The knowledge of church leaders in Taung, Mohale's Hoek about the HIV/AIDS pandemic

Malehana Anna Mafisa

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Africa Centre for HIV/AIDS Management
Faculty of Economic and Management Sciences
Supervisor: Ms Anja Laas
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DECLARATION

By submitting this assignment 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.

Malehana Mafisa

January 2012

SUMMARY

The study intended to ascertain the knowledge level of the church leaders in Taung Mohale's Hoek, Lesotho about HIV/AIDS and identify the constraints for church leaders to make a meaningful contribution to fight against HIV/AIDS.

There were 27 churches in Taung of which 19 were sampled based on the number of members. The qualitative approach and in-depth questions were used to interview the church leaders to ascertain their HIV/AIDS level of knowledge. To ensure the reliability and validity of this study, the interview guide was designed to cover dimensions of knowledge on HIV/AIDS and what the church is currently doing in the fight against HIV/AIDS and what they can do to fight HIV/AIDS.

The result of the study indicated that most church leaders in Taung area still do not have thorough knowledge about HIV/AIDS and transmission modes. The majority of the church leaders could not differentiate between HIV and AIDS. Some of the church leaders did not know about ARVs. The study further reveals that the Sunday pack guide is existent in both Sesotho and English, however, this guide is not known by most churches in Taung. The general finding was that churches only feel it's enough to mention HIV/AIDS at congregational level and dedicate one Sunday tiethe in a year for orphaned and vulnerable children. Only a few churches have sound strategies and procedures to fight this disease beyond just mentioning it on Sundays.

The recommendation is that since there is a Sunday pack already in place for guiding the church leaders about how to preach about HIV/AIDS, the Sunday pack should be revised to include information on care and support so that churches can have a clear strategy with goals and objectives of how they are going to play their role in the fight against HIV/AIDS. The Sunday pack should also be popularised so that all church leaders could know about it.

OPSOMMING

Die doel van die studie was om kerkleiers in Taung Mohale Hoek in Lesotho se vlak van kennis rakende MIV/VIGS te ondersoek en om die struikelblokke te bepaal wat hul verhinder om ‘n betekenisvolle bydrae te maak tot die stryd teen MIV/VIGS.

Daar was 27 kerke in Taung, waarvan 19 in die studie gebruik is, gebaseer op die aantal lidmate van die kerk. The kwalitatiewe benadering en in-diepte vrae is gebruik om onderhoude met die kerkleiers te voer met die doel om hul MIV/VIGS kennis te bepaal. Om die geldigheid en betroubaarheid van die studie te verseker is die onderhoudsgids so ontwerp om kennis rondom MIV/VIGS te dek sowel as om te bepaal wat die kerk huidiglik doen in die stryd teen MIV/VIGS en wat hul moontlik nog kan doen.

Die studie het getoon dat meeste kerkleiers in Taung steeds nie voldoende kennis rakende MIV/VIGS het nie en hoe dit oorgedra word nie. The meerderheid van die kerkleiers kon nie tussen MIV en VIGS onderskei nie. Sommige van die kerkleiers het nie geweet wat antiretrovirale middels is nie. Die studie het verder getoon dat die Sondag-pakket, wat in Sesotho en Engels beskikbaar is, nie aan meeste van die kerke bekend is nie. Die algemene gevoel onder die kerke was dat dit is voldoende is om net na MIV/VIGS te verwys in die kerk en een Sondag in die jaar se kollete te skenk aan wees- en kwesbare kinders. Slegs ‘n aantal kerke het strategiee en prosedures in plek om meer te doen as om net daarna te verwys op ‘n Sondag.

Aangesien die Sondag-pakket beskikbaar is om leiding te gee oor hoe om oor MIV/VIGS te preek, word daar aanbeveel dat die pakket nagegaan moet word om inligting rakende sorg en ondersteuning in te sluit sodat kerke ‘n duidelike strategie met doelwitte het oor watter rol hul in die stryd teen MIV/VIGS kan speel. Dit is ook nodig dat die Sondag-pakket bekend gestel moet word onder die kerke wat tans nie daarvan bewus is nie.

ACKNOWLEDGEMENTS

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CHAPTER ONE: INTRODUCTION

1.1 Background

According to the World Health Organization (WHO) (2008), Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) were ranked the fourth cause of death worldwide, making HIV/AIDS one of the greatest human, economic and developmental challenges in the world. The HIV/AIDS pandemic reverses decades of improvement in health, education, and life expectancy (De Waal, 2002). Lesotho had the first case of HIV/AIDS reported in 1986. Since then the adult (15- 49 years) prevalence rate of HIV was reported to be 23.2% in 2008, placing Lesotho among the three countries with the highest adult prevalence in the world (Lesotho Demographic and Health Survey, 2009).

Despite the high prevalence rate of HIV in Lesotho, high incidence of illness and deaths associated with AIDS and the large number of AIDS-orphans created over the past few years, there has not been sufficient sexual behavioural change. Amongst other factors the HIV/AIDS drivers include lack of empowerment, multiple and concurrent sexual relationships, intergenerational sex, early sexual debut, substance abuse, inadequate education of the population on HIV and AIDS (ALFA Survey, 2007).

1.1.1 Government interventions

The government has prioritised HIV/AIDS as their first goal of the eight millennium development goals; signed in 2000. The Government of Lesotho has taken concrete actions to address the epidemic through the declaration of HIV/AIDS as a national disaster; the development of the National AIDS Strategic Plan (2006–2011) and also a monitoring and evaluation plan. The government further appealed to non-government organisations to join hands with them in the fight against HIV/AIDS. The National AIDS commission and the United Nations have been collaborating closely with religious leaders and faith-based organisations in Lesotho to respond to AIDS. In partnership with groups such as Catholic Relief Services, and World Vision, the National AIDS Council and UNAIDS organized a specialized AIDS training of senior church leaders in June 2007.

1.1.2 The faith-based interventions

In Lesotho 90% of Basotho are Christians affiliated with churches (World Vision, 2010). Kimaryo (2004) indicate that the Church in Lesotho has extensive networks of leaders, people and institutions. Churches are widely spread throughout the country, including in some of the remote and mountainous regions. The churches have a major cultural, social and educational influence. The churches have been taking part in development through their assets such as schools and hospitals to improve the education and health of Basotho. Forty percent of the clinics and hospitals in the country and 80% of the schools belong to churches.

1.1.3 Significance of church leader's participation

According to Cinfwember (2006) an HIV diagnosis is difficult to manage without social support and healthy coping strategies. He considers the church as a place where people living with HIV may turn to for support. The churches are almost everywhere in Lesotho from rural to urban areas. The involvement of church leaders in the fight against HIV/AIDS can help in influencing behavioral change and reducing stigma and discrimination because churches can influence individual values and norms that shape people's attitudes and behavior. Christianity encourages strong values such as integrity and honesty. The love and fear of God encourage Christians to live a Christ centred life which is against most of the cultural practices such as having multiple concurrent sexual partners (Exodus 20:16). The Bible teaches the youth skills that will help them make informed decisions in their lives to avoid risky behaviours that might make them contract HIV. The Bible also advocates for respect of other people's rights, bringing hope to the hopeless and compassionate love to all. Christianity disapproves fornication and adultery; it encourages sex only within marriage.

