PASTORAL CARE AS COMMUNITY CARE: TOWARDS AN INTEGRATIVE APPROACH TO HEALING AND WELL-BEING WITHIN THE HIV & AIDS DISCOURSE

DAWID PETRUS MOUTON

Thesis presented in partial fulfilment of the requirements for the degree of Master of Theology in Pastoral Care and Counselling (HIV and AIDS Ministry) in the Faculty of Theology at Stellenbosch University

Promoter: Prof. D. J. Louw

December 2012

DECLARATION

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

Date: 31 August 2012

Dedicated to Saretta, Aurelia and Joshua for their love, support, trust and sacrifices along the way.

SUMMARY

This study, in addition to problematizing a one-dimensional approach to health and well-being within the HIV and AIDS discourse, also aims to highlight the need and promote the idea for integrative community pastoral care as fundamental in responding to the HIV and AIDS epidemic. In developing such a framework for an integrative approach to healing and care, it becomes clear that a number of paradigmatic shifts in pastoral care are called for.

In the past most of the prevention and intervention strategies within the discourse on healing within the HIV and AIDS epidemic, focused on the people living with HIV and AIDS (PLWHA) and the medical science in its search for cure and effective antiretroviral medication. Little attention use to be given to issues of care as the primary focus appeared to have been on behaviour change strategies. However, as the complex nature of the epidemic and its impacts became more apparent, it gradually dawned on all disciplines that the virus entails more than an individual ailment as a medical concern. With the realization that the epidemic penetrates the quality of life and the basic structures for livelihood and meaningful living on all levels, came the acknowledgement that it has become a systemic and community issue. Any endeavour to be engaged with the epidemic should therefore shift from a merely personal (individual focus) and a medical (pharmaceutical focus) approach, to a community approach. Healing and prevention must also become a systemic and communal endeavour, and thus the reason to connect, in this research project, healing with a community approach to the HIV and AIDS epidemic.

In the process of developing a framework for integrative care and counselling, the study explores the notions of health and well-being and provides a theological framework for understanding these concepts from a community perspective. This framework necessitates a number of paradigmatic shifts, particularly with regards to understanding the ecclesial identity of the church as a community of care. Both the understanding of health and well-being and that of an identity of care culminates

from the understanding of God's passionate involvement in the human predicament of suffering, as implied by a theopaschitic approach. In order to develop an inclusive framework of care to be taken up in the ecclesial identity of the church, a number of metaphors for a community of care are explored as alternatives to the traditional kerygmatik model of the church.

OPSOMMING

Hierdie studie lug nie net die problematiek rondom ‘n eendimensionele benadering tot gesondheid en welstand binne die MIV en VIGS diskoers uit nie, maar poog ook om die behoefte aan ‘n integrerende gemeenskaps-benadering tot die MIV en VIGS epidemie te beklemtoon en sodanige benadering te bevorder. Dit word duidelik dat sodanige raamwerk vir ‘n integrerende benadering tot heling en sorg sekere paradigmatiese skuiwe binne pastorale sorg vereis.

In die verlede het voorkoming en intervensie strategieë met betrekking tot die MIV en VIGS diskoers meestal gefokus op die mense wat met MIV en VIGS leef, asook op die mediese wetenskap se pogings om ‘n geneesmiddel en effektiewe antiretrovirale medisyne te vind. Min aandag was gegee aan die kwessies wat verband hou met versorging, en dit wil voorkom asof die klem eerder primêr geplaas was op strategieë om gedrag te verander. Groter bewuswording van die komplekse aard van die epidemie en sy gevolge het egter geleidelik gelei tot die besef onder alle dissiplines dat die virus meer as net ‘n individuele siekte van mediese belang is. Die besef dat die epidemie lewenskwaliteit, en die basiese strukture van menslike bestaan en ‘n betekenisvolle lewe, op alle vlakke binnedring, het uiteindelik gelei tot die begrip dat dit ‘n sistemiese en gemeenskap probleem geword het. Enige poging dus om die epidemie aan te spreek moet daarom beweeg van ‘n persoonlike/individuele en mediese/farmaseutiese benadering na ‘n gemeenskaps-benadering. Genesing en voorkoming moet daarom ‘n sistemiese en gemeenskaplike poging wees, en daarom ook die rede om, in hierdie projek, genesing in verband te bring met ‘n gemeenskaps-benadering tot die MIV en VIGS epidemie.

Ten einde ‘n raamwerk vir ‘n integrerende benadering tot versorging en berading te ontwikkel, ondersoek die studie die konsepte van gesondheid en welstand, en poog om ‘n teologiese raamwerk te ontwikkel wat hierdie konsepte verstaanbaar maak vanuit ‘n gemeenskaps-perspektief. Hierdie raamwerk noodsaak sekere paradigmatiese skuiwe, veral met betrekking tot die verstaan van die ekklesiale

identiteit van die kerk. Die verstaan van beide gesondheid en welstand asook die van ‘n identiteit van versorging spruit voort uit die verstaan van God se passievolle betrokkenheid by die menslike dilemma van lyding, soos geïmpliseer deur ‘n theopaschitiese benadering. Ten einde ‘n inklusiewe raamwerk van versorging te ontwikkel wat uiteindelik deurslaggewend in die ontwikkeling van die ekklesiale identiteit van die kerk kan wees, ondersoek hierdie studie ‘n aantal metafore vir ‘n versorgende gemeenskap as alternatiewe tot die tradisionele kerygmatiese model van die kerk.

ACKNOWLEDGEMENTS

In the first instance I would like to express my deepest gratitude to our Lord and Saviour for granting me this opportunity and enabling me to complete my studies successfully. I do not have the words to express my heartfelt thanks to my wife, Saretta, and our children, Aurelia and Joshua, for their continued support and trust in me. Thank you for all the sacrifices you have made and for clinging to the belief that God has called us for His ministry. Your faith has often been the only thing that reminded me to stay strong and to continue to trust the Lord even in difficult times. Thank you to Dr Christo Thesnaar for his support and initial guidance. A special word of thanks to my promoter, Prof. Daniel Louw, for his critical, yet always constructive, guidance. Thank you for believing in me.

TABLE OF CONTENT

CHAPTER 1
INTRODUCTION AND BACKGROUND

Within the discourse on healing within the HIV and AIDS epidemic, most of the prevention and intervention strategies focused on the people living with HIV and AIDS (PLWHA) and the medical science in its search for cure and effective antiretroviral medication. In addition, prevention discourses focused primarily on behaviour change strategies, with little attention given to issues related to care. Gradually it dawned on all disciplines that the virus entails more than an individual ailment as a medical concern. It penetrates the quality of life and the basic structures for livelihood and meaningful living, and has become a systemic and community issue. Any endeavour to be engaged with the epidemic should therefore shift from a merely personal (individual focus) and a medical (pharmaceutical focus) approach, to a community approach. Healing and prevention have become a systemic and communal endeavour, and thus the reason to connect, in this research project, healing with a community approach to the HIV and AIDS epidemic.

A brief overview to the epidemic here, followed by an exposition of practical theology and pastoral care, provides the backdrop against which the rest of this thesis takes form.

1.1. Background

The Human Immunodeficiency Virus (HIV) is a retrovirus that attacks and destroys the immune system of humans, making people living with it vulnerable to opportunistic infections such as TB. The HI virus destroys the defenders of the human body, the immune system (CD4 or T-helper cells), and leaves the human body vulnerable to attacks from other viruses and infections. Two major subtypes, HIV-1 and HIV-2, are identified, with the more virulent HIV-1 being predominant in Africa, making it very difficult to find a proper medical response to its spread and destruction in the human body. AIDS or Acquired Immune Deficiency Syndrome is caused by the HI virus. As the term indicates, it develops as a result of an immune

system that is deficient in the resources that provide proper protection against development of ailments, and the collection of specific signs and symptoms associated with the resultant medical condition give rise to the collective term, syndrome. It is in fact a syndrome of opportunistic diseases, infections and cancers, each with the ability to eventually kill the person in the final stages of the condition. (van Dyk, 2008:6-26). Hoffman and Grenz (1990:104)[1] group the indicator diseases of HIV and AIDS in four categories: opportunistic infections, AIDS-related malignancies, HIV encephalopathy (affecting the central nervous system), and HIV wasting syndrome. In short it means that, over time, HIV and AIDS-related illnesses progressively reduce the body's ability to function properly while at the same time it literally wastes away the body of the infected person who presents with AIDS-related complexes.

According to the World Health Organization update (WHO, 2008), 5.7 million people were living with HIV in South Africa in 2007. The total annual deaths related to AIDS was estimated at 310, 000 by AFSA (2010). The number of orphans due to HIV and AIDS in South Africa at the end of 2008 were estimated by UNAIDS (2009) to be 1.8 million, higher than any other country. Whereas the epidemic seems to have stabilized in most regions, it continues to run havoc in Sub-Saharan Africa, including South Africa which is regarded as the country with the most severe HIV epidemic in the world (National Antenatal Sentinel HIV & Syphilis Prevalence Survey, 2008).

A multitude of factors contribute to the spread of HIV, such as poverty, inequality and social instability, high levels of sexually transmitted infections, the low status of women, sexual violence, high mobility (particularly migrant labour), limited and uneven access to quality medical care, and a history of poor leadership in the response to the epidemic.

The effects of HIV and AIDS manifest on all levels of human functioning (Somlai, et al. 1997) - from individual to community level, are very complex in nature, and is regarded by some as "the most devastating plague in our time" (Nwaigbo, 2004). It cannot be responded to appropriately if these complexities are not taken seriously,

[1]For a detailed discussion on this see Hoffman and Grenz, 1990:104-120

since it significantly inhibits the ability of society at large to maintain a healthy state of functioning. Furthermore, such responses must acknowledge and incorporate the need for an integrated view on health, wellbeing and illness. In addition to the biological effects infected people have to deal with, there are also the emotional and personal crises that come with the knowledge of infection (Somlai, et al, 1996). Not only do people living with HIV and AIDS have to deal with the deterioration of their physical, emotional and spiritual well-being when confronted with the realities of the condition, but often this is made worse by stigmatization and a lack of empathetic care in their communities.

The catastrophe is felt most severely at community and household level and the hardship for those infected and their families begins long before people die, often in the form of stigmatization. Not only do stigma and fear cause a reluctance to go for testing and treatment, but the fear and despair that often follow diagnosis also cause significant problems for people living with HIV and AIDS (PLWHA). Effective treatment and the maintaining of a healthy diet are also made difficult by factors such as poverty, poor quality counselling and care, as well as limited resources and support. Logistical problems such as access to treatment facilities, as well as issues surrounding treatment such as ART further exacerbates the problem, and people are often already very ill by the time treatment starts. This in turn has an impact on family systems, as it is often the breadwinner who falls ill. Household resources are now not only reduced, but have to be diverted to the care of the sick person, not to mention the increased emotional burden on the family**.** The trauma and bereavement and often the orphanhood that follows place tremendous stress on the individuals, families and communities affected by HIV and AIDS. The HIV and AIDS epidemic affects real people and the very fabric of society, often leaving infected and affected people “devastated and isolated” (Utley & Wachholtz, 2011:1). Already impoverished, communities find themselves between a rock and a hard place as the burden of care for orphans and affected people weighs heavily on them. It is therefore clear that HIV and AIDS have clear social and structural impacts, in addition to the effects it has on the individual who is infected or affected by the epidemic. However, at the same time the effective treatment and empowerment of PLWA and their affected families are often seriously limited by social and structural

factors such as stigmatization, limited resources, poor infrastructure and poor leadership.

It is true that historically the theoretical framework and praxis of pastoral care and counselling were largely influenced by westernized thinking. This framework has the individual as primary focus, and the setting for pastoral care is that of the consulting room of either the therapist or the minister (Louw, 1999:10)[2]. However, in traditional African cultures, life does not revolve around an individual (Crafford, 1996:4). In fact, traditional African thinking differs from that of Western thinking in that it is more holistic, has a more communal dimension in terms of thinking and decision-making and hence is more collective in nature, it has a stronger magical-mystical orientation, and people think in concrete rather than in abstract ways (Crafford, 1996:4). In addition, religion and church generally have a stronger social aspect to it than in Western communities**,** where religion is mostly seen as a private matter (Crafford, 1996:23). Louw (2008:146-168) also highlights these important aspects of African cultures and contexts, especially the importance of understanding the *Ubuntu* principle[3].

The need for a shift towards a more holistic and communal understanding of pastoral care and counselling within the African context becomes even stronger when one understands the perceptions about illness, health and healing in these traditional contexts. According to Louw (2008: 169-171) illness is in the first place not about medical jargon and diagnosis, but a relational issue. It is seen in the context of broken relationships and disturbed social orders. The question is therefore not about diagnosis, but rather about who or what disturbed the order. Although death is seen as the enemy against life, it is not necessarily the opposite of life and certainly not the end of life within an African cosmology. Health therefore is also not an individual concern, merely limited to physical existence. It is about life and the force of life as a

[2]See Louw, 1999 as well as Gerben Heitink's *Pastorale Zorg* (1998), for more detailed discussions on the paradigmatic shifts in pastoral care and counselling over time.
[3]The notion of *Ubuntu* implies that a person cannot exist without other persons, stressing the importance of community in the African context. The reader is referred to these pages for a full discussion.

collective resource in everyday life. It is about the restoration of relationships, social orders and power balances, and about cleansing within the contexts of relationships.

It is then clear that in the African cultures, much the same as in most poor communities; a paradigmatic shift is required away from individual care as in sophisticated westernized contexts, towards a more holistic, integrated and community-focused framework for pastoral ministry. Instead of making the traditional one-to-one and counselling-room model merely more accessible, pastoral ministry should perhaps be directed outwards to where the people affected by HIV and AIDS are. For instance, how would people who cannot access centres of care receive the care they need? Often people may not be able to go to a clinic or health centre, or even to church. Shouldn't a community-directed pastoral ministry also aim at helping these people? Is it reasonable to expect someone who has been the victim of stigmatizing and discriminatory acts to simply push against the odds and to find the courage and confidence to go out in the open and seek help? Not only do many opt to suffer in isolation because of this, but social and structural discrimination often constricts the delivery of much needed care. Therefore, our understanding of church[4] must shift to become one of an organic fellowship with a community and systems orientation, moving outward to the needy in the world. In such an organic community pastoral ministry is much more than mere service to the faith community. It is about the active involvement with and participation in community structures. In doing so it challenges the people and structures of faith to follow and be out there with those in need, providing care while at the same time challenging and working towards the transformation of the social and structural tendencies and frameworks that deny proper care to those infected and affected.

Howard Clinebell (1984:170-182) argues for another shift in pastoral care and counselling, i.e. from "*uncovering, insight-oriented methods*" to "*supportive methods*"

[4]As an initial working definition I will consider the church in its broadest sense, particularly in terms of the task of theological reflection in relation to the HIV and AIDS context in SA. Church would include the institutional church, but also refers to all those incorporated in the body of Christ through baptism. However, often the concept of well-being and all that relates to it in the context of this study will mainly refer to the local church in relation to its immediate sphere of influence. The whole question of who or what the church is, as well as its ecclesial identity will be the topic of discussion in a later chapter of this thesis.

(170). Although all pastoral care is based on the important role of relationships, in supportive care and counselling the act of support and the relationship of care becomes pivotal and the central theme of pastoral care. However, Clinebell still focuses largely on the one-to-one relationship between pastor and parishioner. In the context of HIV and AIDS, and particularly in our African context and in poor communities around the world, our understanding of "supportive care and counselling" must be expanded to accommodate for the community-orientation and relational dimension of our culture. Given the knowledge that the epidemic is as much a social and structural challenge as it is a personal one, supportive care and counselling must then focus on the optimization of the networks of relationships and resources within affected communities.

Considering the title of this thesis, one has to ask how practical theology, and pastoral care and counselling as a branch thereof, can aid us in rising to the challenge implied by this. Furthermore, the question now should be posed whether the caregiving of the church is really focused on community issues, and to what extent practical theology is still dominated by a clerical model/official model/institutional ecclesiology, and less by an organic, systemic and community centred model. It is therefore appropriate if we now devote some attention to the understanding of practical theology and pastoral care and counselling. Not only will it give some guidance as to the theological discussion that will follow in later chapters, but it will also help to show how this study is relevant in the field of practical theology and provide a basis for the discussion of the methodology to follow later in this chapter.

1.2. On Practical Theology and Pastoral Care and Counselling

Although *Practical Theology* has been defined in various ways, it always seems to be about the relationship and interaction between theology and contextual and contemporary issues (of human significance), in one way or the other (Pattison and Woodward, 2000:5). These authors therefore suggest the following broad definition for practical/pastoral theology from one of their earlier works (7): It "is a place where religious belief, tradition and practice meets contemporary experiences, questions

and actions and conducts a **dialogue** that is **mutually** enriching, intellectually critical, and practically **transforming**". (My own emphasis)

Daniel Louw (1999:119) argues that human experience and interpretation are indeed important elements in practical theology, and hence practical theology can be thought of as an empirical activity. This dialectic of theory and praxis is also emphasized by Dennis and Strain (1985) in their book *Polity and Praxis: A Program for American Practical Theology*. However, Daniel Louw argues that the "empirical activity" in Practical Theology should be understood as more than mere observations. It also reflects on the understanding and role of relationship networks and the existential process of understanding, interpretation and guidance**,** which culminates in an overall process of meaning generation (Louw, 1999:120). In the end practical theology aims at working towards personal and social transformation through the development of praxis-theories and action strategies (125).This focus on transforming social and political environments is also advocated by McCann and Strain (1985:209). However, practical theology is more than just about human beings and their contextual and contemporary issues, or the study thereof. It "reflects on and deals with the *praxis of God as related to the praxis of faith within a vivid social, cultural and contextual encounter between God and human beings*" (Louw, 2005:17). Said differently, it is about the praxis of God's people in relation to God's praxis "within cultural contexts and communities of faith" (Louw, 2005:18), and hence have both a hermeneutic and ecclesial nature associated with it.

Pastoral care and counselling, as a branch of practical theology, is about enabling, healing, empowerment and growth within individuals and groups, within the context of relationships and mutuality, and real contexts (Clinebell, 1984:25-26). For Clinebell, pastoral care and counselling is not only about considering the person as a whole being (the human being in totality), but also about the process of growth towards wholeness (28). Gerben Heitink (1998:40) emphasizes the fact that in pastoral counselling it is not so much about "cure", but rather about "care". According to Heitink (41) pastoral care ("*pastorale zorg"*) is about:

- The human being in totality.
- Context.

- The encounter between care “giver” and “receiver”.
- The element of guidance.
- The Judo-Christian roots of the discipline.
- The relation with the faith community.
- The resultant anticipated experience of healing, support, guidance and reconciliation.
- The relation of care and counselling within the context of a modern society.

Daniel Louw also discusses the functions of pastoral care and counselling, namely that of healing, sustaining, guiding, reconciling nurturing, liberating, empowering and interpreting (2005: 75-77). However, he asserts that pastoral care and counselling as more than just empathy and help, but instead it is about the embodiment of the identification of the suffering Christ with our human vulnerability (2005:75). It is about meeting people where they are - in their being functions. This calls for a position of being with someone, and not only doing for doing for someone. In *Pastoraat as vertolking en ontmoeting*, (1999:63-66) he employs the servant metaphor to explain this “being-with” as the identification, firstly of God, with the suffering. Accordingly it expresses both God’s pathos and compassion with human need. This notion of the suffering servant is present in both the Old Testament (Isaiah 42, 49 & 52) and in the New Testament through the life and death if Jesus Christ. Pastoral care than communicates this willingness to make sacrifice *for* and identification *with* the suffering one. This presents suffering and care in a way that the suffering of people is transformed to new meaning in the light of the redemption and salvation through Jesus. Pastoral care is now defined by the link between God and suffering on the basis of the messianic work of Christ. Suffering may not disappear, but in the presence of the Crucified our shared suffering becomes the starting point of hope and a new vision. However, coupled with this is the fact that such a position now brings suffering and healing under the reign of God’s kingdom, affirming His victory over all destructive powers.(1999:63-66).

In a recent article, (2011:65-76)[5], Louw develops the idea of a compassionate God even more. In the article he emphasizes this idea of a compassionate and suffering God, an idea that calls for a pronounced shift in practical theology, i.e. from the traditional clerical, ecclesial model and the phenomenological paradigm, to a theopaschitic approach - a "practical theology of intestines". In terms of pastoral care and counselling this would imply a shift towards an inclusive approach on the basis of God's 'indiscriminate' compassion. In this he argues that "the normative task of practical theology implies a philosophical-hermeneutical dimension, that is, to interpret undergirding paradigms as related to meaning and being" (65). This hermeneutical and *theo*-ontological approach deals with the character of God's praxis in the world; i.e. God's being within the context of human vulnerability (67), and consequently reframes theological praxis with an understanding of God's passion in the realm of suffering (70). Louw reasons that this type of "passion thinking" leads to the "courage to be", also called "the fortigenetics of '*parrhesia"*". It is through God's eschatological praxis of suffering (theopaschitism), proclaimed by the cross and the resurrection, that 'parrhesia' gains meaning. Only if it is informed and directed by the *passio Dei* (compassion of the suffering God)**,** can practical theology, and pastoral care, attempt to promote change and bring hope in the midst of human vulnerability (70). *Ta splanchna,* referring to "strong feeling of mercy and compassion expressed by the intestines" (Louw, 2011:75), expresses this deep compassionate presence of God, and His involvement in human suffering (74). In the light of the cross and resurrection, this compassionate being of God instils an eschatological hope that leads to a "positive being and hopeful living" (Louw, 2011:75). Through the indwelling of the Holy Spirit and the charisma of the Spirit both caregiver and sufferer are empowered and enlightened to find meaning in the midst of suffering, as it is through the Spirit that the presence of God becomes known. The presence and indwelling of the triune God becomes the sole source of this eschatological hope and new life. The task then of practical theology becomes that of changing our "human brokenness into the healing of eschatological hope" (Louw, 2011:76).

[5] "*Ta splanchna:* A theopaschitic approach to a hermeneutics of God' praxis. From zombie categories to passion categories in theory formation for a practical theology of the intestines". The reader is referred to this article for an in-depth reading.

A theopaschitic framework, through its integrating nature, forms the basis for a hermeneutical and network-oriented approach that culminates in a new understanding of God and the self, reframing human suffering in the presence of this compassionate God from whom all hope flows. In the presence of a suffering, compassionate God who participates and incorporates human suffering, the self becomes more acceptable as God has accepted those who suffer. This acceptance by God is a final verdict against stigma, discrimination and exclusion. Even more, it gives fierce critique on any attempt to reduce the human life to mere biological or psycho-social constituents, and view that denies the integrating presence of the Spirit. Due to the inclusive character of a theopaschitic model and the fact that the notion of a suffering and compassionate God includes structural ad comprehensive healing (the healing of life), the notion of a suffering and compassionate God can help pastoral theology to shift from a theistic God (out there) to the more passionate God (right here).

The theopaschitic framework will form the basis for theory formation in this thesis. It will be argued that the HIV and AIDS epidemic is best dealt with through an integrative approach to health and wellbeing that not only sees people as spiritually integrated beings, but also takes seriously the relational, communal and social aspects of human living. The epidemic has been a social and communal challenge for so long now, and hence calls for a hermeneutical paradigm that integrates all aspects of being. The understanding of practical theology, and pastoral care and counselling, presented here, offers us a framework within which a community care approach may take shape; a framework that could help pastoral ministry to embody the *passio Dei*.

1.3. Research Problem

When approaching illness and health from a biomedical framework, the emphasis inevitably is placed on diagnosis and treatment (Louw, 2008:37), and this puts at the centre of the pastoral relationship the idea of doing something for someone. However, Louw (2008:11), in his book *Cura Vitae*, argues for a paradigmatic shift

from our “knowing and doing” position to our “being” position in pastoral care and counselling. But what does this “being” mean in terms of a pastoral ministry in the context of HIV and AIDS in poor communities? How is it embodied or concretized in the pastoral care relationship and in our ecclesial identity? Daniel Louw (2008:26-35) speaks of “space and place”, not in the sense of physical locality, but rather as a transformative, healing, growth-nurturing encounter where meaning is generated in the context of belief systems, norms, values, experiences and cultural identity. In such a “space” and “place” pastoral care becomes empowering to both individuals and communities, enabling the experiencing of wellbeing and wholeness through the hermeneutics of a new or renewed framework of meaning. This demands that we move beyond the ideas of healing in individual terms only, defined mainly in terms of biological and psychological aspects, to understanding the importance of the healing of relationships, frameworks, structures, systems and living spaces. We need to look at healing from a spiritual and whole-being perspective. Certainly, as Howard Clinebell (1984) suggests, holistic care and wellbeing is only possible within the context of networks of relationships, community and renewed structures. What is called for then is in fact the healing of life.

Before we can even begin to think about an answer to the above, one would have to explore in the first place the impact of HIV and AIDS on structures and communities and how its effects serve to inhibit people’s ability to find meaning and to experience wellbeing in their lives. Yet**,** at the same time**,** one must take cognizance of how social and structural elements serve either to inhibit or advance healing and wellbeing. Moving beyond this, is the issue of what is meant by illness, wellbeing, health and a meaningful life. Considering our preliminary understanding of practical theology and pastoral care and counselling, as discussed in the previous section, such endeavour cannot take place without appropriate theological reflection about the challenges the epidemic presents us with, including that of a suitable theological framework within which pastoral care and counselling may take place.

More specifically the main questions would like to address are:

(1) How are the concepts of healing and wellbeing relevant to pastoral ministry amidst the challenges of HIV and AIDS?

(2) What is the relationship between our understanding of a pastoral-theological anthropology, community care, spiritual wellbeing and integrative healing, and what would be the implication thereof?

(3) How should we understand the identity of the church (ecclesial identity) if it is to be a healing agent in a community ravaged by HIV and AIDS?

It is the intention to develop a theoretical and theological framework, with specific reference to an understanding of a pastoral ministry (care and counselling) within the context of HIV and AIDS, which may empower faith communities to become agents of community care.

In light of the above**,** the following research questions serve to direct this study.

1. How can we move from a fragmented and individualized approach to care to an integrated approach of community care and wellbeing?
2. Whether the traditional kerygmatik model of care and counselling, with its emphasis on the individual, is appropriate within the HIV and AIDS epidemic which seems to have become a systemic and community issue.
3. If pastoral care should become community care, what are the implications on theory formation within pastoral theology?
4. How applicable is the concept of meaning as a spiritual construct to the epidemic and how should spiritual healing be applied to people living with HIV and AIDS? What is meant by meaning within the epidemic?
5. What is the challenge put before the clerical model in traditional ecclesiology – and what is the link between ecclesiology, community care and community health?

1.4. Research Assumptions and Hypothesis

This study assumes that an improved understanding of a hope-giving theology and pastoral ministry is possible through appropriate theological reflection, and that it may contribute to the church's ability to respond to its pastoral calling within the context of HIV and AIDS.

In order to provide a pastoral support system to PLWHA within a context of poverty, our traditional understanding of church as a place where people go and engage in activities for the maintaining of its own existence, should change to that of church as an organic fellowship. Church should develop a community and systems orientation where the pastoral ministry becomes an active, participating agent within the community networks and structures, challenging people and structures of faith to be there where the needy are. A paradigm shift thus needs to happen - from a professional, individual-based pastoral care position to an approach of mutual care. Not only to provide care, but also to challenge and transform the social and structural tendencies and frameworks that deny proper care to those infected and affected. We are challenged to move away from an ecclesial understanding of church as a "static sanctuary" to an understanding of church as a fellowship of believers (koinonia, community) where love and hope is embodied as a means for mediating the Kingdom of God in our present context.

In light of the title of this thesis the question then is: How can the pastoral calling of the church, both local and on a broader scale, contribute to the care, healing and wellbeing of broken people and communities infected and affected by HIV and AIDS. As an important social and structural part of communities, churches not only can provide the kind of supportive care and counselling referred to above, but can also challenge and help mobilize the supportive care resources available in communities. In this sense pastoral care and counselling should therefore not be seen as an exclusively one-on-one encounter, but rather as one of networking, enabling, empowering and growth-nurturing. It is therefore necessary to reflect theologically in this study on our understanding of an ecclesial identity for the people of God, and what paradigmatic shifts may be needed for us to be enabled and mobilized to provide the space and place for care in the African context with HIV and AIDS as a major challenge to our society. Church as an organic entity is strategically placed within communities and can therefor fulfil an important role as driver for a community focus in a supportive pastoral ministry. In the end it is important to reflect on the identity of the church and evaluate it against the ideal of it being a healing community.

The presupposition here is that an integrative approach to healing and wellbeing, coupled with an ecclesial understanding of mutual and compassionate care**,** should improve our understanding of our pastoral calling and help us develop approaches to address challenges associated with the HIV and AIDS epidemic in a systemic and caring manner.

1.5. Methodology

Osmer (2008), in his book Practical Theology: An Introduction describes practical theology in terms of four major tasks that the discipline endeavours to complete. I will use this framework as basis for my methodological approach in this study.

The first task is called the Descriptive-Empirical Task, and the fundamental question asked here is: **"What is going on?"** To answer this question one would have to gather the relevant information that would help you to identify and discern the patterns of behaviour and the specific dynamics related to the situation at hand (Osmer, 2008: 4). This task would involve the review of literature to explore the context of the problem at hand, i.e. HIV and AIDS. Here things like event (the epidemic), context and situation (individual, family, community and how each are affected) are of importance. In previous sections it was argued that although practical theology deals with phenomenology, the approach followed here will be more than mere empirical information. Instead, a hermeneutical approach is followed as it is the intention to move beyond the mere presentation of statistics and facts. It is the aim to discern the meaning and implications of these facts in the context of relationships and our spirituality, which**,** according to Osmer**,** brings us to the second task of practical theology.

The second task (Interpretive Task) is defined by the question: **"Why is this going on?"** Again the dynamics of what is going on are explored**,** and issues such as cultural context, family systems, and psychological considerations may be considered here (Osmer, 2008: 6-8). These considerations will be integrated in the discussion and will not be used as formal structure. Already here reflection will be on both the social context as well as some theological themes, and as with the

previous task the hermeneutical interpretive approach through literature review will also be followed. To a great extent parts of Chapter 1 and the whole of Chapter 2 is aimed at addressing these first two tasks of Practical Theology.

Thirdly we will deal with the task of posing and exploring the theological questions relevant to the context of HIV and AIDS and pastoral ministering**,** in such context (Normative Task) (Osmer, 2008: 8). The question here really is: **"What should go on?"** It is at this stage that our theological reflection will deepen**,** as we deal with theological concepts to derive our ethical norms that will inform our praxis. We are challenged to evaluate the sometimes dominant perceptions on anthropology, health/wellbeing and ecclesial identity, amongst others. The question is then: In light of our reflections, what paradigmatic shifts need to happen, and how will it affect our position towards and in a pastoral ministry? In this paper Chapters 3 and 4 will largely deal with this question, although Chapter 5 will also touch upon it.

Osmer's final task deals with praxis (Pragmatic Task). This task will be addressed more through the development of a theological-theoretical framework for pastoral care as community care, which will serve as the basis for an integrated approach to health, wellbeing and meaning-generation within the present HIV and AIDS epidemic. This links up with the understanding that practical theology is essentially about transformation; informed and guided by a process of sound reflection and dialogue (see introductory section). It is especially in this theoretical framework that the theopaschitic paradigm will play a significant role. When dealing with the question of an appropriate ecclesial identity in Chapter 5, I will attempt to at least partially address this task by presenting a framework for care, which has as its foundation an integrative identity of church.

Theology is a process of human reflection and as such entails a process of interpretation. This interpretation takes place in the context of a meaningful encounter between God and humans - an encounter that affects our understanding of what it is to be human, to be church, and our understanding of the pastoral calling of the church. As such it is the hermeneutic of encountering God in the contexts of the congregation and the world (Louw, 1999:129). Such a hermeneutic structures

the faith praxis of the faith community and may be concretized in various forms. It is therefore**,** not merely a scientific method based only on observation (empirical), but it goes deeper into the meaning of human praxis and experience. Instead of only having a descriptive-analytical focus; it rather opts for an interpretive-analytical and a normative-evaluating approach, including an emphasis on the ethical aspects of practical theology (Louw, 1999:131-132). As such I regard the hermeneutical approach as appropriate for this study. Research for this study will primarily be done by means of an extensive literature review.

1.6. Outline of Thesis

Chapter 1: Introduction

Apart from a brief overview on HIV and AIDS this chapter deals, on an introductory level, with a preliminary understanding of practical theology and pastoral care and counselling. The purpose for this is**:** (1) to indicate the relevance of this study to the field of practical theology, (2) to form the basis for the motivation for the methodological approach chosen. The chapter also sets out to identify the main area of concern of the research, the main assumption of the study and to discuss the methodological approach adopted.

