HIV and AIDS knowledge in the pastoral team of Alleluia Ministries International

by
Tlotliso Ntai

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Supervisor: Prof. JCD Augustyn
Faculty of Economic and Management Sciences
Africa Centre for HIV/AIDS Management

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DECLARATION

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ABSTRACT

Churches have a potential to play a vital role in halting the spread of HIV because they are established in almost all communities. The majority of people believe in their spiritual leaders and obey them; therefore, churches can be a perfect platform to reach out to all communities, both in the urban and rural areas.

The purpose of the study was to investigate HIV and AIDS knowledge in Alleluia Ministries International (AMI) pastoral team. AMI is a church, and it has about 20 branches in and outside South Africa (SA), with the membership estimated at 10,000 in SA. Cultural diversity is one of the strengths of this church as the members are drawn from 11 African countries. The study concentrated on AMI branches in Gauteng Province, including the main church in Lyndhurst, Johannesburg, SA.

The researcher conducted qualitative research method, and fifteen pastors were interviewed. Findings showed that there is a need for HIV and AIDS training programme for the pastors, as only 13% of the participants were able answer the questions correctly. A recommendation was made to the church leadership to consider employing specific training providers such as Lawyers, Epidemiologists, Psychologist, etc, to come and speak to the pastors in order to fill the identified gaps.

OPSOMMING

Omdat kerke so goed verteenwoordig is in die meeste gemeenskappe kan hulle ‘n beduidende rol speel in die bekamping van en die verspreiding van die MIV-virus. Die meerderheid van mense binne ‘n gemeenskap glo hulle kerkleiers en kerke kan dus die ideale platform raak vanwaar gemeenskappe in beide stedelike sowel as plattelandse gebiede vir voorligting bereik kan word.

Die doel van hierdie studie was om die kennisvlakke van die pastorale span van die Alleluia Ministeries Suid-Afrika te bepaal. Hierdie kerk het ‘n ledetal van meer as 10 000 mense in Suid-Afrika met ledetal vanuit uit 11 ander lande in Afrika.

Kwalitatiewe inligting is verkry uit onderhoude met 15 pastore van hierdie bepaalde kerk. Resultate van die studie toon duidelik aan dat daar ‘n ernstige kennisprobleem rakende MIV/Vigs onder pastore bestaan. Voorstelle word gemaak om ‘n interdissiplinêre span van regskenners, kenners van die epidemie , sielkundiges en ander kenners te gebruik om voorligtingsessies aan die pastore van hierdie kerkgroep aan te bied.

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May our Good Lord bless you all.

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CHAPTER 1 INTRODUCTION

1.1 Background

Human Immunodeficiency Virus (HIV) cause a disease called Acquired Immune Deficiency Syndrome (AIDS). This has caused human suffering since their discovery in the early 1980's. According to UNAIDS Global report (2010), about 34 million people live with this virus. It affects all aspects of human society, i.e., it transcends racial, religious, political and economic boundaries (Fisher, Foreit, Laing, Stoeckel and Townsend, 2002).

Sub Saharan Africa, considered to be the epicentre of the epidemics, accounts for about two thirds of people living with HIV (PLHIV) globally (UNAIDS World AIDS Day Report, 2011:7). South Africa's (SA) generalised epidemic is reported to have dropped by a third between 2001 and 2009 from 2.4% to 1.5% (UNAIDS World AIDS Day Report, 2011, p 7). The same document indicates that SA's epidemic burden is estimated at 5.6 million people which equals to 17% of the global HIV and AIDS load.

Although we have gone through three decades of this disease, there is still no cure for AIDS. One of the reasons being that the virus keeps on mutating, thereby giving a challenge to the potential medicines developed for cure. However, there are some promising discoveries such as the one that was recently done in SA. Pluses Global HIV/AIDS news and analysis report dated 26 November 2012 titled: "Two South African women may have helped unlock the key to a vaccine to rid the world of one of its deadliest epidemics" (http://www.plusnews.org/PrintReport.aspx?ReportID=96613). They participated in microbisides' trial conducted in Durban in 2005, and few years later, they contracted HIV and have been on antiretroviral therapy since then. Recent study states that "The women were able to produce broadly neutralizing antibodies.... blocking the virus from infecting healthy cells" (http://www.plusnews.org/PrintReport.aspx?ReportID=96613).

While government and other players deserve to be commended for their efforts in trying to combat the spread of HIV, a great number of people still lack general knowledge of HIV and AIDS.

National Strategic Plan (NSP) on HIV, STI's and TB, 2012 – 2016, and the vision is:

- "Zero new HIV and TB infections
- Zero new infections due to vertical transmission
- Zero preventable deaths associated with HIV and TB
- Zero discrimination associated with HIV and TB"

Under one of the objectives of this initiative “sustaining health and wellness”, the emphasis is made on the significance of adherence to treatment which will then results in effective management of HIV.

The aim of United Nations Millennium Development Goal No. 6 is to “combat HIV/AIDS, Malaria and other diseases” (http://www.un.org/millenniumgoals/aids.shtml). Targets 6B says “Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it”. However, SA was unable to achieve this goal because some people living with HIV (PLHIV) still do not have access to HIV treatment, even today.

In an endeavour to halt the scourge, government, in coalition with Faith Based Organisations (FBOs) and Non Governmental Organisations (NGOs) has implemented a number of initiatives targeted at creating awareness, prevention, treatment, care and support.

1.1.1 Advocacy

SA has demonstrated political commitment to tackle the epidemic. Towards this thrust, Mr Kgalema Motlanthe, the Deputy President, was appointed Chairperson of South African National AIDS Council (SANAC), a clear indication that SA government is taking the problem of HIV and AIDS seriously. This is in addition to the President of SA taking a leading role in the HIV Counselling and Testing (HCT) campaign by being the first person to be tested publicly for HIV in order to encourage all South Africans to be tested.

1.1.2 Non Government Organisations (NGO’s)

Many NGO’s play a big role in combating HIV and AIDS in SA. They are mostly active in information dissemination, communication, education, provision of antiretrovirals (ARVs), condoms, care and counselling, as well as hospices.

1.1.3 The Faith Based Organisations (FBO’s) interventions

Churches have a potential to influence behaviour change as the congregation believes in their church leadership. That is why the study is about exploring how much HIV and AIDS knowledge Alleluia Ministries International (AMI) pastors have so that they can be

equipped with necessary knowledge to enable them to handle HIV positive church members in a professional manner.

Some churches do have HIV programmes, but the greatest success has been achieved through coalition with other stakeholders such as Government, Churches, Private Sector, NGOs, and so on. Churches that run HIV and AIDS programmes include Anglican, Roman Catholic, Lutheran and other churches.