1.2 Research Problem

1.2.1 Failure to disseminate information

The governmental and non-governmental organizations has organized training programmes for senior church leaders to improve their knowledge on HIV/AIDS but unfortunately trained church leaders appear to hold this information among them and not share it with other church leaders,

because there is still a significant gap in knowledge levels among church leaders and the community. As a result church leaders share different messages which some of it is wrong with their congregations and hence cause confusion which can even spread the pandemic. Maybe it is because of their doctrine and this remains a critical challenge to the fight against the pandemic because the church remains among the most popular place where Basotho gather. The study released by WHO in February 2007, indicated that 90% of Basotho are Christians affiliated with churches. Therefore the church is supposed to be one of the gatherings where HIV/AIDS information is effectively disseminated. If the church leaders could empower one another with knowledge, attitudes and skills needed they could all be in a position to make informed decisions and effectively respond to the HIV/AIDS pandemic.

1.2.2 Rigidity of church doctrine

Church members, particularly church leaders, have been found to be tight to church doctrine without considering that HIV/AIDS is a new phenomenon that came after church doctrine. The church doctrine is meant for members and should be able to provide for members care and protection against HIV/AIDS. The rigidity to church doctrine that consider HIV infection as a punishment from God threatens successful fight against HIV/AIDS and also hinders the church's progress because the church has its congregation as their major asset. HIV/AIDS related illnesses reduces the number of their members and also challenges their congregation's faith on God. Most of the infected people with no support from their church turn to doubt the presence of God, while they go through so much pain. The household economy is also negatively affected by HIV/AIDS. Since people spent most of their money caring for their members who are chronically ill, there is nothing or less remaining for them to tithes in their churches. The tithe is the main source of income of most churches. With no tithes the church cannot progress well. Therefore the church has to revise their doctrines to allow it to provide care and support to its congregation because most infected people die of depression as a result of rejection, and one would expect the church to show compassion and love to the infected and affected people as God has called Christians to take care of those who suffer, in spite of their background (Luke 10:34, Galatians 3:28-29).

1.2.3 Lack of knowledge

According to Lundgren (2009) most HIV/AIDS local organizations throughout the world lack the capacity to respond effectively to the HIV/AIDS epidemic in their respective communities and this limits their ability to act accordingly. The church has a critical role to play in reducing the spread of HIV/AIDS and its impact but they appear not to have adequate capacity and knowledge to effectively respond to the challenges. One of the reasons may be because most of the church leaders are old and think HIV/AIDS is not for their generation and hence care less about how to treat it. The church leader needs to have an in-depth knowledge on HIV/AIDS management so that they can play their roles effectively in the fight against HIV/AIDS.

1.2.4 Belief in faith

There are still some of the church leaders who belief that they can cure HIV through prayer. They pray for the People Living With HIV and AIDS (PLWHA) and instruct them to stop taking medication if they belief they are healed and not to go for testing to verify if they are actually negative because they consider testing as an act of disbelief in God and having no faith in him. Their argument is based on the explanation that spiritual things are not based on 'Worldly' facts. This is wrong information that is circulated by some church leaders and this kind of belief threatens the efforts of the world with respect to prevention care and treatment of HIV/AIDS

1.3 Significance of the research study

The study intends to assess the knowledge of different church leaders about HIV/AIDS. This study is significant because of the numerous agencies, organisations and institutions that would benefit from the findings of this study. To be specific the government of Lesotho will be one of the beneficiaries, as the findings will provide useful information that could direct the future policies and programmes for church leaders. The National Aids Commission partners with churches and therefore would also benefit from the study. The findings can also be used to inform the manual that can be developed to inform or guide the church leaders about HIV/AIDS and how to share it with their congregations. The church itself will benefit as the study may provide information about their strengths and weaknesses. Their weaknesses may be

strengthened through the study findings, while they build on their strengths to be more relevant in the fight against HIV/AIDS.

HIV/AIDS organisations are other groups of the stakeholders that would benefit from this study. The findings of this study are expected to provide useful information for HIV/AIDS organisations which partner with the church. Individuals, infected or affected, will also benefit as the study is likely to provide information on how knowledge among church leaders can be improved or strengthened so that they can effectively support the infected and affected. The congregations will also learn about HIV/AIDS through their well informed church leaders.The study will also be significant to agencies and institutions from every participatory research of this kind as the study intends to provide a ground breaking research on knowledge of church leaders about HIV/AIDS. Above all, the study will significantly contribute to the body of knowledge.

1.4 Research questions

- What is the level of knowledge of the church leaders in Taung, Mohale's Hoek about HIV/AIDS?
- What role is the church playing in the fight against HIV/AIDS?
- How can the knowledge of church leaders be improved?

1.5 Aim and objectives of the research study

1.5.1 Aim of the study

The aim is to ascertain the level of knowledge of the church leaders about HIV/AIDS in order to provide guidelines for the common manual on HIV/AIDS for different church leaders.

1.5.2 Objectives of the study

The objectives of the study are:

- To determine the level of knowledge of the church leaders in Taung, Mohale's Hoek about HIV/AIDS.

- To determine how church leaders could make a meaningful contribution to the fight against HIV/AIDS.
- To provide guidelines for the development of an HIV/AIDS training manual for church leaders.

1.6 Definition of concepts

1.6.1 Knowledge

Knowledge is defined as per the Longman dictionary (1998) meaning is familiarity with someone or something, which can include information, facts, descriptions, or skills acquired through experience or education. It can refer to the theoretical or practical understanding of a subject. For the purpose of this study knowledge refers to in-depth understanding about HIV/AIDS.

1.6.2 Church leader

According to the Longman dictionary (1998) meaning a leader is someone who posses power over other or have influence on them. In this study church leader refers to the pastors, the priests, dickens, elder, youth leaders as well as independent participants who are officially given the responsibility to preach in the church and are also responsible for the administration of the church.

1.7 Structure of the study

This study has been organised into five chapters. Chapter one of this study provides the background information, the rationale and the purpose of the study. Chapter two is the review of the relevant literature on HIV/AIDS and churches in Lesotho. Chapter three covers the research methodology used to conduct the study and justifies the choice of data collection method used. The fourth chapter presents the results and findings and also analysis the findings. The fifth chapter presents the conclusion and recommendations of the study.

CHAPTER TWO: LITERATURE REVIEW

2.1. Lesotho country profile

Lesotho, known as the mountain kingdom because of its high altitude, is located in the eastern part of South Africa. It is land locked completely surrounded by Republic of South Africa. It has been independent since 1961. Lesotho is governed by a constitutional monarch. The kingdom covers an area of 30 350 km squared and has a population of about 1.8 million of which 51% of them are females; 23% of the population lives in rural and remote areas. The country is divided in to 10 administrative districts namely: Maseru, Mafeteng, Mohales Hoek, Quthing, Qach's Neck, Thaba Tseka, Mokhotlong, Buthabothe, Leribe and Berea. The population growth declined between 1996 and 2006, from 1.5% to 0.08%. Lesotho currently has the lowest population growth rate in Southern Africa. The life expectancy for Basotho is 44.9 years. The main source of revenue for Lesotho are remittances from Basotho employment in Republic of South Africa (RSA), revenues from South African Customs Union (SACU), and royalties from export of natural resources, in particular water and diamonds (Gol, 2004).