Chapter 2: HIV & AIDS: The impact of the epidemic on communities

The main purpose of this chapter is to contextualize this study. This is done by providing a picture of the impact of the HIV and AIDS epidemic, both biologically and socio-economically. A statistical overview of the HIV and AIDS scenario in RSA is given, to link the study with a specific context and to satisfy the expectation in the title of the thesis. Attention will be given to the biological effects of HIV and AIDS and how they impact on community structures as well as individual and community relationships, resources and abilities to strive for healing and wellbeing. The intention is to relate the information on HIV and AIDS presented here with the impact the epidemic has on communities at grassroots level. Keeping in mind the theme of this study, i.e. community care and integrative healing in a context of HIV and AIDS,

the choice was made to give particular attention to the following: the biological and socio-economic effects of HIV infection and AIDS, and the impact of socially-constructed discrimination and resultant stigmatization. Due to the severe impacts of stigmatization on the psyche of PLWHA, I thought it apt to spend more time on the topic. Stigma (1) attacks identity and a broken identity cannot be healthy as it has significant negative effects on psychological and spiritual wellbeing; (2) is both individual and corporate and only takes effect in the context of relationships and interaction; (3) is a serious inhibitor of help-seeking and treatment potential; (4) has been practiced by faith communities and still inhibits the ability of faith communities to truly be non-judgmental centres of care; (5) and the reality thereof makes it even more necessary that we reflect on our understanding of a pastoral-theological anthropology. The discussion on stigma includes references outside the RSA context as it is not limited to South Africa, yet its manifestations and impacts are very similar all over. As part of contextualizing the study, I will also present a synopsis of some of the theological reflection and discourse that has already gone into HIV and AIDS. Part of this discourse is a focus on prevention strategies, most notably the ABC and SAVE approaches which also feature prominently in religious discourse. I will look at these specifically in evaluating its appropriateness for healing and wholeness on individual and community level.

Chapter 3: On becoming "whole" in healing: The quest for an integrative approach

In this chapter the notions of health and wellbeing will be explored from different perspectives. The bio-medical, psycho-social, and integrated approaches will be evaluated. A discussion on spiritual and religious aspects of wellbeing, including a review of biblical and theological notions thereof, will serve to formulate an understanding of wholeness and integrated community care.

Chapter 4: A Theological Framework for Wholeness and Care

The purpose of this chapter is to provide a theological framework that underpins some of the concepts adopted in the development of an understanding of an

integrated approach to wellbeing. Most notable of these are: understanding the pastoral encounter as space for growth towards wholeness**;** proposing a pastoral anthropology that takes serious the God-human relationship and the integrated view on human beings**;** and the basis for hope and meaning which we want to convey through the pastoral encounter.

Chapter 5: Community care and healing: towards a community oriented ecclesiology

Here the need for having an understanding of an appropriate ecclesial identity and how it directs the pastoral ministry of the church is discussed. Different approaches will be presented in the form of metaphors and suggestions made as to what an appropriate ecclesial identity could look like. This is aimed at providing framework within which praxis-theories and action strategies may be concretized.

Chapter 7: Summary and conclusions

A summary of the main points of this study, and ideas for further research will be presented here.

CHAPTER 2
HIV & AIDS – THE IMPACT OF THE EPIDEMIC ON INDIVIDUALS AND COMMUNITIES

The impact of the HIV and AIDS epidemic is felt by individuals and communities at all levels of existence and functioning: family, social, economic, biological, psychological and spiritual. Although it has been discussed extensively over the years, I endeavour to present an overview in this chapter of these impacts with the intention to give a background of the context within which the need for a holistic approach to pastoral care is highlighted. Despite the initial presentation of statistics on the epidemic, the premise of this study remains the fact that the epidemic is much more than mere statistics – it is about real people and how their lives are affected. Keeping in mind the theme of this study, i.e. community care and integrative healing in a context of HIV and AIDS, the choice was made to give particular attention to the following: the biological and socio-economic effects of HIV infection and AIDS, and the impact of socially-constructed discrimination and resultant stigmatization. As part of contextualizing the study, I will also present a synopsis of some of the theological reflection and discourses on HIV and AIDS that have already seen the light. Part of this discourse is a focus on prevention strategies, most notably the ABC and SAVE approaches which also feature prominently in religious discourse. I intend to evaluate these**,** particularly in the light of a community care approach, and hence I will look at its appropriateness for healing and wholeness at individual and community level. The importance of this chapter is that it provides valuable background relevant to the discussions that follow later.

2.1. HIV and AIDS: Affecting Body and Mind

The Human Immunodeficiency Virus (HIV) is a retrovirus that attacks and destroys the immune system in humans, making people living with it vulnerable to opportunistic infections such as TB. What happens is that the HI virus destroys the

defenders of the human immune system (CD4 or T-helper cells) and leaves the human body vulnerable to attacks from other viruses. Two major subtypes, HIV-1 and HIV-2, are identified, with the more virulent HIV-1 being predominant in Africa, making it very difficult to find a proper medical response to its spread and destruction in the human body. AIDS or Acquired Immune Deficiency Syndrome is caused by the HI virus. AIDS develops as a result of an immune system that is deficient in the resources needed to provide proper protection against development of ailments. The collection of specific signs and symptoms associated with the resultant medical condition gave rise to the collective term, syndrome. It is in fact a syndrome of opportunistic diseases, infections and cancers, each with the ability to eventually kill the person in the final stages of the condition. Although it is called a disease, AIDS is actually not a specific illness, but rather a collection of many different conditions as a result of a weakened immune system due to the HI virus. AIDS is caused by HIV and is the final stage of a broken-down immune system that cannot fight against threats to the body – hence the two are not the same. It is important to distinguish between the two as it has implications for understanding expectations with regard to life expectancy, quality of life, treatment options and for the type of pastoral care that may be needed through the development of the diseases. (Hoffman & Grenz, 1990: 63-74; Magezi, 2007:13-17; van Dyk, 2008:6-26)

According to Hoffman and Grenz (1990: 63-74), Magezi (2007:13-1) and van Dyk (2008:6-26) the disease develops through a number of stages from infection to eventual death. Its progress can be divided in the following stages (no clear boundaries though):

i. The primary infection phase of zero-conversion illness
ii. The asymptomatic latent phase
iii. The minor symptomatic phase
iv. The major symptomatic phase and opportunistic infections
v. The AIDS-defining conditions: the severe symptomatic phase

Chippendale and French (2001:1533-1534) assert that counselling is a core element of a holistic model of health care in HIV and AIDS management, primarily to prevent further transmission and as a support for those already infected and affected. It is

particularly the intense uncertainty that comes with diagnosis that needs to be dealt with in some way. These uncertainties emanate from the realization of the causes, presentation and progression of the illness, deteriorating health, bodily changes, diminished bodily functioning, declining life expectancy and facing death, reactions from others, the demands and effects of treatment, and the impacts of disclosure. Disclosure**,** in particular**,** involves much more than the individual involved and is in essence a community issue. In addition, psychological challenges include shock, fear and anxiety, depression, anger and frustration, and feelings of guilt. All these have to be addressed in a holistic manner.

The above may give the impression that HIV and AIDS only affect individuals and hence need only to be addressed on an individual level. Daniel Louw (2008:416) reminds us that the epidemic has already become a structural and systemic challenge, affecting both local and global communities. The section to follow attempts to paint a picture, albeit not complete, of the havoc the epidemic causes in the South African context, although the information presented may easily be applied to other developing countries with high levels of poverty, and particularly to African countries in general.

2.2. The South African HIV and AIDS Scenario

"The HIV scenario is unfolding so rapidly on a daily basis that it is very difficult to keep up with developments and statistics" (Louw, 2008:415). However, despite its rapid changes, statistics provide an overview of the epidemic that highlights its seriousness and the urgent need for effective, integrative responses to both curbing its spread and dealing with its impacts.

According to the World Health Organisation update (WHO, 2008), 5.7 million people were living with HIV in South Africa in 2007. The 2009 UNAIDS report estimated that of the 33.4 million people living with HIV and AIDS worldwide, 22.4 million are from Sub**-**Saharan Africa, and of these**,** 5.3 million people are living in South Africa alone. Although we already see the need for caution in the use of different statistical estimates, the fact of the matter is that we are faced with a real epidemic in South

Africa, which is in fact the hardest hit country in terms of HIV and AIDS. The rise between 2000 and 2007 can roughly be estimated to be between 1 and 1.1 million (Bate, 2003:197; WHO, 2008). Of the total estimate, the WHO (2008) suggests that 5.4 million are adults 15 years and older (5.3 million reported by AFSA, 2010) and 280,000 are children (220,000 reported by AFSA, 2010). Women are by far the hardest hit and the WHO (2008) estimated that 3.2 million women were living with HIV in 2007 compared to 2.7 million in 2001, representing half of the increased infections since 2001. Again, AFSA (2010) reported that slightly less women (3 million) are living with HIV, and that of the total infected population 181, 000 are male youths (15-24), 831, 000 female youth (15-24), and 220, 000 children (0-14). The adult prevalence rate in 2007 was estimated by the WHO (2008) at 18.1% (up from 16.9% in 2001). Prevalence among young people (15-24 years) in 2007 was estimated by the WHO to be 4% for males and 12.7% for females, three times that of prevalence amongst males. AFSA reported that new infections can be estimated at 436, 000 per annum, with paediatric new infections estimated at 56, 000 per annum. HIV+ births are estimated at 38, 000 whereas infections through breastfeeding is estimated at 26, 000 per year. The total annual deaths related to AIDS was estimated at 310, 000 (350,000 estimated by the WHO, 2008). AFSA (2010) further reported the number of AIDS orphans to be around 1.8 million. Although the WHO (2008) estimate for 2007 was less (1.4 million), this does not serve in any way to lessen the seriousness of the situation. Whereas the epidemic seems to have stabilized in most regions, it continues to run havoc in Sub-Saharan Africa as the worst hit region (Louw, 2008:416) with 67% of global HIV infections and 72% of global AIDS-related deaths, including South Africa which is regarded as the country with the most severe HIV epidemic in the world (National Antenatal Sentinel HIV & Syphilis Prevalence Survey, 2008).

After an extensive period of denial and a lack of political commitment towards curbing the spread of HIV and AIDS during the Mbeki and Tshabalala-Msimang era**,** when the link between HIV and AIDS and the need for an effective antiretroviral therapy (ART) campaign was disputed by both Mbeki and Tshabalala-Msimang, 2008 emerged as a year of hope for the many living with HIV and AIDS (AFSA,

2010)[6]. Among other initiatives, the new era was ushered in by the increased efforts to improve the responsible distribution and use of Antiretroviral Therapy (ART) by the then new Minister of Health, Barbara Hogan, the re-institution of the South African National AIDS Council (SANAC) and the promotion of a National Strategic Plan (NSP), with clear targets for prevention, care and treatment, through active promotion**,** in an attempt to improve and save the lives of many (AFSA, 2010).

Despite already having such a large ART programme (AFSA, 2010)[7], South Africa still faces significant challenges with regard to expanding this programme and improving on its limited success to stem the tide of new infections**.** Issues of drug availability and accessibility, the high cost of drugs, and the limited availability of generic drugs need to be addressed. High levels of knowledge regarding the means of transmission appear not to be translated into HIV-preventative behaviour. A multitude of factors contribute to the spread of HIV, such as poverty, inequality and social instability, high levels of sexually transmitted infections, the low status of women, sexual violence, high mobility (particularly migrant labour), limited and uneven access to quality medical care, and a history of poor leadership in the response to the epidemic.

The catastrophe is most severely felt at community and household level and the hardship for those infected and their families begins long before people die, most notably due to the effects of stigma and discrimination. Not only do stigma and fear

[6] "Mbeki's Minister of Health, MantoTshabalala-Msimang, fought growing national and international appeals for a public treatment programme to save lives, all the way to the highest court in the land. Prevention, nutrition, traditional medicine and a 'positive attitude' were the Minister's prescription. These were touted as an alternative to anti-retroviral treatment, rather than as important components of a comprehensive treatment and support programme. The body that was supposed to drive the national response to HIV and AIDS, the South African National AIDS Council (SANAC), chaired by then Deputy President Jacob Zuma, was dysfunctional and ineffective in the absence of political will. In 2003, the government produced an Operational Plan for the rollout of ARV treatment but lack of leadership and severe capacity problems in the health sector inhibited its implementation" (AFSA, 2010).

[7]Using statistics from the Aspen Pharmacare, the Treatment Action Campaign reported that the number of people on antiretroviral treatment in the public health system in 2008 is estimated to be around 350,000, whereas they quote the Joint Civil Society Monitoring Forum (2007) in reporting that those on treatment in the private health system was then around 100,000 (TAC).

cause a reluctance to go for testing, but the fear and despair that often follow diagnosis also cause significant psychological problems for PLWHA. Effective treatment and the maintenance of a healthy diet are made difficult by factors such as poverty, poor quality counselling and care, as well as limited structural support. Logistical problems such as access to treatment facilities, and issues surrounding treatment (e.g. ART) further exacerbates the problem, leading to a situation where people are often already very ill before treatment starts. This in turn, has an impact on family care as it is often the breadwinner who falls ill. Household resources are now not only reduced, but have to be diverted to the care of the sick person. The trauma, bereavement and orphanhood, amongst others, add to the burden of individuals, families and communities affected by HIV and AIDS. "This all happens in a society where the majority of children live in poverty and 23.2% of the economically active population is unemployed (the figure rises to around 40% if people who have given up looking for work are included)" (AFSA, 2010). What makes this pressure on families and local systems more severe is the fact that in developing countries most of the care and services provided to infected and affected people are provided by the local system of care (Louw, 2008:417). In fact, in Sub-Saharan Africa 95% to 98% of care is provided by the local system (Hunter, in Louw, 2008:417).

The number of orphans due to HIV and AIDS in South Africa**,** at the end of 2008**,** were estimated by UNAIDS (2009) to be 1.8 million, higher than any other country. In the case of AIDS orphans, children are more vulnerable as often they are left to fend for themselves, leaving them open to abuse and high risk exposure. Most of the time these orphans live in dreadful and deeply impoverished circumstances. The number of issues they have to deal with is simply overwhelming: loss of parents, inadequate care and nutrition, limited access to education and health services, increased family responsibilities, having to slot in with extended families or friends whose coping resources have already been stretched, heading households (child-headed households), vulnerability to become involved in exploitative work, and inadequate access to social security grants and other resources. It is hardly possible to describe and explain the full psycho-social impacts this have on these children

and the families of those living with HIV and AIDS. The above is just another indicator of how serious a community issue the HIV and AIDS epidemic has become.

It has been argued that the best way to care for people living with and affected by HIV and AIDS is through family and community structures (Magezi & Louw, 2006:70; Louw, 2008: 458). However, the pressure on households and communities have already reached such an extent that it is overwhelming to these families and communities as resources are stretched to the maximum, and demands even go beyond what can be offered. Apart from the mounting problem of orphans, families have to deal increasingly with the phenomenon of "skip generations" [8](AFSA, 2010).

The HIV and AIDS epidemic is indeed much more than mere statistics. It affects real people and the very fabric of society, and often leave diagnosed people "devastated and isolated" (Utley & Wachholtz, 2011:1). It is also much more than an individual problem and has become a structural and systemic problem, challenging exclusively individual care approaches to transform into a community approach that aims to promote the change and transformation of community structures so that it is able to cope with the effects of the epidemic (Louw, 2008:416). The burden of care for orphans and affected people weighs heavily on already impoverished communities, where the intricate relationship between poverty and HIV is already complex and devastating. Survival becomes increasingly taxing as sick family members return to families and communities of origin when they can no longer work or care for themselves. The capacity to care for dying people and to provide for those left behind is stretched to its ultimate limits. There is thus a desperate need to provide social protection and interventions to support these vulnerable communities and families, and especially the women in society who face a greater risk of infection and yet have to carry most of the burden of care.

The South African Government took a number of positive steps were taken over the last number of years: the approval of the HIV & AIDS and Sexually Transmitted

[8] The phenomena of "skip generations" refer to situations where grandparents have to look after children when both parents have already died (AFSA, 2010).

Infections (STI) Strategic Plan for South Africa 2007-2011 (NSP), the reconstituted South African National AIDS Council (SANAC), progress in increasing the uptake of Mother to Child Transmission Prevention (MTCTP) services and in providing dual ART therapy to infants, the recognition of the need to focus on saving the lives of both mothers and babies, the acknowledgement of the need for HIV to be integrated into health services, and for TB and HIV to be addressed in tandem have also been acknowledged (AFSA, 2010).

Experiences in South Africa, and elsewhere, have shown that as a society we will only have the slightest chance of effectively addressing the phenomena and impacts of HIV and AIDS if all sectors of society are involved – we need an integrative approach. This includes, amongst others, government, business, organised labour, Non-Governmental Organisations (NGOs), Community-Based Organisations (CBOs), Faith-Based Organisations (FBOs) and civil society at large. AFSA (2010) highlights in particular the role of NGOs in this, but also the importance of government, labour, business and a political and legislative framework to create an environment that is conducive to efforts to stem the spread of HIV and AIDS. These institutions play different, yet complementary, roles in this fight**,** including advocacy, service provision, protection, care, training and education and moral formation.

In this section it was demonstrated that the impacts of HIV and AIDS are felt at all levels of society, from the individual to the entire community. Given the resultant increasing pressure on individuals, families and communities, the question of community well-being and healthy functioning becomes even more significant and relevant. However, these are not the only challenges posed. In addition to the biological, psychological, and emotional challenges faced by PLWHA, the issues of guilt, prejudice, judgement, denial and stigma are often a bigger challenge to health and well-being. In the next section I will focus on the phenomenon of stigmatization specifically and how it affects the well-being of PLWHA and their families.

2.3. Stigma and Discrimination as a Response to HIV and AIDS

The previous section primarily served to give a statistical overview of the impact of HIV and AIDS on our societies and on individuals. It is by no means an exhaustive discussion on the matter, and was not intended to be so. However, the real impacts of HIV and AIDS are often felt on deeper levels in the psycho-social and spiritual domains. One aspect that has proven to significantly impact upon the health and well-being of PLWHA – i.e. physical, social, psychological, and spiritual – is the phenomena of discrimination and stigmatization related to HIV and AIDS (Haug, 2009). In this section particular attention will be given to this phenomenon as it is probably the most significant factor that impacts on people's attitudes and willingness to care for PLWHA. Furthermore, as will be discussed here, stigmatization is a community and cultural phenomenon that must be considered in an integrative approach to community care within the HIV and AIDS context. It is also a serious threat that undermines all efforts to effectively prevent, diagnose and treat HIV and AIDS and to provide proper care to those infected and affected (Chitando & Gunda, 2007:185; Simbayi *et al*, 2007:1823 and Visser *et al*, 2009:197). The relevance of including this discussion here stems from the fact that stigmatization proved to be a challenge to the church, firstly in the sense that in the past faith communities practised stigmatization, and secondly in the sense that now more and more faith communities increasingly join the struggle against stigmatization and discrimination (Haug, 2009:215).

HIV and AIDS are considered as probably the most stigmatizing medical conditions in the world. The stigmatization does not only affect the access to care, but also impacts on the social, psychological and spiritual lives of people (Phillips, 2006:328). Stigma related to HIV and AIDS are related to multiple social influences, (Simbayi, 2007:1823) and can take on various forms and types. Eunice Kamaraa (2004:43-46) distinguishes between the following forms of stigmatization: social stigmatization, denial of social amenities and opportunities, neglect of PLWHA, murder or abandonment of infected children, and violence (physical, verbal, rejection, desertion).

Erving Goffman (1963:9) speaks of stigma as the "situation of the individual who is disqualified from full social acceptance". In others words, the person may be

accepted in society, but is never regarded on the same level and with the same dignity as someone who does not possess the stigmatizing characteristic. The term stigma originated in the Greek context and referred to "bodily signs designed to expose something unusual and bad about the moral status of the signifier" (Goffman, 1963:10). Often this was used to designate people such as a slave, criminal, traitor, and blemished person; someone "ritually polluted to be avoided, especially in public places" (Goffman, 1963:11). In modern day contexts the term is used in a manner that is close to the literal sense, but refers more to the disgrace itself than to the bodily evidence of it. In the case of HIV and AIDS I would argue that it is probably a strong combination of the two. Although a lot of emphasis is placed on the disgrace of HIV and AIDS in stigmatizing discourse, there is already an anticipation of the bodily image of someone bearing the physical signs of advanced AIDS, and posing the physical risk of "contaminating" others. Very similar to the situation of lepers in the New Testament, HIV and AIDS are often associated with a fear of infection, deformity, uncleanness and divine punishment (Phillips, 2006: 329). Goffman (1963:14) identified three aspects of stigma that also relate to and are characteristic of HIV and AIDS. These refer to a blemished personal character, a stained social identity and physical deformity or defects. However**,** it also replicates inequalities of class, race and gender. Stigmatization related to HIV and AIDS is particularly worsened by the relationship between certain behaviours (promiscuity, sexual risk-taking, homosexuality, drug abuse, etc.) and HIV infection.

The ethical and moral dilemma of stigmatization is a complex issue (Louw, 2008:426). According to Goffman (1963:15) stigmatization develops when, based on expectations grounded in a perceived social identity that becomes normative, we regard any difference as a deviation and tend to reduce it to wrong or evil. This leads to individuals being discounted in light of the wrong/evil and it becomes stigma. Visser *et al* (2009:197) provides a similar definition and describes stigma as "a social construction of deviation from an ideal or expectation, contributing to a powerful discrediting social label that reduces the way individuals see themselves and are viewed as persons". Edward Phillips (2006:330) defines stigma as "an unhealthy attitude which discredits the basic human integrity of the person in society due to a condition or sickness to which he or she is subjected. The person is seen as "less

than" the rest of society. Stigma is thus some form of branding or marking out whereby the branded identity is often associated with something negative or undesirable (Chitando & Gunda, 2007:186).

Goffman (1963:12) further draws our attention to the fact that the categorisation of people, which ultimately determines what would justify acceptance or not and stigmatization or not, is always determined by the social setting in which we find ourselves. Included in these social settings one can consider cultural aspects, tradition, religion and other worldviews, all playing an important part in shaping people's ideas in terms of what is acceptable or not. In the South African context, and with specific reference to HIV and AIDS, the contextual understanding of sexuality plays a significant role in terms of how we respond to and/or sustain stigmatization of PLWHA. As Goffman (1963:13) also suggests, the so-called discrediting attribute only gains meaning in the context of relationships, and we see that in how stigmatization leads to exclusion, withdrawal and loneliness, amongst other things. In general PLWHA are perceived in negative social terms, and are marginalized as carriers and propagators of this deadly disease. This, together with often pre-existing stereotyping and prejudices, result in HIV and AIDS being put in a moral box where blaming and a mentality of deservedness prevails (Visser *et al*, 2009:197). Therefore people are often judged as the culprits who brought the disease upon themselves by engaging in culturally unacceptable behaviours. Stigma indeed leads to the situation where humans are not seen as worthy, and consequently they are placed on the outside of groups and communities (Chitando & Gunda, 2007:187). People who are excluded are inevitably discriminated against and this gives them the sense of unworthiness and ultimately they internalize and live the stigmatizing belief.

Daniel Louw (2008:426) suggests that on the one hand the perceived discrepancy may have a theological basis, breeding both theological and social prejudice and may even be supported by particular God-images. Persons representing the discrepancy even become symbols of rejection from God and the faith community. On an ethical level people are faced with the issue of contamination, perceiving PLWHA as being contaminated and being a threat to the "purity" of humanity. Often

this is dealt with through scapegoating, labelling, stereotyping and prejudice, all breeding and sustaining stigmatization. (Louw, 2008:426). In such cases the question of how people came to be infected becomes more important than the needs people have in terms of acceptance, love and care. The ultimate effect is that PLWHA continue to live in isolation and are deprived of the much-needed personal and structural support necessary to maintain a decent quality of life (Chitando & Gunda, 2007:187). In fact, "[s]tigmatisation and labelling are synonymous with immediate isolation" (Louw, 2008:427). This is much more than a mere anecdotal statement, but instead the totality of a person's life is at stake.

HIV related stigmatization is indeed a process of devaluing the person and provides a basis for inequality and increased personal stress (Li *et al*, 2009:1007). Li *et al* distinguish between two types of stigmatization[9]: perceived stigma and internalized stigma. Perceived stigma is borne from the awareness or experience of external prejudice and maltreatment and may for instance discourage PLWHA from seeking care and hence limit adherence to antiretroviral therapy (ART). Internalized stigma is more of an own devaluation of the self, leading to a sense of worthlessness, loss of an appetite for life, guilt and feelings of hopelessness, and is fuelled by the internalization of the external experiences of stigma. Both types of stigma inevitably lead to the person becoming withdrawn and isolated, both as a result of personal "choice" and of being excluded or marginalized in one or the other way by others. A study by Simbayi *et al* (2007:1823) found that up to 40% of HIV+ individuals sampled in the Cape Town area had experienced discrimination resulting from having HIV infection, and 20% had lost a job or place to stay because of their HIV status. The study also found that up to one third had internalised the stigma to an extent that they found it difficult not to feel dirty, ashamed or guilty. As Simbayi *et al* (2007:1827) and Li *et al* (2009:1007-1013) found, these types of discriminatory experiences not only lead to increased levels of depression, but also to other psychological challenges for PLWHA. It would thus seem that one cannot talk about the well-being

[9]**Perceived stigma** can be seen as being related to the awareness and experience of stigmatization, prejudice and judgement towards a person from someone else. **Internalized stigma** can also be referred to as internalized shame and has to do with the value and judgement a person passes on himself/herself mostly as a result of stigmatizing experiences and inherent societal judgements based on either popular, cultural of religious beliefs. (cf. Li *et al*, 2009).

within an HIV and AIDS context without also considering the persistent occurrence of stigmatization and its effects on PLWHA and their families.

Often stigmatization is viewed as something that is done by "others", a view often held by members of the faith community. Yet it is suggested that religious groupings in particular have contributed significantly to the problem of stigmatization (Olivier *et al*, 2006:44). In fact, some even argue that the very reason why so many religious entities get involved with orphans and vulnerable children as innocent victims is that it gives them a way out of facing the discomfort of dealing directly with HIV and AIDS and related sexuality issues (Olivier *et al*, 2006:44).

Olivier *et al* (2006:45) suggest a number of religious practices that worsen the situation. These include the exclusion of HIV and AIDS in religious discourse, prevailing religious and social taboos particularly with regard to sexuality, myths and beliefs that HIV and AIDS is a punishment from God for immorality, the use of HIV and AIDS in delineating moral boundaries in society, and placing the disease somewhere outside the religious community as a way of maintaining the belief that believers are immune to the disease and the inferior morality associated with it. In their study, *HIV/AIDS stigma in a South African community*, Visser *et al* (2009:203-4) found that there are also a number of other sources for discrimination and stigmatization within communities, namely poverty, lower levels of education, literacy and knowledge, as well as cultural and traditional beliefs. One other finding they report on is that high levels of stigmatization exist at community level despite a high occurrence of**,** and exposure to**,** HIV and AIDS. They also found that there appears to be a general perception that "others" are more stigmatizing. Although this may suggest a lack of judgmentalism, or that people generally do not want to be judgmental, the danger exists that it could simply be another way of denying the reality of stigma and thus preventing effective interventions to reduce stigma in communities. They also found that stigma in communities may be correlated with strong associations made between HIV and AIDS and issues of death, moral judgment, religious punishment and a failure to live up to cultural expectations, as well as with age, gender, and the perceived messages from the media, as well as cultural and religious traditions.

The strong influence of community factors in HIV and AIDS related stigma is also confirmed in a study done by Rob Stephenson (2009:403-410), *Community factors shaping HIV-related stigma among young people in three African countries*, as well as studies done by Chen *et al* (2005) and Malcolm *et al* (1998). Stephenson found that higher levels of employment due to higher levels of education, not only yields higher monetary and social capital, but also improves the possibility of being exposed to new ways of thinking which may lead to reduced levels of stigmatization. On the other hand Stephenson found that higher levels of risk-taking in communities lead to higher levels of stigmatization. The study concludes that effective ways of addressing stigmatization is a vital and indispensable means to enhance positive behaviour changes to curb the spread of HIV and AIDS. Within the context of the faith community, Phillips (2006:330) also suggests the following as contributing factors to stigma against PLWHA.

- HIV and AIDS seen as life threatening diseases.
- Fear of contracting HIV.
- Links assumed between HIV and AIDS and promiscuity and commercial sex work.
- Belief that AIDS is contracted through immoral behaviour.
- The moral judgement that AIDS is a punishment from God.

Added to these are issues related to understanding of sexuality and gender roles in society (Erikson *et al*, 2010:110). Phillips, like Chitando & Gunda (2007:185), highlights in particular the impact of fear, associated with HIV and AIDS, which ultimately leads to exclusion, rejection, isolation, loss of dignity in care, being judged, blamed, and feelings of guilt and shame. All these severely impact on the well-being and survival ability of the person living with the disease, especially so since it impacts on the PLWHA's willingness to seek care and the type of care given to them.

Not only do people who experience stigmatization find themselves withdrawn and isolated, but stigmatization can potentially worsen the entire spectrum of the psychological well-being of the person. A study done by Li *et al* (2009:1007-1013) on the relationship between stigma, social support and depression among PLWHA in Thailand revealed that a strong correlation exists between depression and both

dimensions of stigma: internalized shame and perceived stigma. The study found that HIV-related stigma has a definite negative impact on the well-being of PLWHA in Thailand, while emotional and social support act as protective factors against depression resulting from stigmatization. Visser *et al* (2009:195) concurs and found that significantly higher levels of depression are found amongst PLWHA when compared with depression levels amongst the general population. Stigma forces people into secrecy as they do not want to risk being discriminated against (Visser *et al,* 2009:194). Unfortunately this means that people are not willing to go for testing or treatment, and in most cases this not only sustains the continuation of high-risk behaviour, but it also means that people do not get the treatment and support they need, and hence their quality of life and well-being simply continues to deteriorate. As Phillips (2006:333) indicates, stigma negatively impact on the medical care, emotional health, social relationships, economics and spiritual life of the PLWHA.

Unfortunately religious institutions have in the past been linked to stigmatizing approaches and responses (Haug, 2009:215), whether knowingly or unknowingly, and it was especially the idea that HIV and AIDS is a punishment from God for our immorality that contributed much to the stigmatizing attitudes we still find in faith communities (Phillips, 2006:3). Despite HIV and AIDS being seen as the biggest challenge for the mission of the Church in Africa (Nwaigbo, 2004:2), surprisingly many churches have yet to devise and seriously implement plans and programs to curb the spread of the disease and to fight stigmatization and its effects. Often there is a sense of ambivalence amongst church leadership when confronted with the reality of HIV and AIDS (Erikson *et al*, 2010: 103-114), which limits the commitment of the church in responding to the challenges posed by the phenomenon. This may in part be due to the fact that many churches who are at least actively responding to the dilemma of HIV and AIDS often lack an “explicit, robust theological rationale for what they are already doing” (Richardson, 2006:39). Despite the many efforts of churches to mitigate the effects of HIV and AIDS, stigma remains a major challenge to deal with (Chitando & Gunda, 2007:184). In fact, as Chitando & Gunda (2007:184) indicate, churches have often been implicated as major perpetrators with regard to HIV and AIDS related stigma, and have even found it appropriate to use the Bible as a basis for such stigmatizing and discriminatory attitudes and actions, despite the

overall message of the Bible being that of liberation and care. In their article, *HIV and AIDS, Stigma and Liberation in the Old Testament (2007:184-197)*, Chitando and Gunda explore the occurrence of stigma in the Old Testament and how references to these have been used and misused to justify stigmatization and discrimination against PLWHA. They concluded that, despite the actual occurrences of stigma in the Old Testament, one must always remember that the overarching message of the Bible is that of liberation. Furthermore, to assume a direct link between sin and illness as punishment would also be to misunderstand the message of the Bible, since there are many instances where no such link exists (Chitando & Gunda, 2007:192).

On the notion of the relationship between sin, punishment and illness, Labooy (2002:306) also argues that we cannot assume a linear relationship of cause and effect with regard to illness. In an effort to make his point, he draws on incarnation theology to argue that it would even be possible for Christ to become ill (2002:306). However, Christ is true God from true God and therefore sinless. He concludes therefore that a linear relationship between sin and illness cannot be assumed without problems. This has important positive implications for the HIV and AIDS debate as "illness is finally removed from the dim, oppressive atmosphere of guilt and punishment" (Labooy, 2002:306), and hence declaring stigmatization and judgement as the true sins and injustice in the HIV and AIDS context. The task of the church is therefore not to continuously search for justifying grounds for judgement, stigmatization and discrimination from the Bible, but rather to rediscover and live the message of liberation. It is incumbent upon the Body of Christ to realize that God is on the side of the downtrodden and that He would want His church to stand with Him in solidarity with all who are excluded and marginalized (cf. Confession of Belhar, 1986).