1.2 Research Problem

Modern day churches have become strategically positioned in society to deal with the ills and evils that affect communities. As such, the basic principles of compassion, leadership and moral responsibility that people of all faiths embrace should not only be limited to preaching and evangelism but be extended to combating the spread of HIV. However, as alluded to in the previous section, not much is being done by the churches to contain the ravaging epidemic. Most believers and church leaders condemn PLHIV, associating them with acts of sexual immorality. The African Development Forum (2000:16) contends that HIV and AIDS have unfortunately been wrapped up in the question of personal morality by some religious authorities. This judgemental attitude and lack of knowledge of HIV and AIDS within the greater church leadership drives away multitudes of congregants who could not continue bearing the brunt of social injustice (Christian Today, 2006). It is against the foregoing discrepancy that the researcher states the research question as:

“What are the HIV and AIDS training needs pastors at AMI have?”

1.3 Significance of Study

HIV and AIDS have ravaged societies, communities and economies. Indeed, if not properly managed, even the most powerful economies will be crippled. In this vein, the armoury to fight the pandemic must come from all sectors of the society, the church included. It is critical that pastors should be fully conversant and endowed with knowledge on HIV and AIDS. In light of this, the researcher was therefore motivated to explore and document the HIV and AIDS training needs for pastors at AMI.

1.4 Aim of the study

Pursuant of the research question alluded to above, the overall major objective of this study aimed to:

- Propose a pastoral HIV and AIDS training programme at AMI

Appropriate HIV and AIDS training programme will be determined by the level of knowledge pastors have regarding HIV and AIDS. Specific objectives were:

- To establish the level of knowledge pastors at AMI have regarding HIV and AIDS.
- To determine if there is any HIV and AIDS education or training provided for pastors at AMI.
- To identify the needs as perceived by pastors.
- To recommend guidelines for the training of HIV and AIDS for pastors at AMI if required.

1.5 Research design and methodology

In this study, the term “research design” refers to the outline, plan or strategy that specifies the procedure the researcher used in seeking an answer to the research question (Christensen, L.B, Johnson, R.B., & Turner, L.A., 2011,232). It is basically a toolkit of techniques and procedures one uses to collect and analyse data. It is generally agreed (Christensen et al, 2011:29) that modern psychological research can either be experimental or descriptive, a dictonony that can further be likened to the one that exists between quantitative and qualitative research. De Vos et al (1997:237) postulate that the manner in which the researcher structures the research design is informed by the research problem and the kind of data required to answer the question.

Dennin and Lincoln (1994) in Christensen et al (2011:52) define qualitative research as an interpretive research approach that lies on multiple types of subjective data. In complying with this definition, the researcher therefore utilises qualitative research design as it is the best suited to collect and analyse data that would answer the question. In this regard, the researcher collected data using structured questionnaire and personal interviews. Data was analysed using Likert Scale method.

1.6 Definition of concepts

The following concepts are relevant to this investigation and are defined as outlined in the following sub-sections.

1.6.1 Church

The word church assumes different meanings in different situations. An all encompassing definition by Sexual Health Exchange (2004:3) defines a "church" as "an organisation or a group of Christians who have their own beliefs and forms of ownership". It can be a physical building, an open air space where divine services take place. With this in mind, whenever the word "church" is used in this investigation, its meaning will be Christians and their leadership of a given congregation.

1.6.2 HIV

HIV stands for Human Immunodeficiency Virus (Wikipedia, the free encyclopaedia; retrieved on 30.11.2012). The virus can only be found in human blood, not in animals. Immunodeficiency means that HIV destroys the person's immune system. According to UNAIDS (1998:4) HIV is a retrovirus that makes the body weak and less able to fight sickness. HIV destroys the body's immune system so severely that it cannot fight certain diseases. The infected person may live with this virus for a long time without any clinically symptoms. It can take up to a decade or longer, during this time, the virus establishes itself in the body and it is busy replicating itself. The period of time before HIV progresses into AIDS varies widely. During the incubation period, the person would be infectious. It is in light of the foregoing explanation that the researcher will refer to HIV as the virus that causes AIDS.

1.6.3 AIDS

AIDS stands for Acquired Immune Deficiency Syndrome. According to Bennett and Dollan (2010:118) AIDS is defined in terms of either a CD4 T cell count below 200 cells per ml or the occurrence of specific diseases in association with an HIV infection. In the absence of any intervention, HIV progresses into AIDS, in this stage, diseases that are normally mild

become life threatening. This is a terminal period where the patient's immune system has been severely weakened to an extent that it can no longer protect the body from new infections. This condition is called AIDS. In this regard, whenever the researcher refers to "AIDS" it means the weakened condition of the immune system resulting from presence of HIV in the patient's blood.

1.6.4. HIV and AIDS Knowledge

Wikipedia, defines knowledge as "a familiarity with someone or something, which can include facts, information, descriptions or skills acquired through experience or education (en.wikipedia.org/wiki/knowledge; retrieved 30.11.2012). Although there is no single agreed upon definition of knowledge, it is treated as belief which is in agreement with the facts (Russel, B in Wikipedia). HIV and AIDS knowledge therefore means the familiarity with the causes of HIV and AIDS, modes of transmission, how to prevent its spread, the effects of stigma and discrimination on societal discourse and the role the society should play to curb the spread of the pandemic. In the same vein, whenever the researcher refers to HIV and AIDS knowledge, in the study, its meaning would be familiarity with all the issues relating HIV and AIDS alluded to above.

1.6.5 Church Leader

Longman dictionary (1998) defines a leader as "someone who posses power over others or have influence on them". In the context of church, leaders include pastors, elders, deacons, youth leaders and priests who are established in authority over other church members. Some of them are officially entrusted with the duty to preach in the church, administer the church as well as assisting congregants with prayers. For the purpose of this research, church leader refers to those identified church participants shepherding the divine flock.

1.7 Outline of Chapters

The research project will be presented as follows:

- Chapter one of this study concentrated on background information, the problem at hand and the general perception of the church about HIV and AIDS.
- Chapter two reviews the relevant literature on HIV and AIDS globally, in the region, in SA and in Gauteng province.
- Chapter three focuses on the research methods and the justification of the choice of the data collection instrument.
- Chapter four presents the reporting of results and analyses of responses.
- Chapter five gives the recommendation.
- Chapter six provides the conclusion of the research study.

1.8 Conclusion

HIV and AIDS have proved to be the most devastating epidemics mankind has experienced thus far. It knows no boundaries. Its severe impacts are on women and society's most productive population. In light of this, it is imperative for all stakeholders, the church included, to team up in finding solution to the menacing epidemic.

The literature review follows in Chapter two.

