by Kubler-Ross's 'Five stages of Grief') (Kubler-Ross 1997), grief management, and empathetic understanding. In addition to these relational skills, they will also receive instruction in basic assessment skills, HIV/AIDS pathophysiology, causes and treatment modalities, along with aseptic technique, hygienic principles and sanitation procedures.

Instruction in these areas will be with a multifaceted approach. In addition to visiting the Nkhotakota field and interacting with and participating in the programs there, their instruction will also include classic classroom instruction, informal and structured group discussions, empirical reading and research and private consultation and individual and small group counselling.

The second group of facilitators will be from the churches participating in the development of their own home care programs. These individuals will be from varied educational, age and economic backgrounds, but will share in their common interest in reaching out to the sick and dying in their communities. Criteria into the initial training group will be quite wide, with the only prerequisite being their love for Christ and a 'heart' for this particular type of outreach. As they progress through the training process, a natural selection will take place as they either grasp the information provided, or fall away as they realize that it is not suited to their interests.

Training for these church volunteers will be undertaken with a multi-level approach. The initial entrance phase of training will consist of basic skills development, designed to equip them to visit those who are sick without spreading germs or disease, provide comfort and gentle kindness through the sharing of their selves and their faith. Although the details of this training are currently in the formation level of development as this text is written, it is anticipated that this level, or 'Phase I' training, will consist of approximately four, weekly sessions. These sessions will train and equip the volunteers in the following areas[59]:

- Basic hygiene, aseptic technique and prevention of cross-contamination

[59] See HBC Training Manuel in Appendix D for full training curriculum.

- Listening and observation skills, with a focus on confidentiality and ethical concerns
- Spiritual guidance and sharing their faith and hope
- Basic comfort measures, needs assessment

Upon completion of this initial phase, the volunteers will be ready to enter the field, and visit the patients in a safe and meaningful way. Once the initial training has been completed, and the volunteers are in the field, additional training will be given on an 'as requested' basis. Although it is anticipated that the following areas will be requested, these will not be imposed on the HBC visitors in order that they will grow in their sense of 'ownership' of the program. Because of the longitudinal nature of this research, and with the realization that the ABC facilitators will be somewhat 'intermittent' due to the nature of their studies, school breaks, holidays and eventual completion and graduation, it is essential that the local church not see this as a 'program' they are participating in, but rather, they must have possession of it for themselves and see it as *their own* program. Therefore it is believed that if they are able to make the choices and 'steer' the program as it develops in their own congregation, they will then consider it to be their own effort and with that, develop a stronger commitment to ensure the success and growth of the program.

Additional areas of training that will be available to participants would include, but not be limited to the following:

- In depth training regarding the anatomy and pathophysiology of HIV/AIDS
- Signs and symptoms of other related disease physiologies
- Medical interventions, which might include: physical assessment; nursing care (beyond the basic comfort measures learned in Phase I); medical interventions, which might include such things as medication administration and basic treatments (would only be done under qualified medical supervision)
- Community resource awareness
- Spiritual counselling and increased training in counselling and grief assessment and care
- Biblical instruction
- Interpersonal relationship building
- Selection and training of more volunteers
- Medical record keeping and reporting

In order to maintain quality control, the curriculum development and training will be provided mainly by this writer, who is a Registered Nurse, with a specialty in cancer nursing and support group facilitation; Hilary Edwards, (B.N., R.G.N., Diploma in Counselling, E.N.B. 931 Care of the Dying), currently working with the VSO as a palliative care specialist and Hospice Nurse; and Mrs. Grace Banda, who has a background in education, and is the national director of the 'Why Wait?' program for HIV/AIDS prevention in Malawi and is currently serving as a program manager and counsellor with the African Bible College Community Clinic 'Partners in Hope' HIV/AIDS awareness and care program. In addition to the skills she will bring to this committee, as a native Malawian, Mrs. Banda will be a valuable resource in making

certain that the curriculum is culturally sensitive, as well as translating it into Chichewa, as it is anticipated that the actual instruction of the church volunteers will be done in Chichewa to promote increased understanding and comprehension.

Appendix D - Home Based Care Volunteer Training Manual

(teaching notes)

I. Session One - Basic Volunteer Training

I. Introduction to Volunteering

Volunteer work is unique and special. It will be appreciated (usually) by the sick person because it is not carried out for financial reward but for love of fellow man, community spirit, increase feelings of self worth, esteem or to carry out God's wishes for us.

- Volunteers need to consider why they have chosen to help others in this very valuable way. What is their personal motivation? (Discussion groups!)
- Perhaps a need to feel needed
- Spiritual wish to help others – practice Christianity
- Help find future employment – take up nursing
- Gain references from church members
- Increase status – life satisfaction

What motivates these volunteers to do such difficult work in the community with HIV/AIDS HBC?

Remember volunteers have needs too. They will require training, ongoing support / interest, debriefing for difficult cases, encouragement and praise. They may need recognition of doing such sensitive work, such as incentives, maybe a certificate for attending training or follow-up meetings. Name badges or printed 'T' shirts or special *chitenge* or carrying bag / umbrella.

What qualities does the HBC volunteer require to carry out visits to the sick?

- **Respect for other's views**, beliefs, lifestyle, religion, attitudes, culture status, class, etc.
- **Acceptance of the sick person's rights**, whether they wish to talk to you or not of if they want help or advice or not.
- **Be sensitive** to their wishes.
- **Issues of confidentiality**. The volunteer must always keep the patient's name, address, family and medical details to themselves unless they obtain permission from the patient to share it in confidence with the trainer or supervisor or church elder or priest. Confidentiality is paramount, so the patient can build a trusting, valuable relationship with the volunteer visitor. Reassurance that no gossiping will take place of anything the volunteer sees or hears.
- **Patience**. It takes time to build up a rapport with someone new. You may need to get to know the guardians too. Try to spend quality time with the sick

person and their family on a regular basis. At least 20-30 minutes each visit (if they are able to tolerate that length of time) Ideally 50-60 minutes is the optimal time for weekly visits to be of any real benefit.

- **Express warmth**; be sincere, genuine and as honest as possible. If you are anxious or nervous on the first visit – say so. Introduce yourself. Shake hands and sit near the person, get comfortable, look at them. Eye contact shows interest, if this is culturally acceptable. (Accept a drink if offered.) Show you are interested by listening carefully to what they have to say.
- **Encourage** them to talk about themselves and their family, their interests, hobbies, what job they did or their health. Ask how their illness has affected their life. It is not appropriate to talk about yourself (just a few details).
- **Do not judge** them or blame them for their illness.
- **Try to put yourself in the sick person's shoes**. How might you feel if you had HIV/AIDS? You may want to discuss this in the training session.
- **Encourage expression** of feeling. This can really be therapeutic for the sick person. Don't be embarrassed if the person cries, gets angry or distressed. If the person is depressed, try to hang on in there, whatever feelings are shown. You may be the first genuine, caring visitor who really tries to understand who the sick person feels about their illness. Try not to offer inappropriate reassurance or hope for full recovery. Miracles are rare and they probably won't get better.
- **Be reliable and consistent**. If you promise to visit be on time.
- **You can offer hope** in the form of regular continuing visits giving emotional, spiritual, physical and social support to the patient and family.

II. Use of Counselling Skills by Volunteers. (God gave us two ears and one mouth)

- Listening Skills
  You are visiting to provide support. Try to hear the patient's story and identify main areas of concern or worry. (You may not be able to solve or fix their problems for them)
- Really listen to what they are saying to you. What worries, concerns or fears do they have?
- Help them to express these fears. To have someone willing to listen and try to understand and accept the situations and emotions expressed and bring great relief and healing.
- Providing support reduces their isolation. They may feel able to share previously secret information with you or tell you something that has embarrassed them if you allow them space to talk.
- Sometimes you can offer advice if specifically asked for your opinion in certain situations. Generally its not good to give advice to someone else because we don't know what's right for them only what's right for ourselves. Do not tell the patient what to do. Only they can make the right decision.
- Encourage as healthy a lifestyle for the patient as possible. To wash regularly; care for their appearance; rest frequently; sleep well; eat small nutritional meals if possible; take frequent sips of drink; can they walk short distances? Write letters for them; read to them;

- What resources to the sick person and his family have? Can you see real financial hardship? Is there evidence of food in the house? Who is the guardian? Are there dependent children in the household?

III. First Part of the Relationship.

- Introduce yourself. Shake hands. Ask what name you should call them by.
- Remember you are trying to get to know them so concentrate on them. Listen well. Sit within a comfortable distance. Try to look relaxed. Smile. Put them at ease.
- Look directly at the person (unless culturally unacceptable). Murmuring encouragement: 'I see', 'Yes, go on'. Don't be put off by silences, they may be waiting to see if you jump in with things you want to talk about. Let them choose what topics to talk about.
- Some non-verbal signs are not helpful such as: looking at watch; looking away; yawing. Don't speak too fast or abruptly; try to make your voice sound kind and encouraging.
- Let the person know you are really listening by reflecting back to them, 'You are saying you're worried about the children'.
- Ask open question to help the person to talk. 'What did you think?' 'What happened next'? Some questions bring out emotions; 'how did you feel when they told you about your condition?'
- Open questions are ones which cannot be answered with a 'yes' or 'no' so the person has to say more and this encourages them to talk further.
- Don't be afraid of humour. It can reduce tension.
- Too much sympathy is not helpful. On the other hand empathy is a real understanding of how the other person is feeling.
- Don't underestimate the value of encouraging a sick person to express or ventilate their feelings.
- A relationship needs to be built over time so trust can develop and hidden issues may be revealed. Encourage positive attitudes, changes in behaviour if appropriate and mobilizing any available resource or other agency that may help with a specific problem.
- The relationship can last for years or only be for a short time. When it is to end, try to prepare the patient. Don't just stop visiting without an explanation. If the patient dies try to attend the funeral and find someone who you can talk to about it.
- Don't advise or tell the person what to do. Let them make their own decisions.
- Don't allocate blame or judge them, just accept them the way they are.
- Don't be too direct or ask 'Why' questions, ('Why did you do that?') can sound too threatening and judgmental (and disapproving).
- Don't preach just because you think they are a captive audience. You could offer to pray or offer spiritual support but only where it is welcomed by the patient and you are comfortable doing so.
- People can be influence by your role model of kind consideration and caring and then ask you why you are a church volunteer. Sometimes they may wish to talk to a pastor or some else who can offer spiritual support.

- Leave the patient with a positive attitude. Tell them you will visit again if they wish. Knowing you are interested in their welfare gives them incentive to go on living life to the full or end. You may help them resolve some of their problems. The reliable volunteer will make an important difference in the life of the sick person.

IV. Holistic Care

It is important to care for the whole person. Holistic Care is an approach which treats the whole person, not just physical symptoms.

1. Socially – consider their family and community or village life. What was their job?
2. Emotionally – are they angry, depressed, distressed, suicidal?
3. Physically – are they in pain; have an AIDS related illness; cancer; deformity; stroke problems; eating disorder (weight loss). How do they look?
4. Psychologically – what is their personality like? Are they shy? Outgoing?
5. Spiritually –are they Christians? Do they believe in life after death? What do they think of God? To they want to talk to a pastor?

All these parts make up the whole person. The attitude that you care about all these aspects of the sick person can be conveyed in a very short time.

There may be barriers between the patient and the HBC volunteer. For example, some man may have difficulty forming a trusting, confidential relationship with a woman. Some female patients may find it difficult to talk about body functions or certain illnesses with a male visitor. Some topics in Malawian culture may be taboo, not spoken, except in certain special private situations. Many Malawians find it not socially acceptable to talk about sex, death, or their HIV status.

As these are really important issues that worry and frighten sick people and their families it is vital that you listen with sensitivity and courage. Don't be afraid to tell the person that you can keep some things private and confidential.

Patients may have very few choices about events in their life, e.g. their illness, family problems, living conditions, etc. Help find small choices they can have control over. 'Where would you like me to sit?' 'Would you like me to help you wash; eat; make a drink' 'Would you like me to read to you, or just sit beside you?'

The patient may wish to change aspects of their ways of thinking or their behaviour. Help the sick person discover realistic alternatives.

II. Session Two – Infection Control

People have been caring for one another and helping the sick since the beginning of time. However, there are times when people have also been hurting each other unintentionally because of ignorance or misinformation. With this class today, we are hoping to provide information and guidance which will enable you to provide compassionate care to those we are seeking to help without causing potential for risk of infection of injury to either the person you are seeking to help, or to yourselves.

Our goal is to reach out and help people in their time of need. In order to do that effectively, it is important that we know some basic facts, which will allow us to 'do no harm'.

(Hippocratic Oath)
Hypocrites (late 5th century B.C.) called the 'Father of Medicine.' By stressing that there was a natural cause for disease he did much to dissociate the care of the sick from the influence of magic and superstition. A moral code for medicine has been established by his ideals of ethical conduct and practice as embodied in the Oath. (Miller 1972:437)

Although Hypocrites did not know God as we do, he none-the-less had some good ideas about medicine that are still in practice today, over 2500 years later. Even today, physicians will recite the oath as part of their training to become a doctor. We can learn from it as well.

'…I will prescribe regime for the good of my patients according to my ability and my judgment and never do harm to anyone. . . . All that may come to my knowledge in the exercise of my profession or outside my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal.'

Let's look at some of the components of this oath that will apply to what we will be doing.

'…I will prescribe regime for the good of my patients . . .

In many ways, you will be overseeing the care of patients and it will be the observations you make and the suggestions that you give which will determine the kind of care which the patient receives.

. . patients according to my ability and my judgment . . .

It is important to remember our abilities and skills, as well as our limitations. While you are receiving training to equip you to give good, compassionate care to those who are sick and in need, it must always be remembered that we are not doctors, and in such, we have no ability or authority to make medical determinations which should be left to medical professionals. No matter how great or small your knowledge and skills are, you can do a good job as long as you know and work within your limits. This

means: Do what you know how to do. Do not try things you have not learned about or have not had enough experience doing, if they might harm or endanger someone.

With this thought in mind, we can move forward to use the knowledge and wisdom we have to make determinations which are in the best interest of our patients.

. . .and never do harm to anyone. . .

By learning general principles of patient care, you will be able to help people without fear of injury to either yourself or the patient.

Germs (and other nasty things), the Building Blocks of Disease

God made man as a most fascinating creation. We are so strong and clever that we can create and appreciate beautiful things like art and music. We can develop our minds by learning an endless supply of new and interesting things. We can strengthen and build up our bodies so we can defeat our enemies. But even with these abilities, we must face the fact that often the enemy we face is unseen, being so tiny that we cannot see it with our naked eyes.