2.4. HIV and AIDS Discourse

2.4.1. Theological Responses over Time

Much has been written theologically with regard to the HIV and AIDS epidemic, as the numerous citations in this thesis also indicate. However, as part of contextualizing the study I would like to give, in this section, a brief overview of some of the theological discourse that has taken place with regard to HIV and AIDS since it first became an issue to society and the church. Again, this will be done from a perspective of a community approach. Included here is also a brief look at prevention strategies, most notably the ABC and SAVE approaches which also feature prominently in religious discourse. I will discuss these, towards the end of this chapter, in evaluating its appropriateness for healing and wholeness on individual and community level.

I am particularly indebted to the article of Martha Frederiks, *HIV and AIDS: Mapping Theological Responses in Africa* (2008:4-22), in which she provides an overview of trends in theological responses to the HIV and AIDS epidemic in Africa. According to her an abundance of material saw the light on HIV and AIDS and theology, and the many citations in this paper is proof of that. Much of the material also covers the intricate relationship of HIV and AIDS with poverty, ignorance, and disease, and rightly so**,** as HIV and AIDS is not just a medical issue, but impact on and are impacted upon by the socio-economic, cultural and educational spheres of society, with mostly devastating effects. However, despite the devastating effects of the epidemic, written theological reflection started off slowly in the 1990s, almost a decade after the first case of HIV was diagnosed in Africa. After the slow start in the 1990s, the turn of the millennium heralded in an era where a flood of material would be produced.

Events during the 1990s, such as the Rwandan genocide and the toppling of the Apartheid regime in South Africa, took preference in theological circles and contributed to it being a period of relative theological silence with regard to HIV and AIDS. Frederiks argues that some other factors may also have contributed to the limited and slow theological response, such as the alleged connection between HIV and AIDS and certain sexual behaviour, as argued by Saayman and Kriel[10], the

[10] In M Frederiks, 'HIV and AIDS: Mapping Theological Responses', 8

unfounded claims that HIV originated from Africa, as well as the idea that HIV should be seen as punishment for particular sins. Indeed much of the earlier theological publications focused on the relationship between HIV and AIDS and controversial sexual behaviour. However, already in 1992**,** Saayman and Kriel highlighted this link between HIV and AIDS and poverty. Ronald Nicolson[11] in 1994 reiterated this link with social disadvantages and other contextual challenges, and joined the growing number of voices who claimed that the presumed relationship between sexual behaviour and HIV and AIDS is seen in too simplistic terms. Later, through the voices of people like Isabel Phiri and Beverley Haddad[12], for example, the relationship between HIV and AIDS and gender imbalances was highlighted. These authors highlighted the role of the church in moralizing HIV and stressing the sin-punishment relationship, and in so doing**,** fueling stigmatization and discrimination against PLWHA. However, as we have seen earlier through the work of Guus Labooy (2002:306), such a straightforward relationship cannot be assumed without problems.

Recent years have seen more emphasis being placed on the complexities of HIV and AIDS and in particular its relation to social matters, cultural practices, gender relations and economic conditions. In this regard authors such as Constance Shishanya, Phillipe Denis and Agnes Matanda are but a few examples that have highlighted this complexity[13]. Coupled with this is the issue of stigmatization and in particular also the role of religious institutions in either worsening or combating this phenomenon. Examples of these also include articles by Eunice Kamaara (2004), Edward Phillips (2006), Ezra Chitando and Massiwa R. Gunda (2007) and Lascelles W. Black (2008), to name but a few. Material on pastoral care, liturgy, Biblical studies and systematic theology have also seen the light (e.g. Daniel Louw, 2000 and Johan Ciliers, 2006 & 2007).

[11] In M Frederiks, 'HIV and AIDS: Mapping Theological Responses', 9

[12] In M Frederiks, 'HIV and AIDS: Mapping Theological Responses', 9

[13] In M Frederiks, 'HIV and AIDS: Mapping Theological Responses', 9

The issue of pastoral theology and care have been present in literature right from the start, dealing to a great extent with issues related to the terminal and chronic nature of HIV and AIDS, stigmatization, isolation and caregiving (Frederiks, 2008: 10-11). Another aspect that has been extensively covered is that of caregiving and counselling. Gunther H. Wittenberg (1994) and Benjamin Kiriswa (2004) for example highlighted the need for sensitive counselling to deal with the psychological and spiritual challenges faced by PLWHA. Stanley Grenz (1993) makes his appeal for care by drawing on the compassionate nature of God, Jesus and God's people. Vhumani Magezi and Daniel J. Louw (2006) takes the issue of care further than mere reflection and calls for an embodiment of the love of God through, what they call an integrated congregational home-based pastoral care model. Peter Byansi[14] appeals for the use of existing structures and networks in Christian communities to reinforce care-giving structures in other spheres of society. Another mode of care, i.e. remembering and storytelling is emphasized by others such as Christina Landman, Musa Dube, Phillipe Denis and Nokhaya Makiwane[15].

According to Frederiks (2008:12) publications on HIV and AIDS and liturgy is rather limited, despite worship being at the heart of the Christian faith. However, the need to adapt church liturgies in the context of HIV and AIDS has been recognized by several authors. Beverly Haddad[16] for instance calls for the life giving character of the Eucharist to be made prominent in the context of HIV and AIDS. Frederiks (:13) refers to works by Musa Dube (*Africa Praying*) and Betty Govinden (*This is My Body Broken for You*) as valuable resources for liturgies, sermon outlines, prayers, litanies and other worship tools, as well as emphasizing the inclusion of contemporary issues into liturgy. Govinden appeals in particular for the inclusion of PLWHA in liturgical practices on the basis of equality and not as objects of liturgical acts. Johan Cilliers in his paper *Preaching as Language of Hope in a Context of HIV and AIDS* (2006) address the issue of silence with regard to HIV and AIDS in the church and in worship practices, as well as the rediscovery of the language of hope and community

[14] In M Frederiks, 'HIV and AIDS: Mapping Theological Responses', 11

[15] In M Frederiks, 'HIV and AIDS: Mapping Theological Responses', 12

[16] In M Frederiks, 'HIV and AIDS: Mapping Theological Responses', 12

in worship as a means of mobilizing the church. Cilliers ends his paper with a discussion on the implications that a renewed worship language should have on homiletic practices.

In the field of Biblical studies a number of responses can be discerned (Frederiks, 2008:14-17). A number of authors draw on Biblical passages to find the words to express the lament and despair caused by HIV and AIDS (e.g. Sarojini Nadar, Anastasia Boniface-Malle, and Ezra Chitando & Massiwa Gunda). Yet others use Biblical passages for pastoral, educational or liturgical purposes (e.g. Njambura Njoroge). Still others attempt a re-reading of the Biblical text in an HIV and AIDS context to find new meaning in suffering and resources for coping (e.g. Musa Dube, Modipoane Masenya, Denise Ackerman and Dorothy Akoto). Gerald West (2003) and West and Zengele (2006) also stresses the importance of listening to PLWHA and the meaning they find in Biblical texts that they have chosen themselves. West is adamant that there is more value in such an approach rather than in one where passages are prescribed to PLWHA.

In the field of systematic theology much attention is given to revisiting issues such as theodicy, human sexuality and the ethical issues pertaining to HIV and AIDS. Daniel Louw (2000), in his article, *The HIV Pandemic? from the Perspective of a Theologia Resurrectionis*, focuses on the theologies of hope and life, as rooted in our understanding of creation and God's presence in suffering as seen on the cross of Jesus. With regard to a theology of life**,** Louw is joined by authors such as Isabel Phiri and Moji Rueles, whereas Musa Dube also stresses Jesus' identification with the suffering and in this context with PLWHA. For Louw (2000) the resurrection of Christ is the final critique to death, suffering and stigmatization and hence the source of hope for all, including PLWHA. Phillip Marshall (2005:131-148) highlights the need for a critical theological reflection on HIV and AIDS and discusses a number of important aspects of our theology that may bear relevance to our discernment and approach amidst the crisis we are left with.

The above references are by no means exhaustive, but serve to give an idea of the type of theological reflection that has taken place thus far. However, much still

needs to be done both in terms of theological reflection and praxis. As Frederiks (2008:22) puts it:

> Theologically speaking the reflections are still in a preliminary stage. Many publications show that religion has served an ambiguous role in the HIV/Aids discourse so far: meant to be a source of strength, it has often been used to condemn and stigmatize people.… Thus, within pastoral care, within liturgy, within Biblical studies and within systematic theology most efforts are geared towards combating the stigma and the affirming of the dignity of all people, especially people living with HIV and Aids.

2.4.2. Prevention Discourse

Daniel Louw (2008:417) argues that it is only through a relevant, applicable and holistic caring model that we as a society will be able to provide an effective response to the HIV and AIDS epidemic and its associated challenges. The material presented so far echoes this as well. Amongst other things**,** this means that our care and counselling strategies should shift from an individual-based approach to a more systemic and structural one. It is the contention of this thesis that the role of the church in particular should not only be to understand the phenomenon and preaches about it. Instead, it should be the task of the church to discern what the "life-in-abundance", so often preached about, means. In other words, it is the task of the church to discern what well-being is and in particular within the community context where HIV and AIDS run havoc. It goes further, in that the Body of Christ needs to evaluate what it is that we need to embody in order to move in the direction of community well-being. In the next chapter we will look at different understandings of well-being, and then propose a way of looking at well-being that may be helpful to the church and other care-giving institutions. At this stage, however, let us continue our reflection on HIV and AIDS discourses by looking specifically at prevention to ascertain how it contributes, or perhaps not, to the issue of care related to HIV and AIDS.

Although a number of public approaches are followed to promote preventative behaviour and discourses within the larger society (cf. Kunda, 2008), I will examine only two of these. The one, the ABC approach has been the source of widespread polemic, also within the church, whereas the SAVE approach seems to be a response by sections of the broader faith community to the ABC approach.

Of these approaches, the ABC approach is the most well-known (Juelson, 2008:26). This approach refers to a behaviour change strategy focussing on **a**bstinence ("A"), the promotion of faithfulness ("B" for **b**e faithful), and the use of **c**ondoms ("C"). (Murphy *et al*., 2006:1443; Dworkin & Ehrhardt, 2007:13; Juelson, 2008:16; Kunda, 2008:52-3; Louw, 2008:423; SAVE Toolkit, 2010:9). This approach has as its aim the promotion of preventative sexual behaviour, primarily aimed at the individual, as a means to reduce the number of new HIV infections. The philosophy behind it is that the only way to be 100% protected against HIV is to abstain from sex. However, since it is assumed that this is not always possible; the next option would be to remain faithful to your uninfected sexual partner. Still, if this is not possible the approach promotes the use of condoms as a means to limit or prevent the transmission of HIV. (Van Dyk, 2008:148).

The ABC approach has been credited widely for a decline in Uganda's HIV prevalence during the 1990's (Okware *et al*, 2005:625-628; Green *et al*, 2006: 335, 343; Murphy *et al*, 2006:1443). However, there is not always agreement as to exactly what elements of the approach should be credited for it (e.g. the abstinence vs. condoms rhetoric) – e.g. Cohen, 2004; Singh *et al*, 2004; Wakabi, 2006; and Dworkin and Ehrhardt, 2007. It is clear though, from the Ugandan story, that it is only through a multiple-intervention behaviour-change approach that the spread of the epidemic can be slowed down (Green *et al*, 2006: 343). Results from programs in Kenya, Addis Ababa, Zambia, and Zimbabwe show that a "comprehensive, behaviour change-based strategy, ideally involving high-level political commitment and a diverse spectrum of community-based participation, may be the most effective prevention approach" (Green *et al*, 2006: 343).

The ABC approach is indeed not without critique, as Murphy *et al* (2006:1446-1447), amongst others, have shown. One of the challenges in implementing the approach, particularly in traditional communities, is the issue of gender inequality. In such communities women often have little power and influence regarding their own sexual matters/choices with their partners and hence abstinence and condom use is not necessarily an option available to them. The inequalities are not addressed by the ABC approach, and even in the case of sex workers, the approach often has little value in empowering them to negotiate for safer sex.

The approach's strong focus on individual choice and behaviour also fails to acknowledge the underlying host of factors that worsen the epidemic and make people vulnerable to HIV and AIDS. It is indeed more person-focussed than community-focussed and does not deal with social, political and economic causes and conditions that not only sustain the epidemic, but also significantly inhibit that potential for health and well-being at both individual and community level (cf. Juelson, 2008:16-18).

Indirectly**,** the ABC approach also passes moral judgement on infected people, as it implies that those people deliberately did not practice safer sex. This includes measures such as abstinence, fidelity and condom use. As the SAVE Toolkit (2010) puts it: "Unfortunately, the way in which it has been presented is more like: 'Abstain. If you cannot abstain, be faithful. And if you cannot be faithful, use a condom' implying that using a condom is the last resort. It also implies that people who are HIV positive have failed in abstinence and being faithful, which increases stigma around HIV. Not only could this serve to increase the levels of guilt, but it may also lead to increased discrimination and judgement, and ultimately increase the psychological burden on infected people. Proponents of the SAVE strategy also argue that the ABC approach is:

> *Narrow* – limiting itself to one mode of HIV transmission; *Inaccurate* – in assuming that people who are abstinent or faithful will completely avoid HIV, and by implying that those who are faithful do not need to use condoms as an added protective measure for sexual transmission; *Stigmatization to People living with HIV (PLHIV)* – by implying that people who are HIV positive have failed in abstinence, faithfulness and condom use; and *Inadequate* – by leaving

> out messages for families, communities and nations, and placing the burden of prevention on the individual. The "ABC" message ignores the role of HIV counselling, testing and treatment in prevention, and fails to highlight other possible modes of HIV prevention such as safe blood transfusions, safe injections, safe circumcision, and prevention of mother-to-child transmission.

The ABC approach fails to acknowledge the struggle of certain groups of people who already have to deal with many challenges that impact negatively on their lives and well-being: e.g. females, sex workers, drug addicts, vulnerable children, affected families. In particular, it offers nothing in terms of a strategy to improve the well-being and care of individuals and communities already infected and/or affected by HIV and AIDS. Instead, it only focuses on prevention (Kunda, 2008:36).

It is in light of the above that the organization, African Network of Religious Leaders Living With or Personally Affected by HIV & AIDS (INERELA +), proposes a different approach to dealing with HIV and AIDS prevention and care, called the SAVE prevention methodology (SAVE Toolkit, 2010). They argue that it is a more holistic approach to HIV prevention, awareness raising and education. The strategy incorporates the principles of "ABC", but in addition**,** emphasises the provision of information about HIV transmission and prevention, support and care to infected people, and challenges denial, stigma and discrimination associated with HIV and AIDS. According to the SAVE+ Toolkit (2010) the approach can be explained as follows:

> **S** Refers to safer practices covering all the different modes of HIV transmission; for example blood transfusions, the use of condoms, or sterile needles for injecting. Abstinence remains the most reliable method of avoiding exposure to STIs, but it must not be taught in isolation.
>
> **A** Refers to access to treatment –not just ART, but treatment for HIV[-]related infections and provision of good nutrition (particularly to help adherence to ART) and clean water. It also refers (sic) to the need for all available pathological (blood) tests which can further inform treatment.
>
> **V**
>
> Refers to HIV related voluntary counselling and testing. It speaks of the need to test regularly, and for the testing to be confidential. If you know you are positive, you can protect yourself and others, and take steps to live a healthy, productive and positive life. If you know you are negative you can take the necessary steps to remain that way.

E

Refers to empowerment through education and advocacy. Stigma, shame, denial, discrimination, inaction and misaction associated with HIV remains a massive challenge to people's uptake of services associated with HIV and also to people living with HIV being able to live productive and healthy lives within their communities and countries.. That is why empowerment remains a vital component of all work on HIV. People need accurate information about HIV to make informed decisions and protect themselves, their partners and children from HIV. Empowerment also challenges the stigma and discrimination that can make the lives of people with HIV so difficult.

The SAVE+ Toolkit and approach goes beyond the ABC strategy in that it addresses issues such as stigma, shame, denial, discrimination, inaction and misaction, and provides detailed material on the HI virus and its transmission, safer practices, access to treatment, voluntary counselling and testing (VCT) and empowerment issues related to sex, sexuality, gender and challenges within prisons. The training approach and material is also devised to improve care-givers' understanding and provide them with the necessary theoretical and practical tools to give some assistance to infected and affected people. However, the approach does not fully acknowledge and address the issues related to care and wholeness. Attention is not adequately given to the spiritual aspects of living with HIV and AIDS and some of the key broader socio-political and economical drivers of the epidemic are not addressed. Also, the empowerment component of this model appears not to adequately incorporate community and structural empowerment aspects as a means to providing or improving community care and well-being. Instead, it mainly has an individual focus and has as its main aim to change the behaviour of individuals. However, it would be unfair to suggest that it is not a step in the right direction, given the fact that it already moves beyond mere prevention and gives considerable thought to the issues of empowerment of vulnerable groups such as women.

Both approaches focus mainly on behaviour changes amongst individuals and fall short in addressing the broader social and structural factors associated with the epidemic. The issue of integrative care is also neglected by both approaches.

2.5. Is Health and Well-being Possible in the HIV and AIDS Context?

We note that the impacts of HIV and AIDS have been documented extensively, and it is often brought in relation to the role of the church, the faith community, religiosity and spirituality, with a prominent concern for the possibility for health and wholeness for those infected and affected (e.g. Black, 2008; Casale *et al.*, 2010; Chitando & Gunda, 2007; Dube, 2010; Farley, 2004; Frederiks, 2008; Grenz, 1993, Haug, 2009; Joshua, 2010; Kamaara, 2004; Kiriswa, 2004; Magezi & Louw, 2006; Miller, 2009; Nwaigbo, 2004; Patterson, 2010; Phillips, 2006; Somlai *et al.*, 1997; Stetnitz, 2006; Thomas, 2008; Williamson, 1998; West & Zengele, 2006). The effects of the epidemic go way beyond the infected person and affect family, friends, communities (local, regional, national and international), labour, economics, etc. Indeed, if one is not infected, one is affected (Nwaigbo, 2004:2). No sector of society is spared from the wrath of this dreadful disease. As stated earlier, the HIV and AIDS epidemic is much, much more than the statistics presented in this chapter. It affects every aspect of human existence – physical, psychological (cognitive, affective and conative domains), societal, relationships, and spirituality – our very existence is under its shadow.

The reality of HIV and AIDS is indeed enormous and devastating (Mashau, 2008:23), and many people are still filled with fear when it is just mentioned. As Ngwaibo (2008:3) states: “When one mentions, HIV/AIDS, the idea of threat to life, perilous misfortune, affliction of human beings with suffering, unavoidable danger, disaster and death come to mind”. Amongst these devastating effects are broken relationships and marriages, children being orphaned, chronic illness and physical deterioration (Somlai *et al.*, 1997:415-426; Mashau, 2008:23). With the decreased ability of the immune system of a person to fight infections, particularly opportunistic infections such as TB, infected people are engaged in a continuous struggle for survival and have to live with recurring and often persistent chronic illness. People observe their bodies being “wasted” away through weight loss, increased fragility, physical deformation and eventual loss of control. This unfortunately not only affects the bodily functions of the PLWHA, but cuts through to the core of the person and eventually the person is faced with a diminished sense of dignity and urge for

survival. PLWHA and their immediate families are challenged with the issue of care and provision (Magezi & Louw, 2006:64-67) and often do not know where to turn to as communities with the highest HIV and AIDS prevalence are often severely impoverished and their resources already stretched to the maximum. Children are orphaned every day by AIDS and are often left to fend for themselves as extended families and communities cannot always take care of them. As a result of continued parental deaths**,** the number of child-headed and gap-households increase. With this comes the unfortunate reality of reduced possibilities, exploitation and increased risk of infection for these children. This leaves us with a number of questions such as where the burden of care should reside, or who should ultimately be responsible for care. An even more burning question for us is one that is related to the role of the church in terms of providing care to PLWHA and their affected families and communities. In the later chapters of this thesis we will come back to this question and will attempt to look at it from a theological and pastoral ministry point of view.

Apart from the social and physical effects of HIV and AIDS, Somlai *et al.* (1997:415) also mention the challenge of dealing with significant questions of faith, spirituality and religion as people are diagnosed with HIV. This is further exacerbated by persistent stigmatization, which often is felt even more strongly from faith communities (e.g. Philips, 2006:328-339; Kamaara, 2004:35-54), and this is often a bigger problem than being diagnosed with HIV itself. As Eunice Kamaara (2004:35) puts is: “For these people who are already suffering physical and social trauma, stigmatization has tremendous effects on their lives. Indeed most persons infected with HIV/AIDS more often die from factors associated with stigmatization rather than from physical effects and scourge”. Unfortunately we are not at a stage where we can claim that society at large and even the church of Christ do not practice stigmatization of various forms. Instead of providing care and comfort, we are just making the psychological and spiritual struggle of PLWHA worse.

The question then is: Can we even talk of community well-being in an HIV and AIDS context? Is it possible for PLWHA and their communities to experience health and well-being? Can the body of Christ assist in any way to make this possible? It is clear that it would not be possible for PLWHA to experience well-being or live

meaningful lives outside the context of healthy and supportive relationship networks, both with other people and with God. As Christians, we cannot simply ask whether it is possible for PLWHA to experience wellness and live meaningful lives, but we should rather ask how and why it is the responsibility of the faith community to help foster the environment and supportive networks to at least give suffering people the hope of a meaningful life in which well-being may also be experienced. How we would respond to this would depend to a large extent on our own theological understanding with regard to our God-human relationship, our own identity, the ecclesial identity of the church, hope, sin, punishment, death and so forth. In Chapter 4 I will be looking at some of these issues in an attempt to build a theological basis for our responsibility and calling to provide the environment for healthy meaningful living to PLWHA and other marginalized people.

2.6. Summary

In this chapter I have demonstrated, by way of statistics and literature review, that the impact of HIV and AIDS is indeed felt by all people, from individuals to entire nations, and in all spheres of life (physical, emotional, psychological, economic, social, etc.). We also saw that it is especially those vulnerable communities and people, such as the poor, women and orphans, who are hit the hardest. Despite the many efforts of the South African government, which includes one of the largest ART programmes, little success has been achieved in curbing the spread of the disease. In addition, the burden on infected and affected people is made worse by the impact of HIV and AIDS related stigma. Despite being accused of also practicing stigmatization, we noted that religious institutions have been involved in the fight against HIV and AIDS. As HIV and AIDS negatively impact the physical, psychological, spiritual, relational, and economic and other aspects of the human existence, the question of well-being and in particular the question regarding the possibility of well-being for PLWHA becomes a relevant one. In the latter sections of this chapter I discussed approaches to HIV prevention, the ABC and SAVE approaches, and concluded that although they may yield some results in terms of reduced infections, they hardly address the issues of care and well-being for PLWHA. The question, as posed in the previous section, remains: is healing and wholeness,

framed by a community care approach, possible for individuals, families and communities carrying the severe burden of HIV and AIDS? In the next chapter we will move closer to answering this question when we begin to develop an understanding of integrated healing and wholeness. The concepts health, well-being, wholeness and healing will be unpacked, with the aim of finding a relation between and integrated understanding of these and the embodiment of care within the HIV and AIDS scenario.

CHAPTER 3
ON BECOMING "WHOLE" IN HEALING: THE QUEST FOR AN INTEGRATIVE APPROACH

In Chapter 2 we saw that the effects of HIV and AIDS manifests on all levels of human functioning, from individual to community level. We noted that these effects are complex in nature and that an appropriate response would be one that not only takes serious these complexities, but also takes as departure point an integrated view on health, well-being and illness. We also noted the effects of the reality of stigmatization on the well-being of PLWHA. Looking at two examples of prominent HIV prevention discourses we found that these hardly address the issues related to care and well-being of people living with or affected by HIV and AIDS, which lies at the heart of this thesis. However, before we can take a closer look at the issue of care, we will first have to explore and develop an appropriate understanding of what it is we mean when speaking of health, well-being and healing. Various approaches towards illness, health and well-being will be discussed, building up to the notion of an integrated approach, that also incorporates biblical and theological considerations related to health and well-being, both on individual and community level. It is the intention to derive some understanding of well-being and care that will form the basis for a pastoral care approach that seeks to speak to the entire human being, not only on an individualized basis, but also with regard to relevant aspects of community care and well-being.

3.1. Different Approaches to Health and Well-Being

3.1.1. The Biomedical Dimension of Health and Well-Being

The biomedical model is primarily based on the seventeenth-century scientific worldview of cause-effect, reductionism, mechanistic thinking and the mind-body dualism where the mind and the body is seen as separate functioning entities, a view that still forms the basis of modern Western medicine (King, 2000:3; Louw, 2008:36). It presumes that there is some ideal state of health that can be attained and

maintained, and that illness is the result of some abnormality in body functioning, where some defunct part simply needs to be repaired and/or replaced, the reason why it is sometime also referred to as the mechanistic approach (King, 2003:3). The emphasis is on the biological cause and effect of illness (e.g. infection) and the treatment (e.g. antibiotics) or removal thereof.

The perspectives of the biomedical model focus more on the individual level than on societal level. It further defines health and illness primarily in terms of physical attributes, and diagnosis and treatment is approached accordingly, thus moving from the premise that illness can be explained largely in biological terms, with the assumption that psychological and social processes are somewhat removed from the phenomenon of disease. Treatment of illness is taken as priority above the promotion of health. The reductionist and atomistic view of the model presupposes that the complex human being can be understood by studying its underlying biological constituents and that it would yield sufficient information for treating any deviation from the "ideal state" of health. This gives rise to the skewed emphasis on symptoms, diagnosis and treatment. Very little integration is allowed for other aspects of being human due to the mind-body dualism inherent in this model, and hence little attention is given to the psycho-social and spiritual aspects of the person (King, 2000:3; Louw, 2008). So far we have seen that there are at least four assumptions that form the building blocks of this approach: mind-body dualism, a mechanistic view on illness and health, a cause-effect-treatment routine, and the scientific method assuming some objective truth explaining illness and the required response to it.

We are indeed overly obsessed with finding a cure for whatever illness we have and this is the premise from which the biomedical model operates. However noble this striving for a cure may seem though, Labooy (2002:305) warns that in our society where we always crave for success and vitality we can actually cruelly disallow people to be ill and underestimate the importance of care.

Daniel Louw (2008:36) critiques the bio-medical model as being too narrow and argues for a broader perspective and an integrative approach to illness and health

that considers the medical, psychological and social dimensions together with spiritual and philosophical considerations. With reference to the Westernized biomedical model Louw asserts that too much emphasis is placed on biological and organic approaches to illness. He highlights the following dangers of the biomedical model (2008:37-41):

- Human beings are reduced to mere functional organisms.
- The patient is no longer the central figure, but is replaced by an emphasis on diagnostics and treatment.
- The analytical approach leads to human beings being reduced to physiological, biological or chemical entities to be analyzed.
- In a diagnostic approach the patient is merely a case and the ailment becomes an established fact.
- Dualistic thinking introduces the danger of degrading the human being to an object while ignoring the spiritual and cultural dimensions in the person's life.
- Due to an emphasis on the various parts of the person through an atomistic approach the focus on the person as an integral unit is ignored.
- Alternatively the emphasis on the interaction between the parts of the person. (biological-organic approach), puts the focus on the function of each part instead of the whole.
- In the positivistic-scientific approach of the biomedical model, obtaining objective, rational, valueless and ethically neutral information becomes the focus itself and the medical practitioner and patient and their relationship are discounted.
- Lastly, modern pharmaceutical advances give the impression that it is merely the symptoms that are to be addressed, and not the person.

Ultimately it appears that we mostly sacrifice an integrated understanding of personhood in addition to neglecting the relational character of being human, which is so vital in maintaining both personal and communal well-being. In terms of HIV and AIDS it is possible that a dualistic thinking may not only place too much emphasis on HIV and AIDS as a primarily biological illness, but also serve to sustain stigmatizing attitudes towards PLWHA, further impacting on the networks of relationships that are so vital in caring for PLWHA.

In response to the biomedical approach, Guus Labooy (2002:313-316) argues against the idea of an ideal bodily state as a sign of health and well-being. Labooy bases his arguments on his understanding of Imago Dei, asserting that, in Christian theology, we regard human beings as image of God - Imago Dei. This cannot be in part only, "for the whole of reality points to God" (Labooy, 2002:303). This image-hood is concentrated in humanity through Jesus Christ, the "true image of God". As we are gathered as brothers and sisters in Christ we become, together with Him, the image (eikoon/εικων) of God. Therefore, Labooy reasons that it is important that we also consider the vulnerability of humanity as part of Imago Dei. If man is Imago Dei, then one would have to reason that the whole reality of man's existence must be considered as image of God. This goes for people with illness too and therefore also for people living with HIV and AIDS. Their vulnerability then points to the vulnerability of God. Yet, "[i]t is often difficult for us to accept vulnerability, and, intuitively, we tend to think of God and vulnerability as direct opposites. In Christ, however, God identified with man in his whole fragile, vulnerable existence" (Labooy, 2002:304). In Christian thinking the notion of perfect bodily condition as an indicator of good health can therefore not hold. Instead, in our humanhood we embody vulnerability and brokenness in some way or the other. The good news, according to my understanding of Labooy, is that even this imperfect and vulnerable state of the human condition is taken up by God in whose image we have been created. We must therefore look for a broader and deeper understanding of health and well-being, other than just in medical terms.

Labooy further highlights the importance of the relational aspects of life and health in his argument that our illness does not depict a dimension that defines our Imago Dei, but the dimension of dependence (2002:304), and hence the need for relations with God and other human beings. Not only was Jesus dependant on his earthly parents for care, but as the Word He remained dependant on the Father, and this dependence suited Him and God. Therefore, Labooy asserts, "God can integrate and accommodate *dependence* in his own history" (2002:305). This means that the dependency of the sick person, the PLWHA, is also integrated and owned by God. Referring to Gregory of Nazianunzus, Labooy continues: "[w]hatever is assumed by

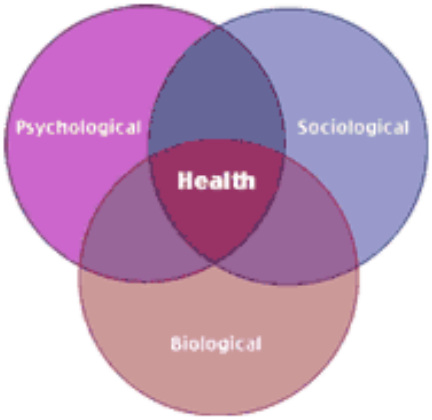
God, is saved … and [t]his provides a new perspective on the vulnerability and dependence of […] a patient" (2002:305). This does not imply that we should regard suffering as good or merely gloss over it. However, the reality of being saved must point to a salvation and restoration of wholeness, which extend beyond bodily health and existence, proving to be the ultimate hope for people living with life-threatening and life-diminishing conditions such as HIV and AIDS. The above does not only raise the important aspect of relationships in our evaluation of health and well-being, but also highlights the importance of these relationships as a resource for finding meaning.

One should not deny the significant contributions made by biomedical approaches in terms of treating HIV and AIDS, and in prolonging and saving lives. Louw (2008:37) acknowledges the contributions made by modern medicine in terms of accurate diagnosis and sophistication in methods of treatment and cure. Kenneth H. Mayer *et al.* (2010:195-202) also provides convincing evidence of how the biomedical approach is helping in changing sexual behaviour, as well as other contributions such as anti-HIV vaccination studies, topical protection treatment, disease control, anti-retroviral therapy (ART) and the role of substance abuse in the spread of HIV and AIDS. It is indeed so that "[l]ife expectancy after HIV infection has increased significantly due to highly active antiretroviral therapy, and changing care for HIV/AIDS patients from treatment of a terminal illness to on-going management and monitoring of a chronic medical condition" (Utley & Wachholtz, 2011:1). However, as these authors have also argued, medical care should be more than mere pharmacological treatment and disease management. Given the complex scenario with interrelated causes and impacts of HIV and AIDS, there is an urgent need for an integrative approach. Such an approach moves beyond mere biological parameters and seeks to account for other aspects - psychological, social and environmental conditions - that play a significant role in the onset and management of illness and the maintenance of health, and is one that incorporate the psycho-social aspects of human living, both on individual and communal level.

3.1.2. The Psycho-Social Dimension of Health and Well-Being

The discussion in Chapter 2 clearly showed that HIV and AIDS is not merely a biological or an individual disease, nor is the cause-effect-treatment relationship a straightforward one, and hence it requires much more than mere bodily reparative work. We also saw that modern medicine is yet to produce an adequate response in terms of preventing, treating and eliminating the spread and development of the disease effectively. It was also clear that a multitude of social and other factors contribute to the development of the phenomenon and hence we have to look beyond the biomedical approach and also consider the psycho-social aspects of human and community functioning if we are to think about the promotion of well-being within the HIV and AIDS context. In this section I will be looking at the basic understanding of such a psycho-social approach and how it could be relevant for the promotion of health and well-being for PLWHA and society at large.