CHAPTER 2 LITERATURE REVIEW

This chapter deals with the theoretical underpinnings against which pastors' opinions regarding church investment in the prevention of HIV and AIDS within AMI and the communities where they operate will be investigated. It commences with a discussion on HIV and AIDS' challenges in SA, followed by a general analysis of HIV and AIDS' impact on SA's economy and society. The church, as a critical role player in the discourse of communities has an important role to play in averting the scourge. To this ends, chapter two concludes with a section detailing the church's potential in dealing with problems related to HIV and AIDS.

2.1 SA country profile

SA is the most southern part of Africa, bounded by Zimbabwe and Botswana to the north, Mozambique and the Indian Ocean to the east, Namibia to the west and the Atlantic Ocean to the south to south-west. It has a population of 51.7 million inhabitants, (Statistics South Africa, 2011, released 30 October 2012). SA is composed of nine provinces with Gauteng constituting 1.4% of the total area, but accounting for 23.7% of the total population (12 272 263 people). Gauteng is the industrial hub of the country and to that effect attracts people from all parts of the country and migrants from sub-Saharan Africa who come to work in industries and/or start their own.

The convergence of people of different socio-cultural backgrounds makes SA prone to most communicable diseases. Contrary to the trend, only HIV and AIDS have caused havoc in SA community. SA's epidemic is a generalised one, with prevalence of around 30% (SANAC, 2011,National Strategic Plan on HIV, STI's and TB. 2012-2016). According to UNAIDS & WHO (2006.505), about 5.5 million people were living with HIV and AIDS in 2005, a figure believed to have risen to 5.6 by Statistics South Africa in 2011 (SSA, 2012). This is mainly due to a cocktail of comprehensive prevention measures implemented by the government and all other stakeholders.

The 5.6 million were believed to be the greatest HIV and AIDS burden in the world. UNAIDS country reports 2012 and 2002 give SA's burden as indicated in table 2.1, overleaf.

Table 2.1 SA HIV and AIDS burden in 2002 and 2011

DESCRIPTION	**2002**	**2011**
No of people living with HIV	5 million	5.6 million
Adults Aged 15 to 49 prevalence rate	20.1%	17.30%
Adults 15years and up living with HIV	4.7 million	5.1million
Women aged 15 and up living with HIV	2.7 million	2.9 million
Children aged 0-14 living with HIV	250 000	460 000
Deaths due to AIDS (annually)	360 000	270 000
Orphans due to AIDS (ages 0-17)		2.1 million

Source: *UNAIDS 2002 & 2011 Country Report*

It is clear from the reports that the burden of the epidemics has increased substantially. The government took a bold decision in 2008 to roll out ARV's achieving the target of one million people receiving HIV treatment by 2009 (statisticssa.gov.24.2010).

2.2 HIV and AIDS in the Province of Gauteng

Gauteng has had one of the worst provincial epidemics amounting to 15.2% with a 30.4% among women who attend antenatal clinics, although its epidemic has shown some degree of stabilisation. Its prevalence was estimated to be 10.3% in 2008, a decline from 10.8% (2005). PEPFAR, in partnership with the Gauteng community have implemented comprehensive prevention initiatives, which contributed to this drop.

2.2.1 The historical background of HIV and AIDS in SA

SA diagnosed its first AIDS case in 1983 with first death occurring in the same year (Ras, Simson, Anderson, Prozesky and Hamersma, 1983; 140-2). The figure rose to 46 cases by 1986. During this period, the disease was concentrated in the men who sleep with men

(MSM) sub population. It was in 1995 that HIV infection reached epidemic proportions (Govendor, 2011). Research among men and women aged 25 and above has shown a high condom usage rate. Furthermore, it has been noted that there is knowledge of HIV and AIDS among the 15 to 45 olds, while less than two thirds know the truth about HIV and AIDS among the 50 year old and older.

2.3 Factors impacting on the spread of HIV and AIDS in SA

Lurie (2000, 343) notes that political, social and economic organisations of the society have a significant influence on the speed at which infectious and lethal diseases spread. In the context of HIV and AIDS, the rate at which it affects different societies has been shown to be dependent on:

2.3.1 Poverty

The causal link between HIV and AIDS and poverty is complex. As Whiteside (2001) contends, poverty has and continues to play an important role in the spread of HIV. Poverty drives young girls to engage in transactional, commercial and trans-generational sex. In their research, Ateka (2001) Buve et al (2002) and Evian (1993) discovered that people may have less access to health care services and even condoms. In SA, the average cost of a packet of three condoms is R10.00 in supermarkets, while attracting as much as R15.00 or more in convenient shops normally relied on for purposes of condom purchasing.

HIV and AIDS, on the other hand, have been shown to have the potential to sustain and perpetuate poverty. A household affected by HIV and AIDS is bound to have its income decline; wealth and material wealth go down. When the productive member falls ill, job loss follows, due to weakness of the body, he is unable to till the land. Some spend time caring for the sick compounded by the fact that the household will have to spend more on health care, medicines and funeral expenses. Subsequently, households are pushed into poverty as members sell their sources of livelihoods in order to survive.

2.3.2 Migration

According to UNAIDS (2001.a.1), migration is the movement of people from one place to another, temporarily, seasonally or permanently for a host of voluntary or involuntary reasons. SA has played host to volume of migrants from all over the globe. As Decosas et al (1995; 826) notes, migration disrupts social institutions and family life, and creates stressful environments. The integration of the host culture and the foreign (migrants) induces people to engage in high-risk behaviours.

2.3.3 Structural factors

Socio-cultural traits and beliefs entrenched in most SA tribes contribute to the spread of HIV, among black Africans in most townships. A 2008 study revealed that HIV and AIDS infection in SA is distinctly divided along racial lines (Wikipedia, retrieved 23 December, 2012). Sexual violence against women, the belief that having sex with a virgin cures HIV, widow inheritance; low levels of male circumcision and unique application of the African Ubuntu philosophy to the disease are among the structural factors that have played a pivotal role in the spread of HIV in SA.

2.4 The impact of HIV and AIDS

HIV and AIDS poses the greatest socio-economic challenge mankind has never experienced, it ravages families and communities and leaves a trail of orphans. This section focuses on the impact of HIV and AIDS on SA's economy.

2.4.1 Economy

The high prevalence in the 15 to 49 age group means that the hardest hit are those in their prime productive and reproductive years. At household level, as bread winners fall ill, the loss of income from work means household cannot get improvised. In the event of death, the household may disintegrate and children are sent to live with relatives or left to fend for themselves. This increases the burden on social services.