There are many micro organisms that are so tiny that they were unknown until recently. In fact, the HIV/AIDS virus is so small that it cannot even be seen with an ordinary microscope. It is hard to imagine that something so tiny could be so powerful at the same time, yet it is these very tiny germs and viruses that can bring destruction and devastation into our lives.

Unfortunately, the very tools that we bring with us to help people are also the very tools which spread germs and disease.

What do you think is the number one cause of spreading infection? (Lippencott 1986:857)

Picture of hand with germs

Share the story of the doctor that discovered hand washing, and how he was 'blackballed' because his peers refused to consider such an idea.

What are some ways that we can prevent the transmission of germs when we visit people who are sick?

This should generate a discussion that will ultimately end in the idea of the caregiver washing his/her hands upon entering the house and before they exit.

Is it reasonable that we visit people and try not to 'touch' them?

Discuss the importance of human touch.
Many people, especially sick people haven't been touched for a long time.

Share the story of orphan babies who died without touch.

What are some ways that we can help the patients and families who are caring for them to reduce the transmission of germs?

Let the people brainstorm to come up with ideas to prevent the transmission of germs and disease.

HIV/AIDS

Christian Leaders in Africa cannot turn a blind eye to the HIV/AIDS pandemic, it is devastating Malawi along with the rest of Africa.

IN MALAWI

- 57% of girls feel it is easier to risk pregnancy than ask their partner to use a condom
- 70% of female sex workers in Lilongwe tested HIV-positive
- 31% of girls do not know that a person infected with HIV or living with AIDS may look healthy
- 90% of teenage boys feel invulnerable to HIV[12]

- HIV (seroprevalence) among antenatal women in urban areas of Lilongwe, Blantyre and Mzuzu increased from 2 percent to 30 percent since the mid 80s. Peak HIV prevalence of 32% was seen among women aged 25-29 years of age.

- Outside of major urban areas, HIV was 14% of women under 20 years old and 28% of women in the 25-29 year old group.

Based on statistical estimates, every day in Malawi:

- 1,640 children are born
- 209 infants (under one year) die of preventable diseases
- 344 children under five die
- **b**

Sources: THRESHOLD 21 simulations and World Bank STARS data, table found: UNDP's 'UNDAF - Malawi', October 1998

What are you, as Christian Leaders going to do to save your country?

Not getting AIDS yourself is commendable, but it is not enough.

HIV/AIDS background:

- It was not heard of in the 70's.
- It was beginning to be noticed in the 80's but they didn't know just what it was.
- The HIV/AIDS in Africa is a very different disease than in the West

What is HIV/AIDS?
AIDS is the name of a disease (Acquired Immune Deficiency Syndrome), which is characterized by the body loosing its ability to fight infection. AIDS is caused by the *human immunodeficiency virus* (HIV), which is a small virus with little proteins on the outside. The virus takes over the lymphocytes (a type of white blood cell), and destroys them, which decreases the body's ability to produce antibodies against infections. It effectively 'hides' inside a cell, so that it cannot be recognized by the immune response cells.

HIV infects the major subset of 'T' cells, the T4 cells in particular
The RNA attaches on the proteins of the helper T cells, CD4 (normal level is 500-1000) is one type of 'T' cell that helps the body recognize foreign substances, goes inside the cells to destroy and slow down their processes.

- Initially, after exposure to HIV, the CD4 level drops and S/S of 'flu' (swollen lymph nodes, fevers, rash, etc.) develop.
- The immune system quickly responds and the CD4 levels rise and S/S go away.
- The HIV 'hides' so the immune system can't see it and the immune system slowly declines.
- Once the CD4 level drops to 200, opportunistic infections begin.
- At a CD4 level of 50, the body can no longer defend itself.

A 'window period' is when a person can be infected with HIV and not test positive on a screening test. 90% will test positive after one month, 98% after 3 months and 100% after 6 months. (Some people refer to the period of time a person is asymptomatic with AIDS S/S as the window period.)

Technically, it is true that people don't 'die of AIDS', because they die for some other 'opportunistic' disease.

How is it spread?

Means of transmission:
- Transmission to another person must require transmission of body substances containing infected cells.
- Blood or plasma (e.g. transfusions and using contaminated needles for injections)
- Plasma containing fluids (such as saliva)
- Any fluid or exudates that contains lymphocytes:
- Semen

- Tears
- Vaginal secretions
- Transmission is easier if tissues are inflamed or traumatized

Effects of AIDS

- Many people infected by the HIV virus, will have no symptoms for many years (they are called asymptomatic carriers)
- Symptoms of AIDS may appear 6 months to 6 years after infection took place
- Lung— lung infections (such as pneumonia or TB)
- Skin — cancer (Kaposi' s sarcoma), that can also affect the internal organs
- Nervous system — mental disturbances, vision problems, blindness, weakness, paralysis
- Digestive system -~ diarrhoea

Some signs and symptoms of AIDS

- Fatigue lasting for weeks
- Swollen lymph nodes
- Decrease in weight
- Fever and night sweats
- Shortness of breath
- Persistent, dry cough
- Diarrhoea for more than a week
- Pink or purple patches on the skin
- Lethargy and depression

So far, no cure for AIDS has been found

Statistics:

- Worldwide incidence is 37 million (infected)
- Sub Sahara Africa has 27 million infected, only 10% of worlds population has 2/3 of all HIV

Malawi - conservative estimates say 14-16%

- Possible 30-50% in Blantyre and Lilongwe
- 60% of the cases are in Women
- 70 - 80% of those in the hospital

- Currently there are 400,000 orphans in Malawi
- Projected figure of 750,000 by 2010

- The Malawi government is currently budgeting $0.65 per person per year for AIDS treatment.
- The young adults are dying and they are the ones that drive the economy.

Who Gets AIDS?
Three groups of people get AIDS

1. Infected babies MTCT (mother to child transmission)
   The baby has 30% chance of getting AIDS if mother has AIDS
   soon there will be free medicine available in Malawi which can reduce the risk of transmission to around 10%
   - 60% get it during the birth process
   - 10% get before birth through the placenta
   - 30% get it through breast-feeding

2. Those who are sexually active
   - Most people develop S/S 2-10 or 12 years after exposure. Rapidity of symptoms depends upon the individual's immune system.
   - Most are infected by sexual contact. HIV is present in blood, semen, and vaginal secretions.
   - It is more contagious for women then for men because of the delicate vaginal lining.

3. From Blood transfusions
   - Although the percentage from blood transfusions is very small in comparison to the other methods, it should also be considered as a mode of transmission.

Treatment:

Old focus was on developing a cure.

Now focus in on:

1. Prevention and
2. Suppression

Currently there is very little treatment available in Africa for those suffering from HIV/AIDS.

Prevention:

Two groups –

1. Birth and over 15 years old
- MTCT
- medicating the mothers before and during delivery against HIV and no breastfeeding can reduce rates to 10-12%
- cost of medicine is $1000 per month

2. Sexually Active Population (15 and over)

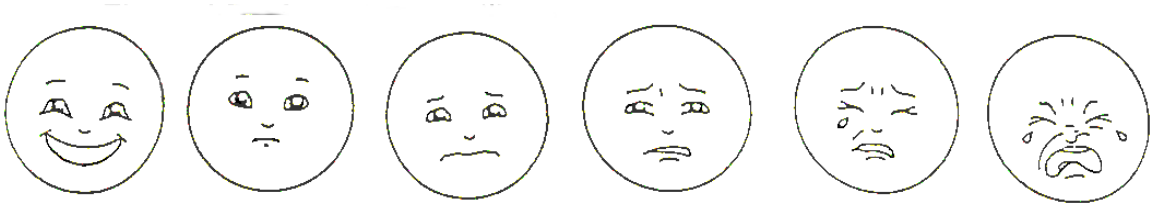
   a. Abstinence
   b. Both partners practicing monogamy after marriage
   c. Education – let's tell the truth

- Condoms have a pregnancy rate of 10-15% and sperms are much larger than HIV
- Comparing the size of a sperm to the HIV virus is like comparing a basketball with a maize seed.
- Another consideration:
  If the pregnancy rate is 10-15% with a condom, you must also factor in the fact that a woman is only fertile one week out of 4! HIV/AIDS can be caught at any time!

  It is not caught by: Casual contact, even close but non-sexual contact

III. Session Three – Basic Comfort Measures

Sometimes it is difficult to communicate with others how we feel. Words don't always express physical or emotional status accurately. Sometimes it is easier to identify with one of these faces, than to try and put feelings and sensations into words.



Sometimes it is the simple things that can make all the difference in how someone feels:

- Smile – look pleased to see them
- Say that you will return if they wish for you to.
- Take an interest in things that are meaningful to the patient (pictures on the wall, their family, etc.)
- Encourage them to talk about their life.
- If patient is in pain or discomfort, try diversional methods to distract them if possible. Can they still write, paint, read, draw, knit, sew, carve.. etc.
- Encourage patients to continue to participate in family life. (preparing vegetables, helping children with schoolwork or just listening to what your children are saying)
- Read the Bible or books to them, sing with them.
- Offer to wash their hands, face, etc. to help refresh them.
- If they have a fever or are hot, put a cool, wet cloth on their head/forehead/neck, etc.
- Bathe sticky eyes if troublesome.
- Encourage patient to wear loose clothing.
- Some people have a special cloth or blanket that brings them comfort.
- If appropriate culturally, offer to cut nails, apply skin cream, etc. This can be very relaxing. Same with feet, if the volunteer feels able to wash someone's feet, stroke neck, hands, massage feet, etc.
- Encourage the family to provide a comfortable seat/bed for the patient near a window for light and fresh air.

Fatigue

Energy conserving measures can make a considerable difference:

- Try to feel relaxed and unhurried and the patient will too.
- Suggest frequent rests, sleep, and sit with feet elevated.
- Encourage patients to pace themselves not to overdo things. This will help them to reserve their energy for the things they enjoy doing.
- Help by supporting weak patients to just walk around room/garden/village.

Sore Mouth

Anything that makes eating or swallowing difficult is worth treating as much for the sake of relatives, who feel that feeding the patient is a way of showing they care.

Management:

Generally keep mouth fresh by rinsing with a saline solution made up of a pinch of rock salt in a mug of water. (Solution should only be mildly salty – like tears)
Foods are usually preferred either icy cold or very hot. Semi solids are preferred to either fluids or solids.

Thrush: small white patches on the inside of the mouth and tongue that look like milk curds stuck to raw meant. They are caused by a fungus or yeast infection called moniliasis. Thrush is common in newborn babies, in persons with AIDS, and in persons using certain antibiotics.

Paint inside of mouth with gentian violet (Vanderkoo 1994:C-20)
(often comes as dark blue crystals. Dissolve a teaspoon of gentian violet in half a litre of water. This makes a 2% solution. Paint it on the skin or in the mouth.)

Chewing garlic or eating yoghurt may also help.

In severe cases, use nystatin.
Put 1 ml. of solution in the mouth and hold it there for at least 1 minute before swallowing. Do this 4 or 5 times daily.

Ulcers (canker sores): small, white, painful spots inside the lip or mouth. May appear after fever or stress (worry). In 1-3 weeks they go away.
Gargle with saline solution mentioned above. Antibiotics do not help.

Cold Sores and Fever Blisters: Small painful blisters on lips that break and form scabs. May appear after fever or stress. Caused by a herpes virus. They heal after 1-2 weeks.
Holding ice on the sores for 1 hour the day they begin may cure them. There are no medications that do much good.

Will need medical intervention if severe.

Halitosis

56%-85% of cases are due to disease of the oral cavity.

Causes:

- Sepsis
- Toxic Condition

- Smoking and dehydration
- Poor oral hygiene

Treatment:
- General:
  - Oral hygiene
  - Fluid intake
  - Treatment of candida (thrush)
- Gargle or mouthwash (artificial Saliva – made of salt and water) may help with a dry mouth.
- Vaseline can prevent dry lips.
- Mouth care every 2 hours.
- Sucking of favourite 'sharp' food or sweet (pineapple, passion fruit, orange or lemon)

Diarrhoea/ Constipation:

Incidence:
Around 50% of terminally ill patients suffer with constipation.

Causes:
- Medication
- Disease
- Diet
- Decreased activity
- Stress

Assessment:
- Attempt to establish cause
- Establish previous and present bowel pattern (aim for usual pattern)
- Assess skin condition

Management:
- Advise increased fluid intake

(Oral rehydration solution for those suffering with diarrhoea)
Oral Rehydration Solution can be homemade using 1 litre of clean water mixed with 9 level teaspoons of sugar and 2 level teaspoons of salt. At least a cupful (preferably more) should be taken after each episode of diarrhoea. This solution should be discarded after 24 hours if not used.

- Skin care and personal hygiene to prevent irritations to skin.
- Advise on increase in fibre in diet, and increase in fluid intake
- Privacy and adequate toilet facilities.

Nausea and Vomiting and Failure to Eat

Causes	***Possible Treatment***
Fear of vomiting	Psychological Support
Unappetizing or too much food	Allow to choose
Feels full	Frequent small meals
Dehydration	Rehydrate earlier, if appropriate
Mouth discomfort	Keep moist, chew saliva stimulant
Pain	Treat
Anxiety/Depression	Counselling
Constipation	Treat according to condition
Trouble swallowing	Soft or pounded foods

Support Relatives: Explain that the terminally ill patient may not feel able to eat or be unable to eat. Relatives sometimes need to see the patients eat and may well need support when the patient is unable to eat. Patients generally eat better when dressed and sitting at a table, if they are able to do this.

Incidence: 40%-70% of patients with advanced cancer suffer with this.

Causes:

- Oral thrush
- Uninteresting, unimaginative food
- Too large helpings, or food offered only at standard meal times
- Odours in environment
- Disease process, medications

Management:

- Encourage small sips of water or juice.
- Offer mild foods like bread, rice, crackers, bananas
- Try to remove the offending cause
- Remember that patients can eat more sitting up with the family or sitting beside the bed
- Avoid strong odours that may cause nausea.
- Do not pressure the patient to eat. Tempt the patient with minute helpings of favourite foods on the smallest plate available.
- Offer attractively served food at frequent intervals unrelated to standard meal times.
- Be reluctant to offer 'invalid' food no matter how nutritious, but be ever ready to permit and encourage any bizarre fancy the patient may have, even if it is not considered suitable for an invalid, (cassava crisps, matoke at breakfast, coke).
- Treat cause if possible (constipation, etc.)
- Psychological Support (especially if anxiety related or anticipatory. Relaxation techniques can be beneficial)
- Dietary modification (increase fluid intake if appropriate and if possible, advise small regular meals, low odour food)

- May need medical intervention
- If they are experiencing problems taking tablets, they can be crushed into powder by grinding them between two spoons. Give plenty of water. If there are many tablets to take, try spreading out the times of taking them (give one each hour instead of six at once)
- Even if patient vomits, the taste of food can give a feeling of well-being. A tiny amount of a food he fancies might be good, even if it is spit out and now swallowed.
- If patient is too ill to drink, moisten lips with water or Vaseline.
- Patients can gargle with salt water (saline solution) or bicarbonate of soda, if having a sore throat.