Already in 1948 the WHO gave a definition on health that attempted to look beyond the mere physical state of the human existence, and defined health as "[a] state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity. Within the context of health promotion, health has been considered less as an abstract state and more as a means to an end which can be expressed in functional terms as a resource which permits people to lead an individually, socially and economically productive life. Health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities." (WHO, 2011*a*) The WHO also argues that in today's world we have come to understand that "most illnesses, mental or physical, are influenced by a combination of biological, psychological, and social factors" (2011*a*). This relationship is illustrated in the diagram below (Lakhan, 2006).



The theory of the bio-psychosocial model was first introduced in 1977 by American Psychiatrist George Engel, and takes into account the biological, psychological, and sociological interconnectedness, each as systems of the body (Borrell-Carrio, et al, 2004, 576-7; Lakhan, 2006; Fava & Sonino, 2008:1). As Engel asserts (in Lakhan, 2006): "To provide a basis for understanding the determinants of disease and arriving at rational treatments and patterns of health care, a medical model must also take into account the patient, the social context in which he lives and the complementary system devised by society to deal with the disruptive effects of illness, that is, the physician's role and the health care system". The approach stresses in particular the concept of wellness where a state of good health also implies a good quality of life and strong relationships (Lakhan, 2006). Such an approach allows for the recognition of the mind-body connectedness to be considered in the evaluation of illness, health and well-being. In fact psychosocial factors serve to facilitate, sustain or change the onset and development of illness to various degrees and depending on the individual (Fava and Sonino, 2008:1). Therefore "[t]he need to include consideration of function in daily life, productivity, performance of social roles, intellectual capacity, emotional stability and psychological well-being, has emerged as a crucial part of clinical investigation and patient care. Moreover, in controlled investigations for a number of medical disorders, the use of psychotherapeutic strategies has yielded a substantial improvement in quality of life, coping and the course of disease." (Fava and Sonino; 2008:2)

Health is definitely not merely the absence of disease or the lack of some fundamental pathology. Instead, that would be a rather narrow view discounting all other variables of well-being, which in any case always shifts along a continuum between good health and bad health due to the influence by a host of complex factors. Instead, health can broadly be "understood as physical, social and mental well-being, each influencing each other" (Visser, *et al*., 2009:167) and means much more than simply the absence of illness (Parmer & Rogers, 1997:55). It is also seen as incorporating the interaction between the physical, social and psychological aspects of human life (Visser *et al.*; 2007:167-8), an understanding also shared by the WHO (2011*a*). The interaction between physical, social and psychological health produces multiple pathways to health outcomes and therefore requires that all these factors are considered. Ultimately it is about people in everyday social contexts and involves reaching out to communities, sharing knowledge and skills, and optimizing community resources. Health promotion therefore requires a comprehensive and systemic approach to interventions at all levels of society and must remain in touch with the context within which it is implemented (Visser *et al*, 2007:168). The 1986 Ottawa Charter for Health Promotion (WHO, 2011*b*) also stresses this relationship and identifies those social and environmental aspect that serve as prerequisites for maintaining good health, and well-being. It further states that "A comprehensive understanding of health implies that all systems and structures which govern social and economic conditions and the physical environment should take account of the implications of their activities in relation to their impact on individual and collective health and well-being" (WHO, 2011*b*).

Since this study set out to explore the notion of integrative health and well-being as framed within a community care approach, and seeing that much of the above may seem to be applicable to individuals only, the question arise as to whether our understanding of health and well-being would be equally valid for individuals and communities. We already noted that when talking of well-being within the HIV and AIDS context, the distinction between individual and community becomes a rather vague one as the impacts of the epidemic is felt on all levels of society. As we shall see below, it ultimately is a matter of how one evaluates health and well-being. Yet,

in the end individual and community well-being indicators are so intertwined that it is inevitable that one cannot speak of the one without also including the other.

For Marcel Sarot (1996:1-25) the question of well-being or wellness is basically related to Socrates' understanding of the "good life". Socrates held the view that an unexamined life is not worth living. Sarot suggests that the Western reflection of the good life is an attempt to mirror this, despite the fact that we have by no means reached a common understanding of what a meaningful or good life is. Instead, Sarot continues, such agreement never existed and with the rapid changes and cultural pluralism of our time it is even more unlikely that we will reach such an agreement. The disagreement goes so far that our context of pluralism cannot even agree on the basic understanding of terminology that constitutes that discourse on happiness, well-being and meaning. Terms such as "happiness", "well-being", "meaning", "quality of life", and "salvation" are not generally agreed upon with regard to their meaning. Yet, all these terms are used in discussions about the health and well-being of people. In the end the question about well-being seems to be an evaluative one and this evaluation will be different for different individuals and communities. Also, one must consider the relation between individual and community well-being and how this understanding relates to the research question of this study. The following sections should assist in clarifying this question when we look at the concepts of subjective and objective well-being as well as that of individual and community well-being.

One way of looking at the difficult concept of well-being is by putting it into the two broad categories of subjective and objective well-being (Guillen-Royo and Velazco, 2005:2; Helliwell & Putnam, 2004:1435). Whereas objective well-being refers to aspects such as economic, social en environmental circumstances, subjective well-being has to do with people's personal experiences and own assessments of these experiences in terms of how it relates to their sense of happiness. One can think of subjective well-being as an internal measure whereas objective well-being can be thought of as an external measure of wellness (Smith & Clay, 2010:11). But it is also said that "well-being is a concept meant to recognize the social, cultural and psychological needs of people, their family, institutions and communities" (Larrissa

Ribova, 2000), a definition that clearly shows the complexity of the concept and the need to consider all aspects of community, including quality of life.

According to Frey and Stutzer (2002: 405) objective well-being has to do with what people should have satisfied in order to lead a good life and these requirements are more or less universal. On the other hand, these authors see subjective well-being as something of which people are their own best judges of and it has to do with a person's own perceptions with regard to the overall quality of their lives. However, integral to this subjective assessment are community and social aspects such as relationship networks, community involvement, friends, church, and family, in addition to a personal health assessment (Helliwell & Putnam, 2004:1436-1442).

In his paper on the role of community- and positive psychology, Stephen Schueller (2009:928) recognizes that well-being should be considered on both individual and community levels. In fact, one cannot talk of community well-being without also talking about individual well-being, and a community wellness approach should strive to balance these two, for it is in growth-promoting communities that both individual and community strengths are identified and utilized, and both individual and community dignity is preserved. Whereas subjective well-being may be linked with the individual experience, objective well-being may be related to external valuations and the notion of community well-being.

Community well-being as a concept refers to the "optimal quality of healthy community life" and includes all the ideals of people to live harmoniously, sustainably and just (RAIN, 2011). It indeed fosters the environment for individual well-being and this may happen in/through three broad areas (Schueller, 2009:928): "strength in social ties, directions of personal growth, and level of structure provided by the environment". These should not be approached in isolation, but it is rather the interaction between them that is of importance. This highlights the need for a systems approach in defining and promoting well-being on both individual and community level, and therefore health and well-being must be defined in terms of a concept of holistic wellness (Parmer & Rogers, 1997:55). It is not merely about structural aspects of contexts, but also requires the promotion of autonomy, control

and empowerment of individuals. Although some authors (e.g. Schueller, 2009) in the domain of psycho-social research, may focus on the psychological aspects of well-being, they do not necessarily exclude non-psychological factors in the promotion of well-being. Yet, the significant contributions of religion and spirituality are still not valued as it should be.

Schueller (2009:924) also talks about wellness as a combination of "markers of well-being with indicators of positive functioning". What this means is that well-being is experienced in both the cognitive and affective domains of human existence, where positive functioning relates to the competence, repertoire of resources, knowledge and desire that individuals and communities have to function effectively. Well-being is thus not merely about a subjective evaluation, but entails a certain state of being and of functioning, within a particular community context or social setting. Focus on strengths and positive aspects of being and on individual and community resources can be powerful in helping PLWHA to find their coping resources that will help realizing meaning and well-being.

3.2. The Spiritual Aspects Dimension of Health and Well-Being: A General Overview

Parmer and Rogers (1997:55) as well as Utley and Wachholtz (2011:1) promote the idea of holism (wholism[17]) that involves the active enhancement of well-being, including cognitive, physical, social, affective, occupational and spiritual well-being. Such holistic approach recognizes the interrelatedness of all these aspect of human life. The importance of religion as an aspect of spirituality helps to evaluate well-being by "(a) encouraging a healthy lifestyle, (b) prescribing healthy behaviours that prevent illness, (c) providing support systems when faced with stressful life events, and (d) fostering spiritual attitudes of faith that will sustain an individual in a crisis" (Parmer and Rogers: 1997:56). This is especially relevant for our discussion here as "functioning continues to be dramatically compromised by HIV and can result in

[17] The term "wholism" in this study serve to place emphasis on the integrated wholeness of both individual and community existence.

reduced quality of life, increased dependency on others, negative mental health outcomes such as depression, anxiety, hopelessness, and fear, as well as negative social outcomes including isolation and stigmatization", in addition to changes in a person's belief in self-competence and coping ability (Utley & Wachholtz, 2011:1). In fact, Poloma and Pendleton (1990:270) found in a study they conducted that religious satisfaction is a powerful predictor of both existential well-being and of general life satisfaction. In the same vein, Fiorito and Ryan (2007:341-368) showed that there is a strong positive relationship between religiosity and spirituality with psychological well-being.

In addition to physical, social and mental indicators of well-being, Somlai *et al.* (1996:181), Parmer and Rogers (1997:56), Louw (2008:36), Utley and Wachholtz (2011:1), and others argue that a fourth element must be added, namely that of spiritual well-being. In fact, Poloma and Pendleton (1990:270), Melvin Kimble (2001:3), Dalmida *et al.* (2009:1-25), Jackson and Bergeman (2011:149), and Utley and Wachholtz (2011:1) all found that religious involvement and spirituality are increasingly associated with positive indicators of well-being. Utley and Wachholtz (2011:1) indicate that spirituality and religion are often paramount to the survival of HIV and AIDS patients as they face a host of existential issue as a result of an HIV positive diagnosis and the subsequent management of the disease, and therefore an effective approach to healthcare and well-being must consider the value of spirituality and religion. These authors reported that a positive relationship exists between spirituality and health outcomes, with a positive view on and experience of spirituality leading to increased life satisfaction, improved health-related quality of life, less pain and increased energy, less psychological distress, less depression, better overall mental well-being, better cognitive and social functioning, and fewer HIV symptoms (Utley & Wachholtz, 2011:2).

Louw (2008: 43) draws our attention to the fact that health is a complex matter, and that the idea that health is normal whereas illness is abnormal is but a one-sided and over-simplified view. In fact, as Louw argues, the WHO (2011*a*) definition of health as "... a state of complete physical, mental and social well-being, and not merely the absence of disease", presupposes health as state of perfect well-being, something

that we are not even certain to exist. Rather, for Louw our starting point should not be to categorize either health or illness as a norm. Of greater relevance is "[t]he quality of the patients' maturity, the normative dimensions of their lives and their value systems, [and] the nature of their relationships" (Louw, 2008:43 & 44). On the health-illness continuum it is therefore more about the dynamic network of relationships, maturity and a sense of meaning related to our fundamental life and existential issues, and not merely a person's physical condition. Louw (2008:46) therefore proposes the following: "In pastoral terms, one is healthy when one has a *source of faith that enables one to live with meaning."* This mature faith implies that one has an understanding of God that enables a meaningful life where there is congruency between what one believes of God and how one acts in the awareness of the presence of God (Louw: 2008:46), irrespective of circumstances. He therefore speaks in his book *Cura Vitae* (2008) of healing of life and not simply healing of the body or the soul. This again implies a holistic and systemic approach to understanding the relationship between illness, health and life. Healing is therefore more than just the responsibility of medical science, but also requires the "utilization of spiritual, cultural, psychological and social resources" (Louw, 2008:47).

With regard to HIV and AIDS, Somlai *et al.* (1996:181,189) and Utley and Wachholtz (2011:1) are but a few authors who have reported on a significant relationship between spiritual dimensions and mental health, psychological adjustment and coping, and that a blending of spiritual traditions and mental health approaches is needed to help people cope with the realities of living with HIV and AIDS. The importance of the spiritual mechanism in coping with HIV and AIDS has, despite its tremendous potential, often been ignored. It has been reported that spiritual coping mechanisms have for example played a significant role in the quality of life of cancer patients for instance (Somlai *et al.*, 1996:182; Andreescu, 2011:23-47). Dalmida *et al.* (2009:119-143) as well as Utley and Wachholtz (2011:1-2) indicated that spirituality and religion are not only important in the meaning-making process of PLWHA, but that a positive religious and spiritual experience relates positively with good physical and mental functioning. With HIV and AIDS, as well as other life-threatening illnesses, the added complication is that a person's religious and spiritual framework becomes entangled in a web of questions and conflicts, further burdening

the already stretched coping resources of the person. This necessitates guiding support and care from religious and spiritual leaders and faith communities, without which the suffering person will find it very difficult to make any sense of life as experienced at that point in time. Somlai *et al.* (1996:189) as well as Andreescu (2011:23-47) concluded that religious practices may provide valuable support when dealing with loneliness, depression, anxiety, and suicidal thoughts, which are often found amongst PLWHA, and we have already cited a number of other studies that concur with this view. This appears to be especially significant amongst Christians, compared to non-Christians – a fact which further highlights the importance of spiritual considerations in the conceptualization of well-being. Interestingly, they found that the idea that HIV as a punishment from God does not inhibit PLWHA who are Christians from seeking for a spiritual response to their emotional distress.

Similar arguments were put forward by Melvin Kimble in his paper, *The Search for Health and the Role of the Faith Community* (2001:3-15). Kimble also argues that the problem starts with the prevailing medical model which pathologises the ill, instead of viewing illness, health and the ill from a broader, more holistic perspective which exists and is to be evaluated along a continuum between sickness and health or well-being. He calls for a move beyond the biomedical model and to include in our understanding of health and well-being "a person's capacity to find meaning even in suffering and dying" (Kimble, 2001:3). Kimble argues that contemporary medical care systems still struggle with adopting a holistic approach. This may partly be due to the fact that there is no general agreement in society on the nature and meaning of health, the purpose of health care and the role of healing ministry and faith communities. He is adamant that the biomedical model is indeed not hermeneutically or philosophically suited or equipped to explore and move towards a holistic understanding of health. There is a need to widen our perspective beyond the biomedical and psycho-social understandings of health and well-being, and it would appear that religious and spiritual dimensions might just be what are needed for this broadening in our understanding. Fortunately, despite the prevalence of the biomedical and psycho-social approaches to health and health care, the last decades have increasingly seen spirituality recognized as an important area for future research and application in the pursuit to develop a holistic understanding of

health and well-being (Kimble, 2001: 9, Andreescu, 2011:23-47). Kimble's view on the role of religiosity and spirituality in finding meaning and well-being is also shared by Steger *et al.* (2010:206) who state that "[r]eligious traditions are considered to provide members with a way to integrate their experiences into a coherent, comprehensible whole; functioning as meaning systems." Steger *et al* (2010:207) also argues that a number of well-being indicators have already been linked with religious beliefs and associated practices, and that meta-analysis supports the positive relationship between religiosity and well-being. These seem to suggest that well-being is also strongly linked to finding meaning, which refers to the "sense people feel their lives have purpose and that they comprehend their experience in life" (Steger *et al.*, 2010:207). Drawing on a number of existing studies, these authors assert that there is considerable support for the idea that meaning, well-being and religiosity are linked somehow.

Instead of persisting with the biomedical approach to health and well-being, Louw (2008:41) proposes that "health care, medical science and all forms of assistance should make use of a systemic and holistic approach". Such an approach requires that every person be seen as "a relational and social being acting within a cultural context" (Louw, 2008:41). This rejects the notion of a human being as a discrete entity. At the same time it argues that a person should be seen more in terms of his or her being rather than only in terms of the function of his or her bodily parts. A systemic and holistic approach further sees a person as a moral, spiritual and social being, who exists within the context of societal structures and relationships - "[t]he *ubuntu* principle implies that a human being is a person through other persons" (Louw, 2008:41). Diseases such as TB and HIV and AIDS which are often "related to [and affected or exacerbated by] poverty, inadequate living conditions..., malnutrition, a lack of education, low income and poor housing conditions" (Louw, 2008:41 & 42), cannot be addressed without due consideration of the social, environmental, cultural and spiritual context within which it is experienced. In such a scenario it is virtually impossible for the individual affected to cope without societal and relational structures and support, which often can only be provided through the involvement and care of faith communities. If community well-being is not possible, true individual well-being is also not possible, and vice versa.

Notwithstanding the importance of the biomedical and psycho-social perspectives on health and well-being, for our pastoral ministry and for the entire body of Christ it is necessary that we develop an understanding of health and well-being that draws extensively on our relationship with God and on the hope that emanates from it. It is also vital that in our understanding of our role in promoting health and well-being we incorporate the reality of the charisma of the Holy Spirit and the empowering realities of the cross and resurrection of Jesus Christ, as taught in the biblical message. It might therefore be helpful that we now look at the concepts of health/well-being and healing functions in a Biblical and theological framework.

3.3. On Wholeness: Biblical and Theological Perspectives on Health and Well-Being

Th. Struys (1968:158) highlights the fact that the Old Testament understanding on human beings as one that regards the human as an insoluble entity, not to be separated. Trevor Rowe (1976:9) agrees and argues that different parts of a whole can only be separated artificially (1976:9). In that sense Rowe described health as the condition when all of who you are function harmoniously, with the "whole" remaining the focus. Undue focus on the parts will only destroy the whole, he asserted. Paul Tillich (1984:21) holds a similar view and defines health as "not the lack of divergent trends in our body or mental or spiritual life, but the power to keep them together. And healing is the acts of reuniting them after the disruption of their unity. Heal the sick means help them regain their lost unity". In talking of unity one has to assume that again the underlying assumption in the health-illness and well-being discourse should be one that takes into consideration the totality of the human being's existence. Looking at it from an African perspective, it should also imply that the network of relationships with the self, others, nature and God should form part of the discourse in addition to the manifested maturity of the self and these relationships. John Wilkinson (1998:4) echoes this conviction as he speaks of healing as being concerned with the "whole of the human being". Indeed, as Wilkinson argues (1980:1 & 1998:7), the Bible extends to the whole of the human being and its relationships, which still today is in contrast to modern thinking where

health-related issues may be confined to the body. Based on his understanding of the Bible, Wilkinson believes that this "being human" finds its true meaning in relationship with God and others and therefore he asserts that "[i]t is only when human beings are whole and their relationships right, that they can be described as truly healthy" (1998:7). Daniel Louw (2008:46) also relates the idea of "being healthy" with the right relationship with God, and refers to it as a mature faith where there is congruency between what one believes of God and how one reacts in the awareness of His presence. This mature faith enables the believer to live a meaningful or healthy life. Based on their reading of the Bible, these authors argue that human beings are much more than mere bodies or bodily parts, and that health must be viewed in light of the understanding of wholeness, incorporating all faculties of human existence – mind, body, soul, spirituality, relationships, etc. Indeed, human beings function as "whole entities", including "spiritual wholeness" (Louw, 2008:47).

With regard to the human being and health, the Old Testament (OT) is not only concerned with the bodily existence or distinct bodily parts, but rather the different aspects of the human being, regarding it as a whole (Wilkinson; 1998:10). Even though the impression may exist that the OT refers to human beings mostly through the term *basar*, which refers to the fleshly body in translations, Louw (2008:47) reminds us that this way of thinking about it is only synthetic. Instead, even though *basar* refers to the flesh, Louw reminds us that a careful reading of the OT will reveal that bodily function is not seen as separate from the spirit (*nephesh*). He draws our attention to that fact that although the Old Testament consistently makes use of the concept of *basar* (flesh), it never means merely the bodily functions as being separate from the soul. Instead, health and well-being in the Old Testament is seen as being expressed by shalom (peace), a notion that "*refers to complete fulfillment and is connected to moral activity, spiritual achievement, righteousness (sedeq), faithful fulfillment of the covenant and the torah (holiness), obedience to God and the law, blessing, fertility and longevity*" as well as to "the right relationships" (Louw, 2008:47; see also Wilkinson, 1998:11-16). These concepts refer to a positive state of being, a sense of dignity and righteousness and the right relationships, and life as more than just the earthly life, but include the idea of eternal life in the presence of

God. Therefore, body and soul or spirit cannot be separated in the discourse about health and well-being. When we search for an integrative approach to pastoral care and well-being, we must therefore start speaking of the concept of "human wholeness" to make it absolutely clear that we are not set out to cure diseases as if only the absence thereof would imply health, but that we provide care for the entire human being. And this must also go beyond the individual to include all relational and community-oriented aspects of well-being. As Louw puts it: "[e]mbodiment and soulfulness are complimentary categories" in the human being (47). This embodiment finds its true meaning only in the right relationship to God, and through communality (both family and community systems) (Louw, 2008:48).

Although the OT does not give a clear-cut definition of health, there are a number of concepts that illustrate what a healthy life may entail (Wilkinson, 1998:11-16; Louw, 2008:47). These are well-being, righteousness, obedience, strength, fertility and longevity. For Wilkinson (1980:4) the concept of health in the Old Testament then may be viewed in the following way:

- "Health is basically a state of **wholeness and fulfilment** of [a person's] being considered as an undivided entity."
- "Health in its ethical side consists of **complete obedience** to God's law"
- "Health on its spiritual side consists of **righteousness** which is basically a **right relationship** of man to God."
- "Health on its physical side is manifested by **strength and long life**."

One Hebrew word that probably best incorporates all of the above concepts is the word שָׁלוֹם(*shalom*). When trying to unravel the meaning of the word one has to keep in mind that the OT notion of life encompasses the bodily existence, moral activity and spiritual achievement (Wilkinson, 1998:11, Louw, 2008:48). The word *shalom* describes not only the idea of health as related to physical health, but rather refers to the "quality of the fullness and well-being of life" (Wilkinson, 1998:11). The root of the word, *shelem*, has the meaning of totality and completeness. The Abridged Brown-Driver-Briggs Lexicon of the Old Testament (1997) gives the meaning of *shalom* as completeness, soundness, welfare, and peace. It refers to being healthy, prosperous and tranquil, and relates to positive human relations. The

notion of shalom/peace, in my mind, refers to a state of contentment which is radically different from a state of learned acceptance where the person awaits the inevitable results of illness and resorts to a hopeless state of being, a stage of wasting away and dying.

Struys (1968:142) also argues that in the OT health is an integral part of shalom, and therefore the restoration of health often had the implied meaning of the return of *shalom*. Struys however sees *shalom* as only meaningful within the context of the covenantal relationship between Yahweh (God) and His people (138). Thus, outside the boundaries or context of the covenant, shalom, and hence health and well-being cannot be possible, for being outside of the covenant is seen as a threat to life itself. Life, the constancy thereof, and the absence of illness, although presented in different ways in the Prophetic literature, for example, is best described by the idea of the presence of *shalom* (142). *Shalom* should not be equated to the ultimate good life, or the highest form of happiness, but rather gains its true meaning only in the context and content of relationships, and particularly so within the bounds of the covenant. However, Struys (144) warns that one should not easily and uncritically assume that the presence of any illness presupposes a break in the covenantal relationship, and hence one should not assume a direct causal relationship between sin and illness that applies right through to all circumstances. Instead, often the notions of illness, pain, and health function in a metaphorical sense where it either gives expression to our human brokenness and frailty or to the gift of *shalom* from God (144). Again, this acknowledgement of our human brokenness should not be interpreted in the light of an assumed causal relationship between sin and illness. Instead, often the way that it is presented in the OT and the Bible as a whole suggests that even when we experience such brokenness, *shalom*, peace and wholeness is possible (See Lubooy, earlier section). However, we are reminded that there are instances where direct links can be made between sin and illness and in fact, a broken relationship with God and others and a breaking away from the blessing of the covenant presupposes an act of turning away from God and hence implies the presence of sin – think for example about the Babylonian exile. In God's presence there is life in abundance, and the gift of *shalom* sustains and restores this life – in the presence of God it is possible to experience well-being despite and

amidst our human needs and brokenness. Illness and health is thus not so much about diagnosis and treatment, but rather about the relationship with God and others. And in the context of relationships illness then is about the disintegration of the relationship with God and others, whereas health or well-being can be seen as the reintegration of personhood in the contexts of these relationships. Furthermore, this reintegration and restoration is ultimately the work of God, whether directly or indirectly through other people and means (Struys, 1968:426). Struys (443-444) concludes that illness and healing as collective phenomena in the OT can be related to judgment and blessing in response to faithfulness, but ultimately the emphasis should be on God's act of salvation and His gift of life. In the end it appears that Struys wants us to understand that illness and health functions in the OT as elements of God's interaction with humanity and as a means for strengthening and restoring the covenantal relationship of *shalom* between Him and His people. When this relationship is broken, illness steps in. This is similar to Daniel Louw's notion of a mature faith that reflects a restored relationship between a person and God and with other people, and that ultimately gives meaning to a person's life.

In the New Testament (NT), the concept of health is also much broader than that of modern-day perceptions, and is expressed through a similar understanding as that of *shalom* in the OT (Wilkinson, 1998:21). In fact, the same understanding from the OT that prompts us to view *shalom* in terms of the cultural context is also present in the NT (Louw, 2008:48). Wilkinson (1998:22-29) discusses a number of Greek words that function in the NT to describe health and well-being. The word *hugies*, like *shalom* expresses the idea of soundness characterized by a balanced state of the whole being (22). *Eirene* on the other hand describes a state of peace and tranquillity as opposed to war. However, Wilkinson argues that its meaning in the NT is much broader and more positive as the Biblical concept of peace also expresses the idea of wholeness and harmony. In the NT this wholeness and harmony is the result of Christ's atoning work which restores relationships to what God intended it to be (23). The idea of peace/harmony, as opposed to war, directs our thinking to be more community-oriented, for only in the context of community does this interpretation makes sense. Harmony is also not limited to the idea of inner peace and tranquillity, but must inevitably refer also to relationships and hence to

community. The third term Wilkinson refers to is the word *zoe*. *Zoe*, like *bio* and *psuche*, refers to life. Yet, in contrast to the other two words which refers to the common human life, *zoe* refers to the quality of life and presents health as a constructive way of living (23; see also Louw, 2008:48). "It is a concept of life that which is not primarily temporal but eternal, and not primarily physical but spiritual" (Wilkinson, 1998:23). According to the Enhanced Strong's Lexicon (Strong, 1996), *zoe* is also used in the sense of referring to "every living soul", suggesting that it has as much reference to individuals as to communities. Hence, not only will such a constructive and spiritual life apply to individuals, but it will also apply to communities. It denotes the idea of a "fullness of life, both essential and ethical", and therefore it is not merely about experiencing health and well-being, but also about taking responsibility for making such a life possible. Another aspect of the NT concept of health is described by the word *teleios*. The word describes that which is perfect, complete and mature, and implies having attained the goal one was created for. Incorporating the idea of having attained one's goal might shift the emphasis to be on the end of a process. However, Wilkinson argues that the NT use of the concept also calls for a maturity, completeness and wholeness in the here and now, and its meaning should therefore not be limited to an eschatological understanding only (23). David Jenkins (1981: xii-xiii) also refers to the eschatological dimension of health, stating that:

> Health is what we enjoy when we are on our way to that which God is preparing for us to enjoy. It is a value and a vision word. Practically speaking, health is never reached. From a faith point of view, health is an eschatological idea. We seek health even as we enjoy it. It is a vision beyond the range and possibilities of medicine.

Jenkins brings in here the eschatological perspective on life, and by so doing implies that our understanding of life, health and illness is never separated from our relationship with God and from the hope that emanates from this relationship. However, Jenkins does not appear to suggest that we can only enjoy life and health and well-being at the end of times, but that it is something that we can already enjoy whilst expecting the fullness of life and well-being when God's Kingdom is established in fullness. Well-being is thus beyond what we can offer and experience

in the moment and is made more pronounced by our eschatological hope. Balz and Schneider (1993:342-350) discuss the occurrence of the word in the NT in detail. They highlight a few other aspects of the meaning of the word in the NT, these referring to: the spiritual aspects of maturity, the role of faith in spiritual maturity, and Christ as the supreme of example of maturity and completeness. The idea of completeness and maturity (both as something in the present and as an eschatological goal) presupposes a process of growth and maturation. In the context of health, illness and pastoral care I would argue that this understanding of an underlying process of growth and developing is the key to providing care and understanding the concept of healing. Once one understands that living life in fullness does not imply a state of being ready to die, but rather of embracing life despite the threat of death, it is possible to find that balance that provides the ground for a continuous process of becoming mature. The last word Wilkinson discusses is *soteria* (25). The word means to be safe and sound. In our Christian understanding it thus refers to our salvation – to be saved. As in the OT it can refer to God's deliverance, but also denotes healing and the restoration of relationships. Although the act of salvation may often be linked to deliverance from sin, *soteria* should rather be seen as the total act of restoration that affects the whole human being and which leads to a condition of safety and soundness, making possible a process of maturing in faith that has effect now and in the life to come. Wilkinson (26-30) thus describes health as wholeness, soundness, well-being, life, strength, and salvation. These concepts are very similar to those we find describing health in the OT.

Concepts or ideas such as peace, restoration of relationships, life, quality of life, completeness, growth, and being safe and sound hardly function in the NT as merely in relation to individuals. Instead, when it comes to wholeness that encompasses all these, it is rather about relationality and communality which form the basis for the interpretation of these concepts (cf. Louw, 2008:48). In other words, individual well-being is only experienced when community well-being is present. In our modern thinking with its focus on individuality we tend to neglect this message from the NT, a message that calls us to re-evaluate our individualized paradigm in the discourse about health and well-being. We learn from the above that health is definitely not about absence of some infirmity – neither health nor sickness can be the norm for

well-being. Instead, well-being is influenced and defined by people's "maturity, the content of their belief system, the normative dimension of their lives and their value systems, the nature of their relationships (their relationships with themselves, their fellow humans, their relationship to nature and their environment, their relationship to their culture and their relationship with God)" (Louw, 2008:43-44). For Louw the integrating aspect of all these is spirituality.

In both *Pastoraat as vertolking en ontmoeting (1999)* and *Cura Vita (2008)* Louw places considerable emphasis on the integrating character of a spiritual approach to health and well-being, suggesting that wholeness is actually spiritual wholeness. This is also the view that Howard Clinebell (1984:26) takes when he states that "*[s]pritual and ethical wholeness is the heart of all human wholeness"*. Defining spirituality is of course not an easy task. Louw (2008:49-100) discusses at length the various views on and relevance of spirituality to pastoral care and counselling. In terms of this study I would highlight only some of the aspects from Louw's synthesis. - one being the integrating aspects of spirituality. Spirituality is not only about a private, individual and internal experience, but includes the integration of all lived experience and generating meaning from such integration. It is therefore as much a social spirituality as it is a private spirituality. Similar to Clinebell who views wholeness and well-being as being a process of growth, Louw sees spirituality as a growth towards maturity - the emphasis is again in movement and progress. Clinebell (1995:18) regards the spiritual component of our human existence as the integrating dimension where all other elements of our being human intersect and where meaning is created. This is where our "realistic hope, our meanings, our values, our inner freedom, our faith systems, our peak experiences, and our relationship with God" takes place and is enhanced (Clinebell, 1995:19). This requires a healthy relatedness with the loving Spirit as the "source of all life" (Clinebell, 1995:19), for all healing and growth. It is through spiritual integration that one is able to move beyond self-actualization to a relational healing process aimed at God, the other, society at large, the environment, and the self. Spirituality that intersects the lived experience of people becomes "*an awareness of transcendence in the midst of existential and social conflicts"* (Louw, 2008:51). These existential conflicts are experienced by all humans to a greater or lesser extent, and may be

particularly intensified for people who have to deal with the realities of HIV and AIDS. These include the threat of anxiety, of guilt, despair, helplessness and vulnerability, and the threat of disillusionment, frustration and unfulfilled needs. The fear of the unknown, rejection, stigmatization, deteriorating health and death is an all too real experience for PLWHA. Add to that the guilt, despair, hopelessness and helplessness they may experience in the face of judgment and inadequate care and treatment, and the question about well-being for these people becomes an even more burning one. If our concept of well-being and care remains inadequate and selective how can we even address the sense of vulnerability and all other threats PLWHA are experiencing? It is clear that we cannot hold to a spirituality that remains private or that is only directed at one day when I die and meet my Lord. It must be a spirituality that intersects with the lived experience of people that is understood within the framework of the existential challenges all people are faced with, and that takes serious the cultural, social and environmental contexts within which people struggle with these existential realities.

In light of the previous discussion, I would like to suggest the following as important aspects of health and well-being:

- Maturity of faith.
- Healthy relationships with the self, others, nature and God.
- Hopefulness in living life that includes both the present and the future (eschatology).
- A state of being, not just functioning, that encompasses peace and a meaningful existence.
- Supporting and functioning social and community structures and networks that provide a growth-stimulating environment and care to both individuals and communities.
- The notion that well-being is experienced in physical, psychological, social, and spiritual dimensions. It is the interrelationship between these that are of importance, rather than the focus on just any one of them.
- Health and well-being must be viewed in a systemic and holistic perspective – human beings are undivided entities.
- Healing of life is the focus rather than curing of the body.