SA's health care system is not the best in terms of resources; however, the epidemic is exerting more pressure as demands for medication, personal and other services increase. The tax base shrinks as AIDS seriously weakens the taxable population in turn negatively affecting the resources available for public expenditures, resulting in economic growth slowing down. A study in Ivory Coast showed that households with an HIV and AIDS

patient spend twice as much on medical expenses as compared to other households (Over, 1992).

2.4.2 Business and Agriculture

Companies' profits are reduced as workers' productivity gets reduced due to illnesses, absenteeism, the rising costs of providing health-care benefits and the payment of death benefits (Ashford, 2006). Gauteng, the province of study, is renowned for commercial agriculture. Agricultural output is therefore reduced by a loss of farm workers. As revealed in a study conducted by the Food and Agriculture Organisation (FAO), the agricultural workforce will decline by between 10% and 26% by 2020 in 10 Southern African countries severely affected by HIV and AIDS. This inevitably results in growing food insecurity.

2.4.3 Health Sector

The HIV and AIDS epidemic increases the demand for public and private health services while, at the same time reducing the supply due to health sector personnel mortality and constrained health budgets. This increases the burden on health personnel as measured by the ratio of HIV-positive patients to physicians. Even with the thrust on home-based care, it is estimated that the share of hospital beds occupied by AIDS patients ranges from 30 to 80 percent.

2.5 The role of church in HIV and AIDS prevention

The WHO (2003.2) notes that churches can play a key role in HIV and AIDS prevention and care, though they need to collaborate with other public-private agencies. Only through collaboration would the goal of universal access towards HIV and AIDS prevention, treatment, care and support be achieved by 2014 (WHO.2004; 2). The churches have an edge over other agencies in regards to reach. Realising this, the government has encouraged the streamlining of FBOs in HIV and AIDS prevention programmes. In light of this need, the government's AIDS Action Plan spearheaded a national capacity building process for interfaith sector. The outcome was the establishment of an interfaith programme called Faith Organisation in HIV/AIDS Partnership (FOHAP) in 2002. All religious faiths participate in FOHAP; i.e. Christians, Jews, Buddhists, Muslims, Hindus and African Independent Churches (AIC). Faith leaders are capacitated on HIV and AIDS prevention initiatives through provincial workshops (Sexual health Exchange.2004:1).

2.5.1 The church's perception about HIV and AIDS

Religion of any kind shapes everyday beliefs and activities. To this end, many Christians, just like the olden Jewish religion, attribute AIDS to punishment from God for sins committed by an individual or his/her family. But in John 9:1-7, Jesus told his disciples that a man's sickness had nothing to do with sin (Happonen and Okaalet, 2002). For "Neither this man nor his parents sinned". Instead of providing care and hope, some churches have propagated the epidemic through stigmatising and discriminating against PLHIV.

The classic role of the church is to accommodate everyone. However, churches have been reported to be shunning those members who become infected with HIV. Of great interest is the marked variation on churches' perceptions about HIV and AIDS as a divine punishment. Henry (2006:1) notes that Anglican Church in Africa has begun offering bible studies on safer sex and HIV and AIDS prevention programmes.

Muslims believe that HIV and AIDS is a problem facing everyone. To this end, they are working in partnership with other organisations in training and offering guidance on HIV prevention, treatment and care issues (USAID, health Policy Institute. August 2008). This lack of general consensus on HIV and AIDS by different Faith Based Organisations is due to the country's democratic constitution that deliberately allows for freedom of worship and association of various religions and cultural traditions.

Thus, the church has been involved in activities targeted towards containing the epidemic. As Sexual Health Exchange (2004; 1) notes, FOHAP's objectives are a clear testimony of the role churches have been playing. These objectives are:

- To critically reflect on the current response of FBOs to HIV and AIDS and explore the key challenges facing the sector;
- To provide a platform for sharing ideas and experiences to assist participants in their future HIV and AIDS planning; and
- To facilitate networking and collaboration across faiths, and between this sector and broader HIV and AIDS initiatives.

The body of literature of HIV and AIDS records the involvement of the church in the fight against the spread of HIV as early as 1986 when the World Council of Churches (WCC) issued a statement that ".... many churches share the responsibility for the fear that has swept our world more quickly than the virus itself" and called on its members to respond appropriately to the need for pastoral care, education, prevention and social ministry (WCC.2006).

2.6 The church's response to PLHIV

Stigma and discrimination have fuelled the spread of the epidemic particularly where HIV sero-positivity is perceived as a sin. This moral role of faith groups entrenched the structural determinants of the epidemic (Cannell, 2008;1). Connel (2008) calls upon the church to try and care for the sick and raise HIV and AIDS awareness. A leading example is the noble commitment by WCC which stated that "stigma and discrimination of people living with HIV is a sin and against the will of God" (Contact, 2006; 18).

Josephs (2006) states that stigma thrives on misinformation and denial. It is vital; therefore, that the church confronts all HIV and AIDS related issues with courage and compassion. The best strategy to fight stigma within the realm of faith, is to use HIV positive religious leaders to live openly and positively, in the process of overcoming self-stigma and shame and become agents of change in their congregations and communities (Health Policy Initiative;2008). A notable example is the Tanzania Network of Religious Leaders Living with or Personally Affected by HIV and AIDS (TANERELA), which is an organisation of HIV positive religious leaders who publicly disclosed their status to the Media (USAID, Health Policy Initiative; 2008). Similarly, pastors in SA should be the first people to open up (religious commitment) and make HIV and AIDS a problem of all humanity that affects everyone. The generalised nature of the SA epidemic calls for the church to make it its business to have care and compassion as their weapons to fight stigma (World Vision; 2001; 1).

2.7 The church, HIV Prevention and the use of condoms

Although the efficacy of condoms as a prevention measure has been proved to be more than 90%, research on condom use in SA townships shows strikingly low rates. Reasons

range from cultural beliefs about sex with a condom, myths on “virgin cure”, gender inequality to socio-economic status of women. Given that 5.6 million are living with HIV in SA, organisations must develop public-private partnerships in the fight against the epidemic by promoting prevention, cure, treatment and support services. FBO’s are among the organisations that should play a pivotal role in educating and making condoms accessible to the general population. However there is no generally agreed position within the church domain concerning the use of condoms for HIV prevention.

The Roman Catholic Church Leaders concluded a debate on condoms by saying that the widespread and indiscrimination promotion of condoms is an immoral and a misguided weapon on the battle against HIV and AIDS since it undermines abstinence and marital fidelity (DeYoung, 2001;1). Although Pope Benedict XVI (the Roman Catholic Church head) accepts the role condoms play in saving life, he views condoms as interfering with the creation of life, hence their use is sin (Wynne, J.J.,2012 in the Telegraph. The Pope drops Catholic ban on condoms in historic shift. 8 August 2012). This is a landmark shift from the previous proclamation such as the one on 13 August 2001 in Pretoria, SA.