If severe, give Promethazine 25 mg every 6 hours

Refer to HCP if

- *Vomiting is severe*
- *Patient is unable to take medicines because of vomiting*
- *Fever or abdominal pain*

Wakeful Nights:

- Increase daytime activity
- Reduce light and noise (although patient may like a small night light)
- Comfortable bed
- Hot drink (lemon grass tea – avoid tea or coffee with caffeine)
- Soothing music according to patient's choice
- Discuss fears and anxieties
- Presence of familiar / trusted person at night-time

Confusion (in previously unconfused)

Causes:

- Unfamiliar stimuli (temperature, wet bed, crumbs, full bladder or constipation, pain, itch)
- Change of environment
- Severe anxiety
- Depression
- Alcohol
- Disease process or medications (medical intervention necessary)

Management:

- Relatives –stress that the patient is not going mad – explain the reason, especially that it is not hereditary.
- Treat the patient as a sane, sensible adult
- Do not use restraints and avoid cot sides
- Allow to walk about accompanied by a trusted friend
- Dispel patient fears – night-light

- Explain all procedures and events
- Do not change bed position, particularly in hospital
- Family member or close friend near by at night
- Do not change environment

Depression
This is often under diagnosed in the terminal patient, one third may need treatment. If it is not treated it can lead to suicide.

Most depression is reactive:
- To dying (leaving everyone and everything)
- To unrelieved pain
- To unrelieved symptoms

Reactive depression is normal in terminal illness and needs support and counselling only.

Pathological Depression Symptoms: <u>May need medical intervention</u>
- Withdrawal
- Agitation

Symptoms:
- Disturbed sleep pattern (especially early morning wakening)
- Impaired concentration
- Feel guilty and burden to others
- Altered eating patterns
- Lack of pleasure in the things a patient usually enjoys
- Occasionally persistent thoughts of suicide (different than normal thoughts of dying in the dying patient

Treatment:
- Speak softly with world of encouragement. (do not offer unrealistic hope)
- Read to the patient, especially Scriptures
- Ask the patient if they would like to speak to a minister, or if they would like to talk about spiritual matters.
- If appropriate, ask them if you can write a letter for them or prepare letters to leave behind if they are aware that they are dying.

  If severe, refer to HCP

Breathing Difficulties

Cough:

Assess cough: Is it productive? Dry?

If patient has a cough, ensure they know to put hand in front of mouth and if expectorating sputum, make certain that there is a pot close by to spit in.
Cough Management:
Productive:

- Encourage patient to drink fluids
- Encourage deep breathing
- Gentle postural drainage
- Steam inhalations if thick sputum
- *Green or bloody sputum requires medical intervention*
-

Short of breath:

- If patient has breathing difficulties, encourage the use of a fan, if no fan, ensure there is a through draft or current of air moving between window and a door.
- Show patient how to breathe easier by leaning forward on elbows resting on a high table or chair in front of them (to expand the ribcage).
- They will probably be more comfortable propped up on pillows or cushions or in a semi-sitting position, rather than lying down.

Refer to HCP if patient has any of the following:

- Cough lasting over 3 weeks
- Fever
- Shortness of breath or rapid breathing

- Have patient cough sputum into a plastic bag or container with a lid.
- Cover mouth when coughing
- If patient has TB, encourage them to take their medicines as directed

Skin problems

Itching

Management:

- Emulsifying ointments
- Sodium bicarbonate washes as often as desired by the patient (one tablespoon of powder in the smallest volume of water sufficient to dissolve it). Patients often report this as more effective than any other measure.
- Cold fan playing on the exposed skin
- Sitz bathe with salt (saline) water solution to bathe irritated areas. (Saline solution = one teaspoon salt to one litre of clean water)
- Calamine lotion
- Antihistamines (chloropheneramine)

For painful rashes (shingles)

- Paracetamol 500mg 1-2 every 4 hours

Or

- Ibuprofen 200mg 2 every 6 hours (Do NOT give to patients with stomach pain or ulcers)

Tip for Acute Herpes Zoster:

- Liquid from frangi pani tree, when applied to the vesicles cause paralysis of nerves for up to 8 hours. Break off a small branch and collect the white fluid into a clean jar. Paint this onto the area.
- Fluid can be kept for up to 24 hours. Then renew from the tree.

Refer to HCP if patient has:

- Severe rash
- Fever
- If patient has painful rash on face and has redness or pain on the eye or blurred vision.

Excessive Sweating

This distresses patients because of the inevitable discomfort and embarrassment.

Management:
Try to treat the cause
Most patients are assisted more by frequent sponging and appropriate advice about clothing and bedding than by medical measures (loose cotton clothes, etc.).

Pain or Headache

If the patient complains of pain, ask:

- Where does it hurt (Ask them to point to the exact place with one finger)
- Does it hurt all the time, or off and on?
- What is the pain like? (sharp? Dull? Burning?)
- Can you sleep with the pain?

Management:

- Paracetamol: Often comes in 500 mg. tablets. Give 1-2 tablets every 4 hours Paracetamol is safer for children than aspirin. It does not cause stomach irritation and so can be used instead of aspirin by persons with stomach ulcers. It can also be used by pregnant women.
- Gentle massaging of the limb may be helpful.
-

Refer to HCP if:

- Headache is severe
- Patient has severe headache with a high fever and stiff neck

Wounds or Bed Sores
Chronic open sores appear in persons who are so ill they cannot roll over in bed, especially in sick old persons who are very thin and weak. The sores from over bony parts of the body where the skin is pressed against the bedding. They are most often seen on the buttocks, back, elbows, or feet.

Prevention is the BEST medicine!

- Turn the sick person over every hour or two: face up, face down, from side to side
- Bathe him every day and rub his skin with baby oil.
- Use soft bed sheets and padding. Change them daily and each time the bedding gets dirty with urine, stool, vomit, etc.
- Put cushions under the person in such a way that the bony parts rub less.
- Feed the sick person as well as possible. If he does not eat well, extra vitamins may help.

Treatment:

- Clean regularly with soap and clean water
- Protect from dirt, stool and urine

Refer to HCP if

- wound is dirty or smells bad
- the edges of wound are red or swollen
- patient has a fever

Fever
When a person's body temperature is too hot, we say he has a fever. Fever itself is not a sickness, but a sign of many different sicknesses.

Treatment:

- Uncover them completely (do not bundle them up in blankets, even if they feel 'cold')
- Give Paracetamol (Panadol) 500 mg 1-2 tablets every 4 hours
  Or
- Aspirin 1 tablet every four hours (Do **NOT** give to children or patients with stomach pain or ulcers)
- Anyone with fever should drink lots of water, juices or other liquids.

If fever is severe or has lasted more than 24 hours, refer patient to HCP.
Consider treating for malaria if patient cannot get to a clinic soon.

IV. Session Four – Sharing the Good News of Jesus Christ

As Christians, we want to demonstrate the love of Jesus Christ in our lives. On way of doing this, is to reach out to those who are sick and in need with hands of compassion as you are doing in the home based care program at your church.

In the Bible, there are many Scriptures that support the idea of doing more than just speaking with our mouth when we want to help people. Christianity is a 'hands on' life!

We want to demonstrate our faith, by putting it in action and physically reaching out to those who are in need, but at the same time, we don't want to neglect the opportunity to share with them the hope and good news of Jesus Christ. Sometimes, it is easier to 'do' than to share, but it is essential that we do both!

When it comes to sharing our faith, we must remember some of these basic principles:

- People often cannot 'hear' our words when they are suffering or in pain. We must do all we can to relieve their suffering and provide comfort.
- If they are frightened or anxious, they will not absorb new information. In these times, our loving actions will speak much more than our words.
- A trust relationship must be developed, so our words will have credibility. W
- Although we will care for everyone in the 'name of Christ', we must take great care to prevent the perception that the care we provide is dependant upon their 'receiving Christ'.
- God does not need to be 'pounded in' to anyone. If a person is given a clear picture of the Gospel, it is up to God whether or not they receive Christ. We are not responsible for the outcome of their 'decision'. We are only responsible for making sure they have been told the way.

Remember the saying, *'A man convinced against his will, is of the same opinion still!'*

On the other hand, it is essential that we look for opportunities to share Jesus with those we are ministering to. In many ways, reaching out to people when they are sick and in need opens doors that would have been closed otherwise.

People who are sick and needy are more open to the Gospel.
When faced with your own mortality, you begin to think about where you will spend eternity and discover an increased interest in spiritual things. Young people especially, but people in general, tend to not like to think about death and the afterlife. Instead, we tend to think that death and sickness happen to 'other people' or that it is going to happen so far away in the future, that it is nothing to concern ourselves with at present. When we are faced with a threat to our health, or the health of those we love and care about, or that we see as 'peers', we often become more reflective and think about eternal things.

It has been proven that people, during a time of change, even a good change, are more open to spiritual things.

Who needs to hear?
Most people, if asked, would call themselves 'Christian', unless they already identified with another group such as Islam, or followed the ATR exclusively. But many who fall under this 'banner' really have no idea of what being a Christian really is.

Sometimes it is helpful to ask EE's two diagnostic questions, to help clarify what a person is putting their trust in.

1. Do you know for certain that you will go to heaven when you die?
2. If you did die tonight, and found yourself standing before God, and he were to ask you, 'Why should I let you into MY heaven?' What would you say?

These two questions help to determine what people are putting their trust in. Many people are trusting in the good things they do to be their ticket into heaven.

There was a story of a man who wanted to go to a football game. It was going to be an exciting game and he really wanted to go. The problem was, he didn't have a ticket. As he was digging down into his pocket to find money to buy the ticket, an idea struck him – maybe he didn't have to have a ticket! Was there another way to get it? As he thought about it, it occurred to him that everyone at the game would be cheering and yelling support for their team. This would make them thirsty. In addition to that, the sun would be beating down on them and they would all be hot and thirsty. As he thought about it, he realized that if he would provide cool, refreshing drinks to everyone there, it would be a real blessing to the people. Surely if he were providing such a wonderful service, they would let him into the game without a ticket!

He set to work preparing for the game. He bought huge containers and filled them with a special drink that he had created just to quench thirst. He worked long and hard to make all the preparations. When finished, he looked over his work and made a mental checklist in his mind:

- *Drinks,*
- *Ice*
- *Cups*
- *Trash container*

He looked his list over and decided that he had indeed thought of everything. He was excited as he anticipated how happy everyone would be with his magnificent plan to refresh them during the game.

Finally the big day arrived. He loaded all of his equipment on a special trailer that he had designed just for this purpose and headed to the game. When he got to the gate, the gatekeeper asked him,
'Ticket please'
he replied, 'I don't have a ticket, but it is okay because I have brought refreshing, cool drinks for everyone'

The gatekeeper said, 'That is very thoughtful of you, but in order to get into the game, you must have a ticket'
Don't you understand, the man said, I have spent a lot more time and money on the preparations I made to give drinks out than it would have cost me to buy 10 tickets!
'I'm sorry', said the gatekeeper, but in order to get into this game, you have to have a ticket. That is the only way I am going to let you in.
After much protesting, the man was so disappointed as he realized that it didn't matter what he had done, what mattered in the end was whether or not he had a ticket. The owner of the stadium set the rule, and there were no exceptions.

Even with all of his preparations, he could not go to the game and he missed it all.

It is very much the same in our lives. Many people think that they can make the rules on how to get to God. They think that if they are 'good' enough, or if they don't hurt anybody, or if they go to church, or if they help the poor and needy…etc. They have this idea that there is something that they can do which will please God enough so that He will let them into His heaven when the time comes that they stand before Him in judgment. The reality is, they will be sadly disappointed, just like the man in the story, because there is only one way to get into heaven. All of our efforts and hard work are meaningless to God if we don't have the one thing (the ticket) that He requires. After all, it is His heaven, and He gets to make the rules on how to get in.

God is love and even in your sickness God still loves you.

John 3:16 For God so loved the world, that He gave His only begotten Son, that whosoever believes in Him, will not perish, but have everlasting life.

This verse explains God's love for the world and the world is you and me. This means God loves us. We destroy this love with our sinful state. Sin is any disobedience towards God.

Man is a sinner. He chooses either to obey or to disobey God. The Bible, in Romans 3:23 says: 'All have sinned and fall short of the glory of God.' This means everyone – no exceptions. Whether one is ill, just as you are, or not.

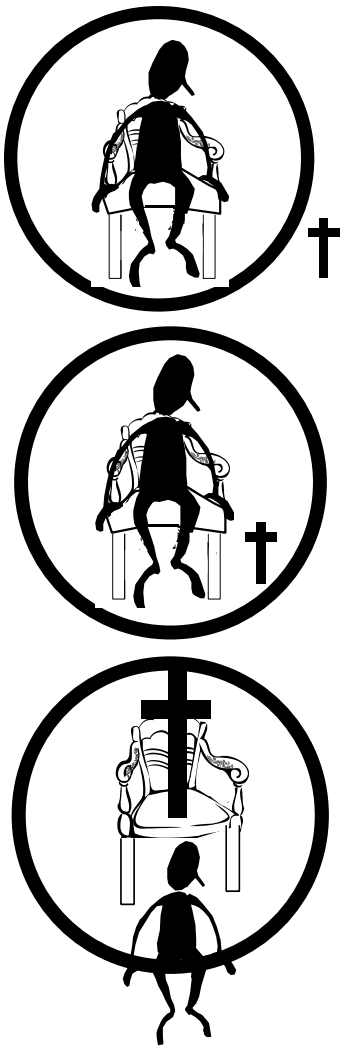
Because of sin, man is now separated from God. Romans 6:23 says: 'For the wages of sin is death. This death does not mean physical death but spiritual separation from God.

Example of separation between God and man. God is holy while man is sinful. (Bridge illustration)

There is separation between us and God. Sin separates us from God. People try to reach God with their own efforts, but any efforts can fail.