2.2 The historical background of HIV/AIDS in Lesotho

In Lesotho the first case of HIV/AIDS was reported in 1986 at Mokhotlong District. The adult prevalence rate of HIV risen from 4% in 2003 to 25% in 1999, 31% in 2002 and destabilized to 25% in 2007 and it is was reported to have dropped to 23.2% from 2008. Presently the prevalence rate is at around 23%, still placing Lesotho among the three countries with the highest adult prevalence rate of HIV/AIDS in the world. The majority of Basotho infected with HIV are between 15-49 years old, who are in their sexually reproductive and economically productive years. It is estimated that one out of three Basotho in this age group is living with HIV/AIDS. By June 1999, over 80% of AIDS deaths came from this age group (USAID, 2010).

2.2.1 HIV/AIDS and gender

From the total number of adults living with HIV/AIDS in 2010 was about 23% in 2002, it was estimated that 41.1% were male and 58.9% female. The male to female disparity is even

pronounced among youth of 15 to 29 years old, where young women account for 75% of all reported AIDS cases leaving young men with 25%.By 1996 HIV prevalence had raised to alarming 26% among pregnant women aged 20-24, from 3.9% in 1992. UNAIDS estimated that by the end of 2002, at least 180,000 of the estimated 330,000 adults living with HIV/AIDS were women, from a total population of 2, 2 million. This is 55% of the total number of adults infected with HIV hence 45% were their male counterparts. Similarly 55% of the nearly 400 new cases reported in 2001 were women (Global Fund). Young women between the ages of 15-29 years old are particularly affected, as they constitute almost 75% of all reported AIDS cases in this age group.

2.2.2 HIV/AIDS distribution per districts

Lesotho is divided into 10 districts namely Mokhotlong, Thaba-tseka, Qacha's Neck, Quthing, Mohales Hoek, Botha-Bothe, Berea, Mafeteng and Leribe. It is also divided into urban and rural areas. The first 4 districts fall within the rural areas (90% rural) while the last six are in the urban areas (70% urban). Although HIV prevalence remains high among all areas of Lesotho, recent surveys suggest that HIV/AIDS is disproportionately affecting urban areas. For example, the HIV prevalence in the Maseru district was 42% in 2000, compared to 23% in the Quthing district. Data indicate that HIV prevalence rates may also be higher among migrant workers. According to Lesotho UNIGASS country report (2009) in 2005 prevalence rate was highest in Leribe with 30% women and about 28% males, followed by Maseru with 29% women and 26% male. The districts with the lowest prevalence are Mokhotlong with 20% women and about 15% women and Thaba-Tseka with the almost same numbers. This trends show that there is high prevalence in districts within the urban area and lower in districts in the rural areas. In 2007 there was a prevalence rate of about 21.9% in women and men in the rural areas as opposed to 29.1% of men and woman in the urban areas.

2.2.3 Major factors causing the spread of HIV/AIDS in Lesotho

The major factors that have been identified as the driver of the pandemic in Lesotho are as follows: The unemployment rate is very high and it induces significant population mobility in search of employment opportunities within and outside the country, thus contributing to increasing risk of exposure to HIV transmission through transactional sex. Poverty and food

insecurity at household level have increased vulnerability to HIV transmission and infection as they drive people into risky behaviours in exchange of food and other materials. Alcohol and drug abuse are rapidly increasing in Lesotho and tend to contribute to increased risky sexual behaviour as well as possibility of transmission through intravenous drug administration. Multiple concurrent sexual partners' relationships: Multiplicity of sexual partners is significantly common in Lesotho increasing the risk of HIV transmission if combined with unsafe sexual practices. Migrant labour to South African mines that mainly provide job opportunities for males in Lesotho has contributed to high transmission of HIV as most of the workers were accommodated in males' only hostels. This increases chances of transmission and further spread to their spouses on return.

Low socio-economic and legal positions of women promote inequality and gender-based violence. Women are not empowered to make decisions in their lives, thus predisposing them to sexual abuse and violation of their rights and increased risk to HIV transmission. Intergenerational sex, especially between older males and younger women, is a common occurrence in Lesotho due to socio-economic vulnerability of young people, particularly girls who get involved in transactional sex and thereby increase their exposure to possible HIV transmission (USAID, 2010).

2.2.4 Government response

The national response was established immediately after the reporting of that first case and the government of Lesotho has, over the years, developed many plans and policies to guide the response to HIV/AIDS. First the major trends of HIV/AIDS, together with modes of transmission, as well as factors causing the spread of HIV/AIDS, were identified. Statistics was collected to monitor and study all these. In 1987, the Government of Lesotho established the National AIDS Prevention and Control Programme (NAPCP). In 1992 the Government of Lesotho initiated greater involvement of private sector in the national response of HIV/AIDS through Labour Code order No. 25, while in 1999 HIV/AIDS work place policy was adopted. The government has also prioritised HIV/AIDS as their number one priority under the poverty reduction strategy where the government planned to reduce the rate of HIV infection by half by the year 2015 because HIV is considered to be the constraint for the country to attain the

Millennium Development Goals. His Majesty, King Letsie III, declared HIV/AIDS a national disaster and called for the development of the national management response by establishing of National AIDS Commission (NAC). The policies and legislative instruments were directed at the identification of the drivers of the pandemic in a multi-factorial, thus, creating a platform of the appropriate policy and legislation to guide interventions to reduce the spread of the pandemic as mentioned in the previous paragraph. In 2006, NAC published the National HIV/AIDS Strategic Plan for 2006 to 2011. The strategy focused on three main areas: (1) prevention, (2) treatment care and support as well (3) impact mitigation.

Prevention

The focus for prevention is to stop the epidemic from growing, by reducing new incidences of HIV to the extent where the epidemic would not sustain itself. Therefore the focus is on reducing the rates of new infections as opposed to prevalence rates. Incidence rate refers to the number of new infections over a period of time which is usually a year while prevalence rate is the total number of infections at a particular time. The strategic plan provided two priority levels, which are interventions backed by strong evidence for their impact and have the potential, in combination with measures at different levels to discontinue the epidemic. These interventions include social and behavioural change communication, male circumcision, prevention of mother to child transmission and condom use in certain populations. Priority two interventions include interventions that have to continue given the benefits accrued over time and their complementary nature to HIV prevention and in particular public health. They encamps prevention of STI, provision of ART, workplace programmes, and ensuring blood safety. This second priority is to focus on some other key populations such as homosexuals and mobile populations. The expected impact for the prevention interventions is reduction in number of new infection to less than 11, 000 in 2011 and this has not been achieved as per the UNGLASS (2010) report.

Treatment care and support

Treatment care and support aims at providing comprehensive support to those who are already infected. This focus at reducing mortality and morbidity among PLWHA, and consequently improve their quality of life. The government intended to increase the number of children and adults with advanced HIV infection enrolled for receiving ART treatment and capacitate to

adhere to the medication. The national strategic plan (NSP) in this area has prioritised ART, TB/HIV co-infection and some home-based care including palliative care. To facilitate the provision of ART, the number of health facilities was increased to improve access to ART. This strategic focus was expected to reduce the rate of mortality due to HIV/AIDS from 26% for men and 31% for woman and 18% for children under 12 years in 2007 to 16% for men, 21% for woman and 8% for children by 2011.