However, different churches hold different viewpoints on the use of condoms as a prevention tool. For example, in Uganda, the Anglican church views condoms as tools for HIV and AIDS prevention, while Muslims’ view is to use them to preserve life (Sexual Health Exchange, 2004:7) The whole condom use dichotomy is premised on false information as evidenced by the president of the Vatican’s Pontifical Council for the Family – Cardinal Alfonso Lopez Trujillo in 2003. He claimed that condoms were permeable to HIV. In light of the lack of scientific knowledge about HIV and AIDS, church leaders need training so that they become HIV and AIDS competent.

2.8 HIV and AIDS Counselling and the church

Counselling is a vital strategy in any disaster and in the context of HIV and AIDS prevention. The church’s position in societies makes it the best avenue for behaviour change. Churches and their leaders can shape social values, increase public knowledge, influence opinion, enlighten attitudes as well as redirect resources for spiritual and social care. The church can also raise funds for prevention, care and support, and promote

action from the grass roots up to the international level (Happonen, Jarvinen, and Virtaneu, 2004).

In contrary, studies worldwide have shown that pre and post HIV testing counselling have a negative effect on high-risk sexual behaviour. Consequently, a number of churches have encouraged the congregants into action; created awareness; established HCT Centres and brought hope.

The church leaders are expected to be true Lord's messengers to the people as stated in Malachi 2.7 "For the lips of a Priest ought to preserve knowledge, and from his mouth men should seek instructions..." Church leaders should provide HIV and AIDS counselling to everyone who needs it.

Church leaders' counselling kit should contain biblical (spiritual) and clinical counselling. As Qubudu (2008:6) aptly notes, "the provision of spiritual and moral care to people infected and affected by HIV and AIDS is necessary because they may experience a range of difficult emotions, including fear of death, depression, suicidal ideation, guilt, anguish, denial, shock and rejection".

2.9 Conclusion

This chapter has unlocked the theory underlying the epidemic from its historical perspective through the role the church ought to play in managing the epidemic. Noted also is the important need to train church leaders so that they competently deal with people infected and affected by the epidemics as they seek to give hope to their congregants and the community at large.

CHAPTER 3 RESEARCH METHODOLOGY

The investigation was primarily concerned with HIV and AIDS knowledge in church leadership, particularly AMI pastors, which will enable them to participate meaningfully in the fight against the epidemic. In this chapter, the researcher focuses on the specific techniques employed, the specific instruments used and the series of activities performed in exploring the nature of HIV and AIDS knowledge AMI pastors need.

3.1 Problem Statement

AMI Head Office is situated in Lyndhurst, Johannesburg, SA. Head Office, which also serve as a branch, has about 4,500 members, about 70% of these members are Africans, and 28% are Coloureds and Indians, whereas 2% are Whites. AMI members are drawn from 11 countries from around the world. This church has 12 branches in Gauteng Province. In SA, AMI has branches in Lyndhurst, Midrand, Pretoria, Ennerdale, Sandton, Fourways, Braamfontein, Kempton Park and Bedfordview. AMI pastoral team in Gauteng Province comprises fifteen men and six women deployed in various branches.

One of the responsibilities of AMI pastors is to do spiritual counselling to church members. During these counselling sessions, it has been found that some church members are infected by HIV. Pastors encourage church members to put their trust in God as the bible says nothing is too hard for God, “I am Jehovah, the God of all flesh: Is there anything too hard for me? (bible.cc/Jeremiah/32-27.htm). AMI pastors support, encourage and strengthen church members so that they may be able to cope with various challenges of life, HIV being one of those. Counselling seems to be helping church members to live positively and not give up; therefore they are able to live a long and happy life in spite of their health condition.

The biblical teaching which church philosophy supports forbids people to have sex before marriage; studies indicate that majority of people acquire HIV through unprotected heterosexual sex with HIV positive partner. Therefore abstaining from sex is an effective HIV prevention strategy. But there are challenges presented by some cultural practices in this regard. When two people have agreed to get married, usually the man pays lobola before the wedding takes place. Traditionally the couple is regarded married once lobola has been partially paid. Therefore such a couple is at liberty to be involved sexually at that moment. At AMI, couples are encouraged to be tested for HIV before they get married.

Based on the test results, the couple can decide whether they will have children or not, or to begin the treatment if they happen to have HIV. If they are HIV negative they will make sure that they pursue a lifestyle that will help them to maintain their HIV free status. Any sexually transmitted diseases should be treated as soon as possible as people in this condition are vulnerable to contracting HIV.

Due to ignorance, people have been rejected not only in the society, but in their churches as well, so stigma prevails among PLHIV and they are ashamed to visit clinics for treatment. Others hide their HIV status, so they continue to infect their sexual partners secretly. In the event where two partners are HIV positive, they should continue to practice protected sex as one of them could be infected with a different strain of HIV.

Some people believe that the epidemics are a punishment from God for the sins they have committed (Garland and Mike.2005) while others believe that Christians cannot have this virus. The judgemental pastors cause people to leave churches, the victims become withdrawn due to stigma (Christian Today. 2006). Such perceptions need to be addressed so that pastors may have a deeper knowledge of HIV and AIDS, and the problems above will be averted. Clearly, some AMI members live a risky sexual behaviour since few young girls have fallen pregnant out of wed-lock. We do not know what the youth are falling prey to, for example, some may be infected with Sexually Transmitted Infections (STI's) due to indulging in unprotected sex.

The pastoral team of AMI has not fully addressed the HIV epidemic issues for example, in the church there are no guidelines in place for providing counselling for church members who are affected or infected by the epidemics and the church does not have HIV policy.

Some of our church members seek guidance from the pastors concerning how they should deal with HIV infected spouses. Some of these people opt to divorce due to fear of being infected by their spouses. To other couples, divorce is caused by anger because HIV negative partner thinks that the spouse has been sleeping around, this behaviour indicate lack of education about HIV and AIDS. In the nutshell, this morbidity is very complex and people react differently when they discover that they are infected by HIV. Therefore, it is important that there is a place where they can seek help when they are faced with a situation such as HIV in order to prevent foolish actions such as suicide, and church has a potential to help such people.

Since some of AMI members come from different countries there is a possibility that they are vulnerable to contracting HIV as a result of hard life conditions in Johannesburg caused by unemployment. Most of them came to Johannesburg seeking greener pastures, so young girls or women fall prey to becoming Sex Workers just to make a living. The issue of HIV and AIDS among migrant labourers is a challenge in the whole world. "Migration increases the risk of HIV infection" (International Journal of STD and AIDS.2003). Research question is given as:

"What are the training needs that pastors at AMI have regarding HIV and AIDS?"