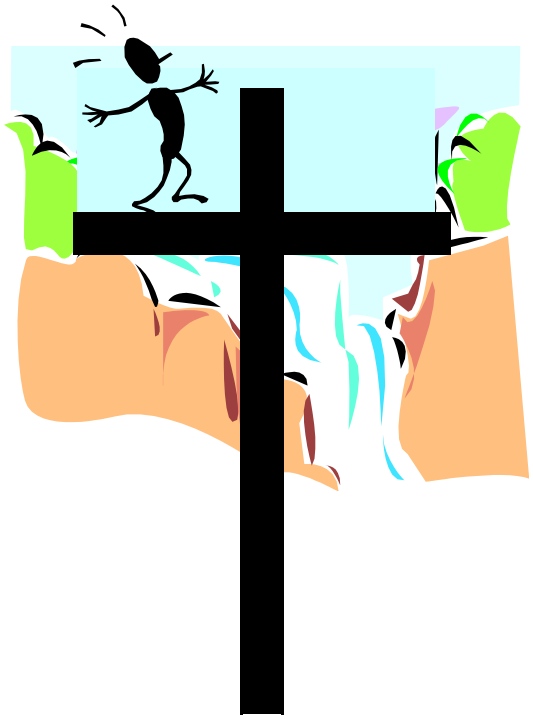
But Jesus came to save us. He is the only way to God. The Bible says in John 14:6; ‘Jesus said to him, ‘I am the way, and the truth, and the life; no one comes to the father but by me.’

Here are three circles to represent your life.
Which circle represents your life?
Which circle would you like to represent your life?



The separation between God and man was filled by Jesus (Bridge illustration)

Only Jesus can fill this separation. 'Jesus said to them, I am the way, the truth and the life, no one comes to the Father but by me.' John 14:6



Jesus died on the cross. 1 Peter 3:18 says 'For Christ also died for the sins once for all, the righteous for the unrighteous, that He might bring us to God' since the wages of sin is death, Jesus died in our place as a gift. He gave his life for us.

As a gift, Jesus needs to be received in our heart. We must receive Jesus as Saviour and Lord. Then we can experience God's love in our lives.

The Bible promises us the honour and privilege of becoming children of God. When we become children, God becomes our father. John 1:12 says, 'But to all who received Him, who believed in His name, He gave power to become children of God.' When you hear the worlds of the Bible as I am telling you take it that Jesus is knocking at the door of your heart. He wants to come in once you open. Revelation 3:20 says; 'Behold, I stand at the door and knock. If anyone hears my voice and opens the door, I will come in to him.'

You receive Jesus by faith, by inviting him into your life. Receiving Christ means turning to God from self (this is what repenting is). We trust Christ to come into our life and to forgive us our sins.

But the good news is that you can receive Christ right now. You ask him to come in your life through prayer. Prayer is asking or talking to God.
Model prayer:

Lord Jesus, I realize I am a sinner. I have been controlling my life. I now ask you to come into my life. Forgive my sins. May you rule my life. In Jesus' name, Amen.

Assurance of salvation:
If you prayed that prayer believe that Christ has come into your life. He promises He will. In Rev. 3:20 Christ promised He will come into our lives.

The Bible promises eternal life to all who receive Christ. 1 John 5:11, 13. God is more interested in what you mean in your heart than what you say or feel. When you receive Christ many things happened to you:

- Your sins were forgiven
- You became a child of God

As a leader, pray to thank God for opportunity of growth.

Faith in God has to grow and you grow by:
Going to God in prayer daily
Reading God's work daily
Obeying God moment by moment
Witnessing for Christ by your life and words
Trusting God for every detail of your life
Having God control and empower your daily life and witness
Having fellowship with other believers in the church.

It is important that we remember we are 'sharing the good news', not pounding them over the head! No one likes to be preached to, but everyone wants to hear really good news. We have not failed if they do not become a Christian, that is up to God, not us!

We are like 'one beggar, showing another beggar, where to find bread.'

Regardless of their response, the most important thing we can do is demonstrate Christ's love to them in a real way that they can see, feel and absorb. That will be more of a witness than any words coming from our mouth.

But it is important that we do share and not just demonstrate. If we never tell them that we are caring for them because of the love of Christ, then the blessing of our visit will be to our own glory and not to God – we don't want to be guilty of stealing God's glory!

Another thing to consider has to do with our thoughts about God. Sometimes when we are sick, or when the circumstances in our life are very difficult, we have questions deep down in side of us that wonder just where God is in this situation.

There was a time when someone I knows mother was sick and dying. The woman was not old, yet she was dying of an incurable illness. My friend was a Christian, and although she knew that God was in control of the situation, she still questioned God. 'How could He do this?' she wondered. 'If He was so powerful, how could He let this happen?' It didn't seem at all fair to my friend and she began to feel angry at God for allowing this terrible thing to happen to someone she loved.

Then, she began to feel guilty for being angry at God, after all, as a Christian, how could she be mad at God?

Although we will never have all the answers, it is important that we allow people to verbalize their feelings.

How could we help someone struggling with the problem my friend had?

- Should we preach at her about how God can do whatever He pleases and we have no right to complain?
- Should we sit silently beside her, offering silent comfort and prayers?
- Should we attempt to console her with words like, 'it will be all right'?

What should we do?
It is not at all unusual for even committed Christians to suffer with such turmoil during times of crisis. Many times when we are visiting the sick our mission is not to bring the good news of salvation, but to comfort the grieving who are suffering with torments in their spirit. Telling someone that they shouldn't be angry, or that 'it will be all right' are meaningless platitudes that help nothing and in fact, tend to discredit you as a caregiver.

It may be helpful to remember that even King David, who was the 'apple of God's eye' had many doubting questions toward God when he was suffering great turmoil. That is what makes up many of the Psalms. We must remember that God knows and feels our sorrows and grief. He understands how we feel.

Many of you have suffered with the loss of a loved one and you know how difficult that can be. You are an example of 2 Corinthians 1:3-4,

'Praise be to the God and Father of our Lord Jesus Christ, the Father of compassion and the God of all comfort, who comforts us in all our troubles, so that we can comfort those in any trouble with the comfort we ourselves have received from God.'

Sometimes the best thing to do is to sit quietly by someone's side as a quiet testimony of our concern for them. It is our human nature that we want to 'fix' the problem. We want to say or do something to make it 'all better'. But it is more important to allow someone to grieve without our judgment coming to bear on them. It might be that our words would be best kept for another visit, when they are ready to hear them.

We must always be sensitive to the needs of those we are trying to minister to. Pray for God to give you wisdom and insights as to what would be the best way to minister to each person. He tells us in His word that, 'If any of you lacks wisdom, he should ask God, who gives generously to all without finding fault,, and it will be given to him.' James 1:5

Sometimes there are thought within us that conflict and confuse us. Often things we know and believe now, conflict with concepts and traditions we learned as a child. When we are sick, or threatened, we often find those old thoughts and beliefs coming to mind and conflicting with what we believe.

Religious and cultural beliefs surrounding death (by J.M. Waliggo)

- African Illness: That which can be cured only by African traditional medicine, by African people and in a truly African way.

- European illness: That which can be cured by modern/Western medicine from outside Africa by people trained in modern/Western medicine.
- Incurable illness: That which goes on and on over a long time and accepts the use of African and modern/Western medicine either simultaneously or alternately.

A strong belief that 'illness and death do not come by themselves' is part of the African's worldview. The implication is that if ever someone is sick and eventually dies, some enemy either living or dead must have caused it. The sick person goes through the list of people who never wished them well to identify the one who may have done this to them. The families of the sick, despite any scientific evidence showing them to the contrary, also go searching for the person responsible.

As healing goes on, this belief continues to distract the sick, the family of the sick and the community who are angry as a result. The search for the culprit destroys the inner healing of the person.

Counselling on forgiveness becomes crucial for a peaceful and happy death. It is here that Christianity helps considerably. It is here that some rational explanation about the causes of the disease that one is suffering from can help.

Questions often asked by someone who is sick and/or dying:

- Why has this happened to me?
- What has caused it?
- For some there may be dual feelings:

Is God angry with me? (Am I angry with God?) Serious illness often tests our faith	What is the cause of my misfortune?
Is God punishing me?	Has somebody bewitched me?
What have I done that this should happen to me?	Has someone put a curse upon me? (what reason would they have?)
What will happen to me when I die?	Are my living/dead ancestors angry with me? Have I failed to honour them as I should?

People wrestling with these questions may appear:

- Lonely, isolated, silent, helpless, shut in, fearful, and they may be feeling far away from God
- Or they may be restless, and experience acute anxiety or guilt.
- Or they may be angry, demanding, hostile and irritable.

We must care for the whole person – not just bodies, but body, mind, emotion and spirit.

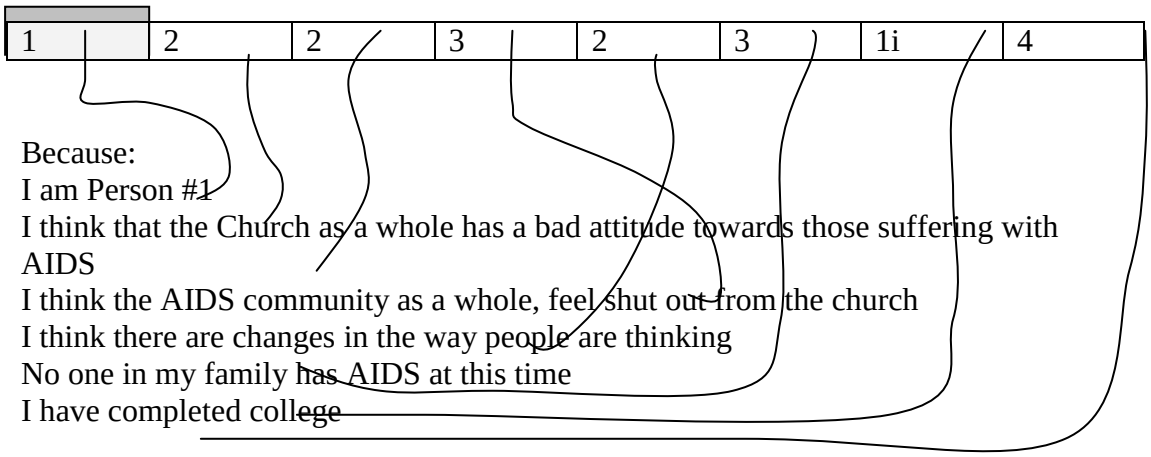
Caring involves all of these, in includes:

- Compassion – suffering with, and avoiding pat answers
- Understanding- trying to understand the problem, not necessarily having the solution.
- Empathy- trying to stand in the person's shoes.
- Listening- in an empathetic way, not only to what they say, but to the underlying feeling shown by tone of voice, eyes and posture.

Appendix E - Instructions for Surveyors

1. Introduce yourself with a friendly smile
2. Explain what you are trying to do – to assess the general attitudes of the community towards the Church and AIDS
3. Ask permission to ask them the questions.
    a. if they say 'yes' then proceed
    b. if they say 'no' then thank them and move on (keep track of how many people do not want to participate)
4. Begin to ask the **Questions 1 and 2**:
    a. Do not ask them how they feel, as they will then want to tell you what they think you want them to say.
        i. Ask them: 'How do you think most people in the church feel about those with HIV/AIDS?'….
        ii. 'How do you think most people with AIDS feel about the church?
5. **Question 3** – see if they feel the attitude of understanding and openness has changed over the last 5 years or so.
6. **Question 4** – As if anyone in their family has had AIDS, or if they suspect that may have been the case. Do not press this issue, take whatever answer they give.
7. **Question 5** – Assess their level of education. Mark which box they have completed.
    a. if they have not completed primary school, put the level they have completed in the box. (example: ' st2 for' standard 2; fm3 for 'form 3'; etc.)
8. **Question 6** – Assess their religion. If they say 'Christian' indicate from the codes at the bottom what denomination. If their denomination is not listed, write it down on the back (example: if person #18 says 'Lutheran', then on the back of the paper, write #18 Lutheran)
9. **Question 7** – Indicate what age group they fall under.

Example: Lets say you were interviewing me, and I was the first one you talked to. The check marks for line #1 would look like this:



Because:
I am Person #1
I think that the Church as a whole has a bad attitude towards those suffering with AIDS
I think the AIDS community as a whole, feel shut out from the church
I think there are changes in the way people are thinking
No one in my family has AIDS at this time
I have completed college

I am Christian/Baptist
I am in my 40's

This type of questioning may open opportunities to share the Gospel. Please be ready and willing to do so! But only in a very gentle, loving way. Remember, your duty as a Christian is to share the Good News, it is up to God to change their hearts and minds.

Please write down any 'quotes' from the people you talk regarding how they perceive things or feel about things that sound interesting.

Thank you for your participation in this survey, it will be a great help to me and I will look forward to your thoughts and feelings about how it went.

Appendix F - Phenomenological/ethnomethodological Strategy with in-depth interviewing

In-depth interviewing was done through established gatekeepers due to the fact that most if not all patients, and most of the volunteers as well are not fluent English speakers. Gatekeepers included Mrs. Grace Banda who has been instrumental in the development of the Home Based Care program, and Aubrey Kanyama, an ABC student who is also working with World Relief and intricately involved in their Home Based Care program, and therefore known and trusted by all those interviewed. Chichewa is the primary language for both interviewers.

F.1 Reverend Akiwa Chimsolo

- Pastor of Chididi Baptist Church for 10 years - *Mgombe 2 Village*.
- 233 members currently
- 1998/99 started home care program with 6 people

Old attitude:

- 5-6 years ago people would laugh at people afflicted with HIV/AIDS, commenting that 'it is your own fault', 'you were negligent', etc.
- They would not associate with them.

Current attitude:

- People suffering with HIV/AIDS are part of the church family and are embraced with love.

What made the change?:

- World Relief supplied
- Education about HIV/AIDS
- Items of relief that can be distributed to those in need which demonstrated love and kindness in a tangible way
- The people's attitudes changed as they became more open and aware

Each person interviewed concurred with the same comments that Rev. Chimsolo was an outstanding demonstration of Christ's love as he continually sought out those who were suffering and offered them love and hope as he not only invited them to join the fellowship group, but also provided counselling, physical assistance and

transport as well as sharing his own personal resources with them when necessary. It appears that he is willing to give and do anything for the cause of Christ.

A story, which impacted the church congregation, was shared with this interviewer and is now added for illustration of the changes that have taken place in this congregation. It is told in the words of Grace Banda, the interviewing translator.