- Wholeness and fulfilment are to be key concepts in the understanding of health and well-being, and not merely physical attributes and experiences.

3.4. On Healing for Wholeness: Towards an Integrative, Spiritual Approach

Howard Clinebell (1984:4) suggests that the church has a continuous struggle against a threat of irrelevance in our continuously changing societies. It would appear that the only way for it to remain relevant is if the church can become and remain a "lifesaving station", allowing it to focus on the deep needs of people (Clinebell, 1984:14). Clinebell argues that the pastoral calling and ministry of the church is the call for it to be such a lifesaving station or human growth and wholeness center by being a loving and relational community. Only through an appropriate pastoral care approach can it become the space of *shalom*, birth and re-birth where people embark upon a road of spiritual healing and wholeness. Indeed the functions of pastoral care and counselling are healing, sustaining, guiding and reconciling of human beings and their relationships (1984:20), with the focus being on growth. By growth Clinebell does not only refer to individual-centered growth, but rather a growth that affects the self, others and the broader society (1984:29). Indeed, wholeness is not about reaching an endpoint, but rather about a growth journey, the heart of which being spiritual wholeness and growth. It is a journey of healing and restoration, both within, horizontally in human relationships and vertically in terms of our relationship with God. It is also a journey of liberation **from** growth inhibiting forces, **for** a life in the Spirit, and **to** a life of fullness (1984:29-30). Therefore Clinebell (1984:31) describes this as a mutli-dimensional process involving the mind, body, relationships, ecology, institutions and God, involving a continual striving towards spiritual integration (see Clinebell, 1984:32-34 for details). Holistic, or rather wholist, care can therefore only truly take place within a context of a covenant of wholeness and through a process of integration of all the dimensions of a person's life (1984:32), both within the individual and the community.

In his book *Counselling for Spiritually Empowered Wholeness. A Hope-Centered Approach* (1995), Howard Clinebell describes the concept of and the process towards attaining wholeness and integration through pastoral care and counselling.

The central notion in this approach is to see humans through the “growth-hope-empowerment-spirituality perspective” (Clinebell, 1995: xi). The following sections will aim to describe the process of healing as an integrative and integrated approach by making use of the wholeness concept as discussed by Clinebell in this book.

Wholeness counselling and care implies an on-going process and involves a focus on spirituality, a process of healing and helping, facilitating the maximum development of a person's potential at each life stage, and empowering someone to contribute to the development of the self, others and society (Clinebell, 1995:2). Important in this approach is that life is not merely seen as the absence of illness, but rather as the presence of a positive, developing wholeness (Clinebell, 1995:3). It is also not a static state to be achieved, but a dynamic growth process on a continuum between illness and health. It further implies the continuous process of liberation from growth-diminishing aspects, whilst being liberated to grow in potential and competency and for the betterment of society. Clinebell identifies seven dimensions of growth or areas of human existence that all contribute to a person's well-being, and that are co-dependent on and influencing each other. These are mind, body, relationships, ecology work and play life, relationships to organization and institutions, and spiritual growth.

With regard to relationships, Clinebell (1995:10) stresses that not only do human beings exist and function within relationships, but are in fact relationships themselves. Only in the context of meaningful relationships can we have our existential needs satisfied and can a life of wholeness be possible. Wholeness and wholeness-directed healing and care are thus always relationship-oriented. This echoes the undergirding understanding of the notion of *shalom* discussed in the previous sections.

Like Daniel Louw (see previous sections), Clinebell (1995:18) regards the spiritual component of our human existence as the integrating dimension where all elements of our being intersects and where meaning is created. This is where our “realistic hope, our meanings, our values, our inner freedom, our faith systems, our peak experiences, and our relationship with God” (Clinebell, 1995:19) take shape and are

enhanced. Only through a healthy relationship with the living and loving Spirit, who is the source of life, healing and growth, can this however be possible. Therefore Clinebell (1995:77) asserts: “Spiritual growth is the key to all human growth. Because human beings are inherently transpersonal and transcendent, there is no way to ‘fulfill’ oneself except in relationship to the larger spiritual reality”. He further asserts that spiritual growth is the only way to satisfy our interrelated needs for a “viable philosophy of life, for creative values, for a relationship with the living God, for developing a higher self, for a sense of trustful belonging in the universe, for renewing moments of transcendence and for a caring community that nurtures spiritual growth” (1995:81-82). Yes, it is through spiritual integration that one is able to move beyond self-actualization to a relational healing process aimed at God, the other, society and the environment in relation to the self. In such a relational and Spirit-mediated mode of living people are freed to become change agents for despite the significance of spiritual growth and healing, wholistic growth and healing only truly manifest where societal transformation remains a major driver for healing and the creation of a healing environment. It cannot be otherwise as wholeness -and growth counselling and care must be about hope generation and hope awakening (Clinebell, 1995:30). Only in the conviction that every person has the capacity to grow, can there be a reasonable hope of having the resources and mind-set to cope with adversity and to use this adversity as an opportunity to become more mature in faith.

Louw (2008:48) highlights the fact that in terms of well-being it is not about doing, but rather about being. Here too the indispensable value of relationships is highlighted and the concept of fullness of life only in the context of right relationship with the self, the other, with nature and with God is emphasized (Wilkinson, 1980:9; Louw, 2008:48). A spiritual approach to life, both past and present, in context of relatedness is seen as paramount to health and well-being. It is the ability, through the right relationships and understanding of God (i.e. maturity), to see the goodness of God despite the physical effects of illness and to find hope in the light of an eschatology which speaks of the imminent return of Christ in the light of the reality of the cross and the resurrection.

We cannot conclude this discussion without looking at a term that functions extensively in relation to healing and restoration in the Bible and that gave rise to the term we use to denote what we do in pastoral care an counselling, namely therapy. This is the Greek word *therapeuo*. The *New international Dictionary of New Testament Theology* (Brown, 1971:163-164) suggests that the "idea of bringing about recovery from bodily or mental sickness is expressed most frequently by *therapeuo*. Although in the Classical Greek and secular use of the word it can mean "to serve", it is almost exclusively used in the NT to indicate the notion of healing (Brown, 1971:164). Still, the idea of serve and a willingness to give in the interest of the well-being of the other remains strongly attached to the word (Wilkinson, 1998:78). The context within which the word is used often refers to Jesus' healing ministry on earth. However, this is not exclusively so as it is clear from the Gospels that Jesus shared this healing ministry with His followers. From a Christian point of view healing is true possibility sanctioned by Christ, performed by Christ and in His Name, and includes the followers of Christ as agents of healing, i.e. the faith community. No wonder that faith seems to be such an important factor in the healing accounts in the Gospels. The use of *therapeuo* is also not exclusively linked to physical healing, but also to other situations such as the deliverance from demonic powers (Brown, 1971:165). Other words that also functions to denote the process of healing in the NT are: *iomai, sozo, apokathistemi, diasozo, apoluo, katherizo* and *huggies* (Brown, 1971:163-171; Wilkinson, 1998:77-84). All of these refer in one way or the other to an act or process of restoration and renewal. It suggests the experience of "becoming well again", highlighting the reality of the possibility to experience well-being and wholeness. However, as is the case with our understanding of wholeness, healing seems to occur within context of relationships, and particularly in the context of a faith relationship with God. It is never a simple case of mere medical treatment, but involves soundness in spirituality and a maturity in faith. We can therefore say that healing is indeed, as indicated in the discussion on the OT view on well-being, about the return of *shalom* and a new beginning in the presence of God. The accounts discussed by the above authors do not serve to merely vindicate Christ's position as the Son of God, but illustrate that the triune God is the source of our healing ability and of our wholeness.

3.5. Summary

Inadequacies in the biomedical approach and the limited application even of the psycho-social framework necessitate the inclusion of religious and spiritual aspects in the assessment of health and well-being and meaning in life. These have been demonstrated as important coping strategies, particularly apt when considering that humans are regarded as being created in the image of God and as relational beings. The discussion highlighted the importance of understanding well-being as something that pertains to both individuals and communities, each one affecting the other. With regard to health and well-being it has been indicated that a shift took place, from a primarily individual approach to a systemic-structural approach, hence the emphasis on community care and community approaches as pivotal within the HIV and AIDS discourse.

One can conclude from the preceding discussions that health and well-being is best understood by and expressed through the notion of wholeness, and more specifically spiritual wholeness. This concept of wholeness incorporates the belief that human beings can never be described in terms of their constituent subsystems, but only as a whole. This whole being incorporates all aspects of human existence, i.e. physical, psychological, socio-economic, cultural, religious and spiritual. This integration of the various aspects of being human happens in the spiritual domain where meaning is generated.

It was further demonstrated that the concept of wholeness does not refer to a static end state, but rather refers to a process of growth towards maturity, freedom, empowerment and faith. This concurs with the Biblical view on health and healing, which to a great extend is expressed through the term *shalom*, and which implies a process of restoration and return to an existence of peace, fulfillment, moral activity, righteousness, spiritual achievement, faithfulness, and obedience to God, blessing, fertility and longevity. This of course is only viable within the context of a covenantal relationship with God, and within a network of healthy relationships with the self, others, society at large and with creation. The Biblical view of well-being or wholeness is also one that extends from the individual to communities; leading to the

conviction that individual well-being is only possible in a context of community well-being, and vice versa. The relationship between integration and wholeness presented here, hinges on a hermeneutical understanding of healing, namely how the various parts, aspects and dimensions of our existence (biological, physical, psychological, social, structural, systemic, etc.) are related to each other with regard to the issue of spiritual maturity defined by an ethos of sacrifice (from a Christian understanding of life).

In the same vein it has been demonstrated that healing is not so much about the removal of an infirmity, but rather refers to a process of growth and integration. It is a process of liberation, and requires more than only medical treatment. Instead it is a journey of discovery and realignment of one's perspective within the context of relationships and communality. The healing process itself is one of spiritual growth aimed at all dimensions of human life.

Given the severity and complexities of the impacts of HIV and AIDS, one must conclude that a one dimensional approach, e.g. only medical, is inappropriate and neglects to address all these complexities. Even a purely psycho-social approach will not suffice. On the other hand an integrative healing approach incorporates all internal and external potential and realities. It seeks to address not only the physical effects of HIV and AIDS, but also the psycho-social and spiritual aspects as well as structural limitations to wholeness.

It becomes clear that an integrated wholeness and a process of integrated healing presupposes a particular relational position towards the triune God - the source of all life, a particular view on humanity and a firm belief in the reality of hope. In order to appreciate how this view on integrated wholeness and healing is possible from a theological point of view, we must reflect on these presuppositions, which will be the focus of the next chapter. However, since it also became apparent, through the notion of *shalom,* that individual care is in fact part and parcel of community care, our theological framework becomes as much a framework for community care and healing as for individual care and healing.

CHAPTER 4
A THEOLOGICAL FRAMEWORK FOR WHOLENESS AND CARE

In Chapter 2 we saw how HIV and AIDS impact on the lives of individuals, families and communities and how not one sphere of life is excluded from the effects of the epidemic. We noted that it challenges people physically, emotionally, socially, financially, and spiritually and puts strain on all structures within our communities. In Chapter 3 we explored the notion of well-being, both on individual and community level, and concluded that HIV and AIDS, and in particular the stigma associated with it, severely limits infected and affected people's ability to live a meaningful life with a fair sense of well-being. It became clear that only an integrated approach to well-being/wholeness and healing can be applicable within such a context. This integrated wholeness and a process of integrated healing presupposes a particular relational position towards the triune God - the source of all life, a particular view on humanity and a firm belief in the reality of hope. Clarifying these presuppositions will now be the focus of this chapter. The three theological questions, I think, that we then should attempt to answer are:

- What is the nature of the care that we give as healing towards wholeness? – A theological theory of care-giving
- Who are we in relation to God and ourselves, and others? - Anthropology
- What is the hope and meaning, or the basis thereof, which we seek to offer in our growth-promoting care that we advocate in this study? – Telic dimension of meaning and ethos

Numerous calls have been made for proper on-going theological reflection and discernment in the on-going battle against HIV and AIDS, of which Kamaara (2004), Phillips (2006), Chitando and Gunda (2007), Demissie (2008), Perkinson (2008) and Thomas (2008) are but a few examples. Phillip Marshall (2005:134-5) briefly paints

a dire picture of the crisis with which HIV and AIDS is challenging humanity with. He reckons that it is especially because of the nature and extent of this crisis that theology should provide a guiding light for our response to it. According to Neville Richardson (2006: 39) many churches who are at least are actively responding to the dilemma of HIV and AIDS often lack an "explicit, robust theological rationale for what they are already doing". The quote by Paul Clifford (2004) in his *Theology and the HIV/AIDS epidemic* says it all: "We have recognised that there is a problem in the church… We have to ask ourselves, what can we do?" As one explores the relationship between the church and HIV and AIDS you become aware of the need for continual theological reflection that will continue to inform and direct the response of the faith community to the challenges posed by the epidemic (cf. Marshall, 2005; Cilliers, 2006; Magezi & Louw, 2006). Indeed, as the effects of HIV and AIDS continue to thrive and its impacts on society become more severe, the demand for a response from the church is felt ever stronger (Clifford, 2004:3). Questions about the meaning of the immeasurable suffering and where God fits in all of it cannot be ignored and must in some way or another be addressed or at least explored theologically if the church is to be taken seriously as the sacramental sign of God's presence on earth. Stigmatization, the conviction of a direct causal relationship between sin and HIV, and the idea that HIV and AIDS is a punishment from God are but a few of the challenges that need proper theological reflection. How these are understood and dealt with is clearly a question for theology and a question that cannot be brushed aside. Our pastoral care response to HIV and AIDS must be conceptualized and directed by an integrative theological framework (Clifford, 2004:3; Richardson, 2006: 39).

In the previous chapter we concluded that health and well-being, from a Biblical and theological perspective, is best understood through the concept of wholeness. Such wholeness in the first place refers to a spiritual wholeness characterized by a process of growth towards a faith maturity defined by and concretized through our relationships with God, others and the self. We noted that this process must ultimately assists in finding meaning amidst and despite suffering. It is an integrated and integrative approach that presupposes an integrated view on human beings and communities alike. The concept of *shalom* not only highlighted the relational

character of such wholeness, but also brings to the fore the ethical responsibility of faith communities as centres for growth and care. A few theological concepts undergird the philosophy of this integrated approach. The ones that I regard as important, and that we should perhaps spend some time on, have to do with: (1) understanding the pastoral care encounter as space for growth and transformation; (2) developing a pastoral anthropology consistent with the integrated approach towards healing and wholeness; (3) exploration of the (Christian) basis for finding meaning amidst and despite suffering, since it is argued that healing for wholeness implies a process through which meaning is generated; and (4) developing an understanding of the church that is centred around a specific identity of church as centre for growth and care. Whereas the first three of these will be discussed in this chapter, the last theme will only be discussed in Chapter 5.

4.1. Understanding the Pastoral Care Encounter as Space for Growth and Transformation

In light of the importance of the relational aspects in our understanding of healing for wholeness, I believe that it is imperative that we look at the pastoral care process as an encounter between God and humans and between humans. It is therefore important that we understand what we mean by pastoral care, and in particular as an event of encounter. Daniel Louw (1999: 92-98) speaks of pastoral care as the embodiment of God's love and care - an encounter with salvation, and one that serves as a metaphor for an encounter with God. This pastoral encounter is at the same time sacrament and incarnation. As sacrament it points to God's grace in Christ and in His sacrifice, as well as to the mysterious presence of God in the pastoral encounter. As incarnation it is the expression of the way God's intimacy and covenantal trust is embodied. This intimacy is a space of unconditional love. As theological metaphors, these place the emphasis on the fact that the pastoral encounter functions in the interest of God. It must express the will, presence and love of God. At the same time we can argue that it is one of the basic traits of humans to encounter and to be encountered (93). Another important aspect of the encounter is that it presupposes mutuality and involvement, and therefore the

encounter is an event of dedication to one another through compassion and care. Louw (94-95) discusses six characteristics of an encounter, which could be integrated in our understanding of the pastoral encounter. Encounter presupposes an event of getting to know each other due to being exposed to one another. It further means that you make contact and in so doing develop an awareness of each other. As mentioned before, in encounter there is mutuality and interaction, to an extent where the result is one of influencing each other and bringing about change. Louw (1999:95) asserts that the encounter is not just any event. It is a Word event which is part of the transfer and pronouncement of salvation.

Karl Barth (cited in Louw, 1999:95) refers to being humans as togetherness ("samesyn") with God. Accordingly we can expect that this God-human relationship will be concretised in the context of a covenantal mutuality. This covenantal encounter between God and human gives to the pastoral encounter a character of nearness and comfort. We need to understand that it is always God who takes the initiative in any encounter. On the basis of this we can know that the pastoral encounter is truly an expression of God's embracing love, and it takes place in a context of dialogue. The pastoral encounter is also a process of knowing and learning – both theologically and anthropologically. In the event of the encounter we get to know God, and this knowledge of God leads to knowledge of the person. This knowledge of the person reaches consummation on the path of faith knowledge.

We can summarise our understanding so far in the words of Daniel Louw: "The pastoral encounter" ... is

> the communication process between God and human in a concrete situation with which the human, in the light of Scripture via faith, unlock meaning, discover and concretely experience God's presence, and to come to a better understanding of the self. (Louw, 1999:98)

This pastoral encounter remains theonomic, dependent on God's grace for humanity, while at the same time it takes serious also the cultural and socio-economic contexts

within which a person or community is encountered. This emphasises the call for pastoral care and counselling to also become involved in identifying structural inadequacies in the plight for healing for wholeness, and to become concerned with the process of transforming such structures. That is why, as Louw (89-101) also argues, the pastoral encounter must essentially be the concern of the entire congregation. In a relationship of brotherly and sisterly love, there can be no other way. If this were not so, the pastoral encounter becomes nothing other than an estranged one of "verbal solidarity". It is therefore important that it happens from its base, namely the congregation. When the encounter in such a context is an encounter with God, salvation inevitably brings about change, influences and renews knowledge and instils a process that affects the attitude, behaviour and lifestyle of people. It is thus clear that the pastoral encounter, which brings hope and care, is never limited to the minister or primary pastoral caregiver, but rather that of every member of the body of Christ, namely the church. As Eunice Kamaara (2004: 35) puts it: "As the Body of Christ, the Church is expected to be a caring community that ministers to all its members in their specific circumstances". This is particularly so with regard to persons living with HIV and AIDS as the epidemic is not about statistics, but is "impoverishing people, breaking their hearts, causing violations of their human rights and wreaking havoc upon their bodies and spirits" (Kamaara, 2004: 37). Care for people infected and affected by HIV and AIDS is indeed the business of the entire church (Richardson, 2006:50).

This pastoral encounter is further the result of a theological hermeneutic, where the relationship between the stories of people and the stories of God's involvement with people is at the centre (Louw, 1999: 133). This again calls for an attentive listening and involvement with each other, highlighting the pivotal role of healthy relationships. In this the stories of people are analysed and understood in the light of God's on-going involvement with humanity. It leads to understanding, togetherness, and an interpretation of salvation in that particular context. It brings us near to God and in particular in the space of our crucified Christ where the suffering of people gains new meaning in light of the suffering of Christ. This brings a new growth in faith and

maturity, and leads to a new life based on a new understanding of God – a renewed God concept.

It becomes clear that the pastoral encounter with God is not limited to private, individual experience. Instead, in line with our understanding of the notion of *shalom*, it is something that happens within a relational context and has a strong community orientation. It is an encounter of dialogue, shared spaces and pain, and togetherness. In such an encounter both the responsibility and the aim of pastoral care has a communal character, for it is within healing relationships and communities that individuals experience the healing presence of God. Where relationships are restored and fellowship with both God and the other is experienced, hope becomes a reality. In the pastoral ministry of the church, it is called to create such spaces for this restorative encounter, and when healing is administered by the community, the community itself becomes healed.

The Bible is full of examples where an encounter with God was a life-changing event and where true liberation and healing flowed from such encounters. I will mention only a few here: God encountering Israel in their destitution in Egypt and liberating them from oppression. God who encounters Hagar and Ishmael in the desert to give them a new promise and a new lease on life. God who encounters Daniel in a foreign land and raised him above his contemporaries. In the New Testament we see how God, in Jesus, encounters the Phoenician women, the Samaritan women, the young man born blind, Mary Magdalene, Levi who became Mathew, and the criminal on the cross, to name but a few. In each of these cases this encounter brought liberation, freedom, healing, and new and fresh ways of living and above all it brought those in the encounter within the comforting presence of God. And all this inevitably flowed over into relationships, bringing meaning and healing not only to those directly involved, but also to the communities within which the encounter took place.

To know the above is not enough though. Communities in the first place consist of individuals – people, human beings. A theological understanding of what it means to be human is accordingly necessary if the pastoral encounter is to be defined by an integrated path of growth, healing and meaning making. I therefor argue that we need to develop a pastoral anthropology that will inform the basis of an integrated pastoral care and healing approach related to both individuals and communities.

4.2. Toward a Pastoral Anthropology of Integration

Sherlock (1996:16) asks: "Given the sparkling variety of people in our world, can any single answer be formed to the question of what it means to be human?" Shirley Guthrie (1979:130) wrote: "An anthropology based on faith in the triune God who is Creator, Redeemer, and Life-giver is the distinguishing characteristic of Christian pastoral counselling." In other words, our understanding of a pastoral anthropology flows from our understanding of our relationship with God, and in fact our understanding of all human beings in relation to God. Not only is such an anthropology vested in faith in God, but it has as its aim the development and establishment of a mature faith (Louw, 1999:157).

The question is not only what type of anthropology we subscribe to, but also what the possible implications of our understanding of such a pastoral anthropology is. My view is that we derive our understanding on anthropology from our understanding of the God-human relationship that defines our human existence, i.e. what it means to be human, and especially so in the light of the covenant and grace of God. In light of the integrative and integrated approach to wholeness and healing I propose that we develop our anthropology in terms of: (1) our God-human relationships, which ultimately defines our understanding of human existence; and (2) an integrated view on human beings as a single, integrated and unified entity. I will now explore each of these in the following sections.

4.2.1. Anthropology in Light of the God-Human Relationship (Who are we in relation to God?)

Daniel Louw (1999:92-135) understands the pastoral process as a tripartite encounter involving God, the caregiver and the person in need of care. This understanding can be traced back to the basic understanding that humans are relational beings, created in the image of God (imago Dei). It further derives from the fact that the pastoral encounter, in which God takes centre place, is ultimately about reconciling humans with God in Jesus Christ. In such an encounter the Christian – lay, clergy or pastoral caregiver - embodies the divine love and saving grace of God, which is only possible if we understand that it is because of the indwelling Spirit of God that we may find healing in the pastoral encounter. From this it is then possible to understand the human being as a pneumatological being, fully integrated and reconciled with its psychological nature and being (151-152).

From a Christian perspective, the doctrine of the Trinity is the foundation for, and the uniqueness of, our anthropology (Guthrie, 1979:131). Hence our anthropology is influenced and defined by our understanding of the triune God – Father, Son and Spirit. Understanding our relationship with the triune God, who is Creator, Redeemer and Life-Giver, helps us in two ways. On the one hand we understand our own "createdness" and hence it helps us not to succumb to the temptation of playing God in other people's lives. On the other hand it helps us to see the other as (i) being created in the image of God to enjoy the fruits of a relationship with God, (ii) sinners, like ourselves, who are unable to live their intended purpose, yet they are loved and redeemed by God, and (iii) being promised a new humanity by God with the ultimate outcome that humans can fulfil their purposes for which they have been created (133).

Although created in the image of God, the human existence is a bodily one integrated with the abilities of rationality, emotionality and desirability and decision-making (Guthrie, 1979:133). This understanding takes serious the here and now

experience of humans, their bodily characteristics, and their sexuality. Being created in the image of God further implies that humans are endowed with the ability to have agency in their lives and to experience their lives as whole beings, free to make choices. Guthrie argues that it is only when we see people in this way that we appreciate their realities in its fullness and it is only then that we are able to help the "total human selfhood in which body, heart, mind, and will are understood in their integrated relationship to each other". In such an integrated anthropology humans are *sarx/soma*, *nous* and *kardia* – body, mind and spirit (Dunn, 1998:51-78). It is now possible to see the human being as the "enfleshment" of soul and spirit, yet at the same time as "ensoulment" of the body.

Relating anthropology to the notion of *imago Dei* implies that our God concept should play an important role in understanding humanity and in developing an appropriate anthropology. It is assumed than that a positive regard for humanity, and vice versa. According to Daniel Louw (2008:92) "spiritual health within a pastoral model refers to the quality and nature of one's maturity in faith, which is determined by one's understanding of God". From this it is clear that any pastoral theology should have an emphasis on understanding the God concept at work in the individual and community where care is needed, and to guide such individual and community in re-evaluating their own God concepts and become open to renewing them if necessary. This is especially important since inappropriate God images inevitably lead to "pathology and 'spiritual illness,'" (Louw, 2008:92). In an African cultural context, for example, God is seen as distant and aloof (Crafford, 1996: 13) and such a God cannot possibly be involved in the suffering of the human. So how can we then expect fellow human beings to be involved in the suffering of others? It is important than to look at Scripture in particular for metaphors denoting the character of God and translate that into contextually meaningful language for the "sufferer" to be able to relate to such images. In the case of PLWHA it is especially important to see how God makes Himself vulnerable in siding with the weak, as attested to in both the Old and New Testaments. Yet, the Bible also shows us a God who is all powerful, who changes situations and circumstances, who brings about

healing and who generally stands up for and by the afflicted even if it means using force at times. The message is thus clear: God does not forsake those in need.

In the HIV and AIDS scenario, negative images of God are often at work (Louw, 2008: 427-9). He may be seen as the vindictive judge, the bookkeeper of mistakes, a sadistic being, or perhaps as an indifferent deity who does not really care about the suffering of people. For many HIV and AIDS is God's punishment for humanity's disobedience and promiscuity. But, is that true? What does the Gospel of Jesus tells us about God in a context such as the one we have with the AIDS epidemic? It is the task of pastoral care, and the church at large, to bring these notions in discussion with the positive images of God that we find in the Bible and in the lives of so many around us and even often in our own pasts. Louw (429) suggests that we move away from a discourse of sin and judgement and rather focus on life and meaning seen in the relatedness and engagement of God in every human suffering. As a church we are then faced with the question of how we live God's compassion in a situation of suffering – also towards people living with AIDS. Rick Williamson (1998: 56-58) demonstrated that discovering the positive images of God, in terms of love, as Lord, Life Giver, Guardian and Force, indeed helps many persons living with HIV and AIDS to cope with their reality and to find hope in what seems to be a hopeless situation; and to discover the true meaning of life amidst the immanent reality of death. It is therefore clear that a view on humanity as being created in the image of God must hold to the idea that we are inherently caring beings in a caring community, and hence we will side with God in the plight of sick and stigmatized and marginalized. This is exactly what we are called to be through the Belhar Confession of the Uniting Reformed Church in Southern Africa (URCSA), i.e. to acknowledge God's position on the side of the afflicted and to join Him there. We therefore cannot hold to a pastoral anthropology that judges, condemns and stigmatizes PLWHA (Belhar Confession, 1986).

The answer to the question of what it means to be human is explicated in our Christian understanding by pointing to Jesus Christ, who is both "the image of the

invisible God" (Col.1:15) and the image of true humanity (Heb. 2:14). In his life, death and resurrection we see what being human means at its deepest and fullest, but even then we are at a loss for words. A simple formula cannot do justice to the wonderful mystery of human life. In addition, being created in the image of God makes us chosen partners in the work of creation, bestowed with the responsibility of positive, responsible stewardship.

> We neither are God's clones nor are we 'miserable offenders,' wholly incapable of doing good. We are God's creatures and chosen partners in the work of creation. We are given ever greater opportunity to be bearers of the divine image, that is: positive responsible stewards in the world, until the day that God makes all things new. (Towner, 2005: 356).

Hence partakers in the healing work of God through our therapeutic contributions. This notion assumes that we are not only in relationship with God, but also in relationship with other human beings – we are social beings (Dunn, 1998:53), and this must be considered seriously in our understanding of a pastoral anthropology in the business of caring for PLWHA.

Louw (2011:152), drawing on Karl Barth, makes the following links between our understanding of Christology and anthropology.

- Christology has a **relational effect** on anthropology. The term "Christ as the image of God" (2 Cor 4:4, Col 1:15) therefore links human beings with their salvation.
- Christology has a **transforming effect**. It transforms a person into a new being (2 Cor 5:17), who is gradually being transformed into the image of Christ (2 Cor. 3:18).
- Christology has **epistemological implications** for anthropology. Christology reveals the human guilt. A theology of the cross unmasks people in the misery and need. However, in Christ they discover that they are God's children, which leads to a positive self-esteem. God accepts me; in Christ, God reveals his unconditional "*yes"* to humanity.

- Christology **restores** people to their ultimate function before God. It supplies a telic dimension in which the search for meaning can take place.
- Christology **provides** people with **a spiritual dimension**: a human is a spiritual being with a transcendental destiny.

However, an anthropological understanding based solely on Christology runs the risk of interpreting salvation in Christ primarily in terms of his function for humanity. On the other hand, it is through the work of the Holy Spirit that humans truly become human and attain a new self-acceptance and discovery of their identity. Only through a pneumatological focus can the humanist vision, which tends to separate spirit and body, be replaced in pastoral care. It is only through the Holy Spirit that Christ lives in people, and that their complete humanity and image of God status can be recovered (Louw, 1999: 211). This concept of the indwelling of the Holy Spirit, termed as inhabitation theology, plays a significant role in all aspects of our human identity and in the ministry of integrated care, as it has been discussed and still to be discussed in later section of this thesis.

The value of such an inhabitation theology, according to Louw (1999: 212-214), lies in the following:

i. The Holy Spirit, in conjunction with Scripture, evaluates, gives **new insight**, works radical **transformation**, and provides an **eschatological end-function** to human existence.
ii. The Holy Spirit gives **a new dynamic alignment in human existence** whereby the focus moves away from the self to **self-transcending hope**.
iii. Through the application and instilment of the salvation in Christ, the Holy Spirit takes people through a process of **faith maturity**, which is far beyond mere psychological maturity, which implies then a **radically new life pattern and behaviour change**.
iv. The process of faith maturity also leads to a **new moral orientation**, individually as well as communally, and it is in this context that **true koinonia**

as being for each other can materialise, and that true encounters between humans and humans and God happen.

v. The work of the Holy Spirit also gives a **new identity**, both to the care giver (pastor) and the one being cared for in the pastoral encounter.

vi. Under the guidance of the Holy Spirit pastoral care is more than psychotherapy – it becomes **salvation therapy**.

vii. Finally, as paraklete, the Holy Spirit **consoles and cares** in a way that **redefines humans** as both bodily and spiritual beings.

In a context of HIV and AIDS people are faced with a bleak future and struggle daily with the feeling of despair and hopelessness. They further struggle with their own identity and with the foreignness of what happens to their bodies and spirit. It is in such a context that the indwelling of the Holy Spirit works hope and meaning in communities ravaged by HIV and AIDS.

A Trinitarian approach to anthropology has certain implications for our human existence. When discussing the theological anthropology in pastoral care, one of the central themes that Louw (1998:147) elaborates on, is the fundamental structure of our 'being human'. He identifies two aspects. Firstly, the human being that is made in God's image (Genesis 1:26-28) and secondly, the human being as a transcendental spiritual being (Genesis 2:7). When thinking about the first aspect, it deals with how human beings represent God and with the relationship between humans and God. The second idea focuses on how "the source for life is dependent on God's creative action and faithfulness" (147). These two ideas are intertwined, as the idea that we are made in His image presupposes that we are spiritual beings. Therefore we can discuss the two aspects together as one concept.

Being created in the image of God, speaks of our relationship with God as our Father and we as His children, and how we are dependent on Him (Louw, 1998:148). It also speaks about how we live our lives and embody the identity that flows from this

understanding. "In all our relations and in every fabric of our life, we are the image of God. True knowledge about ourselves can be found only within this unique relationship" (Louw, 1998:148). Within the idea of being created in His image, is the aspect of us being transcendental and having an eternal destiny (Louw, 1998:148). "The continuity (of remaining the image of God) does not reside in our humanity, but in God's faithfulness" (Louw, 1998:149). "Throughout history God's people have been sustained by the knowledge that they are created in the image of God" (Krause, 2005). Being created in His image, we can be aware of the joy and beauty, in spite of the world's pain and cruelty, and are encouraged to live as God's new creation in Christ (Krause, 2005). Thus, in the pastoral encounter there is hope and encouragement within this knowledge of being created in His image.

As much as the above goes for the individual it goes for communities who consist of individuals. The implication of this view is that it enables us to take a positive view of ourselves and others, despite brokenness and apparent illness. It is not a positivistic view about human potential, but rather a positive view based on the godlike nature and identity of being human.