3.1.1 Research Approach

The investigation employed a qualitative method utilising a questionnaire as a data collection instrument to explore the various HIV and AIDS issues AMI pastors in Gauteng Province should know. A research design is a plan or blueprint (De vos; 2005) of how the researcher intends to conduct the study. Given the explanatory nature of this study, a research design utilising participatory approach is the most appropriate method.

Bogolan and Bitclen (1992) in Ashleigh (2005) identified five key features of qualitative research, one of which is the natural setting is the data source and the researcher is the key data collection instrument. In this regard, in-depth questions were designed to determine AMI pastors' HIV and AIDS' knowledge requirements as to contribute effectively to the fight against the epidemics. Systematic research encompassed specific methods to collect data, deliberation on the significance of the results obtained, and an explanation of any limitations experienced (Saunders et al, 1997:1).

3.1.2 Qualitative versus Quantitative approach

A research study can be either quantitative or qualitative; the choice is based on the research problem, aims and objectives. Scholars such as Mintzbert (1973), Hodgson, Levison and Zalezink (1965) favour quantitative approach due to lack of objectivity and internal validity of qualitative results approach (Ashleigh, D.A.; 2005). Because results may be questionable, it is difficult to compare the results of studies concluded by different researchers (Gill and Johnson 1977; 15(in Ashleigh 2005).

The reliability, validity and generalizability of the measurement under quantitative approach means the research is scientific and based upon formulating the research hypothesis and verifying them empirically in specific set of data (Frankfort-Nchmins and Nachmias;1992).

On the other hand, qualitative method fails to provide the researcher with information on the context of the situation where the studied phenomenon occurs. Furthermore, it is inflexible in that, it cannot control the environment where the respondents provide the answers to the questions in the survey.

Qualitative research approach is best when designed to explore the human factor and cause-and-effect nuances. The interplay between the researcher and the interviewee has a bearing on the results. Carsell and Symon (1994) (in Matveew,AX 2002) state that qualitative research is less driven by specific hypothesis and categorical frameworks and more concerned with emergent themes and idiographic descriptions, hence the approach offers flexible ways to perform data collection, subsequent analysis, and interpretation of collected information as well as descriptive capability based on primary and unstructured data.

The researcher chose qualitative as it goes well with the research question – namely "What are the training needs that pastors at AMI have regarding HIV and AIDS?" The literature review revealed that not much research on this subject has been done. This qualifies the research to be exploratory one. According to Roodt (1992.30) exploratory research is a study that investigates a research question on which there has been no significant research.

3.2 Sampling

3.2.1 Study setting

The current research study was based on the AMI pastors in Gauteng Province, SA. Although the denomination has branches in and outside SA, Gauteng has the greatest pastor population size serving more than 75% of the entire congregants. Aside of this, Gauteng has the second highest provincial HIV prevalence (UNAIDS Country Report, 2011). The church's pastoral team has members from diverse socio-cultural backgrounds

such as Zimbabweans, Zambians, Congolese etc, as well as Africans and Coloured from South African.

3.2.2 Study Population

The population is the full set of elements (Christensen et al., (2011; 150) or people from which the researcher sampled. In this regard, the population comprises 15 out of 20 pastors in the Gauteng Province. It includes men and women who have been recognised for at least two or more years.

3.2.3 Sampling

Christensen et al., (2011; 150) defined sampling as "referring to drawing elements from a population to obtain a sample." It is thus the process of obtaining a representative set of elements similar to the population on all characteristics. That is to say, a sample is just a "mirror image" of the population from which it was selected (Christensen et al., 2011).

The researcher utilised convenience sampling principally because it provided some benefits; only pastors in and around Johannesburg were easily accessible to participate in the study. Their participation afforded them opportunity to learn more about HIV and AIDS issues. The sampling frame was all the AMI pastors in Johannesburg. A register of pastors was used to determine pastors who were at least two years and more in the team and the sample size was 15. As put by Christensen et al., (2011), a population of less than 100 people does not require a sample but include the entire population, hence the inclusion of all 15 pastors who meet the criteria. This was done despite awareness of the weakness of this non-random sampling technique. The details indicated on Table 3.1 attached overleaf:

Table 3.1: AMI Branches in Johannesburg

Branch	**Female**	**Male**	**Qualification for study based on period recognised**
Sandton		X	X
Kempton Park		X	X
Bedfordview	X	X	XX
Braamfontein		X	X
Fourways	X	X	XX
Midrand 1	X	X	XX
Midrand 2	X		X
Midrand 3		X	X
Main Church	X	XX	XXX
Edenvale		X	X

3.2.4 Ethical considerations

All primary ethical requirements of a research of this type were complied with, i.e. the submission of the proposal, participation information sheet, the questions guide and consent forms were submitted to the Departmental Ethics Screening Committee (DECS) of Stellenbosch University to obtain ethics' clearance. The purpose of this committee is to ensure that the study contains all ethical and legal issues required to carry out a research. Subsequently, the rights and dignity of the interviewees should not be violated.

The study took place after the approval of the proposal by DECS. Simple English was used in this study as all pastors at AMI understand English well and the truthful feedback was obtained. Participants were assured of the confidential nature of their responses as their names were not asked anywhere in the questionnaire. Again all interviews were preceded by in-depth explanation of the purpose of the study, explanation of how the interviews were to be conducted, followed by the signing of the informed consent form by the participant.

Further, interviews took place in a private setting and respondents were assured that the information obtained would be treated as confidential.

3.2.5 Research Instrument

The researcher conducted face-to-face interviews with the respondents using a structured questionnaire. Interviews took place at AMI offices in Lyndhurst, Johannesburg. An interview took between 20 to 30 minutes. Letsela (2008) concurred with Babbie (2008) on the benefits of face-to-face interviews. Apart from higher response rates, interviews have the advantage of giving the detailed information because the researcher has a chance to observe a non-verbal communication of participants (cited in Mafisa, M.A., 2012). The interviews were preceded by reading out the written participation and informed consent forms, Addendums A and B, attached under addendums, by the researcher to ensure that the participants understand the purpose for interview and that, should they feel uncomfortable during the interview, they have a right to withdraw from the study. This process was followed by signing of the consent form by participants as a confirmation that they have volunteered to participate in the study.