Impact mitigation

Under impact mitigation, the NSP focuses on reducing the negative impact on the vulnerable households, individuals and groups of people such as orphans and vulnerable children and PLWHA among others. This strategic intervention is expected to provide psych-osocial care and support, as well as advocacy for the rights of the infected and affected through strengthening of community system, for example the development of the paralegals. While the priority are those that reduce the level of impact, the focus shift from the short term mitigation to long term interventions, including developing appropriate policies and alternative livelihoods. The expected outcome was a reduced percentage of vulnerability due to HIV/AIDS among the community members.

2.3 The impact of HIV/AIDS on churches

2.3.1 High mortality rates arising from HIV/AIDS

HIV/AIDS is a health condition that affects the individual; however it impacts on families, communities, nations and the world. HIV/AIDS affects human security in various dimensions: health, economy, food and environment. These dimensions are tightly linked to human existence and good health as they are encompassing. Chen (2004) reflects that good health is intrinsic to human security. Thus for people to exist and survive they are bound to be secure. HIV/AIDS is one typical threat of the moment to human security as it kills the broader spectrum of human life that is at all age levels, across poverty and economic levels. The National World Summit Report (United Nations, 2002) shows that due to the HIV/AIDS pandemic there are many orphans and vulnerable children who live under unacceptable and hardship conditions as they have lost their parents through various HIV/AIDS related illness. These children grow up in the atmosphere of

unhappiness and without a family environment. Around 18 000 people died from AIDS in 2007 and 110 000 children were orphaned by the epidemic (Lesotho Demographic and Health Survey, 2007).

As more and more members of the church die leaving the orphans behind, the church is culturally expected to replace the lost breadwinners by taking the responsibility of caring and supporting these orphans. According to Xapile (2010), the church is the primary family which is expected to continue with the responsibilities of the family in a normal situation to ensure survival of the orphans. When the church fails to respond this put its reputation at stake because people begin to doubt its commitment to its members. The church may also lack some resources to act because HIV/AIDS impacts on the coping abilities of human resources which in turn directly affect the economical aspect forming the bases for survival. It results in loss of the productive members of the family, leaving families with dependents who could not even pay their tithe or any offerings that churches raise their funds from. Therefore HIV/AIDS greatly reduce the resources and funds of the churches stretching its expenses on transport for funerals or caring and supporting the HIV infected and affected.

2.3.2 Stigma and discrimination associated with HIV/AIDS in the church

Talking about sexuality is considered as a taboo in some churches and for the church to share information on HIV/AIDS there is a need to include sexuality. Some churches also belief that HIV/AIDS is not their problem but the sinner's problem and hence there was no need to talk about it in their churches. This denial made it even more difficult for their infected members to open up, as they were afraid of being rejected and expelled from the churches. The first decision that HIV positive people need to take is very often whether they should disclose or not. With this decision they often need support from a counsellor, church leader, or other people they trust (Raubenheimer, 2005). The church used to see HIV as a punishment from God. This has resulted in them discriminating and stigmatising the HIV/AIDS infected and affected. The term discrimination is given when someone is given unequal or unjustifiable treatment based on their HIV status. This is normally an infringement on their human rights. Stigma is often created by the feeling of exposure to a certain risk based on a lack of information or misinformation (Qubuda, 2010).

Qubuda (2010) further states that stigma discourages people from knowing their status with the fear of being testing HIV positive. The reluctance of people to know their status increases their chances of further spreading the disease through unprotected sex or mother to child transmission, if they are positive and contracting the disease if they were negative. It also delays patients to be enrolled on treatment until they are on an advanced stage that even ARV could not help and they die. Stigma further denies one the support they deserve because their families and friends would not be aware of their status. Addressing stigma is the base for effective interventions in the prevention of HIV/AIDS. Because of this long judgemental attitude the churches had in the past, congregations still do not trust the church/church leaders for sharing their HIV status with them. People die lonely as a result of depression because they had no one to turn to.

2.4 The relevant information church leaders should be equipped with

The church and the church leaders have to be in a position to identify myths from facts about HIV/AIDS. They have to know what HIV and AIDS are and the difference between the two. They should know the global and national statistics of HIV so that they can understand the impact of HIV on the country, the community, families, individuals and the church. The picture of the impact on the church will stimulate the church to partner in response to the HIV/AIDS pandemic. The church leader also has to understand the progression of HIV through all the stages from infection to death. The knowledge of how one gets infected or modes of transmission will help change their attitude of stigmatising HIV positive people with the fear of transmitting the infection (Channels of Hope manual, 2006).

The church leaders should also know that HIV/AIDS has no cure. They should not raise the hopes of their congregations by claiming they will be cured after they have prayed for them. However they should understand that infected people can still live meaningful, self-fulfilling lives contributing to the wellness of their families and society. An HIV diagnoses is not a death sentence, but rather an opportunity to take control over one's life and make decisions for a healthier lifestyle. They have to understand that HIV/AIDS can be prevented and managed but not cured. They should also understand that there is treatment for management of HIV/AIDS but it is not a cure and treatment needs adherence. The origin of HIV should also be shared with

them but let them know that it does not matter much where it comes from but what matters is preventing its spread and the damage it is causing (Raubenheimer, 2005).

2.5 The church intervention in responding to HIV/AIDS pandemic

2.5.1 Hope initiatives

In a study conducted by Sarvela, Lydia, Searestang, Anion & Roweld (2000) on the role of churches in the prevention of HIV among high risk individuals in Germany, he discovered that the majority of the high risk individuals are somehow affiliated with churches. He also discovered that very few of them have heard any information about HIV/AIDS from church, yet most of the HIV positive individuals have somehow shared their status with someone from church. In the same study it is articulated that systematic reviews and meta-analyses quantitavely confirm that religious involvement is the fight against cancer. It was found that the number of conditions is improved as a result of religious belief and spirituality, including heart disease, cancer and stroke because the church can give hope to the hopeless. Therefore if the church leaders within Taung can effectively play their role as the hope initiatives they can help improve the lives of the PLWHA.

In Lesotho most areas, especially in the rural areas, religious leaders have shaped the lives of people because they are considered to be spiritual pillars and trusted source of guidance, moral support and advisers on every day issues. Christianity is based on demonstration of Christ like life that is living according to the Bible's teachings. The Bible compares Christianity to light and salt. This is based on the fact that "light is light giving". It is a positive force. It removes darkness. Therefore Christianity or churches have to play a positive role in their society. Where darkness prevails, Christians must bring light. Salt is a medium that prevents decay and preserves food. It also has a healing effect. Therefore the church must play a decay preventing and healing role in the society. Where decay prevails the church must bring new life (Bible Society of Australia, 2009).

2.5.2 Psychosocial support

Chimfwember (2006) in his dissertation about HIV and AIDS, disclosure, stigma and social support within churches also support the importance of the church taking a role in the fight

against HIV/AIDS. He states that due to the difficulty of managing HIV without a social support and healthy coping strategies, the church is the one place to which PLWHA may turn for support. The church is strategically positioned for the fight against HIV because they are found everywhere, but PLWHA avoids the church because of stigma and there is decreased disclosure which results in less access to supportive resources that may be available for them.