Human beings as being created by God, implies a responsibility and dependence on God. "Responsibility" implies that a person is responsible **to**, and responsible **for** because of the relationships in which a person functions. This extends further and includes a relationship with God as well. The implication for our positioning within the HIV and AIDS context is that we as the Body of Christ, the church, will not only deny our own identity as Imago Dei but also the true identity of God when we turn a blind eye to the challenges the epidemic presents to us, and especially if our responses to it are not focussed on the embodied soul who has been created in the image of God. It will also imply that we deny our relational character.

A theological anthropology that works with the notion of humans as responsible beings with a motivated life direction breeds faith. Faith, thus, is the medium through

which pastoral care and therapy, anthropologically speaking, will work. Love and thankfulness is the effect of a theological anthropology working with a Christological directedness of humans existing as new beings. The further effect of theological anthropology that works with the resurrection is hope. Faith, love, hope, thankfulness and joy remains fundamental for a pastoral strategy. These five elements strengthen our identity as being created by God. It helps to build a mature faith and gives direction to the future. Theological anthropology is indeed connected to the transcendental and eschatological factors of human existence, namely God's faithfulness to his creation and his love through renewing grace.

An appropriate pastoral anthropology sees every human being, even the person living with HIV and AIDS, as being created in the image of God, unique and able. It recognises and affirms the individuality of the person. However, this individuality is one which only finds its true value in human community, while at the same time it is this very human community that nourishes and protects that individuality (Guthrie, 1979:134). It is therefore an anthropology within which the aspects of self-affirmation and self-determination are validated, contrary to the idea of only self-denial which has plagued the anthropological stance of the church for so long.

An anthropology that deems important the idea that humans have been created in the image of God and who only find their identity in relation to God and others assumes that the human existence is both good and sinful (Guthrie, 1979:136). None of these two sides of our existence should never be underestimated, but should rather be kept in a constructive tension with each other. Humans have been created in the image of God and hence should be inherently good. However, as we have "fallen" into sin, this inherent goodness intended by God has been tarnished. But this is not the end of the human story. In Christ we are all recreated and we can all live as renewed beings in accordance with God's purpose and intentions. Here it is important to remember that our sin does not take away God's approval of our human existence (137). Instead, through His loving grace in Christ, God affirms our human existence. It is an existence in which God has, to some extent, given up His own power to control humanity and blessed us with the gift of freedom, a freedom

that however asks of us to take serious our vocation as imago Dei, yet at the same time as promise of the good that God is still doing and that He will continue to do for humanity (137).

As Louw (2005:192-195) asserts, the biblical view on humans is formed from the central presupposition that all humans are dependent on God and that our very being must be understood from this relationship with God – our existence is one of dependency on God. Humanity must be understood within the context of togetherness with God and with the others. Christian love is unconditional. There is no explanation for the unconditional love of God. This unconditional love must inform our understanding of a pastoral anthropology suited to care for and side with PLWHA.

The Bible in the first place speaks not of humans only as sinners, but especially as recipients of God's gift of grace and as new beings in Christ. It puts humanity in the context of a covenantal relationship with God, where God's grace renews and restores. It also tells us about the fulfilling of God's promises as an eschatological truth, about the victory dimension of the resurrection truth, and about glory of God's rule over all destructive powers. Because Scripture speaks firstly about human beings in terms of this eschatological truth, it is not possible to take sin and guilt as the primary stance for theological anthropology. Our identity, worth, and existential meaning can therefore not be directed by sin, but by the grace of God and the salvation in Christ. Sin and guilt is revealed from the perspective of grace. This is why a person is not addressed in pastoral care and therapy in terms of the negative, destructive components, but rather in terms of the positive, transforming powers from the eschatological truth of being saved. Yes, the Biblical view on humanity is realistic and acknowledges our sinfulness. However, it does not fixate on sin and the sinfulness of humanity, while at the same time it is also not merely optimistic. Instead, it rather focuses on the renewing power of salvation. This brings about a process within the human person, and this is a process of realisation that humans are miserable and sinful – this happening in terms of God's grace. Because of this

realisation a person can then say “I believe” which leads to a doxology, giving praise to God. This realism is a realism of faith and in pastoral therapy one encounters the other in terms of this realism of faith, with the end goal being to give praise to God.

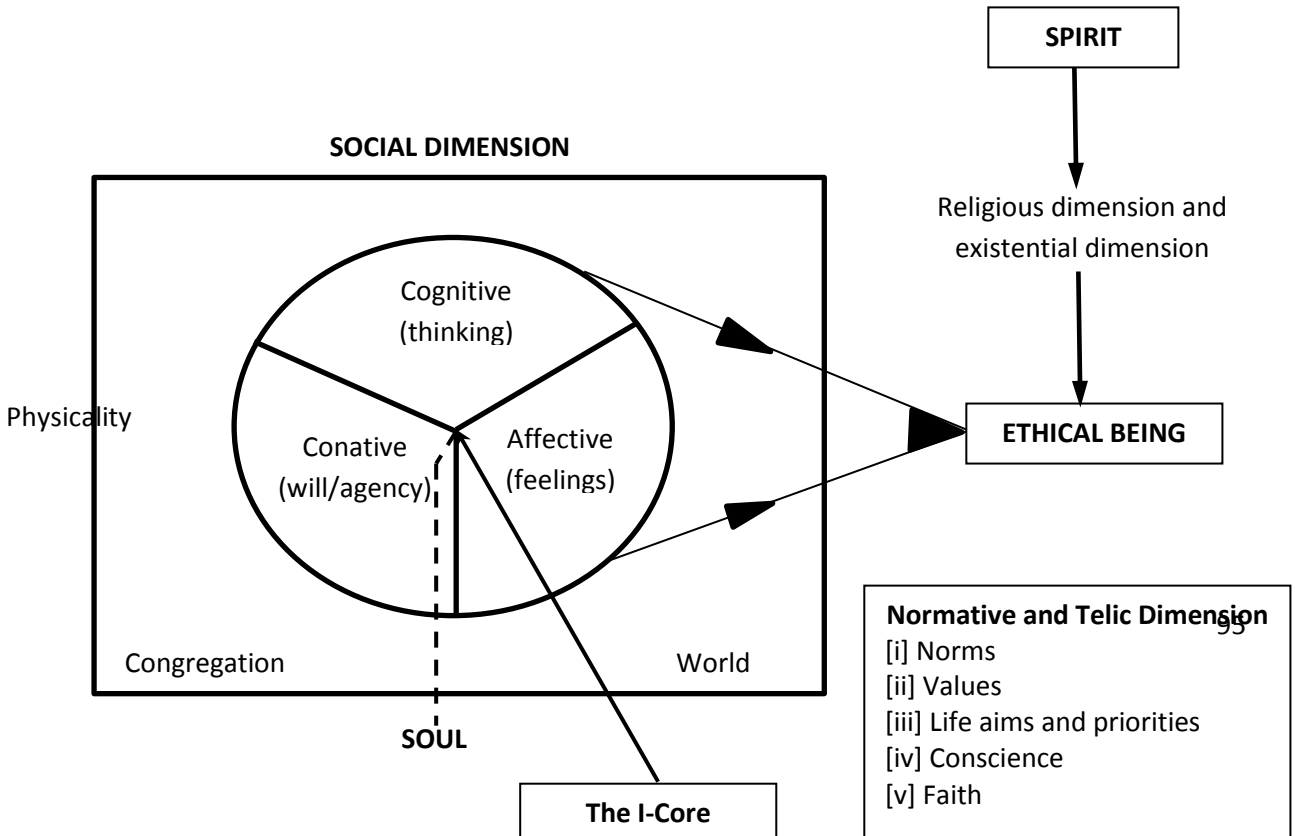
4.2.2. Human Beings as Spiritual Beings - Single, Integrated and Unified (Who are we in relation to ourselves?)

The idea of human beings as multifaceted, integrated beings has been around for long. In 1976 Trevor Rowe (1976:10) stated that the view of a human being as a single entity is founded in the Bible, and not only in the Genesis accounts but throughout the Bible. He describes human beings as flesh, soul, breath, life, body, all seemingly expressing one thing – “the whole man” (11). He continues by saying that in Jesus, as the complete being we are truly body and truly soul in all wholeness. The whole being – human - can think, feel sense and have intuition, all of these forming only sub-worlds of the “one world’ comprising human existence. “These subsystems combine to form a complex system of the person ... [and] what happens in one subsystem affects the whole” (Rowe, 1976:74). But the understanding of who we are as humans is not only found within the composite individual and integrated being. Instead, as Rowe (1976:74) indicates, “[w]e cannot understand human beings on their own, but only in their relationships”.

Daniel Louw (1999:296), drawing on the Biblical view of the human being as a unity (heart, reason and body), argues for an integrated approach to pastoral praxis theory formation. Louw sees the human being as being comprised of four components: the affective (feelings), cognitive (thinking), conative (decision making) and bodily components. All of these are seen as an integrated whole. When we acknowledge the pneumatological perspective of our being, we need to add two more components, Louw suggests. These are the normative and koinonial components. In pastoral care it is important to gain access to what people think and what they base their thoughts on, what they feel in terms on their internalized awareness of reality, how they respond to their feelings and thoughts through decisions and actions, and how

their bodies not only respond to experienced reality but also how it exerts itself on these realities. However, on their own these four components do not interact straightforwardly and hence do not generate meaning from reality in an arbitrary fashion. Instead, as Louw (1999:297) argues, meaning is generated when these components intersect at the very core of a person's being – integration takes place at this spiritual core. This integration is facilitated through the norms, values and the ethical nature of every person. It is within this normative dimension that pastoral care wishes to engage with the person and bring about a change of perspective that should lead to new meaning in terms of the experienced reality. Yet, it is only through the work of the Spirit that such an engagement and growth process is possible. It is only when the spiritual being and the Spirit of God connects that meaning is generated in all four dimensions of existence. Further integration and meaning-making is made possible when our pastoral anthropology allows a corporate and communal engagement through, what Louw calls, the koinonial component. Louw argues that the corporative dimension of *communion sanctorum* is the necessary element for concretizing the message of salvation. It is in community that growth and meaning making ultimately takes place.

Louw's praxis model for a pastoral anthropology can be depicted as follows (from Louw, 1999:297).



4.2.3. Summary

Louw (2008: 429) argues that an understanding of God requires the consideration of a theological anthropology. Such anthropology firstly develops from the fact that humans, as being in the likeness of God, are relational beings that are open to pain and vulnerability. God, from whom this relationality flows, must then be embracing the ones suffering from AIDS instead of being judgemental towards them. At the same time God's incarnation in Christ, and His suffering, helps us to understand that he is indeed involved in the suffering of humanity. Through the cross, God showed His vulnerability, but at the same time this is an expression of His grace towards humankind. This implies that we should not merely see humans as sinful beings that, as in the case of HIV and AIDS, are to be stigmatised. Rather such an anthropology calls for a theology of compassion and understanding which works towards unearthing the inherent goodness in humans as intended for right from creation.

Linking to the above is the notion of humans as the Imago Dei. Williamson (1998: 59) calls us to recognise that we, being created in the image of God, are in every respect "linked to our identity as created in God's image", and that makes us a part of what He called "good". The reality, however, is that AIDS attacks this imago Dei – physically, emotionally and spiritually. It becomes increasingly difficult for the person living with HIV and AIDS to reconcile the deteriorating body and spirit with the notion of image of God. It is therefore the task of pastoral care, and the church in general, to rethink together with the person living with HIV and AIDS "what God looks like".

We are to see the image of God not only in the suffering brought on by HIV and AIDS, but also in the suffering of the "weak" Christ on the cross (61). He too was disfigured and deserted. Yet His suffering was but a precursor of the renewal to come through the resurrection. It seems important that, in order to hold to a view on humanity that allows for the generation of hope and meaning, we allow for the view that we as human beings have been created in the image of the triune God - Creator, Redeemer and Life-Giver.

In light of our discussion above one can then deduce the following as a consequence for our pastoral care praxis. Praxis of pastoral care needs to be based on a theory which takes cognizance of three very important components of pastoral care: the functioning of the human person, counselling, and the relationship between pastoral care and psychology. These three components determine the eventual therapy and practice in pastoral care. (Louw 2011:244)

- Pastoral anthropology and a model for pastoral ministry.

  Scripture combines three dimensions: the heart, the reason and the body. Pastoral care is thus obliged to treat the human person as a unity, and to ensure that all three dimensions are taken into consideration when designing a model for pastoral care. Louw (1999:411) refers the affective (emotional and experiential component), cognitive (thinking component), conative (motivational and decision-making component) and normative (spiritual and faith component) dimensions as the constituents of an anthropology that represents the integrated nature of human beings. All these components need to be accounted for in our pastoral care approach. Such view is particularly apt in the current HIV and AIDS context as we have seen that the disease indeed impinges on human functioning on all these levels.

- The pastoral conversation and counselling: a trialogue.

  The identity of the pastoral conversation is derived from the fact that God wishes to be a conversational partner and that God speaks in our midst.

- The relation: pastoral care and psychology.

  There is a difference in perspective between anthropology in pastoral care and anthropology in psychology. Psychology seeks the highest measure of self-realization and congruency of the personality, whereas pastoral care seeks the highest measure of faith development and reconciliation. Both make an important contribution. Therefore a multi-disciplinary approach is necessary.

4.3. What is the hope and meaning that we seek to offer in our growth-promoting care?

In Chapter 3 I indicated that the process of healing for wholeness anticipates the generation of hope and meaning amidst and despite suffering. Theologically we have to ask how this can be possible. In other words: what could be the basis for such hope and meaning? Daniel Louw, in *Meaning in Suffering: A theological reflection on the cross and the resurrection for pastoral care and counselling* (2000) argues that the primary basis for a meaningful life is in the understanding of the death and resurrection of Jesus Christ. He asserts that the firm belief in these as affirmation that God truly enters the world of human suffering is the only foundation for hope and meaning amidst human suffering. Since this work of his is so extensive and authoritative, I will use it as primary source for the discussions that follow.

4.3.1. Hope in the Cross: A Theology of the Cross[18]

Taking our viewpoint about human beings as being created in the image of God, one can conclude that suffering affects both our human identity and God's identity. Thus, we do not only ask "Why?" in suffering, but also "How?", and in particular we ask "How is God in human suffering? and "Can God suffer?". Such questions touch on

[18] From Louw, *Meaning in Suffering: A theological reflection on the cross and the resurrection for pastoral care and counselling* 2000:73-116.

the very fabric of Christian spirituality and the question of who God is and how is He involved in suffering becomes a theological issue probing God's identification in suffering. Louw asserts that for a deeper insight into such questions one has to look at the cross of Christ, since it is in the cross that a vivid understanding of Christian hope is found as it identifies God in human suffering in a way that undermines all human attempts to spiritualize suffering or the meaning of salvation. Suffering, such as that caused by HIV and AIDS for instance, is therefore against the will of God.

According to Louw the question of whether God can suffer expresses the need to reflect on the relationship between God and the cross, making the theology of the cross an important component of a theology of pastoral care since it engages with the act of God's involvement, solidarity and identification with suffering. Louw further argues that a theology of the cross lodges an emphatic protest against a metaphysical doctrine of a theistic God that places Him so high and far away that the sufferer feels abandoned by Him, such as it can possibly be seen in traditional African religions where God is viewed as being distant and aloof. In other words, the theology of the cross bridges the distance between the sufferer and God, hence the goal of pastoral care is not to eliminate suffering but to point the sufferer to the cross. Therefore, the theology of the cross becomes the revelation of how God deals with suffering (1 Corinthians 2: 23-25). A theology of the cross relates to both the existential dimension (our being human) and the essential dimension (the identity and characteristics of God's Being), and affecting both our human misery as well as the mode of God's existence. We now consider these.

4.3.1.1. The Existential Dimension of the Cross: Luther's *Theologia Crucis*

Luther (from Louw, 2000) declares that the theology of the cross describes essential reality and perceives being in terms of its essential characteristics. Therefore, Luther asserts, the visible as well as the not yet revealed aspects concerning the presence of God should be perceived from the perspective of suffering and the cross. Hence

the cross becomes a resource of comprehension and understanding. Luther also proclaims the pastoral dimension of the cross in that God relates to human suffering as the cross does not only play a role in our salvation, but it is the very epicentre of all theological statements. Louw adds that the cross of Christ and the cross of the Christian belong together and the cross of Christ reveals the nature (the how) of the relationship between God and human beings.

For Louw, Christ's suffering cannot be separated from God's suffering which implies a discovery of divine identification that sheds new light on our quest for meaning in suffering. This means that, without God's direct involvement, human life is without hope and without fulfilment. The cross of Christ creates a vivid understanding of Christian hope because it identifies God in human suffering in such a way that the cross of Christ undermines all attempts to spiritualize the meaning of salvation.

Luther (in Louw, 2000) further articulates that, the sole authentic locus of our human knowledge of God is the cross of Christ in which God is to be found revealed and yet, paradoxically, hidden in this revelation. God is revealed in the humility and shame of the cross. The hidden God is only recognizable through faith. Faith therefore discovers that God's works are hidden under the form of their opposite. God is recognized by means of faith and not of natural knowledge. For Luther faith discovers God's strength which is hidden under apparent weakness as well as His wisdom under apparent folly and the future glory of Christians under present suffering. This weakness makes God fully part of the plight of those living with HIV and AIDS. To truly share in their suffering and meaning-making processes demands that we become weak ourselves.

God the father suffers in compassion with the Son in the Spirit of love between them. Therefore the Christian faith consists of the fact that God, in the passion history of Jesus Christ, has suffered the curse of death and misery on behalf of humanity and we therefore do not need to live with the anxiety and despair of the shadow of death.

Luther's emphasis is on this "How of God: God with us and God for us" and not the speculation of how God may be in and for Himself. Louw adds that the significance of Luther's contribution is that faith consists of both cognitive and existential components. Hence Louw states that in order to discover meaning in suffering a person does not need to depend on human moral activity or created order, but should turn to the cross and the sufferings of Christ. Hence, true theology and knowledge of God are found in the crucified Christ. Louw adds that God therefore is only known through suffering as He is revealed as a God of passion and not as an impassable God.

4.3.1.2. The Ontological Dimension of the Cross: Moltmann's *Eschatologia Crucis*

Louw discusses Moltmann's eschatologia cruces and describes it as multifaceted; difficult to categorize it as only a theology of the cross, a theology of hope or a theology of resurrection. According to Louw, Moltmann places all the emphasis on the resurrection and eschatology where the resurrection becomes the key to and the exegesis of, the cross. Without the cross then, eschatology evaporates into Utopia; hence the importance for understanding the meaning of the theology of hope as actually a theology of the cross. Moltmann asserts that eschatology is an integral part of history and the theology of the cross attempts to link God to the reality of history and the pain of suffering. The intimate relationship and dialectic between the cross and resurrection therefore stamps out clearly in Moltmann's theology as fundamentally an eschatologia crucis. Therefore the cross must be understood in the light of Jesus' resurrection because it reveals the meaning dimension of the message of salvation. It becomes clear then that the resurrection is grounded on the historicity of the cross; meaning Christian theology finds its unique character in the crucified Christ. Louw states that hope therefore becomes a Person, based upon the fulfilled promises of a suffering and living God. Moltmann bases hope on the nucleus provided by the historicity of the cross. According to Louw, Moltmann's intention here is to make theology relevant to the question of suffering. Moltmann therefore sees the cross as the definitive point of identity for Christian theology which attempts

to bring pastoral comfort and liberation. In other words, the theology of the cross is a liberating theology of God whose intention is focused on the distress of suffering.

The theology of the cross once again is seen as emphasizing the solidarity of God in the midst of the human suffering. Louw adds, “God’s identification with suffering is active resistance and a demonstration against suffering” (Louw, 2000:85). This understanding is very helpful since it makes the idea of the identification of a compassionate God with suffering of people a reality. However, the cross is indeed about punishment, sin and forgiveness and any theological approach cannot ignore the reality of sin. As indicated before, sin never becomes normative. It is rather the grace in the cross that is definitive. Yet, without the resurrection God’s identification with human suffering would be meaningless because the suffering on the cross becomes a source of hope for the sufferer only when it is seen in the light of the resurrection. It is clear then that Moltmann does not isolate the suffering on the cross from the victory of the resurrection, because hope is essentially the hope of resurrection.

Although the cross of Jesus points to His earthly life leading to the cross, it should also be interpreted eschatologically from the viewpoint of the resurrection and Advent. In Christ both God’s divinity and humanity are involved in suffering. On the other hand, Christ’s death means victory over suffering and his substitution eliminates guilt.

Finally, the theology of the cross reframes our understanding of God as vulnerable and wounded, meaning that God is there although suffering is not abolished. It becomes clear than that the theology of the cross, which incorporates both Christ’s reconciliatory work and God’s mercy and grace, provides the hope and the fundamental framework in which one can discover meaning in suffering.

4.3.1.3. The Pastoral Dimension in a *Theologia Crucis*: Vulnerability, Compassion and Reconciliation

The reality of God's Spirit in suffering is the very reason why a theology of the cross could be a theology of hope. In it lies our salvation and reconciliation with God. According to Louw the connection between suffering and God finds meaning in Christ and is expressed in several dimensions through which human life is touched. He asserts that suffering, as a theological theme, reveals the following dimensions of a theologia crucis: reconciliation (justification), representation (sacrifice), redemption/liberation, transformation, expiation/propiation, and pathos (the suffering and crucified God). These are briefly discussed below.

Suffering and the reconciled state of peace and victory (justification)

According to Louw, it is in suffering that one's faith must allow us to *"discover that […] God has healed the breach and made possible a new, restored relationship and fellowship [with us humans], through Christ as our Mediator"* (Louw, 2000:165).
Through our sins, our relationship with God has been destroyed, but we are brought into a new relationship with God, where the powers of guilt, death, anxiety, enmity and sin are broken. This restored relationship, creates a state of peace. Therefore, "[t]he believer exists in a state of redemption and takes part in the new creation in Christ" (Louw, 2000:105). Peace is not just an attitude, but an indication of the all-encompassing eschatological redemption - it is the state of shalom.

Suffering and the act of representation (sacrifice)

When Christians experience suffering, it takes place in an 'occupied space', meaning that Christ substitutes Himself in our place, sharing our suffering. But, as High Priest, Christ also brings our suffering to and before God; a sacrifice that was already made on the cross.

Suffering and the redemption/liberation from death

The message of the atonement (ransom) assures us that death and anxiety will not have the last word on our lives. Instead, it is a message of redemption and liberation from death. This assures us of a pardoning from condemnation for our sins, liberation through reconciliation. So, even where HIV was contracted through a sinful and irresponsible lifestyle, it is not the final word on the life of such a person. Even the guilt and consequences of such acts were paid for, and the PLWHA can live a liberated life reconciled with God, without condemnation.

Suffering and the reconciled transformation of the new person

Reconciliation is linked to forgiveness - to set free, to cancel and to release, and this is absolute in Christ. The sinner is released as Christ takes his/her place. Now, as a released person, one can live as a different and changed person. Suffering is no longer a punishment, but proof of God's "solidarity, compassion and even resistance to the reality of suffering" (Louw, 2000:107).

Suffering and the events of expiation and propitiation

When reading Scripture (Rom. 8: 25-26) it can be seen that justification is an act of God. It is God who took the initiative and gave us his Son. This is the expiation (*hilasterion*), meaning that God's act wiped out all sin. There however arises a theological problem as '*hilasterion'* can also be translated with propitiation, implying that humans are the subject and God is the object. In other words humans do something to appease God's anger, suggesting the doctrines of satisfaction and penal substitution. This translation must not be seen as an either/or situation, but rather as a choice between propitiation and expiation. If these two words are

determined by a God-image, shaped by a Hebrew understanding of God (compassion, pathos), reconciliation can never be mere satisfaction and penal substitution. Instead it reveals divine identification or involvement and sincere compassion and solidarity.

Both words explain God's faithfulness regarding His promises of salvation and redemption, just from different perspectives. Satisfaction and substitution are, therefore, not in opposition to one another, but are rather supplementary.

Pathos: A hermeneutics of the cross

In Gal. 2: 20 Paul writes that the Son of God loved us and thus gave Himself up for us. It is important to note that the theology of the cross is not intended to create a schism between God and Christ. Although Christ is the Subject, it should not be regarded as though Christ loved us, but God was always angry with us. 'God shows his love for us in that...Christ died for us' (Rom. 5:8). God's love for us is a concrete event of Christ's death on the cross (*theologia crucis*).

"The contribution of a theology of the cross is that it enables what could be called a 'hermeneutics of the cross' from *below,* i.e. from God's condescendence and his identification with our human misery" (Louw, 2000:108).

4.3.1.4. A theology of the Crucified God

If we assume that the Father and the Son are truly God, it raises a theological question of whether or not we can call Christ a 'crucified God' and God 'a suffering God'. According to Philippians 2:6-11 one should consider the notion of a crucified God as correct. The passage indeed connects God to suffering and the cross and sheds light on the meaning of the cross within the Being of God.

A theology of the crucified God operates with the assumption that Scripture discloses a relationship between the human Jesus and God *and* between the two aspects of the *Being of God Himself* - the Father aspect and the Son aspect. It can be said that the Son is the exegesis and the hermeneutics of the Father, because of a unity of origin and Being. In this way we can argue that the "Son aspect of God was directly involved in the suffering and death of the cross" (Louw, 2000:109), whereas the Father aspect was indirectly involved.

Jesus, as the definitive revelation of God the Father and of God the Son, died a whole person (human and divine) on the cross, and this mystery of the Father-Son relation makes possible a *theologia crucis*. This is a reality only when viewed from a pneumatological understanding of the events of the cross and the resurrection, where the mystery of the relation between the Son and the Father was vindicated by the Spirit. This relationship, vindicated by an act of the Spirit, is revealed by the resurrection. Such an understanding underscores God's vulnerability and compassionate, yet liberating involvement in suffering.

4.3.1.5. The Significance of the Notion of a 'Crucified God' for Pastoral Theology

In conclusion, we can say that the theology of the cross means (Louw, 2000:112-116):

- All people are sinners and are therefore lost.
- In atonement God reveals His woundedness, love, presence, pathos and solidarity. However, "[a] theology of the cross declares the punishment and judgment concerning sin" (Louw, 2000:112).
- In Christ, our Mediator, God's divinity and humanity are both involved in suffering. So, on the grounds of Christ's high-priestly suffering, we can say that God is in suffering and identifies Himself with our suffering.
- In the death of Christ's there is victory over suffering and elimination of guilt. This makes possible a new state of redemption where we can share in this

triumphant, juridical and ethical consequence of Christ's work of redemption, through the Holy Spirit.

- "For the believer, reconciliation means self-denial …in which suffering forms part of the process of spiritual growth", and which is not merely an "imitation of Christ's suffering, but a consequence of His vicarious suffering" (Louw, 2000:113).
- The theology of the cross and the atonement in Christ provides hope, so that everyone can know that God is alongside us and with us, providing the framework in which meaning in suffering may be discovered. In the cross we can deal with our existential questions and struggles about life's anxiety, despair, absurdity, purposelessness and meaninglessness.
- A theology of the cross leads us to understand that God's weakness becomes His power. His involvement in our suffering reveals vulnerability and woundedness, affirming Him as our Wounded Healer. In pastoral care to the suffering this is important as it highlights the importance of God's loving solidarity with the world in its suffering.

We are aware of the contradiction between the cross and the resurrection that creates a dialectical eschatology, where the promise of a new creation contradicts the present reality of suffering. However, it is also true that this hope and perspective of resurrection does not explain suffering, but rather provides a perspective on God's final triumph over all evil and suffering, which in itself becomes a source of hope. This hope is grounded in God's grace and salvation, as wells as in His faithfulness.

The task and purpose of pastoral care to the suffering is then to embody the same solidarity of God with all who suffer, knowing that the problem of suffering is insolvable despite even of the cross. Yet, because of this notion of a suffering and crucified God, we can believe that:

- Suffering is never final.
- We can always address God in our suffering, even accuse Him and vent one's anger, because God's vulnerability and faithfulness makes the lament an important component of pastoral care.

- Despite the insolvability of suffering, we should not understand the theme of solidarity as promoting a fatalistic submission, but rather as an active resistance to suffering.
- A theology of the cross is a radical theology. In Scripture we read that God made Jesus Christ to be sin on our behalf (cf. 2 Cor. 5:21). This must not be understood in mere functional terms. Instead, Paul is thinking here of an existential relationship between God and sinners which Christ enters and transforms, and in qualitative terms. Here the paradox is that Christ, who was without sin, was made a sinner by God, and this reveals the contradictory and foreign reality of a theology of the cross, as well as the radical character of salvation and redemption.

4.3.2. Hope for the Today and Tomorrow: A Theology of Resurrection[19]

Tragedy is part of life and it exposes our human misery, hopelessness and vulnerability. Every time we experience suffering we question that experience, the purpose and meaning thereof and the agony it brings with it. It is indeed true that suffering becomes pointless if it does not at least address our need for healing and transformation or change.

Main issues that become pertinent to a pastoral care approach are: how does God identify with suffering, and how does God transforms suffering to become meaningful to the suffering person? In essence this is a question of theodicy and no matter how we want to relate God with suffering and sin (directly, indirectly or teleologically), God's identification with and His transformation of suffering are fundamental, raising the all-important issue of trust in God.

[19] From Louw, *Meaning in Suffering: A theological reflection on the cross and the resurrection for pastoral care and counseling.* 2000:147-168.

In suffering our human flaws, weaknesses and wickedness are exposed, yet at the same time suffering challenges us to search for healing and hope amidst the tragedy. Sometimes the tragedy and suffering we experience is comprehendible, but at other times it just seems meaningless, tempting us to withdraw from life in despair and resignation. However, it can also be viewed as a challenge for meaning-making in anticipation of healing and well-being. Yes, even healing and well-being that transcends the most basic and final tragedy for humankind – death, the irrevocable and unchangeable reality of all life. Can we ever overcome our anxiety for death? Louw suggests that this anxiety will remain with us for all time. However, even though theology may not be able to answer the question about the time-frame for the disappearance of our anxiety for death, it can deal with the quality of human life in terms of the transformative reality of the new age in Christ. The question of time (the "when" question) is then not seen in terms of a temporal category, but rather as an existential and ontological category of status and quality of life. Eschatologically it becomes possible to think of the status of our new being in Christ as made possible by His resurrection. It then becomes a question of faithfulness in terms of the threats of anxiety, despair and death, and confronts theology with the notion of the transformation and wholeness of life. In the end it refers back to the hope of our salvation (cf. Rom. 6:4). A meaningful answer to the question of the time of liberation ("when") seems to be vested in an understanding of the resurrection of Jesus Christ, which points back to both the cross (perfectum) and the promise of the parousie (futurum), and these form the two base element of the eschatological reality we embody in care.

Christ fulfilled God's promises on the cross, whereas the victory of the resurrection gives a new faith to humankind, precisely because it is both a new perspective and a historical reality. Furthermore, the historic reality of the empty grave becomes the source of our hope, even if the present reality of suffering, i.e. HIV, AIDS and an empty grave, points to the contrary.

4.3.2.1. Resurrection as a Hermeneutic of Life and Radical Transformation

Any spiritualization of the resurrection is denied by the reality that Jesus rose from the dead and appeared to his disciples and others in His new resurrected body, making it completely relevant and attuned to our bodily and earthly existence. The interconnectedness of the cross and the resurrection then points to God's faithfulness even in our time and bodily existence in the here and now. Despite the eschatological nature of the promise of the resurrection, it is possible that a resurrected life can be lived and experienced daily through the work of the Holy Spirit, and in the forms of faith, hope, love, and peace. This new reality of the resurrection then opens up for us the possibility of a ministry of hope in pastoral care – a hope amidst suffering which provides the basis for our calling to help people live a new and transformed life.

Yet, one has to be wary of the danger of a theology of glory (*theologia Gloria*). "Hope and victory in suffering do not necessarily mean victory out of suffering" (Louw, 2000:157). Sometimes the hope we cling to, and that is grounded in the resurrection, is a hope that embraces the possibility and even the reality of not overcoming - we embrace that hope of not overcoming. It is not a hope that subscribes to a *theologia gloriae* based on an optimistic view on humankind and creation. It also does not allow us to underestimate sin and misery, or to assume that we could be immune to pain and suffering. Instead, through the resurrection hope we are called to endurance, and even protest, amidst suffering. A *theologia gloriae* (based on human achievement) is therefore contrasted with a *theologia crucis* which is about the confession of sins and a *theologia resurrectionis* which is about the resurrection hope. Therefore, a pastoral position of victory is only rooted in God's compassion and has nothing to do with the psychological category of optimism that is rooted in self-actualization.

4.3.2.2. Pastoral Care from the Perspective of a *Theologia Resurrectionis*

In choosing the resurrection as a point of orientation for a theology of pastoral care, we affirm that it gives shape and theological significance to the salvific meaning of the atonement. The resurrection therefore creates a hermeneutical lens through which we get to know God, discover meaning in suffering, and understand it. The resurrection is an indication of God's trustworthiness and the conclusiveness of the Gospel - "And if Christ has not been raised, our preaching is useless and so is your faith" (1 Cor 15:14).