> Rev. Climsolo shared with us an incredible and touching experience worth noting which has transformed the attitudes of parents in the community around Chididi. A family early this year (2002) had a judgmental and accusing attitude towards their daughter after she was diagnosed HIV+. They accused her of the promiscuous life that she was living and that she was now reaping the fruits of that life – but the girl has signs and symptoms of full – blown AIDS.
>
> The insults she got from the parents led her to disappear in the bush for a whole week until church members of the Baptist discovered her and took her home. The Church members went to talk with the parents and a lot of counselling was done when they accepted her back home. But the stigmatisation from the parents had already done a lot of harm that she was not the same. She lived a miserable, closed life which made her life to deteriorate very badly. Within a month she died. This incidence affected the whole community up to the extent that the chief had to call for an emergency meeting to address all the people in the area. Today parents have a loving , caring and concerned attitude towards those affected with HIV/AIDS.

F.2 Abiti[60] (Mary) Ali

Environment:

Seated at first on mats in front of house with 3 women, the Pastor, several men and many children. She was apologizing for being 'dirty' because she was just coming in from working in the garden. Interview was done in privacy of small house belonging to daughter, which was located directly next door to patients house.

Status:

- Current HIV/AIDS patient
- Diagnosed in 1999
- Involved in Christian HIV/AIDS fellowship
- Involved in Chididi Baptist Church
- Married several times, husband ran away last year
- 6 children, born 1980, 82, 88, 91, 94, 99 (all are aware of diagnosis)

[60] *Abiti* is a title assumed by a daughter in respect for her father when she takes her husbands name in marriage. Instead of being called by her married name, she takes the title *Abiti*, followed by one of her father's names (first, middle, last, etc.) Can also be done by single women. This is a Yao tradition.

- Encouraged to have testing done, relieved to finally know what was wrong
- Not accepting that her behaviour contributed to her getting the disease – denies knowing how she got it, maybe razor blades?

Attitudes:

- Pastor Chimsolo approached her about joining the group and paid for transport for testing along with providing counsel
- Viewed the church as loving and caring from the start
- First person she told was her mother, was supportive and concerned if anyone else knew, encouraged pt to go slowly (reason?)
- Said many people laughed at her but she did not feel bad because she was a Christian and had peace of mind due to Jesus Christ.
- Says people don't laugh anymore because she has joy in her life
- People don't believe that she has HIV/AIDS due to her happy spirit and healthy look
- She feels surrounded by Christians who comfort and love her
- She feels the diagnosis has made her stronger
- Counsels others now about HIV/AIDS
- Counsels her children to live a holy life and abstain
- Her spiritual and prayer life have grown, quoted several verses (John 14:1; Romans 3:23 – personal Bible was recently stolen)

Comments from Interviewers:

Mrs. Banda and Aubrey felt that the patient was somewhat inconsistent and although she stated she was able to be open and frank about her illness due to her acceptance of it, she did not always answer questions directly and gave the impression that she was not as 'open' as she claimed to be. Affect was very pleasant and cheerful, with frequent, easy smiles. She appeared very eager to cooperate.

Action taken:

Send Bible (as promised to replace hers that was stolen) along with photo taken today

F.3 Mr. Khirex Asimu

Environment:

Very neat home and village. Curtains on windows, with some screens in place. Children were busy peeling Cassava, while other adults were processing Maize. Everyone seemed to be purposefully busy.

Status:

- Moslem
- Age - 32
- Married 8 years to same woman, Fatima Majidy
- 2 children, both girls, approximately aged 6-7 and about 2
- works as a farmer and fisherman
- Multiple tattoos on torso and upper limbs from witchdoctor treatments[61], which seemed to be Mr. Asimu's first sought after treatment for his unknown illness and continued for 3-4 years before his diagnosis.
- Healer said the problem he suffered was because his father had died and left him a fishing net. His relatives (uncle in particular) were jealous and therefore bewitched him
- Joined the Christian fellowship group in 2001. Calls himself a 'pioneer' of the group
- Does not know how he got HIV/AIDS, but suspects it is from the razor blades used by the traditional healer
- Though the wife looks healthy – she has not been tested and it obvious that she is HIV/AIDS positive.
    - Very active supportive wife who encourages the husband to attend fellowship group weekly

Comments from interviewers:

- (Grace's comment)The first name '*Khirex*' does not sound Moslem – this name has a connotation of young men who are very outspoken with women. It is possible he must have had a good time with girls in his teenage period.

[61] Common treatment used by herbalists when it is suspected that bewitching has taken place. 5-6 small cuts, approximately .5cm, 1-2 mm apart are made on the skin of torso, arms or forehead. A black compound, made of herbs is then rubbed into the open wounds to cure the patient of the curse.

- (Aubrey's comment) Pastor Chimsolo's visits were a demonstration of love unlike the *Mwalimus* (sheiks) who have never visited him to see how he is coming with his illness.

Attitudes:

- When World Relief first began coming, people in the village would jeer and yell at them and those they were coming to see.
- Today, this does not happen because the people have observed the love and healing that has taken place. They see love in action.
- Mr. Asimu commented several times that this kind of love was not present in the Muslims. They mostly keep distant from the AIDS issue.
- He tells his Muslim friends about the love he receives at the Christian fellowship
- He states that Muslim leaders would not visit a sick person
- He made multiple references to the fact that there was love present in the Christian fellowship and that is what draws him to it.
- He was first invited by Rev. Chimsolo to join the group. Sees Rev. Chimsolo as a true Christian who demonstrated real love and concern for him
- He sees the Christian Church as a place of love since he has observed it personally
- Prior to this personal contact, he did not know that Christians loved like this
- Has made a commitment with his wife to abstinence and plans no more children

Comments:

Very nice man. Soft spoken and transparent. He genuinely seemed impressed with the Christian love, which has been demonstrated to him but is reluctant to become a Christian. We will be praying for him.

F.4 Abiti (Martha) Suwedi

Environment:

Pretty home, well maintained. She was mixing mud to fix the floor in the main room as we arrived. Many flowers and decorative plants in well manicured flower beds.

Status:

- 39 years old
- Anglican
- 5 children son born in 73, daughter 25 years old lives next door, girl born in 82, girl born in 90, twins born in 96 (boy died, girl lived)
- She started getting sick after the birth of the twins1997 (1987?)
- Husband died in 1998 after severe, short (days only) case of cerebral malaria
- Tested for HIV/AIDS 5 times, all negative
- Thought she was 'bewitched'. Herbalist said it was because she was 'well to do,' gave her herbs which made her stomach swell, so she resorted to the hospital.
- Sells donuts to provide income for her family when she is well enough
- Recent surgery in January at Lilongwe Central Hospital
- Joined Christian fellowship group in 1998

Attitudes:

- Told her mother and children immediately, shared with them the encouragement she received from the counsellors who tested her
- Says people talked, and still do (gossip) but she doesn't care because they don't know Jesus Christ
- Her church is supportive and her pastor will visit if she misses church
- Members come and help her when she needs it and bring her things
- She feels loved and cared about
- Feels fellowships group is a very tight knit group
- People (neighbours) used to shout at those like us and World Relief, saying 'you've come to see the AIDS patients!'
- Now, because of the love they have seen demonstrated, they don't do that anymore but are helpful and try to give support

Comments from interviewers:

(Grace's comment) The fact that she started getting sick after the birth of the twins (especially if we consider that one twin died), there is an explanation to her HIV status. Therefore it can not be ruled out that the husband died of AIDS even though he had severe cerebral malaria in a few days – in the village environment, it is

possible he may have been having bouts of headaches and fever without getting hospital assistance, he may have depended on traditional herbs until very late.
Seemed very open and honest. Did say there were negative attitudes among some, but refused to partake in such gossip. She is obviously a hard worker and goes far beyond most villagers in trying to make her surroundings beautiful.
Says fellowship group has grown from 6 to 37 members in last year.

F.5 Joyce Chipalasa

Environment:

Met with Joyce and Mr. Peter Chijoge and another patient whose name we did not catch, at the St. Anne's Hospital where she works as a dietary consultant and AIDS counsellors. She is articulate and interview was done primarily in English.

Status:

- 31 years old
- 2 children, Wezzie 13, and Patrick 6 (different fathers)
- now single parent
- lives with extended family and cares for children of her 2 elder sisters and brother who have all died – all 'well educated'
- Diagnosed HIV+ 1995, after complaints of headache, fever
- Joined NASO (Nkhotakota AIDS Support Organization) a local, secular community AIDS group
- Tried to be a UNV (United Nations Volunteer) for AIDS work, but was unable to attend the interview, but was from there referred to World Relief
- Began working for World Relief and speaking in churches and any opportunity she could about AIDS
- She thought she was bewitched because she was working and living comfortable

Attitudes:

- After a radio interview, that many of her friends/relatives heard where she openly declared she had AIDS, there was a lot of flack from them towards herself and her family. Her sister and children were harassed as well as her mother.

- She stopped attending church due to the attitudes there, until she was encouraged by World Relief to begin going again.
- Now she is accepted and loved by the church. She is a member of the woman's choir, Daughters of the King and has been asked to take a visible role in the church, including reading of Scripture as part of the main church service up in front of the congregation.
- Feels her children are exceptionally loving and supportive of her. For instance, yesterday she came in so tired she went right to bed and didn't have energy to eat. Her son fixed her mosquito net and brought her food, encouraging her to take a bite to gain her strength.

Comments from interviewers:

(Aubrey's comment) Her mother has also been very supportive to Joyce.

This lady is a real dynamo. She is the energy and force behind the success of much of the success, which has been made by the fellowship group. There are now several fellowship groups in progress at many of the churches. She is also working on helping others write 'memory books' for their families.

Her health is beginning to decline. In this last year she has suffered from TB (has one month to go of treatment) and shingles.

Joyce Chipalasa has died since this interview took place.

F.6 Mr. Peter Chijoge

Environment:

See Joyce Chipalasa

Status:

- Age 45
- Married a woman with a small child who became ill (age 1 ½), now 4 and doing well
- After child tested positive, it was suggested that he be tested as well.
- He and his wife[62] are both members of the fellowship group

Attitudes:

[62] Patient was reluctant to share this, but it seems his 'wife' found another man in the fellowship group that she left her husband for and he is now single – Joyce (counsellors/patient) cleared this by explaining this bit of story, which Peter was not comfortable to share.

- Was afraid of diagnosis.
- Afraid to reveal diagnosis to others, depressed
- Says AIDS patients are treated as the lepers of the Bible and felt like outcasts
- They were ostracized from village activities
- Those who were sick were told, 'go away you people with AIDS', 'You give us a lot of trouble'. This attitude was prevalent in the village and in the hospital where they worked and were also patients
- This attitude changed because of the Christian fellowship groups.
- 1999 Church fellowship gave counsel, and hope, because of this, he lives without fear and feels he is living well
- Believes he will die when the time is right, and it is OK
- People in his church equated AIDS with promiscuousness
- Love and education have changed people

Comments from interviewers:

Was very open and honest, but seemed reluctant to share his present heartache of his wife with us[63]. He works to educate people on HIV/AIDS and dangerous cultural practices that promote the spread of AIDS such as the marriage of a surviving spouse to a family member, and the use of razor blades for the traditional healers.

[63] Patient was reluctant to share this, but it seems his 'wife' found another man in the fellowship group that she left her husband for and he is now single

Appendix G - Single-system designed randomised cross-sectional quantitative survey.

Within the dissertation this report has been adjusted by percentages to give a reflection of the attitudes and ideas of the respondents. The actual figures are indicated on the charts listed in this appendix.

Results of the initial survey revealed:

*Question #1: How do you think people in the Church feel about those suffering from HIV/AIDS? (total respondents 321)***

1	2	3	4	5
Christians don't get HIV/AIDS. Those that do are receiving the punishment they deserve for the sins they have committed.		There aren't any people in the church with HIV/AIDS. It isn't a problem that they have to deal with.		They want to reach out to them with the love of Christ and do all they can to relieve their suffering.
62	36	26	59	138

*Question #2: How do you think people in the AIDS community feel about the Church? (total respondents 424)***

1	2	3	4	5
People with HIV/AIDS are not welcome in the Church because they are sinners.		People with HIV/AIDS can come to the church, but people keep their distances from them.		People with HIV/AIDS feel love and acceptance when they are in the Church or around Christian people.
30	17	106	46	225

*Question #3: Do you think attitudes between the church and the HIV/AIDS community have changed in the last few years? (total respondents 342)***

1	2	3	4	5
There is no difference in attitudes in		People are more open and aware, but		The church is seen as more loving and

these groups.		continue to act in the same way		accepting of the HIV/AIDS community now.
100	28	89	28	177

*Question #4: Has anyone in the family suffered from HIV/AIDS? (total respondents 421)***

1	2	3
Yes	No	Uncertain
178	151	92

*Question #5: Level of Education (total respondents 416)***

1	2	3	4	5
Primary	Secondary	College	Trade	Other
222	100	15 (questionable)	54	25

*Question #6: Religious Beliefs(total respondents 427)***

1	2	3	4	5
Christian*	Muslim	African Traditional	None	Other
330	66	9	21	1

** For a breakdown of the various Christian denominations, please refer to Appendix.*

*Question #7: Age(total respondents 418)***

1	2	3	4	5
15-20	21-30	31-40	41-50	51+
97	117	107	61	36

**The number of total respondents varies from question to question because the surveyors were instructed to allow participants to not answer any questions that they chose not to answer for whatever reason in an attempt to get accurate and honest answers for the ones they did choose to answer.