According to Channels of Hope (2005), the church has to consider the HIV/AIDS crises as an opportunity to evangelise people that are infected and affected by the disease and the church should also demonstrate the love of God, irrespective whether the people in crisis learn more about God or not The church can also provide care and support to their infected and affected members in the form of home-based care and support groups and many other. The church leaders should also change their attitudes from judgemental to compassionate, condemnation to acceptance, and from rejection to love. Then the church will be in a position to provide spiritual support to create a positive mental attitude to its congregation so that they can live a healthy long life despite their HIV positive status. A positive mental attitude reduces stress and prevents unnecessary infections, therefore health and well-being, and thereby helping to keep people well for longer. The support and guidance offered should assist the HIV/AIDS positive people to develop a positive mental attitude towards health, social life, support structures, the virus and his/her unique role and place within the society (Raubenheimer, 2005).

According to Sarvela et al (2000), the church has been taking care of the people it served. The church and associated institutions provided direct care through hospitals for centuries. Beyond this the church provided nursing homes and schools for the people. The faith-based proposal (2009) support this statement that even in Lesotho the church has made a remarkable contribution in the health and education sectors.

Since 2000 when the government appealed to the non-governmental organisations and institutions to join hands with them in the fight against HIV/AIDS, the church demonstrated an interest. The tragic effect of the HIV/AIDS pandemic and its continuous spread in Lesotho edged the commitment of the faith-based organisations. In July 2007, 14 church leaders in Lesotho

signed a statement of commitment on HIV/AIDS pledging to confront the pandemic and support PLWHA.

2.6 Church's commitment in the fight against HIV/AIDS pandemic

The church leaders stated that the AIDS crisis has brought them together because they are all affected by HIV/AIDS. They showed an interest in sharing the knowledge, understanding and experience from their different religious communities so they unite their efforts to become more effective and inclusive. The churches went further to form a consortium for the fight against HIV/AIDS, called Lesotho Inter-religious Aids Consortium (LIRAC) which respects the uniqueness within church's traditions while focussing on their shared values of human rights. They declared their commitment in working with the government in the fight against HIV/AIDS.

Through their declaration, church leaders pledged to promote dignity, equality and rights of all people, especially those living with HIV; to discuss openly about AIDS and about effective means of HIV prevention; to reject negative statements that AIDS is a form of 'divine' punishment; and to support effective HIV preventive education, comprehensive care and treatment, impact mitigation and full inclusion of people living with and affected by HIV in the community. The religious leaders vowed to implement policies, strategies and frameworks within religious institutions and structures to combat any marginalization of people living with or affected by HIV.

The leaders underlined their support for the elimination of the root courses of the AIDS pandemic including gender inequality, social and cultural norms such as having multiple concurrent sexual partners, sexual abuse, and prejudice against those whose way of life or sexual orientation is different from the majority of the community, systematic injustice and unequal distribution of wealth among citizens. The churches went further to work with other Christian organisations like World Vision Lesotho and Catholic Relief service to conduct a baseline survey as their starting point to inform their joined faith-based programmes on HIV/AIDS. The baseline was on knowledge, attitudes and beliefs of the community. LIRAC developed different

HIV/AIDS programs which are funded and coordinated with other interventions by NAC (UNAIDS, 2007).

Among the projects that LIRAC participated in is the development of the book called Sunday pack, which was intended to assist church leaders in teaching and preaching about on issues around HIV/AIDS. The book covers five distinct topics: Basic facts about HIV/AIDS, Prevention of HIV, Stigma and discrimination, Treatment, care and support, as well as other important issues. Each topic is divided into seven sections which include: key message, facts, biblical quotation, statement of commitment, key thought, lived experience and ideas for action.

The title of the day refers to an HIV/AIDS related topic a pastor or priest may choose to preach on. Facts refer to what is globally known as established truths about the chosen topic. Such facts are meant to support the key message. Lived experience refers to people's accounts of what their own existential experience is in connection with the topic. The pastors are encouraged to discuss one topic, with its different sections. The Sunday pack has been divided 54 Sundays of the year so that every Sunday the church leader can have something to say on issues of HIV/AIDS.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

This section includes a description of the specific techniques employed, the specific instruments used and the series of activities performed in making the research realistic. It is in this section the researcher outlined approaches employed in data collection as well as data analysis.

3.2 Target population and sampling approach

The target population for this study is the church leaders within Taung area of Mohale's Hoek district in Lesotho.

3.2.1 Taung Area

Taung is situated in a rural area in Mohale's Hoek district. Taung falls within the lowlands part of the country in Mohale's Hoek district about 110km south west of Maseru the capital town of Lesotho. The programme area is 33 818 ha. The population of Taung is 55 139 comprising of 27 303 children, 19 730 females and 8 106 males. The average household size is 5 but 7 - 8 is found in other households. There are low economic prospects for Taung area due to lack of industries. This area had the Development Organization working in it, but despite all the interventions the development organizations like World Vision implemented this area still experience an increase in the number of orphans and vulnerable children like many other areas in the country (World Vision Taung design document, 2009).

According to Collins (2003,) a population is the entire group of persons or set of objects and events the researcher wants to study. Collins further states that because researchers hardly have access to the entire population, the population that the researcher has access to differs from the entire population, thus pointing out that the population the researcher can reach is defined as the study population. For the purpose of this study the population is the 27 church Leaders from different denomination in Taung area, Mohale's Hoek, Lesotho namely: the African Methodist Episcopal Church and the Anglican Church of Lesotho. The area has a representation from

different churches such as Lesotho Evangelical Church, Dutch Reform, Methodist Church of Southern Africa, Roman Catholic Church, Anglican Church of Lesotho and other 'Apostolic' churches.

The church leaders are the member of churches responsible for sharing the word of God with the congregation. The inclusion criteria for the church leaders are that their members should be more than 15 and they should have their churches within Taung area in Mohale's Hoek, Lesotho.

3.2.2 The criteria for choice of churches

In this study the researcher has resolved to involve churches that have more than 15 members. There were 19 churches which met these criteria out of the 27 churches within the Taung area. The use of a qualitative approach had implications for the number of participants included. The information on what the church leaders should know will be derived from the literature review that guides on what knowledge the church leaders should have.