The reality of Christ's crucifixion assures us of God's involvement and compassion in our own suffering and especially also in the suffering of a person living with HIV and AIDS. Yet, Christ was resurrected and as such has dealt decisively with the realities of suffering and death. Without approaching the resurrection from a triumphantalistic point of view, we cannot ignore the immense hope that it gives to every human being. Louw (2008: 435) speaks of the resurrection as "a hermeneutic of life and radical hope". He asserts that the Christian hope that flows from the resurrection is not in response to, or an antithesis of anxiety, but it is rather a hope despite our anxieties (Louw, 2008:436). The resurrection of Christ tells us that death was overcome, that we are empowered to a new life, that there is a new freedom without label and stigma since sin was dealt a final blow, that in Christ our own physicality and embodiment in terms of disfigurement was taken up, that we have hope in the face of death, and that trust in life was restored and we can therefore embrace life. The implications of this for pastoral care are, according to Louw (2008: 439 – 441), as follows: transformation to a new reality, freedom and liberation, a new visioning and imagining of the future, a sense of witness in reaching out to others, faithfulness, support to others, comfort and truth. Most of all, in the realisation of Christ's death and resurrection we embrace and live an ethics of love that cultivates understanding, empathy, true support, sharing of meaning, and living with a new morality.

4.3.3. Summary

Maintaining the God-human relationship and a bi-polar tension in pastoral care requires a theological dimension, such as an eschatological perspective. Such a perspective is in the first place based on that which has already been fulfilled in the salvific work of Christ. In this process the Christian hope plays a fundamental role. Such hope is determined by the reconciliatory work of Christ on the cross, yet its character is based on the resurrection of Christ. This in turn provides the faith with a dimension on the future of the fullness of salvation in Jesus. We then find that the perspectives on life, victory, hope and resurrection play an increasingly important role in the encounter between God and human (Louw, 1999:84-85). In this sense we can say that pastoral care wants people to live through hope so that the victory in salvation illuminates everyday life, even in suffering (Louw, 1999: 87). We can argue that through God's solidarity and identification with human suffering on the basis of a theology of the cross (God in our place for everyone and everything) and a theology of resurrection (the final annihilation of all forms of death, including stigma and discrimination) care as community phenomenon becomes not only possible but a reality. In practice a shift towards an eschatological perspective means (Louw, 1999: 91-92):

i. A positive horizon to our existence.
ii. Maintaining the bond with God's faithfulness in spite of life's ambiguities and discontinuities.
iii. A critique to human self-efficacy, eschatology becomes normative and gives direction to life.
iv. Lastly, eschatology provides a unique profile and character to pastoral care based on the fact our instrument, organ or medium here is faith. This faith allows Christians to live with the hope of God's coming reign and Kingdom, reframing the experience of suffering even as we live with HIV and AIDS.

In essence what has been presented here is a continuation of the discussion on a theopaschitic approach (a theology of intestines) in Chapter 1. It is exactly the compassionate participation of God in the suffering of people that gives hope as an

integrating factor on our way to a new way of being. Theopaschitism makes possible a hermeneutical and *theo*-ontological framework on the basis of God's compassionate involvement in human vulnerability. This is a deep compassion referred to by Daniel Louw as *ta splanchna* - "strong feeling of mercy and compassion expressed by the intestines" (2011:75). In the presence of the compassionate God an eschatological hope becomes possible, particularly through the cross and resurrection of Christ. Such eschatological hope makes possible a "positive being and hopeful living" (Louw, 2011:75). Within the HIV and AIDS epidemic the resultant integrative approach to health and well-being, where people are not only seen spiritually integrated beings, but where all relational, communal and social aspects of human living are important, becomes a framework for community care. This theopaschitic framework of hope, through its integrating and transforming nature, gives rise to a new way of being – both individually and communally.

CHAPTER 5
ECCLESIAL IDENTITY AND AN INTEGRATIVE APPROACH TO COMMUNITY HEALTH AND WELL-BEING

5.1. The Identity of the Church

Church exists within concrete cultural, social and economic context (v.d. Ven, 1993:31 & 80). How it exits and behave within this context is very much dependant on how it sees its core functions. Van der Ven (1993:78-91) suggests that the church has four core functions which enables it to exist and function in a transformative way within real contexts. These functions are: identity formation (*identiteit*), integration (*integratie*), policy formation (*beleid*) and management (*beheer*). Identity has to do with self-understanding and how the church positions itself within society with regard to it convictions, norms and values. Integration deals with the connectedness between individuals, communities and leadership to form a unit that identifies and deals with the challenges posed by contextual elements and its relation to the church. This requires an awareness and response to the call for holiness, catholicity (unity) and apostolicity (calling). The third function has to do with concretizing the identity of the church within real contexts. This is where the church's responsive position is defined and actualized. *Beheer* or management has to do with identifying, allocating and optimizing resources. This is where the quality of the concretization of the church's identity is tested through active intervention and involvement with contextual issues. Van der Ven's understanding of the relationship between these functions is that only if an adequate identity is defined, owned and lived will there be integration. And only through effective integration will policy formation and implementation be relevant to the contexts within which churches exist. We thus see that an adequate pastoral response to HIV and AIDS, grounded in the principles of an integrative approach to health and well-being, demands that we reflect upon the identity of the church as it will become the driving force affecting our intent, qualities and the intensity of response to the challenges posed by HIV and AIDS.

The statement by Yohannes Demissie (2008:9) that "[t]he HIV and AIDS epidemic indelibly impacts what it means to be church. [And that t]he reality of the epidemic obliges the church to redefine its self-identity" is quite apt. It indeed calls for a paradigm shift where churches move from a state of apathy and inactivity to one of care and active involvement with solidarity in the plight of those living with HIV and AIDS. This is especially so in the light of the mission mandate of the church to be a healing and compassionate community. Further shifts that Demissie (2008:10) proposes is that the identity of the church needs to move from an ecclesial clerical emphasis to a small group fellowship/koinonia; to move from merely being positive to being active – I would even add to be pro-active. With regard to fellowship and koinonia we draw on the New Testament portrayal of what it means to be church and it will be referred to again later in this discussion.

Taking his cue from a broad understanding of the discipline of ecclesiology, Sven-Erik Brodd (2008: xviii) argues that when we talk of 'church', and thus also of an ecclesial identity, we must not restrict our thinking to that of an institution, dogma or merely to the study of systematic theology. When we think of church and of an ecclesial identity we must therefore think of it as the entire people of God, the Body of Christ whose identity culminates in praxis so that the church lives up to the ethical expectation raised by how it sees itself. It is thus not merely a theoretical exercise when we reflect on the identity of the church, but we must include praxis in our reflection too. My understanding of church and ecclesial identity concurs with that of Brodd, and when I refer to church I also refer to all those who declare Christ as Lord and have taken on the identity of a chosen people of God, a Holy Priesthood who lives and exists solely in and through Christ the true Vine, irrespective of the institutional arrangement that may or may not apply. Key however, as shall be highlighted below, is the notion of community and communality in this understanding of church. Let us at this point be reminded that the purpose of this discussion is to link our understanding of church (our ecclesial identity) to our calling and ability to care for those in need, those who are suffering, and as in the case of this thesis, particularly those who live with HIV and AIDS.

Eunice Kamaara (2004: 49) draws our attention to the fact that the identity of the church is vested in the identity of Christ, as it is the church of Christ. Himili Kimweri (2008:63) speaks of the church as representative of Jesus, and because of this status, Kimweri argues, the church must play a distinctive role in facing the challenges presented to the world through HIV and AIDS. Yohannes Demissie (2008:2-13) speaks of the church as a healing and compassionate community, and based his view on Biblical teaching. It is a community who demonstrates love, care and support for those who may be experiencing any form of need, be it physical, emotional, or spiritual. However, what does such a healing and compassionate community, whose identity is vested in Christ, look like? What type of identity are we talking about? In this section I would like to explore some metaphors of the church in order to highlight some aspects of an ecclesial identity that may guide our responses to HIV and AIDS, and suffering in general, and in particular in how we embody the loving grace of God as a faith community. I have to agree though with Sven-Erik Brodd's notion that the Christian faith is a faith reflected in practice within communion (Brodd, 2008:xvi), which implies that our being church must translate into the active practice of love, grace, inclusion and the compassionate act of care.

For Demissie (2008:2) the compassionate nature of the church should never been an optional item of her identity. Instead, it is through being a compassionate community that the church can care and make a meaningful contribution to the fight against HIV and AIDS and all its impacts. This is also the teaching of the Bible when we as a church are called to demonstrate love, care, and support to those in need of care and healing (Demissie, 2008:3), and it already points to the church's being, and not so much to her functionality. However, as we have seen in earlier discussions, it is this being status that drives compassionate acts of care and love and inclusion. Such a state of being excludes a moralistic, judgmental attitude as well as stigmatizing and remaining silent about the plight of the suffering. Instead, it calls for solidarity and care (cf. also Confession of Belhar, 1986).

When talking of church as a healing and compassionate community, Demissie (2008:7) reminds us of the definition of healing in the *Dictionary of Pastoral Care*, which defines healing as "a process of being restored to bodily wholeness, emotional well-being, mental functioning and spiritual aliveness". In addition, in pastoral care it also implies the renewal of relationships with the self, the other and with God. In a compassionate community, compassionate care refers to a "deeply felt sense of solidarity with suffering persons" (Demissie, 2008:8). It is in and through the embodiment of solidarity that PLWHA are empowered to again learn to develop meaningful relationships of trust and love towards God and others. We saw in the earlier sections on an appropriate pastoral anthropology that without meaningful relationships where acceptance and solidarity is experienced, it is hardly possible for PLWHA to experience any sense of well-being or to be able to engage in a meaning-making process that will enhance that much needed sense of well-being. We have also discussed in the previous section the notion of a suffering God who fully participates in human suffering, and leads the sufferer to find meaning amidst the suffering. God opted for this vulnerable position so that people who suffer may find hope despite their suffering and pain. We realize that God's vulnerability in Christ on the cross was both a sign of reactive care in terms of salvation from sin and its devastating effects and a sign of pro-activeness in providing hope for the future and a new life and way of being. In the same vein it may be argued that the care the church of Christ is to provide must also demonstrate this reactive (e.g. care for the ill, the orphans, etc.) and pro-active (e.g. education, skills, awareness, etc.) character (Demissie, 2008:9).

Sven-Erik Brodd's discussion (2008:xvii-xl) on ecclesiological elements in understanding the church in the HIV and AIDS epidemic is very useful in clarifying not only the need for such an ecclesiological understanding but also in how he proposes that such understanding should operate in the HIV and AIDS context. In referring to that calling of the church to practice the faith in Christ, Brodd (2008: xvi) refers to the church as the Body of Christ (1 Cor 12:13), the people of God (Tit 3:5), a Royal Priesthood (1 Peter 2:5), engrafted branches in the vine (John 15:5) and as living stones of God in which Christ is the corner-stone (1 Cor 3:16). Again, from this

it is clear that the church cannot assume any other identity other than one in Christ as endowed by God, and church can never exist merely for her own survival. Should that be the case, none of the above descriptions of or metaphors for the church will have any meaning both with regard to forming an ecclesial identity as well as with regard to living the ethical implications of such an identity. In short, our understanding of an ecclesial identity must be one that develops from the understanding of our Christian faith as a faith culminating in a "communal, reflected praxis" (Brodd, 2008: xvii). The notion of community and communality is therefore indispensable in our reflections on the ecclesial identity of the church. Leading on from this, if we talk of community and communality, we must talk about care and compassion. Often, as church, we neglect this and look at the HIV and AIDS epidemic as an insurmountable challenge. However, perhaps HIV and AIDS are providing us with a timely opportunity to live our ecclesial identity as a caring community, challenging us to reconsider the very substance of our existence and the missional nature and calling of the church.

In our deliberations on the ecclesial identity of the church, Brodd (2008: xvi-xl) draws our attention to a number of aspects that we need to consider in the process of finding and embracing that identity. Some of these may be enhancing an appropriate and caring identity, whereas others may actually be a threat to such an identity.

With reference to violence, sexual abuse, and gender roles Demissie draws our attention to the ever-present power relations between men and women and the vulnerability of women with regard to HIV infection. It has been reported that women are the hardest hit by the epidemic (see Chapter 2), whereas women are also often seen as the true backbone of the church, despite their disadvantaged position in a mainly patriarchal society. Demissie therefore suggest that we need to look not only at the role of women in the fight against HIV and AIDS and in the caring of those affected by it, but that we should also consider taking on some of that motherly character in our ecclesial identity. Such an identity would presume vulnerability and

a willingness to sacrifice for the other, yet at the same time it would presume a position of care. Incorporating a motherly character in the identity of the church does not suggest a willingness to tolerate abuse or to succumb to the inequalities in gender power relations that plague society and that still contribute significantly to the spread of HIV and AIDS. One then has to argue that such a position would rather be one of a paradoxical challenge to these power relations, i.e. in assuming the motherly position of vulnerability and care the church challenges those structures, dynamics and practices that propagate and maintain the suffering that stems from inequality, abuse and violence. Such an identity would also be in line with the critique of the cross where Christ, in His vulnerability, challenged the powers of inequality, oppression, disease and suffering.

Another aspect that Brodd (2008: xxvii) draws our attention to is that of a Eucharistic ecclesiology. This understanding of ecclesiology suggests that all those incorporated in the Body of Christ by faith and baptism and who participate in the Eucharistic meal form part of the Christian community. This promotes an attitude of and a commitment to sharing. This sharing is not only in the sense of the Eucharistic meal and cup, but also in terms of pain and suffering – if one suffers the entire body suffers. Still another aspect of the Eucharist is that it proclaims healing and wholeness in and through Jesus Christ, not merely in private but as a public act and witness. In sharing the Eucharist meal and taking on a Eucharistic identity the church in fact commits to proclaiming and working the healing that is witnessed to in the Eucharist. This is not something that is restricted to the Holy Communion, but is in fact a call for the active embodiment of what the church witness to and about in the Eucharist.

Despite everything said above, the ecclesial identity of the church in the current HIV and AIDS context will always be threatened by sin and its perceived and real relation to sexuality, HIV and AIDS (Brodd, 2008:xxx). At least three things emerge from this awareness: (1) we are all sinners in need of salvation in Christ in order to live a holy life that promotes health and well-being and a responsibility to the self, the other and

God; (2) sin is not only private but also communal and always remain a threat to the ecclesial identity and life of the church; and (3) sin can easily become the causal explanation for the current HIV and AIDS epidemic leading to blame, judgement, stigma, discrimination and a disinterest in providing care to those affected by HIV and AIDS.

In an attempt to help us think about the ecclesial identity of the church, we will now look at a few ecclesiological metaphors that might be fitting in the context of an HIV and AIDS epidemic.

In light of the strong emphasis on the aspect of community and communality that runs through this entire thesis, I opted to restrict this discussion to two metaphors only, which in my mind quite aptly embrace and demonstrate the principles of community as a caring space.

5.2. Metaphors for Describing the Church in the HIV and AIDS Context

Metaphors involve the use of particular imagery as a way to provide an explanation of the understanding of something, or to describe something. It is never absolute and should not be seen as something that has to be upheld to the letter in practice. Metaphors and models are also never a complete picture of reality as it is only an attempt to present an understandable picture of reality, and therefore one can never assume that one metaphor is all that is needed to describe the church. All metaphors have advantages and disadvantages and it is thus wise to see them as complimentary to each other and to use them as such. We bear this in mind as we now continue to look at some of the metaphors that may be useful in understanding the ecclesial identity of the church.

5.2.1. The Body of Christ Metaphor

This metaphor not only provides us with a hermeneutical framework through which we interpret socio-economic and political contexts, but also serves to provide us with corrective norms for Christian life in the church (Brodd, 2008:xxiii). As we meet Christ as the Saviour who has always surrounded himself with the outcasts and ordinary people, this metaphor also gives us the motivation for doing theology from below and takes the contexts and practices of the local church serious.

The analogy is firmly grounded in the New Testament and frequently referred to by the Apostle Paul (e.g. Eph. 5:23, Col. 1:18). As Brodd (2008:xxiii) argues, although Paul makes a distinction between the head and body in these texts, the two can never be separated, despite the fact that they can also not coincide, and hence an ecclesiological identity that is aligned with the Body of Christ metaphor must visibly show the Lordship of Christ the Saviour.

As the use of the word 'body' implies some corporate existence, the analogy then must refer to communality and common life that must be demonstrated in the life and structure of the church. This of course is contrary to the understanding of a person as the sum total of his or her existence. When we emphasise the corporate character of the church we also imply that everyone who is regarded by God as His created children are included. It may also imply that we speak of being together – a togetherness that is characterised by concern and care for the other. Despite consisting of individuals, the analogy of the church to the Body of Christ means that the church is not made up by simply adding individuals as distinct entities, but rather refers to a communion of saints, and a total togetherness (Brodd, 2008:xxiv). We therefore can speak of an organic union, living and growing, yet also a communion with soul that can feel and care and love.

The implication is not only for a cosy togetherness where we continually affirm our Christian identity. No, it also means that we share in the good and the bad of each other, all as part of the same community. HIV and AIDS can therefore not be viewed as something only present in and affecting the individual that has contracted the virus or who is living with the disease. As an organic whole, it would mean that if one is suffering then all is suffering, and if one is living with HIV and AIDS, then all of the Body of Christ is living with it (Kelly, 2009:20). Therefore, if we do not care for any member of the Body of Christ, or if we discriminate against and practice stigmatization towards any member of the Body of Christ, we are doing it to the body corporate, to the organic whole, and thus to ourselves. What this metaphor calls us to be is a body of sacrificial love and care, as it is the only example that Christ gave us in terms of God's being with us in the suffering of his people. As we have seen in the previous sections, God, in Christ, took upon Him the suffering of the world and thereby made himself available to care for those who suffer in solidarity and through an active presence.

An ecclesial identity that is developed around the Body of Christ metaphor stands up against apathy. Instead, such an identity acknowledges the position of Christ on the cross, and God's position alongside those who suffer and those who are marginalized, and hence it moves us to do exactly the same. It calls us to move beyond sermons on HIV and AIDS to actual home care, education, advocacy, resistance, lobbying and social activism to fight for the plight of PLWHA. However, at the same time it affirms the faith community as a hopeful community who, on the basis of faith in the resurrection, live to share God's healing and liberating presence as a reality, both in the present and in the future. It is this community who embraces and embodies the eschatological hope given to us in the resurrection faith.

5.2.2. The Extended Family as Metaphor for the Church

Vhumani Magezi and Daniel Louw (2006:64-79), in their analysis of congregational home-based pastoral care as a response to HIV and AIDS makes extensive use of

the concept of the extended family, particularly as it functions in the African context, as a way of enabling a caring church in an HIV and AIDS context. They refer to the fact that the extended family is a common form of family in Africa, although nowadays it does not necessarily mean that those included in such a family lives together (Magezi & Louw, 2006:73). However, they remain connected and supportive of each other. Whereas the understanding of family in the Old Testament is very similar to that which we understand in terms of family today and in particular that of the African extended family, in the New Testament it has a much stronger spiritual meaning and understanding where all Christians actually form part of this family. In the New Testament it is the koinonia or togetherness that separates the Christian community from others. Be that as it may, one of the foundational aspects of a family structure is that the individual is always in relationship with the others that form part of the family and his/her position is viewed in the light of the dynamics of such an extended family (Magezi & Louw, 2006:77). It is a system of relations in which the togetherness, the koinonia, in the family structure serves to buffer the individual from the impacts of hardship such as sickness.

Linking this notion of the African extended family, the Old Testament family and the koinonia of the New Testament with a spiritual understanding of family has certain implications for our understanding of what it means to be church if we use this as a metaphor or as an example for the existence and functioning of the church. Such spiritual linkage will lay the (spiritual) foundation for care, be it home-based care (as Magezi & Louw suggested) or any other form, and will consist of the elements of love, care and sacrifice, based on the understanding of the life and death of Jesus Christ as head of the Christian family. Considering that congregations are made up of individual families, it is possible to envisage that with such spiritual character in family identity and functioning, the African family may provide a valuable resource in the care of people infected and affected by HIV and AIDS. Magezi and Louw (2006:78) not only see the family as an extension of the pastoral care function of the church, but also propose that the system of care in these family structure could serve as an example for the church as well. I concur with this idea as the extended family, as we understand it as a communion of care and protection, may then become an

analogy for the ecclesial identity and function of the church in an HIV and AIDS context. The implications for such an ecclesiology would be (after Magezi & Louw, 2006:78-79):

- Individual believers are not seen in isolation, but as part of a system and network of relationships, where the ethos of embracing those in need comes to the fore strongly. Such an ecclesiology not only buffers against family and social conflict, but also serves as an extension or even replacement, if necessary, for family structures. In a context where sometimes the bulk of families die of AIDS related complications, the congregation may become the only family that an infected or affected person has. However, as Magezi and Louw argues, the first aim should be to strengthen the family structures and resources.

- It is an ecclesiology that calls for patience and mercy.

- Care in a church with a family-like ecclesial identity is sensitive to the needs of others, and serves both as an advocate for the needy and as facilitator for the acquiring of resources that addresses the needs of those who are poor and in need of care.

Brodd (2008:xxv) refers to such a community as one characterised by solidarity, and in the context of this discussion, solidarity with those living with HIV and AIDS and experiencing all its effects as well as those conditions that worsens the epidemic.

The above goes with Eunice Kamaara's reference to Jesus as the Good Shepherd who would lay down His life for His sheep, and who calls the church to also see itself in the role of shepherd and to take care of the needs of its entire flock, including those living with HIV and AIDS (2004: 49). She also links the notion of the church as a caring community to the image of Christ (and the church) as life giving vine who does not ostracise, but work towards keeping everyone intact in the vine. We therefore see an ecclesial identity that is forgiving, healing, inclusive, reaching out to the marginalized and destitute, and of proclaiming the good news of liberation. Jaap Breetvelt (2009) gives ample attention to a theology of liberation as an appropriate

response to HIV and AIDS. Such a theology of liberation embraces the values of compassion and care, and becomes a defining paradigm for making real the Kingdom values of the Kingdom of God. Although all these may be discussed in greater detail and as separate analogies for the identity of the church, I believe that in essence it goes with the character of an identity that is exhibited already by both metaphors discussed so far.

However, it has been demonstrated that HIV and AIDS are most severely felt by families and in particular in marriages (Mashau, 2008:23-34). In Chapter 2 the impact of the epidemic on family and social structures have also been mentioned. In other words, if we subscribe to a metaphor of the extended family as a communion of care in the HIV and AIDS context, we must also be aware of the vulnerability that is inherent in this metaphor and identity. Just as real families are continuously under the threat of the devastation of the epidemic, so too is the church continuously challenged by it. So much more the need for a proper reflection on the meaning of the ecclesial identity that we take on as church and for the theological reflection as basis for our response to the HIV and AIDS epidemic.

5.2.3. The Church as Growth and Wholeness Centre

Howard Clinebell (1995:46-49) speaks of the church as “human wholeness centres”, placing it amongst those social structures that facilitate growth and wholeness. His motivation for the church as a growth and transformative centre is (1995:47-48): (1) it can draw on its resources from tradition, both in terms of theological reflection and praxis; (2) it has regular contact with community members; (3) it has strategic resources and contacts related to it clergy; (4) most churches have internal support structures and groups; (5) it has a natural growth ability through its growth-enabling and facilitating abilities of its members; (6) it usually recognizes the importance of

spiritual growth and other aspects in caring for people; and (7) clergy often have received some form of specialized training in counselling.

To remain relevant in society, churches must mobilize its ability to be effective spiritual wholeness centres. As a wholeness centre, churches provide a form of wholeness care and counselling that is relationship oriented and that enables people to become free agents of change (Clinebell, 1995:5). This idea of church as a change agent is an important aspect of its identity (1995:17), for care and counselling can never be practised for its own sake only, but for the transformation of people's lives and societies.

Growth images function throughout the Bible and serve as an affirmation of human potential (Clinebell, 1995:104-105). From Jesus' ministry (e.g. John 10:10) it appears that the goal of growth is to experience life in its fullness. Again this encompasses all spheres and dimensions of human life. If Christ is proclaiming wholeness and growth towards a life of fullness, shouldn't the church do that too? To be a place of wholeness then requires church to be a space for liberating, nurturing and empowering life in it fullness – in individuals, in intimate relationships, and in society and its institutions (Clinebell, 1984:28). Indeed, in Christ we encounter healing and life (Clinebell, 1995:108) and therefore being a human wholeness centre is intrinsically linked to the ecclesial identity of the Christian church. Yes, if the Gospels is concerned with the wholeness of the total being, this must be the concern of the Christian Church too, finding expression not only in individual care, but also in challenging and influencing political and other structure that affect the well-being of people (Rowe, 1976:77). The proclamation of the coming of God's Kingdom, as in the Gospels, promises the arrival of a "new transformed era of wholeness", and the church is called to embody this transformation which is already present in this age. As a *shalom* community, church embodies the characteristics of a Spirit-filled community and a space of mutual growth (Clinebell, 1995:109). This is a space of relationality, otherness, mutuality, caring, liberation and responsibility, all being internalized in the identity of the church.

It is true that the concept of church mat be defined in different ways, depending on where the emphasis is placed, i.e. on function, character, roots, etc. One thing is certain though, and that is that church is in the first place the church of Christ. Whichever way we see it, as a wholeness centre we live by the Spirit, and integrate all functions of the ministry of the church with that of tasks of pastoral care (i.e. healing, sustaining, guiding, reconciling, nurturing) in order to be an instrument of healing and transformation. We do this with a focus both inward and outward, as we renew and transform as a church continually to become and remain and agent for renewal and transformation in the communities within which we exist and live.

This approach is applicable to both individual and community care. One of the strengths of it is the liberating aspects associated with a journey towards spiritual maturity. In this people not only experience healing, but become empowered to be the bearers of the healing ministry of Christ. The danger exists though that church may be seen as merely a service provider to society. The real challenge would be to involve those outside the faith community and have them join this journey towards wholeness and maturity.

5.2.4. The Church as Grassroots Communities

Jürgen Moltmann, in *The Church in the Power of the Spirit* (1993) discusses the phenomenon of grassroots communities as a result of church reforms *from below* (1993:328-336). This phenomenon, which had its centre of gravity in Latin America, is becoming more widespread globally. These grassroots communities exist on the premise that it is church by the people, and not only for the people. Although these communities are often associated with congregations, a strong emphasis is on lay ministry and members really minister to each other, and it really becomes instrumental in filling the voids those church structures most often do not fill. Most commonly these communities are found amongst the poor, with a strong emphasis on mutual help and care, and people really become the subject of their own Christian fellowship. Part of its appeal is probably the fact that these communities would

rather exist amongst and serve the poor than to serve organised structures. In such a fellowship from below, people are really allowed to become 'the subject of their own history in the liberating history of God" (Moltmann, 1993:330). Not only is this liberating history shaped by mutual care (community care), but also be the ability of these grassroots communities to be the drivers of democratic social construction.

Traditionally the concept of a double ecclesiology refers to "the church as institution" and "the church as an event" (Moltmann, 1993:333) and therefore there may be the temptation to choose either one or the other. One may opt for a grassroots community model as example of church as an event, and neglect the institutional identity of the church. This may particularly be so where one feels that the institutional church has lost its ability to be church by and for the people as a transformative community. However as Moltmann (332) also suggests, church reform may happen simultaneously as a top-down and a bottom-up process. The grassroots communities become a model for a congregation deepening through growth in faith, fellowship and social practice. Core groups are established in congregations to be the initial starting point for the church to become a community of fellowship at the very level of the deepest impact of social challenges such as poverty and HIV and AIDS. Change than also takes effect on this level and for the benefit of those most severely affected, and not only in service of structures and clergy.

In essence, the grassroots community model reverberate the compassionate character of God that finds its true meaning in God's intimate involvement in human vulnerability and suffering. In that sense the model does not really require a complicated theology. It is about embodying the compassionate nature of God in service of the other. The value of the model is that it is not about doing for the other, but really doing with the other. In addition it is a mutual process of growth towards meaning, healing and a wholeness that transcends physical hardship and even diseases, for it is within the context of fellowship and mutual worship and service that health, well-being and care is defined. It is therefore a true model of community care

that really transcends the individual and draws on the multitude of spiritual and other gifts that all members bring to the community.

5.2.5. The Calcutta Model of Mother Teresa

Mother Teresa, since 1948 till her death, devoted her life to the betterment and treatment of the poor and dying on the streets of Calcutta, where she had become the universal symbol of mercy. She and her order of sisters, called the Missionaries of Charity, in caring for the least of society became witnesses to the dignity and worth of every person. Their intention is to wholeheartedly provide free care to the poorest of the poor. She always described this work as “love in action” or “something beautiful for God” (Zambonini, 1992:x). She firmly believed that poverty was not created by God, but by humans, and therefore took serious to call to attend to the needs of the poor (xi). For her it was never about social change, as she believed that there are people who may have been called for such a ministry (x). Instead, it has always been about the embodiment of love (xi). Similarly, she did not believe in the necessity to be tied through congregational affiliation. Instead, she saw the work they do as something borne out of the need to be church outside walls, in those spaces in society where congregations do not go (10). Valuing every human being, she and the sister of Missionaries of Charity simply want to embody the spirit of compassion and of Christian service. We have seen earlier that a theospachitic theology calls for such an embodiment on the basis of God’s compassionate presence in human suffering and vulnerability.

Mother Teresa’s ministry, and that of the Missionaries of Charity, has been referred to as her “way of love” (Muggeridge, 1971:65). It is a love in the first place for God, but also for every human being in need. Mother Teresa strongly believed that the embodiment of God’s love requires a “soul of prayer” (65) where the awareness of the oneness with Christ is experienced. Through prayer, she believed, one can become holy and a worthy of Christ’s inhabitation. Only then will one be “all love, all faith, all purity, for the sake of the poor” (Muggeridge, 1971:65). An intimate

relationship with God is always the source of strength and direction. This is maintained, amongst others, through silent fellowship with Him, holiness, humility, submission to God, vicarious suffering and kindness (66-75). This ministry of love by the Missionaries of Charities is not merely about care-giving, but is made more pronounced by the fact that they live amongst the poor, sick and dying people, under the same circumstances and according to the same standards of the people they attend to. Day in and day out they would walk amongst and lovingly help those in need, working faithfully for the restoration of dignity of every person. And for those who have to be taken off the streets in order to care for them there are the facilities for the lepers, the dying and children that the order has established in Calcutta. This is truly where the difference with most other approaches lies. The different mode of the Calcutta model express the embodiment of the passion and inclusiveness of God – a truly theopaschitic approach to care and counselling. In being with those who have been deserted by society and the system, Mother Teresa and her sisters become testimonies of the God who is with those in need.

Today the order has a presence around the world, providing care to the poorest of the poor and to the most vulnerable in society (Zombonini, 1992).

In its approach the Calcutta model is a concretizing the theopaschitic theology that this study is promoting. Its take on community care lies outside the establishment and preservation of social structures aimed at providing social care. Instead, the Calcutta model advocates a community care approach that is entirely rooted in the love of and the love for God and that finds its expression in being with the ill, downtrodden and marginalized. Within the theological framework presented in this study, this approach probably comes closest in providing an example of community care that is modelled to God's compassionate solidarity with the vulnerable in society.

5.1. Summary

Throughout the entire discussion that one theme that remained prominent was that of church as community. It is a community of love called to imitate Christ, proclaims the salvation in Christ, and embodies and lives the eschatological hope of the resurrection. Such community is characterised by love, compassion, care, solidarity, inclusivity, reconciliation, as well as active participation not only in care-giving, but also in resisting those structures and dynamics that maintain the status quo with regard to the HIV and AIDS epidemic. It is a community that takes on and work for the liberation from suffering, as it is exactly what we have been graced with in Christ. And in so doing it becomes a positive growth centre, providing the space for healing, liberation and empowerment. We have also seen that the compassionate love, presence and care of God form the foundation of an ecclesiology with a focus on pastoral care as community care.

As indicated before, metaphors serve as representations of reality and as such no one metaphor will be applicable under all circumstances. Therefore, instead of choosing one metaphor over the other it would be best to draw on those aspects of each that may be most relevant to the context. It would appear though that the one metaphor that may best describe the kind of integrated community care approach where everyone in society is involved in caregiving and empowerment is that of the grassroots communities. The approach proved to be particularly suitable for poor communities. Not only does it have a strong focus on community for community, but it also lends itself to the incorporation of aspects from other models that may enhance it owns relevance and effectiveness. The model does not necessarily asks for new grassroots communities to be established, but provides a framework for core communities of care within congregations and broader society. Like the Body of Christ metaphor emphasis is not only placed on shared suffering and care, but also on the fact that each member of the community is a spiritual being, empowered by the Holy Spirit and endowed with particular gifts by the same Spirit. Despite the fact that this study argues for a community care approach, individual care is not excluded and in fact is assumed to be part and parcel of community care. In fact, strong emphasis is also placed on community participation and community transformation in and through caring for the community. Strengthening the grassroots community

concept is the Family Care metaphor. The construct of family provides an apt analogy and framework for community care. It highlights the connectedness of people in relations and draws on the optimisation of shared resources.