Results of the ONE YEAR LATER survey revealed:

*Question #1: How do you think people in the Church feel about those suffering from HIV/AIDS? (total respondents 250)***

1	2	3	4	5

Christians don't get HIV/AIDS. Those that do are receiving the punishment they deserve for the sins they have committed.		There aren't any people in the church with HIV/AIDS. It isn't a problem that they have to deal with.		They want to reach out to them with the love of Christ and do all they can to relieve their suffering.
0	9	1	224	16

*Question #2: How do you think people in the AIDS community feel about the Church? (total respondents 250)***

1	2	3	4	5
People with HIV/AIDS are not welcome in the Church because they are sinners.		People with HIV/AIDS can come to the church, but people keep their distances from them.		People with HIV/AIDS feel love and acceptance when they are in the Church or around Christian people.
2	9	2	127	89

*Question #3: Do you think attitudes between the church and the HIV/AIDS community have changed in the last few years? (total respondents 250)***

1	2	3	4	5
There is no difference in attitudes in these groups.		People are more open and aware, but continue to act in the same way		The church is seen as more loving and accepting of the HIV/AIDS community now.
12	12	1	81	144

*Question #4: Has anyone in the family suffered from HIV/AIDS? (total respondents 220)***

1	2	3
Yes	No	Uncertain
141	87	22

*Question #5: Level of Education(total respondents 250)***

1	2	3	4	5
Primary	Secondary	College	Trade	Other
190	57	1	0	0

*Question #6: Religious Beliefs(total respondents 250)***

1	2	3	4	5
Christian*	Muslim	African Traditional	None	Other
223	27	0	0	0
46 CCAP*	70 RC	22 AoG	16 EP	3 A
2 AA	3 NA	3 UMC	57 Misc	2 JW

*Question #7: Age(total respondents 250)***

1	2	3	4	5
15-20	21-30	31-40	41-50	51+
55	172	15	7	1

*Question #8: Are you familiar with Partners in Hope Home Based Care which was started one year ago?(total respondents 250)***

1	2
Yes	No
198	52

*Question #9: Do you think the Home Based Care has helped to change attitudes between the Church and the HIV/AIDS community? (total respondents 195)***

1	2	3	4	5
Attitudes are worse now		No change in attitudes		Attitudes are better now
0	0	0	83	114

* The denominational codes are as follows: CCAP – Church of Central Africa Presbyterian; RC – Roman Catholic; AoG – Assemblies of God; EP – End Times Pentecostal; A – Anglican; AA – African Abraham; NA – New African; JW – Jehovah's Witnesses

**The number of total respondents varies from question to question because the surveyors were instructed to allow participants to not answer any questions that they chose not to answer for whatever reason in an attempt to get accurate and honest answers for the ones they did choose to answer.

Appendix H - The Idea of Limited Good

http://ist-socrates.berkeley.edu/~peis100a/lectures_material/Limited_good_chart.htm

IDEAS / VALUES	VALUE CHANGE REQUIRED
'Good' is finite; there is a limited amount of material good, love, friendship	**'Good' is infinite**; there are infinite amounts of both material and non-material goods
Community is a closed system ruled by personal relationships and ascriptive hierarchies	**Community is an open system** guided by impersonal laws and freedom.
If my situation is improved, yours is worsened and vice-versa: therefore, don't try to improve your position or you will be punished and others won't like you	**If my situation improves, it doesn't hurt you**, if fact, it may help you and vice-versa; we can both be rewarded by improvement
Value cannot be created by man; it is given by God. Therefore luck is rewarded, but hard work is not rewarded; no relationship between hard work and the acquisition of wealth	**Value can be created through work**; hard work should be rewarded
Wealth is inherent in nature; there are limitations on land and technology; additional hard work will not improve anything	**Wealth comes from work**; work and thrift create wealth
Progress is impossible; it will only come at the expense of others	**Progress is both possible and necessary**
Individual achievement is punished; contentment with what you have is valued	**Individual achievement is valued**; contentment with what you have is punished.

Appendix I - Projected Project Cost by Department

Partners in HOPE

Projected Project Cost by Department

A. Partners in Hope-HIV Clinic

Phase I
Staffing (24 month totals)

- Project Coordinator (masters level C.O) $12,000
- 2 Registered nurses $12,000
- HIV Counsellors $10,000
- Receptionist/Data Entry $ 6,000

$40,000

Facility development
Already existing

Phase II
Additional Staffing (12 months total)

- Clinical officer (Jr. level) $ 4,500
- Registered Nurse $ 3,000
- Records Clerk $ 1,500
- 2 Cleaners $ 1,800

$10,800

Facility Development

- 1500 Sq. Foot X $20/Sq.Ft. $30,000
- Furniture, file cabinets etc $ 4,000
- Medical Equipment (Otoscopes, BP Cuffs etc) $ 2,500

$36,500

B. Microbiology Laboratory

PCR Viral load

• Roche Amplicor and supplies	$45,000
• Training in US-1 Technician	$ 5,000
• Training in Malawi – 3 Technicians	$ 5,000
	$55,000

CD4+ Count

• Becton-Dickinson Flow cytometer for CD4+	$25,000
• Training in Malawi	$ 3,000
	$28,000

Hematology Analyser

• Blood analyser	
	$9,000

Staffing (24 month totals)

• 2 Laboratory technicians	
	$18,000

Laboratory totals

• Equipment	$92,000
• Staffing X 24 months	$18,000
	$110,000

C. Home-Based Care Program

Staffing (24 month totals)

• Project Coordinator	$ 8,000
• 2 Nurses	$12,000
• Driver	$ 5,000
	$25,000

Vehicle Costs

• Vehicle $23,000	
• Fuel	$ 5,000
• Maintenance	$ 2,000
	$40,000

Volunteer Equipping

• Training Materials	$ 200
• 10 Bicycles	$ 700
	$ 900

Home Based Care Total Amount **$65,900**

Summary by Program

- HIV Clinic $ 87,300

• Microbiology Laboratory	$110,000
• Home-Based Care	$ 65,900
	$265,200

Cost based upon Malawian Kwacha Exchange Rate = 60MK/US$1

Appendix J - Expenses underwritten for 'volunteers' by World Relief

Expenses Currently being underwritten by World Relief: (as of 24 May 2002)

- Program development
- Training – skills based
    - Pastoral Counselling (give books, writing materials, etc.)
    - Holistic Orphan Care, with emotional, spiritual physical support
    - Ministry planning – assist the ministries in making plans/goals for the upcoming year
- Spiritual growth of team members (retreats, etc.)
- Seed funding
- Drug Access Program within the Church
- Program is designed to be a 'seed' of non-prescription drugs. Package of drugs given to the churches for distribution, with expectation of the churches replenishing the supplies as they are used.
- Trips (1-3) per month from World Relief staff
- Family empowerment for families with orphans (seed and fertilizer)
- Materials (books, pastoral counselling materials)
- Transport
    - Bicycles –(2 per team)
    - Bicycle Ambulance

Numbers of Patients currently involved (numbers are guesses, as they change frequently)
Chididi Baptist Church 53 patients
Anglican Church 20 patients
Another church 8 patients

Breakthroughs:

- At a recent funeral, the parents of the deceased said openly that their daughter died of AIDS.
- Youth groups attached to ministry teams
- Decrease the workload of team members
- Show youths the reality of AIDS (works as a preventative program)
- Original program involved only team members, now the church is participating church wide
- The patients themselves are participating in the visitation and giving as they can
- Land has been identified where team members/patients can use for food production and as an I.G.A.

Appendix K - Letter of dissolution to HBC volunteers

Dear Partners in Hope Home Based Care volunteers,

It has come to our attention that there is some dissatisfaction and frustration amongst the Home Based Care volunteers. The following issues were carefully considered and discussed by the Partners in Hope planning and training team:

1. The original goals and vision for the development of the Home Based Care program which were taught and discussed at length during the training session, that of home based care serving as an avenue of benevolent ministry whereby the 'volunteers' could tangibly demonstrate the love of Christ, as commanded in Scripture, to the sick and suffering, were no longer the motivating factors by the volunteers.
2. The volunteers were no longer serving solely as a benevolent ministry to the sick and suffering without any thought of gain or reimbursement. Instead of their primary focus, which had been to demonstrate the love of Christ to the sick, has shifted to seeking 'incentives' to enhance their personal (as well as the patient's) welfare.
3. The initial plan to help the church develop and enhance their own visitation program to more effectively meet the needs of the sick in their congregations has been completely sidelined. The 'committee' had taken all responsibility for home visitation and the church was not longer directly involved, if at all.
4. Actual patient visitation has been reduced and is often sporadic. Patients are being seen who are already associated with other home care initiatives.
5. The volunteers are becoming increasingly dissatisfied with their role, believing that they are not being treated fairly and insinuating that Partners in Hope is taking food and money that was supposed to come to them, as well as not providing 'incentives' they feel they were promised and deserve.

Following discussion and consideration of the above situation, it was determined by the training committee that despite efforts aimed at moving the program back towards its original goals, the outlook of the home care volunteers and their relationship with Partners in Hope has continued to deteriorate. Because of this, the training committee has decided to completely disband the Partners in Hope Home Based Care volunteer visitation program.

May God bless you all as you continue to serve Him in whatever ways He will lead you. Thank you for participating in the Home Based Care program.

Sincerely,

Mrs. Janet Brown Dr. Perry Jansen Mrs. Grace Banda Sr. Anne Mpanje

Appendix L –Testimonials from Individuals participating in the churches involved in the study

The testimonials below were taken (in Chichewa) by Thomas Mambo (6.3.2), the primary gatekeeper for the Chimbalame Assembly of God, and related to this researcher as indicated below. He was instructed to talk with those people within the congregation in a casual, conversational manner in order, to get an understanding of their perceptions regarding the effects of HBC on the faith community as a whole, the individuals making it up and whenever possible on their perceptions regarding the attitudes of those outside these communities. Although seventeen testimonials similar to the ones below were taken in this manner, due to the many similarities noted in each of the testimonies, only the two below supplied as a sample of the response.

Testimonial number 1:

Name: Mr. Jackson Mangani
Age: 39 years
Sex: male
Marital status: Married with 2 children
Denomination: Assemblies of God
Relationship with HBC members: brothers and sisters in Christ

Original Attitude Towards AIDS Patients:

- At first I could not take the disease as a deadly one because I had already had knowledge of other sexually transmitted diseases e.g. Gonorrhoea and Syphilis, which are curable.
- When I learnt that the disease is incurable I was scared and could hardly stay close to victims since I was regarding them as sinners.

Reasons for the Attitude:

- I had no knowledge about the disease and how it is transmitted and also how it can be prevented.

Time for the Original Attitude:

- I had this negative attitude before I became a born again Christian[64].

Present Attitude:

- Soon I became a born again Christian I started learning more about AIDS both spiritually and physically. As of now, I take victims as my fellow friends who need my help and comfort. As a Christian I have a responsibility of sharing with him the word of God which brings hope to all who receive it.

Did you ever visit AIDS patients before you were born again?

- NO. I had no interest since I was regarding them as sinners.

[64] In many of the testimonies, the phrase 'born again Christian' is synonymous with the individual's coming into the faith community.

At present, do you visit AIDS patients?

- I do visit them whenever I have time

Who taught you that it is important to visit AIDS patients?

- I have been learning from the church since the Scripture says we should 'carry each others burdens'.
- Apart from the church even on the radio[65] there are programs about AIDS which teaches people ways of getting and preventing AIDS.

Have you benefited from HBC members duties in the village?

- I have benefited a lot and this program has encouraged many people in the village.

How do you evaluate the Church?

- The church has completely changed its attitude. At first Christians were not eager to help but now many Christians are participating caring for AIDS victims.

Which people are visited by the Church?

- All people regardless of denomination are cared for.

Are there areas of concern which need an improvement?

- The church should continue encouraging its members to keep on visiting AIDS victims
- The church should teach its people new and better ways of handling victims
- The church should also assist providing physical needs to victims since most of them cannot work to earn money.
- The church should teach its people from family level details about AIDS.

What have you changed mainly?

- My attitude towards AIDS victims
- Number of visitations have improved
- I can share with victims the word of God at present.
- I sometimes share my physical things with some of the victims, e.g. food, money and clothes.

Testimonial number 2:

Name: Mr. Ken Knhoma
Sex: male
Age: 42 years
Marital Status: widower

[65] Radio ABC 88.3 FM is a Christian radio ministry of African Bible College and as part of their regular programming, broadcasts informative information regarding HIV/AIDS and the Christian perspective.

Denomination: Assemblies of God
Relationship with members of HBC: my fellow church members

Initial attitude towards AIDS victims:

- At first I was not scared with AIDS because I had no experience of how serious the disease is. I was comparing it with other STDs.

How were you treating AIDS victims?

- I was not concerned because I was thinking that victims need to face it.
- I could not visit them because of my negative attitude

Present Attitude:

- I have a positive attitude towards victims.
- Looking at ways of getting AIDS, there is a possibility that even innocent people can also be victims.
- I don't regard victims as sinners, but I also think of my responsibility that I have to give them hope though they may be dying
- I do visit the victims.

Is there a need to be visiting them?

- Spiritually there is need to share with them the word of God because as a believer I know that there is life after death.
- Physically these victims need love, comfort and physical needs, so it is the responsibility of each one of us to be helping them

Who taught you about the importance of visiting AIDS victims?

- Through church meetings.
- Through radio broadcast.
- Through NGO.
- Through hospital programs.
- Through HBC.

What comment do you have on the work of HBC in the village?

- It is important to have HBC members within the community
- Members are able to teach family members of the victims improved methods of caring for victims based on the word of God.
- Members are also able to teach through their actions other community members good ways of caring for AIDS victims.

How do you look at the church?

- There is a big difference between how the Church was dandling AIDS issues and how it is doing now.
- At first the church had not enough knowledge about AIDS and it could treat victims as sinners/outcasts. It could hardly visit victims.
- At present many church members including myself take part visiting AIDS victims and even giving them other needs.

Which people are visited?

- All victims are visited including non-church members.

Are there areas of concern?

- The church should continue to visit the victims so as to maintain this hope towards God.
- The church should continue to be assisting by supplying physical needs such as food, clothes, beddings.
- The church should take care of the well-being of victims, eg. Washing victims beddings, etc.
- The church should be teaching its members more about AIDS so thtat they can fully be aware of AIDS.

What have you mainly changed?

- I was not visiting AIDS patients
- I could hardly share any things with victims.
- I could hardly eat with them

At present, what has changed?

- I visit them.
- I share with them the word of God.
- I talk to them freely.
- I share with them the little I have, like food.
- I draw water for them.

References:

Ackerman, D M 2000. *Tamar's Cry: Re-reading an ancient text in the midst of an HIV/AIDS pandemic,* as quoted from a speech entitled '*Involvement of people living with HIV/AIDS – how to make it more meaningfu*l' Cameron, J E at the Second National Conference for PLWA, 8-10 March. Durban.

Adherents.com (2000) *Collection and organization of data*. [online] Available from: http://www.adherents.com/adhloc/Wh_192.html [accessed 8 Feb 2004]

African Journal of Evangelical Theology (AJET) Ed. 2000. The AIDS pandemic: Any solution? *Africa Journal of Evangelical Theology* 19 2, 103-104.