The number of churches leaders who participated in this study is shown below

Table 1. Number of churches in Taung

Church denomination	**Male**	**Female**	**Qualification for study based on congregation size**
1. Makhineg Roman Catholic Church (RCC)		**X**	**X**
2. Khitsane Methodist church	**X**		**X**
3. Khitsane Dutchreform	**X**		
4. Kololola pere Roman Catholic Church		**X**	**X**
5. Liphing Lesotho Evangelical Church (LEC)	**X**		**X**
6. Liphing RCC	**X**		**X**
7. Lefikeng Folisa	**X**		**X**

8. Lefikeng LEC		**X**	**X**
9. Mohalinyane LEC	**X**		**X**
10. Tlokotsing LEC	**X**		**X**
11. Liphiring Word of Life	**X**		**X**
12. Liphing AME	**X**		
13. Mahase AME	**X**		**X**
14. Sephopo AME		**X**	**X**
15. Itumeleng LEC	**X**		**X**
16. Mofumahali oa rosary RCC	**X**		**X**
17. Siloe LEC		**X**	**X**
18. Qhoqhaone LEC	**X**		**X**
19. Moletsane RCC	**X**		**X**
20. Moletane AME	**X**		**X**
21. St John			**X**
22. Khore ea tsepo AFM		**X**	
23. Matsoareng church of Christ	**X**		
24. Pholoho church of zion	**X**		
25. Tlokotsing church of Zion	**X**		
26. Moletsane folisa	**X**		
27. Kubaki pholosoa	**X**		

3.3 Research design and motivation

De Vos (2005) defines a research design as a plan or blueprint of how you intend to conduct the research. A single research design with inclusive participatory approach is in most cases better for a study of this nature and is the appropriate approach in this study.

The qualitative approach and in-depth questions guide was designed to identify the church leader HIV/AIDS knowledge level and how the church can make a meaningful contribution to the fight

against HIV/AIDS. The questions were developed based on the literature and reviewed by the Ethical Committee of the University of Stellenbosch. The question guide was used as the instrument for this study. A variety of participatory techniques were employed to professionally facilitate the processes required by this study. The components of this study are as follow:

- To ascertain the knowledge level of church leaders about HIV/AIDS
- To determine the constraints that hinder churches to effectively play their role in the fight against HIV/AIDS
- To analyse of the roles churches are playing in the fight against HIV/AIDS

3.4 Research tool design

The research tool was designed with the focus on the aims, objectives and the research problem. The question guide also focused on some research questions. The research tool was tested in Maphutseng area which is a nearby area to Taung on 5 church leaders, where the researcher realized that there were gaps in the question guide and these gaps were filled. The researcher designed probing questions in line with the HIV/AIDS issues that churches need to know and act on. The proposed question guide consisted of more of open-ended questions. The question guide was written in two different languages, Sesotho and English, which are common in Lesotho so that the interviewees could choose their language of preference. The length was reasonable and did not take respondents more than 30-45 minutes to complete. The arrangement of the questions was also important, they were made sequential.

3.5 Administration of question guide

On the other hand, the credibility of the members and their statements confirm the reliability of the research. The qualitative approach is used because it aims for the in-depth rather than quantity of understanding (Henning, 2009). The interview questions were translated to Sesotho, because most of the church leaders do not understand English. The interview took 30 minutes. The questions tested the general knowledge about HIV/AIDS. The interview has a higher response rate than mail surveys (Babbie 2001). Letsela (2008) supports this view by stating that

interviews have the advantage of giving in-depth information because the researcher has a chance to observe a non-verbal communication of the participants. Interviews often reach parts that other methods cannot reach. Then observation allows study of people's facial expression while answering certain crucial HIV/AIDS questions. The research took place at the church leader's homes and at their churches after service to ensure comfort and privacy. The interviews were recorded on tape and the researcher noted non-verbal communication during the process.

3.6 Data collection procedures

The source of information used by the researcher was based on primary and secondary sources. Loyal and Royal Consultants (2005) define the primary sources as consisting of data collected by the researcher during the process of work. Secondary data sources as consisting of data that already exists. Therefore in this regard the primary data collected by the researcher from work comes from the interview that was conducted face to face with the church leaders. For this study, data was collected during weekends. The researcher was the interviewer.

The secondary data was collected through the literature review. De Vos (2005) stated that a literature review in fact refers to a scrutiny of all relevant sources of information. It was necessary to establish what others have done in the chosen area of study and possibly what research methods have been used. Therefore, some literature search and review was also necessary. While relying on research reports and texts available in the libraries, an internet search was conducted to be able to make a wise and meaningful contribution to this study.

World Vision Taung Area Development Mohale's Hoek, Executive Committee members provided the list of all churches within Taung in their villages. They also assisted the researcher in facilitating appointments for the church leaders. Therefore appointments were made in advance with study participants. The appointments were made with all church leaders within Taung area for the researcher to obtain approval for interviewing them. All the church leaders who participated in the study were visited and the study was explained to them.

The researcher conducted the research with the help of a research assistant who was asking

questions as the researcher was taking notes. It took the researcher a month to complete collecting data on weekends starting from Friday 4th of November to Sunday 4th of December 2011. Below are the dates for the interviews of different church leaders.

Table 2 Sampled churches

Date	**Church leader**
12/11/11	Liphing LEC Liphiring Word of Life
13/11/11	Liphing RCC Makhineg RCC
18/11/11	Lefikeng Filisa Lefikeng LEC
19/11/11	Tlokotsing LEC
20/11/11	Moletsane RCC
25/11/11	Moletsane AME
26/11/11	Siloe LEC Qhoqhaone LEC
27/11/11	Mofumahali oa rosary RCC
2/12/11	St John
3/12/11	Khitsane Methodist church
4/12/11	Kololola pere RCC
9/12/11	Mahase AME Sephopo AME
10/12/11	Itumeleng LEC
11/12/11	Mohalinyane LEC

3.7 Analysis of Data

The data for this study was analysed qualitatively. During the data collection the church leaders were interviewed verbally and records of their discussions and interactions were hand written by

the researcher.

The hand written records of the discussion were later transcribed into a comprehensive report. In doing this the researcher carefully went to her records and put the report in a readable and accessible manner. This means that information that was similar was put together while those that were different were put differently. It did not in any way involve statistical analysis and therefore no statistical analysis was employed. However references to literature were made during data analysis.

3.8 Ethical considerations

The researcher submitted the research proposal to the Ethical Committee of Stellenbosch University, together with the questions guide and consent form from the church leaders for review to ensure that the study will consider the ethics of research with people. The research proposal was approved to conduct the study.

Participants were encouraged to participate because there was no way to link their responses to them as the researcher did not ask them their names. They were also informed that the information they gave will be treated confidential. They were also informed that the final report would be available after the study. Having given them these details, they were requested to ask questions that bother them about the proposed research. After further clarification, the researcher advised them to sign the consent forms individually and then interviewed. Using this procedure, it was expected that all ethical issues were considered in this study.

CHAPTER FOUR: RESULTS AND FINDINGS

4.1 Introduction

This chapter is subdivided into three sections, the first section is on participant information, the second section is on results on general knowledge, the third section is on the results in the current role the church plays in the fight against HIV/AIDS while the fourth section is on suggestions on action that church leaders think could be taken to improve their role against HIV/AIDS.

4.2 Section one - participant information

In this section the following questions were asked:

1. What is your church denomination?
2. For how long have you been a church leader?

4.2.1 Participant denomination

The churches in Taung are from mainly 9 different denominations dominated by the Roman Catholic (RCC) and Lesotho Evangelical Church (LEC). Most of these churches have signed for the commitment of churches in the fight against HIV/AIDS with the government of Lesotho as per the Sunday pack for use by the church leaders in Lesotho.

4.2.2 Participant length of leadership experience

The answers to the question on length of experience shows that there is quiet a frequent migration of church leaders from one place to another because most of the church leaders have been within Taung for less than five years but have been engaged in evangelism for a much longer time. During the interviews the researcher noticed that most of the church leaders were men and there were very few women. Also most of the church leaders were older people between the ages of 40 to 70 years and were very much reluctant to talk about issues of sexuality.