The Shepherd and Calcutta metaphors, in particular, place strong emphasis on the importance of being with those who suffer, and on sharing the suffering and needs of others. These have as its primary base the inclusiveness of the love of God. Although it may not have a high regard for program-like social change projects, its strengths lies in the fact that it advocates for the immersion into the lives of those who suffer. The nature of these fits very well with the theological framework of this study.

The HIV and AIDS epidemic have proven to be more than a mere individual challenge. It has become a social, structural and cultural phenomenon and challenge and cannot be addressed through individual care only. A community care approach, providing integrative care is needed. Pastoral care can no longer be focussing on individual care, but must become community care that involves the very communities mostly affected by the impacts of HIV and AIDS. In one way or the other, all the metaphors presented here have something to offer in terms of devising a framework for community care. It remains a challenge for the church to embody the passion of God and to be the healing and growth centres that reach out to those in need, finding its ecclesial identity not within the walls of a church building or within the boundaries of wards, but in the world outside these boundaries. How the integration of the models discussed here may benefit the South African society is perhaps an endeavour for future research.

CHAPTER 6
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.1. Summary and Conclusions

This study managed to problematize, through the presentation of the impacts and responses to HIV and AIDS, any one-dimensional approach to health and well-being within the HIV and AIDS context. It was demonstrated that the impacts of HIV and AIDS are complex and calls for an integrative approach to healing and care, demanding a number of paradigmatic shifts in pastoral care.

The title of the study *Pastoral Care as Community Care: Towards an Integrative Approach to Healing and Well-being within the HIV & AIDS Discourse* presented a number of questions that needed consideration. These were: (1) how are the concepts of healing and well-being relevant to pastoral ministry amidst the challenges of HIV and AIDS?, (2) what is the relationship between our understanding of a pastoral-theological anthropology, community care, spiritual well-being and

integrative healing, and what would be the implication thereof?, (3) how should we understand the identity of the church (ecclesial identity) if it is to be a healing agent in a community ravaged by HIV and AIDS? It was the intention to develop a theoretical and theological framework, with specific reference to an understanding of a pastoral ministry (care and counselling) within the context of HIV and AIDS, which may empower faith communities to become agents of community care.

In light of this the following research questions directed the study.

1. How can we move from a fragmented and individualized approach to care to an integrated approach of community care and wellbeing?
2. Whether the traditional kerygmatik model of care and counselling, with its emphasis on the individual, is appropriate within the HIV and AIDS epidemic which seems to have become a systemic and community issue.
3. If pastoral care should become community care, what are the implications on theory formation within pastoral theology?
4. How applicable is the concept of meaning as a spiritual construct to the epidemic and how should spiritual healing be applied to people living with HIV and AIDS? What is meant by meaning within the epidemic?
5. What is the challenge put before the clerical model in traditional ecclesiology – and what is the link between ecclesiology, community care and community health?

In addition to the main study questions, the methodology based on Osmer's four task of practical theology provided the framework for the approach to and organisation of the study and thesis. In short these tasks aims to address the following guiding questions: (1) What is going on; (2) Why is this going on?; (3) What should be going on; and (4) What praxis framework will provide the impetus for movement from the current to the desired position. Right from the onset this was set out to be a theological-theoretical study making use of a *theo*-ontological hermeneutical approach.

In terms of a methodological framework the study successfully painted a picture of the current HIV and AIDS scenario, mainly in chapters 1 and 2. It was demonstrated that the epidemic impacts on all levels of human existence and have clear structural, social and cultural components to it. Current prevention discourses also contribute very little in terms of a framework for care and well-being. The issue of individual care was problematized and the need for an integrated community care approach to HIV and AIDS highlighted. The discussion on healthcare approaches in Chapter 3 to a large extent demonstrated in particular the inadequacy of a purely bio-medical or psycho-social approach to dealing with issues of healing, care and well-being within the HIV and AIDS context. This, together with the analysis if the HIV and AIDS context in Chapter 2, provided ample evidence to argue for a paradigmatic shift in our understanding of health and well-being, and care. These shifts will be summarized later on in this chapter. The new understanding on health, well-being and care that developed in Chapter 3 and the theological theorization in Chapter 4 not only started to paint an alternative picture of what should be going on in terms of our response to HIV and AIDS, but also provided the theological framework within which pastoral care can become community care. These were integrated in Chapter 5 where the analysis of the ecclesial identity of the church as centres for community care was considered. In reviewing a number of metaphors for an appropriate ecclesial identity, it was concluded that it is possible to provide pastoral care as community care when such identity is built on the character of the triune God. The grassroots community model in particular seems quite apt for our South African churches. I believe that the study have succeeded to address the four questions associated with the four tasks of practical theology as suggested by Osmer. Although no practical framework has been provided, I believe that a theoretical framework for community care praxis has been suggested in this study.

Inadequacies in the biomedical approach and the limited application even of the psycho-social framework necessitate the inclusion of religious and spiritual aspects in the assessment of health and well-being and meaning in life. These have been demonstrated as important coping strategies, particularly apt when considering that humans are regarded as being created in the image of God and as relational beings.

The discussion highlighted the importance of understanding well-being as something that pertains to both individuals and communities, each one affecting the other. With regard to health and well-being it has been indicated that a shift took place, from a primarily individual approach to a systemic-structural approach, hence the emphasis on community care and community approaches as pivotal within the HIV and AIDS discourse.

It was concluded, in Chapter 3, that health and well-being is best understood by and expressed through the notion of wholeness, and more specifically spiritual wholeness. This concept of wholeness incorporates the belief that human beings can never be described in terms of its constituent subsystems, but only as a whole. This whole being incorporates all aspects of human existence, i.e. physical, psychological, socio-economic, cultural, religious and spiritual. This integration of the various aspects of being human happens in the spiritual domain where meaning is generated.

The concept of wholeness was presented as encompassing a process of growth towards maturity, freedom, empowerment and faith. This concurs with the Biblical view on health and healing, which to a great extend is expressed through the term *shalom*, and which implies a process of restoration and return to an existence of peace, fulfilment, moral activity, righteousness, spiritual achievement, faithfulness, and obedience to God, blessing, fertility and longevity. The Biblical view of well-being or wholeness is also one that extends from the individual to communities; leading to the conviction that individual well-being is only possible in a context of community well-being, and vice versa. The relationship between integration and wholeness presented hinges on a hermeneutical understanding of healing, namely how the various parts, aspects and dimensions of our existence (biological, physical, psychological, social, structural, systemic, etc.) are related to each other with regard to the issue of spiritual maturity defined by an ethos of sacrifice (from a Christian understanding of life).

In the same vein it has been demonstrated that healing is not so much about the removal of an infirmity, but rather refers to a process of growth, integration and

liberation. On this journey of discovery a re-alignment of perspective takes place within the context of relationships and communality.

It became clear that an integrated wholeness and a process of integrated healing presupposes a particular relational position towards the triune God - the source of all life, a particular view on humanity and a firm belief in the reality of hope. An appreciation of how this view on integrated wholeness and healing is possible from a theological point of view, we must reflect on these presuppositions, which will be the focus of the next chapter. However, since it also became apparent, through the notion of *shalom,* that individual care is in fact part and parcel of community care, our theological framework becomes as much a framework for community care and healing as for individual care and healing.

Chapter 4 considered a number of theological presuppositions pertaining to a position of integrative community care. It was concluded that the entire chapter can actually be summarized by the notion of a theopaschitic approach – a theology of intestines. The central idea of this approach is built on the compassionate participation of God in the suffering of people, providing hope as an integrating factor on our way to a new way of being. Theopaschitism makes possible a hermeneutical and *theo*-ontological framework on the basis of God's compassionate involvement in human vulnerability. This deep compassion referred to by Daniel Louw as *ta splanchna* - "strong feeling of mercy and compassion expressed by the intestines" - (2011:75) makes is the basis of an eschatological hope derived from the meaning of the cross and resurrection of Christ, making possible a "positive being and hopeful living" (Louw, 2011:75). Within the HIV and AIDS epidemic the resultant integrative approach to health and well-being, where people are not only seen spiritually integrated beings, but where all relational, communal and social aspects of human living are important, becomes a framework for community care. This theopaschitic framework of hope, through its integrating and transforming nature, gives rise to a new way of being – both individually and within community.

The HIV and AIDS epidemic have proven to be more than a mere individual challenge. It has become a social, structural and cultural phenomenon and

challenge and cannot be addressed through individual care only. A community care approach, providing integrative, care is needed. Pastoral care can no longer be focussing on individual care, but must become community care that involves the very communities mostly affected by the impacts of HIV and AIDS.

In one way or the other, all the metaphors presented in this study have something to offer in terms of devising a framework for community care. Integrating these on the basis of the needs in our society may be the best option. One must however ensure that the approach taken have a strong focus on 'community for community', while at the same time the calling of the church, i.e. to embody the all-inclusive love of God, becomes normative. Despite the fact that this study argues for a community care approach, individual care is not excluded and in fact is assumed to be part and parcel of community care.

The study emphasized a number of paradigmatic shifts in the strife towards an integrative community care approach in pastoral care within the HIV and AIDS context. Not only were these highlighted, but a theological-theoretical framework for it was also presented. These shifts can be summarized as follows:

1. From knowing and doing to 'being-with'.
2. From an individual focus to community focus in care where the networks of relationships form the backbone of care.
3. A move from the bio-medical and psycho-social dimensions of healing to an integrative community care approach.
4. A move from wanting to fix people to journeying with them on a path of meaning-making.
5. A shift from understanding humans as dichotomous or fragmented beings to an understanding of 'whole beings' – from an anthropology of segregation to an anthropology of integration and interconnectedness.
6. A shift from an inward-looking ecclesiology to an outward-looking one.
7. A shift from 'doing for' to 'doing with' as demonstrated in the grassroots community approach.

8. A shift from a passive, top-down ecclesiology to an active/pro-active, bottom-up ecclesiology.
9. A shift from a clerical, kerygmatik ecclesiology to one of a caring community with an integrated, community-directed and systemic approach.

It can be concluded that this study not only contributed theoretically to the praxis of practical theology, but provided a viable framework for a praxis of community care within the field of pastoral care and counselling, and particularly so within the HIV and AIDS context.

6.2. Recommendations for Further Study

As with all academic studies, not all angles on a particular topic can be covered adequately. I believe that the following could be explored in further studies:

1. Refining the theological-theoretical framework for an integrated community care approach.
2. More in-depth studies on the ecclesial metaphors presented here, with the possible addition of other metaphors. I think that much more could possibly be said especially about the grassroots community and Calcutta models.
3. Consideration of the integrating components of the various ecclesial models and how those may provide a framework for community care.
4. Research on community care models that are already in place in South African communities and that are addressing, amongst others, the needs of individuals and communities burdened with the impacts of HIV and AIDS.
5. Developing proposals for appropriate ecclesial models with a focus on community care, relevant to South Africa.
6. Research on the existing and potential role of a tri-partite joint venture between church, government and non-governmental organizations as a result of a community-directed ecclesial understanding.

BIBLIOGRAPHY

AFSA, 2010. *HIV Prevalence in South Africa | AIDS Foundation of South Africa* [Online]. Available: http://www.aids.org.za/page/hiv-prevalence-south-africa [2011, June 28].

Andreescu, A. 2011. Rethinking prayer and health research: An exploratory inquiry on prayer's psychological dimension. *International Journal of Transpersonal Studies*, 30(12): 23-47

Balz, H. & Schneider, G. (ed.). 1991. Exegetical Dictionary of the New Testament, Vol 2. Michigan:William W Eerdmans Publishing Company. 143-145

Bate, S.C. 2003. Catholic pastoral care as a response to the HIV/AIDS pandemic in Southern Africa. *The Journal of Pastoral Care & Counseling*, 57(2):197-209

Black, L.W. 2008. Commentary on impacts of HIV/AIDS stigma on family identity and interactions in China. *Families, Systems, & Health*, 26(4):443-446

Borrel-Carrió, F., Suchman, A.L. & Epstein, R.M. 2004. The biopsychosocial model 25 years later: Principle, practice, and scientific inquiry. *Ann Fam Med*, 2(6):576-582

Breetvelt, J. 2009. Church, Theology and HIV/AIDS: African Churches' Involvement in the Struggle against HIV/AIDS. In *Kerk In Actie. Theological Responses to the HIV and AIDS Endemic*

Brodd, S-E. 2008. Ecclesiological elements in understanding 'Church' in the HIV and AIDS pandemic. In Ward, E. & Leonard, G. (eds.). *A Theology of HIV & AIDS on Africa's East Coast*. Pietermaritzburg:Interpak Books (Pty) Ltd. xvi-xl

Brown, C. (ed). 1971 (1976). *The New International Dictionary of New Testament Theology*. Exeter:The Paternoster Press. 163-171

Casale, M., Nixon, S., Flicker, S., Rubincam, C. & Jenney, A. 2010. Dilemmas and tensions facing a faith-based organisation promoting HIV prevention among young people in South Africa. *African Journal of Aids Research*, 9(2):135-145

Chen, J., Choe, M. K., Chen, S. & Zhang, S. 2005. Community Environment and HIV/AIDS—Related Stigma in China. *AIDS Education and Prevention*, 17(1):1-11

Chitando, E. &. Gunda, M. R. 2007. HIV and AIDS, Stigma and Liberation in the Old Testament. *Exchange,* 36:184-197

Cilliers, J. 2007. Breaking the syndrome of silence: Finding speech for preaching in a context of HIV and AIDS. *Scriptura*, 96:391-406

Cilliers, J. 2006. Preaching as language of hope in a context of HIV and AIDS. Paper delivered at the 7th International Conference of the Societas Homiletica, held in Pretoria, South Africa, on 5-10 August 2006.

Clifford, P. 2004. Theology and the HIV/AIDS epidemic. *Christian Aid*, 1-23. Available: http://www.christianaid.org.uk/images/hiv_theologyfinal.pdf. [2011, July 8].

Clinebell, H. 1984. *Basic types of pastoral care & counseling. Resources for the ministry of healing and growth (Revised and enlarged)*. Nashville: Abingdon Press

Clinebell, H. 1995. *Counseling for spiritually empowered wholeness. A hope-centered approach*. New York: The Haworth Pastoral Press

Cohen, S. 2004. Beyond slogans: Lessons from Uganda's experience with ABC and HIV/AIDS. *Reproductive Health Matters*, 12(23):132-135

Crafford, D. 1996. African Traditional Religions. In *Meiring, P (ed.). A World of Religions (A South African Perspective)*. Pretoria: Kagiso Publishers

Dalmida, S.G., Holstad, M.M., Dilorio, C. &Laderman, G. 2009. Spiritiual well-being, depressive symptoms, and immune status among women living with HIV/AIDS. *Women Health*, 49(2-3):119-143

Demissie, Y. 2008. The church as a healing and compassionat community: An ecclesiology reonrientation. In Ward, E. & Leonard, G. (eds.). *A Theology of HIV & AIDS on Africa's East Coast*. Pietermaritzburg:Interpak Books (Pty) Ltd. 2-13

Dube, M. W. 2010. Go Tla Siama, O tla Fola: Ding Biblical Studies in an HIV and AIDS Context. *Black Theology: An International Journal,* 8(2):212-241

Dunn, J.D.G. 1998. *The Theology of Paul the Apostle*. Michigan: William B. Eerdmans

Dworkin, S.L. & Ehrhardt, A.A. 2007. Going beyond "ABC" to include "GEM": Critical reflections on progress in the HIV/AIDS epidemic. *American Journal of Public Health*, 97(1):13-18

Erikson, E., Lindmark, G., Axemo, P., Haddad, B. & Ahlberg, B. M. 2010. Ambivelance, silence and gender difference in church leaders' HIV-prevention messages to young people in KwaZulu-Natal, South Africa. *Culture, Health & Sexuality*, 12(1):103-114

Fava, A.G. & Sonino, N. 2008. The biopsychosocial model thirty later. *Psychother Psychosom*, 77:1-2

Fiorito, B. & Ryan, K. 2007. Spirituality and Psychological Well-Being: A Mediator-Moderator Study. *Review of Religious Research*, 48(4):341-368

Frederiks, M. 2008. HIV and Aids: Mapping Theological Responses in Africa. *Exhange*, 37:4-22

Frey, B.S. & Stutzer, A. 2002. What can economists learn from happiness research? *Journal of Economic Literature*, 40(2):402-435

Goffman, E. 1963. *Stigma. Notes on the Management of Spoiled Identity*. London: Penguin Books

Green, E.C., Halperin, D.T., Nantulya, V. & Hogle, J.A. 2006. Uganda's HIV prevention success: the role of sexual behavior change and the national response. *AIDS and Behaviour*, 10(4):335-346

Grenz, S.J. 1993. Why reach out to persons with AIDS? *Direction*, 22(1):63-72

Guillen-Royo, M and Velazco, J. 2005. Exploring the relationship between happiness, objective and subjective well-being: Evidence from rural Thailand. Paper presented at the Capabilities and Happiness Conference 16-18 June 2005.

Guthrie, S. C. 1979. Pastoral Counselling, Trinitarian Theology, and Christian Anthropology. *Interpretation*, 33(2):130-143

Heitink, G. 1998. *Pastorale zorg : theologie, differentatie [i.e. differentiatie], praktijk.* Kampen : Kok, Kampen.

Helliwell, J.F. & Putnam, R.D. The social context of well-being. *Phil. Trans. R. Soc. Lond.*, 359(1449):1435-1447

Hoffman, W.W. 1990. *AIDS ministry in the midst of an epidemic*. Grand Rapids, Mich.: Baker Book House

Haug, K.S. 2009. Overcoming HIV/AIDS-related stigmatisation and affirminfg life in the African context: The role of theology. *Swedish Missiological Themes*, 97(2):211-227

Jackson, B.R. & Bergeman, C.S. 2011. How does religiosity enhance well-being? The role of perceived control. *Psychology of Religion and Spirituality*, 3(2):149-161

Jenkins, D. 1981. "Forward" in McGilvray, J., *The quest for health and wholeness*, Tubingen:German Institute for Medical Missions, xii-xiii

Joshua, S.M. 2010. A critical historical analysis of the South African Catholic Church's HIV/AIDS response between 2000 and 2005. *African Journal of AIDS Research*, 9(4):437-447

Juelson, K. A. 2008. The struggles of youth in a time of HIV/AIDS awareness and prevention programs. Unpublished master's thesis. Linköpings: Linköpings Universitet

Kamaara, E. 2004. Stigmatization of persons living with HIV/Aids in Africa: pastoral challenges. *African Ecclesial Review*, 46(1):35-54

Kelly, A. 2009. The body of Christ has AIDS. The Catholic Church responding faithfully to HIV and AIDS in Papua New Guinea. *Journal of Religion and Health*, 48(1):16-28

Kimble, M.A. 2001. The search for health and the role of the faith community. *Journal of Religious Gerontology*, 13(2):3-15

Kimweri, H.G.H. 2008. Prevention strategies for combatting the spread of HIV and AIDS within the Evangelical Lutheran Church in Tanzania (ELCT), Kipawa Congregation. In Ward, E. & Leonard, G. (eds.). *A Theology of HIV & AIDS on Africa's East Coast*. Pietermaritzburg:Interpak Books (Pty) Ltd. 56-64

King, D.E., 1956- 2000, *Faith, spirituality, and medicine : toward the making of the healing practitioner,* New York : Haworth Pastoral Press

Kiriswa, B. 2004. Pastoral care and counselling of persons living with HIV/AIDS. *African Ecclesial Review*, 46(1):80-99

Krause, D. 2005. Keeping it real. The image of God in the New Testament. *Interpretation*, 358-368

Kunda, L.J.E. 2008. 'They have ears but they cannot hear'. Listening and talking as HIV prevention: a New approach to HIV and AIDS campaigns at three of the Universities in KwaZulu Natal. Unpublished doctoral dissertation. Durban: University of KwaZulu Natal

Guus Labooy, 2002. Freedom and Dsipositions. *Contributions to Philosophical Theology*, 8. Frankfurt an Main: Peter Lang: 303-316

Lakhan, S. (2006, August 3). The Biopsychosocial Model of Health and Illness [Online]. Available: http://en.scientificcommons.org/36244879 [2012, June 7]

Li, L., Lee, S-J., Thammawijaya, P., Jiraphongsa, C. & Rotheram-Borus, M.J. 2009. Stigma, social support, and depression among people living with HIV in Thailand. *AIDS Care*, 21(8):1007-1013

Li, L., Liang, L-J., Ding, Y. Y. & Guoping, J. 2011. Facing HIV and a Family: Predicting Depressive Symptoms with Correlated Responses. *Journal of Family Psychology*, 25(2):202-209

Louw, D. J. 1998. Theory of science within theology: scientific research as a theological problem: Study guide. Department Practical Theology, Faculty of Theology. Stellenbosch: University of Stellenbosch

Louw, D. J. 1999. *Pastoraat as vertolking en ontmoeting*. Kaapstad: Lux Verbi.BM

Louw, D. J. 2000. *Meaning in Suffering. A theological reflection on the cross and the resurrection for pastoral care and counselling*. Frankfurt am Main: Peter Lang

Louw, D. J. 2006. The HIV pandemic from the perspective of a *theologia resurrectionis*: resurrection hope as a pastoral critique on the punishment and stigma paradigm. *Journal of Theology for Southern Africa*, 126(2):100-114

Louw, D. J. 2008. *Cura Vitae. Illness and the healing of life*. Wellington: Lux Verbi.BM

Louw, D. J. 2011. *Ta Splanchna*: A theopaschitic approach to a hermeneutic of God's praxis. From zombie categories to passion categories in theory formation for a practical theology of the intestines. *HTS Teologiese Studies/Theological Studies*, 67(3):65-77

Magesi, V. 2007. *HIV/AIDS – Poverty and Pastoral Care and Counselling*. Stellenbosch: SUN PReSS

Magezi, V. & Louw, D. 2006. Congregational home based pastoral care: Merging the African family and church family systems for effective HIV ministry. *Journal of Theology for Southern Africa*, 125:64-79

Malcolm, A., P. Aggleton, M. Bronfman, J. Galvão, P. Mane, and J. Verrall. 1998. HIV-related stigmatization and discrimination: forms and contexts. *Critical Public Health*. 8(4): 347-370

Marshall, P. 2005. Toward a theology of HIV/AIDS. *ERT*, 92(2):131-148

Mashau, T.D. 2008. Where and when it hurts most: The theology of hope and accompaniment in the context of HIV and AIDS in marriage and family life. *Exchange*, 37:23-34

Mayer, K.H., Skeer, M. & Mimiaga, M.J. Biomedical approaches to HIV prevention. *Alcohol Research & Health*, 33(3):195-202

McCann, D.P. & Strain, C.R. 1985. *Polity and Praxis: A Program for American Practical Theology*. Minneapolis: Winston Press

Miller, R. L. Jr. 2009. A rock in a weary land: AIDS, South Africa, and the church. *Social Work in Public Health*, 24:22-38

Moltmann, J. 1993. *The Church in the Power of the Spirit*. Minneapolis: Fortress Press

Mouton, J. 2001. *How to succeed in your Master's & Doctoral studies: A South African Guide and Resource Book*. Pretoria: Van Schaik Publishers

Muggeridge, M. 1971. *Something Beautiful for God*. Middlesex: Collins Sons & Co.

Murphy, E.M., Green, M.E., Mihailovic, A. & Olupot-Olupot, P. 2006. Was the "ABC" Approach (Abstinence, Being Faithful, Using Condoms) Responsible for Uganda's Decline in HIV? *PLoS Med* ,3(9):1443-1447

The National HIV and Syphilis Prevalence Survey South Africa. 2007[Online]. Available: http://www.unaids.org/en/dataanalysis/epidemiology/countryestimationreports/20080904_southafrica_anc_2008_en.pdf [2011, June 12]

Nicolson, R. (1995). *Aids. A Christian response.* Pietermaritzburg: Cluster Publications.

Nwaigbo, F. 2004. The HIV/AIDS Pandemic: A Crucial Task for the Church in Africa. *African Ecclesial Review*, 46(1):2-22.

Okware, S., Kinsman, J., Onyango, S., Opio, A. & Kaggwa, P. Revisiting the ABC strategy: HIV prevention in Uganda in the era of antiretroviral therapy. *Postgrad Med. J*, 81:625-628

Olivier, J., Cochrane, J. R., Schmid, B. & Graham, L. 2006. ARHAP Literature Review: Working in a bounded field of unknowing. *African Religious Health Assets Programme*. ARHAP-UCT

Osmer, R. R. 2008. *Practical Theology: An Introduction*. Grand Rapids, Michigan: William B. Eerdmans Publishing Company

Parmer, T. & Rogers, T. 1997. Religion and Health: Holistic Wellness from the Perspective of Two African American Church Denominations. *Counseling and Values*, 42(1):55-67.

Patterson, A.S. 2010. Church mobilisation and HIV/AIDS treatment in Ghana and Zambia: a comparative analysis. *African Journal of AIDS Research*, 9(4):407-418

Pattison, S. & Woodward, J. 1999. In Woodward, J. & Pattison, S. (eds). *The Blackwell Reader in Pastoral and Practical Theology.* Oxford:Blackwell

Perkinson, J.E. 2008. Breaking the silence, bearing the stigma: The pastoral and prophetic responsibility of the church in the political economy of HIV/AIDS. *The Journal of the ITC*, 161-172

Phillips, E. 2006. Stigmatization and the Silence of the Church. *African Ecclesial Review*, 48(1):328-340

Poloma, M.M. & Pendleton, B.F. 1990. Religious domains and general well-being. *Social Indicators Research*, 22(3):255-276

RAIN. 2011 Community Well-being [Online]. Available: http://www.rain.net.au/community_wellbeing.htm [2011, October 17]

Ribova, L. 2000. Individual and Community well-being. *The ARCTIC* [Online]. Available: http://www.thearctic.is/PDF/Individual and Community well.pdf [2011, September, 19]

Richardson, N. (2006). A Call for Care: HIV/AIDS Challenges the Church. *Journal of Theology for Southern Africa , 125*, 30-50.

Rowe, T. 1976. *Wholeness. Body, kind and spirit – one man.* Londen: Epworth Press

SAVE TOOLKIT. 2010 [Online]. Available: http://issuu.com/inerela/docs/save_toolkit [2012, February 8]

Sarot, M. 1996. "Introduction", in Brümmer, V. & Sarot, M. (eds.). *Happiness, well-being and the meaning of life: A dialogue of social science and religion*. Kampen: Kok Pharos Publishing House. 1-25

Schueller, S. M. 2009. Promoting wellness: Integrating community and positive psychology. *Journal of Community Psychology, 37*(7):922-937

Sherlock, C. 1996. *The Doctrine of Humanity.* Leicester: Inter-varsity Press (303)

Simbayi, L.C., Kalichman, S.C., Strebel, A., Cloete, A., Henda, N., & Mqeketo, A. (2007). Internalized AIDS stigma, AIDS discrimination, and depression among men and women living with HIV/AIDS, Cape Town, South Africa. *Social Science and Medicine, 64,* 1823-1831

Singh, S., Darroch, J.E. & Bankole, A. 2004. A, B and C in Uganda. The roles of abstinence, monogamy and condom use in HIV decline. *Reproductive Health Matters*, 12(23):129-131

Smith, C.L. & Clay, P.M. 2010. Measuring subjective and objective well-being: Analysis from five commercial fisheries. *Human Organization*, 69(2):158-168

Somlai, A. M., Kelley, J. A., Kalichman, S. C., Mulry, G., Sikkema, K. J., McAuliffe, T., Multhauf, K. & Davantes, B. 1996. An Empirical Investigation of the Relationship Between Spirituality, Coping, and Emotional Distress in People Living with HIV Infection and AIDS. *Journal of Pastoral Care*, 50(2):181-191

Somlai, A. M., Heckman, T. G., Kelly, J. A., Mulry, G. W., & Multhauf, K. E. 1997. The Response of Religious Congregations to the Spiritual Needs of People Living with HIV/AIDS. *The Journal of Pastoral Care, 51*(4):415-426.

Steger, M.F., Pickering, N.K., Adams, E., Burnette, J., Stauner, N., Shin, J.Y. & Dik, B.J. 2010. *Psychology of Religion and Spirituality*, 2(4):206-226

Stephenson, R. 2009. Community factors shaping HIV-related stigma among young people in three African countries. *AIDS Care*. 21(4):403–410

Stetnitz, L.Y. 2006. Meeting the challenge with God on our side. Churches and faith-based organizations confront the AIDS epidemic in Namibia. *International Review of Mission*, 95(576/577): 92-103

Strong, J. (1996). *The exhaustive concordance of the Bible : Showing every word of the test of the common English version of the canonical books, and every occurence of each word in regular order.* (electronic ed.) (H0). Ontario: Woodside Bible Fellowship.

Struys, Th. 1968. *Ziekte en genzing in het Oude Testament*. Kampen: Kok

The Belhar Confession [Online]. Available: http://www.vgksa.org.za/documents/The Belhar Confession.pdf [2011, November 7]

Thomas, L.E. 2008. What the mind forgets the body remembers: HIV/AIDS in South Africa – A theological and anthropological issue. *Currents in Theology and Mission*, 35(4):276-286

Tillich, P. 1984. Theological perspectives in health care, in Tillich, P. *The meaning of health*. Chicago:Exploration Press

Towner, W.S. 2005. Clones of God. *Interpretation*, 341-356

Treatment Action Campaign [Online]. Available: http://www.tac.org.za/community/keystatistics [2011, August 17]

UNAIDS Report. 2009 [Online]. Available: http://www.unaids.org/en/regionscountries/countries/southafrica/. [2011, July 8]

Utley, J. L. & Wachholtz, A. B. 2011. Spirituality in HIV+ Patient Care. *Psychiatry Issue Briefs,* 8(3):1-3

Van der Ven, J.A. 1993. *Ecclesiologie in context*. Kampen:Kok

Van Dyk, A. 2005. *HIV/Aids care & counseling: a multidisciplinary approach*. Cape Town: Maskew Miller Longman (Pty) Ltd

Van Dyk, T. & Coetzee, M. 2010. *Make sense of referencing. The Harvard, APA and Vancouver methods and the footnote system, 3rd ed*. Stellenbosch: University of Stellenbosch

Visser, M. (ed.). 2007. *Contextualising Community Psychology in South Africa.* Pretoria: Van Schaik.

Visser, M.J., Makin, J.D., Vandormael, A., Sikkema, K.J., Forsyth, B.W.C. 2009. HIV/AIDS stigma in a South African Community. *AIDS Care*, 21(2):197–206

Wakabi, W. 2006. Condoms still contentious in Uganda's struggle over AIDS. *The Lancet*, 367 (9520):1387-1388

West, G. 2003. Reading the Bible in the light of HIV/AIDS in South Africa. *The Ecumenical Review*, 55(4):335-344

West, G. & Zengeli, B. 2006. The medicine of God's Word: What people living with HIV and AIDS want (and get) from the Bible. *Journal of Theology for Southern Africa*, 125:51-63

WHO. 2008. Epidemiological Fact Sheet on HIV and AIDS. Core data on epidemiology and response. *UNAIDS/WHO Working Group on Global HIV/AIDS and STI* [Online]. Available: http://www.afro.who.int/ [2011, June 30]

WHO. 2011 *a*. *Mental health* [Online]. Available: http://www.who.int/topics/mental_health/en/ [2011, June 30]

WHO. 2011 *b*. *Health Promotion Glossary* [Online]. Available: http://www.who.int/hpr/NPH/docs/hp_glossary_en.pdf [2011, September 19]

Wilkinson, J. 1980. *Health and healing: Studies in New Testament principles and practice*. Endinburgh:Handsel

Wilkinson, J. 1998. *The Bible and healing: A medical and theological commentary*. Endinburgh:Handsel Press

Williamson, R. L. 1998. Images of God among persons with Aids. *Journal of Pastoral Care*, 52 (1):56-61

Wittenberg, G. H. 1994. Counselling AIDS Patients: Job as a paradigm. *Journal of Theology for Southern Africa*, 61.

Whitaker, R., Brown, F., Driver, S. (. R., & Briggs, C. A. (. A. (1997, c1906). *The Abridged Brown-Driver-Briggs Hebrew-English Lexicon of the Old Testament : From A Hebrew and English Lexicon of the Old Testament by Francis Brown, S.R. Driver and Charles Briggs, based on the lexicon of Wilhelm Gesenius*. Oak Harbor WA: Logos Research Systems, Inc.

Zombonini, F. 1992. *Teresa of Calcutta. A pencil in God's hand*. New York:Alba House (Translated by J Aumann)