AFRICAN POLICY INFORMATION CENTER, (2000) *WHO Issues new healthy life expectancy rankings* [online] available from: http://www.africaaction.org/docs00/life0006.htm [re-accessed 17 June 2003]

AIDS Interfaith Network: *Some Brief Theological Thoughts on AIDS,* (2002) [online] Available from: http://www.aidsinterfaithnetwork.org/thoughts.htm [accessed 2 September 2002]

Alsworth, L (1990). *Stress, mental health and need satisfaction among Indochinese in Colorado*, Thesis (PhD). [online] available from: http://www.sdp.org/sdp/diss/aylesworth.html, [accessed 4 July 2003]

Altman, L K 1983. Concern over AIDS grows internationally, [online], NEW YORK TIMES. 24 May. available from: http://www.nytimes.com/1983/05/24/

Ayittey, G B N (2000). *CNN Special war on AIDS.* [online] available from: http://www7.cnn.com/SPECIALS/2000/aids/stories/war.africa.aids/ [re-accessed 13 June 2003]

Banda, G 2002. Cultural Behaviours in Malawi that have an impact on the spread of HIV, An overview by a mature Malawian science teacher, [unpublished paper]

Barker, K (gen. ed) 1985. *The NIV study bible, new international version.* Grand Rapids: Zondervan.

Barlow, D L 1992. *Educational psychology: The teaching-learning process*. Herndon, VA: TechBooks.

Barr, D L 1995. *New Testament story, an introduction*, 2nd ed. Belmont: Wadsworth

Bate, S C 2003. Catholic pastoral care as a response to the HIV/AIDS pandemic in Southern Africa. *Journal of Pastoral Care & Counselling* 57, 2, 197-210

Bearak, B 2003. Why people still starve. *New York Times Magazine.* 13 July, section 6, 32-61.

Beresford, B (June 2001). *Africa Recovery, Vol.15# 1-2.* p19 [online] Available from: http://www.un.org/ecosocdev/geninfo/afrec/vol15no1/151aids9.htm [re-accessed 20 June 2003]

Berkhof, H 1973. *Christian faith, an introduction to the study of the faith*. Grand Rapids: Eerdmans.

Berkhof, L 1959. *Systematic theology*. London: Banner of Truth Trust.

Berkhof, L 1933, *Manual of Christian doctrine*. Grand Rapids: Eerdmans.

Best, W E ca. 1991. *The church, her authority and mission*. Houston, TX: South Belt Assembly of Christ.

Boff, L 1986. *Ecclesiogenesis: The base communities reinvent the church*, Maryknoll: Orbis.

Boon, M 1996. *The African way*. Wynberg, Sandton: Zebra

Bosch, D J 1991. *Transforming mission paradigm shifts in theology of mission.* American Society of Missiology Series, no. 16, Maryknoll: Orbis.

Browning, D S 1996. *A fundamental practical theology*. Minneapolis: Fortress Press.

Centers for Disease Control (CDC) (1993). *HIV/AIDS Surveillance Report*. [online] Atlanta, February. available from: http://www.cdc.gov/hiv/stats/hasrlink.htm [re-accessed 8 Dec 2003]

Champagne, E, (2000) *Aids in Africa*, [online] Available from: http://www.cbc.ca/news/indepth/aidsinafrica/ July 2000 [re-accessed 17 June 2003]

Chapman, S, [s a]. *Dogma disputed: potential endemic heterosexual transmission of human immunodeficiency virus in Australia*. [Online] Available from: http://www.virusmyth.net/aids/data/dmchurch.htm [re-accessed 13 June 2003]

Chisala, 2003. Personal interview with Malawian Social Welfare representative.

Chopp, R S (1986). *The praxis of suffering* [online] Available from: http://www.religion-online.org/cgi-bin/relsearchd.dll/showbook?item_id=1935, [accessed 14 Dec 2002]

CHURCH WORLD SERVICE FACT SHEET (2002). *Africa has 10 percent of the world's population, but 70 percent of global HIV/AIDS cases.* [online] available from: http://www.churchworldservice.org/aidsfactsheet.html [re-accessed 13 June 2003]

Church World Service, (2000) (a ministry of the National Council of the Churches of Christ in the U.S.A.) *CWS - Aids in Africa: A Generation at Risk AIDS IN AFRICA* [online] Available from: http://www.churchworldservice.org/aidsfactsheet.htm [re-accessed 18 June 2003]

Clark, H R (1993) *The cure for HIV and AIDS,* [online] available from: http://www.cures4aids.com/ [re-accessed 17 June 2003]

Clowney, E P 1995. *The church.* Downers Grove, IL: InterVarsity Press.

Cochrane, J R, De Gruchy, J W & Peterson, R 1991. *In word and deed: Towards a practical theology for social transformation.* Pietermaritzber: Cluster Publication.

Cole, & Ngewa, S et al (ed.) 1998. *Issues in African Christian theology*. Nairobi: East African Educational Publishers.

Colson, C (2000) *Africa's AIDS orphans: What can Christians do?* Commentary from *BreakPoint*®, 1 May. Prison Fellowship Ministries [online] Available from: http://www.worthynews.com/breakpoint/africa-aids.html [re-accessed 18 June 2003]

Conner M G, (2000) *Understanding the differences between men and women,* [online] available from: http://www.oregoncounseling.org/ArticlesPapers/Documents/DifferencesMenWomen.htm [re-accessed 17 June 2003]

Cowan, L 2002. Raising boys, *Living & Loving Magazine*, Nov.

Crowter, J (ed) 1995. *Oxford advanced learners dictionary of current English,* Oxford: Oxford University Press.

Crunutte, M (2000). *Church breaks silence on AIDS AME leaders struggling to stem crisis in Africa,* Cincinnati Enquirer [online] Available from: http://enquirer.com/editions/2000/07/10/loc_church_breaks.html [re-accessed 13 June 2003]

Dayton, E R et al 1993. *Strategy for Leadership*. Grand Rapids: Fleming H. Revell, div. of Baker Book House.

De Gruchy, J W & Villa-Vicencio, C (eds) 1994. *Doing theology in context, South African perspectives; Theology and praxis: Volume One,* Maryknoll: Orbis.

De Vos, A S (ed) 1998. *Research at grass roots.* 3rd ed. Pretoria: Van Schaik.

Dingemans, G D J 1996. Practical theology in the academy: A contemporary overview, *The Journal of Religion, University of Chicago* 76, 01

Divorce Magazine.com (2003). *Divorce Statistics* [online] Available from: http://www.divorcemag.com/statistics/statsUS.shtml [accessed 27 October 2003]

Dortzbach, K & Nduge Kiiti, (eds.) 1996. *Helpers for a healing community: A pastoral counseling manual for AIDS*, Nairobi: MAP International.

Dudley, C S 1996. *Next steps in community ministry: Hands-on leadership).* New York: Alban Institute.

Forster, P G 1998. Religion, Magic, Witchcraft, and AIDS in Malawi. *Anthropos: International Review of Ethnology and Linguistic* 93 (4-6): 537-545

Foster, G M 1967. *Tzinizuntzan: Mexican peasants in a changing world*. Boston: Little, Brown and Company.

Foster, G M 1967. University of California, Berkeley, *American Anthropologist* 67, 293 – 31 [online] available from: http://ist-socrates.berkeley.edu/~peis100a/lectures_material/Limited_good_chart.htm

Fountain, D E (1998). *AIDS: The 15/45 window,* (Vol. 34, No. 1) [online] available from: http://www.wheaton.edu/bgc/EMIS/1998/aids.htm [re-accessed 22 June 2003]

Fowler, J W 1999. The Emerging New Shape of Practical Theology, 75-92, in*:* Schweitzer, F & Van der Ven, JA (eds.) *Practical Theology: International Perspectives.* Frankfurt: Peter Lang.

Frame, 1985. The Church's Response to AIDS, *Christianity Today* 29, 17, 50-51

Frankel, A P (2002) Moving the mountain, *Princeton University Report to the Circumnavigator's Club Foundation*, [online] available from: http://www.advocacynet.org/pdf/resource/move_mountain.pdf [re-accessed 29 Jan. 2004]

Fumento, M (1989). *The myth of heterosexual AIDS*. New York: Basic Books [online] available from: http://www.virusmyth.net/aids/data/dmchurch.htm [re-accessed 13 June 2003]

GAY AND BLACK GLOSSARY (2002) *Dry sex/wankie,* [online] available from: http://mindprod.com/gglosswankie.html [re-accessed 17 June 2003]

General Board of Global Ministries (GBGM) (1981) [online] (MMWR, 5 June / Vol. 30/ No. 21). available from: http://gbgm-umc.org/health/aids/timeline.stm [re-accessed 13 June 2003]

Gibbs, E & Coffey, I 2001. *Church next, quantum changes in Christian ministry*, Leicester: Inter-Varsity.

Greaves, N 1993. *When lion could fly*. 2nd ed. Cape Town: Struik

Greyling, C 2003. Poverty, HIV, and AIDS – the challenge to the Church in the new millennium. *in* Couture, P D and Miller-McLemore, B J (eds) *Poverty, Suffering and HIV/AIDS, International practical theological perspectives*, 117-136. Fairwater, Cardiff: Cardiff Academic Press.

Grudem, W 1994. *Systematic theology*, Grand Rapids: Zondervan.

Grunlan, S A, et al 1988. *Cultural anthropology: A Christian perspective,* 2nd ed. Grand Rapids: Zondervan.

Guder, D L 1985. *Be my witnesses: The church's mission, message and messengers.* Grand Rapids: Eerdmans.

Hall, D J 1986. *God & human suffering: An exercise in the theology of the cross*, Minneapolis: Augsburg.

Hallman, D G (ed.) 1989. *AIDS issues, confronting the challenge.* New York: Pilgrim Press.

Hauerwas, S G, Bondi, S & Burrell, D B 1977. *Truthfulness and tragedy: Further investigations in Christian ethics*. Notre Dame: University of Notre Dame Press.

Heitink, G 1999. *Practical theology, history, theory, action domains: Manual for practical theology*, tr by R Bruinsma. Grand Rapids: Eerdmans.

Hendriks, H J [2003]. *Studying Congregations in Africa*, Stellenbosch (Forthcoming).

Hendriks, H J 2002. Doing missional theology in an African context. in Hendriks, H J et al, (eds), *Reformed Encounters with Modernity*, 74-83. Stellenbosch: Print24.com.

Hillery, M 2000. The role of community home based care within the church. *HIV Care and Support, Strategic Framework, Family health International*, December 2000.

Hodge, C 1871. *Systematic theology*, London & Edinburgh: Thomas Nelson

Hodge, C [s a]. *Systematic theology, part 1, Theology proper* [online]. available from: http://www.dabar.org/Theology/Hodge/HodgeV1/P1_C01.htm [accessed 25 October 2003]

Hodge, C 1993 (reprinted), *Systematic theology*, Grand Rapids: Eerdmans.

Hoffman, W W & Grenz, S J 1990. *AIDS ministry in the midst of an epidemic*, Grand Rapids: Baker Book House.

Holman, (1992-1994) *Holman Bible Dictionary*, Rairdin, C et al (ed). *Quick Verse For Windows* [CD-ROM] (Version 3.0h) Parsons Technology, Inc.

Hullquist, C G 1988. *Simply Chichewa*, Makwasa, Malawi: Malamulo Publishing House.

Imasogie, O 1993. *Theological perspectives in Africa: No. 5. Guidelines for a Christian theology in Africa.* Achimota, Ghana: African Christian Press.

Jamiseson, P 2003. *AIDS Comment, Women Against AIDS*, The Chronicle Vol. 11 No. 412 10 March-16.

Joda-Mbewe, O L 2001. The Challenges that Face Reformed Christianity in Malawian Cities, in Hendriks, H J et al, (eds), *Reformed Encounters with Modernity*, 24-31. Stellenbosch: Print24.com.

Johnson, S D 1987. Factors related to the intolerance of AIDS victims. *Journal for the scientific study of religion*. 21 (1), 105-110

Kasirye, S 1991. Personal interview with World Relief representative for Malawi

Kennedy, D J 1996. *Evangelism explosion III.* Wheaton: Tyndale House.

Kubler-Ross, E 1997. *On death and dying*, Simon & Schuster

Ligomeka, B (2002) *Many Malawians Are Reluctant to Go for HIV Tests*, Malawi Insider (Blantyre) [online] available from: http://allafrica.com/stories/200209260411.html [re-accessed 17 June 2003)

Linden, I 1975. Chewa initiation rites and Nyau societies, *History of Central Africa*, :30-44

Lippincott, J B 1986. *The Lippincott manual of nursing practice*, Philadelphia: Lippincott Publishing.

Louw, D J 1994. *Illness as crisis and challenge: Guidelines for pastoral care.* Doornfontein: Orion.

Louw, D J 1998. A *pastoral hermeneutics of care and encounter: A theological design for a basic theory, anthropology, method and therapy*, Lux Verbi

MAIL & GUARDIAN, (1999), *Aw, c'mon, you don't really believe those Aids myths*? [online] Available from: http://www.q.co.za/news/1999/9906/990611-aidsmyths.htm [re-accessed 17 June 2003]

MALAWI NEWS ONLINE (1998) January [online] Available from: http://www.sas.upenn.edu/African_Studies/Newsletters/mno39.html [re-accessed 18 June 2003]

MAP International 1996, *Choosing Hope, The Christian Response to the HIV/AIDS Epidemic.* Curriculum Modules for Theological and Pastoral Training Institutions, MAP: Nairobi

Mbiti, J S 1971. *New Testament eschatology in an African Background, A study of the encounter between New Testament theology and African traditional concepts,* London: Oxford.

McBeth, H L 1987. *The Baptist heritage*, Nashville: Broadman.

McQuilkin, R 1995. *Biblical ethics*, 2nd ed., Wheaton: Tyndale House.

Mead, L B 1994. *Transforming congregations for the future*, New York: Alban Institute

Mead, L B 1996. *Five challenges for the once and future church*, New York: Alban Institute

Mendis, D 1987. The 6th commandment and the church's response to AIDS, *Presbyterian*. Spring (13): 29-43.

Mertz, D & Schuklenk, U (1989) Deathly doctrine: Christian churches and AIDS, *Australian journal of public health*, 16(1): 128-41. [online] available from: http://www.virusmyth.net/aids/data/dmchurch.htm [accessed 2 September 2002]

Mertz, D (1989a) [online] Available from: http://www.virusmyth.net/aids/data/dmchurch.htm, as quoted from article, Wallack J J. AIDS anxiety among health care professionals. *Hospital and Community Medicine* 40(5): 507-10. [re-accessed 13 June 2003]

Mertz, D (1989b) [online] available from: http://www.virusmyth.net/aids/data/dmchurch.htm as quoted from article by Austin D, et al. Some determinants of fear about AIDS among Australian college students. *Psychological Reports* 64: 1239-44. [re-accessed 13 June 2003]

Mertz, D (1989c) [online] Available from: http://www.virusmyth.net/aids/data/dmchurch.htm, as quoted from article Bundesgesundheitsamt 1993 AIDS-Fälle und HIV-Infektionen in der Bundesrepublik Deutschland. *Bundesgesundheitsblatt* Nr. 1/1993: 43-47.