The researcher was assisted by AMI Head Office Administrator, who facilitated appointments with the respondents. Data collection took about two months to complete; conducting two interviews per weekend. Interviews were conducted as shown in Table 3.2 overleaf:

Table 3.2 Schedule of interviews

Date	**Branch**	**People interviewed**
6 October 2012	Bedfordview	Interviewee 1
22 October 2012	Braamfontein & Pretoria	Interviewee 2 & 3
3 November 2012	Sandton	Interviewee 4
10 November 2012	Fourways	Interviewee 5
26 November 2012	Midrand	Interviewee 6 & 7
1 December 2012	Enerdale	Interviewee 8
8 December 2012	Kempton Park & Fourways	Interviewee 9 & 10
16 December 2012	Bedfordview & Midrand	Interviewee 11&12
17 December 2012	Sandton & Main Branch	Interviewee 13, 14 & 15

3.2.6 Data Analysis

The research data was analysed quantitatively. The researcher coded the responses, that is, responses to a particular topic were put together. A tally table was prepared. No statistical analysis tool was used other than percentages of those who agreed or disagreed.

3.2.7 Limitations of the study

The majority of AMI pastors are business men and women; therefore it was difficult to schedule the meeting with some of them as they may have been on business trips outside SA.

CHAPTER 4 RESULTS

The results are presented in three sections, namely:

- Participant information.
- Participants' general knowledge on HIV and AIDS issues.
- Perceived role the church should play in the fight against the epidemic.
- Pastors' view on required HIV and AIDS knowledge or training needs.

4.1 Analysis of Responses

The Table below is a frequency table summarising the responses.

Table 4.1: Frequency distribution of responses

Question	Negative (Disagree)		Positive (Agree)	
	Frequency	Percentage	Frequency	Percentage
1	14	93	1	7
2	2	13	13	80
3	15	100	0	0
4	2	20	13	80
5	14	93	1	7
6	12	80	3	20
7	15	100	0	0
8	5	33	10	67
9	0	0	15	100
10	15	100	0	0
11	1	7	14	93
12	11	73	3	20
13	2	13	11	73
14	14	93	1	7
15	4	27	11	73
16	15	100	0	0
17	11	73	4	27
18	6	40	7	47
19	1	7	14	93
20	10	67	3	20

4.1.1 Participants' information

Although it is the norm in any research of this type to illicit demographic information on the respondents, this study deliberately left questions on this subject. The assumption was that; they are all of the same denomination and length of leadership experience (period of pastoral work) was part of the selection criteria. Finally, the researcher wanted to use observation to determine some obvious demographic characteristics such as gender and race.

During the interviews it was noted that out of fifteen pastors, five were female pastors.

4.1.2 Participant's general knowledge on HIV and AIDS

The general knowledge section was designed to test pastors' understanding of HIV and AIDS issues. Questions in this section included:

- Scientists have found a cure for Acquired Immune Deficiency Syndrome (AIDS).
- HIV/AIDS was discovered in the early 1980's.
- If you stay with someone suffering from AIDS, you must always open the windows; otherwise you are at a risk of being infected by the virus.

4.1.3 HIV and AIDS Awareness

Generally, HIV awareness is high among the pastors. All pastors were able to indicate when and where HIV and AIDS cases were first discovered.

4.1.4 HIV/AIDS knowledge

The majority (93%) of pastors displayed greater understanding of HIV and AIDS issues. This could be attributed to the integration of HIV and AIDS in Sunday sermons at the head office. The church has made a policy to talk about HIV and AIDS issues in their Sunday sermons. Among the testimonies of church members, some people have disclosed their seropositive status and how they were healed at AMI.

Overall responses to questions three to five show that pastors have sound knowledge about HIV and AIDS; however, it appears the greatest challenge is in implementation, practising and dissemination of knowledge to lower levels of the church.

4.1.5 Modes of transmission

Questions six to seven focused on the modes of transmission of HIV. The questions were designed in a Likert Scale item like measurement with four possible responses. Strongly Disagree and Disagree were treated to mean a negative response while Agree and Strongly Agree meant a positive response.

All pastors answered in the negative to the question on the virus being transmitted through utensils.

4.1.6 HCT and the role of the church

The general feeling was that people should receive proper counselling before and after testing for HIV. However, there was no consensus on the role the church should play before solemnising marriages. One group (66%) was of the opinion that the church should force people to go for HCT prior to marriage. Others felt that it was an individual's decision whether to go for HIV testing or not. The church should only play an advisory role while not making it mandatory.

4.1.7 Post-Exposure Prophylaxis/ sero discordance

Most pastors (93%) agreed that once raped or exposed to infected blood, one must seek medical treatment within 72 hours. This is a clear indication that modes of transmission are known and that ARV's though not absolute cure, have the potential to reduce the risk of getting infected.

The question on discordance was also answered in the negative indicating that pastors have knowledge that discordant couples can live together and maintain discordant status. One participant raised a question on whether this scenario could be sustained. The researcher explained that to be sure of maintaining the status, it was imperative that the

sero negative partner uses prevention whenever they have sex while the HIV positive partner tries to live positively.

4.1.8 Identification of people most at risk of being infected by HIV

Although the question was not age-group exhaustive, most pastors felt the 15 to 49 year olds are not the most infected. This question could have been misunderstood to mean the age-group only affected by or infected with HIV. This response avails opportunities for designing comprehensive HIV and AIDS education programmes targeted at the church leaders; with the aim of addressing these information gaps.

4.1.9 The role of the church

The majority of the pastors know the role of the church is not only confined to spiritual matters. Answering question 16 on the negative was clear confirmation of the vital role the church should play in the fight against the epidemic.

4.1.10 Provincial distribution of the epidemics

This question was not explicit with regards to provincial prevalence. However, most (seven out of fifteen) disagreed that Gauteng ranked first in the country on HIV prevalence.

4.1.11 Knowledge about Mother-to-Child Transmission

Ninety-three percent of pastors answered this question in the affirmative signalling knowledge about the efficaciousness of ARV drugs in preventing transmission particularly from mother to child.

4.1.12 Conclusion

The responses indicate a considerable level of HIV and AIDS knowledge among AMI pastoral body. HIV and AIDS awareness is high as evidenced by sermons incorporating

HIV and AIDS confessions. Contrary to common belief, pastors are aware that the church could play a pivotal role in managing the epidemic.

CHAPTER 5 RECOMMENDATIONS

The old adage “information is power” holds water in the context of HIV and AIDS management. It is globally agreed that to contain HIV and AIDS, a continuum of interventions including prevention, treatment, nutrition, healthy life-style, care and support should be implemented. The efficacious of these depends on a knowledgeable society. Communities need to know the transmission modes, the value of HCT, preventive measures and the role communities can play in the containment of the virus.

The burden is on knowledge agents to disseminate information to their constituents. Pastors, therefore, as influential community members are best placed to reach the communities. Hence they are the ones, needing training so that they eradicate myths and confusion about HIV and AIDS.