4.3 Section two - General knowledge about HIV/AIDS

This section included questions which were meant to test the general knowledge of the church leaders about HIV/AIDS. The questions were as follow:

1. Have you ever heard of HIV/AIDS?
2. What is HIV?
3. What is AIDS?
4. Is there a difference between HIV and AIDS?
5. If yes what is the difference?
6. Have you ever tested for HIV?
6. Can you identify an HIV Positive person by mare look?
7. If yes, how?
8. How is HIV transmitted from one person to another?
9. Who is at risk of being infected by HIV/AIDS?
10. Can a person protect himself/herself from being infected with HIV?
11. Can HIV/AIDS be cured?
12. What is ART/ARV?
13. What is the use of ART/ARV?

4.3.1 HIV/AIDS awareness

All of the church leaders have heard about HIV/AIDS from somewhere.

4.3.2 Knowledge about HIV and AIDS

Though all the church leaders were aware of HIV/AIDS most of them could not tell the difference between HIV and AIDS. Some were even referring to HIV as just an STI like any other STI and could not distinguish the difference between HIV and other STIs. Considering the fact that there are three organisations working on HIV/AIDS within Taung area one would expect the church leaders as part of the community to know the difference between the two. This issue becomes even more amazing because a larger proportion of churches within Taung are members of the churches that their senior church leaders indicated that they will discuss openly and accurately the basic facts about HIV/AIDS. Also the senior church leaders have been trained by NAC, LRAC and CCL about general knowledge of HIV but it seems like the information

dissemination is a challenge. This information does not reach the church leaders placed in the community in rural areas like Taung. This also shows the challenge for churches to effectively engage in the fight against HIV/AIDS because according to Hawatt (2010), understanding of the problem is part of the solution meaning if one does not understand the problem it would be difficult to solve it. This paragraph includes answers to question two up to five because they were related.

4.3.3 HIV testing for participants

When church leaders were asked whether they have tested or not, most church leaders change their reaction in such a way that their facial expression indicated the discomfort to answering the question. The researcher further explained that they are free not to answer it if they are not comfortable with answering it but they decided to answer it except three church leaders. Most of the church leaders have not tested, their reasons ranged from that they only have one partner to that they are either too old or are afraid to know their status. As the leader the church leaders are expected to set an example by testing for HIV because they would be leading by example. This has been demonstrated by the Prime Minister Mr Pakathitha Mosisili and his Majesty King Letsie III who always take part in HIV testing during the national campaigns on 'Know Your Status', one would expect the same example from the church leaders because they are very influential and are considered as the most influential institution in behavioural change.

4.3.4 Identification of a person living with HIV

The answer from most of the church leaders was yes for question six which asked if one can see an HIV infected person. They indicated that an HIV positive person can be identified because they are emaciated and their hair is sparsely scattered and their lips turns red. This still emphasised the fact that the church leaders do not understand the difference between HIV and AIDS. It also indicate why they are not interested in knowing their status, it is likely that they belief they are not HIV positive because they do not have the feature they identify an HIV positive person with, hence they will only test when they look like that. This perception the church leaders have can negatively affect the interventions for the fight against HIV/AIDS because people have to know that one can only ascertain his or her status through clinical testing. The knowledge of this information is the basis for all people to test and know their status so that

if they are HIV positive they can monitor their CD4 counts and get help as early as possible to maintain their health and if they are negative they could be advised on how to remain negative.

4.3.5 Means of transmitting HIV among people

Most of the church leaders could at least mention sex as a means of transmission. Few of the church leaders mentioned that unprotected sex instead of just sex. Few of them would clearly state three ways in which HIV can be transmitted from one person to another. From these responses the researcher wonder how the church leaders would protect themselves and their congregation from being infected through other means such as use of the same skin cutting things that are shared among family members during traditional rituals which are common within Taung area. According to Fisher, Foreit and James (2002) prevention of transmission remains the key strategy for reducing the effects of the epidemic on the future generations. Most prevention focuses on changes in sexual behaviour and requires clear understanding of social context within which the behaviour takes place. Therefore it is very crucial for church leaders to understand popular modes of transmission within their areas for them to be able to implement HIV/AIDS prevention interventions.

4.3.6 Identification of people at risk of being infected by HIV/AIDS

Most of the church leaders indicated that it is mainly the youth and women were the people at risk of being infected by HIV and the answer to question 11 which asked how one can protect himself /herself against HIV was mostly answered as, by being faithful to one partner and few mentioned a condom, and the church leaders who mentioned use of condoms were very embarrassed even as they mention it. Other ways were hardly mentioned by respondents.

4.3.7 The cure for HIV/AIDS

The majority of church leaders knew that HIV does not have a cure, but there were a few who indicated that it can be cured through prayer, some through cleansing in a river some through use of traditional medicine and some said by ARVs. One of the church leaders said:

'If ever people could stop undermining God's power and have faith in God they could not be suffering like this! Even in the Bible it is written that there were diseases like leprosy which did not

have a cure but Jesus cured them, so lady this HIV of yours cannot defeat the Lord, if you can have it come and I will pray for you so that you can go and testify to other how powerful and faithful God is to his promises.

4.3.8 Knowledge about ARV

Most of the church leaders are aware that ARV is a medication for the treatment of HIV. A few of the church leaders said the ARV's can cure HIV while a very small number said they have never heard of ARVs.

4.4 Section three -The role played by the church in the fight against HIV/AIDS

This section is on questions that were intended to determine if churches are currently playing any role in the fight against HIV and if there is any way they would like to be capacitated to either start or improve on what they are already doing. The questions asked in this section were:

1. Have you ever talked about HIV/AIDS in your church?
2. If not, why? If yes what did you say?
3. Does your church play a role in the fight against HIV/AIDS?
4. If yes, what is it doing? If not, why?

4.4.1 Discussion about HIV/AIDS in the church

Most of the church leader indicated that they do talk about HIV and AIDS in their churches; even those that failed to differentiate between HIV and AIDS, and could not mention how it is transmitted said they talk about it in their churches. Few of them said they do not talk about it in their churches because people are tired of hearing about it everywhere they go. Some also indicated that it is not the church's responsibility; they said the church's responsibility is to preach about the word of God not HIV. For those who said they do talk about HIV in their church indicated that they mostly tell the youth to abstain from sex and the married people to be faithful to one partner. Some said that they tell them that it is a disease that kills people so they should be careful of whom they sleep with. One church leader said '*I tell them that if they have sex with multiple concurrent partners they will die soon*'.