Miller, B F et al, 1972. *Encyclopedia and dictionary of medicine and nursing*, Philadelphia: W. B. Saunders

Mirken, B (2000), Dangerous denial of AIDS holocaust in South Africa [online] available from: http://www.aegis.com/news/sfe/2000/SE000402.html, *San Francisco Examiner* – 26 April [re-accessed 17 June 2003]

Mkandawire, F 2002. Radio broadcast on ABC Christian Radio (88.3 FM) 20 October, featuring a report on the *SADAC Leadership Conference* held in Pretoria, SA.

Mohan, T N. 1996. *The life, convictions and martyrdom of Dietrich Bonhoeffer*, (video), Lathika International Film and Entertainment Inc., Distributed by Vision Video, Worcester, PA.

Morgan, T C 2000. Have We Become Too Busy With Death? *Christianity Today*, 44 (2), 36-44

Murray, J 1957. *Principles of conduct, aspects of biblical ethics*, Grand Rapids: Eerdmans.

Musick, M (2000). Theodicy and life satisfaction among black and white Americans. *Sociology of religion magazine.* Issue: Fall [online] available from: http://www.findarticles.com/cf_0/m0SOR/3_61/66498056/p1/article.jhtml?term=sociology+%2Breligion+%2Bresearch [accessed 30 October 2003]

Mwalwimba, M 2003. *The Nation*, (Malawian Newspaper) 12 May

National Centre in HIV Epidemiology and Clinical Research (NCHECR) (1993) *Australian HIV Surveillance Report.* 9(1): 1-32.

Neely, M E (1996) *Lincoln's Failures* [online] available from: http://members.aol.com/RVSNorton/Lincoln42.html [re-accessed 17 June 2003]

Nervi, L 1994. *Malawi*, tr Belotti, M and Ogle, S 1999. 24040 Gorle, (BG): VELAR s.p.a.

Neville, P L (1999) *Modern-day plague afflicts Africa*, [online] available from: http://www.registerguard.com/africa/plague.html, [re-accessed 17 June 2003]

NEW WORLD ORDER (2002) *AIDS, conspiracy and genocide?* [online] available from: http://www.geocities.com/newworldorder_themovie/aids/html, [re-accessed 17 June 2003].

NEW YORK TIMES. 1981. Rare Cancer Seen in 41 Homosexuals [online], 5 July. available from: http://www.nytimes.com/1981/07/03/health/03AIDS.html [re-accessed June 2003]

Newbigin, L 1986. *Foolishness to the Greeks: The gospel and western culture*, Grand Rapids: Eerdmans.

Newbigin, L 1995. *The open secret: An introduction to the theology of mission*, Grand Rapids: Eerdmans.

Ngewa, S., *et al* (ed.) 1998. *Issues in African Christian Theology*, Nairobi: East African Educational Publishers.

Nicholson, R 1994. AIDS: The ethical issues, *Missionalia magazine*. 22 (3), 227-244.

Oxford, 1999. *Oxford advanced learner's dictionary of current English*, 5th ed. New York: Oxford University Press

Pelican Bay State Prison, (ca. 2000*), If the SHU fits: Cruel and unusual punishment at California's Pelican Bay State Prison*. [online] available from:

http://www.punchjurists.com/visitors/PrisonLore/romano1.html [Accessed 4 July 4, 2003]

Phillips, B, (2001) *Baby rape shocks South Africa*, [online] available from: http://news.bbc.co.uk/1/hi/world/africa/1703595.stm [re-accessed 17 June 2003]

Phiri, I A, & Cox, J L, ed. 1998. *Rites of passage in contemporary Africa: Interaction between Christian and African traditional religions,* RCAS: Cardiff Academic Press.

Phiri, K M 1982. Some changes in the matrilineal family system among the Chewa of Malawi since the nineteenth century, *Journal of African History* 24, (2):257-274

Pick, S 2003. *HIV/AIDS our greatest challenge yet! The road ahead for the church in South Africa.* Wellington: Lux Verbi:BM.

Ploeger, A 1999. Practical Theology Theory and the Praxis of the Church, *International Journal of Practical Theology*, 3 (1): 69-93

Population Reports (1999). *Closing the Condom Gap*. (26) No. 1 April, series H, No. 9. [online] available from: http://www.jhuccp.org/pr/h9edsum.stm [re-accessed 13 June 2003]

Porter, C (ca. 2002) *AIDS Epidemic Likely to Reverse Sustainable Development,* Washington File Staff Writer for the USA Embassy in Tokyo, Japan, [online] available from: http://usembassy.state.gov/tokyo/wwwhgl0430.html [re-accessed 20 June 2003]

Probst, P 1999. The sudden fame of Billy Godson Chisupe; Healing, social memory and the enigma of the public sphere. *Africa* 69 (1):108-137

Rairdin, C (1992-1994) *Quick Verse For Windows* [CD-ROM] (Version 3.0h) Parsons Technology, Inc.

Rasmussen, L 1993. *Moral fragments and moral community, A proposal for church in society.* Minneapolis: Fortress.

Root-Bernstein, R S, (1993) *Rethinking AIDS: The Tragic Cost of Premature Consensus*. New York: The Free Press. Quoted [online] Available from: http://www.virusmyth.net/aids/data/dmchurch.htm [re-accessed 13 June 2003]

Rosas, F 2003 Posting on AF-AIDS 26 August, regional forum on HIV/AIDS in Africa, coordinated by the Health & Development Networks Moderation Team (HDN, www.hdnet.org)

Ross, K R 2002. *Following Jesus and fighting HIV/AIDS: Windows on mission 4,* Edinburgh: St. Andrews.

Ruch, F L ca. 1960. *Psychology and life, 6th Ed,* Chicago: Scott, Foresman.

Ruden, S 2000. AIDS in South Africa: Why the churches matter, *Christian Century,* 117 (16), 566-570

Saayman, W 2003. Ex Africa *sempter aliquid novi*: Some random reflections on challenges to Christian mission arising in Africa in the twenty-first century. *Journal of the international association for mission studies*. (XX-1) 39:57-83.

Sanderson, E J 1994. *AIDS – a challenge to the church*, in *Our Time Has Come,* Mbugua ed., Grand Rapids: Baker Book House.

Schaper, R L 2003. *Pastoral care for persons with AIDS and for their families*. [online] available from: http://www.religion-online.org/cgi-bin/relsearchd.dll/showarticle?item_id=329, [Accessed 26 June 2003]

Schlosser, S E (webmaster) (2003) *American Folklore and Heroes* [online] available from: http://www.americanfolklore.net/ff.html [re-accessed 17 June 2003]

Schoffeleers, M 1999. The AIDS pandemic, the prophet Billy Chisupe, and the democratisation process in Malawi, *Journal of Religion in Africa,* 29 (4), 406-493

Schreiter, R C 2002. *Constructing local theologies,* Maryknoll: Orbis.

Scott, W 1987. Mercy and social transformation, in SAMUEL, V and SUGDEN, C ed. *The church in response to human need*. Grand Rapids: Eerdmans.

Scroggs, R 1995. Biblical authority and human sexuality, *Interpretation - Journal of Bible and Theology*, 49 (1), 17-30

Sithole, E (2000) *Mbeki opens AIDS conference stressing poverty,* Reuters NewMedia. 9 July [online] available from: http://www.aegis.com/news/re/2000/RE000714.html [accessed 26 Jan. 04]

Smith, R (2002), *Condom campaign causes stir*, Washington Blade - January 18 [online] available from:

http://www.aegis.com/news/wb/2002/WB020103.html [re-accessed 13 June 2003]

Somlai, A M 1997 The response of religious congregations to the spiritual needs of people living with HIV/AIDS, *Journal of Pastoral Care.* 51:415-426

SOWETAN 2001. *Hit TV Series Explores Religious Attitudes to AIDS* (2003) episode on SABC1, aired June, [online] Available from: http://allafrica.com/stories/200106200225.html [re-accessed 22 June 2003]

Stearns, R E 2001, Mercy impaired: Lets shock the world by reversing our apathy toward African sufferers, *Christianity Today*, 45 (11), 100

Stone, H W 1993. *Crisis counselling (Revised Ed.)*, Minneapolis: Fortress.

Strong, A H 1907, 25th printing 1967, *Systematic theology*, Valley Forge: Judson Press.

Swarns, R L 2000. Comments on AIDS weaken Mbecki, [online], NEW YORK TIMES 1 Nov. available from: http://query.nytimes.com/gst/abstract.html

Teen Challenge South Africa (ca. 2002) *Examining attitudes by looking at AIDS* [online] available from: http://www.tc.asn.au/feature/default.asp [re-accessed 22 June 2003]

Tracy, D 1981. *The analogical imagination: Christian theology and the culture of pluralism.* New York: Crossroad.

UN Integrated Regional Information Networks, (2001) *Girls still dropping out from school*, [online] available from: http://allafrica.com/stories/200109270454.html September 27, 2001, [re-accessed 17 June 2003]

UNAIDS (2000) *Education can help save young people from AIDS* [online] available from: http://www.unaids.org/whatsnew/press/eng/pressarc00/dakar260400.html [re-accessed 18 June 2003]

UNAIDS/PennState Project: 1999. *Communications framework for HIV/AIDS*, p41

UNESCO (United Nations Educational, Scientific and Cultural Organization) 2001. *HIV/AIDS and education*, [online] available from: http://www.unesco.org/education/efa/ed_for_all/background/background_kit_HIV.shtml [re-accessed 17 June 2003]

UNFPA, (2002) *Widespread violence against women in Africa documented*, [online] Fact sheet available from: http://www.afrol.com/Categories/Women/wom003_violence_unfpa.htm [re-accessed 17 June 2003]

UNICEF (2002). [online] *Country statistics, Malawi.* available from: http://www.careinternational.org.uk/cares_work/where/malawi/malawi_stats.htm [accessed 24 July 2003]

UNJPA, (s a). *Promoting reproductive health*, [online] available from: http://www.unfpa.org/modules/factsheets/aids_condom.htm [re-accessed 13 June 2003]

UPCSA (2000). Church profile Uniting Presbyterian Churches in Southern Africa (UPCSA). [online] available from: http://www.cwmission.org.uk/pcsa.htm [re-accessed at site: http://www.presbyterian.org.za/Files/justice.htm 13 June 2003]

US National Research Council. (1993). *Social impact of AIDS*. Washington DC: National Academy Press [online] available from: http://www.virusmyth.net/aids/data/dmchurch.htm [re-accessed 13 June 2003]

USAID (2000), *Abuse of women escalates HIV infections in Africa*, [online] available from: http://www.afrol.com/Categories/Women/backgr_abuse_aids.htm [accessed 17 June 2003]

USAID (2000), *Global Health Report, Africa, Regional Overview* [online] available from: http://www.usaid.gov/pop_health/aids/Countries/africa/ [accessed 17 June 2003]

USAID/Malawi (2002), Community based condom distribution, Ntcheu child survival project (NCSP); USAID/ *Africare Malawi*, [online] available from: http://www.usaid.gov/regions/afr/ss02/malawi.html [accessed 25 June 2003]

Van der Ven, J 1998. *Practical theology: An empirical approach.* Leuven: Peeters.

Van Engen, C 1997. *Mission on the way: Issues in mission theology.* Grand Rapids: Baker Bookhouse.

Van Rensburg, J J 2000. *The paradigm shift: An introduction to postmodern thought and its implications for theology*. Pretoria: Van Schaik.

Vanderkooi, M 1994. *Village medical manual*, Pasadena, CA: William Carey Library.

Warren, P N (1996). *Sodomy law — Does it really prevent AIDS?* [online] available from: http://www.sodomylaws.org/usa/useditorial12.htm [re-accessed 13 June 2003]

Werner, D 1996. *Where there is no doctor*, London: MacMillian.

Westminster Confession of Faith, 1646. 3rd ed. 1990. Atlanta: The Committee for Christian Education & Publications (PCA Bookstore).

Williams, C W 1998. *New directions in theology today, Volume IV: The church.* Philadelphia: Westminster.

Wiltshire, S F 1977. Process theology and God as parent, *Christian Century*, 5 October 874

Wittenberg, G 1994. Counselling AIDS patients: Job as a paradigm, *Journal of Theology for Southern Africa*. (88):61-68

Wong, D L et al 1990. *Clinical manual of pediatric nursing*, 4th Ed. St. Louis: Mosby.

Wood, G G & Dietrich, J E 1990. *The AIDS epidemic, balancing compassion & justice.* Portland: Multnomah.

World Council of Churches. 1997. WCC study document *FACING AIDS – The challenge, the churches response.* Geneva: WCC

World Council of Churches. (2001). [online] available from: http://www.wcc-coe.org/wcc/news/press/01/hiv-aids-plan.html, [re-accessed 12 Dec. 03]. WCC Global consultation on the Ecumenical response to the challenge of HIV/AIDS in Africa, 25-28 November. *Plan of action, The ecumenical response of HIV/AIDS in Africa.* Nairobi: WCC.

WORLD FACTBOOK *(CIA) (*2002), [online] Available from: http://www.odci.gov/cia/publications/factbook/geos/mi.html [re-accessed 17 June 2003]

World Service 2003. *National Council of the Churches of Christ in the U.S.A.* [online] available from: http://www.churchworldservice.org/aidsfactsheet.htm [re-accessed 13 June 2003]

Zhu, T B et al (1998). *The origins of AIDS and HIV and the first cases of AIDS, An African HIV-1 sequence from 1959 and implications for the origin of the epidemic nature*. 391: 594-597 [online] available from: http://www.avert.org/origins.htm [re-accessed 13 June 2003]

Zingani, M (2003) *HIV/AIDS affecting girls education*, The Chronicle Newspaper 20 April (Lilongwe) [online] available from: http://allafrica.com/stories/200304200088.html [accessed 17 June 2003)

Zulu, E 2001. An African response to modernism, in Hendriks, H J et al, (eds), *Reformed Encounters with Modernity*, 4-9. Stellenbosch: Print24.com.