Pastors usually come through induction programmes designed to equip them with the dictates of pastoral work. In light of this, it is suggested that HIV and AIDS should be part of the curriculum of this induction course, at least. Just like they are made custodians of the spiritual component of human life, pastors need to know that they have a moral obligation to manage HIV and AIDS in the communities they work.

One interesting discovery made by the research is testimonies by PLHIV during church services. This indicates that the church embraces the challenges the epidemic poses to its members, and believes that divine intervention can cure the disease. The researcher thus recommends that pastors team up with all stakeholders in the management of HIV and AIDS. This concerted effort will ensure PLHIV receive the whole package on the continuum.

Modern churches, just like most organisations require HIV and AIDS competent leaders. Theology being the field pastors specialise in, should be blended with HIV and AIDS.

CHAPTER 6 CONCLUSION

This study was done with the aim of establishing the HIV and AIDS knowledge gap among AMI pastors in Gauteng Province. Implicit in the study was determination of pastors' perceptions about the role of the church in the management of HIV and AIDS.

SA's epidemic burden has compelled all stakeholders to pool their resources towards intervention programmes to halt the spread of the epidemic. The church in general, is one that has been spearheading initiatives to create HIV and AIDS awareness, prevention, treatment and psychosocial measures. This research has revealed encouraging scenes. AMI believes the church is a place where PLHIV can find comfort, hope and love.

The knowledge that pastors demonstrated was not ample and consistent. They showed various gaps regarding knowledge in different HIV and AIDS topics. This acts as a barrier in their efforts to conscientise the congregants and the communities around them. However, knowledge displayed by two of the pastors was thorough. It is envisaged that if all pastors' knowledge gets to this level, they could effectively use their influence on the community to help in management of HIV and AIDS. If training on HIV and AIDS issues is carried out among pastors and other church leaders, church leaders could play a very important role, especially in programming areas such as counselling, awareness and support.

The inconclusive nature of the study, therefore, makes further research on the information needs of pastors necessary so as to develop informed HIV and AIDS training packages. In spite of the above, the study's revelations provide clear signals for the need to train pastors on HIV and AIDS issues. The World Council of Churches (1997) says that the general conduct of churches is "worsening the problem" (Happonen et al, 2002). With that said, there is a great need for pastors to be trained so that they may have a deeper HIV and AIDS knowledge.

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Addendum A

Participation information sheet

HIV knowledge in the Pastoral team of Alleluia Ministries International (AMI)

In partial fulfilments of the requirements of the Master Philosophy Degree in HIV/AIDS Management from the Africa Centre of HIV/AIDS Management at Stellenbosch University, I am carrying out a study with the above title. The information you will supply is for academic purposes and will be treated with confidence. The purpose of this study was to gather baseline information on AMI Pastor's knowledge on HIV/AIDS. Through the questionnaire I intend to ask the following research question " How much knowledge to AMI Pastors have on HIV/AIDS?

The aim of the study is to:

- Propose a pastoral HIV and AIDS training programme at AMI

Appropriate HIV and AIDS training programme will be determined by the level of knowledge pastors have regarding HIV and AIDS. Specific objectives were:

- To establish the level of knowledge pastors at AMI have regarding HIV and AIDS.
- To determine if there is any HIV and AIDS education or training provided for pastors at AMI.
- To identify the needs as perceived by pastors.
- To recommend guidelines for the training of HIV and AIDS for pastors at AMI if required.

Addendum B

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jou kennisvennoot • your knowledge partner

STELLENBOSCH UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

HIV knowledge in the Pastoral team of Alleluia Ministries International (AMI)

You are asked to participate in a research study conducted by Tlotliso Ntai, Master of Philosophy in HIV/AIDS Management, from Africa Centre for HIV/AIDS Management at Stellenbosch University. The results will be contributed to research paper, thesis or dissertation. You were selected as a possible participant in this study because one of your roles at AMI is to provide counselling to church members.

1. PURPOSE OF THE STUDY

To ascertain the level of HIV and AIDS knowledge Pastors at AMI have in order to establish training needs for improved HIV and AIDS' support for AMI church members.

2. ROCEDURES

If you volunteer to participate in this study, we would ask you to do the following things:

Please give a detailed answer to all the questions. As the questions are being read to you, you are welcome to stop the investigator if she is reading too fast, and you may request that the question should be read again. You are free to stop the researcher if you feel that any of the questions should need further explanation. At the end of the interview, you will be requested to read the answers you have provided to ensure that your answers have been accurately recorded and that important information has not been left out.
The questionnaire should take 40 minutes and one hour to complete.

3. POTENTIAL RISKS AND DISCOMFORTS

There is foreseeable discomfort in participating in this study, AIDS helpline number will be provided for you to call should you need any assistance.

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

There is a potential to acquire professional counseling skills in HIV/AIDS which will help the Pastors to have confidence when providing counselling to church members.

There is potential of making extra cash for Pastors by involved in other HIV Counseling initiatives outside church. Pastors will be able to help their family members as well as their various communities with HIV/AIDS matters. There is a possibility of increase in number of membership retention which will lead in the growth of the church as people learn that our church accommodates respects and cares for people who live with HIV and their rights are protected.

5. PAYMENT FOR PARTICIPATION

No payment will be made to the participants in this study.

6. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of not using people's names; only codes such as Participant A or Participant B will be used for confidentiality purposes. Electronic data will be password protected and only the researcher will have access to this information. Hard copies of the questionnaire will be kept in a locked up cupboard in the researcher's office. The information will be trashed after six months of completion of the study.

Information will only be released to other party if there is a requirement by law or in an event where another researcher is conducting the same study for further development or improvement.

Organisation's real name or participants' names will not be used

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact Tlotliso Ntai; Principal Investigator; 49 2nd Avenue, Kew, Johannesburg; Tel: 011 676 7250 and emergency number 082 997 2103 or Prof Johan Augustyn; Stellenbosch University, Cape Town; Tel: 028 316 4667, Emergency no. 0836263081.

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was described to me by Tlotliso Ntai in English and I am the participant in command of this language. I, the participant was given the opportunity to ask questions and these questions were answered to my satisfaction.

I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

_____

Name of Subject/Participant

_____

Name of Legal Representative (if applicable)

_____ _____

Signature of Subject/Participant or Legal Representative Date

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____ [*name of the subject/participant]* and/or [his/her] representative _____ [*name of the representative]. [H*e/she] was encouraged and given ample time to ask me any questions. This conversation was conducted in English and no translator was used.

_____ _____

Signature of Investigator **Date**

PA,Nvl, Wlt, Syd, Tim, Bil, Fran, Chris, Ste, TK, Ali, Than, tl, cel, chr, jack, mar