4.4.2 The role played by the church

The majority of church leaders said there is a Sunday in their churches that is dedicated to orphans and on that Sunday the tithe collected is distributed among the orphans. They continued to say on that Sunday one can also bring some gifts for the orphans either it being food or clothes. Only one church leader said they even go further to visit the sick and provide home-based care and prey for them. He also said they have an income generating project for orphaned and vulnerable children which caters for about eight orphans' school fees and provide for their basic needs such as food and shelter. The church leader indicated that there are even some of these orphans who stay with them in the church yard. He seemed very passionate about his work. He has also gone through some training on HIV/AIDS. The church leader in this church is also a senior church leader for other churches of the same denomination. The fact that he is a decision maker and has been capacitated with knowledge may be what made him to have advantage over others by being so much involved in the fight against HIV/AIDS. If all church leaders could have the same exposure they would do the same. For the church leaders who said they are doing nothing they said it is because there is nothing they can do, some said they are busy with their responsibilities of which fighting HIV/AIDS is not part of. Most church leaders also indicated that they teach their congregation about HIV/AIDS so that they can protect themselves from being infected.

The fact that most churches did not say much about their role in the prevention for the spread of HIV/AIDS came as a surprise because among things that churches indicated they are committed to is ensuring that through education on accurate information about ways of prevention for further spread of HIV, especially around abstinence and delay in onset of sexual debut and promotion of sexual debut as well as reduction of sexual partners (Sunday pack, 2007).

One would think that some churches are held back by their doctrines but it is revealed that churches of the same denomination ruled by the same doctrine responds differently to the challenge posed by HIV/AIDS. From the interviews it is clear that even the Roman Catholic Church (RCC) in Taung area is not doing much but the RCC church in Zambia fulfil the culture of care for people affected and infected by HIV/AIDS by establishing the Integrated AIDS Program (IAP). This program is aimed at addressing the holistic care, prevention, community

development and advocacy. The programme also provides medical and nursing care, counselling, psychosocial and pastoral support and provision of welfare support, care of orphans and children in distress and to support PLWHA support groups. If this trend could extend to other churches in other countries like Lesotho, a greater impact could be achieved in regard to reducing the impact of HIV on the communities (Chimfwember, 2006).

4.5 Section four-church leader's opinion

This section covers questions that give church leaders a chance to give their personal opinions about HIV and the church. Below are the questions which were asked;

1. Does HIV/AIDS affect the church?
2. If yes, how? If no, why?
3. Should an HIV positive person be allowed to attend church?
4. What role do you think a church can play in the fight against HIV/AIDS?
5. In what ways do you think the church can be capacitated?
6. If yes, what kind of support? If not, why?

4.5.1 Effects of HIV/AIDS on the church

More than half of the church leaders said yes, HIV/AIDS affect the church because it kills their congregation and surprisingly even church leaders who said they are not doing anything because it is not part of their responsibilities did mention that HIV/AIDS kills their members and this sounded contradictory.

4.5.2 Acceptance of PLWHA for church attendance

On the question of whether an HIV positive person being allowed to come to church they all said yes but the reason for saying yes were different from one church leader to another. This gives an impression that even though the church leader's knowledge about HIV/AIDS is so low, they do not discriminate against the HIV positive. The answer to why they should allow the HIV positive people to come to church was that they are also people like any other person, hence they have a right to come to church and they cannot infect the congregation just by being in a church. Few of

the church leaders said they have to come to church so that they can cure them through prayer or cleansing in the river.

4.5.3 Improvement of church capacity for effective involvement in the fight against HIV

In response to the above questions, most of the church leaders said they would need ARVs to give to their congregation who are HIV positive. Some said they need money to give to the double orphans for their basic needs, few of them said they wanted to be trained so that their knowledge about HIV could improve. Some said they are not interested in doing anything about HIV because a lot has been done by the government and other non-governmental organisations responsible for the fight against HIV/AIDS.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

The study was conducted in order to ascertain the knowledge level of church Leaders in Taung area, Mohales Hoek about HIV/AIDS and also reveal the role the churches in Taung are playing in the fight against HIV/AIDS. There were 27 churches in Taung of which 19 of them were sampled for participation in the study.

It has been indicated that the church leaders in Lesotho have committed to join hands with the government of Lesotho in the fight against the HIV/AIDS pandemic. They even developed a guiding book for church leaders on how to share HIV/AIDS messages with their congregation during their sermons. This book is developed based on the assumption that all the church leaders would have been educated about HIV/AIDS, so that they can be able to use this book. The book is also translated into Sesotho but from this study it was discovered that none of the church leaders in Taung area has ever seen the book nor ever heard of it.

World Vision Taung ADP indicated in their 2008 annual report that they have sensitised the church leaders within Taung area about HIV/AIDS and has mobilised them to address the needs of HIV/AIDS affected and infected people. But despite all these efforts, this study revealed that most of the church leaders do not know the difference between HIV and AIDS and modes of transmission. The church leaders considered women and youth as the people mostly at risk of being infected, excluding men who contribute the majority of church leaders. Another amazing finding was that some of the church leaders still belief they can cure HIV, which is a crucial issue in regard to the fight against HIV/AIDS because HIV positive people on treatment are encouraged to stop taking the treatment after being prayed for the cure.

The study also revealed that, though senior leaders were capacitated and empowered to effectively take part in the fight against HIV/AIDS, there is still a gap in knowledge levels among church leaders. The church leaders with little knowledge did not contribute much in the fight against HIV/AIDS except a Sunday dedicated to tieth for the orphaned and vulnerable children. There was an exception of one church leader who covers three thematic areas of the

fight against HIV/AIDS which are prevention care and support. This particular church leader had thorough knowledge about HIV/AIDS. Therefore based on this finding it is clear that if all church leaders' knowledge about HIV/AIDS could be improved, they could all fight against HIV/AIDS. None of the church leaders indicated a need to be capacitated with counselling techniques - one wonders if it is because they do not consider it as part of their responsibility or they assume they can do it. Pastoral counselling is one of the potential roles the church can play as it was indicated that religion play a crucial role it the fight against critical illness like cancer.

This study is not conclusive because it only involved the church leaders but not other stakeholders such as the congregation, PLWHA, the community at large and organisations working within Taung area. In this regard this study leaves room for further research especially on the question on what role the church should be playing to reduce the impact of HIV/AIDS on its congregation and the community at large.

5.2 Recommendations

The church leaders in Taung area need intensive training which will improve their knowledge on myths and facts about HIV/AIDS. The church leaders also have to understand the progression of HIV through all the stages from infection to death so that they can differentiate between HIV and AIDS. The knowledge of modes of transmission helps them to know how they protect themselves and others from being infected with HIV. The church leaders should know that HIV/AIDS has no cure and they should stop claiming that they can cure it and they should also understand that there are ARVs for management of HIV/AIDS but it is not a cure and treatment needs adherence.

It is further suggested that HIV/AIDS should be part of the syllabus for the theology schools where church leaders are trained for all the different denominations to ensure that every qualified church leader has a deep understanding of HIV/AIDS. They also need to understand that he/she has a role to play to reduce the impact of HIV/AIDS on the community he/she will be preaching to.

There should also be clear communication channels from senior church leaders to other church leaders among different churches because it is clear that information dissemination is a problem among church leaders. Church leaders should use the Sunday pack for guidance on topics to be covered under HIV/AIDS so that they can share the same and correct information with their congregation about HIV/AIDS. The Sunday pack should also be revised to cover issues of care and support or there could also be a manual that guides churches with clear objectives that they need to achieve in the fight against HIV/AIDS. The manual should also include resources needed to achieve the expected objectives and activities that can be implemented by churches, so that churches could just choose among them depending on their capacity.

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